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BRINGING WEST VIRGINIA PROVIDER SCREENING AND ENROLLMENT ACTIVITIES IN COMPLIANCE WITH THE NEW AFFORDABLE CARE ACT REQUIREMENTS

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TRUVEN HEALTH ANALYTICS

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1 – INTRODUCTION

Now that the Supreme Court has confirmed the constitutionality of the Affordable Care Act (ACA), it is time for state Medicaid agencies to finalize their solution to meet the requirements of ACA 6028. And time is of the essence, as each state is responsible for implementing the new provider screening and enrollment requirements beginning in 2014. The core need is timely and accurate information with which to validate, score and manage provider networks. Data alone, however, is not enough. You need a reliable partner whom you can trust to perform for your states by meeting and exceeding the ACA 6028 requirements. In working with us, you are guaranteed to increase the quantifiable value we currently bring to you and ensure a positive return on investment (ROI). Given the potential changes to both the law and funding pending the outcome of the national election in November, we are recommending Georgia began implementing ACA 6028 requirements by initially focusing on high risk providers. This approach allows you to reinforce payment integrity standards, begin the process of identifying and eliminated high risk providers, and establish an infrastructure to complete a full roll-out of the required ACA 6028 requirements upon completing initial screenings and ongoing monitoring of the riskiest providers in your network. It is within this context we offer these services for your consideration and acceptance.

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2 – REQUIREMENTS

Controlling fraud requires a multi-faceted approach across the full range of Payment Integrity (PI) functions. In an effort to mitigate and reduce fraud in the healthcare delivery system, the Patient Protection and Affordable Care Act (ACA) of 2010 includes a provision that allows The Centers for Medicare and Medicaid (CMS) to establish additional methods to combat fraud, waste, and abuse in federal health care programs. As a result, CMS has established both provider screening and enrollment requirements, as well as categorical risk assignment based on the provider type. Each state is responsible for implementing the new screening and enrollment requirements beginning in 2014 for those providers in Medicaid or CHIP.

As required by CMS, states must validate all new providers using the new ACA 6028 requirements. They must also evaluate Medicaid providers not enrolled in Medicare and assign them an appropriate Categorical Risk Score. Further, to be compliant, every state Medicaid agency must acquire and maintain dates of birth and social security numbers for all persons with an ownership or controlling interest in the Medicaid provider, states must validate these owners according to ACA 6028 criteria as well. Moderate and high-risk providers must undergo background checks, including fingerprinting and site visits. Monthly monitoring of every provider for sanctions and death as well as three to five year revalidation by provider type is required. We have developed a Provider Surveillance solution to meet these extensive requirements. Our approach includes:

- Retrieving public records for the providers (and their owners) using batch processing
- Fusing the various records together
- Organizing the data into a usable format
- Comparing the data to the input file provided by you to determine if the retrieved public data matches the data elements on the application
- Using deterministic modeling techniques like distance calculators and similarity calculators to determine if the retrieved data matches the submitted date (e.g., is John Green and John Greene the same person?)
- Computing a provider risk score using our predictive modeling solution
- Generating a Provider Risk Score Report Card that allows your users to automatically drill into the public records data, by data category, that drove a specific risk score
- Automatically conducting monthly monitoring
- Computing a Provider Risk Score Trend Report to identify changes in risk over time

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We summarize the requirements for ACA 6028 validation of providers and their owners below.

REQUIRED LICENSURE, SANCTIONS, CERTIFICATIONS, ETC.	CREDENTIALING STANDARD			
	LIMITED (L)	MODERATE (M)	HIGH (H)	MONTHLY MONITORING
State(s) of licensure; status	Y	Y	Y	N
Sanctions (with detail) AKA Adverse Legal Actions/Convictions	Y	Y	Y	Monthly (L,M, H)
National Plan and Provider Enumeration System (NPPES/NPI)	Y	Y	Y	N
GSA Exclusion List (EPLS)	Y	Y	Y	Monthly (L,M, H)
List of Excluded Individuals and Entities (LEIE)	Y	Y	Y	Monthly (L,M, H)
Drug Enforcement Administration (DEA) Number	Y	Y	Y	N
Practice Address	Y	Y	Y	N
Specialty Certifications: educational background and residence	Y	Y	Y	N
Hospital Affiliations	Y	Y	Y	N
Group Practice Associations	Y	Y	Y	N
Shared Address, Business Association	Y	Y	Y	N
Required Personal / Corporate Information				
DOB	Y	Y	Y	N
TIN & FEIN	Y	Y	Y	N
SSN (Actual & Associated)	Y	Y	Y	N
Death Records (SSA Death Master file and other sources)	Y	Y	Y	Monthly (L,M, H)
Corporate Officers & Owners	Y	Y	Y	N
Bankruptcies, Liens, and Judgments	Y	Y	Y	N
Site Visits	N	Y	Y	1-2 times per year
Criminal Background Check	N	N	Y	N
Fingerprinting	N	N	Y	N

Our turn-key, end-to-end solution includes provider screening and enrollment, revalidation, background checks and fingerprinting and site visits are included in our proposed services. We provide a description of each as follows.

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Public Records Data Retrieval, Fusion and Organization

Public records data is critically important to the process of validation of provider applications. It significantly reduces the time it takes to screen and verify each application and monitor each provider and owner. The variance of public records data makes it difficult to work with; it is largely unstructured and contains differing levels of detail, based on who initially recorded the data. Misspelled names are common. There is no uniformity to sanction information or criminal records. There can be one address for a provider or twelve – each formatted differently. We access thousands of files to retrieve the data for a single individual, and each file has different data and different formats. When accessing and printing a report of public records data for a provider, it may be two or fifty-five pages long. Reviewing this much data is very time consuming, whether done by reading paper or an online file. We batch query the public records data assets and include

- Names, Aliases and SSNs
- Business Names and Tax IDs, including Doing Business As (DBA)
- Branches, Subsidiaries, Parent Companies and Headquarters
- NPIs and DEA Numbers
- SSA Death Records
- Current and Historical Addresses, Shared Addresses
- State Licensure Data for all states
- Sanctions for all states
- Federal Sanctions from GSA and LEIE
- Tax IDs, SSNs and DEA Numbers of Providers
- Provider Specialty and Educational Information
- Hospital and Group Affiliations, as possible
- Dates of Birth
- Listed and Unlisted Phone Numbers, Landline and Cell Phone
- Corporate officers and owners of businesses, current and previous employees
- Adverse Indicators
- Criminal Records
- Bankruptcies, Foreclosures, Liens and Judgments
- Assets including Vehicles and Property
- Utilities Records
- Email Addresses and Social Networks
- Relatives, Associates and Neighbors

- Uniform Commercial Codes (UCC) Filings

There are additional data sets that enhance the quality and thoroughness of information collected on providers and owners. Many of these datasets, owned and managed by CMS, are available only to states. If you makes these datasets available to us electronically as an "Authorized Agent", we incorporate those data sets into our overall solution as well, feeding the data to you, provider-by-provider, on our drillable Provider Risk Score Report Card. These data sets include:

- The Medicare Exclusion Database (MED)
- The National Provider Data Bank (NPDB)
- The Healthcare Integrity and Protection Data Bank (HIPDB)
- The Medicaid and Children's Health Insurance Program, CHIP, State Information Sharing System (MCSIS)

ACA 6028 requires validation of all owners of businesses when they own 5% or more of the business. It is our expectation you will provide owner information. In instances where this information is either a) not available or b) not provided, we will pull all of the owners and Corporate Officer records for each provider and screen each of those owners and agents against the ACA 6028 requirements. This process results in identifying owners who have been sanctioned (perhaps in another state) or have criminal convictions or are deceased. The online Provider Surveillance tool allows you to research any providers with high risk scores. As an example, if we score a DME or ambulance provider as very risky, you may elect to look at other data, beyond ACA 6028 data, to help determine your final decision on the provider. For the DME supplier, you can look at other businesses owned by the owners. For the ambulance provider, you can look at their motor vehicle records to see if they own vans that can transport patients.

