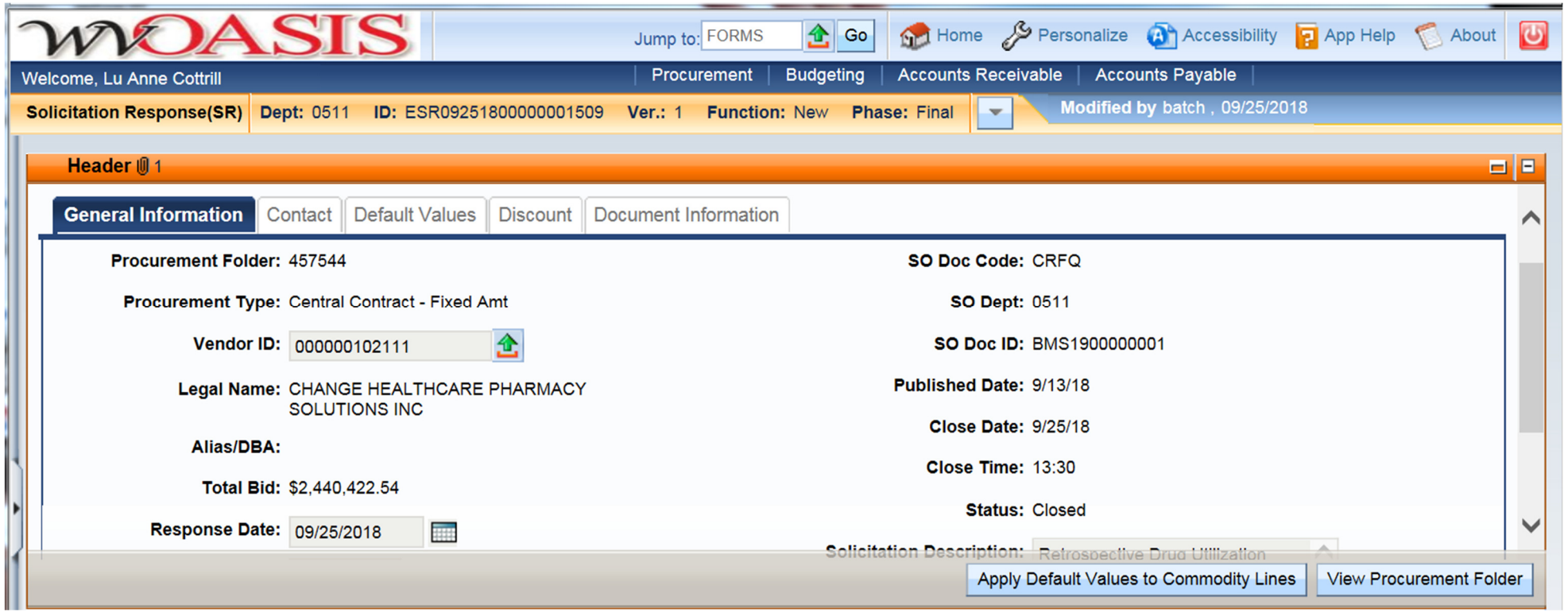
The following documentation is an electronically-submitted vendor response to an advertised solicitation from the *West Virginia Purchasing Bulletin* within the Vendor Self-Service portal at ***wvOASIS.gov***. As part of the State of West Virginia's procurement process, and to maintain the transparency of the bid-opening process, this documentation submitted online is publicly posted by the West Virginia Purchasing Division at ***WVPurchasing.gov*** with any other vendor responses to this solicitation submitted to the Purchasing Division in hard copy format.


WVOASIS
Jump to: FORMS Go
Home
Personalize
Accessibility
App Help
About
Welcome, Lu Anne Cottrill
Procurement
Budgeting
Accounts Receivable
Accounts Payable
Solicitation Response(SR) Dept: 0511 ID: ESR09251800000001509 Ver.: 1 Function: New Phase: Final
Modified by batch , 09/25/2018
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Contact
Default Values
Discount
Document Information
Procurement Folder: 457544
Procurement Type: Central Contract - Fixed Amt
Vendor ID: 000000102111
Legal Name: CHANGE HEALTHCARE PHARMACY SOLUTIONS INC
Alias/DBA:
Total Bid: $2,440,422.54
Response Date: 09/25/2018
SO Doc Code: CRFQ
SO Dept: 0511
SO Doc ID: BMS1900000001
Published Date: 9/13/18
Close Date: 9/25/18
Close Time: 13:30
Status: Closed
Solicitation Description: Retrospective Drug Utilization
Apply Default Values to Commodity Lines
View Procurement Folder

Purchasing Division
2019 Washington Street East
Post Office Box 50130
Charleston, WV 25305-0130

State of West Virginia
Solicitation Response

Proc Folder : 457544

Solicitation Description : Retrospective Drug Utilization Review Services - Addendum #1

Proc Type : Central Contract - Fixed Amt

Date issued	Solicitation Closes	Solicitation Response	Version
	2018-09-25 13:30:00	SR 0511 ESR09251800000001509	1

VENDOR

000000102111

CHANGE HEALTHCARE PHARMACY SOLUTIONS INC

Solicitation Number: CRFQ 0511 BMS1900000001

Total Bid : $2,440,422.54 **Response Date:** 2018-09-25 **Response Time:** 08:33:48

Comments:

FOR INFORMATION CONTACT THE BUYER

April E Battle

(304) 558-0067
april.e.battle@wv.gov

Signature on File **FEIN #** **DATE**

All offers subject to all terms and conditions contained in this solicitation

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
1	Start up Cost	0.00000			$303,296.30

Comm Code	Manufacturer	Specification	Model #
85111617			

Extended Description : Year 1 Start up cost (Two month)

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
2	Data Collection-Year 1	0.00000			$44,681.54

Comm Code	Manufacturer	Specification	Model #
85111617			

Extended Description : Year 1 Data Collection (10 month operations)

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
3	Member Profiles-Year 1	0.00000			$67,022.30

Comm Code	Manufacturer	Specification	Model #
85111617			

Extended Description : Year 1 Member Profiles
(10 months operations)

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
4	Educational Programs for Providers-Year 1	0.00000			$156,385.38

Comm Code	Manufacturer	Specification	Model #
85111617			

Extended Description : Educational Programs for Providers Year 1 (10 months operations)

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
5	Retrospective Drug Utilization Reports-Year 1	0.00000			$111,703.84

Comm Code	Manufacturer	Specification	Model #
85111617			

Extended Description : Retrospective Drug Utilization Reports Year 1 (10 months operations)

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
6	Lock in Program-Year 1	0.00000			$67,022.30

Comm Code	Manufacturer	Specification	Model #
85111617			

Extended Description : Retrospective Drug Utilization Reports Year 1 (10 months operations)

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
7	Data Collection-Optional Renewal Year 1	0.00000			$54,958.29

Comm Code	Manufacturer	Specification	Model #
85111617			

Extended Description : Data Collection-Optional Renewal Year 1

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
8	Member Profiles-Optional Renewal Year 1	0.00000			$82,437.43

Comm Code	Manufacturer	Specification	Model #
85111617			

Extended Description : Member Profiles-Optional Renewal Year 1

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
9	Educational Programs for Providers-Optional Renewal Year 1	0.00000			$192,354.01

Comm Code	Manufacturer	Specification	Model #
85111617			

Extended Description : Educational Programs for Providers-Optional Renewal Year 1

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
10	Retrospective Drug Utilization Reports-Opt. Renewal Year 1	0.00000			$137,395.72

Comm Code	Manufacturer	Specification	Model #
85111617			

Extended Description : Retrospective Drug Utilization Reports-Optional Renewal Year 1

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
11	Lock in Program-Optional Renewal Year 1	0.00000			$82,437.43

Comm Code	Manufacturer	Specification	Model #
85111617			

Extended Description : Lock in Program-Optional Renewal Year 1

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
12	Data Collection-Optional Renewal Year 2	0.00000			$56,332.25

Comm Code	Manufacturer	Specification	Model #
85111617			

Extended Description : Data Collection-Optional Renewal Year 2

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
13	Member Profiles-Optional Renewal Year 2	0.00000			$84,498.37

Comm Code	Manufacturer	Specification	Model #
85111617			

Extended Description : Member Profiles-Optional Renewal Year 2

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
14	Educational Programs for Providers-Optional Renewal Year 2	0.00000			$197,162.86

Comm Code	Manufacturer	Specification	Model #
85111617			

Extended Description : Educational Programs for Providers-Optional Renewal Year 2

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
15	Retrospective Drug Utilization Reports-Opt. Renewal Year 2	0.00000			$140,830.62

Comm Code	Manufacturer	Specification	Model #
85111617			

Extended Description : Retrospective Drug Utilization Reports-Opt. Renewal Year 2

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
16	Lock in Program-Optional Renewal Year 2	0.00000			$84,498.37

Comm Code	Manufacturer	Specification	Model #
85111617			

Extended Description : Lock in Program-Optional Renewal Year 1

Comments: This is for the lock-in program for renewal year 2, although it is labeled as year 1.

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
17	Data Collection-Optional Renewal Year 3	0.00000			$57,740.55

Comm Code	Manufacturer	Specification	Model #
85111617			

Extended Description : Data Collection-Optional Renewal Year 3

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
18	Member Profiles-Optional Renewal Year 3	0.00000			$86,610.83

Comm Code	Manufacturer	Specification	Model #
85111617			

Extended Description : Member Profiles-Optional Renewal Year 3

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
19	Educational Programs for Providers-Optional Renewal Year 3	0.00000			$202,091.94

Comm Code	Manufacturer	Specification	Model #
85111617			

Extended Description : Educational Programs for Providers-Optional Renewal Year 3

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
20	Retrospective Drug Utilization Reports-Opt. Renewal Year 3	0.00000			$144,351.38

Comm Code	Manufacturer	Specification	Model #
85111617			

Extended Description : Retrospective Drug Utilization Reports-Opt. Renewal Year 3

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
21	Lock in Program-Optional Renewal Year 3	0.00000			$86,610.83

Comm Code	Manufacturer	Specification	Model #
85111617			

Extended Description : Lock in Program-Optional Renewal Year 3

Retrospective Drug Utilization Review Services

CRFQ 0511 BMS1900000001

West Virginia Department of Health and Human Resources, Bureau for Medical Services

RFQ Proposal Response Prepared by:
Change Healthcare Pharmacy Solutions, Inc.

45 Commerce Drive, Suite 5
PO Box 1090
Augusta, ME 04332-1090
Phone: 800.832.9672
Fax: 207.623.5125
September 25, 2018

Proposal Prepared By:

Change Healthcare Pharmacy Solutions, Inc.
P.O. Box 1090, 45 Commerce Drive, Suite 5,
Augusta, Maine 04332-1090

Proprietary and Confidential Proposal

The information contained in this proposal is prepared expressly for the

State of West Virginia
Department of Health and Human Resources
Bureau for Medical Services

Change Healthcare understands that the State of West Virginia considers our entire response, submitted to the State for this RFQ, and a resulting contract as public documents that may be disclosed to the public following the bid / proposal opening or award of contract as required by the competitive bidding laws of West Virginia Code §§ 5A-3-1 et seq., 5-22-1 et seq., and SG-1-1 et seq. and the Freedom of Information Act West Virginia Code§§ 29B-1-1 et seq. We reserve the right, however, to consult with the State of West Virginia prior to release of information for public viewing.

CHANGE HEALTHCARE

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Augusta, Maine 04332-1090
www.changehealthcare.com

Tel: 207.622.7153
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COVER LETTER

September 24, 2018

Ms. April Battle, Buyer File #22
Department of Administration, Purchasing Division
2019 Washington Street East
Charleston, WV 25305-0130

Dear Ms. Battle,

On behalf of Change Healthcare's Medicaid Pharmacy Benefits Services (PBS) division, Change Healthcare Pharmacy Solutions, Inc. I am pleased to present the State of West Virginia Bureau of Medical Services (BMS) hereinafter referred to as the "Bureau" or "the State," with our response to the Request for Quote (CRFQ) CRFQ 0511 BMS1900000001. Our team is a dedicated division providing PBS services exclusively to state Medicaid clients and we look forward to enhancing our partnership in the State of West Virginia.

As Senior Vice President (SVP) and General Manager (GM) of Change Healthcare, I shall be responsible for the overall management of any potential contract that results from this RFQ, including any requests for clarification or other communication needed between the State staff and Change Healthcare. My contact information is as follows:

Dan Hardin, SVP and GM
Change Healthcare Pharmacy Solutions, Inc.
PO Box 1090
45 Commerce Drive, Suite 5
Augusta, Maine 04332-1090

P: 800.832.9672
C: 630.300.4407
F: 207.623.5125
E: dhardin@changehealthcare.com

We have developed our proposal in the prescribed format with content to address each requirement, taking into consideration additional information released in the answers and subsequent amendments. The Bureau will find our proposal consists of our technical and cost proposals, submitted in electronic format via the wvOASIS. This proposal will remain in effect until a contract is signed or the RFQ is cancelled.

