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NASPO ValuePoint

PARTICIPATING ADDENDUM

THIRD PARTY LIABILITY SERVICES (2021-2023)

Led by the State of Georgia

Master Agreement #: 99999-NVP-DCH0000120-0001

Contractor: Health Management Systems, Inc.

Participating Entity: STATE OF MISSISSIPPI

Master Agreement Terms and Conditions:

1. **Scope**: This Participating Addendum covers the Third Party Liability Services Master Agreement led by the State of Georgia for use by state agencies and other entities located in the Participating State authorized by that State's statutes to utilize State contracts with the prior approval of the State's Chief Procurement Official.

2. **Participation:** This NASPO ValuePoint Master Agreement may be used by any state agency, institution of higher education, political subdivision or other entity authorized to use statewide contracts in the State of Mississippi ("Purchasing Entity"). Purchasing Entities shall have the same rights under the Master Agreement as Participating Entities. Issues of interpretation and eligibility for participation are solely within the authority of the State Chief Procurement Official and, if applicable, the State Chief Information Officer.

3. **Primary Contacts:** The following (or their named successors) are the primary contact individuals for this Participating Addendum:

Contractor

Name:	Health Management Systems, Inc.
Address:	5615 High Point Drive, Irving, TX 75038
Telephone:	404-290-2020
Fax:	469-359-4413
Email:	James.Finley@gainwelltechnologies.com

Participating Entity:

Name:	Brittney Thompson, Deputy Executive Director, MSDFA
Address:	501 North West Street, Suite 1300. Jackson, MS 39205
Telephone:	601-359-3446
Fax:	
Email:	Brittney.thompson@dfa.ms.gov

4. **Modifications to the Master Agreement and Additional Terms and Conditions:** Changes modifying or supplementing the Master Agreement and any additional terms and conditions, if

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any, are included as Attachment A to this Participating Addendum, which is hereby incorporated by this reference. These modifications and/or additions apply only to actions and relationships with the Participating Entity and/or Purchasing Entities referenced under Paragraph 2 of this Participating Addendum.

5. **Statement of Work:** A Statement of Work specific to the Participating Entity's engagement shall be negotiated and executed by Contractor and Participating Entity as provided in the Master Agreement. Such Statement of Work shall be incorporated into this Participating Addendum as Attachment B.

6. **Termination of this Participating Addendum:**

   A. **Immediate Termination**. The Participating Entity may terminate the Participating Addendum for any one or more of the following reasons effective immediately, absolutely, and without advance notice:

      i. In the event the Contractor is required to be certified or licensed as a condition precedent to providing goods and services, the revocation or loss of such license or certification may result in immediate termination of the Participating Addendum effective as of the date on which the license or certification is no longer in effect;

      ii. The Participating Entity determines that the actions, or failure to act, of the Contractor, its agents, employees or subcontractors have caused, or reasonably could cause, life, health or safety to be jeopardized;

      iii. The Contractor fails to comply with confidentiality laws or provisions;

      iv. The Contractor furnished any statement, representation or certification in connection with the Master Agreement, Participating Addendum, or the bidding process which is materially false, deceptive, incorrect or incomplete;

      v. If the Participating Entity determines that adequate funds are de-appropriated such that the Participating Entity cannot fulfill its obligations under the Participating Addendum, which determination is at the Participating Entity's sole discretion and shall be conclusive.

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B. **Termination for Cause.** The occurrence of any one or more of the following events shall constitute cause for the Participating Entity to declare the Contractor in default of its obligations under this Participating Addendum:

i. The Contractor fails to deliver or has delivered nonconforming goods or services or fails to perform, to the Participating Entity's satisfaction, any material requirement or is in violation of a material provision, including, but without limitation, the express warranties made by the Contractor;

ii. The Participating Entity determines that satisfactory performance of the Participating Addendum is substantially endangered or that a default is likely to occur;

iii. The Contractor fails to make substantial and timely progress toward performance of the Participating Addendum;

iv. The Contractor becomes subject to any bankruptcy or insolvency proceeding under federal or state law to the extent allowed by applicable federal or state law including bankruptcy laws; the Contractor terminates or suspends its business; or the Participating Entity reasonably believes that the Contractor has become insolvent or unable to pay its obligations as they accrue consistent with applicable federal or state law;

v. The Contractor has failed to comply with applicable federal, state and local laws, rules, ordinances, regulations and orders when performing within the scope of the Participating Addendum;

vi. The Contractor has engaged in conduct that has exposed or may expose the Participating Entity to liability, as determined in the Participating Entity's sole discretion; or

vii. The Contractor has infringed any patent, trademark, copyright, trade dress or any other intellectual property rights of the Participating Entity or a third party.

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C. **Notice of Default.** If there is a default event caused by the Contractor, the Participating Entity shall provide written notice to the Contractor requesting that the breach or noncompliance be remedied within the period of time specified in the Participating Entity's written notice to the Contractor. If the breach or noncompliance is not remedied within the period of time specified in the written notice, the Participating Entity may:

i. Immediately terminate the Participating Addendum without additional written notice; and/or
ii. Procure substitute goods or services from another source and charge the difference in cost between the Participating Addendum and the substitute contract to the defaulting Contractor; and/or,
iii. Enforce the terms and conditions of the Participating Addendum and seek any legal or equitable remedies.

D. **Payment Limitation in Event of Termination.** In the event of termination of the Participating Addendum for any reason by the Participating Entity, the Participating Entity shall pay only those amounts, if any, due and owing to the Contractor for goods and services actually rendered up to and including the date of termination of the Participating Addendum and for which the Participating Entity is obligated to pay pursuant to the Participating Addendum or Purchase Instrument. Contractor shall be permitted to continue to invoice for services provided up to and including the date of termination for a period of 120 calendar days thereafter. Contractor shall not initiate any new collection claims during the 120 calendar day period following termination. At the close of the 120-calendar day period, Contractor shall not be paid for further collection of outstanding claims and the full amount of subsequent recoveries shall revert to the Participating Entity. Payment will be made only upon submission of invoices and proper proof of the Contractor's claim. This provision in no way limits the remedies available to the Participating Entity under the Participating Addendum in the event of termination. The Participating Entity shall not be liable for any costs incurred by the Contractor in its performance of the Participating Addendum, including, but not limited to, startup costs, overhead or other costs associated with the performance of the Participating Addendum.

E. **The Contractor's Termination Duties.** Upon receipt of notice of termination or upon request of the Participating Entity, the Contractor shall:

i. Subject to the Run Out Period, cease work under the Participating Addendum and take all necessary or appropriate steps to limit disbursements and minimize costs, and furnish a report within thirty (30) days of the date of notice of termination, describing the status of all work under the Participating Addendum, including,

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without limitation, results accomplished, conclusions resulting therefrom, and any other matters the Participating Entity may require;

ii. Immediately cease using and return to the Participating Entity, any personal property or materials, whether tangible or intangible, provided by the Participating Entity to the Contractor;

iii. Comply with the Participating Entity's instructions for the timely transfer of any active files and work product produced by the Contractor under the Participating Addendum;

iv. Cooperate in good faith with the Participating Entity, its employees, agents and contractors during the transition period between the notification of termination and the substitution of any replacement contractor; and

v. Immediately return to the Participating Entity any payments made for goods and services that were not delivered or rendered by the Contractor.

7. **Orders:** Any order placed by a Participating Entity or Purchasing Entity for a service available from this Master Agreement shall be deemed to be a sale under (and governed by the prices and other terms and conditions of) the Master Agreement unless the parties to the order agree in writing that another contract or agreement applies to such order. Unless expressly set forth herein, the Master Agreement referenced at the top of this Participating Addendum is incorporated herein by reference.

(signatures on following page)

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NASPO ValuePoint

PARTICIPATING ADDENDUM

THIRD PARTY LIABILITY SERVICES (2021-2023)

Led by the State of Georgia

IN WITNESS WHEREOF, the parties have executed this Participating Addendum as of the date of execution by both parties below.

Participating Entity:	Contractor:
State of Mississippi	Health Management Systems, Inc.
Signature: 	Signature: DocuSigned by: Mark Knickrehm 4EE6B8D6856646D...
Name: Brittney Thompson	Name: Mark Knickrehm
Title: Deputy Executive Director, MSDFA	Title: President and CEO
Date: 11/9/23	Date: November 7, 2023

[Additional signatures may be added if required by the Participating Entity]

For questions regarding NASPO ValuePoint Participating Addendums, please contact the Cooperative Contract Coordinator team at info@naspovaluepoint.org.

Fully executed NASPO ValuePoint Participating Addendums must be submitted via email in PDF format to pa@naspovaluepoint.org.

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Attachment A
"Modifications to the Master Agreement and Additional Terms and Conditions"

APPLICABLE LAW
The contract shall be governed by and construed in accordance with the laws of the State of Mississippi, excluding its conflicts of laws provisions, and any litigation with respect thereto shall be brought in the courts of the State. Contractor shall comply with applicable federal, state, and local laws and regulations.

APPROVAL
It is understood that if this contract requires approval by the Public Procurement Review Board and/or the Mississippi Department of Finance and Administration Office of Personal Service Contract Review, and this contract is not approved by the PPRB and/or OPSCR, it is void and no payment shall be made hereunder. This contract was approved by the Public Procurement Review Board on 02/01/2023.

PAYMODE
Payments by state agencies using the State's accounting system shall be made and remittance information provided electronically as directed by the State. These payments shall be deposited into the bank account of Contractor's choice. The State may, at its sole discretion, require Contractor to electronically submit invoices and supporting documentation at any time during the term of this Agreement. Contractor understands and agrees that the State is exempt from the payment of taxes. All payments shall be in United States currency.

TERMINATION

A. Any party may terminate the contract in whole or in part with 90 days written notice to the other party(ies). Contractor shall stop work to the extent specified and incur no further obligations in connection with the terminated work on the date set in the Notice of Termination. Contractor must still complete the work not terminated by the notice of termination and may incur obligations as are necessary to do so. Payment for completed services delivered and accepted by the State shall be at the contract price. In the event of a termination for convenience or upon expiration of the Participating Addendum, Contractor shall be entitled to continue to invoice and be paid for recoveries for a period of 120 calendar days thereafter for work performed up to and including the effective date of termination or expiration (the "Run-Out Period").

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STOP WORK ORDER

(1) *Order to Stop Work:* The Participating Entity, may, by written order to Contractor at any time, and without notice to any surety, require Contractor to stop all or any part of the work called for by this contract. This order shall be for a specified period not exceeding 90 days after the order is delivered to Contractor, unless the parties agree to any further period. Any such order shall be identified specifically as a stop work order issued pursuant to this clause. Upon receipt of such an order, Contractor shall forthwith comply with its terms and take all reasonable steps to minimize the occurrence of costs allocable to the work covered by the order during the period of work stoppage. Before the stop work order expires, or within any further period to which the parties shall have agreed, the Participating Entity shall either:

(a) cancel the stop work order; or,

(b) terminate the work covered by such order as provided in the Termination for Default clause or the Termination for Convenience clause of this contract.

(2) *Cancellation or Expiration of the Order:* If a stop work order issued under this clause is canceled at any time during the period specified in the order, or if the period of the order or any extension thereof expires, Contractor shall have the right to resume work. An appropriate adjustment shall be made in the delivery schedule or Contractor price, or both, and the contract shall be modified in writing accordingly, if:

(a) the stop work order results in an increase in the time required for, or in Contractor's cost properly allocable to, the performance of any part of this contract; and,

(b) Contractor asserts a claim for such an adjustment within 30 days after the end of the period of work stoppage; provided that, if the Participating Entity decides that the facts justify such action, any such claim asserted may be received and acted upon at any time prior to final payment under this contract.

(3) *Termination of Stopped Work:* If a stop work order is not canceled and the work covered by such order is terminated for default or convenience, the reasonable costs resulting from the stop work order shall be allowed by adjustment or otherwise.

(4) *Adjustments of Price:* Any adjustment in contract price made pursuant to this clause shall be determined in accordance with Master Agreement **99999-NVP-DCH0000120-0001**.

AVAILABILITY OF FUNDS

It is expressly understood and agreed that the obligation of the Participating Entity to proceed under this agreement is conditioned upon the appropriation of funds by the Mississippi State Legislature and the receipt of state and/or federal funds. If the funds anticipated for the

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continuing time fulfillment of the agreement are, at any time, not forthcoming or insufficient, either through the failure of the federal government to provide funds or of the State of Mississippi to appropriate funds or the discontinuance or material alteration of the program under which funds were provided or if funds are not otherwise available to the Participating Entity, the Participating Entity shall have the right upon ten (10) working days written notice to Contractor, to terminate this agreement without damage, penalty, cost or expenses to the Participating Entity of any kind whatsoever other than payment of fees pursuant to the Run-Out Period. The effective date of termination shall be as specified in the notice of termination.

COMPLIANCE WITH LAWS

Contractor understands that the State of Mississippi is an equal opportunity employer and therefore, maintains a policy which prohibits unlawful discrimination based on race, color, creed, sex, age, national origin, physical handicap, disability, genetic information, or any other consideration made unlawful by federal, state, or local laws. All such discrimination is unlawful and Contractor agrees during the term of the agreement that Contractor will strictly adhere to this policy in its employment practices and provision of services. Contractor shall comply with, and all activities under this agreement shall be subject to, all applicable federal, State of Mississippi, and local laws and regulations, as now existing and as may be amended or modified.

PROCUREMENT REGULATIONS

The contract shall be governed by the applicable provisions of the *Mississippi Public Procurement Review Board Office of Personal Service Contract Review Rules and Regulations*, a copy of which is available at 501 North West Street, Suite 701E, Jackson, Mississippi 39201 for inspection, or downloadable at http://www.DFA.ms.gov.

REPRESENTATION REGARDING CONTINGENT FEES

Contractor represents that it has not retained a person to solicit or secure a state contract upon an agreement or understanding for a commission, percentage, brokerage, or contingent fee, except as disclosed in Contractor's bid or proposal.

REPRESENTATION REGARDING GRATUITIES

The bidder, offeror, or Contractor represents that it has not violated, is not violating, and promises that it will not violate the prohibition against gratuities set forth in Section 6-204 (Gratuities) of the Mississippi Public Procurement Review Board Office of Personal Service Contract Review Rules and Regulations.

TRADE SECRETS, COMMERCIAL AND FINANCIAL INFORMATION

It is expressly understood that Mississippi law requires that the provisions of this contract which contain the commodities purchased or the personal or professional services provided, the price

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to be paid, and the term of the contract shall not be deemed to be a trade secret or confidential commercial or financial information and shall be available for examination, copying, or reproduction.

E-PAYMENT
Contractor agrees to accept all payments in United States currency via the State of Mississippi's electronic payment and remittance vehicle. The agency agrees to make payment in accordance with Mississippi law on "Timely Payments for Purchases by Public Bodies," which generally provides for payment of undisputed amounts by the agency within forty-five (45) days of receipt of invoice. Mississippi Code Annotated § 31-7-301 *et seq.*

E-VERIFICATION
If applicable, Contractor represents and warrants that it will ensure its compliance with the Mississippi Employment Protection Act of 2008, and will register and participate in the status verification system for all newly hired employees. Mississippi Code Annotated §§ 71-11-1 *et seq.* The term "employee" as used herein means any person that is hired to perform work within the State of Mississippi. As used herein, "status verification system" means the Illegal Immigration Reform and Immigration Responsibility Act of 1996 that is operated by the United States Department of Homeland Security, also known as the E-Verify Program, or any other successor electronic verification system replacing the E-Verify Program. Contractor agrees to maintain records of such compliance. Upon request of the State and after approval of the Social Security Administration or Department of Homeland Security when required, Contractor agrees to provide a copy of each such verification. Contractor further represents and warrants that any person assigned to perform services hereafter meets the employment eligibility requirements of all immigration laws. The breach of this agreement may subject Contractor to the following:

1) termination of this contract for services and ineligibility for any state or public contract in Mississippi for up to three (3) years with notice of such cancellation/termination being made public;
2) the loss of any license, permit, certification or other document granted to Contractor by an agency, department or governmental entity for the right to do business in Mississippi for up to one (1) year; or,
3) both.

In the event of such cancellation/termination, Contractor would also be liable for any additional costs incurred by the State due to Contract cancellation or loss of license or permit to do business in the State.

TRANSPARENCY
This contract, including any accompanying exhibits, attachments, and appendices, is subject to the "Mississippi Public Records Act of 1983," and its exceptions. See Mississippi Code Annotated

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§§ 25-61-1 *et seq.* and Mississippi Code Annotated § 79-23-1. In addition, this contract is subject to the provisions of the Mississippi Accountability and Transparency Act of 2008. Mississippi Code Annotated §§ 27-104-151 *et seq*. Unless exempted from disclosure due to a court-issued protective order, a copy of this executed contract is required to be posted to the Mississippi Department of Finance and Administration's independent agency contract website for public access at http://www.transparency.mississippi.gov. Information identified by Contractor as trade secrets, or other proprietary information, including confidential vendor information or any other information which is required confidential by state or federal law or outside the applicable freedom of information statutes, will be redacted.

SEVERABILITY

If any part, term or provision of this Participating Addendum (including items incorporated by reference) is held by the courts or other judicial body to be illegal or in conflict with any law of the State of Mississippi or any Federal law, the validity of the remaining portions or provisions shall not be affected and the obligations of the parties shall be construed in full force as if the contract did not contain that particular part, term or provision held to be invalid.

WAIVER

No assent, expressed or implied, by the parties hereto to the breach of the provisions or conditions of this Participating Addendum, inclusive of any SOW, shall be deemed or taken to be a waiver of any succeeding breach of the same or any other provision or condition and shall not be construed to be a modification of the terms of this Participating Addendum or any subsequent SOW.

Moreover, no delay or omission by either party to this Participating Addendum or SOW in exercising any right, power, or remedy hereunder or otherwise afforded by contract, at law, or in equity shall constitute an acquiescence therein, impair any other right, power or remedy hereunder or otherwise afforded by any means, or operate as a waiver of such right, power, or remedy. No waiver by either party to this Participating Addendum or SOW shall be valid unless set forth in writing by the party making said waiver. No waiver of or modification to any term or condition of this Participating Addendum or SOW shall void, waive, or change any other term or condition. No waiver by one party to this Participating Addendum or SOW of a default by the other party shall imply, be construed as or require waiver of future or other defaults.

RECORDS RETENTION

The Contractor shall maintain detailed records evidencing all expenses incurred pursuant to the Contract, the provision of services under the Contract, and complaints, for the purpose of audit and evaluation by DOM and other Federal or State personnel. All records, including training records, pertaining to the contract must be readily retrievable within ten (10) business days for

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review at the request of DOM and its authorized representatives. All records shall be maintained and available for review by authorized federal and State personnel during the entire term of the Contract and for a period of seven (7) years thereafter, unless an audit is in progress or there is pending litigation. The right to audit shall exist for seven (7) years from the final date of the contract period or from the date of completion of any audit or litigation, whichever is later.

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Attachment B

Scope of Work (SOW) – Mississippi Division of Medicaid Third Party Liability (TPL) Services

Table of Contents

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1.0 MISSISSIPPI TPL SCOPE OF WORK

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1.1 Work Plan: Medical and Pharmacy TPL Data Matching and Identification

HMS's Approach to Data Matching

HMS's approach to identifying other health insurance coverage (and providing cost avoidance services to our clients) for Mississippi Medicaid members is comprehensive, technically sound, and consistently proven effective with our large client base. Our unique ability to engage third-party payers, amass their eligibility data into a national database, match DOM data to this resource, and identify both exact (e.g., five-point matches) and near matches all confirm DOM succeeds in identifying new coverage for Medicaid Members.

Our TPL data match (identification) solution is already in place for DOM and is flexible, comprehensive, and innovative. Features in our data match approach include the following:

Comprehensive National Eligibility Database (NEDB)

HMS's NEDB is one of the largest commercial datasets in the United States for identifying other health coverage for Medicaid members. This highly accurate and continuously updated database houses more than 1.5 billion insurance carrier-eligibility records from approximately 1,250 payers across the United States. Through this dataset, we can verify an average of 11 million insurance policy segments per month covering 1 million current Mississippi residents.

Vast Data Sharing Network

HMS's success in identifying the availability of other coverage for DOM lies in our ability to obtain eligibility information from our vast data-sharing network that extends well beyond the top commercial insurance carriers in Mississippi. This network includes local, regional, and national commercial healthcare payers, third party administrators (TPAs), pharmacy benefit managers (PBMs), and federal programs, such as TRICARE and Medicare Advantage and Part D plans, when relevant to client needs.

We currently receive eligibility data from payers covering more than 90% of Mississippi's insured residents. The breadth of our network allows us to increase recoveries and reduce cost for DOM. We will continue to build relationships to actively recruit new carriers and establish data exchanges with new information sources that would add value for DOM.

Our Data Sharing Agreements available for use for Mississippi explicitly allow the use of carrier data to support Medicaid TPL services.

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HMS's Data Match Process to Identify TPL

We illustrate the HMS data match approach to TPL identification in **Figure Appendix 1-2** and describe the process and steps in more detail below.

Figure Appendix 1-2 HMS's TPL Data Match (Identification) Process for DOM
HMS's industry-best data match resources maximize TPL identification for DOM

Incoming DOM Data (Via SFTP Site)

HMS can receive Medicaid files from DOM without any reformatting or reprogramming. **Table Appendix 1-3** describes all of the DOM data files currently received by HMS, and their utilization to fulfill TPL project needs.

Table Appendix 1-3 DOM Data Files
HMS's TPL project experience includes familiarity with all project-related data

File Name	Description
Carrier File	The Carrier File is the master file that contains all of the commercial carrier codes available to DOM. These codes enable HMS to develop a crosswalk between the State's carrier data and the data available in the HMS NEDB.
Medicaid Eligibility File (MEF)	The MEF provides monthly Medicaid member eligibility information. HMS uses this file to match eligibility with commercial coverage information provided by DOM and the HMS NEDB; we reformat the data to update the HMS Eligibility Master File.
Resource File	The Resource File provides the commercial insurance coverage data that DOM has on file for Medicaid members. HMS reformats the resource file data, which provides updated commercial segments to the HMS Eligibility Master File. HMS regularly reviews the Resource File to identify carriers for which HMS does not receive data directly, such as Kaiser, and determine billing opportunities.
Paid Claims File	The Paid Claims File provides original and adjusted claims history for fee-for-service claims each month. HMS reformats the data to update the HMS cumulative Paid Claims File.
Provider File	The Provider File provides an update of all Medicaid provider information, including each provider's National Provider Identifier and contact information. HMS uses the data to populate the provider information on direct bill claims or provider listings.
TBQ File	The TBQ file includes additional Medicare entitlement information, including Medicare Part D enrollment data. HMS uses the information to verify entitlement and enrollment information we reformat the data to update the HMS Eligibility Master file.