Provider Enrollment Chain and Ownership System (PECOS)

We can either perform all application services or work with the state's team to support and validate the application process. Once we establish this process and receive the required information, we validate Medicare providers using Medicare's Provider Enrollment Chain Ownership System (PECOS) and enter the results into the workflow tracking system so that the monitoring can take place effectively. Validating and revalidating providers by using PECOS significantly reduces the overall cost and time required to complete the ACA 6028 verifications. We estimate that over 50% of the providers are eligible for this streamlined service. If there are

no alerts or "red flags" after checking the GSA and LEIE schedules, state sanctions and the SSN Death Master File, we approve the provider and finalize the credentialing process for Medicare-enrolled providers. If the provider shows adverse alerts or red flags we do not recommend them for billing privileges in the network. For Medicaid-only providers the validation/revalidation process entails:

- Running the Provider Risk Score Report Card
- Reviewing the results, using the drillable feature of the report card
- Researching and verifying any adverse information retrieved
- Verifying application information through phone calls, letters, and web research as required
- Determining if the provider passed or failed the ACA 6028 requirements
- Summarizing the results to present to the Provider Credentialing Council

If the provider has a Medicare Provider Transaction Access Number (PTAN), they do not need to complete an application. They only need to provide a copy of the Medicare authorization letter, and with your agreement and authority, we validate the provider using Medicare's Provider Enrollment Chain Ownership System (PECOS). Depending on the final staffing model you adopt, the provider or the state faxes the Medicare authorization letter to our secured fax line for digital ingestion into the workflow.

The significant difference from the Provider Surveillance solution presented above is that our credentialing experts review the Provider Risk Score Report Card and do the investigation of providers receiving a moderate or high-risk score. We make the telephone calls that may be necessary and go online into the Public Records data for a deeper review of the provider. Our results are recommendations of who should and should not have billing privileges.

Verification of Provider Licenses

Public records contain much of the information required for most of the providers and owners. That said, the data in the public domain can and does contain errors. For example, providers with revoked medical licenses can be show in some states as having an active license because the "update" of the data just was not performed in that system when the revocation occurred. While most of the data is correct, additional review is important; therefore providing data in a drillable format is imperative. We work with multiple partners to access public records data. One of our partners goes the extra mile to "validate" the data in the public records. They have dozens of Data Stewards who verify the healthcare content we can use in our Provider

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Surveillance solution, and validate every healthcare sanction on LEIE and EPLS. Because names are shared by many, they make sure that the sanction is attached to the correct Dr. John Doe or Diagnostic Imaging Center or owner of Home Care for You whose name is Nancy Smith. The Data Stewards also harvest data from Hospital websites and group practice websites in order to gather hospital affiliations and group practice information – data not available in public records. They review over 300 Medical Board websites to gather provider board certification and specialty data. This data verification process is important to provide accurate information with the fewest false positives.

With the public records and healthcare content, we validate as much of the provided data as possible. For example, if the provider puts on the application one address, one NPI and one Tax ID (or SSN for individuals), we pull from the public records all of the addresses for that provider, all of their NPIs and all of their Tax IDs. We add a flag that tells whether any of the addresses, NPIs or Tax IDs retrieved matched the ones on the application data provided by you. We then return to you the matched records and all of the other addresses, NPIs and Tax IDs associated with the given provider. If the NPI or address does not match the one on the application, we put "no" in the flag and send you back all of the NPIs, Tax IDs and addresses that we located for that provider. By having our Provider Surveillance solution do the matching of much of the submitted data, we significantly reduce your efforts to verify the application. Your credentialing staff need only review exceptions. Like data fusion and organization, this process also significantly reduces the man hours required on your part.

Computed Provider Risk Score

CMS established three levels of risk that must be assigned to each provider as part of the credentialing process. Further, CMS indicates that risk categories are not static; Medicaid agencies must maintain ongoing monitoring and re-credentialing of providers and suppliers to be compliant with ACA 6028 requirements.

"Limited" risk providers include physicians, non-physician practitioners and medical groups or clinics (excluding physical therapists), hospitals, ambulatory surgery centers, most pharmacies, radiation therapy centers, skilled nursing facilities, and providers and DME suppliers that are traded on the NYSE or NASDAQ.

"Moderate" risk providers include non-public or government owned ambulance suppliers, comprehensive outpatient rehabilitation facilities (CORF), independent diagnostic testing facilities (IDTFs), community mental health centers (CMHCs), independent clinical laboratories,

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hospice agencies, physical therapy providers and groups, and currently enrolled home health agencies and DME suppliers (unless they are traded on the NYSE or NASDAQ).

"High" risk providers include newly enrolling home health agencies and durable medical equipment, prosthetics, orthotics and supplies providers (unless they are traded on the NYSE or NASDAQ), including their owners.

Given our extensive experience evaluating Medicaid fraud and abuse, we know that some Limited Risk providers commit health care fraud, while many High Risk providers are totally honest and commit no fraud. Therefore, it is imperative to take additional steps to identify and remove all fraudulent providers from networks. A key differentiating component of our solution is the integration of advanced fraud detection methods. In addition to the CMS assigned risk categories, we calculate a Provider Risk Score based on information we collect from our automated search of public records databases and our expertise in what indicators suggest problems with the providers. We do this by using predictive models we have developed to assign a Provider Risk Score to every provider, regardless of Categorical Risk.

To begin this process, we take the data we retrieve from the application, public records and supplemental data sets and assign risk scores for adverse indicators. We assign a higher risk weight to sanctions and death and lesser weights to liens and judgments. We have designed the predictive model to be highly flexible. For example, we can change weights and incorporate additional weighting criteria either across your book-of-business or on a client-by-client basis. We will work with you to establish weighting preferences and incorporate them into the model accordingly. Each provider will be run through our models and assigned a Provider Risk Score. Our approach exceeds the CMS requirements and illuminates the riskiest providers.

Public records contain much of the information required for most of the providers and owners. That said, the data in the public domain can and does contain errors. For example, providers with revoked medical licenses can be show in some states as having an active license because the "update" of the data just was not performed in that system when the revocation occurred. While most of the data is correct, additional review is important; therefore providing data in a drillable format is imperative. With the public records and healthcare content, we validate as much of the provided data as possible. For example, if the provider puts on the application one address, one NPI and one Tax ID (or SSN for individuals), we pull from the public records all of the addresses for that provider, all of their NPIs and all of their Tax IDs. We add a flag that tells whether any of the addresses, NPIs or Tax IDs retrieved matched the ones on the application

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data provided by you. We then return to you the matched records and all of the other addresses, NPIs and Tax IDs associated with the given provider. If the NPI or address does not match the one on the application, we put "no" in the flag and send you back all of the NPIs, Tax IDs and addresses that we located for that provider. By having our Provider Surveillance solution do the matching of much of the submitted data, we significantly reduce your efforts to verify the application. Your credentialing staff need only review exceptions. Like data fusion and organization, this process also significantly reduces the man hours required on your part. As we illustrate on the following report, your team can drill-down to the public records data, for any provider, on any underlined element in the report to review the details supporting the assigned Provider Risk Score, saving significant research and investigation hours.