Change Healthcare has a long history of effective collaboration with our State Medicaid Agency partners, including West Virginia, to deliver projects on time and on budget. We are confident we will deliver the Bureau with a retrospective drug utilization review (RetroDUR) program that will meet or exceed your expectations and program goals. Our organization brings the Bureau over 22 years of experience managing RetroDUR programs and more than 43 years of supporting Medicaid pharmacy benefits solutions in more than a dozen states. Our RetroDUR solution has proven to improve patient care and reduce drug expenses for our state partners; this is a solution we are excited to implement for the State of West Virginia.

CHANGE HEALTHCARE

PO Box 1090
Augusta, Maine 04332-1090
www.changehealthcare.com

Tel: 207.622.7153
800.832.9672
Fax: 207.623.5125

We thank you for your time and consideration of our RetroDUR proposal. We look forward to answering any questions you might have, providing any other information you might request, and working with the Bureau staff in the near future.

Sincerely,

Dan Hardin, SVP and GM
Change Healthcare Pharmacy Solutions, Inc.
800.832.9672
dhardin@changehealthcare.com

TABLE OF CONTENTS

Figures and Tables:

EXECUTIVE SUMMARY

Change Healthcare is pleased to present the West Virginia Purchasing Division and the Bureau for Medical Services with our response to bid solicitation #CRFQ 0511 BMS1900000001 for retrospective drug utilization review services (RetroDUR). We welcome the opportunity to continue cultivating the trusting partnership we have developed with the Bureau for the past several years during our tenure managing West Virginia's clinical contract for preferred drug list (PDL) and supplemental rebates (SRs).

The Change Healthcare RetroDUR program promotes clinically appropriate and cost-effective medication use through the incorporation of both financial and disease management strategies. We have designed a RetroDUR program for West Virginia that will improve patient care and directly support reductions in the overall drug cost and/or medical expenses.

Change Healthcare works in partnership with our clients toward accelerating the journey of improved lives, healthier communities and value-based care.

Our organization is inspiring a better healthcare system. Working alongside our client partners, we leverage our software and analytics to help them improve efficiency, reduce costs and increase cash flow. Together, we are accelerating the journey toward improved lives, healthier communities and value-based care. To do this for West Virginia's RetroDUR program, we will use our expertise to collect data, generate member profiles, develop meaningful therapeutic criteria, improve patient care through a pharmacy lock-in program and provide education programs, such as newsletters and review letters for stakeholders.

Change Healthcare's PBS division provides pharmacy solutions and is currently represented in 16 states across the country, including West Virginia. We are excited to expand on our clinical solutions for the State.

An Experienced Partner for West Virginia

Change Healthcare has a successful track record of driving down Medicaid costs through the effective implementation and management of carefully crafted programs. With **more than four (4) decades of experience** bringing comprehensive pharmacy management to our partners, we understand the Bureau's objectives and expectations of reliable and experienced management of their clinical programs. As evidenced by the following map, Change Healthcare brings multi-state experience to the State's RetroDUR solution, including most recent implementations in Pennsylvania and Ohio. Between our advanced reporting capabilities, our abilities to accommodate states and their vendors technically and our incredible track record of meeting deadlines and performance guarantees, we have the utmost confidence that these objectives will be met to the State's satisfaction.

Although our current partnership with the Bureau is focused on SRs and PDL management, we understand all things pharmacy including, but not limited to, online, real-time pharmacy bills processing, invoicing, prospective and retrospective drug utilization reviews (ProDUR) / RetroDUR, and highly sophisticated reporting, analytics and auditing. As the vendor of full PBM services in seven (7) of our 16 PBM states (Iowa, Maine, Ohio, Vermont, Wyoming, and as a Software-as-a-Service (SaaS) solution in Illinois and Utah), we are well-positioned in the most current industry and technology practices, updates and trends.

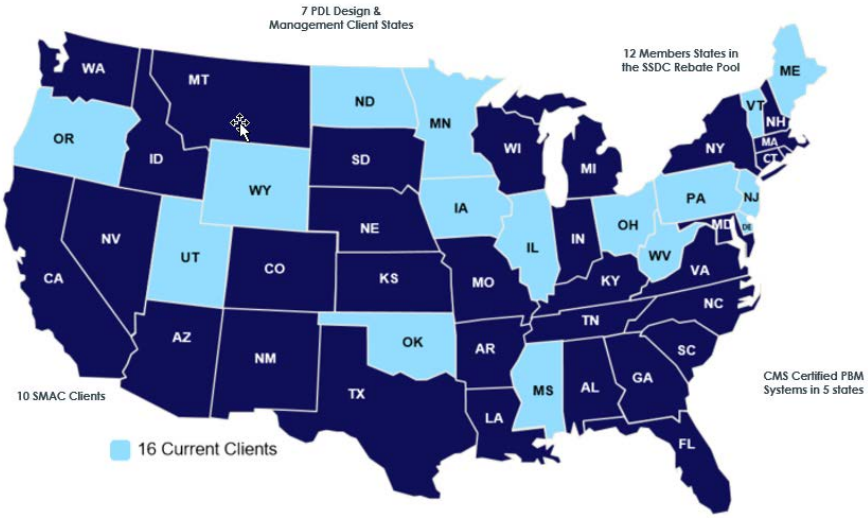


Figure 1: Change Healthcare's Current Client States

We will leverage our experience and knowledge gained from our many clients to provide the Bureau with recommendations and services that are both clinically and empirically based to achieve healthier patient outcomes and overall program savings for the State. It is our goal to continue to grow our partnership with West Virginia in continued execution of our clinical solutions. With customer service, cost savings and technical accuracy as our foremost priorities, we pride ourselves on and embrace the relationships our team has built with our clients while producing consistent and reliable deliverables.

The Change Healthcare Solution Advantages

The solutions we are presenting the Bureau comprise of modules that, with our thorough implementation procedures, can quickly and efficiently integrate with the Bureau's processes and comply with state, federal and industry technical standards. Our highly competent team members are ready to assist with proactive clinical oversight, technical innovation and unsurpassed customer service. The following outlines our high-level solution:

MEMBER PROFILES

Our clinical team helps develop member profiles to identify members that are at risk for clinical issues such as inappropriate therapy, misuse / abuse, over-and under-utilization and drug-induced illnesses. For the Bureau, we will produce patient profiles through complex screening processes and standard algorithms tailored to specific state programs.

EDUCATIONAL PROGRAMS

Change Healthcare is sensitive to the Medicaid populations with which we work and understand that communication is an essential part to the success of a RetroDUR program. We have experience in several other states with creating meaningful and easy to understand educational materials for patients, prescribers and pharmacies. We will bring this experience to the West Virginia solution in creating and distributing newsletters, interventions and review letters for the RetroDUR solution.

RETRODUR REPORTING

Our knowledgeable reporting and analytics team will provide the Bureau with complex analysis to assist in program management and oversight to achieve clinical objectives and savings. These reports help to ensure that performance standards are met. Through dashboards and reporting tools, the Bureau will have the ability to analyze its programs. As the Bureau's partner, our analytics teams work with our clinical staff to provide valuable insights.

LOCK-IN PROGRAM

Our focus with implementing the lock-in program will be on improved patient care through coordination of the activities from the healthcare providers and pharmacies. Change Healthcare provides various lock-in programs across the country including in Illinois and Ohio. Our capabilities and experience with other states will be configured to the population and needs of West Virginia members to bring the Bureau the most cost-effective solution while still focusing on the health outcomes of the members.

EXPERIENCED STAFF

The Bureau will have access to a talented group of individuals for this solution that are experienced in pharmacy solutions and familiar with West Virginia's programs. Account Manager, Brent Breeding, PharmD will provide day-to-day contract oversight and communications. We also bring the expertise of Ashleigh Holeman, PharmD, as the Clinical Staff Pharmacist. She has experience working with several of Change Healthcare's pharmacy clients and will bring this talent to the Bureau. They will be supported by a talented pool of individuals familiar with not just the Bureau's programs, but several other pharmacy accounts across the country. This team brings ideas and practices best used in several other states, assuring the State a leading RetroDUR solution. As always, we value the State's input on the personnel we offer and will consult with the Bureau during project implementation to assure these personnel meet the State's expectations.

Addressing the Opioid Crisis for West Virginia

While we are sensitive to the necessity of opioid therapy for some patients with life-threatening, chronic or debilitating illnesses, our RetroDUR program monitors inappropriate utilization, adverse outcomes and irregular high dose / quantities associated with these therapies. Strategies for alleviating inappropriate usage that Change Healthcare has seen successful in other states include aggressive clinical prior authorization (PA) criteria and / or ProDUR edits.

Change Healthcare's RetroDUR solution brings measurable outcomes to our clients!

Verification: Our process verifies the existence of an opiate contract between the patient and prescriber and provides further review per the intended monitoring plan for compliance.

Identify Abuse: In circumstances of egregious abuse identification, we recommend member and provider inclusion in the state's specified lock-in program.

Pioneering Approach: We have pioneered a unique examination of newly prescribed opioid medications and proactively monitor risk for long-term need.

Project Timeframe

With years of experience as a Medicaid pharmacy benefits administration vendor, Change Healthcare is familiar with numerous approaches used by states transitioning to a new vendor, including those used in West Virginia. We have been working with state Medicaid programs to improve efficiency and apply cost effective management practices to pharmacy benefits since the days of paper claims and continue to do so in today's technologically and clinically sophisticated environment. Our team has implemented several complex pharmacy services on time and on budget. **After carefully examining the scope of services included in this RFQ, we are confident it is possible to implement these services within a timeframe that is satisfactory to the Bureau.** Change Healthcare will work with the Bureau to achieve the desired timeline for this project, taking into consideration the current vendor and / or any other project constraints.

Continuing as West Virginia's Partner

Our proven pharmacy solutions and processes ensure maximum efficiency and convenience, while working with the Bureau's established processes. The result is a seamless, comprehensive partnership. With our strong technology and transparent services, Change Healthcare is ready to bring West Virginia a focused solution that works to promote positive outcomes and financial impacts. We look forward to a continued **proactive, strategic partnership with the Bureau** for the future of its RetroDUR program.

TECHNICAL RESPONSE

Overview of RetroDUR

Our team will develop and deliver RetroDUR intervention strategies promoting appropriate cost savings strategies and use of medications / disease management for the West Virginia program. We have developed initiatives and analyses that are used to influence the prescribing behaviors of physicians and provide valuable information to pharmacists. Our capabilities to manage the West Virginia RetroDUR program are strengthened by our experience operating similar programs in seven (7) other states. The rule sets developed from DUR analyses assist prescribers in determining appropriateness, effectiveness and compliance of drug therapy. We are also able to employ these rules to identify patterns of fraud, misuse and abuse among individual recipients. This method will also facilitate the recommendations of therapeutic criteria, interventions and potential PA criteria for adoption into the State's PBM.

Change Healthcare is an experienced, national leader in providing PBM services including RetroDUR services, to multiple state Medicaid programs.

Our organization operates a fully functional RetroDUR program that is compliant with applicable state and federal regulations. **Our RetroDUR initiatives for West Virginia utilize clinical-data teams that are comprised of doctors and pharmacists working with data analysts, data administrators and developers to achieve patient health and safety.** Our solution regularly reviews indicators, pharmacy and medical profiles to identify recipients with real or potential drug therapy concerns. Our experienced staff will assist Bureau stakeholders when a problem exists and implement interventions as necessary. Our partnership in this effort will help to achieve an effective and efficient RetroDUR program.

Our expert staff has developed and implemented a successful RetroDUR process in Maine, Iowa, Mississippi, Pennsylvania, Ohio, Vermont and Wyoming whereby the Bureau's Medicaid members and drug profiles will be generated through a complex screening process with standard algorithms to determine if those members are at risk for inappropriate drug therapy. This might be due to over- or under-dosing, drug:drug, drug:disease or other identified issue(s). We are constantly reviewing the medical literature to add relevant new clinical information to the algorithms. When certain threshold criteria are met, as determined in conjunction with the West Virginia program, those profiles are flagged for further review. Our clinicians and analysts refine this information on an ongoing basis. We customize reports and algorithms to be consistent with the Bureau's program policies. Our detailed working knowledge of the industry standards allows synergistic configuration of the RetroDUR program, resulting in improvements to patient outcomes.