PERFORM DATA MATCH (IMATCH)

Once HMS receives, validates, and compiles third party payer enrollment and coverage data into our NEDB, we will perform data matching to identify Medicaid recipients with other, third party health insurance coverage. HMS deploys data matching technology on commercial insurance carrier and Medicaid eligibility data, comparing the two datasets for like individuals.

The iMatch process applies more than 130 exclusive algorithms successively, resulting in comprehensive, validated identification of other coverage. Through iMatch, we can assess the integrity of each match and take the steps necessary to investigate near-matches for confirmation or discard. Our compliance analysis, which relies on reported mismatches, proves that iMatch (together with our post-match rules), results in 99.99% match accuracy.

Table Appendix 1-4 provides an example of the types of matches we can detect and confirm through iMatch that most match processes would miss.

Table Appendix 1-4 Sample TPL Match and Results via iMatch
iMatch correctly determines that these two records are for the same individual, even where several data elements are unequal across eligibility files

Medicaid File	Carrier File	Results of Match
Elizabeth	Liz	First name variation
J		Data absent in one file
Kramer	Kramer-Smith	Near match
123 Main St.	123 N. Main St.	Near match
Jackson	Jackson	Exact match
MS	MS	Exact match
39207	80227	ZIP code is different
601.222.3331	601.223.3331	Near match
2/22/1958	2/20/1958	Near match

IDENTIFYING MEDICARE COVERAGE

For our current process, HMS receives the TBQ file on a monthly basis in using this data, we can identify precisely what types of coverage, including Parts A, B, and C, a Medicare beneficiary possesses. We load the consolidated Medicare Coverage File into NEDB and use it to match against the DOM's Medicaid Eligibility File to identify participants covered by both Medicaid and Medicare through a process similar to that described for commercial insurance matches.

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1.2 HMS's Verification Process Enhances Our Data Match Results

Our approach to TPL verification includes the following key features:

- **Multiple processes for validating results.** Before we deliver information to DOM, we work with carriers and payers, applying the most reliable and efficient method to fully validate our match results.
- **Effective infrastructure.** HMS's verification engine supports our verification approach across all payer types—from large national carriers to Mississippi-specific TPAs, unions, and other types of specialty carriers, regardless of their electronic-transmittal capabilities.
- **Rigorous QA processes and standards.** Our QA standards at both the front and back ends of the coverage-verification process generate accurate and complete results.

The Importance of TPL Verification/Validation

Our systems receive eligibility information from the "raw" data sent from TPAs and insurance carriers. It is important to note the information received from these third parties is accurate as of the date the eligibility file HMS receives is created by the carrier. After verifying each policy, HMS identifies if the information received on the carrier's eligibility file is the most up to date and accurate. If we cannot fully verify the information, then we do not deliver the policy to DOM for use in cost avoidance.

HMS's Verification Process Maximizes TPL Recovery Value

Following our complex proprietary data matching algorithms to identify TPL policy leads, we validate this information directly with payers before delivering the data to providers and ultimately to DOM – maximizing savings results.

We illustrate our HMS TPL Verification approach in the process steps included in **Figure Appendix 1-5** and described below.

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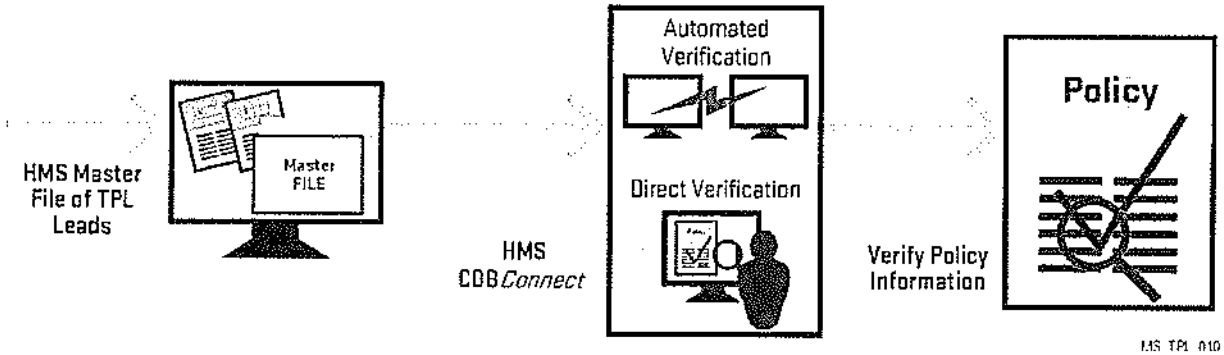
Figure Appendix 1-5 HMS's Process for DOM TPL Verification
HMS's industry-best automated and manual verification resources maximize costa avoidance value for DOM



HMS's Verification Services

Our methods for verifying coverage with payers include direct outreach, American National Standards Institute (ANSI) 270/271 transactions, automated web agents, and source-data validation, all of which work in concert with one another to return reliable and complete information to DOM as quickly as possible.

HMS will send TPL add and update data files for upload into MESA on a weekly basis. Each Friday, we transmit through an agreed-on layout using MESA's SFTP server to protect the security and integrity of the data. Once transferred, we process the file into MESA for utilization in cost avoidance processing. HMS monitors the loads into MESA through load and error reports, reviews the reports for correction and reload opportunities.

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METHOD OF BILLING (INVOICING) FOR DATA MATCH (IDENTIFICATION)

After the close of each calendar month, HMS will provide DOM with a report that details for each week the number of policies delivered, the number of policies rejected, and the net number of policies accepted into MESA. A sample of such a monthly report is below in **Figure Appendix 1-6.**

Figure Appendix 1-6 HMS Monthly Detailed MESA Policy Acceptance Report
Providing DOM the visibility it needs into MESA's policy acceptance, provides transparency

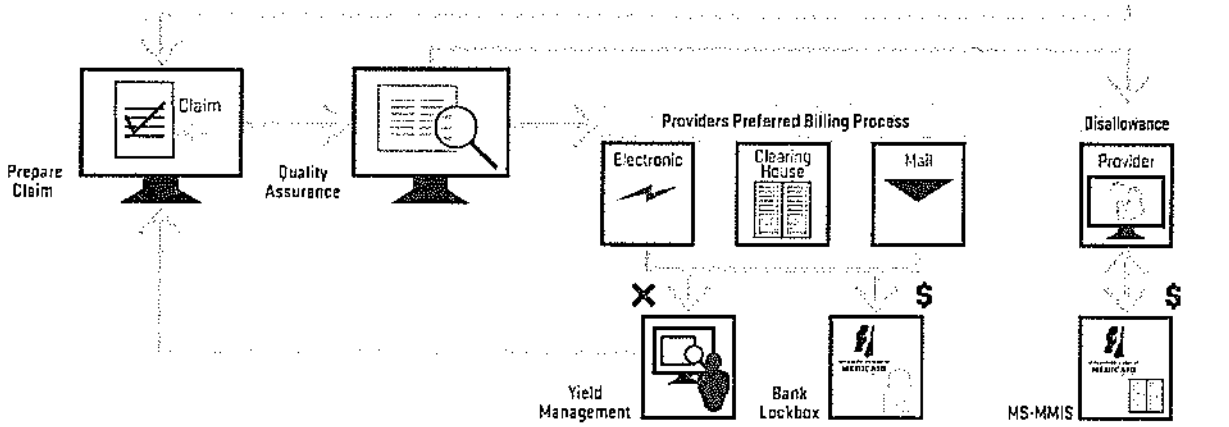
Date	CAV Deliverables	Items Rejected	Uploaded to MESA
5/5/2023	4,540	547	3,993
5/12/2023	770	238	532
5/19/2023	2,763	222	2,541
5/26/2023	2999	408	2591
Total	11,072	1,415	9,657

***NOTE:** The Defense Enrollment Eligibility Reporting System (DEERS) has been on hold for a few years. When DEERS is restored, HMS shall conduct an annual electronic data match with DEERS in accordance with the date and file formatting required by DEERS. The DEERS online data system shall be used in conjunction with the annual file.

1.3 Work Plan: Commercial Insurance and Provider Disallowance TPL Recovery

We will pursue commercial TPL recovery activities through two methodologies: direct commercial insurance billing and the provider disallowance process, shown at a high level in **Figure Appendix 1-7.**

Figure Appendix 1-7 HMS's Commercial Insurance Direct Billing and Provider Commercial Insurance Disallowance Processes
We leverage our expertise to select Medicaid claims and bill them to the appropriate liable third party in a secure and efficient manner



We will use each of these methods in a manner that maximizes recoveries and minimizes provider and carrier abrasion.

- **The commercial insurance billing process** involves submitting Medicaid reclamation claims directly to the insurance carrier electronically, through a clearinghouse, or if needed, through paper processes.
- **The provider disallowance process** engages providers for high dollar claims and claims within filing deadlines. The process allows the provider to bill and receive payment from the appropriate payer prior to DOM recoupment.

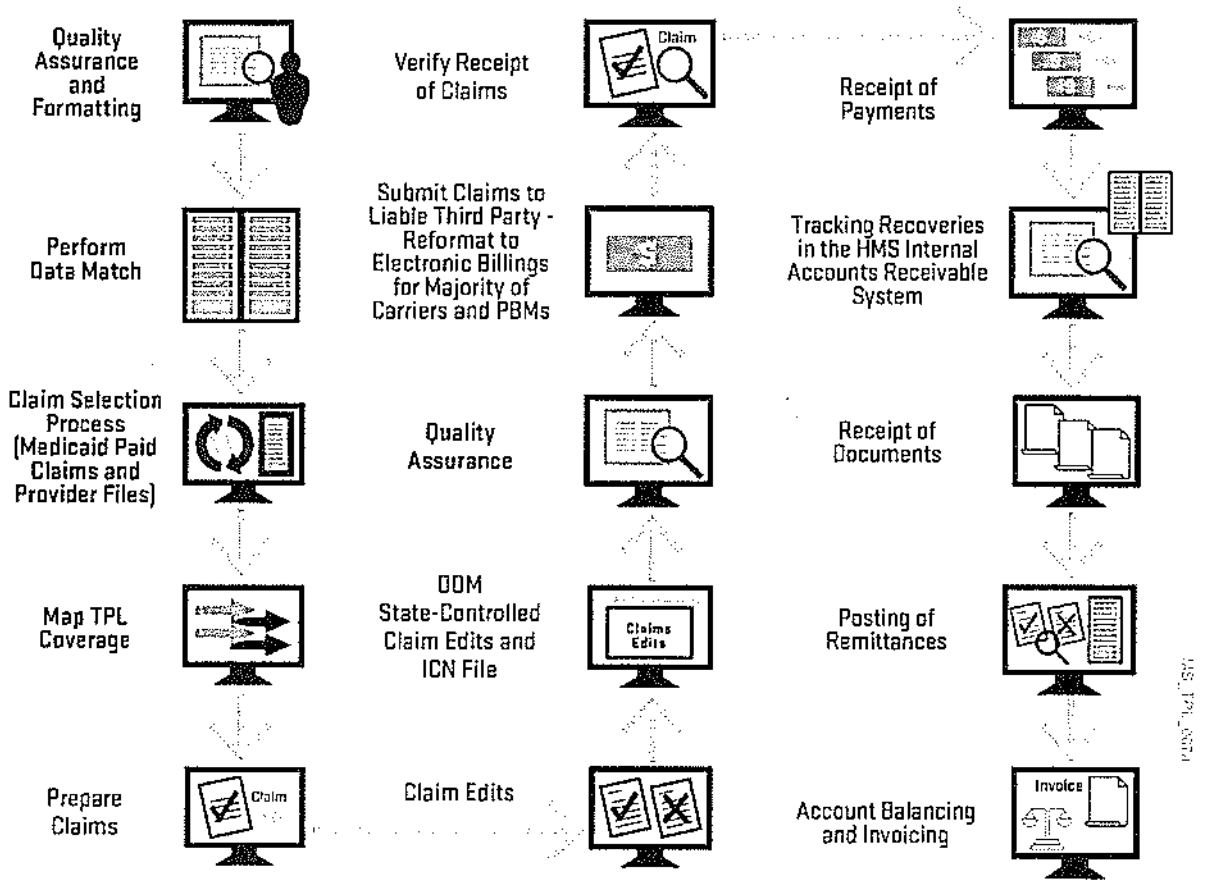
Direct Claims Billing of Liable Third Parties

HMS's approach incorporates Mississippi-specific claim-level edits and validation checks to eliminate claim populations identified by DOM as exempt from the reclamation process. We will continue the successful practices and issue monthly billings to commercial carriers on behalf of DOM.

Figure Appendix 1-8 reflects our commercial insurance direct billing process.

Figure Appendix 1-8 HMS's Commercial Insurance Direct Billing Process for DOM.

HMS's streamlined direct billing process maximizes recoveries for DOM



Selecting Claims After Identification

Using the current data match from our identification process, HMS will perform a match to the cumulative DOM-paid claims history file. We modify this data repository of all DOM claims, after receipt of the monthly paid claims file. This particular match process enables us to identify those claims paid for by Medicaid during the last three years for which a third party may be liable.

Preparing Claims

HMS employs effective and verified billing processes to provide timely and accurate claim submission. Our billing protocols make sure we can prepare and submit Medicaid TPL claims to liable third parties in accordance with all federal and state regulations.

Applying Claim Edits

We program all claim level edits according to client- and carrier-specific requirements and policies. Some examples of claim level edits include procedure codes, procedure modifiers, facility types, rate codes, and claims associated with certain recipients and/or providers.

Our claim-level checks also prepare the claims in the correct format for the carrier to process and perform validation checks against the Provider Demographic File, National Drug Code listing, and ICD-9/10 code

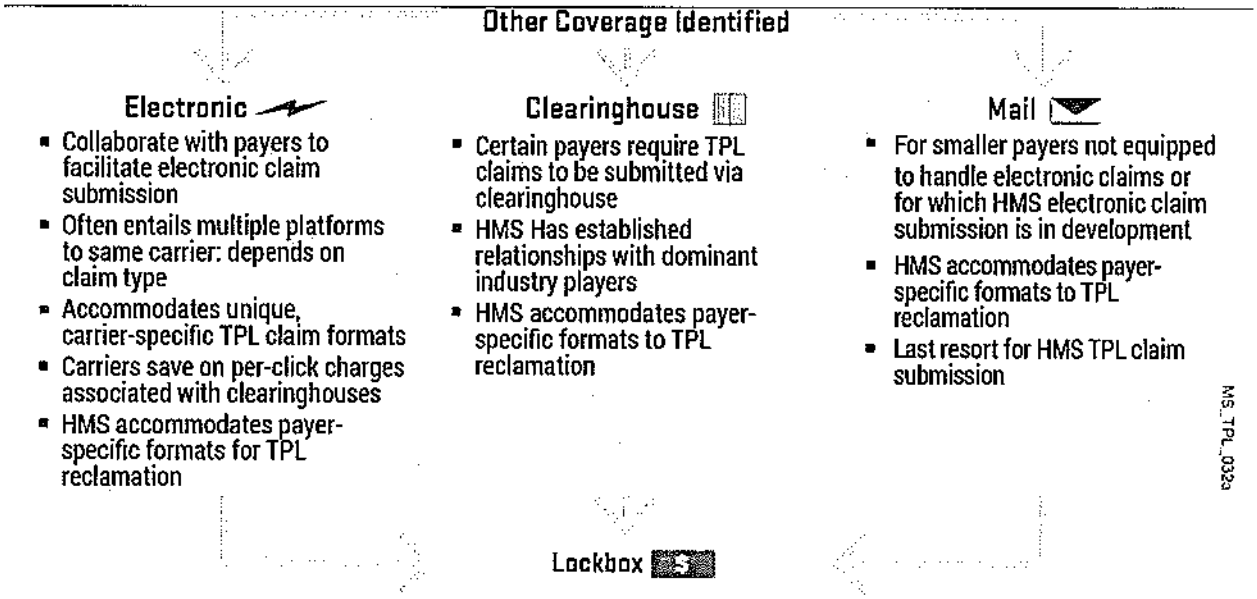
sets, among others, to check that all entities and medical or pharmacy codes are valid.

SUBMIT CLAIMS/BILLINGS TO LIABLE THIRD PARTY

For commercial carriers and other payers, HMS will prepare and submit electronic or paper billings to payers using a variety of methods. We will select the most appropriate method as per the insurance carrier, ensuring their acceptance and resulting in payment or actionable denial.

Figure Appendix 1-9 describes our three direct-billing methods.

Figure Appendix 1-9 HMS's TPL Billing Methods.
HMS selects the most appropriate billing method on a carrier-by-carrier basis



RECEIPT OF PAYMENTS

All claims submitted to liable third party payers by HMS on behalf of DOM include clear instructions for the payer to make checks payable to DOM at the Trustmark lockbox address. The bank sends electronic images of the checks and original related documentation received with payments to the TPL Team daily for posting to the A/R.

The following steps described our process for tracking recoveries in the HMS A/R system.

TRACKING RECOVERIES IN THE HMS INTERNAL ACCOUNTS RECEIVABLE SYSTEM

HMS uses its unique A/R system to house all billed claims and their adjudication results. Our A/R management process utilizes a balanced combination of technology and manual verification to post, track, and reconcile payments from initial receipt through monthly invoicing.

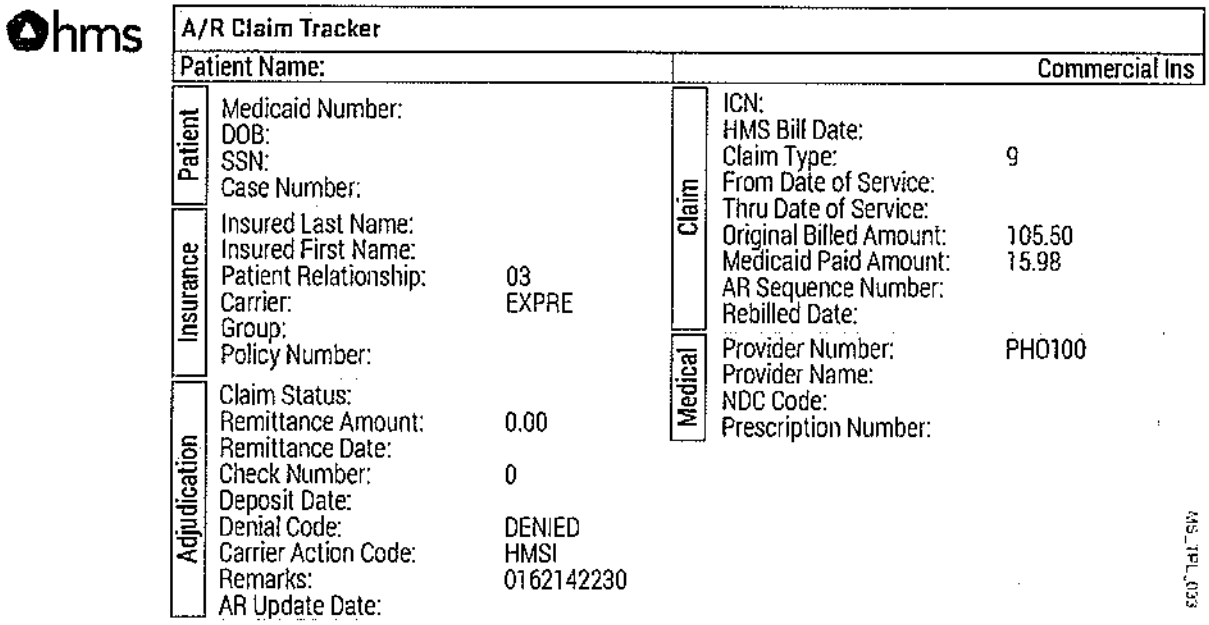
ACCOUNTS RECEIVABLE MANAGEMENT APPLICATIONS FACILITATE RECOVERY TRACKING

Our easy-to-use **A/R Claim Tracker** application allows users to view claim payment and denial status as well as to generate reports on demand. Both summary and detailed information about claims billed to

carriers by the TPL Team are available for review and report.

Figure Appendix 1-10 illustrates the level of claim detail viewable in A/R Claim Tracker.

Figure Appendix 1-10 HMS's A/R Claim Tracker: Claim Detail
Our A/R Claim Tracker application allows users to view claim payment and denial status



Receipt of Documents

Our Processing Center receives daily lockbox images on the prior day's deposits from our designated project lockbox. We process the documentation, performing the following tasks:

- Validation of deposits received to make sure that items indicated on the deposit summary are present
- Assignment of each deposit-date batch with a unique transmittal batch ID for tracking purposes
- Processing and validation of payment images and data from Trustmark

Posting of Remittances

After processing the documents, team members perform the following tasks:

- We key all line items associated with each check for that batch, capturing the check number, payer name, amount, and date.
- Our A/R team sends an email verification alert with the detailed information for each deposit date received to Electronic Data Interchange (EDI) personnel and the Invoicing team to alert them of receipt of the batch.
- Simultaneously, the A/R team updates **DocDNA** (described later in this section) with the scanned images for the specific deposit.
- For carriers who provide electronic remittances, the check still goes to the lockbox, but we upload the posting information to the A/R from the electronic file.

UPDATING THE HMS INTERNAL ACCOUNTS RECEIVABLE SYSTEM

After data entry of remittances, the following tasks occur:

- Batch-posting jobs run nightly to reconcile records from the DOM-specific repository to search for the claim associated with the Remit Record and post that record to the correct A/R.
- We then perform the following activities:
  - Change the status of these claims on the A/R from OPEN to PAID
  - Update the record with all check and payment information keyed for that specific claim
- If the batch-posting logic fails to find an appropriate claim in the A/R system, we will place the remits in an UNMATCHED status, and our invoicing team will manually key the records.

ACCOUNT BALANCING AND INVOICING

Our Invoicing Team reviews the Payment Exception Reports generated by batch posting daily to incorporate these unposted items to our A/R system. In some instances, this involves viewing a scanned image of the EOB or searching for the claim in our internal system. If our A/R team fails to identify the claim(s) to which the payment should apply, we categorize the recovery as NOT FOUND or UNIDENTIFIED PAYMENT.