BNAME	STATE	CITY	NPI	TAX ID	TYPE	claims FFS	claims MC	claims	payments FFS	pay
					DME/Medical Supply Dealer	34	144	178	50088.87	144
					DME/Medical Supply Dealer	924	834	1758	1226158.62	817
					DME/Medical Supply Dealer	330	2210	2540	74861.72	228
					DME/Medical Supply Dealer	0	2183	2183		332
					Home Health Agency	3353	0	3353	2822926.34	
					DME/Medical Supply Dealer	0	314	314		291
					DME/Medical Supply Dealer	55	1059	1114	6908.19	301
					Hospice	501	0	501	1328357.27	
					DME/Medical Supply Dealer	562	0	562	1252877.52	
					Hospice	730	0	730	2098665.4	

query key	Total Score	Business Sanction Records	Person Sanction Records	Most Recent Sanction	Sanction Name Match	Sanction Name	Search Name	Unique NPIs	Matching NPI	Oldest NPI	Newest NPI	NPI Name
84	1725	2	7	06/08/2012	1			1	Y	07/29/2005	07/29/2005	
10	1621	2	18	06/14/2012	0.93			1	Y	04/03/2006	04/03/2006	
107	1500		4	02/07/2012	1							
98	1325		31	06/08/2012	1			1	Y	11/15/2006	11/15/2006	
217	1315		20	01/31/2012	1			4	Y	07/15/2005	03/15/2006	
275	1170		11	09/02/2011	1			5	Y	01/19/2006	05/11/2011	
204	1080		1	05/17/2011	1			7	Y	08/23/2005	07/12/2011	
26	1025		8	08/12/2010	1			1	Y	08/31/2006	08/31/2006	
90	1025		1	03/30/2012	1			1	Y	02/09/2007	02/09/2007	
127	1025		2	06/08/2012	1			1	Y	05/17/2006	05/17/2006	

Unique Tax IDs	Matching TaxID	Owner Name	Associated Exec Records	Person Search Records	Business Lein Dolan Records	Business Lein Mixed Records	Business Lower Court Records	Business Public Court Records	Person Criminal Records	Person Charges Records	Felony	Person Death Records
0	N		27	3	3				9	9	N	
1	Y		3	3	5	1	3					
7	Y		32	1	4	2	7	2				
0	N		4	3	1	1	2					
1	Y		6	3	1		2		1	1	N	
1	Y		35	3	96							
1	Y		3	2								
1	N		1	1								
0	N			1								
1	N		5	1								

Drill-Down by Sanction

query key	query BNAME	query CITY	query STATE	query SEARCH TYPE	Crt SancActn key	Crt Sanction Key	Crt SancActn ActionCode	Crt SancActn ActionStartDate	Crt SancActn ActionTerm	Crt SancActn TypeOfAction
8				B	1973	2593		2007-04-23		
8				B	1974	2594	1128a1			
8				B	1975	2595	1128a1		10 YRS	
8				B	1976	2596	1128a1			
8				B	1977	2597		2002-02-20		1128b8
8				B	1978	2598	R; Z1		Indef.	
8				B	1979	2599	R; Z1		Indef.	
8				B	1980	2600	Z1		Indef.	
8				B	1981	2601	1128b8	2002-02-20		

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Drill-Down by Action

Actions Records	Notes Records	Crt Sanction ActionSummary	Crt Sanction CaseStatus Date	Crt Sanction EmployeeOccupationCategoryText	Crt Sanction EntryDate	Crt Sanction Findings
1		Vendor Debarment			2010-06-29	
1	1	Exclusion: 1128a1 - Program-related conviction				
1		Exclusion: 1128a1 -Program-related conviction				
1		Program-related conviction				
1		KY OIG Excluded Providers			2011-09-16	
1	1	TREATMENT R: Listed persons are excluded as participants or principals in all primary a				CAUSE R: Debarment by any Fe
1	3	TREATMENT R: Listed persons are excluded as participants or principals in all primary a				CAUSE R: Debarment by any Fe
1	3	TREATMENT Z1: For exclusions imposed prior to August 5, 1997, the scope is limited to				CAUSE Z1: Excluded by the Dep
1	3	EXCLUSION: 1128(b)(8) Entities owned or controlled by a sanctioned individual.				

We are confident this drillable formatted file significantly reduces the data processing required by your team, providing immediate access to information on risky providers. Using this format for validations and revalidations, you immediately know which of the tens of thousands of providers reviewed "passed" on the data provided to us and do not have to do anything for those providers. We need only complete a more detailed of those providers with a high-risk assignment; saving thousands of hours of review time. We provide this same report card in our monthly monitoring report set, illuminating those providers who had changes in the month – including death or sanctions. Our solution can also include disseminating provider records/changes in an electronic format to support the MMIS provider file updates. We will work with you to develop a mutually acceptable file format.

Validation and Revalidation

As part of the ACA 6028 requirements, the validation requirements have been increased, including the need to validate all owners of businesses if they own more than 5% of the business. CMS also addressed the need to revalidate providers based on categorical risk. As a result, providers must be re-credentialed either every three (e.g., DME) or five (e.g., physicians, hospitals, etc.) years. States must also re-credential any change elements for providers when there is either a change in ownership or when a provider opens or closes new practice locations (e.g., ambulance company opens a second location). Our solution includes data retrieval and risk scoring services to meet these requirements, as described above. Because we have your claim data, once we identify any risky providers, we link that information to the data warehouse and determine what, if any, retrospective payments. Further, as required by the law, any provider who has not received payments in the last twelve months must be re-credentialed. We can set up an automatic trigger to identify these providers using, "Last Date Paid" to automatically track these types of outliers in our monthly reporting. We also mutually develop an action plan to ensure no the provider receives no further payments until the provider completes the credentialing process. We believe this unique "extra step" in the ACA 6028

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services helps you be more than just compliant. You can take this information to help recover inappropriate payments thereby using these services to save money.

Monthly Monitoring

The ACA 6028 requirements include a mandate to screen every provider, every month for Federal (LEIE or GSA, EPLS) sanctions and death (SSA Death file). We will also screen every provider for state sanctions for every state – verifying that providers sanctioned in one state do not relocate to another state to attempt to gain practicing privileges. We will conduct monthly monitoring and match each provider to the Federal sanction databases (LEIE, GSA) and the SSA Death Master file. Further, to the extent the public data contains the required data elements, we will provide a report that shows any changes from the prior to the current month (e.g., provider has new liens or judgments). This will allow you to consider providers for removal from the network to mitigate the potential losses from inappropriate billing.

Trend Report

To provide additional value, we also trend the Provider Risk Scores over time to illustrate those providers with Risk Scores that are increasing over time. Your team can access this information and use it to prioritize provider reviews as well. Through trend reporting, even if a provider "passes" the monthly monitoring, your team will receive an early alert if certain providers are becoming increasingly risky over time.

Background Checks and Fingerprinting

Background checks begin with an FBI criminal check with adjudicative review. We will work with you to develop a recommended adjudication approach of the criminal history report based on specific state and/or provider type criteria. Additionally, the public records data including criminal history, bankruptcies, lien, judgments and other data described earlier is provided to you to validate and enhance the adjudicated FBI data. Our partner, KeyPoint (a portfolio company to Truven Health), currently provides these same background screening services to the Transportation Security Administration (TSA) and the U.S. Army National Guard (ARNG). KeyPoint currently holds a contract with the Federal Bureau of Investigation (FBI) and is an authorized channel of fingerprint-based criminal record histories using the Integrated Automated Fingerprint Identification System (IAFIS). The secure portal ensures secure transmission of electronic fingerprint records and ensures a proper chain of custody of provider criminal history records.