Through regular reviews of member histories, we generate profiles for those members whose claims fall outside accepted therapeutic standards. Profiles are screened for potential problems involving dozens of major therapeutic categories of prescription drugs most frequently dispensed in the identified population. This screening process includes drug:drug interactions, drug:disease contraindications, patient: drug considerations, dose limit exceptions and drug:laboratory considerations at a minimum. These modules and algorithms for this process are constantly updated in response to new drugs, new warnings, new interactions, etc.

We will work with the West Virginia DUR Board to design parameters for claims data analysis and provider data reports as well as analyzing potential areas of therapeutic misuse that potentially may lead to patient harm, physician education or increased state cost.

The purpose of our RetroDUR program is to improve patient care and, as a by-product, reduce overall drug costs.

Our organization has a full understanding of the commitment needed to fulfill the RetroDUR services requested by the Bureau's RetroDUR programs. We deliver on this commitment by providing clients with a clear set of utilization rules, as well as by performing associated reporting and analyses. Our RetroDUR initiatives meaningfully influence the prescribing behaviors of physicians and provide valuable information to pharmacists. The rule sets developed from RetroDUR analyses help prescribers determine and deliver appropriate, effective and compliant drug therapy. The rule sets used for the RetroDUR program are constantly being updated as new drugs are introduced, new interactions are discovered and peer reviewed, best practice guidelines are updated. We also look toward input from the providers on the DUR Board for rules that are clinically relevant and important to the recipients in the West Virginia Medicaid program. Through these various sources, we will ensure the rule sets used are clinically relevant and timely for use in the program.

We understand that DUR Boards rely on clinically based and scientifically valid, RetroDUR compatible predetermined standards to assess medication therapy. We will work with the Bureau to develop standards consistent with peer-reviewed medical literature and official compendia. The standards are used to determine whether there is a population at risk for clinically significant adverse medical outcomes.

In our client state of Iowa, our clinical staff coordinates and supports the DUR Commission. We are responsible for providing the RetroDUR and educational components of the program as well as administrative and clinical support. We also administer the ProDUR component of the Iowa programs and present the Iowa DUR Commission with potential DUR educational initiatives including, but not limited to, those based on FDA announcements, clinical guidelines, regional and national utilization trends, suggestions made by the DUR Board members, patterns identified through regular profile review and suggestions from Iowa Medicaid. We provide a summary for each proposed initiative:

Summary of Proposed Initiative			
Background information	**Initiative goal**	**Quotes from associative peer-reviewed articles**	**High-level overview of the issue**

RETRODUR ACTIVITIES

The goal of our RetroDUR program is to improve patient care and, as a by-product, reduce overall drug costs. We deliver on this commitment by providing clients with a clear set of standard utilization rules, state-specific rules and thorough performance of associated reporting and analyses. Our RetroDUR initiatives meaningfully influence the prescribing behaviors of physicians and provide valuable information to pharmacists. The rule sets developed from

RetroDUR analyses help prescribers determine and deliver appropriate, effective and compliant drug therapy.

Retrospective reviews are conducted on a continual basis and target patients who are at risk for medication-related problems for medication issues, such as inappropriate therapy, misuse / abuse, over / underutilization and drug-induced illnesses. Monthly reviews are conducted using data on Medicaid claims data to identify patterns for physicians, pharmacists, patients or drugs. Intervention letters and response forms are sent to select providers. An outcomes-based review is conducted after the original review to calculate cost savings, which can include decreased medication cost, decreased ER / hospitalization visits and more. To ensure a configuration based on West Virginia's needs and in consideration of the approval process required by the Bureau, we will work collaboratively with the State to execute these duties.

One example of Change Healthcare's experience in making specific RetroDUR interventions has been due to the reaction to increasing concerns regarding the appropriate and safe use of opiates. In response to this, our staff has been proactive in recommending initiatives that help identify and curb overuse, inappropriate use, misuse, and diversion of opioid narcotic analgesics. Our organization has been successful in building modules that screen and identify patterns of inappropriate health care using evidence-based rules by assessing resource utilization, analyzing high-cost and high-risk beneficiaries, building individual provider and member utilization history files and profiles, identifying deficiencies in the level of care or quality of service provided, and identifying providers who may benefit from education or other intervention concerning more appropriate service utilization.

Our clinical staff has real-world experience in addictive medicine treatment and offers unique perspectives and methods for tackling opioid abuse. Monitoring for inappropriate utilization, adverse outcomes, higher than accepted doses and/or quantities of opioid narcotics is an ongoing process, which allows us to provide timely, relevant data and feedback to our DUR state clients. At the same time, we are cognizant of those recipients under the care of hospice being actively treated for life threatening illnesses such as AIDS, HIV or cancer, who often are using high quantities and high doses of opioid narcotics appropriately. We have recommended aggressive clinical PA criteria and ProDUR edits based on our monitoring of opioid narcotic utilization, along with corresponding procedure and diagnosis codes.

In one of our client states, we generate a quarterly narcotic report to prescribers as an educational initiative that identifies any patient for whom they have written a prescription for a narcotic who has also received narcotics from two or more additional prescribers and/or have had narcotics prescriptions filled at three or more pharmacies. Additionally, when recipient profiles are reviewed and egregious abuse is identified, we recommend that the recipient be included in the state's lock-in program. These examples illustrate some of the approaches our organization takes to perform all necessary clinical data analyses based on research of our client states' data to develop recommendations for specific RetroDUR interventions and the associated objectives, protocols, guidelines and operational procedures.

INTERVENTION STRATEGIES

An example of our experience in making specific RetroDUR interventions was spurred by concerns regarding the appropriate and safe use of opiates. We have been proactive in recommending initiatives that help identify and curb overuse, inappropriate use, misuse and diversion of opioid narcotic analgesics. We have successfully built modules that screen for patterns of inappropriate health care using evidence-based rules through assessment of:

- Resource utilization;
- Analysis of high-cost / high-risk members;
- Building individual provider and member utilization history files / profiles;
- Identifying deficiencies in the level of care or quality of service provided; and
- Identifying providers who may benefit from education or other intervention concerning more appropriate service utilization.

With constant monitoring of these and other areas, our organization has been successful in providing DUR boards with up-to-date analyses, member profiles and areas of potential problems by means of problem-focused reviews to assist them in ensuring the highest quality of care for Medicaid members in our client states.

Qualifications (RFQ Section 3)

Vendor shall have the following minimum qualifications:

In the following section, Change Healthcare provides the Bureau with details of how our staffing approach meets the qualification requirements of the State. For the RetroDUR services contract, we provide experienced staff with extensive Medicaid experience to work cooperatively with the Bureau and its partner vendors to assist in managing this program. The combined Medicaid experience of our proposed staff is unparalleled and their broad Medicaid experience and specific knowledge of West Virginia's unique needs and vendor relationships will bring many benefits to the State.

Serving our PBM Customers:				
Providing PBM service to more than 12 million covered FFS lives.	Process nearly 40 million pharmacy claims transactions annually.	Providing more than 275,000 clinical prior authorizations and over 2 million autoPAs annually.	Collect $3.6 billion in rebates annually.	More than 1.55 million combined help desk calls.

With more than four (4) decades of experience providing value-driven, flexible, comprehensive pharmacy management services, Change Healthcare maintains a current presence in 16 client states. Furthermore, our parent company currently employs over 14,000 personnel in 110 offices across 34 states. This corporate footprint represents a sizeable contribution to the economy of the states in which we are established and in which we provide services. As a vendor with more than 22 years of RetroDUR-specific experience; **we bring the Bureau ideas and information shared in our many client states** that will help our team bring innovative and industry-leading ideas to the Bureau's solution.

KEY PERSONNEL (RFQ SECTION 3.1)

We realize the commitments required to provide the necessary resources to implement and operate the systems and programs described in this RFQ. We propose an account management team and support staff of extremely talented, competent and capable employees who have several decades of collective experience in pharmacy operations. We are dedicated to providing the highest quality services to the State in a manner that is both transparent and

accountable. **Our staff is acutely aware of the importance of the healthcare programs we manage, not only in terms of the provision of quality services, but also in terms of maintaining cost efficiencies and program savings.**

Change Healthcare's Standard Approach to Staffing

Our vision is to make healthcare more efficient. We continuously seek talented people who work together as a team and are committed to our **values of integrity, honesty, trust, accountability, customer focus, quality, innovation, teamwork and communication.** These values and our commitment to quality staffing directly benefit the quality of the West Virginia project.

Industry expertise, innovation and foresight are what guide us. New product development, high quality of service, an advanced technology infrastructure, a positive company culture and availability of engaging employee programs are just some of the positive by-products. Our employees work diligently, generously giving of their passion and dedication in pursuit of our shared vision with our clients and making this a great place to work.

Change Healthcare's employee policies include the provision of comprehensive health and dental insurance, 401k, generous vacation and personal time benefits as well as on-site fitness rooms, cafeterias and break areas. Our organization also offers several incentive programs that reward employees for participation in activities ranging from health to fitness to preventative care regimens. Our office locations include employee-run People Committees, which specifically target employees, designing office theme days, volunteer opportunities, information sharing and the social promotion of diversity and community.

Our organization has also adopted an affirmative action plan, committed to making a good faith effort to achieve the objectives of the plan. We take affirmative measures to recruit women, minorities, persons with disabilities or protected veteran status, including disabled veterans, ensuring that such employed individuals have an equal opportunity for career advancement. Change Healthcare has grown exponentially in diversity with the onset of these actions, resulting in increased interest in our organization from both employees and clients alike.

As our business continues to grow and develop, we realize the need to attract and retain our most valuable asset – our employees. We remain committed to equipping employees with the training, tools and opportunities needed to advance not only the business, but themselves.

Once a candidate has been selected, we conduct background checks on all prospective employees, contractors and consultants. The scope of the background check includes employment and education verification, criminal record screen / social security trace and professional employment reference checks. All employees have gone through HIPAA privacy training via an online course or through a video presentation. In addition, all employees must sign confidentiality/ security agreements. Depending upon the contractual obligations of the business unit for which the employee works, employees may be required to complete drug screens, as permitted by applicable law.

Individuals with direct, recent experience with the implementation of clinical solutions and / or other commensurate pharmacy projects make up our key and support personnel teams. Our technical team is responsible for the ongoing maintenance and enhancement of our suite of products. Our implementation method takes a team approach, using the same teams and implementation software development life cycle (SDLC) we have successfully followed in our

past implementations. West Virginia's Account Manager will oversee project activities with support from the State and Change Healthcare teams with the full backing of Change Healthcare's extensive resources. Our proposed Account Manager, Brent Breeding, brings management-specific expertise from multiple projects and extensive managerial experience that are benefits to the RetroDUR program, ensuring an efficiently managed contract. As the proposed Implementation Project Manager, LaShawna Tye will be dedicated to the smooth implementation of this project, helping to capture requirements and ensuring all are implemented appropriately, carefully tracking the project status as an integral leader in implementation. Both have overseen relevant implementations and bring respected expertise to this project.

The key personnel identified in our response will work collaboratively with the State. We understand the importance of having key personnel on board and well-versed in their respective roles as quickly as possible to facilitate the implementation process, with additional support personnel fully trained prior to the go-live date. We are pleased to present the Bureau with the background, experience and resumes of these individuals, all of whom we are confident the State will approve. The key personnel decisions will be based on the final approval by the Bureau. We offer a great team; however, we appreciate that the State has the final sign-off on any staff put in key positions and the Change Healthcare team will collaborate on staffing efforts.

In the following pages, we provide snapshots into the experience and qualifications of our proposed staff. We direct the Bureau to review the Supplemental Attachments section of our response for full resumes for each of these individuals. The following table depicts the number of years of experience each brings to West Virginia:

Name	Key Position	Number of Years of Experience
Brent Breeding	Account Manager	30 years
Ashleigh Holeman	Clinical Pharmacist	13 years
Jacquelyn Hedlund	Medical Director	27 years
Rick Erickson	Database Analyst	23 years
Total years of experience of West Virginia key staff:		**93 years**

Table 1: West Virginia Key Staff Experience Summary

Minimum Staffing Requirements

Vendor staffing must include at minimum the following:

Change Healthcare is committed to providing the following key positions to the Bureau. Although we present talented individuals to serve the RetroDUR program, we recognize the State has the final say in the key staff for this contract.

Medical Director (RFQ Section 3.1.1)

(MD/DO) available for consultation by e-mail and telephone.

We have a team of physicians available to support the West Virginia pharmacy programs as needed. Dr. Jacquelyn Hedlund will be the primary point of contact and is the named physician for this contract; however, as the Bureau has experienced, our Medical Directors are often available on an ad hoc basis to provide consultation on the State's programs when needed. Our practicing doctors bring a physician team to the Bureau's solution with over 50 years of

combined pharmacy experience. These clinical experts lend their expertise to our clients on an as needed basis. Their support for this solution will include but not be limited to:

- Involvement during implementation and operations phases;
- Provide subject matter support for clinical, coding and billing, drug file and other areas of technical / clinical expertise;
- Work on aspects of implementing innovative projects for client states as needed; and
- Responsible for working with analysts to analyze and forecast drug trends, summarize data and prepare reports.