COMMERCIAL AND MEDICARE DISALLOWANCE

To achieve significantly higher recovery rates, we will continue to supplement our commercial insurance direct billing process with our Medicare and commercial insurance provider recoupment process – recovery from providers with the disallowance process.

MEDICARE DISALLOWANCE

Our Medicare disallowance claims selection process, shown in **Figure Appendix 1-11** allows providers to maximize their successes when recovering payments from Medicare/Medicare MCOs. For each cycle released, we review claims for dual-eligible recipients to exclude claims not covered under Medicare Part A or Part B. Because the basic design of our Medicare recovery process places some burden on providers to bill identified claims to Medicare, it is critical we select claims in a way that maximizes the chance of payment and minimizes the resources that providers expend to comply with DOM mandates.

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COMMERCIAL DISALLOWANCE

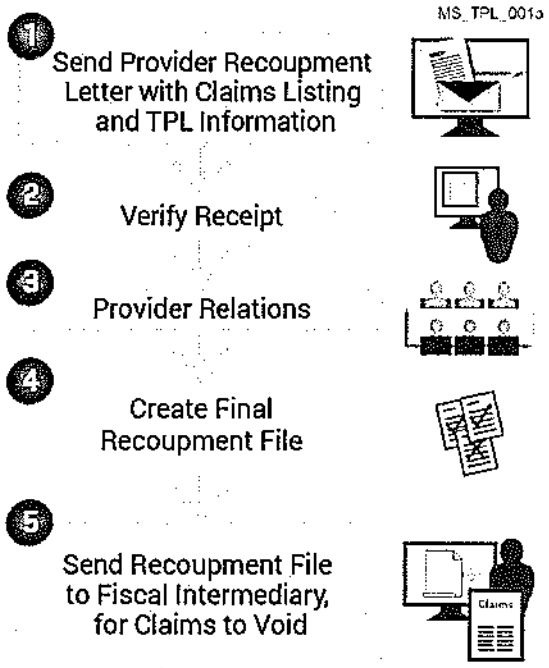
Our commercial insurance disallowance process follows the same key steps outlined in the direct billing process for claims selection and QA mentioned previously. However, instead of billing claims directly to insurance carriers, we will create and send a listing of claims for providers to submit for payment to the liable third party.

HMS validates policy coverage for all claims selected for disallowance to mitigate unnecessary work on the part of providers, loads the data into our secure, web-based Provider Portal.

The Provider Portal allows providers to communicate with HMS in real-time and monitor the status of any claims selected for review. Providers enrolled in the portal have the option to acknowledge receipt of the Disallowance Notification Letter and listing through the portal rather than by a confirmation telephone call. Providers can directly upload documentation to the Provider Portal as well as submit it by mail or fax.

Figure Appendix 1-11 HMS's Disallowance Process

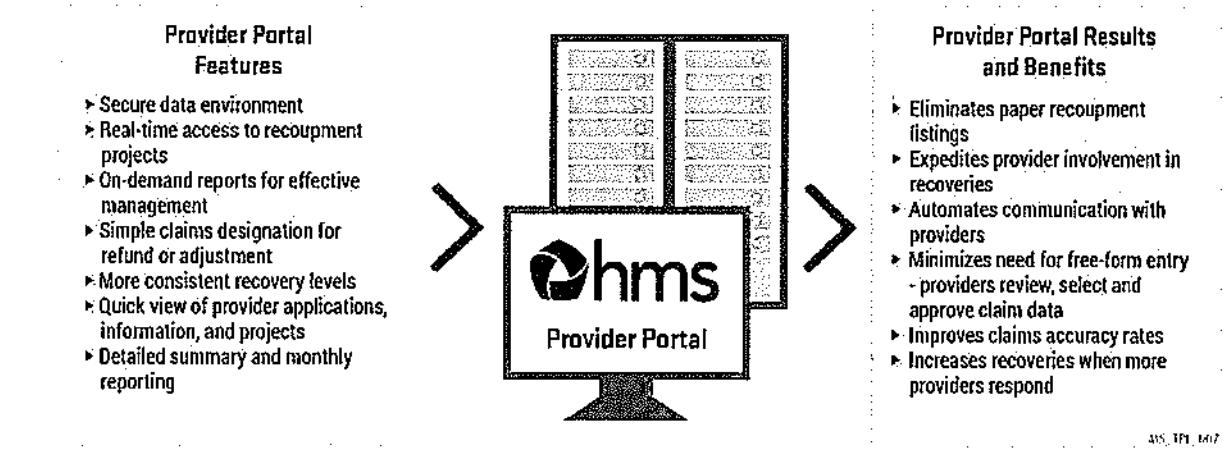
The HMS disallowance process approach for DOM has generated more than $26 million in recoveries



GENERATE RECOUPMENT CYCLE

Once we have identified claims for recovery, HMS notifies providers of the State's intent to recoup any identified Medicaid overpayments. To recover on identified claims, we will prepare and send a DOM-approved Disallowance Notification Letter along with the report of claims identified for disallowance. Along with an option to receive the listing via mail, we also will electronically send notices and claims listings through the Provider Portal (**Figure Appendix 1-12**) to providers enrolled in this option.

Figure Appendix 1-12 Features and Value of HMS's Provider Portal
Our Provider Portal makes participation in HMS's recovery and cost avoidance efforts on behalf of DOM easy for providers statewide.



This correspondence provides detailed information about our intent to recover payments on the State's behalf along with information needed to bill claims to the appropriate party. The notification package:

- Notifies providers of our intent to recover payments on DOM's behalf, citing any relevant rules or regulations
- Instructs providers on billing claims in a timely manner
- Informs providers of the 60-day Response period for submitting all refuting documentation to us as well as options for submitting this documentation
- Provides a detailed listing of claims included in the disallowance
- Lists recoupment-payment instructions
- Provides our contact information

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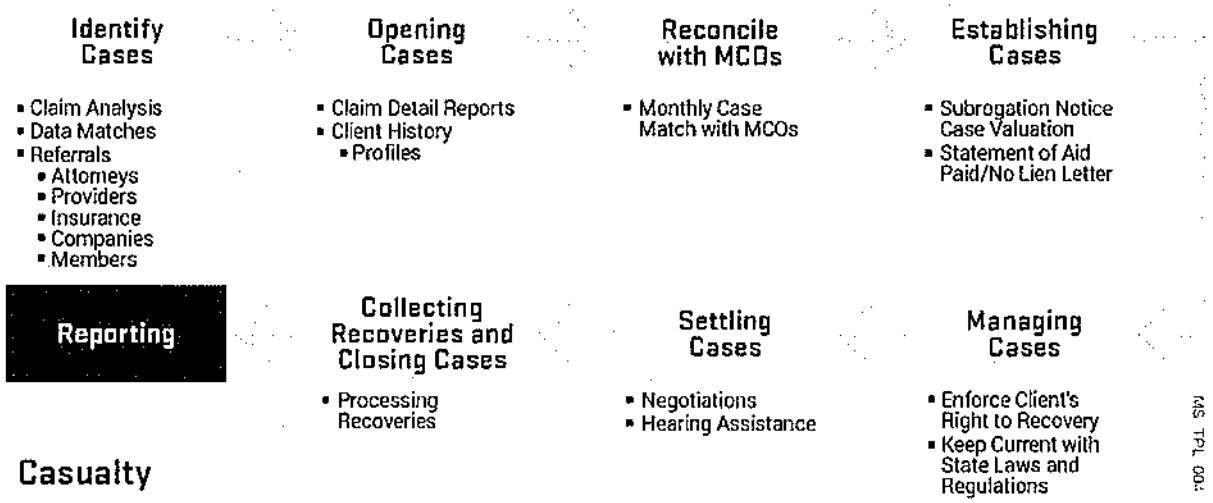
1.4 WORK PLAN: CASUALTY RECOVERY

We will employ proven processes to identify cases, and use our specialized proprietary Maestro™ case management system to manage all facets of the recovery process. Our HMS Casualty team will continue to leverage Maestro and operational infrastructure to support casualty recovery efforts.

Figure Appendix 1-13 depicts our casualty process for recoveries. Maestro streamlines the process for achieving recovery results.

Figure Appendix 1-13 HMS's Casualty Recovery Process
Our proven casualty recovery process maximizes recoveries for DOM



IDENTIFYING CASES THROUGH REFERRALS FROM ORGANIZATIONS AND ENTITIES

HMS will identify potential Casualty leads through a variety of methods including our TPL data match process as well as other data match sources; referrals from attorneys, providers, insurance companies, and participants.

REFERRALS

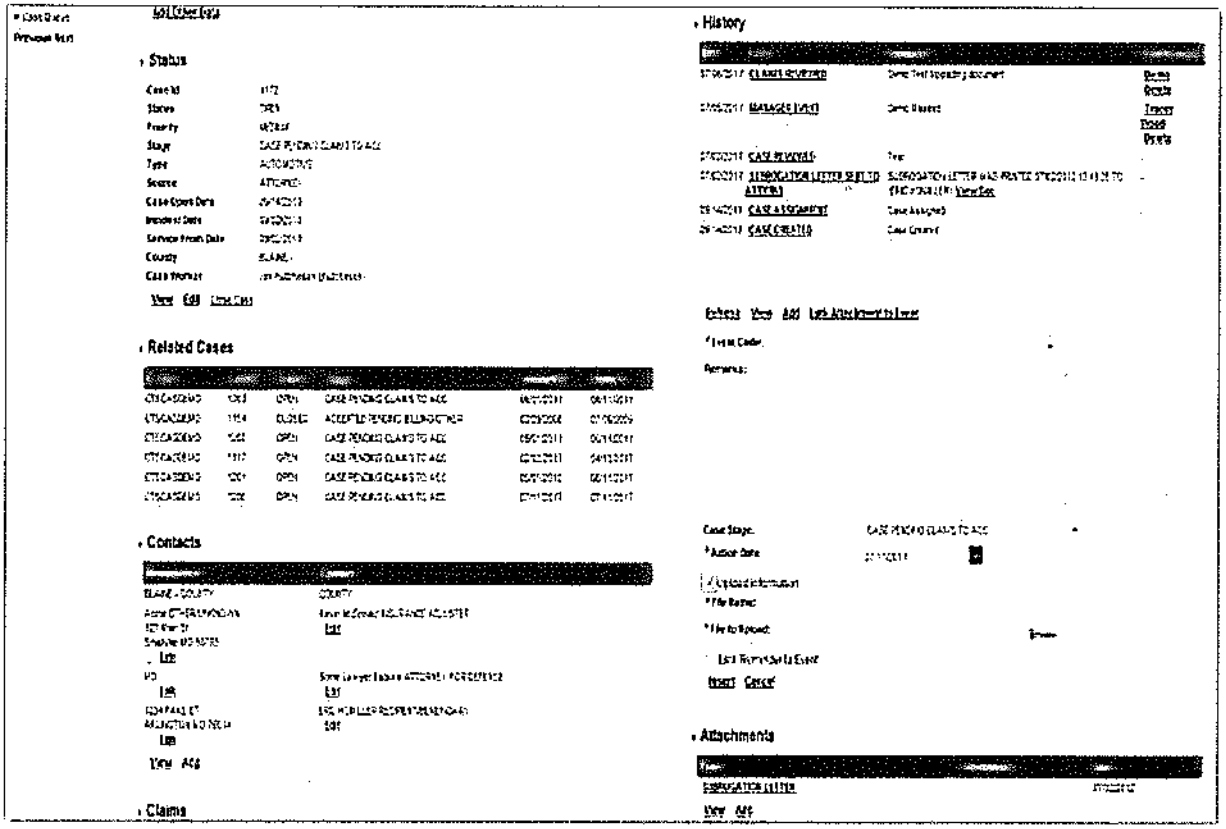
HMS will solicit casualty recovery referrals via a range of additional sources including, attorneys, insurance agents, Medicaid members and providers. We encourage attorneys to ask their clients during the intake process if they are Medicaid recipients, so their office can notify us of potential reimbursement as early in the process as possible. Per Mississippi Code 43-13-125 (2), Medicaid recipients are required to provide a copy of any pleadings to DOM at the time the institutional suit is filed. HMS will work with the legal community to confirm they follow the statutes. We also encourage the insurance companies to require the attorney and/or recipient to notify Medicaid of any benefits paid by Medicaid upon settlement of the insurance claim.

OPENING AND SETTING UP CASES

After vetting that the recipient was in an accident with third party liability identified, an HMS Subrogation team member will open a case in Maestro, consolidating all the information we gather into an easily accessible electronic case file. We work with attorneys, insurance companies, and Medicaid recipients to make sure they submit requests that include the requisite authorization for the release of medical or claims records.

Figure Appendix 1-14 shows how Maestro streamlines various information that goes in and out of the system to support casualty recoveries.

Figure Appendix 1-14 Maestro Case Management System Streamlines Subrogation Recoveries.
Maestro puts key information at a caseworker's fingertips



Reconciling With Managed Care Organizations (MCOs)

Due to the historical and often long-term nature of the medical expenses incurred from a traumatic injury, it is common for a case to have claims paid by both the fee-for-service and managed care programs. However, the attorney or recipient may not realize that both DOM and the MCO need to be notified of the case. Therefore, it is critical that DOM and the MCOs regularly exchange case leads to determine if there is a shared interest in the case. HMS performs this exchange of case leads with the MCOs on a monthly basis. This process ensures that the Medicaid program as a whole is receiving its appropriate share of the settlement on casualty cases.

Establishing the Claim

At this stage of the case, we will perform a valuation to determine the current amount of DOM's claim. Once the claim amount is established, HMS updates the case in Maestro. After totaling the incident-related claims and updating the claim amount in the case, Maestro generates an interim SOAP Letter to the participant, participant's attorney, or insurance carrier, as applicable. We will subsequently review any new claims to keep the valuation of Mississippi Medicaid's claim accurate.

CONFIRMING CASE VALUATION AND CONTINUED CASE FOLLOW UP

When HMS receives notice that a case has settled, we review the case for final valuation, generate a Final Statement of Aid Paid ("SOAP") Letter in Maestro, and provide it to the participant, participant's attorney, or insurance company.

If a participant, participant's attorney, or insurance company questions the claim amount or asserts that one or more claims comprising DOM's lien do not relate to the injuries resulting from the incident, the caseworker reviews the case and claims at issue. Any errors identified in our calculation are corrected, the claims in the case are updated and a revised Interim SOAP Letter is provided, as appropriate. However, if after review of the disputed claims, the caseworker does not agree with the challenge, we request supporting documentation from the attorney (medical records and notes from the treating physician or an independent medical examination to substantiate that the disputed claims are not related). Upon receipt and confirmation that the documentation meets the criteria for establishing that the claim is unrelated, the caseworker adjusts the related claims and sends a revised final SOAP Letter to the participant or participant's legal representative or insurance company for the new lien amount.

LITIGATION

HMS is expressly prohibited from litigating on behalf of DOM. Should a case require litigation, HMS will notify DOM immediately and turn the case, including all correspondence, over to DOM for further action. HMS understands that the Mississippi Attorney General's Office maintains sole authority to effect the release of Medicaid's subrogation interest.

Attorneys employed by HMS may not represent themselves as attorneys for or representatives of DOM or the State of Mississippi.

REPORTING

Maestro provides robust reporting capabilities, which incorporates automated production of reports and ad hoc reports. We currently provide DOM with a Casualty Case Summary Report as shown in **Figure Appendix 1-15**, itemizing casualty case activities, including the number of cases opened, number of cases closed, total recoveries, total posted amount, and total active case count.

Figure Appendix 1-15 Casualty Case Summary Report Sample.
HMS's Casualty team generates reports for DOM

Activity to Date	JANUARY	FEBRUARY	MARCH	APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	YTD
Cases Created in Time Period	232	705	174	574	145								1,830
Cases Closed in Time Period	200	203	257	761	195								1,822
Number of Current Open Cases	6,700	7,202	7,119	6,932	6,882								34,835
Amount Of Payments Received In Time Period	$ 80,755.67	$290,881.99	$195,458.18	$219,711.73	$242,665.38								$1,029,412.95

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1.5 PROVIDER CREDIT BALANCE AUDIT AND RECOVERY

HMS will continue to perform provider (hospital) credit balance audit services for DOM to identify overpayments and seek recovery from Mississippi Medicaid providers. We added and implemented dialysis provider credit balance audits in March 2018 which will continue as part of the scope.

HMS will use our proprietary InVision credit balance recovery management application to manage reviews, track review findings, and generate reports. By compiling and making information available to users as needed through a secure web-based interface, InVision facilitates effective audit management. The system functions as an electronic case file, capturing and maintaining audit data, including demographic, claim, and recovery information as well as review documentation.

We will use three main methods to review and validate potential credit balances on DOM's behalf:

- **Provider self-audits** – We send amnesty letters to providers to identify overpayments within their systems. As providers begin to submit self-audits with amnesty, they will be encouraged to use our web-based secure Provider Portal to complete the process.
- **Desk Audits** - We conduct desktop reviews at our HMS office, typically targeting providers with low claim volume or a reduced opportunity for overpayments. Providers are requested to submit Patient Accounting Reports, system screenshots (e.g., Demographics, Payments/Adjustments, Summary of Charges, Relevant Notes), and EOB copies.
- **Onsite audits** - Our onsite reviews typically last one-to-four days. We select providers for onsite reviews based on criteria developed by Mississippi and the HMS Credit Balance Recovery team, including provider size, historical refund amounts, known issues, and amount of the payments. /

Figure Appendix 1-16 illustrates the DOM-approved onsite credit balance review work plan and is followed by a description of the tasks related to each step of the process.

Figure Appendix 1-16 HMS's Provider Credit Balance Review Process

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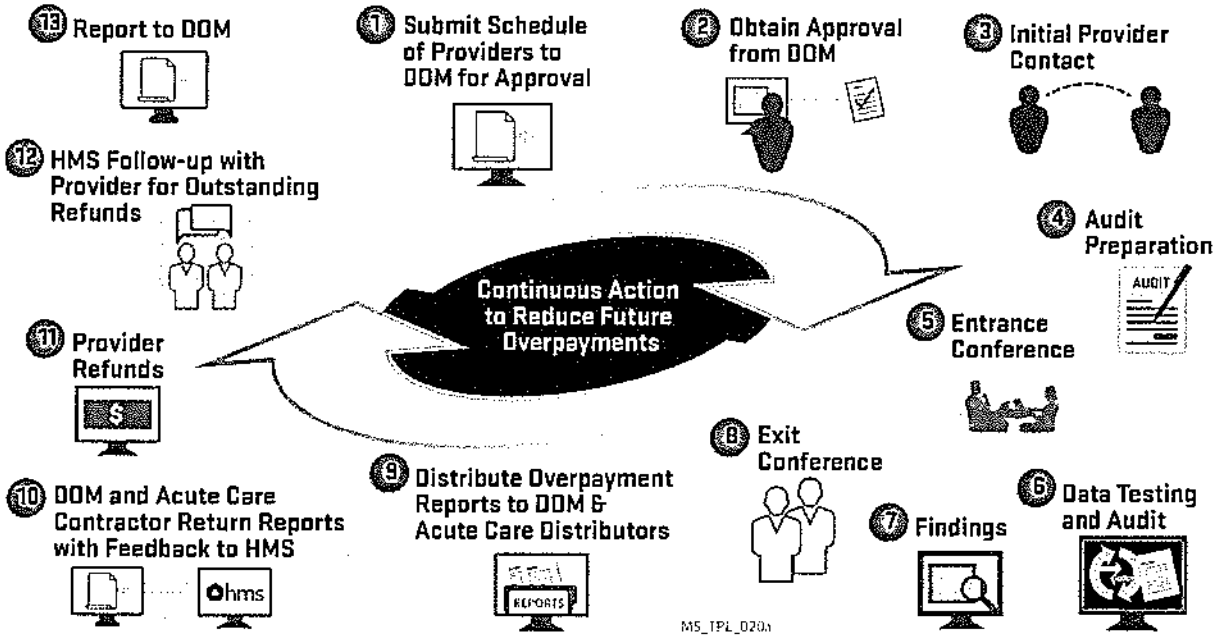
Our credit balance audit solution is implemented and fully operational for DOM



SUBMIT SCHEDULE OF PROVIDERS TO DOM FOR APPROVAL

Prior to initiating any audits, HMS will submit to DOM a request for audit approval. This request will detail the specific provider information necessary for DOM to make an approval decision.

OBTAIN APPROVAL FROM DOM

After approval from DOM, finalize the audit schedule and notify DOM of any changes to the schedule requested by providers.

MAKE INITIAL PROVIDER CONTACT

- Mail audit notification letters and data requests to the provider's patient accounts manager/controller approximately 30 to 45 days before the review
- Contact the provider, explaining the process and documentation that will be required for review
- Request specific credit balance ledgers and financial reports required to perform a more efficient review

PREPARE FOR AUDIT

Review provider's credit and collection policies, reconcile credit balances to aged credit balance summary, and select accounts for review.\

CONDUCT ENTRANCE CONFERENCE

- Describe the purpose of the duration, procedures, and review to the provider's patient accounts manager/controller
- Obtain requested documents and billing systems access
- Request an explanation of any unusual billing/reimbursement practices
- Identify a technical resource who has the authority to sign off on account findings and resolve account

posting questions

- Explain that a brief Exit Conference will be conducted at the end of the review to discuss findings and review the provider appeal process.

PERFORM DATA TESTING AND AUDITING

- Perform credit balance reconciliation
- Review provider debit adjustment reports
- Conduct data analytics reconciliation
- Review A/R reconciliation to the General Ledger to ensure that the entire credit balance population has been identified

ACCUMULATE FINDINGS

Accumulate findings by overpayment cause (e.g., TPL)

CONDUCT EXIT CONFERENCE

- Meet with the provider's staff to review findings
- Notify the provider that refunds must be processed within 30 days of confirmation from HMS

PROCESS PROVIDER REFUNDS (OVERPAYMENTS)

- Within 45 days of refund confirmation, providers will refund overpayments via check to HMS.

FOLLOW UP – NOTIFY STATE OF NON-REFUNDED OVERPAYMENTS

If the provider does not refund the overpayment within 30 days of sign-off, HMS will perform follow-up and outreach activities. If a provider continues to remain uncooperative, we notify DOM and create an appropriate action plan.

REPORTING

- HMS will notify DOM within 3 business days of any probable instances of fraud.
- HMS will forward a report to DOM of all overpayment findings; overpayments are broken down between DOM and the Acute Care Contractor refunds by claim.