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With respect to fingerprinting, to ensure a cost-efficient solution consistent with the requirements of the RFP, we recommend authorizing applicants to obtain their prints through their local law enforcement agency; typically a sheriff's office or police department. Applicants would schedule an appointment at a location convenient to them and provide two proofs of identification to the law agency when being printed. After fingerprints are collected, the applicant sends completed fingerprint cards to our headquarters for processing and channeling to the FBI. Our proposed pricing reflects this approach. As an alternative, we can provide a mobile electronic collection solution via a Livescan device or schedule appointments at other brick-and-mortar collection locations. If these alternatives are of interest to you, we will provide the associated additional fees.

Site Visits

We are also offering a solution to meet the Site Visit requirements of ACA 6028. To complete site visits, we will leverage our portfolio company KeyPoint and their existing nationwide field workforce of more than 1,900 investigators. All inspectors have Top Secret clearance, and many are retired law enforcement or military personnel. Inspectors perform site visit inspections without any prior notification to the provider or personnel at the provider site. All attempted inspections are performed during the operational hours for the provider location as specified by the provider in their enrollment application and transmitted with the inspection request. Inspectors will make two physical attempts to verify the listed location of the provider during business hours, and will provide a description of on-site business activities as witnessed during the visit. Additionally, inspectors will provide up to five digital photographs of the location. Inspectors will electronically transmit a complete report of findings, and the quality review staff will review reports for accuracy and completeness prior to providing the results to you. We will work with you to define the specific requirements for site visits for each provider type.

Monthly Status Reports

We will provide a comprehensive set of monthly reporting metrics. Our monthly reports, at a minimum, contain:

- Count of provider records received
- Count of providers returned, with results
- Provider Risk Score Report Card statistics for validations and revalidations
- Number of providers with sanctions and other adverse indicators

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- Total risk level counts (e.g. high and moderate)
- Provider Risk Score Report Card statistics for monthly monitoring
- Number of providers with sanctions and other adverse indicators
- Total risk level counts (e.g. high and moderate)
- Variances from previous month
- Provider Risk Score Trend Report
- Background checks and fingerprinting counts and results (pass, fail)
- Number of users trained
- Online access statistics

3 – FEE STRUCTURE

Our fees for these services are fixed, based on the number of providers in your network. Unlike other solutions, we do not charge additional fees for multiple hits to public data. If for example, we need to access five databases for one provider and fifteen for another, our fees are the same. We must always consider budget constraints and their potential limiting effect when executing the services we are proposing for to you. Our solution is a modular component of Medicaid operations, enhancing MITA maturity levels. Our MITA compliant solution entitles you to utilize Federal Matching Funds for this work. Based on the CMS Medicaid Director's Letter dated December 23, 2011, and given our solution meets the MMIS modular requirements of MITA, the project is subject to a 90% Federal Match for design, development and implementation, and Ongoing Operations are subject to a 75% Federal Match

4 – FULL BPO CREDENTIALING SOLUTION

In addition to the Application Processing Solution to supplement your team, our nationally recognized subject matter experts took market feedback and developed an end-to-end, turn-key Provider Surveillance solution. With our teaming partner, CGS Administrators, LLC, we offer full Business Process Outsourcing (BPO) services; taking on the entire credentialing responsibility for states, Medicare Administrative Contractors (MACs) and Health Plans. These services include Application In-Take, Application Validation, Provider Enrollment Recommendations, Provider Contact Centers, and Application Appeals Processing. This solution:

- meets all of the new ACA 6028 enrollment standards;
- passes CMS audits for payment integrity;
- transforms manual screening and enrollment processes into a paperless electronic system with automated monthly monitoring;
- delivers benefits to Medicare/Medicaid providers with a single credentialing solution; and
- meets the requirements as quickly as possible, without the need to hire additional staff.

For instance, if you elect our full service in addition to processing all fees, we maintain all of the applications, documents and statuses and make them readily available to you. This solution includes responding to provider appeals and call center support to help providers successfully complete the application. We maintain the workflow management tools and databases necessary to complete the work. You have no software purchase, hardware investment, or ongoing system maintenance costs.

Our end-to-end provider surveillance and credentialing capabilities ensures you deliver a best-in-class, cost-efficient solution to your customers. Our full-service, automated query and monitoring approach results in a paperless intake/output process and provides a single enrollment process for providers who serve Medicaid and/or Medicare beneficiaries. This ensures you meet both ACA 6028 requirements and pass CMS payment integrity audits. It also makes it easy for both you and the providers to meet these requirements and provide seamless administration of the provider credentialing requirements. We welcome the opportunity to discuss these services with you.

Application In-Take Process

The credentialing process begins with the receipt of an application. Medicaid only providers complete the appropriate state application – physician or non-physician practitioner (e.g., Institutional, Clinic, Group Practice, DME, Home Health and certain other providers) – via your

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website. The provider can follow the current states process of printing the application, and complete it before submission. If your team receives and reviews the application, we establish a mechanism, for you to acknowledge that portion of the process is complete, typically facsimile with an authorization to collect fees. Under this approach, we need only collect fees for Medicaid hospital, group practice, clinics, home health and hospice, DME and certain other suppliers (e.g., ambulance). If we are performing application services for any and/or all providers, we provide a fax transmission number for the provider to use to submit the application and its attachments to our secured Right fax line for digital ingestion into the workflow. Your response to questions regarding this RFI indicates your intent to not waive fees for any provider. Unless the provider is Medicare-enrolled or the state changes this intent, the provider is required to pay the application fee either by check or PayPal. Once we mutually determine the application receipt and review process, our credentialing team collects the $500 application fee. If the provider has either not provided appropriate documentation and/or not paid fees, we place the application in a hold status and contact the provider via electronic communication. Finally, with your approval, we apply the fees collected to off-set our monthly services invoice.

Application Verification Process

Once we receive the required information and fees are paid, we then complete the Application Validation processes. We validate Medicare providers using Medicare's Provider Enrollment Chain Ownership System (PECOS) and we enter the results into the workflow tracking system so that the monitoring can take place effectively. Validating and revalidating providers by using PECOS significantly reduces the overall cost and time required to complete the ACA 6028 verifications. We estimate that over 50% of the providers are eligible for this streamlined service. If there are no alerts or "red flags" after checking the GSA and LEIE schedules, state sanctions and the SSN Death Master File, we approve the provider and finalize the credentialing process for Medicare-enrolled providers. If the provider shows adverse alerts or red flags we do not recommend them for billing privileges in the network.

For Medicaid-only providers the validation/revalidation process entails:

- Running the Provider Risk Score Report Card
- Reviewing the results, using the drillable feature of the report card
- Researching and verifying any adverse information retrieved

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- Verifying application information through phone calls, letters, and web research as required
- Determining if the provider passed or failed the ACA 6028 requirements
- Summarizing the results to present to the Provider Credentialing Council

It is our goal to help providers successfully complete the credentialing process and correct any errors of omission. When providers do not respond to the requests within a timely manner, we abandon the request and provide this information to the Credentialing Council. The significant difference from the Provider Surveillance solution presented above is that our credentialing experts review the Provider Risk Score Report Card and do the investigation of providers receiving a moderate or high-risk score. We make the telephone calls that may be necessary and go online into the Public Records data for a deeper review of the provider. Our results are a recommendation of who should and should not have billing privileges.