Dr. Jacquelyn Hedlund, West Virginia Medical Director

Dr. Jacquelyn Hedlund joined the Change Healthcare clinical team in 2015 and brings more than 27 years of relevant experience to our clinical team. She also currently holds the position of Assistant Medical Director at Community Health Options, one of the original not-for-profit health insurance cooperatives born out of the ACA.

Daily, she works closely with our Medical Directors and our clients, bringing innovative clinical expertise with her consultation to states including Iowa, Maine, Mississippi, Ohio, Pennsylvania, Vermont and West Virginia. Her experience includes utilization management, prior authorization, PDL design and implementation, new drug evaluation, quality assurance, multidisciplinary program development and clinical trial implementation. Her industry knowledge, combined with real-world medical experiences benefit our Medicaid clients.

Jacquelyn is board certified in Internal Medicine and Hematology continues to be an active member in the clinical world. She has been in practice for 18 years, providing care to patient in Maine with benign and malignant hematologic conditions. She was the first Medical Director for the Maine Medical Center Cancer Institute and was instrumental in its conception and development. She continues her practice part-time at New England Cancer Specialists in southern Maine. She is a fellow of the American College of Physicians and a member of the American Society of Hematologists and the American Society of Clinical Oncologists.

She received her medical degree from the University of Vermont College of Medicine and a Master of Science in health policy and management from the Harvard School of Public Health. Jacquelyn frequently shares her insight and expertise with her medical peers through presentations and trainings. Her expertise as a Board-Certified Hematologist and Internist complements the clinical breadth of expertise already present.

Dr. Laureen Biczak, Medical Director

As Medical Director, Dr. Biczak oversees all clinical aspects of Change Healthcare's programs. She has extensive experience working on the clinical and fiscal aspects of the pharmacy benefits for the Medicaid Agencies in multiple states. Prior to joining our team, she spent more than six (6) years as the Medical Director for the State of Maine's Medicaid program, MaineCare, at the Department of Health and Human Services. She brings to the table extensive experience in all aspects of Medicaid Programs, including PDL design and implementation, drug evaluations, prior authorizations and in-depth knowledge of policy and regulatory issues. She also has worked extensively with the medical prior authorization program for Maine Medicaid.

Dr. Biczak is board certified in Internal Medicine and Infectious Diseases. Her continued part-time clinical practice offers Change Healthcare a unique view of pharmacy issues – from both the State and provider perspective. Dr. Biczak is a member of the American College of

Physicians, the Maine Medical and Maine Osteopathic Societies, and several professional Infectious Disease Societies. She has in the past served as a gubernatorial appointee to the Maine Quality Forum Advisory Committee, which is devoted to not only improving the quality of healthcare in Maine but also the transparency of that quality for Maine citizens.

She received her Doctor of Osteopathy from the University of New England College of Osteopathic Medicine.

Dr. Jeffrey Barkin, Associate Medical Director

Dr. Jeffrey Barkin has been employed as an Associate Medical Director with Change Healthcare since 2010. He has maintained a private and forensic psychiatry practice since 1991, treating individuals with a variety of mood, anxiety, and psychotic disorders. Dr. Barkin has special expertise in clinical trial design and analysis and is especially interested in applying evidence based best practices in administrative and legal settings. Prior to his current position, he served as Chair of the Maine Medicaid DUR Committee and Chair of the Psychiatric Work Group. He is currently President of TriCounty Mental Health Services, Immediate Past President of the State of Maine Association of Psychiatric Physicians and is on the board of the Maine Medical Association.

In his five (5) years working with the Change Healthcare team, he has undertaken medical director responsibilities for Medicaid pharmacy programs in Maine, Vermont, Ohio, Iowa, Mississippi, West Virginia and has been involved in all clinical programs related to Medicaid at Change Healthcare, and actively participates in the development of clinical therapeutic class and drug reviews. He also has multiple years of experience in interpreting clinical trial data to help inform placement of products on preferred drug lists, as well as application of research methods and outcomes in numerous settings including administrative and legal. Dr. Barkin is also an active member of clinical team which oversees pharmaceutical utilization for multiple client states, multi-state drug negotiation pool, and high cost (specialty) pharmacy services.

West Virginia Account Manager, Brent Breeding, RPh (RFQ Section 3.1.2)

An Account Manager assigned to coordinate all meetings and interactions between the Bureau and the Vendor. The Account Manager and the pharmacist specified in 3.1.3 may be the same person.

We offer the Bureau the account leadership of Brent Breeding as the Account Manager. As the Account Manager for the West Virginia PDL and SMAC programs, Brent is familiar with the State's programs, policies and stakeholders.

Brent joined the Change Healthcare team in 2015 and has since been a valued member of the clinical team, helping to oversee the clinical solutions for Pennsylvania and West Virginia. In his role for account oversight, he is accountable for the daily activities for the pharmacy benefits solutions. He brings almost 30 years of pharmacy experience to Change Healthcare's clients with a wide array of knowledge including retail pharmacy and management. His past experiences working with various states allow him to bring a unique multi-state and multi-industry perspective to the states he works with.

Clinical Staff Pharmacist, Ashleigh Holeman, PharmD (RFQ Section 3.1.3)

A Clinical Staff Pharmacist (PharmD/RPh) assigned to the WV RetroDUR account. This pharmacist shall attend each quarterly DUR Board meeting in person where they will make presentations regarding RetroDUR activity and proposals for

population based educational interventions for Medicaid prescribers. Schedules and agendas are published via http://www.dhhr.wv.gov/bms/BMS%20Pharmacy/DUR/Pages/DUR-Board-Meetings.aspx.

Ashleigh Holeman currently collaborates with several of Change Healthcare's state clients, sharing her clinical expertise in PDL, RetroDUR, prior authorization and maximum allowable cost solutions. For the RetroDUR program for West Virginia, Ashleigh will serve in the Clinical Staff Pharmacist role, including attending and making presentations at the quarterly DUR Board meetings.

Ashleigh joined the Change Healthcare clinical team in 2016 in support of our client's clinical services. Prior to joining our team, Ashleigh worked in a similar role as a clinical pharmacist for Xerox. She brings our clients more than 10 years of relevant Medicaid pharmacy experience with focus as a clinical pharmacist. Her extensive knowledge on the state pharmacy programs make her a trusted contributor for PDL solutions, state maximum allowable cost (SMAC) initiatives, RetroDUR criteria and interventions, as well as PA support and contribution.

As the Clinical Pharmacist, Ashleigh is closely involved in the implementation of programs for our clients, as well as supports programs throughout operations. She acts as a liaison for clinical matters between our client states and Change Healthcare stakeholders, ensuring clinical matters are communicated effectively and properly, always keeping the client's best interest in mind. For the West Virginia program, she will be the day-to-day contact for operations included in this scope of work. She brings this solution her clinical expertise to support the State's clinical matters with support from our expert clinical team

Database Analyst, Rick Erickson (RFQ Section 3.1.4)

A Database Analyst meeting all qualifications established by the vendor and fully trained in the software/system utilized by the vendor. The analyst must be proficient in running reports requested within this contract, as outlined in Sections 4.9 and 4.11.

The need for reliable and meaningful reports is an essential aspect of any pharmacy benefits program. Change Healthcare's data analytics staff are a talented pool of individuals that truly understand how to present data to our clients is ways that highlight programs performance measures, outliers within the program's stats, cost effectiveness of the solution and more. For the West Virginia RetroDUR program, we offer the state Rick Erickson. Not only is Rick intimately familiar with RetroDUR programs across several of our client states, but he is familiar with West Virginia's clinical programs, having supported both the PDL and SR solutions that Change Healthcare currently manages.

Rick has more than 20 years of experience in relational database development, design, reporting, and data analysis, and been with Change Healthcare over 14 years. He has experience in pharmacy / medical claim reporting and analysis, using MS SQL Server and SSRS, and Crystal Reports to support multiple Medicaid State Agency programs within a wide range of reporting and analysis. He also has experience in database design including data warehousing design and ETL. These include implementation of Medi-Span MDDB (Master Drug Database) v2.5 daily incremental database, the weekly First Databank (FDB) drug database. He served as developer of the Drug Formulary, PDL, and feeds automation to and from multiple trading partners. He also developed a Medicaid Drug Rebate application supporting supplemental rebate pricing.

Rick currently is the primary reporting analyst for the Iowa State reporting suite, and the RetroDUR). He collaborates with two Iowa account manager registered pharmacists, who work directly with Iowa State management. He has also developed the Illinois Medicaid RDUR

reporting suite. Rick interacts with analyst team members, through sharing of business knowledge, ideas, specialized areas of interest and skill, and personal support. This team focuses on techniques in writing MS Transact-SQL queries, view, function, stored procedures and deploying and maintaining SSRS reports.

SUPPORT PERSONNEL FOR THE WEST VIRGINIA PROJECT

We also provide the Bureau with the experience of two additional personnel recommendations for the RetroDUR contract: the aforementioned Project Manager and an Operational Account Coordinator (OAC). Although these positions are not specifically required by the RFQ, it is our experience that the implementation of any project is most smoothly facilitated by a qualified Project Manager. Although the Account Director will be at the helm of operations, our proposed OAC will cater to many of the components of an implemented project in support of the Change Healthcare / West Virginia team.

Our organization's efforts to support program and quality focus on a collaborative effort with our state partners and all stakeholders. Our experience has taught us that one of the keys to project success is to have full understanding and consensus on the end goals of the project. We come to West Virginia with a high-level understanding of what the Bureau wants to accomplish. Through kick-off meetings and joint discussions, we seek to define all aspects of the program. **Our goal is to be the best partner for West Virginia for this solution**. We have appointed LaShawna Tye, PMP, a project management veteran, to the position of Project Manager. Together with State stakeholders and Change Healthcare staff, LaShawna will facilitate the implementation process for the RetroDUR project. We have found that it is best practice to involve a project manager from the onset of a project, beginning with the procurement phase ahead of contract award. LaShawna is already becoming familiar with the requirements and timeline for implementation of this project. She will be focused from day one to facilitate a smooth and inclusive implementation.

As the implementation phase progresses, we will also assign Jenn Seymour as Operational OAC to support the contract during the operations phase. This important position will work closely with the Project Manager to ensure a seamless and effective hand-off of all relevant information required to manage and coordinate post go-live activities. The OAC will become the main point-of-contact in conjunction with the Account Manager and other key personnel during the operations phase of the contract. This approach has proven to be highly successful for our state clients as it ensures a qualified representative from the project management office is available throughout the life of the contract.

In the following pages, we provide the experience of these individuals and direct the Bureau to the Supplemental Attachments section for review of their full resumes.

Project Manager, LaShawna Tye, PMP

Change Healthcare's approaches to project management based on a strong foundation that follows Project Management Institute (PMI) guidelines. PMI developed the Project Management Body of Knowledge (PMBOK®) Guide, which provides the framework for managing projects. Based on these guiding principles, we assign an implementation project manager to each of our projects. For the West Virginia RetroDUR solution, we recommend Ms. LaShawna Tye.

LaShawna has honed skills related to leadership, strategic planning, compliance, communication, and strategic relationship building over the course of her career, with the last six (6) years being within the healthcare industry.

LaShawna has experience in building and maintaining positive working relationships with CMS at both the regional and national office levels, possesses wealth of knowledge and experience in federal regulatory compliance specifically related to the Medicaid Information Technology Architecture, Medicaid Enterprise Certification Lifecycle, and Federal Financial Participation regulations. She is well-versed in federal and state procurement, contracting, budgeting and accounting rules and processes as well as regulatory reporting requirements for healthcare information technology projects.

In her former position with the State of Colorado's Department of Health Care Policy and Financing, she was responsible for supervision of the Project Management Unit tasked with overseeing projects such as ICD-10 and the implementation and certification of legacy Medicaid Management Information System (MMIS) component replacement projects for the claims processing and adjudication system, business intelligence and data management system and pharmacy benefits management system.

Operational Account Coordinator, Jenn Seymour

Ms. Jenn Seymour currently supports the West Virginia clinical contract and will serve as the RetroDUR contract's OAC, managing the daily project activities of the Bureau's contract. She will be heavily informed on the implementation activities of the project, assisting LaShawna in such activities during the handover process. She currently manages the project activities for our state clients, including most recently Mississippi, Pennsylvania and West Virginia, delivering reports, managing work requests and collaborating and communicating with the State and its partners. Her administrative experience with Change Healthcare over the past decade have exposed her to the many intricacies of our PBM programs. She is well prepared to seamlessly take on this role, bringing her familiarity with the programs as well as the staff for this project.