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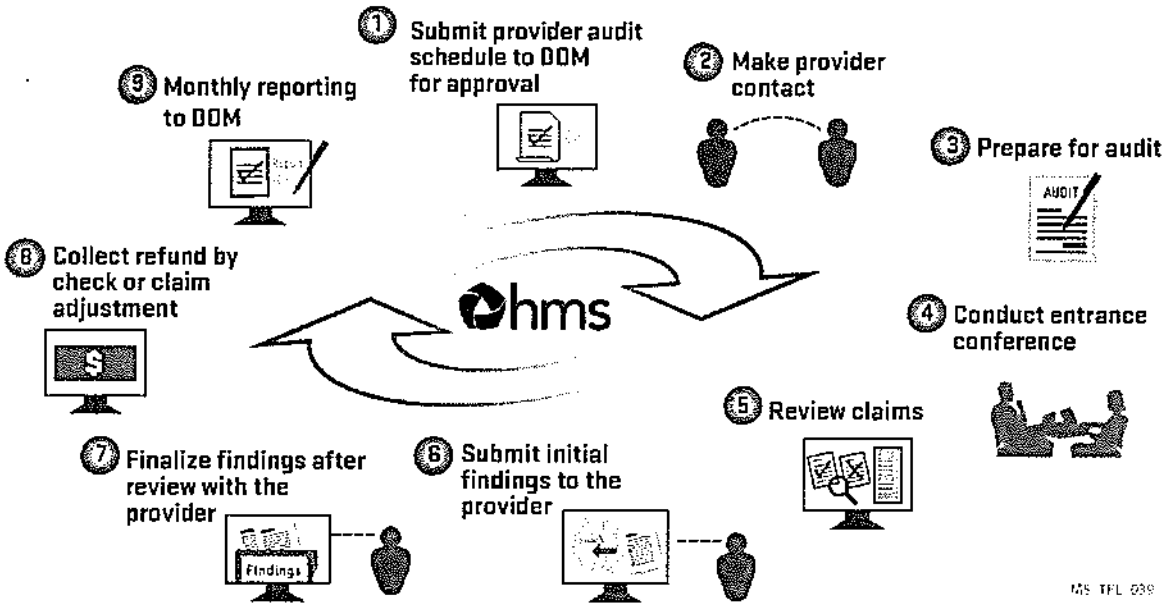
1.6 Work Plan: Long Term Care (LTC) Audits

Long Term Care (LTC) facilities present a particular challenge for overpayment identification and recovery efforts. This provider type is associated with the majority of credit balances, due primarily to improper coordination of benefits between Medicare and Medicaid. Overpayments typically result when Medicare coverage expires and Medicaid becomes the primary insurer.

Under this new SOW, our experienced team will continue to analyze the billing, collection, and disbursement functions of the LTC facilities in Mississippi to identify billing discrepancies, maximize claim recoveries, and recommend detailed improvements to the cost containment efforts of the State. Similar to our process for Provider Credit Balance Reviews and Audits, the process for LTC Audits is illustrated in **Figure Appendix 1-17**.

Figure Appendix 1-17 HMS LTC Audit Work Plan Process
The process for LTC Audits is similar, yet customized for these facilities, to our Provider Credit Balance Audit work plan



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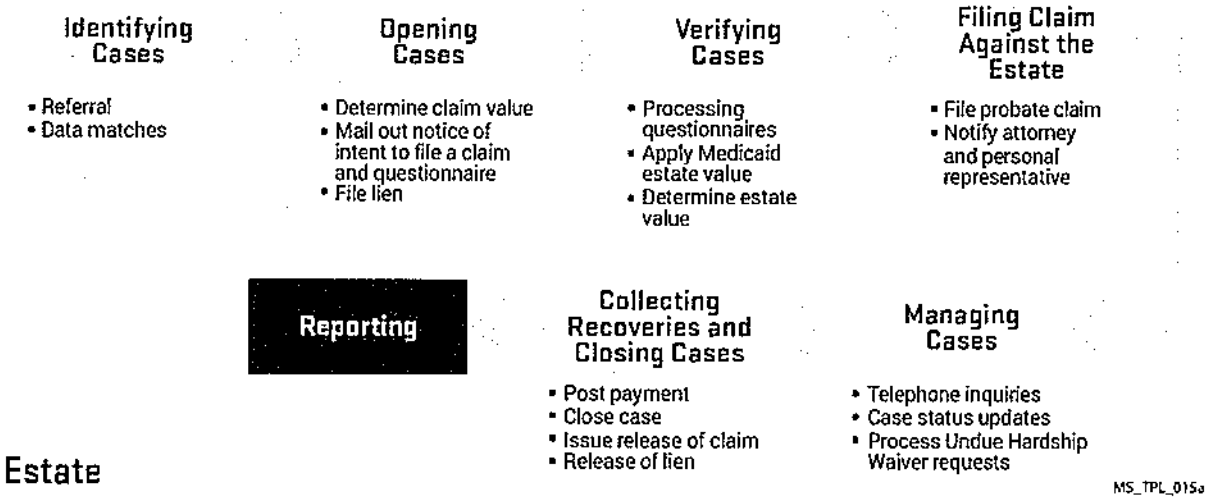
1.7 WORK PLAN: ESTATE RECOVERY

HMS will provide DOM with estate recovery services.

Figure Appendix 1-18 provides a high-level view of HMS's estate recovery work plan, while the following sections describe our approach and process to meeting DOM and the State of Mississippi scope of work in greater detail.

Figure Appendix 1-18 Overview of HMS's Estate Recovery Process
We use our proven estate recovery process for 14 states nationwide

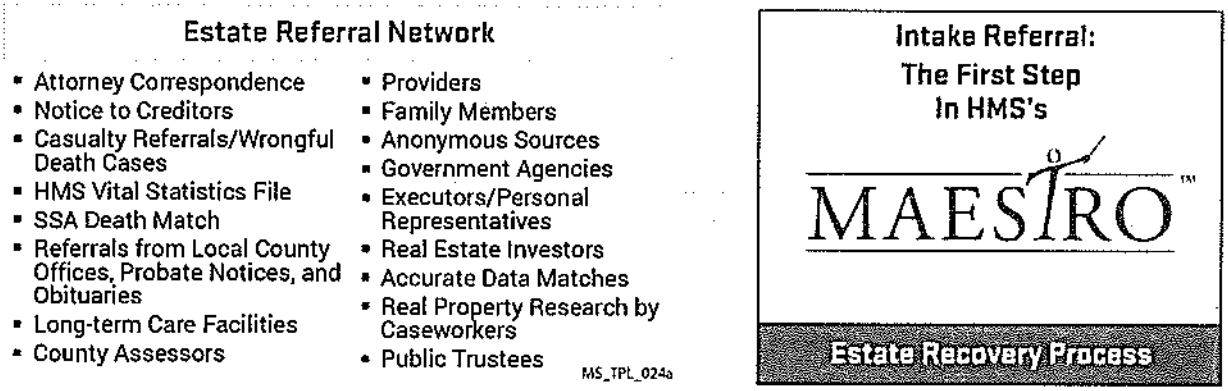


IDENTIFYING CASES

HMS will create a new estate recovery case by two primary methods: establishing a referral network and data matching. When the necessary data sources are not available, a broad referral network is critical.

Figure Appendix 1-19 lists the types of key partners that will be in the Mississippi referral network.

Figure Appendix 1-19 HMS's Estate Referral Network.
HMS has established a national and state-specific referral network for identification of estate recovery cases



DATA MATCHING

HMS will conduct data matches comparing various electronic referral sources with DOM's Eligibility File, which indicates the recipients that received LTC services. These matches include monthly data matches with vital statistics, Social Security, and Accurint to identify property. We also identify cases using DOM's date of death file.

If our comprehensive asset identification match processes or secondary manual review does not locate any assets, HMS closes the case. HMS will record all events related to asset identification in Maestro to create a clear audit trail of all case activity.

VERIFYING CASES

CONFIRMING ELIGIBILITY FOR ESTATE RECOVERY

After receiving a new case lead, HMS first checks Maestro and/or the State's MESA system to determine if the decedent meets the requirements for estate recovery. These requirements include confirming:

- The decedent was age 55 or older or the resident of a long term care facility
- There is not a surviving spouse
- There are no minor children
- There are no blind or disabled children of any age

PROCESS EXEMPTIONS AND DEFERRALS

Based on the protocols established with DOM, HMS will either issue the exemption directly or obtain a DOM review and approval prior to issuing the exemption. In addition, cases with a surviving spouse or child under 21 are routed to an appropriate deferral status.

DETERMINE PROPERTY OWNERSHIP

HMS uses many methods to identify cases in which the deceased Medicaid recipient owns real property and ensures all statutory and regulatory criteria are met.

To identify cases where the Medicaid recipient owns real property and estate recovery is appropriate, HMS would like to review the Mississippi eligibility systems to see if ownership of the property was disclosed upon enrollment. After that search, HMS can apply our data matching methodology to a variety of data files to identify additional assets. These searches include:

- County Assessor's information
- Real Property records
- Court filing data/records
- Accurint, LexisNexis, and other relevant statistics/data, as needed, to operate the Estate Recovery program

CREATING CASES IN MAESTRO

If the name of the owner of the real property and/or the address of the real property matches to any of the variations of name or address belonging to the Medicaid recipient, an estate recovery case is opened in Maestro.

HMS's Estate Recovery team individually verifies each case of real property ownership and pursues the case for recovery if the asset is indeed determined to belong to the Medicaid recipient and does not fall into an exclusion or hardship category.

IDENTIFYING RECOVERY

Where applicable, HMS seeks documentation substantiating the existence of any recoverable estate assets, subject to any exclusions or limitations under state probate law. Such documentation may include the following:

- Inventory of assets
- Final Accountings and/or other probate documents
- Copy of will
- Property assessment records
- Property deeds
- Correspondence returned from personal representatives.
- Market Analysis or Appraisal documents

HMS automatically searches and identifies assets for thousands of DOM recipients in a matter of hours. In concert with our automated asset identification process, we use Accurint, an industry-leading, online, asset search subscription service that compiles listings from public sources.

After using Accurint, our caseworkers then manually review each case through local assessor office databases and LexisNexis, another industry-leading online asset search subscription. It searches county online databases and can identify assets not recorded in the decedent's name and verify results provided through the automated identification process.

After concluding the asset searches, Maestro is updated with the property assessed value and the potential value of the estate.

VALUING THE ESTATE CLAIM

HMS determines the value of DOM's claim against the estate by adding the appropriate DOM expenditures that were incurred during the recipient's LTC enrollment period when the recipient was age 55 and older.

Once the valuation is calculated, HMS updates the file in Maestro to include the case value.

FILING THE CLAIM

After the case has been valued, HMS can generate a series of documents to protect DOM's interest in the property. These documents include:

- Estate Recovery questionnaire sent to the personal representative, attorney, or family representative

- Demand for Notice or Claim Against the Estate
- Notice of the Claim against the Estate sent to the personal representative or their attorney.

PERFORMING CASEWORK

Caseworkers monitor the estate recovery process by requesting case status updates; exclusion, waiver, and reduction information; researching asset information; and determining the value of the estate subject to recovery (after other prioritized expenses and claims have been first deducted per probate law). Once a claim has been filed, HMS may use public and private record searches to determine assets by reviewing the estate inventory, documents from estate proceedings, closing statements from casualty cases, researching online property appraisal records, and computerized asset searches. Heirs and others may review correspondence, as well as other documents, including deeds to real property, bank statements, property appraisals, or stock information.

We have representatives available to respond to inquiries from a dedicated telephone number between 8:00 a.m. and 5:00 PM Central Time, Monday through Friday. HMS's caseworkers respond timely and efficiently to personal representatives or other interested parties who request updated information on a case.

HMS responds to telephone calls and written correspondence that request exclusions, reductions, or waivers to paying the estate recovery claim by creating and mailing follow-up correspondence. This correspondence describes the specific information that must be provided for the request to be granted. Our team reviews the resulting documentation to determine if estate recovery should proceed.

DOM may reduce or waive recovery of the estate if it determines that recovery would create an Undue Hardship.

Appropriate documentation supporting all Undue Hardship or Partial Recovery applications must be submitted prior to referring the case to DOM for a decision. Some examples of the documentation required includes:

- Copy of the will
- Inventory of Assets of the estate and any encumbrances
- Property tax records
- Documentation supporting residency at the decedent's property
- Tax returns
- Bank statements
- Other documentation to support an informed decision

These situations may result in maintenance of DOM's claim, deferral of the claim, reduction of the claim, or a waiver.

INITIATING RECOVERY AND COLLECTION

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Case management is an essential step of the recovery process, in that an assigned caseworker individually monitors and recovers each case. When HMS receives the payments, our estate recovery caseworkers review them thoroughly to verify that the correct payment amount was tendered. If the amount is correct, they post the payment in Maestro, file a Withdrawal of Demand for Notice or a Satisfaction of Claim with the court, and record a release of any applicable lien.

In rare circumstances, the personal representative may dispute an estate claim after payment has been made, or another higher priority creditor may claim that DOM was paid before its higher priority claim; in these cases, the personal representative or the creditor must contact HMS. We forward a refund request along with any supporting documentation to DOM for a decision. Once a decision has been established, we communicate it to the requestor.

CLOSING CASES

We close an estate case upon payment once the claim is paid in full or if the payment represents the balance of all available assets. Additionally, the case may be closed or payment may be deferred for an approved hardship waiver or reduction, or if the case has met other exclusion criteria. HMS mails the appropriate withdrawal or satisfaction of claim, releases any applicable lien, and closes the file or defers collection in accordance with Mississippi law.

REPORTING

Maestro incorporates automated reporting used to produce the reports required for this project, as well as any ad-hoc reporting as requested. In the upcoming engagement, DOM staff will continue to have access to Maestro.

HMS's ability to produce project status reports for DOM includes, but is not limited to, the following reports:

- **Case Status Report.** Provides the total number of cases opened and closed during the month, including the reason the case was closed
- **Case Value Report.** Indicates the number of cases with recovery and total recovery dollars
- **Case Status Aging Report.** Shows a summary of cases in open status, current case stage, and associated case value amount.
- **Monthly Deposit Report.** Indicates the number of cases where payment is received, amount of payment received, recipient name, Medicaid identification number, case number, and total amount of claim.

Figure Appendix 1-20 Estate Case Summary Report Sample.
HMS's Estate team generates reports for DOM

Activity to Date	JANUARY	FEBRUARY	MARCH	APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	YTD
Cases Created In Time Period	232	705	174	573	145								1,830
Cases Closed In Time Period	200	200	257	701	156								1,522
Number of Current Open Cases	6,700	7,202	7,119	6,932	6,882								34,835
Amount Of Payments Received In Time Period	$ 80,795.67	$290,881.99	$195,458.18	$219,711.73	$242,665.36								$1,029,412.95

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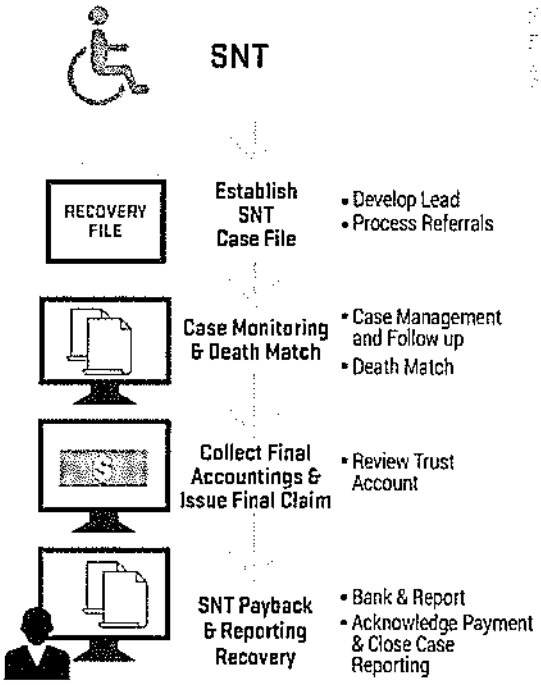
1.8 WORK PLAN: SPECIAL NEEDS TRUSTS (SNTS) RECOVERY

Special Needs Trusts (SNTs), also known as "payback trusts," allow clients to recover pre-trust Medicaid liens and payback claims owed to the State upon trust termination. HMS is the leading vendor of Special Needs Trust (SNT) management services, including trust monitoring and recovery, to Medicaid agencies.

HMS's unique and innovative trust services system—acknowledged within the industry as the national service benchmark—protects the financial interests of our clients at three essential points in time: (1) lien settlement, (2) expenditures during life of the trust, and (3) Medicaid payback at the death of the trust beneficiary.

Figure Appendix 1-20 illustrates the trust recovery work plan that we perform on behalf of DOM. Below we describe the steps we will undertake to meet the State's trust review and recovery needs.

Figure Appendix 1-20 HMS's Special Needs Trusts (SNT) Recovery Process.
HMS has performed SNT Recovery services for DOM since SFY 2021



DEVELOP LEAD

HMS will use our proprietary Trust Services system for the review of trust documents received from all sources, including the Mississippi Division of Medicaid Legal Services, eligibility personnel, trustees, and the Mississippi Elder Bar. This system enables HMS Trust Services team members to determine whether the trust meets the federal and State requirements for approval as an SNT, which is exempt from the general rules regarding self-settled trusts. To enhance lead generation HMS issues follow-up questionnaires to attorneys handling high-dollar subrogation settlements to determine if the recipients who they represent are establishing SNTs.

PROCESS REFERRAL

After identifying an established trust, HMS reviews all information submitted and references the DOM systems as necessary to (a) confirm that the individual is or was a Medicaid recipient and (b) determine if

the recipient is still living. To initiate a Trust Review, we request and obtain a copy of the trust document. After we receive it, we then establish and maintain a case file in the Maestro case-management system. In addition, we load all Medicaid and DOM eligibility data (e.g., name, SSN, DOB, Medicaid ID) into Maestro, linking the beneficiary to any existing subrogation, estate recovery, and trust recovery records in the system.

Maestro features the ability to scan all documents associated with a case and link them, creating an electronic case record that authorized users can access on demand. This feature allows other HMS and DOM personnel, with Trust Services needs, to view images of the trust documentation and supporting case notes quickly and easily, without having to locate and access the physical file.

The purpose of the Trust Review is to validate the SNT and ensure compliance with federal and state law as well as DOM trust recovery program rules and policies. Once approved, the SNT becomes part of the DOM inventory of trust recovery cases and is monitored for trust termination that initiates our Trust Recovery process.

CASE MANAGEMENT AND FOLLOW UP

To ensure the State's right to recover is preserved, we review the trust status regularly. Part of this follow-up process can also include the request of annual accountings from the trust. The accounting review allows HMS to track the balance of the trust from year-to-year, and report any potential inappropriate expenditures to DOM.

RECOVERY

The SNT Recovery process begins with the notification of death or the dissolution of the trust. The most common notification sources are the trustee, DOM, or a family member. In addition to these common notification sources, HMS performs a data match between the Medicaid trust database and other data files that identify the death of a Medicaid recipient.

Regardless of the reason for trust termination, the recovery process begins promptly with:

- Case valuation
- Notification to the trustee of the amount of the payback claim

Payback starts first with the trust property. When HMS becomes aware of a recipient's death or dissolution of the trust, we value the case. HMS has customized an interface with DOM's MESA to extract the valuation described below.

Once the DOM claim amount is determined, Maestro is updated and HMS contacts the trustee and advises them of the DOM claim and the responsibility to repay the balance of the trust to DOM. HMS understands the importance of quickly notifying the trustee of the DOM claim when the trust is to be dissolved. If the recipient is deceased or no longer on Medicaid, HMS determines the amount of the DOM claim and notifies the trustee.

If the recipient is on Medicaid, the trustee receives a reminder of its duty to repay DOM for the medical benefits provided. If the remainder in the trust cannot satisfy the DOM claim, a full accounting of the trust must be submitted along with the payment. This typically consists of bank statements showing

expenditures and the final balance. After receipt and review of the trust accounting, HMS requests additional information as necessary.

BANK AND REPORT

After determining the amount remitted by the trustee is correct, HMS caseworkers post the payment to the case in Maestro. After posting, HMS forwards the payment to DOM for deposit. We conduct all banking procedures per DOM guidelines for financial transactions management. For all payments received, HMS documents, delivers, and then later invoices the recovery in the DOM-approved manner.

ACKNOWLEDGE PAYMENT AND CLOSE CASE

When HMS posts payment of the anticipated amount, we send the trustee an Acknowledgement of Payment Letter. We will not send the acknowledgement prior to physically receiving the entire anticipated amount. After we send the Acknowledgement of Payment Letter, the caseworker closes the case, and archives it in accordance with State requirements.

REPORTING

HMS will provide DOM the customized monthly report as the monthly reconciliation of the trust case inventory, the number of cases and recovery amounts, and the monthly inventory of open trust claims, by recipient.

Figure Appendix 1-21 Trust Case Summary Report Sample.
HMS's Trust team generates report for DOM

Activity to Date	JANUARY	FEBRUARY	MARCH	APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	YTD
Cases Created In Time Period	232	705	174	574	145								1,830
Cases Closed In Time Period	203	203	257	761	199								1,822
Number of Current Open Cases	6,700	7,202	7,119	6,932	6,002								34,835
Amount Of Payments Received In Time Period	$ 80,795.67	$290,881.99	$195,458.18	$219,711.73	$242,645.38								$1,029,412.95

1.9 WORK PLAN: MANAGED CARE COME-BEHIND RECOVERIES

In Mississippi, MCOs have 180 days from date of payment to seek recovery on claims where another third party is liable to pay prior to Medicaid. After this period ends, we will pursue recovery for any claims not billed by the plans. Given that federal law allows Medicaid agencies to pursue commercial insurance recoveries for up to three (3) years from the date of service, this recovery project has a window of up to 2.5 years to pursue recovery on older claims.

There are two steps to incorporating encounter claims billing into our standard commercial insurance billing process described earlier: 1) adding the logic to only consider claims that are more than 180 days past the date of payment, and then 2) checking to see if the claim was already pursued or recovered by the MCO.

HMS implemented billing edits to ensure that the claim is more than 180 days past the date of payment.

Next, we match our Claims Selection File against MCO A/R data containing previously billed claims, dropping any claims already billed to a third party by the MCO, no matter the system claim status (e.g., OPEN, PAID, DENIED). If an MCO plan does pursue recovery, we can coordinate with the plan to match-off against claims already pursued by the plan as well as perform collection efforts on any claim populations where the plan is restricted from recovery but the State is not.