Provider Recommendation Process

We recommend establishing a Credentialing Council who ultimately decides what action to take on each provider that goes through validation/revalidation and monthly monitoring. The Credentialing Council can also include state staff, if warranted by your state contracts. On a daily, weekly or monthly basis and after each Provider Risk Score Report Card and Trend Report is complete, our credentialing experts present our recommendations for provider action to the Credentialing Council. Specifically, we recommend to:

- Reject or terminate the provider if the computed Provider Risk Score is high and the verification shows the provider should be rejected or terminated
- Accept or keep the provider if the computed Provider Risk Score is low
- Only accept the provider into the network (or keep them in the network) for special cases (e.g., need providers of that type in the network) when the computed Provider Risk Score indicates a non-desirable level of risk. These recommendations also include a suggestion that the provider be on pre-payment review or claims-based monitoring by the Surveillance Utilization Review (SUR) team.

As previously discussed, the rationale for our recommendations are available for you to review in the Provider Risk Score Report Card presented earlier in this proposal. We make recommendations to exclude providers for Categorical Risk Scores of Low and Moderate, as well as High, based on information not previously available to your team (e.g., an owner was sanctioned even though the business was not, or the business is showing a significant number

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of business liens that could impact the delivery of healthcare services). The ultimate decision on whether to accept providers into the network always remains with the Credentialing Council.

For newly enrolling or revalidating providers, our experience suggests that we recommend the majority of providers for inclusion in the network. We anticipate providing recommendations for these providers to the Credentialing Council electronically within 48 hours of completing the Application Development process. For those providers who have adverse information and high-risk scores, we recommend a more thorough review by our staff, who make the phone calls required to make certain the adverse information is in fact for the specific provider being reviewed (e.g., John Green vs. John Greene – sanctioned in another state three years ago). For these providers with adverse indicators and high-risk scores, we deliver results as soon as available and within 30 days. We meet with the Credentialing Council in a weekly conference call to review all recommendations completed that week. Once the Credentialing Council's decision is final, our team can send a welcome packet or denial letter, as appropriate, to the respective provider.

Monthly Monitoring Process

During the monthly monitoring process, our staff runs the Provider Risk Score Report Card for all providers and owners using the monthly review criteria for sanctions and death (and licensure status as requested in the RFP). Our credentialing team reviews the results and changes from the previous month and determines appropriate action steps. After we perform the required validations each month, we present any adverse findings to the Credentialing Council during our ongoing meetings. We perform all activities without any action required by you or the state, except decision making regarding our recommendations.

Provider Support and Appeals Process

To facilitate the provider experience, we provide customer support through a toll-free number. We provide information during the in-take process on the application confirmation requirements. During the development process, we identify any additional information that the provider must supply to complete the validation process. If the provider does not deliver the information within the requested timeframe, we deny the application and the provider must reapply.

Our service includes application questions support throughout the processing life cycle, and a review of the provider's appeal when we have denied their request for billing privileges and they believe that we have not properly assessed their application. We supply a recommendation on the provider's appeal and the final appeals decision remains with the Credentialing Council.

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Reporting

In addition to the reporting we describe above, we provide a comprehensive set of monthly reporting metrics for validations, revalidations and monthly monitoring. The reports contain information you request, as well as:

- Applications awaiting payment
- Applications pending additional provider information
- New applications/Revalidations
- Approvals
- Denials
- Changes received/completed
- Results of monthly monitoring including Risk Score Trend Report
- Site Visits performed
- Appeals upheld/over-turned
- Timeliness and Quality Metrics
- Fee collections

We post all reports to a SharePoint site, readily accessible by you and by each state, with written approval from you.

About CGS Administrators, LLC

Our teaming partner – CGS Administrators, LLC – has been credentialing Medicare providers for over 40 years. They currently credential providers in 17 states and specialize in managing high-risk providers, like DME and Home Health and Hospice providers. CGS' ability to efficiently process provider applications is well-known within the Medicare community. CMS referred Medicare Administrative Contractors (MACs) to CGS on three occasions to assist with reducing provider application backlogs. Their experience includes serving as a BETA test site during the development of the PECOS online provider application. CGS has been credentialing to the new ACA 6028 requirements since March of 2011.

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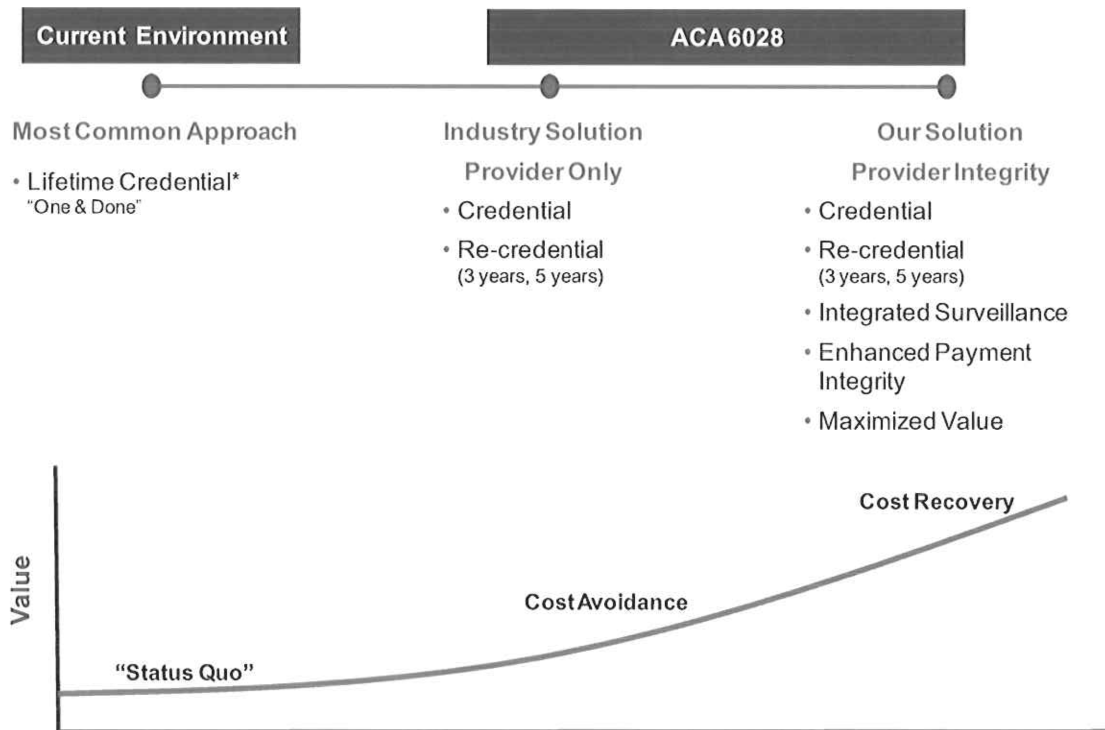
5 – CONCLUSION

Preventing risky providers from entering the state networks, and quickly detecting those high-risk providers already in network, are critical to maintaining the integrity of Medicaid programs. Identifying and monitoring potential provider fraud is, by its very nature, highly complex and schemes are constantly changing. Our approach to ACA 6028 helps you recover funds, not just remove providers from the system. Prior to ACA 6028, most states, unless otherwise required by statute, had a "one and done" approach to credentialing; upon the initial screen, providers stayed in the networks indefinitely. To meet the new requirements, other vendors offer support in validation and revalidation efforts. This siloed, provider only solution is a good first step that ensures ACA 6028 compliance. It is not, however, enough to achieve the savings demanded by states facing tremendous budget pressures. Our approach goes far beyond simple compliance, taking your credentialing process a significant step further. By linking provider validations to claim data, we provide an integrated surveillance solution that maximizes value to you.