Jenn joined our organization in 2007. During her tenure, she has gained a full understanding of the healthcare industry and currently provides project coordination and support for several of our clinical and PBM client solutions. She is involved with our projects during all stages, beginning with the implementation phase all the way through to ongoing, operational support. Her involvement with each project ensures she has a thorough understanding of each project and client's needs.

Jenn is experienced in providing communication between several stakeholders, including P&T Committees and DUR Boards. Her professional, trustworthy demeanor make her an asset in handling client-facing communications and all aspects of project coordination, including weekly meeting agendas, status reports, clinical support and billing. Her detail-orientated work ethic and proven time management make Jenn essential to the success of the projects she supports.

HELP DESK STAFF (RFQ SECTION 3.2)

In addition to the key personnel listed in 3 .1, the Vendor shall staff and maintain a toll-free Help Desk for Medicaid prescribers, pharmacy providers and members to answer inquiries about the RetroDUR Program, including the lock-in program, and any communications that may have been received by them. The Help Desk must be staffed during standard business hours (i.e. 8:00 am to 4:00 pm, 8:30 am to 4:30 pm, or 9:00 am to 5:00 pm ET), Monday through Friday excluding State holidays. A list of holidays may be found at the following address http://personnel.wv.gov/employees/benefits/Pages/Holidays.aspx.

Our organization has been providing a wide range of call center and help desk services to physicians, pharmacists and members across 15 states for over 20 years. Our help desk staff, made up of customer service specialists, pharmacy technicians and registered pharmacists, have the training and knowledge necessary to promptly answer and respond to provider inquiries. Help desk staff is required to take a phone-based customer service course each year. They work closely with our administrative staff to ensure that issues are quickly brought to the attention of appropriate individuals within the company for prompt resolution. They also assist in monitoring the types and frequencies of calls to support efforts to improve the system.

For the West Virginia RetroDUR program we are committed to providing the staff for a help desk as well as a toll-free line for Medicaid prescribers, pharmacy providers and members. We will operate the call center within the Bureau's specifications.

In our experience, staffing our help desk and pharmacy call center with Certified Pharmacy Technicians (CPTs) is the most successful staffing model. We are actively recruiting individuals in this market to fill these roles for this solution to ensure this team will be on board and fully trained prior to go-live. This team will be involved during the operations phase, executing the following tasks to include, but not be limited to:

- Responding to calls from providers, including physicians, pharmacists, and technicians regarding help desk issues; and
- Working in a timely and efficient manner, adhering to the State's specifications.

We understand the help desk is a critical feature of services provided under this scope of work. Our solution has been designed and honed across our other state clients to best assist and resolve issues related to the RetroDUR program, lock-in program and any of the communications Medicaid members, providers and prescribers may have.

Our organization has been providing a wide range of call center and help desk services to physicians, pharmacists and members across 15 states for over 20 years. Our experience includes over a decade of call center support specifically related to PA processing. Some of the call center services we currently provide include the following:

- Support calls from pharmacists or technicians regarding state-specific programs;
- Providing reports, analyses and monthly logs with responses to provider inquiries and requests upon state request;
- Providing professional support to answer questions from providers, members, pharmacies, municipalities and state staff concerning the RetroDUR and lock-in programs;
- Responding to all inquiries regarding communications and general questions regarding policy and regulations;
- Providing support and enacting the distribution of literature / reference materials upon request regarding therapeutic criteria; and

- Ensuring the quality and integrity of all program representation, learning policies and procedures to maintain accurateness of responses.

Mandatory Requirements (RFQ Section 4)

Contract Services must meet or exceed the mandatory requirements and deliverables listed below:

In the following pages, we provide response to the mandatory requirements as outlined in the scope of work (RFQ Section 4).

THERAPEUTIC CRITERIA DEVELOPMENT (RFQ SECTION 4.1)

4.1 The Vendor shall develop West Virginia-specific therapeutic criteria within two (2) months of the contract award. The West Virginia-specific criteria must meet the following requirements:

Change Healthcare agrees to develop the West Virginia-specific therapeutic criteria within two (2) months of mutually agreeable contract award. In the following responses, we further describe our understanding of the therapeutic criteria development requirements.

In-Full Testing

4.1.1 Vendor's West Virginia-specific therapeutic criteria must be available for in-full testing on West Virginia Medicaid claims data two (2) business days prior to implementation of the system.

We will work to ensure that the West Virginia-specific therapeutic criteria are available for in-full testing on West Virginia Medicaid claims data two (2) business days prior to implementation of the system.

Testing Dates

4.1.2 The Vendor shall coordinate the testing dates with the state's current fiscal agent.

As part of our implementation process, we will communicate with the State's current fiscal agent to coordinate such activities as testing dates for any West Virginia-specific therapeutic criteria.

Therapeutic Criteria Requirements

4.1.3 The Vendor's therapeutic criteria shall reflect current drug policies and programs (including prior authorized products and criteria for approval) and patterns of use. The Vendor's therapeutic criteria must take into account newly marketed drugs and must be updated monthly for this purpose at no cost to the Bureau's pharmacy program. These policies can be found at:

4.1.3.1 Lock-In Policy, http://www.dhhr.wv.gov/bms/BMS%20Pharmacy/DUR/Pages/Retrospective-DUR-and-Lock-In.aspx
4.1.3.2 Pharmacy Manual, http://www.dhhr.wv.gov/bms/Pages/Chapter-518-Pharmacy-Services.aspx
4.1.3.3 Preferred Drug List and Prior-Authorization Criteria, http://www.dhhr.wv.gov/bms/BMS%20Pharmacy/Pages/default.aspx

Change Healthcare will bring to the Bureau a set of standard criteria commonly used across state RetroDUR programs that encompasses many of the profiles that are listed in this RFQ. These standard criteria encompass drug:drug, drug:disease, maximum daily dose, member diagnosis, quantity limits, age, accumulated days' supply and more. We will utilize this criteria for West Virginia, continuing to tailor it to the specific needs of the State. Additional therapeutic criteria designed for West Virginia in consideration of the lock-in policy, pharmacy manual, PDL and PA criteria will be the responsibility of our account management team comprised of licensed pharmacists, analysts and doctors. The development of this criteria may occur as the result of Bureau / DUR Board requirement, recommendations our organization can make and / or regulatory changes (e.g. FDA safety warnings, federal regulation changes, etc.).

We will consider and include current drug policies, programs and patterns of use as we develop therapeutic criteria for West Virginia. As we have honed our processes in the Medicaid pharmacy industry across 16 states, we have developed and perfected practices that ensure an inclusive and thorough approach to environmental scanning, which includes taking account clinical outcomes that are in the best interest of all stakeholders. Our clinical staff will update on a monthly basis any criteria that is impacted by changes in the market landscape.

We design, operate and tailor therapeutic criteria to our clients' specifications rather than requiring our clients to comport to a single process.

Environmental Scanning

Pertinent information obtained through environmental scanning will be incorporated in our recommendations to the State. Depending on the level of urgency (defined by the Bureau or Change Healthcare), our account management team will enact escalation procedures and be available for additional conversations and communications outside of the scheduled DUR Board and RetroDUR Committee meetings. Additionally, our clinical team actively reviews the drug and biologic pipeline to anticipate significant changes in the pharmaceutical market, paying specific attention to the timing of new agents. Our focus on this pipeline enables us to anticipate market shifts and proactively recommend changes to therapeutic criteria. **We will be West Virginia's trusted partner, striving to align the needs of the Bureau with the clinical and fiscal attributes of the dynamic marketplace.**

The members of Change Healthcare's clinical team are immersed in the clinical and regulatory aspects of Medicaid pharmacy every day and are pro-active in ensuring that timely, actionable information is shared with our clients as often as is needed.

Our team utilizes multiple mechanisms to monitor the entire pharmaceutical market in order to stay abreast of legal, clinical, market and administrative news that has the potential to affect Medicaid pharmacy programs. The successful experience we have historically demonstrated underlines our ability to tailor a client's RetroDUR therapeutic criteria development to establish best approaches, profile generations, interventions and monitor the clinical and financial successes our state partners seek to realize. Our clinical staff actively and aggressively monitors the entire pharmaceutical market in pursuit of safety and clinical efficacy. The following table exemplifies some of our key methods of practice:

Market trends and analyses	Change Healthcare continuously reviews multiple professional publications and maintains subscriptions to several online sources of information related to the pharmaceutical market, pharmacy benefit management and the Medicaid program. Our staff maintains membership in pharmacy organizations such as the Academy of Managed Care Pharmacy (AMCP) and in medical organizations, including the American Medical Association (AMA), the Infectious Disease Society of America, the American Osteopathic Association (AOA), the American Psychiatric Association and the American Society of Clinical Oncology (ASCO). While much useful information can be obtained from these sources, we recognize that information must also be looked at in relevant context, often not the focus of these groups.

Practices and initiatives of other states	Our team gathers information from other state programs, whether they are a current customer or not. Our clinicians constantly monitor the industry and gather information that will provide our state clients with insightful and relevant analysis of pharmacy benefit trends. Our staff are active participants at ADURS and regularly attend other national and regional Medicaid meetings (e.g. WMPAA, EMPAA NAMD, MHPA).
Changing trends in pharmacy benefit management	Our ongoing analysis of changing PBM trends takes multiple different forms, but one of our core processes is to proactively monitor a specific subset of reference data to identify trends over time, forecasting results or monitoring the results of a change in policy or procedure, using these findings to report to and assist our clients.
New drugs to market and pipeline monitoring	Our team utilizes various services and resources to monitor both brand and generic drug pipelines. Expected PDUFA dates, patent expiration and exclusivity dates are tracked on a 24-month timeline that is revised as news of settlement agreements, outcomes of litigation and actions of the FDA becomes available. This information is received in near real time so that initiatives are always based on the most current information that is available. We report new NDCs included in each week's drug file and addresses the role of these new NDCs with timely recommendations.
New indications and updates to current treatment guidelines	We have experienced clinicians who scan the peer-reviewed literature, compendia and treatment guidelines to stay on top of new or changed indications/guidelines. We subscribe to multiple paid sources of very timely clinical information, as well as the major compendia. The conclusions and recommendations in our class reviews are based on a review of the full text (not abstracts) of the clinical evidence found in the prescribing information, drug compendia, current treatment guidelines and published peer-reviewed literature.
Patent expirations	With an intensive and targeted focus on the pharmaceutical marketplace, including the drug pipeline and patent expirations, we proactively manage, not just retroactively report on, the pharmacy benefit of our state Medicaid clients.
Health and safety warnings such as FDA alerts	We subscribe to the FDA's automated e-mail service that provides timely information related to drug approvals, labeling changes and safety issues regarding existing drugs. We also have multiple pharmacists across the country in a collaborative model that enables rapid dissemination of information and ensures that we are aware of important information (such as drug shortages), so that all our client states may benefit.

Figure 2: Criteria Development Practices

Patient Focused Reviews

Patient-focused reviews can be completed with the review of a prescribed number of member profiles for each meeting. We generate these profiles through a complex screening process, including a therapeutic criteria screen. If a profile shows failure on one or more therapeutic criteria, the member profile is assigned a level of risk based on medication history and the potential for adverse events. Profiles with the highest level of risk are selected for the DUR Board to review. Member profiles are reviewed by the DUR Board members and Change Healthcare's clinical staff to minimize potential false positives generated during the computer selection process.

The DUR Board members and our clinical staff identify cases where educational intervention is appropriate. Therapeutic or cost saving educational suggestions generally take the form of letters to providers but are also communicated via conference call or in person, as needed. Providers are invited to voluntarily respond to the DUR Board's suggestions and to request additional information; we track provider response rates. Suggestions are classified by problem type for reporting purposes.

Common classifications used in our other client states include:

- Not Optimal Drug;
- Not Optimal Dose;
- Not Optimal Duration;
- Unnecessary Drug Use;
- Therapeutic Duplication;
- High Cost Drug;
- Drug-Drug Interaction;
- Drug-Disease Interaction;
- Adverse Drug Reaction;
- Patient Overuse;
- Patient Underuse;
- Therapeutic Alternative;
- Missing Drug Therapy;
- Not Optimal Dosage Form;
- Potential Generic Use; and
- Inappropriate Billing.

Suggestions are intended to promote appropriate and cost-effective use of medications. Cost savings are calculated based on decreased medication costs. Several of these classes of interventions, such as member underuse and missing drug therapy, are intended to increase the use of medications. Additional medication therapy causes an increase in medication expenditures but is beneficial to the member's quality of life and should result in future cost savings for medical services. Cost savings for increased medication use cannot be calculated due to data limitations; the suggestions have a positive impact on the program but realize little to no cost savings.