2.0 REQUIREMENTS

2.1 REPORTING REQUIREMENTS

1. HMS shall provide DOM with written reports that are clear, concise, and useful for the audience for whom they are intended. The reports shall be composed in a manner consistent with DOM specifications and with HMS stated criteria. All reports shall be provided in electronic formats compatible with software applications in use by DOM (i.e., MS WORD, Excel, SQL, Crystal, COGNOS, and others as appropriate) , as specified by DOM. All reports shall be made available to relevant DOM staff via web portal. Where required, HMS shall provide supporting documents such as report appendices.

2. HMS shall obtain written approval from DOM for all form letters and form documents prior to issuance.

3. HMS must provide reports due on or before the tenth (10^{th}) business day of the month following the report period, unless otherwise agreed to in writing by DOM.

4. Reports defined and approved by DOM to be generated by HMS shall meet all applicable state and federal reporting requirements. The needs of DOM and other appropriate agencies for planning, monitoring, and evaluation shall be considered when developing report formats and compiling data. Reports to be generated shall be agreed upon during the Contract Implementation Phase and shall include those listed below;

    a. Monthly Data Match Progress Reports. These are narrative reports by Carrier specifying benchmarks, problems and proposed solutions;

    b. Monthly Administration Project Report (Status Report);

    c. Monthly Report of estimated savings for cost avoidance policies delivered;

    d. Monthly Reports of Credit Balance, LTC audits, Casualty, Estates and Trusts Recoveries;

    e. Detailed Report of Actual Recoveries, including date of check receipt, client name, Medicaid ID number, carrier, date of service, TCN number, Medicaid billed amount and date of deposit. This information should balance to the deposits made to the bank account for each date. If any unidentified payments remain as of a given date, they shall be included on the report. This report is due to DOM within ten (10) calendar days of check receipt. (NOTE: See Section 2.2.1 Item 3 which requires disposition within seven (7) calendar days of receipt, thus allowing three (3) days for delivery of the report.);

5. Annual Report of Collections. This report must include the total amount billed and recovered, percentage of recovery, and number of claims involved. These totals should not be duplicative;

6. Monthly Accounts Receivable Summaries. Report by carrier, detailed claims billed and re-billed, detailed claims and amounts paid, detailed claims and dollars outstanding, percentage of claims paid for initial and re-billings, with appropriate totals;

7. Monthly Report of Carrier Payments. Detailed listings identifying payee, recipient, and paid claims affected on a weekly basis. Additionally, a summary report by carrier, number and percentages of claims billed and dollar amounts requested and payments made. Outstanding claims should be reported in 30, 60, 90, 120 and over 120 day intervals;

8. Newly Identified TPL coverage by Carrier. Verified data match results by carrier indicating number of recipients with newly identified coverage by type of coverage, due within thirty (30) calendar days of match completion;

9. Comprehensive Recovery Report by Carrier. This will be a detailed report produced after all significant recoveries have been effected which will specify recoveries billed and paid by claim type

10. Monthly Report of Recoveries. This report must include the total amount billed and recovered, and the number of unduplicated claims;
    a. Monthly status report that includes the number of newly identified and verified health insurance periods of coverage;
    b. Monthly Report of Medicare Retroactive Recoveries that includes the number of newly identified and verified Medicare entitlement;

11. Quarterly and Year-to-Date Reports of above reports by calendar year and by fiscal year;

12. Monthly Report of Managed Care Come Behind Recoveries. This will be a detailed report of claims with potential recoverable TPL by the CCOs where a recovery did not occur.

13. A limited number of Ad Hoc reports will be supplied to the extent required for Legislative Sessions, Budget Meetings and other similar events.

2.2 INFORMATION TECHNOLOGY REQUIREMENTS

2.2.1 DATA EXCHANGE

HMS shall work with DOM and existing Fiscal Agent in carrying out the work described in SOW. HMS shall assure coordination between other systems including, but not limited to DOM's fiscal agent, ERISA health plans, Pharmacy Benefit Manager, and Decision Support System.

HMS shall have the capacity (hardware, software and personnel) sufficient to fully manage and report on the project described in this SOW. HMS information system must include a scalable database repository that supports large data sets and exponential growth in total database size over the life of the contract.

HMS shall fully comply with all HIPAA requirements and shall maintain compliance with federal HIPAA

requirements throughout the term of the contract at no additional cost to DOM.

HMS shall have protocols and internal procedures for ensuring system security and the confidentiality of recipient identifiable data.

HMS shall provide to DOM the results of the carrier specific data matches for Mississippi Medicaid recipients. These results may be used by DOM for future cost avoidance.

DOM will coordinate with the HMS concerning which of DOM's additional data files will be shared and the frequency with which they will be made available to perform data matches and recover against previously unidentified Third Party Resources. DOM has the first right to pursue any recoveries that are the result of third party liability resource other than HMS provided resource record for a period of 120 days.

2.2.2. SYSTEM ACCESS

HMS shall provide DOM Third Party Recovery staff access to HMS systems as specified below to view and access relevant system reports and DOM cases initiated by HMS as follows:

DOM shall be provided access to Maestro related to Casualty, Estate Recovery, Special Needs Trust, and Tort cases.

DOM shall be provided access to the HMS proprietary Provider Portal to view letters and documentation from Medicaid providers.

DOM shall be provided access to the HMS' proprietary A/R Claims Tracker system to view claim payment and denial statuses for verification against monthly invoices. DOM shall also be provided access to DocDNA to obtain copies of checks.

2.2.3 UPDATE TO EXISTING TPL RESOURCE FILE

HMS is responsible for providing an automated interface to update the MESA file with the new TPL information. TPL Resource File updates shall be provided in a separate file extract in a format approved by DOM and within a timeframe specified by the Code of Federal Regulations. The new TPL information must be verified and validated by HMS and DOM prior to transmission.

HMS must also have a method for correcting information in the event previously transmitted information is found to be erroneous.

2.3 ADMINISTRATION AND MANAGEMENT REQUIREMENTS

HMS shall be responsible for performance of the services pursuant to this contract and this SOW. Any

delegation of authority to subcontractors does not relieve HMS of responsibility. This includes all subcontracts, employees, agents and anyone acting for or on behalf of HMS.

The relationship between HMS' management personnel and DOM shall be set forth in writing, including each person's authority, responsibilities, function, and position descriptions for key personnel.

2.3.1 STAFFING

HMS must designate Key Staff persons (see positions below which constitute the "Key Staff") that will be responsible for implementation and program operations. Key staff persons are defined as core staff experienced in systems, operations, and policies necessary for overall project management, systems management, and contract implementation and operations.

Within five (5) business days of final contract signature, HMS must provide a detailed Staffing Plan that includes the name, title, and duties of each Key Staff person. Replacement of any Key Staff person should be accomplished within forty-five (45) calendar days of the position vacancy, regardless of the reason for the vacancy, unless a longer period is approved by DOM.

HMS may not make any permanent or temporary changes in Key Staff assigned to this Contract without DOM's prior written approval. DOM reserves the right to approve all Key Staff persons assigned to this Contract. Resumes must be submitted to DOM for review and approval at least five (5) business days prior to HMS submitting an offer of employment. Resumes must demonstrate that the individual has the educational background and work experience that meet the requirements and support the individual's ability to perform the duties of the position. DOM must provide written approval, which approval may be in the form of an email, within three (3) business days of receipt of resumes from HMS.

HMS must provide an updated Organizational Chart and Staffing Plan that identifies each Key Staff person assigned to this Contract and identifies other non-key staff positions and update this Chart and Staffing Plan when there are changes in Key Staff.

Staffing levels must be sufficient to complete the responsibilities outlined in this SOW.

2.3.2 KEY STAFF

This section states the minimum requirements for staffing during the term of the contract. HMS must ensure that these minimum requirements are met and may also propose additional staff to ensure that all contract requirements are met and program operations are performed effectively and efficiently. Key Staff persons may be based outside the state of Mississippi except where specifically noted otherwise.

HMS shall develop a written Staffing Plan that designates Key Staff persons who will be responsible for program operations.

Key Staff and allocations of their time to DOM for program operations must include the following:

1. Project Manager (50% of time allocated to DOM) – This key staff person will be the person responsible for implementation of the contract requirements, including all deliverables for this

phase. This person must have experience in project management in a TPL program and must have a college or university degree in public health, public administration, hospital administration, nursing or business administration with a health-care emphasis.

2. Data/Information Systems Manager (50% of time allocated to DOM) – This Key Staff person will be responsible for developing and implementing all requirements related to hardware and software, data collection, information management, file transfers, and data coordination with DOM's fiscal agent. This person should be skilled and experienced with data systems in a TPL program and be able to work with DOM and the fiscal agent to develop and implement a data and information systems plan for implementation and operations. This person must have a college or university degree in information systems management, computer science, or business administration with emphasis in information systems management, or similar degrees that relate to the required job duties.

3. Customer Service Manager (75% of time allocated to DOM) – This Key Staff person will be responsible for management of the local staff. This person must have experience in management and must have a college or university degree in business administration, public administration public health management or other related field.

4. Other support staff – Other staff persons as assigned by HMS. All duties must be clearly defined and responsibilities must be directly related to program operations.

HMS is required to maintain an employee training manual for all positions that will be dedicated to this project. HMS is required to provide to DOM a copy of all Operation and Procedure Manual(s) and Employee Training Manual(s) utilized for the Mississippi TPL project and inform DOM when revisions are made to any manuals.

2.4 OTHER HMS RESPONSIBILITIES

1. Secure any necessary approvals and clearances required to conduct the tasks required by this SOW.

2. Select and establish a site(s) at which all HMS functions will be performed, permanently, and temporarily, if necessary. HMS must have permanent location in Mississippi. HMS must obtain DOM acceptance of site selection in writing.

3. Provide a system for effective communication with a variety of entities including but not limited to employers, providers, recipients and insurance carriers. This communication should include a tollfree number to answer inquiries. The toll-free line must be operable and manned on business days from 8:00 a.m. - 5:00 p.m. CST.

4. HMS Project Manager must be available and prepared to meet with DOM staff and other individuals as considered necessary for the discussion of the SOW and contract requirements. The Project Manager must also be prepared to answer pertinent inquiries regarding the program, its implementation, and operation. Meetings between the representatives of HMS and DOM shall be on an as-needed basis throughout the implementation phase and on a monthly basis, or as otherwise required by DOM during the operations phase.

5. Provide adequate cash control procedures in HMS processes of deposit of funds and disposition of recoveries to the accounts receivable files. These procedures must include separation of staff

deposit and disposition functions, security of receipts during working and non- working hours and balancing deposits to the accounts receivable files within seven days of receipt of recoveries. Any unresolved variances must be reported to DOM within seven days of receipt.

6. Submit monthly invoices to DOM based on finalized recoveries.

7. HMS will be required to assist in the eventuality of an audit.

2.5 PERFORMANCE STANDARDS, DAMAGES, AND RETAINAGE

2.5.1 CORRECTIVE ACTION

Participating Entity may require corrective action in the event that any deliverable, report or contract requirement indicates that the Contractor is not in compliance with any provision of this SOW, the applicable Participating Addendum, and/or the Master Agreement. As part of a corrective action plan (CAP), Participating Entity may also require the modification of any Mississippi specific policies or procedures of the Contractor relating to the fulfillment of its obligations pursuant to this contract. Participating Entity may issue a deficiency notice and may require a CAP) be filed within fifteen (15) calendar days following the date of the notice or such other amount of time as agreed upon by the parties. A CAP shall delineate the time and manner in which each deficiency is to be corrected. A CAP shall be subject to approval by Participating Entity, which may accept it as submitted, accept it with specified modifications or reject it. Participating Entity may extend or reduce the time frame for corrective action depending on the nature of the deficiency and shall be entitled to exercise any other right or remedy available to it, whether or not it issues a deficiency notice or provides Contractor with the opportunity to take corrective action.

Should Participating Entity determine, in its sole reasonable discretion, that a CAP will not be sufficient to remedy a Contractor deficiency, Participating Entity will inform the Contractor, and the Contractor shall cure the deficiency within a time frame specified by Participating Entity. No payment related to the deficiency shall be made to the Contractor until the deficiency has been corrected. If the Contractor exhibits a pattern of non-performance as shown by repeated deficiencies, Participating Entity may terminate the contract without further obligation to the Contractor.

2.5.2 LIQUIDATED DAMAGES

The parties declare and agree that time and punctuality are material and essential elements of this SOW, the applicable Participating Addendum, and/or the Master Agreement, and that the terms thereto must be strictly and literally carried out. DOM may assess actual or liquidated damages for the Contractor's failure to carry out the provisions of this SOW, the applicable Participating Addendum, and/or the Master Agreement. The parties further declare and agree that the specified liquidated damage amounts to be paid are not meant to be penalties or punitive in nature. The parties also declare and agree that Participating Entity will incur damages in the event of a breach of this SOW, the applicable Participating Addendum, and/or the Master Agreement by Contractor. Where liquidated damages are available through this SOW, the applicable Participating Addendum, and/or the Master Agreement for breaches of Contractor's obligations, the Parties have agreed to such liquidated damage amounts because:

1) The actual damages cannot be measured with a reasonable degree of accuracy at the time this Agreement is made;

2) The cost and difficulty of proving such damages makes it impractical; and

3) The liquidated damages assessed are a reasonable estimate of the loss which will be incurred.

If liquidated damages are insufficient, Participating Entity has the right to pursue actual damages instead of liquidated damages. In the event such actual damages arise from the same event for which Contractor has already been assessed liquidated damages, the amount of any such liquidated damages paid by Contractor shall be credited against the amount of actual damages assessed for the same event. Assessment of any actual or liquidated damages does not waive any other remedies available to Participating Entity pursuant to this SOW, the applicable Participating Addendum, and/or the Master Agreement or available under state or federal law. Participating Entity's failure to assess liquidated damages in one or more of the instances described herein will in no event waive the right for Participating Entity to assess liquidated damages or actual damages in the future. Continued violations of the requirements in this SOW, the applicable Participating Addendum, and/or the Master Agreement may, in Participating Entity's sole discretion, result in termination of the SOW without Participating Entity having any further obligation to the Contractor.

Participating Entity will provide written notice to Contractor of Participating Entity's intent and its basis to assess liquidated damages. Contractor shall be provided fifteen (15) calendar days from the date of written notice to respond before Participating Entity invokes the liquidated damage assessment. Any liquidated damages will, in Participating Entity's sole discretion, either be: (1) offset against the subsequent monthly payment(s) to the Contractor by Participating Entity, or (2) paid directly to Participating Entity by the Contractor monthly. Participating Entity, at its sole discretion, may establish an installment deduction plan for the amount of any liquidated damages. Determination of the amount liquidated damages shall be at the Participating Entity's sole discretion, up to the below provided amounts. Self-reporting by the Contractor will be taken into consideration in Participating Entity's determination of liquidated damage amounts to be assessed. Any assessed liquidated damages collected may be rescinded, reduced, or retained in full pending Participating Entity's determination of timely disputes. Should the Contractor elect to dispute, it should do so in writing and include any and all evidence it wishes for Participating Entity to consider in support of its dispute. Any decision by Participating Entity on such a dispute constitutes a final decision and can be appealed through Participating Entity's administrative appeal process.

CONTRACTOR FAILURE	LIQUIDATED DAMAGES
Failure for the Contractor or any of its subcontractor(s) to meet the requirements of the Business Associate Agreement (BAA). An "Occurrence" under this Contractor Failure shall be exclusive of the notice requirements provided under Article III(c) and (e) of the BAA.	Liquidated Damages up to $2,000 per Occurrence. An "Occurrence" means a single event which may consist of one or more failures to comply with the BAA requirements, regardless of the number of persons impacted by the failure or the number of entities responsible for or involved in the failure.
Failure of Contractor or subcontractor to notify the State under Article III(c) and (e) of the BAA of an "Incident" both in writing and by telephone within three business	Liquidated Damages of up to $1,000 per "Incident." An "Incident" means, with respect to protected health information (PHI),

days of discovery. Incident is related to Protected Health Information (PHI) and is further defined as: (i) any successful Security Incident which results in or is related to unauthorized access, use or disclosure of PHI; (ii) breach of unsecured PHI, or (iii) any loss, destruction, alteration, or other event in which PHI cannot be accounted for.	(i) any successful Security Incident which results in or is related to unauthorized access, use or disclosure of PHI, (ii) Breach of Unsecured PHI, or (iii) any loss, destruction, alteration or other event in which PHI cannot be accounted for.
Unauthorized utilization or disclosure of any confidential information not classified as PHI, in violation of the requirements listen herein. An occurrence means each unauthorized use or disclosure, regardless of the number of persons impacted by the failure or the number of entities responsible for or involved in the failure.	Liquidated Damages of up to $2,000 per occurrence.
Failure by the Contractor to submit by the due date any material required by the Contract for deliverables, audit/work plans, provider correspondence, or reporting requirements. Contractor shall have 15 calendar days following receipt of DOM written notice to cure the failure by submitting the complete and accurate material.	Liquidated Damages of up to $500, for each late instance in which the cure is not provided within the 15 calendar day period.
Failure by the Contractor to complete corrective action as designated within an applicable Corrective Action Plan (CAP). Contractor may submit a written request to DOM for an extension prior to the conclusion deadline of the corrective action period that provides a detailed justification for the request and a revised timeline for completion. Approval of such written request would be at DOM's sole discretion.	Liquidated Damages of up to $250 per calendar day for each day the corrective action is not completed in accordance with CAP requirements.
Failure by the Contractor to comply with the close out and turnover requirements as agreed to by DOM and Contractor.	Liquidated Damages of up to $5,000 per calendar day, which, if imposed, shall be deducted from the final payment to be made to Contractor.
Failure by the Contractor to comply with case file maintenance requirements in which documentation (other than deliverables) is unacceptable as to format, accuracy, and completeness based on DOM review and contractual requirements.	Liquidated Damages of up to $100 per business day that the failure remains uncorrected.
Failure by the Contractor to report to DOM all instances of probable fraud, waste, and abuse of which Contractor has actual knowledge and as required in this SOW within three business days.	Liquidated Damages of up to $500 per business day that instance is not reported .
As to services for Credit Balance and Long Term Care, failure by Contractor to timely complete audit reviews and failure to document rationale for determinations and	Liquidated Damages of up to $100 for each late instance

failure to timely perform rebuttal reviews to validate audit findings as required in this SOW.	
Failure by the Contractor to fill Key Staff positions within the required 45 calendar day period.	Liquidated Damages of up to $500 per business day that the position remains vacant beyond the 45 calendar day period

2.6 IMPLEMENTATION, OPERATIONS AND TURNOVER PHASES

2.6.1 IMPLEMENTATION PHASE

DOM and the Contractor will determine the timeline of the Implementation Phase; if one is necessary. HMS shall be responsible for the preparation and execution of a final implementation plan. This plan shall be based upon the requirements of this SOW and coordinated with DOM to ensure readiness to complete required tasks by specified dates. HMS will develop an implementation plan to be approved by DOM that outlines in detail all steps necessary to begin program operations.

During the Implementation phase a written report of program progress shall be submitted to DOM every week. The progress report must specify accomplishments during the report period in a task-by-task format, whether the planning tasks are being performed on schedule and any administrative problems encountered.

2.6.2 OPERATIONS PHASE

During the Operations phase, HMS must perform the responsibilities described in this SOW. HMS will be required to adhere to the performance requirements of the contract as well as the requirements of any revisions in federal and state legislation or regulations which may be enacted or implemented during the period of performance of this contract that are directly applicable to the performance requirements of this contract. Such requirements will become a part of this contract effort through execution of a written contract amendment to be signed by both Parties.

2.6.3 TURNOVER PHASE

During this phase HMS will provide DOM with a Turnover Plan in order for DOM to take over the operations of those initiatives implemented under this contract. HMS shall provide detailed written non-proprietary documentation of all HMS Mississippi-specific procedures implemented and any DOM system changes made during the HMS Operations Phase for DOM to continue each initiative even after the project is completed and after expiration of the contract.

Upon receipt of notification of DOM's intent to transfer the contract functions, HMS must provide a Turnover Plan to DOM within a timeframe of no less than 30 business days. Timelines for turnover activities will be specified by DOM. The Turnover Plan must include, but is not limited to, the following:

- Proposed approach to turnover;
- Tasks and subtasks for turnover;

- Schedule for turnover;
- HMS nonproprietary Process and Workflow Diagrams for specific SOW scope components;
- Final Staffing Plan in effect prior to submission of Turnover Plan and,
- Transfer of DOM documents to DOM or its designated agent.

Deliverables must be produced in an organized manner according to reasonable and customary business standards. Deliverables must be turned over to DOM in a form and condition that is satisfactory to DOM and in the timeframes specified by DOM. Unless otherwise agreed upon in writing, deliverables include the following:

- Detailed organizational chart (Final HMS Staffing Plan);
- All DOM documents; and,
- Turnover Results Report.

Upon termination of the contract, HMS shall have one hundred twenty (120) calendar days to complete recoveries initiated before the termination date. HMS may initiate no new collection claims during the one hundred twenty (120) calendar day period. After one hundred twenty (120) calendar days HMS shall not be paid for further collection of outstanding claims and the full amount of subsequent recoveries shall revert to DOM.

2.7 BUDGET SUMMARY

2.7.1 **COST FOR SERVICES:** The total amount payable by DOM to HMS under this SOW shall be limited as described herein and shall be at a total amount not to exceed Sixteen Million Six Hundred Thirty-Six Thousand Three Hundred Seventy-Seven Dollars and Ninety-One Cents ($16,636,377.91) for the base term of this SOW. HMS shall invoice DOM pursuant to the rates and amounts in Exhibit A to this SOW based on funds recovered.

2.7.1 **BILLING:** Billing for the cost specified in Sec. 2.7.1 will be made by HMS on a form prescribed by DOM for such purposes. HMS shall submit invoices on a monthly basis pursuant to the rates and amounts included in Attachment A to this SOW and include any necessary supporting documentation as requested by DOM to verify amounts invoiced.

3.0 Terms and Conditions

This SOW is governed by and subject to the terms and conditions of the Third Party Liability Services Master Agreement led by the State of Georgia and the State of Mississippi Participating Addendum. In addition, the Parties to this SOW hereby agree that the following SOW Terms and Conditions shall be applicable to Third Party Liability Services performed under this SOW.