Our experience in running ACA verifications to date has universally identified providers who should not be participating in the Medicaid network and are being paid millions of dollars. We believe this unique "extra step" in

In every assessment completed to date, we found significant opportunities to remove risky providers.

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our ACA 6028 services helps you be more than compliant. We are in the process of developing an initial review of your network and will share with you as it becomes available. Our approach goes beyond the cost avoidance of removing providers from future payments. Rather, it guarantees cost recovery opportunities, and as result, your ROI on our services is many-fold. Once we complete the implementation of the DSS currently underway, we can include any payments associated with risky providers based on our credentialing review. In total, this added benefit more than covers the price of our services, resulting in significant ROI to you and ensuring removal of the riskiest providers from your network. At the same time, it establishes an infrastructure to quickly support full ACA 6028 compliance. We know there is no "silver bullet," no single technology, system, service, strategy, or tactic that detects or prevents every type of healthcare fraud. As your current DSS partner, and as the industry leader for 30 years we offer you the most comprehensive set of tools, advanced analytics, algorithms and predictive models, all from the most experienced professionals in the industry. This translates to success for you, allowing you to achieve your ACA 6028 compliance goals on time and within budget. We look forward to working with you on this initiative.

APPENDIX A – SIGNED RFI FORMS & ADDENDA

As required, we have included the following signed RFI forms:

- RFI Cover Page
- Purchasing Affidavit
- Vendor Preference Certificate
- Agreement Addendum for Software
- Certification and Signature Page
- Addendum Acknowledgement Form
- Addendum 1 Cover Page
- Addendum 2 Cover Page

State of West Virginia
Department of Administration
Purchasing Division
2019 Washington Street East
Post Office Box 50130
Charleston, WV 25305-0130

Solicitation

NUMBER	PAGE
INS13004	1

ADDRESS CORRESPONDENCE TO ATTENTION OF:
CONNIE OSWALD
304-558-2157

VENDOR

RFQ COPY
TYPE NAME/ADDRESS HERE

Truven Health Analytics Inc.
777 E. Eisenhower Parkway
Ann Arbor, MI 48108

SHIP TO

INSURANCE COMMISSION

1124 SMITH STREET
CHARLESTON, WV
25305-0540 304-558-3707

DATE PRINTED: 09/05/2012

BID OPENING DATE: 09/27/2012 BID OPENING TIME 1:30PM

LINE	QUANTITY	UOP	CAT. NO.	ITEM NUMBER	UNIT PRICE	AMOUNT

REQUEST FOR INFORMATION

THE STATE OF WEST VIRGINIA AND ITS AGENCY THE WEST VIRGINIA INSURANCE COMMISSION ON BEHALF OF THE DEPARTMENT OF HEALTH AND HUMAN RESOURCES IS SEEKING INFORMATION ON DETERMINING HOW TO FULFILL THE SELECTION OF A CREDENTIALING VERIFICATION ORGANIZATION (CVO) PER THE ATTACHED SPECIFICATIONS.

THIS IS A REQUEST FOR INFORMATION ONLY AND IS SOLELY USED FOR INFORMATION AND PLANNING PURPOSES. THIS REQUEST FOR INFORMATION DOES NOT CONSTITUTE EITHER A REQUEST FOR PROPOSAL OR QUOTATION (RFP/RFQ) OR A PROMISE TO ISSUE A RFP OR RFQ IN THE FUTURE.

RESPONSES WILL BE RECEIVED UNTIL SEPTEMBER 27, 2012.

REFERENCE ATTACHED INSTRUCTIONS TO BIDDERS AND SPECIFICATIONS.

LINE	QUANTITY	UOP	CAT. NO.	ITEM NUMBER	UNIT PRICE	AMOUNT
0001	1	JB		962-47		

INSURANCE SERVICES

SELECTION OF CREDENTIALING VERIFICATION ORGANIZATION (CVO) PER THE ATTACHED SPECIFICATIONS.

SIGNATURE: [signature] TELEPHONE: 734-913-3000 DATE: October 2, 2012

TITLE: EVP FEIN: 06-1467923 ADDRESS CHANGES TO BE NOTED ABOVE

WHEN RESPONDING TO SOLICITATION, INSERT NAME AND ADDRESS IN SPACE ABOVE LABELED 'VENDOR'

RFQ No. INS13004

STATE OF WEST VIRGINIA
Purchasing Division

PURCHASING AFFIDAVIT

MANDATE: Under W. Va. Code §5A-3-10a, no contract or renewal of any contract may be awarded by the state or any of its political subdivisions to any vendor or prospective vendor when the vendor or prospective vendor or a related party to the vendor or prospective vendor is a debtor and: (1) the debt owed is an amount greater than one thousand dollars in the aggregate; or (2) the debtor is in employer default.

EXCEPTION: The prohibition listed above does not apply where a vendor has contested any tax administered pursuant to chapter eleven of the W. Va. Code, workers' compensation premium, permit fee or environmental fee or assessment and the matter has not become final or where the vendor has entered into a payment plan or agreement and the vendor is not in default of any of the provisions of such plan or agreement.

DEFINITIONS:

"Debt" means any assessment, premium, penalty, fine, tax or other amount of money owed to the state or any of its political subdivisions because of a judgment, fine, permit violation, license assessment, defaulted workers' compensation premium, penalty or other assessment presently delinquent or due and required to be paid to the state or any of its political subdivisions, including any interest or additional penalties accrued thereon.

"Employer default" means having an outstanding balance or liability to the old fund or to the uninsured employers' fund or being in policy default, as defined in W. Va. Code § 23-2c-2, failure to maintain mandatory workers' compensation coverage, or failure to fully meet its obligations as a workers' compensation self-insured employer. An employer is not in employer default if it has entered into a repayment agreement with the Insurance Commissioner and remains in compliance with the obligations under the repayment agreement.

"Related party" means a party, whether an individual, corporation, partnership, association, limited liability company or any other form or business association or other entity whatsoever, related to any vendor by blood, marriage, ownership or contract through which the party has a relationship of ownership or other interest with the vendor so that the party will actually or by effect receive or control a portion of the benefit, profit or other consideration from performance of a vendor contract with the party receiving an amount that meets or exceed five percent of the total contract amount.

AFFIRMATION: **By signing this form, the vendor's authorized signer affirms and acknowledges under penalty of law for false swearing (*W. Va. Code* §61-5-3) that neither vendor nor any related party owe a debt as defined above and that neither vendor nor any related party are in employer default as defined above, unless the debt or employer default is permitted under the exception above.**

WITNESS THE FOLLOWING SIGNATURE:

Vendor's Name: Truven Health Analytics Inc.

Authorized Signature: [signature] Date: October 2, 2012

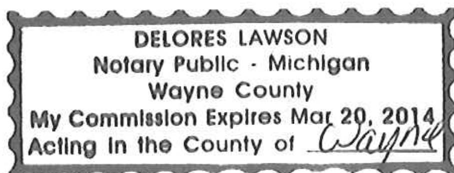
State of Michigan

County of Wayne, to-wit:

Taken, subscribed, and sworn to before me this 3 day of October, 2012.

My Commission expires 3/20, 2014

AFFIX SEAL HERE NOTARY PUBLIC Delores Lawson



Rev. 07/12

State of West Virginia

VENDOR PREFERENCE CERTIFICATE

Certification and application* is hereby made for Preference in accordance with *West Virginia Code*, §5A-3-37. (Does not apply to construction contracts). *West Virginia Code*, §5A-3-37, provides an opportunity for qualifying vendors to request (at the time of bid) preference for their residency status. Such preference is an evaluation method only and will be applied only to the cost bid in accordance with the *West Virginia Code*. This certificate for application is to be used to request such preference. The Purchasing Division will make the determination of the Resident Vendor Preference, if applicable.