Once a member's profile is reviewed, it is excluded or suppressed from the selection process for a Bureau-specified to eliminate repeat selections. After this waiting period, the current profile for each member is reviewed to determine if the DUR Board's suggestion was implemented; fiscal considerations resulting from the change are calculated.

Literature Documentation

4.1.4 The Vendor shall reference literature documentation and make such documentation available in print form within ten (10) business days of any request by a medical provider or the Bureau. Documentation shall be produced and delivered by the Vendor to the requesting entity free of charge.

Our clinical team references any literature included in our research and rationale for the development, recommendation and creation of therapeutic criteria. We will ensure the documentation used to support our claims is appropriately referenced and available in print for the Bureau and / or medical providers should they request review of such artefacts in compliance with the 10-business day response requirement.

Our recommendations are based on thoroughly researched clinical data.

We maintain all research, references and requests from the DUR Board as components of literature to be potentially provided as evidence supporting therapeutic criteria creation or amendment. Our expert Clinical Pharmacist, Ashleigh Holeman, is adept at creating criteria and tracking the rationale and substantive information that supports criteria. Even in instances where the DUR Board requires certain criteria, we apply references ranging from peer-reviewed

literature to the minutes from a DUR Board meeting should providers / prescribers request such evidence. Our approach is both evidence-based and transparent, which is valuable to the establishment and fostering of reputable and effective partnerships with our state clients and their Medicaid communities. We will bring this approach to the State of West Virginia.

Change Healthcare recognizes the importance of remaining current on all medical and pharmacy-related information, not only related to the services provided to our state partners, but for the industry as a whole. We are committed to providing the Bureau's programs with insights that are industry-leading. Our clinicians continually monitor new studies and literature, participate in industry conferences and maintain memberships with respected organizations to glean up-to-date information about Medicaid and healthcare in general, especially within the pharmaceutical industry.

Our clinical staff monitors and reviews the medical literature on an ongoing basis to identify and review pertinent information including full-text journal articles, evidence-based clinical guidelines, prescribing information, the FDA and compendia such as Micromedex. We provide rigorous, evidence-based analyses comparing the safety, efficacy and appropriate placement in therapy of the drugs in a therapeutic class. Our clinical team carefully monitors the preclinical, clinical and regulatory literature, anticipating new drug launches and the likely availability of generics as well as CMS or other federal and state regulatory changes. We actively maintain access to the following information resources, among others:

- Micromedex
- Facts & Comparison
- The National Comprehensive Cancer Network Guidelines and Compendia
- Lexicomp
- UptoDate
- Dynamed
- Cochrane Library

Our multiple sources of information and notification services allow us to keep abreast of legal, clinical, regulatory market and administrative news that can affect Medicaid pharmacy programs. Rather than just cut, paste and forward such news to the State, **we utilize our experience and knowledge to analyze and formulate a response to such news as it relates specifically to West Virginia.**

We have regularly scheduled clinical team meetings and a web-based, information sharing site that allows our clinicians to share insights and collaborate on best practices in a real-time manner from across the country.

In addition to the many sources of evidence-based information, we also bring to West Virginia a clinical team with nearly a combined century of experience in the healthcare industry, including decades of Medicaid-specific and pharmacy industry experience. Members of our team present regularly at national conferences including the NCPDP and National Association of State Medicaid Directors (NAMD) as well as the Medicaid Health Plans of America (MHPA), both national meeting as well as the clinical leadership meetings, and have presented to the Drug Utilization Research Project (DURP) in the past two (2) years. Change Healthcare currently has clinical team members who hold active memberships in NCPDP and ADURS. We regularly have our staff attend meetings of MHPA, NCPDP, ADURS, NAMD, Medicaid Enterprise Systems Conference (MESC) and many of the regional DUR conferences (e.g. EMPAA, SAMPA, etc.). We also have regularly scheduled clinical team meetings and a web-based information sharing site that allows our clinicians to share insights and collaborate on best practices and share information on a very timely basis regarding pharmacy issues around

the country. They come highly qualified with associations and / or membership in the following, but not limited, professional organizations:

- Academy of Managed Care Pharmacy (ACMP);
- American Association of Blood Banks;
- National Council for Prescription Drug Programs (NCPDP);
- American Drug Utilization Review Society (ADURs)
- American Psychiatric Association;
- American Society of Clinical Oncology (ASCO);
- American Society of Hematology;
- American College of Physicians;
- American Osteopathic Association;
- Infectious Disease Society of America;
- International Society of Hemostasis and Thrombosis;
- Maine Medical Association; and
- Maine Osteopathic Association.

Targeted Criteria

4.1.5 The Vendor shall develop the therapeutic criteria with attention given to types of diseases, therapeutic classes of drugs, and specific problems most often associated, or implicated in, cases of inappropriate drug therapy so that clinically significant alerts will be generated. The Vendor's therapeutic criteria shall be utilized to screen for potential therapeutic problems. Targeted disease categories shall include, but not be limited to:

4.1.5.1 Cardiovascular
4.1.5.2 Endocrine
4.1.5.3 Psychiatric Disorder
4.1.5.4 Gastrointestinal Disorders
4.1.5.5 Arthritis
4.1.5.6 Asthma
4.1.5.7 Chronic Obstructive Pulmonary Disease
4.1.5.8 Diabetes
4.1.5.9 Cancer

Our staff will develop therapeutic criteria for the contract resulting from this RFQ with attention paid to types of diseases, therapeutic classes of drugs and specific, frequent issues that arise regarding drug therapy. Our standard criteria and any new criteria we develop for the Bureau will screen for potential therapeutic problems inclusive, but not limited by, the target disease categories outlined in this requirement. We can create, amend, remove or add criteria as the Bureau requires and / or as we identify as necessary to ensure specificity and, when applicable, granular level detail. Our RetroDUR application tool, into which we feed criteria and generate profiles, is equipped to manage these components.

Drug Therapy Criteria

4.1.6 The Vendor shall develop criteria to screen for problems most often associated with inappropriate drug therapy which shall include, but not be limited to:

4.1.6.1 Over and underutilization;
4.1.6.2 Drug(s) contraindicated by diagnosis;
4.1.6.3 Drug interactions;
4.1.6.4 Duplication therapy;
4.1.6.5 Therapeutic appropriateness;
4.1.6.6 Appropriate use of generic drugs;
4.1.6. 7 Incorrect drug dosage or duration of therapy;
4.1.6.8 Clinical abuse and misuse;
4.1.6.9 Iatrogenic complications;
4.1.6.10 Treatment failure

Our staff will develop criteria to screen for problems most often associated with inappropriate drug therapy to include, but not be limited by those detailed in this requirement. For one of our client states, the 10 components listed in this requirement are part of our standard criteria. We include parameters for each drug that include these potential problems and more. Upon contract award and throughout operations of a contract resulting from this RFQ, we will tailor this criteria to the specific needs of the West Virginia Medicaid community, making further updates as needed.

Ongoing Adjustments

4.1.7 The Vendor's therapeutic criteria shall allow for ongoing adjustments to be made by the DUR Board and/or the Retrospective Drug Utilization Review Committee. The Retrospective Drug Utilization Review Committee meets on the first Monday of every month while the DUR Board meets quarterly. Meeting schedules are determined by member and/or room availability. The Vendor shall implement adjustments prior to the next generation of profiles, or within 10 business days of notification by the BMS Pharmacy Program, whichever is longer. Profiles shall be generated every month for review.

As previously confirmed, our therapeutic criteria – both standard and that which is designed for the Bureau – will allow for ongoing adjustments based on DUR Board and RetroDUR Committee decisions. We will meet the requirement to ensure adjustments are made prior to the next generation of profiles or within 10 business days of notification from the Bureau Pharmacy Program, whichever is longer. As a standard point of practice, our pharmacists adjust parameters and make criteria alterations sometimes within only a few days, depending on the complexity and approvals needed. We will generate profiles for review on a monthly basis, meeting the requirement to enact new / changed criteria prior to the following profile generation.

Records

4.1.8 The Vendor shall maintain a complete record of current West Virginia Medicaid therapeutic criteria. The Vendor shall incorporate into their criteria all changes resulting from DUR Board meetings no more than 10 days after the meeting has occurred. The Bureau shall notify the Vendor by e-mail of any other criteria changes that occur outside the DUR Board. The Vendor must incorporate those changes into their system within 10 business days of notification.

We will ensure maintenance of a complete record of current West Virginia Medicaid therapeutic criteria. As required, we will incorporate changes resulting from DUR Board meetings into this criteria within 10 days after the meeting occurs. Our West Virginia Account Manager will facilitate the implementation of additional email requests that occur outside of the DUR Board within 10 days of notification.

Hard Copy Listing

4.1.9 The Vendor shall provide a hardcopy listing of therapeutic criteria within ten (10) business days of request by the Bureau's Pharmacy Program.

Our account management staff will maintain a hard copy listing of therapeutic criteria and provide it to the Bureau within 10 days of a request for it.

Clinical Significance

4.1.10 The Vendor's system shall rank criteria by clinical significance to reduce the number of alerts likely to be false positives or clinically insignificant.

Change Healthcare's solution allows for the ranking of criteria by clinical significance. We understand the Bureau's purpose for this feature is to reduce the number of alerts likely to be false positives or clinically insignificant. It is our experience that managing such potential issues as false positives is managed within the criteria and parameters of the profile generation. That is to say, if a member or provider meets the criteria, there is reasonable expectation it is a true

positive. Our solution allows for further analysis to investigate, for example, a PA or override that may exempt or mitigate risk, therefore differentiating between a “positive” and “false positive.” We are confident that our solution will meet the needs of the state and look forward to discussing the Bureau’s expectation and classification of these terms during requirement validation sessions to ensure our full understanding.

Recommendations to the Bureau’s Pharmacy Program

4.1.11 The Vendor shall provide the Bureau's Pharmacy Program with monthly recommendations, delivered by e-mail on the first Monday of each month and active within 30 calendar days after approval by BMS. The recommendations shall encompass new clinical edits and prior authorization criteria based on the findings in the retrospective therapeutic review of profiles. These recommendations shall be beneficial to the healthcare of the Medicaid member, cost effective to the State, or both.

Our Account Management team will make recommendations to the Bureau that encompass new clinical edits and PA criteria based on RetroDUR profile review, doing so via email on the first Monday of each month and active within 30 calendar days after Bureau approval. Proposal of new PA criteria based on profile review can be the result of apparent issues of significance or through the more in-depth analysis of profiles based on any given therapeutic criteria. Our Account Manager, Brent Breeding and Clinical Pharmacist, Ashleigh Holeman, are both experienced in this type of analysis and recommendation. We approach the creation of PA criteria very similarly to our evidence-based approach to therapeutic criteria creation and will bring this proven process to West Virginia.

Experience Recommending PA Criteria

As the PBM vendor in seven (7) states, Change Healthcare is responsible for researching and recommending PA criteria to our partners for review and implementation. We consider our PA program to be a critical function we carry out for our state clients. Proper pharmacy PA administration is vital to the various attributes that influence prescribing patterns and drug utilization and is integral to controlling programmatic costs. The pharmacy PA solution is a highly rewarding, cost savings program enabling those who manage state Medicaid pharmacy programs to reduce costs and ensure proper utilization. We bring this understanding to West Virginia to conduct this component of the RetroDUR program, making recommendations that are based on our mutual understanding of the importance of the PA program, doing so as a result of the evidence-based analytics we conduct for the RetroDUR program.

Our clinical team leads the industry in PA design and the creation of PA criteria. We use our depth of clinical experience across multiple Medicaid programs to ensure that we bring timely best practice guidelines on any recommended changes or additions to PA criteria. We use similar innovative, cost-saving methodologies and service solutions for Medicaid pharmacy PA programs in the states of Iowa, Maine, Mississippi, Vermont, Wyoming and Ohio. Through our efforts on current PDL and SR contracts, we provide PA criteria recommendations on behalf of the Medicaid program in the states of Pennsylvania and West Virginia. Furthermore, the states of Illinois and Utah operate our PBM solution as a software-as-a-service (SaaS) contract to manage PAs. Drawing upon this experience in the PA realm, we are well-poised to make recommendations to the Bureau and its stakeholders for new or amended PA criteria beneficial to the State’s PBM.

Long-Term Care Indicators

4.1.12 The Vendor shall be able to read the Long-Term Care (LTC) indicator(s) to distinguish LTC members from Community-based members. The Vendor shall include LTC beneficiaries in the retrospective DUR therapeutic criteria reviews.