3.1 **Period of Performance:** The term of this SOW shall commence on November 8, 2023, and shall expire on November 7, 2026 unless this SOW is terminated pursuant to the terms of this SOW or the Participating Addendum. DOM shall have the option to renew this SOW for one (1) two-year period, provided DOM obtains approval form the Mississippi Public Procurement Review Board (PPRB) as necessary.

3.2 **Right of Inspection:** The Division of Medicaid (DOM), Mississippi Office of the State Auditor (OSA), Department of Health and Human Services (DHHS), Centers of Medicare and Medicaid Services (CMS), Office of Inspector General (OIG), General Accountability Office (GAO), the Medicaid Fraud Control Unit (MFCU), or any other authorized representative prior-approved by DOM, at all reasonable times during business hours, and upon advance notice, have the right to enter onto the Contractor's premises, or such other places where duties under this contract are being performed, to inspect, monitor, or otherwise evaluate the work being performed as well as Contractor's books and records pertaining to the fees paid to Contractor and the services furnished to DOM.

Contractor shall allow DOM to audit contractor conformance to contract terms and system security as appropriate. DOM may self-perform this audit, or, at DOM's discretion and expense, contract with a third party. DOM will exercise reasonable efforts in selecting a third-party auditor that is not a direct Third Party Liability services competitor of Contractor.

The Contractor shall provide access to: (i) records and information relating to the services and Contractor's performance of its obligations under the Contract; (ii) accounting processes and procedures; (iii) customer data and equipment held by Contractor (if any); and (iv) those premises, facilities, personnel, systems, data, practices, and procedures used to perform the services and provide reasonable assistance for DOM and OSA representatives. Except where required by law, DOM's audit/access rights expressly exclude: (i) information and data relating to other customers; (ii) attorney-client or legally privileged material; (iii) cost or margin information; (iv) records or minutes of Contractor's internal management meetings; and (v) any Contractor internal audit reports. All inspections and evaluations shall be performed in such a manner as to not delay work. Refusal by the Contractor to allow access to all relevant documents, papers, letters or other materials, shall constitute a breach of contract. All audits performed by persons other than DOM staff shall be coordinated through DOM and its staff.

3.3 **OWNERSHIP AND FINANCIAL INFORMATION**

A. **Information to Be Disclosed:** In accordance with 42 C.F.R. § 455.104(b), the Contractor shall disclose to DOM the following:

1. The name and address of any individual or corporation with an ownership or control interest in the disclosing entity, DOM's Fiscal Agent, or managed care entity. The address for corporate entities shall include as applicable primary business, every business location, and P.O. Box address;
2. Date of birth and Social Security Number (in the case of an individual);
3. Other tax identification number (in the case of a corporation) with an ownership or control interest in the disclosing entity (or DOM's Fiscal Agent or managed care entity) or in any subcontractor in which the disclosing entity (or DOM's Fiscal Agent or managed care entity) has a five percent (5%) or more interest;
4. Whether the individual or corporation with an ownership or control interest in the disclosing entity (or DOM's Fiscal Agent or managed care entity) is related to another person with ownership

or control interest in the disclosing entity as a spouse, parent, child, or sibling; or whether the individual or corporation with an ownership or control interest in any subcontractor in which the disclosing entity (or DOM's Fiscal Agent or managed care entity) has a five percent (5%) or more interest is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling;

5. The name of any other disclosing entity (or DOM's Fiscal Agent or managed care entity) in which an owner of the disclosing entity (or DOM's Fiscal Agent or managed care entity) has an ownership or control interest; and,

6. The name, address, date of birth, and Social Security Number of any managing employee of the disclosing entity (or DOM's Fiscal Agent or managed care entity).

B. When Information Will Be Disclosed: In accordance with 42 C.F.R. § 455.104(c), disclosures from the Contractor are due at any of the following times:

1. Upon the Contractor submitting a bid in accordance with the State's procurement process;
2. Annually, including upon the execution, renewal, and extension of the contract with the State; and,
3. Within thirty-five (35) days after any change in ownership of the Contractor.

C. To Whom Information Will Be Disclosed: In accordance with 42 C.F.R. § 455.104(d), all disclosures shall be provided to DOM, the State's designated Medicaid agency.

D. Federal Financial Participation: In accordance with 42 C.F.R. § 455.104(e), Federal financial participation (FFP) is not available in payments made to a disclosing entity that fails to disclose ownership or control information as required by said section and may be recouped by DOM.

E. Information Related to Business Transactions: In accordance with 42 C.F.R. § 455.105, the Contractor shall fully disclose all information related to business transactions. The Contractor shall submit, within thirty-five (35) days of the date on a request by the Secretary of Health and Human Services or DOM, full and complete information about:

1. The ownership of any subcontractor with whom the Contractor has had business transactions totaling more than twenty-five thousand dollars and zero cents ($25,000.00) during the twelve (12)-month period ending on the date of the request; and,
2. Any significant business transactions between the Contractor and any wholly owned supplier, or between the Contractor and any subcontractor, during the five (5)-year period ending on the date of the request.

F. Disclosure of Identity of Any Person or Entity Convicted of a Criminal Offense: In accordance with 42 C.F.R. § 455.106(a), the Contractor shall disclose to DOM the identity of any person or entity who:

1. Has ownership or control interest in the Contractor, or is an agent or managing employee of the Contractor; and,
2. Has been convicted of a criminal offense related to that person's or entity's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception

of those programs.

G. **Disclosure to the Inspector General:** In accordance with 42 C.F.R. § 455.106(b), DOM must notify the Inspector General of the Department of any disclosures under § 455.106(a) within twenty (20) working days from the date it receives the information. DOM must also promptly notify the Inspector General of the Department of any action it takes on the Contractor's agreement and participation in the program.

H. **DOM's Right of Refusal:** In accordance with 42 C.F.R. § 455.106(c), the Division may refuse to enter into or renew an agreement with the Contractor if any person or entity who has an ownership or control interest in the Contractor, or who is an agent or managing employee of the Contractor, has been convicted of a criminal offense related to that person's or entity's involvement in any program established under Medicare, Medicaid, or titles XIX or XXI services programs. Further, the Division may refuse to enter into or may terminate the Contractor's agreement if it determines that the Contractor did not fully and accurately make any disclosure required under 42 C.F.R. § 455.106(a)

I. **Additional Requirements of DOM and Contractors:** In accordance with 42 C.F.R. § 455.436, the State Medicaid agency and all Medicaid Contractors shall do the following:

1. Confirm the identity and determine the exclusion status of Contractors/subcontractors and any person with an ownership or control interest or who is an agent or managing employee of the Contractor/subcontractor through routine checks of federal databases; and,

2. Consult appropriate databases to confirm identity of the above-mentioned persons and entities by searching the List of Excluded Individuals/Entities (LEIE) and the System for Award Management (SAM) upon enrollment, re-enrollment, credentialing, or re-credentialing, and no less frequently than monthly thereafter, to ensure that the State does not pay federal funds to excluded persons or entities.

The Contractor shall notify DOM, Office of Program Integrity within two business days of discovery of any Contractor or Subcontractor owners or managing employees, network provider, or driver identified as a result of federal database checks and the action taken by the Contractor. Failure to disclose the required information accurately, timely, and in accordance with federal, state and Contract standards shall result in termination of this contract and/or liquidated damages.

3.4 **SUBCONTRACTING:** HMS is solely responsible for fulfillment of the SOW terms with DOM. DOM will make contract payments only to HMS.

HMS shall not subcontract any portion of the services to be performed under this SOW without the prior written approval of DOM. HMS shall provide to DOM in writing a list of subcontractors to be utilized by HMS and outline the SOW services performed by each subcontractor.

Any subcontract shall be in writing and shall contain provisions such are consistent with and subject to the applicable terms of this SOW, the Business Associate Agreement, and the Data Use Agreement, if any. HMS shall provide DOM a redacted version of the fully executed version of any subcontract no later than thirty (30) days after execution. The fully executed subcontract shall not be redacted to the extent that DOM is unable to identify the subcontract's alignment with the terms of this SOW.

Approval of any subcontract shall neither obligate DOM nor the State of Mississippi as a party to that subcontract nor create any right, claim, or interest for the subcontractor against the State of Mississippi or DOM, their agents, their employees, their representatives, or successors

HMS shall be responsible for the performance of any subcontractor under such subcontract approved by DOM.

HMS shall give DOM immediate written notice by certified mail, electronic mail (email), or any other carrier that requires signature upon receipt of any action or suit filed and prompt notice of any claim made against HMS or subcontractor which in the opinion of HMS may result in litigation related in any way to the contract with DOM.

3.5 **INDEMNIFICATION:** The Contractor agrees to indemnify, defend, save, and hold harmless DOM, the State of Mississippi, their officers, agents, employees, representatives, assignees, and Contractors from any third party claims and losses accruing to or resulting from any and all Contractor employees, agents, subcontractors, laborers, and any other person, association, partnership, entity, or corporation furnishing or supplying work, services, materials, or supplies in connection with Contractor's performance of this Contract, and from any third party claims and losses accruing or resulting to any such person, association, partnership, entity, or corporation who may be injured, damaged, or suffer any loss by the Contractor in the performance of the contract.

The Contractor agrees to indemnify, defend, save, and hold harmless DOM, the State of Mississippi, their officers, agents, employees, representatives, assignees, and Contractors against any and all liability, loss, damage, costs or expenses which DOM may sustain, incur or be required to pay: 1) by reason of any person suffering personal injury, death or property loss or damage of any kind either while participating with or receiving services from the Contractor under this contract, or while on premises owned, leased, or operated by the Contractor or while being transported to or from said premises in any vehicle owned, operated, leased, chartered, or otherwise contracted for or in the control of the Contractor or any officer, agent, or employee thereof; or 2) by reason of the Contractor or its employee, agent, or person within its scope of authority of this contract causing injury to, or damage to the person or property of a person including but not limited to DOM or the Contractor, their employees or agents, during any time when the Contractor or any officer, agent, employee thereof has undertaken or is furnishing the services called for under this contract.

The Contractor agrees to indemnify, defend, save, and hold harmless DOM, the State of Mississippi, their officers, agents, employees, representatives, assignees, and Contractors against any and all liability, loss, damages, fines, civil or criminal monetary penalties, costs or expenses which DOM or the State may incur, sustain or be required to pay by reason of the Contractor, its employees, agents or assigns: 1) failing to honor copyright, patent or licensing rights to software, programs or technology of any kind in providing services to DOM, or 2) breaching in any manner the confidentiality required pursuant to federal and state law and regulations.

The Contractor agrees to indemnify, defend, save, and hold harmless DOM, the State of Mississippi, their officers, agents, employees, representatives, assignees, and Contractors from all third party claims, demands, liabilities, and suits of any nature whatsoever arising out of the contract because of any breach of the contract by HMS, its agents or employees, including but not limited to any

occurrence of omission or commission or negligence of HMS, its agents or employees.

3.6 **Privacy/Security Compliance:** HMS shall execute DOM's Business Associate Agreement (BAA) attached to this SOW as Attachment A to this SOW. Moreover, all activities under this contract shall be performed in accordance with all applicable federal and/or state laws, rules and/or regulations including the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, as amended by the Genetic Information Nondiscrimination Act (GINA) of 2008 and the Health Information Technology for Economic and Clinical Health Act (HITECH Act), Title XIII of Division A, and Title IV of Division B of the American Recovery and Reinvestment Act (ARRA) of 2009, and their implementing regulations at 45 CFR Parts 160, 162, and 164, involving electronic data interchange, code sets, identifiers, and the security and privacy of protected health information (PHI), as may be applicable to the services under this SOW. Each party to this contract shall treat all non-public data and information to which it has access under this contract as confidential information to the extent that confidential treatment of same is required under federal and state law and shall not disclose same to a third party without specific written consent of the other party. In the event that either party receives notice that a third party requested divulgence of the confidential or otherwise protected information, including an open records request, and/or has served upon it a subpoena or other validly issued administrative or judicial process ordering divulgence of the confidential or otherwise protected information, the party shall promptly inform the other party and thereafter respond in conformity with such subpoena as required by applicable state and/or federal law, rules, and regulations. The provision herein shall survive the termination of the contract for any reason and shall continue in full force and effect and shall be binding upon both parties and their agents, employees, successors, assigns, subcontractors, or any party claiming an interest in the contract on behalf of, or under, the rights of the parties following termination.

3.7 **Proprietary Rights**

A. **Ownership of Documents:** Where activities paid for under this contract produce original writing, sound recordings, pictorial reproductions, drawings, or other graphic representation, DOM shall have the right to use, duplicate, and disclose such materials in whole or in part, in any manner, for any purpose whatsoever provided that such use, duplication, and/or disclosure does not include any HMS confidential components. Contractor shall grant to DOM a royalty-free, non-exclusive, and irrevocable license to reproduce, translate, publish, use, and to authorize others to use such materials, in whole or in part, in each instance for DOM's internal purposes.

B. **Ownership of Information and Data:** DOM shall own all right, title and interest in all data used by, resulting from, and collected within the scope of this contract. Data shall include, but not be limited to, all: documents, files, reports, work papers, and working documentation (electronic or otherwise) created in connection with the work that is the subject within the scope of this contract and paid for by DOM, except for Contractor's internal administrative and quality assurance files and internal project correspondence. Contractor shall deliver such documents and work papers to DOM, and in a manner or format specified by DOM, within an agreed upon time period after termination or completion of this contract. The foregoing notwithstanding, Contractor shall be entitled to retain a set of such data for its files. Contractor shall be entitled to use such data only after receiving written permission from

DOM and subject to any copyright protections.

The Contractor shall not access DOM User accounts, or DOM Data, except:

a. In the normal course of TPL operations;
b. In response to service or technical issues;
c. As required by the express terms of the contract; or
d. Upon written request by DOM.

The Department of Health & Human Services (DHHS), the Centers for Medicare and Medicaid Services (CMS), the State of Mississippi, and/or their agents shall have unlimited rights to use, disclose, or duplicate all information and data developed, derived, documented, or furnished by the Contractor and paid for under this Contract.

The Contractor agrees to grant in its own behalf and on behalf of its agents, employees, representatives, assignees, and subcontractors to DOM, DHHS, CMS and the State of Mississippi and to their officers, agents, and employees acting in their official capacities a royalty-free, non-exclusive, and irrevocable license throughout the world to publish, reproduce, translate, deliver all such information described in the preceding sentence now covered by copyright of the Contractor.

Excluded from the foregoing provisions in this Contract, however, are any Proprietary Tools as defined below, owned, developed, or otherwise obtained by Contractor. Contractor is and shall remain the owner of all rights, title and interest in and to the Proprietary Tools, including all copyright, patent, trademark, trade secret and all other proprietary rights thereto arising under Federal and State law, and no license or other right to the Proprietary Tools is granted or otherwise implied. Any right that DOM may have with respect to the Proprietary Tools shall arise only pursuant to a separate written agreement between the parties.

Contractor's Proprietary Tools. Notwithstanding anything to the contrary in this contract, collectively, Contractor Proprietary Tools ("**Proprietary Tools**") means, collectively, Contractor's analyses, tools, designs, databases (exclusive of DOM data contained therein) and database rights, processes and process flows, programs, software, works of authorship, inventions (whether or not patentable), trade secrets, patents, trademarks, trade names, systems and system documentation, analytical methodologies and algorithms, information management systems, associated proprietary forms of data organization, , all enhancements, modifications, improvements or derivatives thereof, and all intellectual property and proprietary rights whether arising by operation of law, contract, license, or otherwise in and to the foregoing. Participating Entity acknowledges and agrees that all rights, title and interest in the Contractor Proprietary Tools will remain at all times the sole property of Contractor (and its licensors, as applicable). All rights not expressly granted in this Contract are reserved by Contractor. Participating Entity acknowledges that the Contractor Proprietary Tools includes valuable trade secrets of Contractor (and/or its licensors, as applicable), and is protected or protectable by domestic and international trade secret, copyright and patent laws and other forms of proprietary rights.

Restrictions. Participating Entity will not, and will not allow third parties under its control or acting on behalf of Participating Entity to: (i) copy, modify, create a derivative work of,

reverse engineer, decompile, translate, disassemble, or otherwise attempt to extract any or all of the Contractor Proprietary Tools; (ii) use Contractor Proprietary Tools to create, train, or improve (directly or indirectly) a similar or competing product or service; or (iii) sublicense, resell, or distribute the Contractor Proprietary Tools. Contractor may immediately suspend or terminate Participating Entity's use of the Contractor Proprietary Tools based on any suspected violation of these terms, and violation of these terms is hereby deemed an infringement and misappropriation of Contractor's intellectual property rights. Participating Entity will provide Contractor with any assistance Contractor requests to reasonably confirm compliance with these terms.

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hms®
A Gainwell Technologies Company

The signatures provided below certifies that the information above has been agreed upon by both parties and that the signors possess the legal authority to represent and bind the company.

DocuSigned by:
Mark Knickrehm
4EE68BD6856648D...
Signature

11/7/2023
Date

Title: President and CEO

Health Management Systems, Inc.

Signature

11/8/23
Date

Executive Director
Title

MS Division of Medicaid
Organization

HMS TPL SERVICES ATTACHMENT B - STATEMENT OF WORK
Exhibit A

	SFY 2023 (Jul 22 - Jun 23)		SFY 2023 Monthly Average	Base Contract: 3 Years (Oct 2023 - Sep 2026)			Extension Years (Oct 2026 - Sep 2028)			
Service	Recoveries and Savings	Invoiced Amt	Recoveries and Savings	Projected Recoveries and Savings	Fee	Projected Invoice Amt	Projected Recoveries	Fee	Projected Invoice Amt	Comments
Commercial/Medicare Recovery (FFS)	$ 5,898,019.41	$ 737,252.43	$ 491,501.62	$ 20,348,166.96	10.25%	$ 2,085,687.11	$ 14,745,048.53	10.25%	$ 1,511,367.47	Recoveries on FFS population include CI Direct Bill, CI Provider Disallowance and Medicare (Part A & B) Provider Disallowances. Accounts for a 5% increase in recoveries year over year due to historical Medicaid Eligibility growth.
MCO Come-Behind Direct Bill (ENC)	$ 2,608,874.67	$ 456,553.07	$ 217,406.22	$ 9,000,617.61	10.75%	$ 967,566.39	$ 6,522,186.68	10.75%	$ 701,135.07	Recoveries behind the 3 MCOs following the end of the 180 day period. Accounts for a 5% increase in recoveries year over year due to historical Medicaid Eligibility growth.
Cost Avoidance (Policies Delivered)	163,763	$ 3,494,970.00	13,647	564,982	$ 20.00	$ 11,299,647.00	409,408	$ 20.00	$ 8,188,150.00	Verified TPL policies sent to MES for the purpsoes of denying claims for due to presence of TPL. Accounts for a 5% increase in recoveries year over year due to historical Medicaid Eligibility growth.
Casualty	$ 2,611,677.14	$ 417,868.34	$ 217,639.76	$ 9,010,286.13	16.00%	$ 1,441,645.78	$ 6,529,192.85	16.00%	$ 1,044,670.86	Casualty subrogation recoveries for cases that qualify and had FFS paid claims. Accounts for a 5% increase in recoveries year over year due to historical Medicaid Eligibility growth.
Credit Balance/LTC Audits	$ 956,321.38	$ 153,011.42	$ 79,693.45	$ 3,299,308.76	16.00%	$ 527,889.40	$ 2,390,803.45	16.00%	$ 382,528.55	Credit Balance and Long Term Care audits. Accounts for a 5% increase in recoveries year over year due to historical Medicaid Eligibility growth.
Estate Recovery	$ 399,274.81	$ 63,883.97	$ 33,272.90	$ 1,377,498.09	16.00%	$ 220,399.70	$ 998,187.03	16.00%	$ 159,709.92	Estate recoveries captured for Medicaid members who qualified and had FFS paid claims. Accounts for a 5% increase in recoveries year over year due to historical Medicaid Eligibility growth
Special Needs Trust Recovery	$ 169,461.10	$ 27,113.78	$ 14,121.76	$ 584,640.80	16.00%	$ 93,542.53	$ 423,652.75	16.00%	$ 67,784.44	Special Needs Trusts recoveries captured for Member members who qualified and had FFS paid claims. Accounts for a 5% increase in recoveries year over year due to historical Medicaid Eligibility growth
	$ 12,643,628.51	$ 5,350,653.00	$ 1,053,635.71	$ 43,620,518.36		$ 16,636,377.91	$ 31,609,071.28		$ 12,055,346.31	

RECOVERY SERVICES COST PROPOSAL WORKSHEET

Name of Supplier_____

Attachment R
TPL Recovery Services - Supplier Fees

Note: Contingency fee rates should include all implementation and operational costs, e.g. staffing, supplies, equipment, postage, printing, mailing, and file maintenance. These costs cannot be billed separately. 2018 annual Georgia TPL recovery amounts are provided and will be used for evaluation purposes only. Recovery pertains to the following programs: Casualty, Trust, STABLE. Costs will be evaluated over a 10-year time period.

Instructions: Please enter the annual contingency fee rate percentage which you will charge in the unprotected cells below. This rate must be the same for the 10 years. Four (4) tiers are provided in order for you to provide appropriate pricing for states with with different numbers of Medicaid members.