1. **Application is made for 2.5% resident vendor preference for the reason checked:**

____ Bidder is an individual resident vendor and has resided continuously in West Virginia for four (4) years immediately preceding the date of this certification; **or,**

____ Bidder is a partnership, association or corporation resident vendor and has maintained its headquarters or principal place of business continuously in West Virginia for four (4) years immediately preceding the date of this certification; or 80% of the ownership interest of Bidder is held by another individual, partnership, association or corporation resident vendor who has maintained its headquarters or principal place of business continuously in West Virginia for four (4) years immediately preceding the date of this certification; **or,**

____ Bidder is a nonresident vendor which has an affiliate or subsidiary which employs a minimum of one hundred state residents and which has maintained its headquarters or principal place of business within West Virginia continuously for the four (4) years immediately preceding the date of this certification; **or,**

2. **Application is made for 2.5% resident vendor preference for the reason checked:**

____ Bidder is a resident vendor who certifies that, during the life of the contract, on average at least 75% of the employees working on the project being bid are residents of West Virginia who have resided in the state continuously for the two years immediately preceding submission of this bid; **or,**

3. **Application is made for 2.5% resident vendor preference for the reason checked:**

____ Bidder is a nonresident vendor employing a minimum of one hundred state residents or is a nonresident vendor with an affiliate or subsidiary which maintains its headquarters or principal place of business within West Virginia employing a minimum of one hundred state residents who certifies that, during the life of the contract, on average at least 75% of the employees or Bidder's affiliate's or subsidiary's employees are residents of West Virginia who have resided in the state continuously for the two years immediately preceding submission of this bid; **or,**

4. **Application is made for 5% resident vendor preference for the reason checked:**

____ Bidder meets either the requirement of both subdivisions (1) and (2) or subdivision (1) and (3) as stated above; **or,**

5. **Application is made for 3.5% resident vendor preference who is a veteran for the reason checked:**

____ Bidder is an individual resident vendor who is a veteran of the United States armed forces, the reserves or the National Guard and has resided in West Virginia continuously for the four years immediately preceding the date on which the bid is submitted; **or,**

6. **Application is made for 3.5% resident vendor preference who is a veteran for the reason checked:**

____ Bidder is a resident vendor who is a veteran of the United States armed forces, the reserves or the National Guard, if, for purposes of producing or distributing the commodities or completing the project which is the subject of the vendor's bid and continuously over the entire term of the project, on average at least seventy-five percent of the vendor's employees are residents of West Virginia who have resided in the state continuously for the two immediately preceding years.

7. **Application is made for preference as a non-resident small, women- and minority-owned business, in accordance with *West Virginia Code* §5A-3-59 and *West Virginia Code of State Rules.***

____ Bidder has been or expects to be approved prior to contract award by the Purchasing Division as a certified small, women- and minority-owned business.

Bidder understands if the Secretary of Revenue determines that a Bidder receiving preference has failed to continue to meet the requirements for such preference, the Secretary may order the Director of Purchasing to: (a) reject the bid; or (b) assess a penalty against such Bidder in an amount not to exceed 5% of the bid amount and that such penalty will be paid to the contracting agency or deducted from any unpaid balance on the contract or purchase order.

By submission of this certificate, Bidder agrees to disclose any reasonably requested information to the Purchasing Division and authorizes the Department of Revenue to disclose to the Director of Purchasing appropriate information verifying that Bidder has paid the required business taxes, provided that such information does not contain the amounts of taxes paid nor any other information deemed by the Tax Commissioner to be confidential.

Under penalty of law for false swearing (West Virginia Code, §61-5-3), Bidder hereby certifies that this certificate is true and accurate in all respects; and that if a contract is issued to Bidder and if anything contained within this certificate changes during the term of the contract, Bidder will notify the Purchasing Division in writing immediately.

Bidder: Truven Health Analytics Inc. Signed: ____________________

Date: October 2, 2012 Title: Executive Vice President

WV-96A
Rev. 9/11

AGREEMENT ADDENDUM FOR SOFTWARE

In the event of conflict between this addendum and the agreement, this addendum shall control:

1. DISPUTES - Any references in the agreement to arbitration or to the jurisdiction of any court are hereby deleted. Disputes arising out of the agreement shall be presented to the West Virginia Court of Claims.
2. HOLD HARMLESS - Any provision requiring the Agency to indemnify or hold harmless any party is hereby deleted in its entirety.
3. GOVERNING LAW - The agreement shall be governed by the laws of the State of West Virginia. This provision replaces any references to any other State's governing law.
4. TAXES - Provisions in the agreement requiring the Agency to pay taxes are deleted. As a State entity, the Agency is exempt from Federal, State, and local taxes and will not pay taxes for any Vendor including individuals, nor will the Agency file any tax returns or reports on behalf of Vendor or any other party.
5. PAYMENT - Any references to prepayment are deleted. *Fees for software licenses, subscriptions, or maintenance are payable annually in advance.* Payment *for services* will be in arrears.
6. INTEREST - Any provision for interest or charges on late payments is deleted. The Agency has no statutory authority to pay interest or late fees.
7. NO WAIVER - Any language in the agreement requiring the Agency to waive any rights, claims or defenses is hereby deleted.
8. FISCAL YEAR FUNDING - Service performed under the agreement may be continued in succeeding fiscal years for the term of the agreement, contingent upon funds being appropriated by the Legislature or otherwise being available for this service. In the event funds are not appropriated or otherwise available for this service, the agreement shall terminate without penalty on June 30. After that date, the agreement becomes of no effect and is null and void. However, the Agency agrees to use its best efforts to have the amounts contemplated under the agreement included in its budget. Non-appropriation or non-funding shall not be considered an event of default.
9. STATUTE OF LIMITATION - Any clauses limiting the time in which the Agency may bring suit against the Vendor, lessor, individual, or any other party are deleted.
10. SIMILAR SERVICES - Any provisions limiting the Agency's right to obtain similar services or equipment in the event of default or non-funding during the term of the agreement are hereby deleted.
11. FEES OR COSTS - The Agency recognizes an obligation to pay attorney's fees or costs only when assessed by a court of competent jurisdiction. Any other provision is invalid and considered null and void.
12. ASSIGNMENT - Notwithstanding any clause to the contrary, the Agency reserves the right to assign the agreement to another State of West Virginia agency, board or commission upon thirty (30) days written notice to the Vendor and Vendor shall obtain the written consent of Agency prior to assigning the agreement.
13. LIMITATION OF LIABILITY - The Agency, as a State entity, cannot agree to assume the potential liability of a Vendor. Accordingly, any provision limiting the Vendor's liability for direct damages to a certain dollar amount or to the amount of the agreement is hereby deleted. Limitations on special, incidental or consequential damages are acceptable. In addition, any limitation is null and void to the extent that it precludes any action for injury to persons or for damages to personal property.
14. RIGHT TO TERMINATE - Agency shall have the right to terminate the agreement upon thirty (30) days written notice to Vendor. Agency agrees to pay Vendor for services rendered or goods received prior to the effective date of termination. ***In such event, Agency will not be entitled to a refund of any software license, subscription or maintenance fees paid.***
15. TERMINATION CHARGES - Any provision requiring the Agency to pay a fixed amount or liquidated damages upon termination of the agreement is hereby deleted. The Agency may only agree to reimburse a Vendor for actual costs incurred or losses sustained during the current fiscal year due to wrongful termination by the Agency prior to the end of any current agreement term.
16. RENEWAL - Any reference to automatic renewal is deleted. The agreement may be renewed only upon mutual written agreement of the parties.
17. INSURANCE - Any provision requiring the Agency to purchase insurance for Vendor's property is deleted. The State of West Virginia is insured through the Board of Risk and Insurance Management, and will provide a certificate of property insurance upon request.
18. RIGHT TO NOTICE - Any provision for repossession of equipment without notice is hereby deleted. However, the Agency does recognize a right of repossession with notice.
19. ACCELERATION - Any reference to acceleration of payments in the event of default or non-funding is hereby deleted.
20. CONFIDENTIALITY - Any provision regarding confidentiality of the terms and conditions of the agreement is hereby deleted. State contracts are public records under the West Virginia Freedom of Information Act.
21. AMENDMENTS - All amendments, modifications, alterations or changes to the agreement shall be in writing and signed by both parties. No amendment, modification, alteration or change may be made to this addendum without the express written approval of the Purchasing Division and the Attorney General.