Our solution includes the ability to read long-term care (LTC) indicators, distinguishing LTC members from community-based members and will include LTC beneficiaries in RetroDUR therapeutic criteria reviews. We understand the dichotomy of LTC versus community-based members such that there are different preliminary monitoring procedures placed on LTC members. This group is less apt to doctor shop / pharmacy shop, typically seeing the same prescriber(s) and filling prescriptions from a single pharmacy consistently. LTC members are also subject to regular chart reviews by a consultant pharmacist. Community members who are not standardized by the LTC approach may be at greater risk for the aforementioned issues and, as a result, must be differentiated in therapeutic criteria reviews and profile generation. We understand; however, that it remains important to monitor both of these groups of Medicaid members and in any therapeutic criteria review we run, can distinguish which category in which the member belongs. This is done through our RetroDUR tool, which has the capability to read indicators within the patient's information that denotes their type of benefit. Should the State require further investigation into either of these groups, we can further define therapeutic criteria and continue to segregate this population while including both in review and report.

RETRODUR COMPUTER SYSTEM (RFQ SECTION 4.2)

4.2 The Vendor shall design a RetroDUR computer system utilizing West Virginia-specific therapeutic criteria for both member profile generation and a lock-in program (further described in section 4.5) and begin operation two (2) months of the contract award.

Change Healthcare understands that the State of West Virginia requires a RetroDUR computer system, utilizing West Virginia-specific therapeutic criteria for member profile generation and lock-in, with an implementation timeline of two (2) months leading into the operations and management portion of the contract. Our organization will comply with these requirements and detail our approach to meeting them in the section that follows.

RetroDUR Application Tool

Change Healthcare's RetroDUR tool was designed to manage documents, track provider inquiries and record responses pertaining to RetroDUR initiatives. This tool will help our staff manage the many tasks associated with creating, distributing and collating responses to patient profiles for the West Virginia RetroDUR contract. Through this tool, our clinicians can track and report to determine the quality and cost impact of interventions.

We are able to enhance the features of the RetroDUR application so that it can be configured to help in the prevention of fraud, misuse, overuse of controlled substances, narcotics, etc. and all of the document management tools associated with initiatives recommended by West Virginia's DUR Board, RetroDUR Committee or other policy staff. The following figure depicts our easy-to-navigate RetroDUR dashboard:

Features of the RetroDUR tool include, but are not limited to:

- Versatility – each education campaign can be configured within the application;
- Ability to look up members, including pharmacy and medical claims;
- Result Sets – capability to run various algorithms on a member and claim data;
  - Examples include:
    - Duplicate therapy – identifies when multiple drugs are taken in the same drug group; and
    - ADHD medical diagnosis with any ADHD drug claims.
- Ability to select / create individual cases from result sets;

- Generation of correspondence via letters that allows for canned and custom language or a combination of both;
- Receives correspondences (e.g. faxes);
- Profile generation and management; and
- Ability to generate and send surveys and then collect responses.

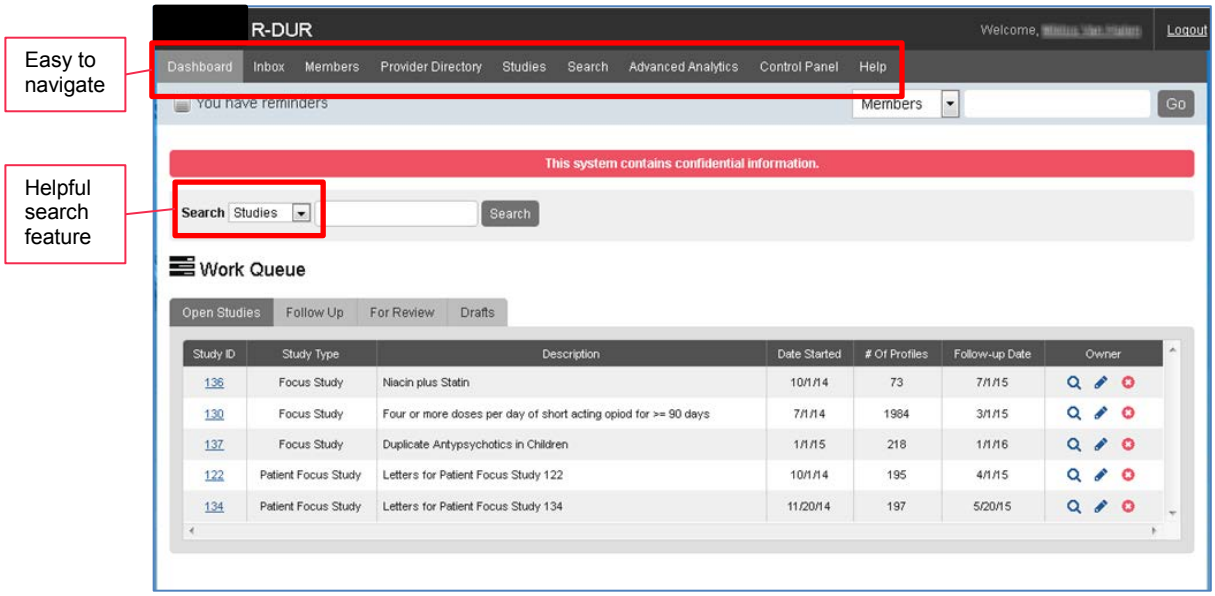


Figure 3: RetroDUR Tool Dashboard

A highly powerful feature of our RetroDUR tool is its custom querying ability. Custom queries can be created based on a myriad of criteria including, but not limited to: age, gender, diagnosis codes, CPT codes, GPIs, multiple providers and concurrent therapies (duplicate therapy type search where combinations of GPIs in ABA pattern can be queried). These results can be imported and the providers surveyed as an effort of problem-focused study. Additionally, patient-focused studies can be conducted through our RetroDUR tool utilizing criteria designed by Medi-Span that incorporates the number of members the State requires (475 or other number) based on the user-specified criteria.

This solution includes identifying the patient profiles necessary for review, based on criteria approved by the Bureau.

Functions of the RetroDUR Tool

Our clinicians assigned to the West Virginia contract will have the ability to search member profiles as seen in the example the follows. They can assign a specific clinician for review of interventions, view patient profiles, make comments, edit details and select certain profiles for intervention. Profiles can be tagged for review of determination for intervention necessity. The following figure is an example of our member profile screen. Please note that the information in these screenshots is demonstration data and contains no PHI.

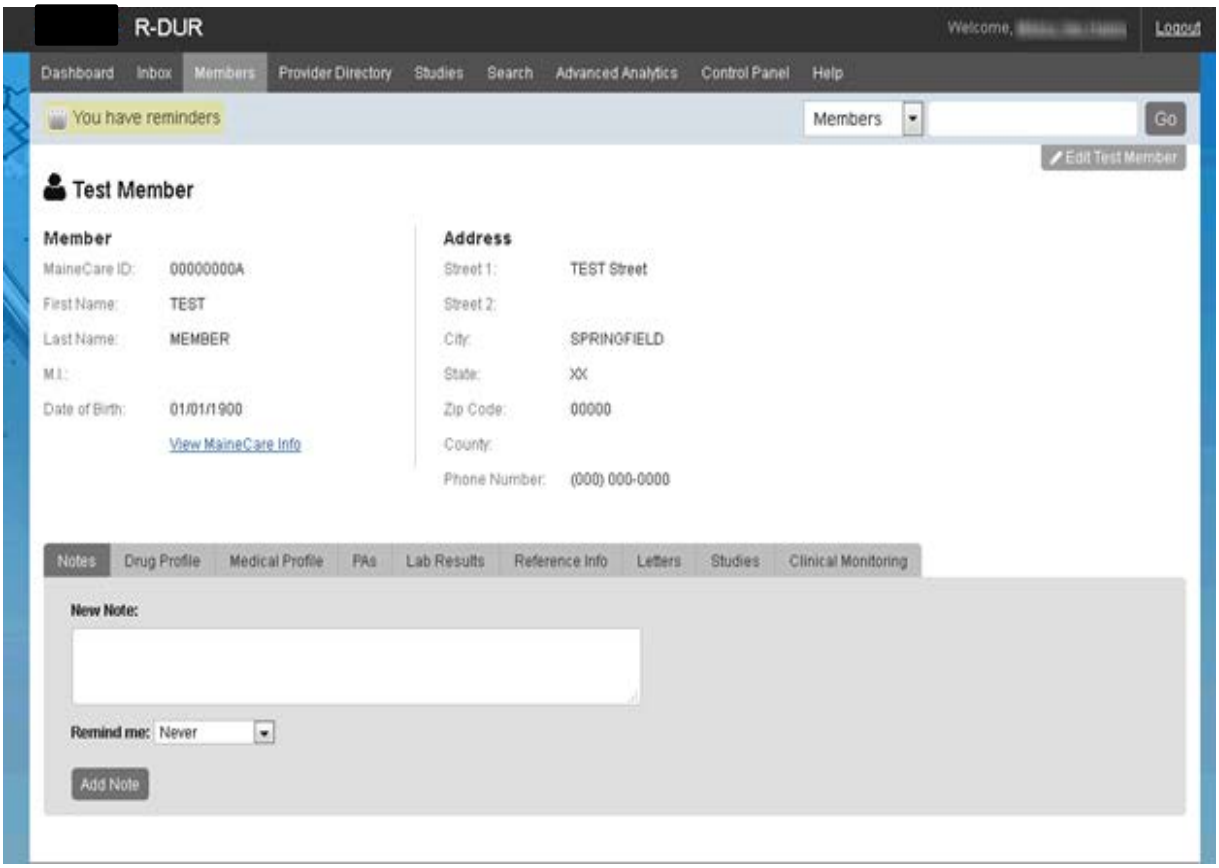


Figure 4: RDUR Member Profile Screen

Our RetroDUR application has the ability to generate letters for RetroDUR initiatives. When profiles are generated or the results of selection criteria produced, the data is migrated into the application to produce targeted letters. Our staff can populate any Bureau-approved form letter with recipient-specific information from profiles and / or selection criteria. Letters can be produced on a regular schedule or ad hoc basis.

For various reasons, the Bureau may choose to suppress or delay an intervention. We will work with the Bureau to create general suppression reasons and the user will have the ability to suppress criteria and intervention letters within the tool. Criteria and letters can be suppressed for a designated time frame, which can be determined by the Bureau's clinicians. During requirements validation sessions, we will collaborate with the State stakeholders to further define these parameters if this is a desired feature.

Our clinicians can instigate suppression criteria and intervention letters from our RetroDUR tool. In collaboration with the Bureau, our organization will create standard reasons to choose from to suppress an intervention. Our team can also recommend standardized reasons from which the clinicians can choose. Information will be stored within the patient profiles for future reference by authorized users.

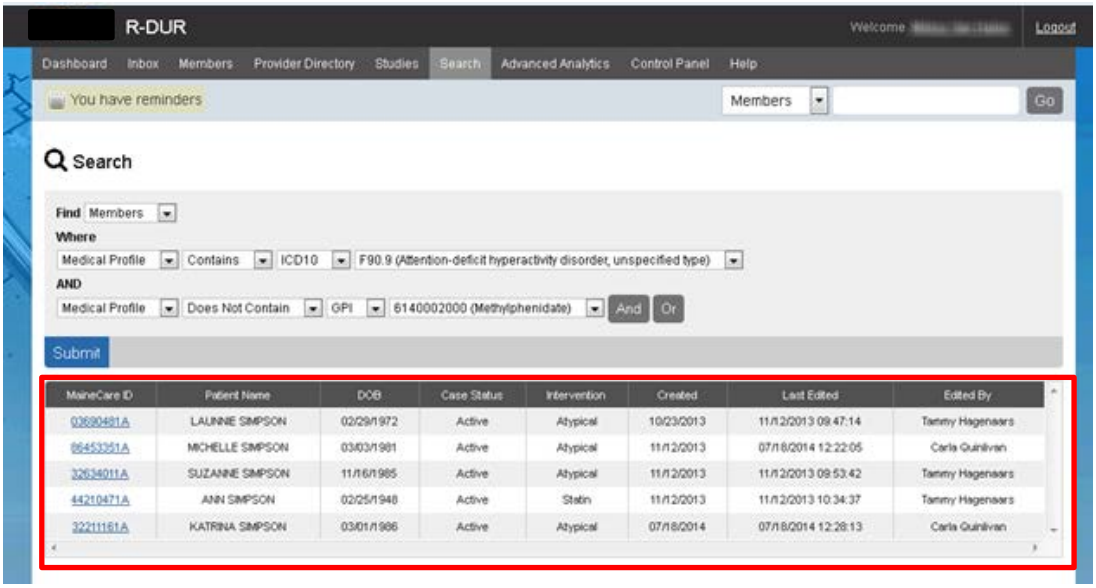


Figure 5: RetroDUR Search Screen

Provider Feedback

Within the DUR survey tool, users can implement a standard provider feedback template or customize the template to meet the needs of a particular intervention. An example of the provider feedback template follows:

MEDICAID DUR COMMISSION OBSERVATION

The DUR recently recommended implementing a quantity limit of 120 tablets per 30 days for all strengths of clonazepam, alprazolam, and lorazepam tablets. A review of pharmacy claims for the month of January 2015 finds this member receiving one of the aforementioned benzodiazepines at a quantity greater than 120 tablets per 30 days. Prior to the implementation of these quantity limits, letters are being sent to allow providers to make adjustments to their patient's regimen. Alprazolam and clonazepam are typically dosed up to three times daily while diazepam can be dosed up to four times daily. Consider decreasing the total daily dose of medication and/or consolidating the dose to bring the total number of tablets dispensed to a maximum of 120 per 30 days.