Tier I: 1 to 500,000 Medicaid members
Tier II: 500,001 to 1,500,000 Medicaid members
Tier III: 1,500,001 to 2,500,000 Medicaid members
Tier IV: 2,500,001 to 3,500,000 Medicaid members
Tier V: 3,500,001 to 5,000,000 Medicaid members

Contingency Fees	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10	Total
Projected Recovery Amount (per year)	$13,000,000	$13,000,000	$13,000,000	$13,000,000	$13,000,000	$13,000,000	$13,000,000	$13,000,000	$13,000,000	$13,000,000	$65,000,000
Annual Contingency Fee Rate (%) - Tier I	16.50%	16.50%	16.50%	16.50%	16.50%	16.50%	16.50%	16.50%	16.50%	16.50%	
Annual Contingency Fee Rate (%) - Tier II	16.50%	16.50%	16.50%	16.50%	16.50%	16.50%	16.50%	16.50%	16.50%	16.50%	
Annual Contingency Fee Rate (%) - Tier III	16.50%	16.50%	16.50%	16.50%	16.50%	16.50%	16.50%	16.50%	16.50%	16.50%	
Annual Contingency Fee Rate (%) - Tier IV	16.50%	16.50%	16.50%	16.50%	16.50%	16.50%	16.50%	16.50%	16.50%	16.50%	
Annual Contingency Fee Rate (%) - Tier V	16.50%	16.50%	16.50%	16.50%	16.50%	16.50%	16.50%	16.50%	16.50%	16.50%	
Total Cost - Tier I	$2,145,000	$2,145,000	$2,145,000	$2,145,000	$2,145,000	$2,145,000	$2,145,000	$2,145,000	$2,145,000	$2,145,000	$21,450,000
Total Cost - Tier II	$2,145,000	$2,145,000	$2,145,000	$2,145,000	$2,145,000	$2,145,000	$2,145,000	$2,145,000	$2,145,000	$2,145,000	$21,450,000
Total Cost - Tier III	$2,145,000	$2,145,000	$2,145,000	$2,145,000	$2,145,000	$2,145,000	$2,145,000	$2,145,000	$2,145,000	$2,145,000	$21,450,000
Total Cost - Tier IV	$2,145,000	$2,145,000	$2,145,000	$2,145,000	$2,145,000	$2,145,000	$2,145,000	$2,145,000	$2,145,000	$2,145,000	$21,450,000
Total Cost - Tier V	$2,145,000	$2,145,000	$2,145,000	$2,145,000	$2,145,000	$2,145,000	$2,145,000	$2,145,000	$2,145,000	$2,145,000	$21,450,000

Instructions: Please enter the monthly fee rate cost which you will charge for each of the 10 years in the unprotected cells below. This rate must be the same for the 10 years. Assume 656 HIPP and 391 CHIPRA members for evaluation purposes.

Flat Fee Costs	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10	Total
Monthly Cost for the HIPP and CHIPRA program- Tier I	$39,205	$39,205	$39,205	$39,205	$39,205	$39,205	$39,205	$39,205	$39,205	$39,205	$392,050
Monthly Cost for the HIPP and CHIPRA program- Tier II	$84,000	$84,000	$84,000	$84,000	$84,000	$84,000	$84,000	$84,000	$84,000	$84,000	$840,000
Monthly Cost for the HIPP and CHIPRA program- Tier III	$108,900	$108,900	$108,900	$108,900	$108,900	$108,900	$108,900	$108,900	$108,900	$108,900	$1,089,000
Monthly Cost for the HIPP and CHIPRA program- Tier IV	$143,279	$143,279	$143,279	$143,279	$143,279	$143,279	$143,279	$143,279	$143,279	$143,279	$1,432,790
Monthly Cost for the HIPP and CHIPRA program- Tier V	$200,525	$200,525	$200,525	$200,525	$200,525	$200,525	$200,525	$200,525	$200,525	$200,525	$2,005,250
Total Annual Flat Fee Cost (Monthly Cost X 12)- Tier I	$470,460	$470,460	$470,460	$470,460	$470,460	$470,460	$470,460	$470,460	$470,460	$470,460	$2,352,300
Total Annual Flat Fee Cost (Monthly Cost X 12)- Tier II	$1,008,000	$1,008,000	$1,008,000	$1,008,000	$1,008,000	$1,008,000	$1,008,000	$1,008,000	$1,008,000	$1,008,000	$5,040,000
Total Annual Flat Fee Cost (Monthly Cost X 12)- Tier III	$1,306,800	$1,306,800	$1,306,800	$1,306,800	$1,306,800	$1,306,800	$1,306,800	$1,306,800	$1,306,800	$1,306,800	$6,534,000
Total Annual Flat Fee Cost (Monthly Cost X 12)- Tier IV	$1,719,348	$1,719,348	$1,719,348	$1,719,348	$1,719,348	$1,719,348	$1,719,348	$1,719,348	$1,719,348	$1,719,348	$8,596,740
Total Annual Flat Fee Cost (Monthly Cost X 12)- Tier V	$2,406,300	$2,406,300	$2,406,300	$2,406,300	$2,406,300	$2,406,300	$2,406,300	$2,406,300	$2,406,300	$2,406,300	$12,031,500

Note: *Your cost proposal will be evaluated on total cumulative costs to DCH. Do not enter data into this table. It is summary of the costs above.

Total Costs to DCH	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10	Total
Contingency Fee Rate Amount per year- Tier I	$2,145,000	$2,145,000	$2,145,000	$2,145,000	$2,145,000	$2,145,000	$2,145,000	$2,145,000	$2,145,000	$2,145,000	$21,450,000
Contingency Fee Rate Amount per year- Tier II	$2,145,000	$2,145,000	$2,145,000	$2,145,000	$2,145,000	$2,145,000	$2,145,000	$2,145,000	$2,145,000	$2,145,000	$21,450,000
Contingency Fee Rate Amount per year- Tier III	$2,145,000	$2,145,000	$2,145,000	$2,145,000	$2,145,000	$2,145,000	$2,145,000	$2,145,000	$2,145,000	$2,145,000	$21,450,000
Contingency Fee Rate Amount per year- Tier IV	$2,145,000	$2,145,000	$2,145,000	$2,145,000	$2,145,000	$2,145,000	$2,145,000	$2,145,000	$2,145,000	$2,145,000	$21,450,000
Contingency Fee Rate Amount per year- Tier V	$2,145,000	$2,145,000	$2,145,000	$2,145,000	$2,145,000	$2,145,000	$2,145,000	$2,145,000	$2,145,000	$2,145,000	$21,450,000
Flat Fee Rate Amount per year- Tier I	$470,460	$470,460	$470,460	$470,460	$470,460	$470,460	$470,460	$470,460	$470,460	$470,460	$2,352,300
Flat Fee Rate Amount per year- Tier II	$1,008,000	$1,008,000	$1,008,000	$1,008,000	$1,008,000	$1,008,000	$1,008,000	$1,008,000	$1,008,000	$1,008,000	$5,040,000
Flat Fee Rate Amount per year- Tier III	$1,306,800	$1,306,800	$1,306,800	$1,306,800	$1,306,800	$1,306,800	$1,306,800	$1,306,800	$1,306,800	$1,306,800	$6,534,000
Flat Fee Rate Amount per year- Tier IV	$1,719,348	$1,719,348	$1,719,348	$1,719,348	$1,719,348	$1,719,348	$1,719,348	$1,719,348	$1,719,348	$1,719,348	$8,596,740
Flat Fee Rate Amount per year- Tier V	$2,406,300	$2,406,300	$2,406,300	$2,406,300	$2,406,300	$2,406,300	$2,406,300	$2,406,300	$2,406,300	$2,406,300	$12,031,500
Total Cumulative Costs to DCH per year- Tier I*	$2,615,460	$2,615,460	$2,615,460	$2,615,460	$2,615,460	$2,615,460	$2,615,460	$2,615,460	$2,615,460	$2,615,460	*$25,802,300
Total Cumulative Costs to DCH per year- Tier II*	$3,153,000	$3,153,000	$3,153,000	$3,153,000	$3,153,000	$3,153,000	$3,153,000	$3,153,000	$3,153,000	$3,153,000	*$26,690,000
Total Cumulative Costs to DCH per year- Tier III*	$3,451,800	$3,451,800	$3,451,800	$3,451,800	$3,451,800	$3,451,800	$3,451,800	$3,451,800	$3,451,800	$3,451,800	*$27,984,000
Total Cumulative Costs to DCH per year- Tier IV*	$3,864,348	$3,864,348	$3,864,348	$3,864,348	$3,864,348	$3,864,348	$3,864,348	$3,864,348	$3,864,348	$3,864,348	*$30,046,740
Total Cumulative Costs to DCH per year- Tier V*	$4,551,300	$4,551,300	$4,551,300	$4,551,300	$4,551,300	$4,551,300	$4,551,300	$4,551,300	$4,551,300	$4,551,300	*$33,481,500

Instructions: Please enter an estimate of the costs to implement your services and/or solution.

Implementation Costs	Annual Cost- Tier I	Annual Cost- Tier II	Annual Cost- Tier III	Annual Cost- Tier IV	Annual Cost- Tier V
Onboarding, Planning, Requirements	$91,667	$91,667	$91,667	$91,667	$91,667
Design, Build, Configure	$164,251	$164,251	$164,251	$164,251	$164,251
System Integration Testing	$91,667	$91,667	$91,667	$91,667	$91,667
Data Migration	$142,637	$142,637	$142,637	$142,637	$142,637
Training	$45,000	$45,000	$45,000	$45,000	$45,000
Acceptance, Deployment	$91,667	$91,667	$91,667	$91,667	$91,667
Certification	$81,500	$81,500	$81,500	$81,500	$81,500
Total Operational Cost:	$708,389	$708,389	$708,389	$708,389	$708,389

COMMERCIAL BILLING RECOUPMENT SERVICES COST PROPOSAL WORKSHEET

Name of Supplier_____

Attachment R
TPL Commercial Recoupment Services - Supplier Fees

Note: Contingency fee rates should include all implementation and operational costs, e.g. staffing, supplies, equipment, postage, printing, mailing, and file maintenance. These costs cannot be billed separately. 2018 annual Georgia TPL recoupment amounts are provided and will be used for evaluation purposes only. Costs will be evaluated over a 10 year time period.

Instructions: Please enter the annual contingency fee rate percentage which you will charge in the unprotected cell below. This rate must be the same for the 10 years. Four (4) tiers are provided in order for you to provide appropriate pricing for states with with different numbers of Medicaid members.

Tier I: 1 to 500,000 Medicaid members
Tier II: 500,001 to 1,500,000 Medicaid members
Tier III: 1,500,001 to 2,500,000 Medicaid members
Tier IV: 2,500,001 to 3,500,000 Medicaid members
Tier V: 3,500,001 to 5,000,000 Medicaid members

Contingency Fees	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10	Total
Projected Recovery Amount (per year)	$20,000,000	$20,000,000	$20,000,000	$20,000,000	$20,000,000	$20,000,000	$20,000,000	$20,000,000	$20,000,000	$20,000,000	$200,000,000
Annual Contingency Fee Rate (%) - Tier I	10.25%	10.25%	10.25%	10.25%	10.25%	10.25%	10.25%	10.25%	10.25%	10.25%	
Annual Contingency Fee Rate (%) - Tier II	10.25%	10.25%	10.25%	10.25%	10.25%	10.25%	10.25%	10.25%	10.25%	10.25%	
Annual Contingency Fee Rate (%) - Tier III	10.25%	10.25%	10.25%	10.25%	10.25%	10.25%	10.25%	10.25%	10.25%	10.25%	
Annual Contingency Fee Rate (%) - Tier IV	10.25%	10.25%	10.25%	10.25%	10.25%	10.25%	10.25%	10.25%	10.25%	10.25%	
Annual Contingency Fee Rate (%) - Tier V	10.25%	10.25%	10.25%	10.25%	10.25%	10.25%	10.25%	10.25%	10.25%	10.25%	
Total Cost - Tier I	$2,050,000	$2,050,000	$2,050,000	$2,050,000	$2,050,000	$2,050,000	$2,050,000	$2,050,000	$2,050,000	$2,050,000	$20,500,000
Total Cost - Tier II	$2,050,000	$2,050,000	$2,050,000	$2,050,000	$2,050,000	$2,050,000	$2,050,000	$2,050,000	$2,050,000	$2,050,000	$20,500,000
Total Cost - Tier III	$2,050,000	$2,050,000	$2,050,000	$2,050,000	$2,050,000	$2,050,000	$2,050,000	$2,050,000	$2,050,000	$2,050,000	$20,500,000
Total Cost - Tier IV	$2,050,000	$2,050,000	$2,050,000	$2,050,000	$2,050,000	$2,050,000	$2,050,000	$2,050,000	$2,050,000	$2,050,000	$20,500,000
Total Cost - Tier V	$2,050,000	$2,050,000	$2,050,000	$2,050,000	$2,050,000	$2,050,000	$2,050,000	$2,050,000	$2,050,000	$2,050,000	$20,500,000

Instructions: Please enter an estimate of the costs to implement your services and/or solution.

Implementation Costs	Annual Cost-Tier I	Annual Cost-Tier II	Annual Cost-Tier III	Annual Cost-Tier IV	Annual Cost-Tier V
Onboarding, Planning, Requirements	$91,667	$91,667	$91,667	$91,667	$91,667
Design, Build, Configure	$164,251	$164,251	$164,251	$164,251	$164,251
System/Integration Testing	$91,667	$91,667	$91,667	$91,667	$91,667
Data Migration	$142,637	$142,637	$142,637	$142,637	$142,637
Training	$45,000	$45,000	$45,000	$45,000	$45,000
Acceptance, Deployment	$91,667	$91,667	$91,667	$91,667	$91,667
Certification	$81,500	$81,500	$81,500	$81,500	$81,500
Total Operational Cost:	$708,389	$708,389	$708,389	$708,389	$708,389

HOSPITAL PHYSICIAN RECOUPMENT SERVICES COST PROPOSAL WORKSHEET

Name of Supplier_____

Attachment R

TPL Hospital Physician Services - Supplier Fees

Note: Matching fees are based on the number of supplier monthly TPL member adds and updates (A/U) resulting from data matching. See monthly fee calculation table below. The costs will be annualized and summarized across 10 years for evaluation purposes. File maintenance activities should be included in these fees.

Instructions: Please enter the estimated average monthly count of adds and updates, resulting from data matches, which you expect to perform in each of the 5 years in the unprotected cells below.

Matching Fees	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10	10 Yr Total
Average Monthly Count of Adds + Updates	1100	1150	1200	1250	1300	1,350	1,400	1,450	1,500	1,550	13,250
Average Monthly Matching Fee	$40,000	$40,000	$40,000	$40,000	$40,000	$40,000	$40,000	$40,000	$40,000	$40,000	
Annualized Fees (monthly x 12)	$480,000	$480,000	$480,000	$480,000	$480,000	$480,000	$480,000	$480,000	$480,000	$480,000	$4,800,000

Instructions: Please enter the estimated average monthly fees for the range of adds and updates per month which you expect to perform.

Monthly Fee Calculation Table		
Minimum Monthly Count of A+U	Maximum Monthly Count of A+U	Fee per Month
1	50	$1,000
51	150	$3,000
151	250	$5,000
251	500	$10,000
501	1,000	$20,000
1,001	2,000	$40,000
2,001	5,000	$100,000
5,001	10,000	$200,000
10,001	50,000	$1,000,000
50,001	100,000	$2,000,000

Tier I: 1 to 500,000 Medicaid members
Tier II: 500,001 to 1,500,000 Medicaid members
Tier III: 1,500,001 to 2,500,000 Medicaid members
Tier IV: 2,500,001 to 3,500,000 Medicaid members
Tier V: 3,500,001 to 5,000,000 Medicaid members

Instructions: Please enter an estimate of the costs to implement your services and/or solution.

Implementation Costs	Annual Cost-Tier I	Annual Cost-Tier II	Annual Cost-Tier III	Annual Cost-Tier IV	Annual Cost-Tier V
Onboarding, Planning, Requirements	$91,667	$91,667	$91,667	$91,667	$91,667
Design, Build, Configure	$164,251	$164,251	$164,251	$164,251	$164,251
System/Integration Testing	$91,667	$91,667	$91,667	$91,667	$91,667
Data Migration	$142,637	$142,637	$142,637	$142,637	$142,637
Training	$45,000	$45,000	$45,000	$45,000	$45,000
Acceptance, Deployment	$91,667	$91,667	$91,667	$91,667	$91,667
Certification	$81,500	$81,500	$81,500	$81,500	$81,500
Total Operational Cost:	$708,389	$708,389	$708,389	$708,389	$708,389

CMO COME BEHIND SERVICES COST PROPOSAL WORKSHEET

Name of Supplier_____

Attachment R

TPL Care Management Organization (CMO) Come Behind Services - Supplier Fees

Note: Contingency fee rates should include all implementation and operational costs, e.g. staffing, supplies, equipment, postage, printing, mailing, and file maintenance. These costs cannot be billed separately. 2018 annual Georgia TPL recoupment amounts are provided and will be used for evaluation purposes only. Costs will be evaluated over a 10 year time period.

Instructions: Please enter the annual contingency fee rate percentage which you will charge in the unprotected cells below. This rate must be the same for the 10 years. Four (4) tiers are provided in order for you to provide appropriate pricing for states with with different numbers of Medicaid members.

Tier I: 1 to 500,000 Medicaid members
Tier II: 500,001 to 1,500,000 Medicaid members
Tier III: 1,500,001 to 2,500,000 Medicaid members
Tier IV: 2,500,001 to 3,500,000 Medicaid members
Tier V: 3,500,001 to 5,000,000 Medicaid members

Contingency Fees	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10	Total
Projected Recovery Amount (per year)	$20,000,000	$20,000,000	$20,000,000	$20,000,000	$20,000,000	$20,000,000	$20,000,000	$20,000,000	$20,000,000	$20,000,000	$200,000,000
Annual Contingency Fee Rate (%) - Tier I	10.75%	10.75%	10.75%	10.75%	10.75%	10.75%	10.75%	10.75%	10.75%	10.75%	
Annual Contingency Fee Rate (%) - Tier II	10.75%	10.75%	10.75%	10.75%	10.75%	10.75%	10.75%	10.75%	10.75%	10.75%	
Annual Contingency Fee Rate (%) - Tier III	10.75%	10.75%	10.75%	10.75%	10.75%	10.75%	10.75%	10.75%	10.75%	10.75%	
Annual Contingency Fee Rate (%) - Tier IV	10.75%	10.75%	10.75%	10.75%	10.75%	10.75%	10.75%	10.75%	10.75%	10.75%	
Annual Contingency Fee Rate (%) - Tier V	10.75%	10.75%	10.75%	10.75%	10.75%	10.75%	10.75%	10.75%	10.75%	10.75%	
Total Cost - Tier I	$2,150,000	$2,150,000	$2,150,000	$2,150,000	$2,150,000	$2,150,000	$2,150,000	$2,150,000	$2,150,000	$2,150,000	$21,500,000
Total Cost - Tier II	$2,150,000	$2,150,000	$2,150,000	$2,150,000	$2,150,000	$2,150,000	$2,150,000	$2,150,000	$2,150,000	$2,150,000	$21,500,000
Total Cost - Tier III	$2,150,000	$2,150,000	$2,150,000	$2,150,000	$2,150,000	$2,150,000	$2,150,000	$2,150,000	$2,150,000	$2,150,000	$21,500,000
Total Cost - Tier IV	$2,150,000	$2,150,000	$2,150,000	$2,150,000	$2,150,000	$2,150,000	$2,150,000	$2,150,000	$2,150,000	$2,150,000	$21,500,000
Total Cost - Tier V	$2,150,000	$2,150,000	$2,150,000	$2,150,000	$2,150,000	$2,150,000	$2,150,000	$2,150,000	$2,150,000	$2,150,000	$21,500,000

Instructions: Please enter an estimate of the costs to implement your services and/or solution.

Implementation Costs	Annual Cost-Tier I	Annual Cost-Tier II	Annual Cost-Tier III	Annual Cost-Tier IV	Annual Cost-Tier V
Onboarding, Planning, Requirements	$91,667	$91,667	$91,667	$91,667	$91,667
Design, Build, Configure	$164,251	$164,251	$164,251	$164,251	$164,251
System/Integration Testing	$91,667	$91,667	$91,667	$91,667	$91,667
Data Migration	$142,637	$142,637	$142,637	$142,637	$142,637
Training	$45,000	$45,000	$45,000	$45,000	$45,000
Acceptance, Deployment	$91,667	$91,667	$91,667	$91,667	$91,667
Certification	$81,500	$81,500	$81,500	$81,500	$81,500
Total Operational Cost:	$708,389	$708,389	$708,389	$708,389	$708,389

THE DIVISION OF MEDICAID
OFFICE OF THE GOVERNOR
STATE OF MISSISSIPPI

BUSINESS ASSOCIATE AGREEMENT

THIS BUSINESS ASSOCIATE AGREEMENT ("Agreement") is entered into by and between the **DIVISION OF MEDICAID IN THE OFFICE OF THE GOVERNOR**, an administrative agency of the **STATE OF MISSISSIPPI** (hereinafter "DOM"), and **HEALTH MANAGEMENT SYSTEMS, INC.** (hereinafter "Business Associate"), hereinafter collectively referred to as the Parties, and modifies any other prior existing agreement for this purpose. In consideration of the mutual promises below and the exchange of information pursuant to this Agreement and in order to comply with all legal requirements for the protection of this information, the Parties therefore agree as follows:

I. RECITALS:

a. DOM is a state agency that acts both as an employer and as a Health Plan for public benefit with a principal place of business at 550 High Street, Suite 1000, Jackson, Mississippi 39201. Business Associate is an individual or a corporation qualified to do business in Mississippi with a principal place of business at 5615 High Point Drive, Irving, Texas 75038.
b. Pursuant to the Health Insurance Portability and Accountability Act ("HIPAA") of 1996 (as amended by the Genetic Information Nondiscrimination Act ("GINA") of 2008 and the Health Information Technology for Economic and Clinical Health Act ("HITECH Act"), Title XIII of Division A, and Title IV of Division B of the American Recovery and Reinvestment Act ("ARRA") of 2009) and its implementing regulations, including 45 C.F.R. Parts 160 and 164, Subparts A and E ("Privacy Rule"), and Subparts A and C ("Security Rule"):
    i. DOM, as a Covered Entity, enters into this Agreement to obtain satisfactory assurances that Business Associate will comply with and appropriately safeguard all Protected Health Information ("PHI") created, received, maintained, or transmitted by Business Associate from or on behalf of DOM, and
    ii. Certain provisions of HIPAA and its implementing regulations apply to Business Associate in the same manner as they apply to DOM and such provisions are incorporated into this Agreement.
c. DOM desires to engage Business Associate to perform certain functions, activities, or services to, for, or on behalf of DOM involving the Disclosure of PHI by DOM to Business Associate, and/or the creation, receipt, maintenance, or transmission of PHI by Business Associate, and Business Associate desires to perform such functions, activities, or services, as set forth in the Service Agreements, and wholly incorporated herein.