ACCEPTED BY:

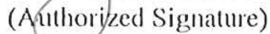
STATE OF WEST VIRGINIA	VENDOR
Spending Unit: ______	Company Name: Truven Health Analytics Inc.
Signed: ______	Signed: [signature]
Title: ______	Title: Executive Vice President
Date: ______	Date: October 2, 2012

CERTIFICATION AND SIGNATURE PAGE

By signing below, I certify that I have reviewed this Solicitation in its entirety; understand the requirements, terms and conditions, and other information contained herein; that I am submitting this bid or proposal for review and consideration; that I am authorized by the bidder to execute this bid or any documents related thereto on bidder's behalf; that I am authorized to bind the bidder in a contractual relationship; and that to the best of my knowledge, the bidder has properly registered with any State agency that may require registration.

Truven Health Analytics Inc.

(Company)



(Authorized Signature)

Jonathan S. Newpol, EVP

(Representative Name, Title)

734-913-3000   734-913-3338

(Phone Number)   (Fax Number)

October 2, 2012

(Date)

ADDENDUM ACKNOWLEDGEMENT FORM

SOLICITATION NO.: INS13004

Instructions: Please acknowledge receipt of all addenda issued with this solicitation by completing this addendum acknowledgment form. Check the box next to each addendum received and sign below. Failure to acknowledge addenda may result in bid disqualification.

Acknowledgment: I hereby acknowledge receipt of the following addenda and have made the necessary revisions to my proposal, plans and/or specification, etc.

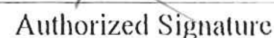
Addendum Numbers Received:
(Check the box next to each addendum received)

[x]	Addendum No. 1	[ ]	Addendum No. 6
[x]	Addendum No. 2	[ ]	Addendum No. 7
[ ]	Addendum No. 3	[ ]	Addendum No. 8
[ ]	Addendum No. 4	[ ]	Addendum No. 9
[ ]	Addendum No. 5	[ ]	Addendum No. 10

I understand that failure to confirm the receipt of addenda may be cause for rejection of this bid. I further understand that any verbal representation made or assumed to be made during any oral discussion held between Vendor's representatives and any state personnel is not binding. Only the information issued in writing and added to the specifications by an official addendum is binding.

Truven Health Analytics Inc.

Company



Authorized Signature

October 2, 2012

Date

NOTE: This addendum acknowledgement should be submitted with the bid to expedite document processing.

State of West Virginia
Department of Administration
Purchasing Division
2019 Washington Street East
Post Office Box 50130
Charleston, WV 25305-0130

Solicitation

NUMBER	PAGE
INS13004	1

ADDRESS CORRESPONDENCE TO ATTENTION OF:

CONNIE OSWALD
304-558-2157

VENDOR

RFQ COPY
TYPE NAME/ADDRESS HERE

Truven Health Analytics Inc.
777 E. Eisenhower Parkway
Ann Arbor, MI 48108

SHIP TO

INSURANCE COMMISSION

1124 SMITH STREET
CHARLESTON, WV
25305-0540 304-558-3707

DATE PRINTED: 09/25/2012

BID OPENING DATE: 10/04/2012 BID OPENING TIME 1:30PM

LINE	QUANTITY	UOP	CAT. NO.	ITEM NUMBER	UNIT PRICE	AMOUNT

ADDENDUM NO. 01

1. TO MOVE THE BID OPENING DATE FROM: 09/27/2012 @ 1:30 PM TO 10/04/2012 AT 1:30 PM. LOCATION IS THE SAME.
2. TO PROVIDE ADDENDUM ACKNOWLEDGMENT. THIS DOCUMENT SHOULD BE SIGNED AND RETURNED WITH YOUR BID. FAILURE TO SIGN AND RETURN MAY RESULT IN DISQUALIFICATION OF YOUR BID.

END OF ADDENDUM NO. 1

SIGNATURE	TELEPHONE 734-913-3000	DATE October 2, 2012
TITLE EVP	FEIN 06-1467923	ADDRESS CHANGES TO BE NOTED ABOVE

WHEN RESPONDING TO SOLICITATION, INSERT NAME AND ADDRESS IN SPACE ABOVE LABELED 'VENDOR'

State of West Virginia
Department of Administration
Purchasing Division
2019 Washington Street East
Post Office Box 50130
Charleston, WV 25305-0130

Solicitation

NUMBER	PAGE
INS13004	1

ADDRESS CORRESPONDENCE TO ATTENTION OF:

CONNIE OSWALD
304-558-2157

VENDOR

RFQ COPY
TYPE NAME/ADDRESS HERE

Truven Health Analytics Inc.
777 E. Eisenhower Parkway
Ann Arbor, MI 48108

SHIP TO

INSURANCE COMMISSION

1124 SMITH STREET
CHARLESTON, WV
25305-0540 304-558-3707

DATE PRINTED
09/27/2012

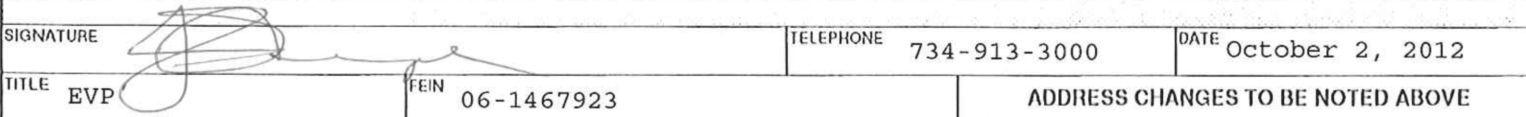
BID OPENING DATE: 10/04/2012 BID OPENING TIME 1:30PM

LINE	QUANTITY	UOP	CAT. NO.	ITEM NUMBER	UNIT PRICE	AMOUNT

ADDENDUM NO. 02

1. TO PROVIDE ANSWERS TO QUESTIONS RECEIVED FOR THIS SOLICITATION.
2. TO PROVIDE ADDENDUM ACKNOWLEDGMENT. THIS DOCUMENT SHOULD BE SIGNED AND RETURNED WITH YOUR BID. FAILURE TO SIGN AND RETURN MAY RESULT IN DISQUALIFICATION OF YOUR BID.

END OF ADDENDUM NO. 02



SIGNATURE	TELEPHONE 734-913-3000	DATE October 2, 2012
TITLE EVP	FEIN 06-1467923	ADDRESS CHANGES TO BE NOTED ABOVE

WHEN RESPONDING TO SOLICITATION, INSERT NAME AND ADDRESS IN SPACE ABOVE LABELED 'VENDOR'