II. DEFINITIONS:

a. "Access" shall have the same meaning as the term "Access" in 45 C.F.R. § 164.304.
b. "Affiliate" shall mean any entity that controls, is controlled by or is under common control with the Business Associate as well an any entity that is a subsidiary of an entity that controls the Business Associate.

c. "Breach" shall mean the acquisition, access, use or disclosure of PHI in a manner not permitted by the Privacy Rule which compromises the security or privacy of the PHI, and subject to the exceptions set forth in 45 C.F.R. § 164.402.
d. "Business Associate" shall also include all workforce members, representatives, agents, successors, heirs, and permitted assigns of Business Associate.
e. "Data Aggregation" shall have the same meaning as the term "Data aggregation" in 45 C.F.R. § 164.501.
f. "Designated Record Set" shall have the same meaning as the term "Designated record set" in 45 C.F.R. § 164.501.
g. "Disclosure" shall have the same meaning as the term "Disclosure" in 45 C.F.R. § 160.103.
h. "Discovered" shall have the same meaning as the term "Discovered" in 45 C.F.R. § 164.410.
i. "DOM" shall mean the Division of Medicaid in the Office of the Governor, an administrative agency of the State of Mississippi.
j. "ePHI" shall mean Electronic Protected Health Information.
k. "Health Plan" shall have the same meaning as the term "Health plan" in 45 C.F.R. § 160.103.
l. "Incident" means, with respect to PHI in Business Associate's custody or control, (i) any successful Security Incident, (ii) Breach of Unsecured PHI, or (iii) any loss, destruction, alteration, or other event in which PHI cannot be account for. Unless otherwise required by applicable laws, Successful Security Incidents shall not include pings and other broadcast attacks on Business Associate's firewall, port scans, unsuccessful log-on attempts, denials of service, and any combination of the above, so long as no such incident results in or is related to unauthorized Access, Use, or Disclosure of PHI.
m. "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191.
n. "HIPAA Regulations" means the regulations promulgated under HIPAA by the United States Department of Health and Human Services ("HHS"), including but not limited to, 45 C.F.R. Part 160 and Subparts A and E of Part 164 ("HIPAA Privacy Rule"), 45 C.F.R. Part 162 ("HIPAA Transaction Rule"), and 45 C.F.R. Part 160 and Subparts A and C of Part 164 ("HIPAA Security Rule") which includes requirements of the HITECH Act of 2009, as subsequently modified.
o. "HITECH Act" shall mean the Health Information Technology for Economic and Clinical Health Act, as incorporated in the American Recovery and Reinvestment Act of 2009, and any accompanying regulations.
p. "Individual" shall have the same meaning as the term "Individual" in 45 C.F.R. § 160.103 and shall include a person who qualifies as a personal representative in accordance with 45 C.F.R. § 164.502(g).
q. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 C.F.R. Parts 160 and 164, Subparts A and E.
r. "Protected Health Information" or "PHI" shall have the same meaning as the term "Protected health information" in 45 C.F.R. § 160.103, and refers to Protected Health Information, ePHI, and other data elements that identify an individual or that could be used to identify an individual, including but not limited to an individual's first name or initial and last name, all geographic subdivisions smaller than a state, all elements of dates (except year) for dates direct related to an individual including birth date, admission date, discharge date, date of death, telephone numbers, fax numbers, electronic mail addresses, social security numbers, medical record numbers, health plan beneficiary numbers, account numbers, certificate or driver's

license numbers, vehicle identifiers and serial numbers, including license plate numbers, biometric identifiers, including finger and voice prints, full face photographic images and any comparable images; and any other unique identifying number, characteristic, code or combination that allows identification of an individual.

s. "Required by Law" shall have the same meaning as the term "Required by law" in 45 C.F.R. § 164.103.
t. "Secretary" shall mean the Secretary of the Department of Health and Human Services or his/her designee.
u. "Security Incident" shall have the same meaning as the term "Security incident" in 45 C.F.R. § 164.304.
v. "Security Rule" shall mean the Security Standards for the Protection of Electronic Protected Health Information at 45 C.F.R. Parts 160 and 164, Subparts A and C.
w. "Service Agreements" shall mean any applicable Memorandum of Understanding ("MOU"), agreement, contract, or any other similar device, and any proposal or Request for Proposal ("RFP") related thereto and agreed upon between the Parties, entered into between DOM and Business Associate.
x. "Standard" shall have the same meaning as the term "Standard" in 45 C.F.R. § 160.103.
y. "Subcontractor" shall have the same meaning as the term "Subcontractor" in 45 C. F. R. § 160.103.
z. "Unsecured Protected Health Information" shall have the same meaning as the term "Unsecured protected health information" in 45 C.F.R. § 164.402.
aa. "Use" shall have the same meaning as the term "use" in 45 C.F.R. § 160.103.
bb. "Violation" or "Violate" shall have the same meaning as the terms "Violation" or "violate" in 45 C.F.R. § 160.103.

All other terms not defined herein shall have the meanings assigned in HIPAA and its implementing regulations.

III. OBLIGATIONS AND ACTIVITIES OF BUSINESS ASSOCIATE:

a. Business Associate agrees to not Use or Disclose PHI other than as permitted or required by the Service Agreement or as Required by Law.
b. Business Associate shall use appropriate safeguards and comply with Subpart C of 45 C.F.R. Part 164 with respect to electronic PHI (ePHI) to prevent Use or Disclosure of PHI other than as provided for by this Agreement.
c. Business Associate agrees to notify DOM without unreasonable delay and no later than seventy-two (72) hours after discovery, of any Use or Disclosure of PHI not provided for by this Agreement of which it becomes aware, and any Security Incident of which it becomes aware.
d. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a Use or Disclosure of PHI by Business Associate in Violation of the requirements of this Agreement and take prompt steps to prevent the recurrence of any Incident, including any action required by applicable federal and state laws and regulations.
e. Business Associate agrees to notify DOM without unreasonable delay, and no later than seventy-two (72) hours after discovery of any actual or suspected Breach of Unsecured PHI, all in accordance with 45 C.F.R. § 164.410. The notification shall include, to the extent

possible and subsequently as the information becomes available, the identification of all Individuals whose Unsecured PHI is reasonably believed by Business Associate to have been Breached along with any other available information that is required to be included in the notification to the Individual, HHS, and/or the media, all in accordance with the data Breach notification requirements set forth in 45 C.F.R.§ 164.410.

f. Once an actual or suspected Breach is reported to DOM, Business Associate agrees to provide a written assessment to determine whether the incident is reportable within ten (10) working days. An impermissible Use or Disclosure of protected health information is presumed to be a Breach unless the DOM or Business Associate, as applicable, demonstrates there is a low probability the PHI has been compromised or one of the exceptions to the definition of Breach applies, all in accordance with 45 C.F.R. § 164.410.

g. Business Associate agrees to fully cooperate, coordinate with, and assist DOM in gathering information necessary to notify the affected individuals and government agencies following an Incident to ensure that any notices sent in connection with the Incident are, subject to 45 C.F.R. §164.412, sent without unreasonable delay, and in no case more than 60 days after discovery of the Incident, and perform such notifications if so required by DOM in its sole discretion.

h. Business Associate agrees to be solely responsible for all costs and expenses incurred as a result of an Incident, including costs associated with mitigation of the Incident and preparation and delivery of notices to affected individuals and government agencies.

i. With respect to an Incident, deliver to DOM within fifteen (15) business days after discovery of an Incident a written corrective action plan ("CAP") describing, at a minimum, the measures Business Associate has taken and intends to take to halt or contain the Incident and mitigate the effects of the Incident, and, if the CAP is approved by DOM, promptly and fully implement any remaining requirements of the CAP.

j. Business Associate agrees to promptly notify DOM upon notification or receipt of any administrative, civil, or criminal claims, demands, causes of action, lawsuits, or governmental enforcement actions ("Actions") arising out of or related to this Agreement or PHI, or relating to Business Associate's conduct or status as a business associate for DOM, regardless of whether DOM and/or Business Associate are named as parties to such Actions.

k. In accordance with 45 C.F.R. §§ 164.502(e)(1)(ii) and 164.308(b)(2), Business Associate agrees to ensure that any subcontractors that create, receive, maintain, or transmit protected health information on behalf of the Business Associate agree to the same restrictions, conditions, and requirements that apply to Business Associate with respect to such information. Business Associate agrees to ensure that any Subcontractors that create, receive, maintain, or transmit electronic PHI (ePHI) on behalf of Business Associate will agree to comply with the applicable requirements of the Security Rule and Privacy Rule by entering into a Business Associate Agreement and Business Associate shall provide DOM with a copy of all such executed agreements between Business Associate and Business Associate's Subcontractors at least thirty (30) calendar days prior to disclosing any of DOM's PHI pursuant to said agreements by submitting a written or an electronic copy to DOM's Privacy Officer at the address included in Section VII(f) of this Agreement. Business Associate understands that submission of their Subcontractors' Business Associate Agreement(s) to DOM does not constitute DOM approval of any kind, including of the use of such Subcontractors or of the adequacy of such agreements.

l. Business Associate agrees to provide access, at the request of DOM, and in the time and manner designated by DOM, to PHI in a Designated Record Set, to DOM or, as directed by DOM, to an Individual in order to meet the requirements under 45 CFR § 164.524.
m. Business Associate agrees to make any amendment(s) to PHI in a Designated Record Set that DOM directs or agrees to pursuant to 45 CFR § 164.526 at the request of DOM or an Individual, and in the time and manner designated by DOM.
n. Business Associate agrees to document such Disclosures of PHI and information related to such Disclosures as would be required for DOM to respond to a request by an Individual for an accounting of Disclosures of PHI in accordance with 45 CFR § 164.528. Business Associate agrees to retain such documentation for at least six (6) years after the date of disclosure or provide a full accounting and relevant documentation to DOM at the time of termination.
o. Business Associate agrees to provide to DOM or an Individual, in a time and manner designated by DOM, information collected in accordance with section (III)(h) of this Agreement, to permit DOM to respond to a request by an Individual for an accounting of Disclosures of PHI in accordance with 45 CFR § 164.528.
p. Business Associate agrees that it shall only use or disclose the minimum PHI necessary to perform functions, activities, or services for, or on behalf of, DOM as specified in the Service Agreements. Business Associate agrees to comply with any guidance issued by the Secretary on what constitutes "minimum necessary" for purposes of the Privacy Rule, and any minimum necessary policies and procedures communicated to Business Associate by DOM.
q. Business Associate agrees that to the extent that Business Associate carries out DOM's obligations under the Privacy Rule, Business Associate will comply with the requirements of the Privacy Rule that apply to DOM in the performance of such obligation.
r. Business Associate agrees to make internal practices, books, and records, including policies and procedures, available to the Secretary for purposes of determining Business Associate's and/or DOM's compliance with the Privacy Rule pursuant to 45 C.F.R. § 160.310.
s. Business Associate agrees that nothing in this Agreement shall permit Business Associate to access, store, share, maintain, transmit or use or disclose PHI in any form via any medium with any third party, including Business Associate's Subcontractors, beyond the boundaries and jurisdiction of the United States without express written authorization from DOM.

IV. PERMITTED USES AND DISCLOSURES BY BUSINESS ASSOCIATE:

a. General Use and Disclosure Provisions: Subject to the terms of this Agreement, Business Associate may Use or Disclose PHI to perform functions, activities, or services for, or on behalf of, DOM as specified in the Service Agreements, provided that such Use or Disclosure would not violate what is required by Law or the Privacy Rule if done by DOM.
b. Specific Use and Disclosure Provisions:
   i. Business Associate may use PHI, if necessary, for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate under the Service Agreements entered into between DOM and Business Associate.
   ii. If Business Associate must disclose PHI pursuant to law or legal process, Business Associate shall notify DOM without unreasonable delay and at least five (5) days in advance of any disclosure so that DOM may take appropriate steps to address the disclosure, if needed.

iii. Business Associate may use PHI to provide Data Aggregation services exclusively to DOM as permitted by 42 C.F.R. § 164.504(e)(2)(i)(B).

V. OBLIGATIONS OF DOM:

a. DOM shall provide, via its external website at www.medicaid.ms.gov, Business Associate with the Notice of Privacy Practices that DOM produces in accordance with 45 C.F.R. § 164.520, accessible
b. DOM shall notify Business Associate of any limitation(s) in its Notice of Privacy Practices to the extent that such limitation may affect Business Associate's use or disclosure of PHI.
c. DOM shall notify Business Associate of any changes in, or revocation of, permission by an Individual to use or disclose PHI, to the extent that such changes may affect Business Associate's use or disclosure of PHI.
d. DOM shall notify Business Associate of any restriction to the use or disclosure of PHI that DOM has agreed to in accordance with 45 C.F.R. § 164.522, to the extent that such restriction may affect Business Associate's use or disclosure of PHI.
e. Permissible Requests by DOM: DOM shall not request Business Associate to use or disclose PHI in any manner that would not be permissible under the Privacy Rule if done by DOM.

VI. TERM AND TERMINATION:

a. Term. For all new Service Agreements entered into between DOM and Business Associate, the effective date of this Agreement is the first day that a Business Associate is provided, or has access to, PHI. For any ongoing Service Agreements entered into between DOM and Business Associate, the effective date of this Agreement is the first day that Business Associate is provided, or has access to, PHI under the applicable Service Agreement. This Agreement shall terminate when all of the PHI provided by DOM to Business Associate, or created or received by Business Associate on behalf of DOM, is destroyed or returned to DOM, or if it is infeasible to return or destroy PHI, protections are extended to such information, in accordance with the termination provisions of this section.
b. Termination for Cause. Upon DOM's knowledge of a material Breach or Violation by Business Associate, DOM shall, at its discretion, either:
   i. provide an opportunity for Business Associate to cure the Breach or end the Violation and terminate this Agreement and the associated Service Agreements, if Business Associate does not cure the Breach or end the Violation within the time specified by DOM, or
   ii. immediately terminate this Agreement and the associated Service Agreements if Business Associate has Breached a material term of this Agreement and cure is not possible.
c. Effect of Termination.
   i. Upon termination of this Agreement, for any reason, Business Associate shall return or destroy all remaining PHI received from, or created or received by Business Associate on behalf of, DOM in accordance with Privacy and Security Rule guidelines. This provision shall apply to PHI that is in the possession of Subcontractors or agents of Business Associate. Business Associate shall retain no copies of the PHI. Business Associate shall certify the return and/or destruction/sanitization of the PHI in writing upon termination of this Agreement.

ii. In the event that Business Associate determines that returning or destroying the PHI is infeasible, Business Associate shall provide to DOM notification of the conditions that make return or destruction infeasible. Upon notification in writing that the return or destruction of PHI is infeasible, Business Associate shall extend the protections of this Agreement to such PHI and limit further Uses and Disclosures to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such PHI.

VII. MISCELLANEOUS:

a. Statutory and Regulatory References. A reference in this Agreement to a section in HIPAA, its implementing regulations, or other applicable law means the section as in effect or, as amended, and for which compliance is required.

b. Amendments/Changes in Law.
   i. General. Modifications or amendments to this Agreement may be made upon mutual agreement of the Parties, in writing signed by the Parties hereto and approved as required by law. No oral statement of any person shall modify or otherwise affect the terms, conditions, or specifications stated in this Agreement. Such modifications or amendments signed by the Parties shall be attached to and become part of this Agreement.
   ii. Amendments as a Result of Changes in the Law. The Parties agree to take such action as is necessary to amend this Agreement as is necessary to effectively comply with any subsequent changes or clarifications of statutes, regulations, or rules related to this Agreement. The Parties further agree to take such action as is necessary to comply with the requirements of HIPAA, its implementing regulations, and other applicable law relating to the security and privacy of PHI.
   iii. Procedure for Implementing Amendments as a Result of Changes in Law. In the event that there are subsequent changes or clarifications of statutes, regulations or rules relating to this Agreement, or the Parties' compliance with the laws referenced in section (VII)(c)(ii) of this Agreement necessitates an amendment, the requesting party shall notify the other party of any actions it reasonably deems are necessary to comply with such changes or to ensure compliance, and the Parties promptly shall take such actions. In the event that there shall be a change in the federal or state laws, rules or regulations, or any interpretation of any such law, rule, regulation, or general instructions which may render any of the material terms of this Agreement unlawful or unenforceable, or materially affects the financial arrangement contained in this Agreement, the Parties may, by providing advanced written notice, propose an amendment to this Agreement addressing such issues.

c. Interpretation. Any ambiguity in this Agreement shall be resolved to permit DOM to comply with HIPAA, its implementing regulations, and all other applicable law relating to the security and privacy of PHI.

d. Indemnification.
   i. To the fullest extent allowed by law, Business Associate shall indemnify, defend, save and hold harmless, protect, and exonerate DOM, its employees, agents, and representatives, and the State of Mississippi from and against all claims, demands, liabilities, suits, actions, damages, losses, and costs of every kind and nature whatsoever including, without limitation, court costs, investigative fees and expenses, and attorney's fees, arising out of or caused by Business Associate and/or its partners, principals, agents, and employees in the performance of or failure to perform this Agreement. In DOM's

sole discretion, Business Associate may be allowed to control the defense of any such claim, suit, etc. In the event Business Associate defends said claim, suit, etc., Business Associate shall use legal counsel acceptable to DOM. Business Associate shall be solely responsible for all costs and/or expenses associated with such defense, and DOM shall be entitled to participate in said defense. Business Associate shall not settle any claim, suit, etc. without DOM's concurrence, which DOM shall not unreasonably withhold.

ii. DOM's liability, as an entity of the State of Mississippi, is determined and controlled in accordance with Mississippi Code Annotated § 11-46-1 *et seq.*, including all defenses and exceptions contained therein. Nothing in this Agreement shall have the effect of changing or altering the liability or of eliminating any defense available to the State under statute, common law, or any other applicable law.

e. Disclaimer. DOM makes no warranty or representation that compliance by Business Associate with this Agreement, HIPAA, its implementing regulations, or other applicable law will be adequate or satisfactory for Business Associate's own purposes or that any information in Business Associate's possession or control, or transmitted or received by Business Associate, is or will be secure from unauthorized Use or Disclosure. Business Associate is solely responsible for all decisions made by Business Associate regarding the safeguarding of PHI.

f. Notices. Any notice from one party to the other under this Agreement shall be in writing and may be either hand delivered, delivered by Certified United States Postal Service Mail, Return Receipt Requested, postage fully prepaid, or by other carrier that requires signature upon receipt addressed to each party at the addresses which follow, or to such other addresses provided for in this Agreement, or as the Parties may hereinafter designate in writing. The party providing notice shall also provide a copy of any notice under this section via email with return receipt requested to the email address in the signature block below. Any such notice shall be deemed to have been given as of the date the original is transmitted.

For DOM:
DOM Privacy Officer
Mississippi Division of Medicaid
550 High Street, Suite 1000
Jackson, Mississippi 39201
privacyofficer@medicaid.ms.gov

For Business Associate:
James Finley
Health Management Systems, Inc.
5615 High Point Drive
Irving, Texas 75038
james.finley@gainwelltechnologies.com

g. Severability. It is understood and agreed by the Parties hereto that if any part, term, or provision of this Agreement is by the courts or other judicial body held to be illegal or in conflict with any law of the State of Mississippi or any federal law, the validity of the remaining portions or provisions shall not be affected and the obligations of the parties shall be construed in full force as if the Agreement did not contain that particular part, term, or provision held to be invalid.

h. Applicable Law. This Agreement shall be construed broadly to implement and comply with the requirements relating to HIPAA and its implementing regulations. All other aspects of this Agreement shall be governed by and construed in accordance with the laws of the State of

Mississippi, excluding its conflicts of laws provisions, and any litigation with respect thereto shall be brought in the courts of the State. Business Associate shall comply with applicable federal, state, and local laws, regulations, policies, and procedures as now existing and as may be amended or modified. Where provisions of this Agreement differ from those mandated by such laws and regulations, but are nonetheless permitted by such laws and regulations, the provisions of this Agreement shall control.

i. Non-Assignment and Subcontracting. Business Associate shall not assign, subcontract, or otherwise transfer this Agreement, in whole or in part, without the prior written consent of DOM. Any attempted assignment or transfer of its obligations without such consent shall be null and void. No such approval by DOM of any subcontract shall be deemed in any way to provide for the incurrence of any obligation of DOM in addition to the total compensation agreed upon in this Agreement. Subcontracts shall be subject to the terms and conditions of this Agreement and to any conditions of approval that DOM may deem necessary. Subject to the foregoing, this Agreement shall be binding upon the respective successors and assigns of the parties. DOM may assign its rights and obligations under this Agreement to any successor or affiliated entity.

j. Independent Contractors. It is expressly understood and agreed that Business Associate and any Subcontractor of Business Associate are independent contractors of DOM, and none of the provisions of this Agreement shall establish or be deemed or construed to establish any partnership, agency, joint venture, or employer-employee relationship between the Parties.

k. Entire Agreement. This Agreement contains the entire agreement between the Parties and supersedes all prior discussions, instructions, directions, understandings, negotiations, agreements, and services for like services.

l. No Third Party Beneficiaries. Nothing express or implied in this Agreement is intended to confer, nor shall anything herein confer, upon any person other than the Parties and their respective successors, heirs, or permitted assigns, any rights, remedies, obligations, or liabilities whatsoever.

m. Assistance in Litigation or Administrative Proceedings. Business Associate shall make itself and any workforce members, contractors, subcontractors, representatives, agents, affiliates, or subsidiaries assisting Business Associate in the fulfillment of its obligations under this Agreement, available to DOM, at no cost to DOM, to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against DOM, its directors, officers, or any other workforce member based upon claimed Violation of HIPAA, its implementing regulations, or other applicable law, except where Business Associate or its workforce members, contractors, subcontractors, representatives, agents, affiliates, or subsidiaries are a named adverse party.

n. Injunctive Relief. Business Associate agrees that any violation of the terms and conditions of this Agreement shall cause irreparable harm for which there exists no adequate remedy at law. In addition to any other remedies available to DOM at law or in equity, DOM shall be entitled to an injunction or other decree of specific performance with respect to any violation of this Agreement or explicit threat thereof, without the necessity of demonstrating actual damages.

o. Waiver. No failure to exercise and no delay in exercising any right, remedy, or power hereunder shall operate as a waiver thereof, nor shall any single or partial exercise of any right, remedy, or power hereunder preclude any other or further exercise thereof or the exercise of any other right, remedy, or power provide herein or by law or in equity.

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IN WITNESS WHEREOF, the Parties hereto have duly executed this Business Associate Agreement to be effective on the date provided for in section (VI)(a) of this Agreement.

Mississippi Division of Medicaid

By: _____
Drew L. Snyder
Executive Director

Date: 11/8/23

Business Associate

DocuSigned by:

By: Mark Knickrehm
4EE6BBD6856846D...
Mark Knickrehm
Health Management Systems, Inc.

Date: 11/7/2023