Figure 6: Sample Intervention Letter

Communications to Prescribers

We will develop and deliver communications to targeted prescribers, disseminating such information through written communication. Our clinical staff are constantly assessing the value of various therapeutic regimens, both clinically and financially, arriving at the regimens that provide the best value. It is then one of our primary responsibilities to make this information accessible to providers in a useable format. We use multiple methods of communication to help providers understand the drugs, drug regimens and choices in the pharmacy benefit including the newsletters.

All survey communications are imaged, managed, archived and stored within the RetroDUR application, which is designed to assist in decreasing and controlling over-utilization of controlled substances, minimizing medically unnecessary and addictive drug usage and

increasing the use of appropriate healthcare services, especially meaningful substance abuse treatment.

System Capabilities

4.2.1 The Vendor's RetroDUR system shall be able to:

4.2.1.1 Utilize file extracts from the State's Fiscal Agent West Virginia Medicaid Medical Management Information System (MMIS).
4.2.1.2 Read all available medical diagnoses codes, procedure codes and pharmacy history.
4.2.1.3 Utilize all physician specialty codes listed for specific prescribers.
4.2.1.4 Differentiate between an adjudicated claim, a voided claim, and a rejected claim when reviewing the patient's drug history.
4.2.1.5 Read and utilize demographic information for members and providers, including, but not limited to, the member's county code, county of service, county of residence, and the Medicare eligibility indicator code.

Change Healthcare's RetroDUR application will meet the expectations outlined in this requirement provided that all required codes / information is included in the file extracts from the MMIS vendor. We will utilize the file extracts to differentiate and report on as needed, the demographics, specialty codes, diagnoses codes, pharmacy history and other data received within the file extracts.

Incorporating Changes

4.2.2 The Vendor's system shall incorporate changes within ten (10) working days from the time changes are made to the State's Fiscal Agent, the MMIS system or when the BMS Pharmacy Program determines additional fields must be added to the format in order to capture required data for review.

We will make every effort to incorporate changes into our system within 10 working days from the time that changes are made to the State's Fiscal Agent, MMIS system or when the Bureau's Pharmacy Program determines additional fields must be added to the format to capture required data for review. Depending on the complexity and impact of the requested changes, we may request additional time to ensure accurate understanding and incorporation into our system. We look forward to discussing these potential changes with the Bureau during JAD sessions to develop a stronger understanding of the State's expectations and collaborating with the Bureau to ensure that our solutions meet their needs.

File Layout Coordination

4.2.3 The Vendor shall be responsible for coordinating file layouts from the State's Fiscal Agent MMIS Vendor to populate the Vendor's RetroDUR system and a mutually acceptable method of transferring the files once weekly. The Vendor will be responsible for any costs associated with the transfer of files.

Our staff will coordinate file layouts and a mutually acceptable method of transferring files between our organization and the State's Fiscal Agent MMIS Vendor. Our standard preference is to utilize a secure FTP site to make these weekly transfers, but we are open to a collaborative discussion with the MMIS vendor to determine this is the solution.

RetroDUR System Operation

4.2.4 The Vendor shall ensure the operation of the RetroDUR system and the production of all member profiles and reports required herein satisfies the requirement of the Bureau by hosting a monthly quality-assurance meeting as further detailed in section 4.12 (change management process).

Across all of our state contracts, Change Healthcare account management teams are accustomed to frequent and regular quality assurance meetings to ensure our solution and administration efforts are meeting our state partners' expectations. We invite constructive criticisms, honest and factual feedback and overall review of our services so that we may be assured of our strengths and improve upon any weaknesses. **Transparency and**

incorporation of client feedback is the backbone of the partnership we seek to enhance with West Virginia. We will ensure the operation of our RetroDUR system and production of member profiles and reports as depicted by this RFQ and subsequent JAD sessions. We invite the Bureau to review our response to Change Management Process (RFQ Section 4.12) for details regarding our approach to change management.

Drug and Diagnostic Data Assessment

4.2.5 The Vendor's Retrospective DUR system shall assess drug and diagnostic data against explicit predetermined standards including, but not limited, to monitoring for:

- ***4.2.5.1 Therapeutic appropriateness***
- ***4.2.5.2 Over-utilization***
- ***4.2.5.3 Under-utilization***
- ***4.2.5.4 Incorrect drug dosage or duration of therapy***

Our RetroDUR system will assess drug and diagnostic data against explicit, predetermined standards such as therapeutic appropriateness, over-utilization, under-utilization and incorrect drug dose / duration of therapy, among others. We refer the Bureau to our responses in the Therapeutic Criteria Development section for more information, as our standard and West Virginia-specific criteria will be applied within our RetroDUR application to complete these assessments. Updates to criteria will be applied and we will continue to monitor for these and other standards for the State.

Medical and Pharmacy Claims Histories

4.2.6 The Vendor shall scan Medicaid members' medical and pharmacy claims histories, applying the DUR Board approved therapeutic criteria (as specified in 4.1.3), to identify members whose drug use indicates a significant level of risk for drug induced or exacerbated outcomes.

We will meet this requirement to scan Medicaid members' medical and pharmacy claims histories in order to apply DUR Board-approved therapeutic criteria to identify members whose drug use indicates a significant level of risk for drug induced or exacerbated outcomes. We are of the opinion that this is one of the most – if not the most – important components of a RetroDUR initiative. The proactive monitoring of at-risk or potentially at-risk members not only improves patient outcomes, but dramatically increases the ability to enforce adherence and appropriate use and drug therapies. Our solution is designed to facilitate this requirement, provided that detailed medical and claims histories are received from the State's MMIS / PBM vendor(s).

An example of successful management for at-risk members is from our client state of Maine, in which we act as the full PBM vendor. This example, however, is indicative of our RetroDUR initiatives that can pave the way for West Virginia to enact similar processes. In the State of Maine, our reviews of recipients chronically using opioid narcotic analgesics include the confirmation of an appropriate indication, as well as a review of non-pharmacologic and non-opioid treatments considered and / or tried. We also verify that an opiate contract exists between the patient and prescriber and review the intended monitoring plan (e.g. urine screens or random pill counts), as required in Maine. With the State's approval, prescribers are contacted by our clinical staff when these parameters are not fully met. Additionally, we have successfully recommended (and the State subsequently implemented) a chronic narcotic program to identify members with initial narcotic use of greater than 90 days. Based on this analysis, requests are now sent to prescribers regarding the identified members and their narcotic medication profile, asking the providers to submit to Maine, documentation of treatment plans, urinary drug screens, random pill counts, Prescription Monitoring Program utilization, member / physician narcotic contract and other pertinent clinical documentation. If appropriate

monitoring is not documented the State will block narcotic utilization by requiring PAs for subsequent refills until prescribers are compliant with State requirements for proper, safe use of long term narcotics. This initiative also included widespread adoption of key elements of the standards of care pertaining to new chronic narcotic patients.

Profile Generation

4.2. 7 The Vendor shall provide a system for profile generation that will identify and select for various demographics requested by the Bureau such as, but not limited to, specific criteria exceptions for specified patient populations, provider types and disease states. This system shall have the capability to read up to six provider specialty codes and their corresponding effective date and end dates.

As a common RetroDUR component, our system for profile generation identifies and selects demographics based on request to include, but not be limited to, specific criteria exceptions, provider types and disease states. As our experience has not required the ability to read up to six (6) provider codes (and their corresponding effective / end dates), we will expand our application to be meet this requirement during the implementation of this contract.

Suppression of Profile Generation

4.2.8 The Vendor's system shall suppress profile generation for previously identified criteria after the initial flagging, for a period of time specified by the Bureau. This feature is to prevent providers from receiving repeated alerts for the same or similar situations.

Our system has the ability to suppress profile generation in instances where previously identified criteria has already been flagged for a Bureau-specified period of time. This is typically triggered when the profile indicates that a letter has been sent under the specified criteria. We understand the necessity to ensure providers receive applicable letters; however, one of the ways in which our organization maintains reputable relationships with the provider communities in our client states is through efforts of efficiency. Should a profile be generated for new or different criteria, suppression will not occur and there may be potential that a provider receives an additional letter, though for a different situation. Our communications will relate the appropriate information to ensure repeated alerts are mitigated.

Interactive Selections

4.2.9 The Vendor's system shall allow for interactive selection of population-based interventions, provider profiling options, and population and patient-specific intervention tracking reports. The Vendor shall present potential population-based educational interventions, based on the review of data and therapeutic criteria from the Vendor's RetroDUR system, to the DUR Board at each quarterly Board meeting.

Our RetroDUR has expansive querying capabilities that will facilitate the meeting of this requirement. Interactive selection of population-based interventions, provider profiling options and population / patient-specific intervention tracking reports are available through our solution. At each of the quarterly DUR Board meetings, we will present recommendations for population-based educational interventions and / or make presentations pertaining to the outcomes and analysis of completed interventions. Please be referred to our response to DUR Board Support for additional details on our experience and approach to this process.

Medicaid Patient Profiles

4.2.10 The Vendor shall generate Medicaid patient profiles monthly based on therapeutic criteria, high risk patient profiles, and provider profiles (prescribers and pharmacy providers). The Vendor must deliver these profiles in either hard or electronic format to the RetroDUR Committee for review no later than five (5) business days prior to the each RetroDUR Committee meeting (scheduled for the first Monday of every month).

We will meet this requirement to generate Medicaid patient profiles on a monthly basis that are based on therapeutic criteria, high-risk patient profiles and provider profiles. These will be

delivered to the RetroDUR Committee in minimum advance of five (5) business days prior to each Committee meeting on the first Monday of each month. We direct the Bureau to our response to Therapeutic Criteria Development for details on profile generation methodology.

Monthly Profiles

4.2.11 The Vendor shall generate no less than 475 member profiles for clinical review per calendar month. The profiles shall be reviewed against the therapeutic criteria and cover all age groups, including LTC members. This total does not include profiles meant for lock-in review (see section 4.5 for Lock-in requirements).

Our system (and staff) will generate a minimum of 475 member profiles for clinical review each calendar month. These reviews will measure against the therapeutic criteria, covering all age groups and LETC members. We understand that the lock-in profiles described in RFQ Section 4.5 are in addition to the 475 profiles stated in this requirement.

Profiles for Review

4.2.12 The profiles for review shall be made available for the Pharmacy Program's monthly RetroDUR Committee meeting (held on the first Monday of every month) and generated within five (5) working days before transfer to the Bureau. The profiles will be provided to the Bureau and returned to the Vendor at no additional cost to the Bureau.

We understand and will comply with this requirement to provide the RetroDUR Committee with monthly profiles generated within five (5) working days before transfer to the Bureau. We refer the Bureau to our response to Overview of RetroDUR which details our approach to profile generation.

Weighting and Ranking Mechanisms

4.2.13 The Vendor's system shall generate patient and provider cases monthly by weighting and ranking mechanisms, which have been approved prior to use by the BMS Pharmacy program, to sort exceptions by potential seriousness. These patient and provider cases are due within five (5) working days prior to the committee's monthly profile review.

Our system will account for Bureau-approved weighting and ranking of the profiles generated each month, accounting for potential seriousness. We will ensure these profile cases are provided to the RetroDUR Committee within five (5) working days in advance of their monthly meetings.

Claims History

4.2.14 The profiles developed by the Vendor's system must contain at least eighteen (18) contiguous months of claims history, representing a summarized review of all drug information and diagnoses for which claims were reimbursed. The Vendor shall be able to differentiate between a claim that was voided or cancelled and a paid claim. The Vendor's RetroDUR system shall produce profiles in either hard or electronic format for RetroDUR review no fewer than five (5) business day prior to each meeting. Electronic profiles must be accessible by a secure Internet site. The Vendor shall provide any necessary electronic hardware required to access these profiles. All costs associated with hardware and access to this site will be the responsibility of the Vendor and must satisfy all applicable WV Office of Technology Policy (https://technology.wv.gov/security/Pages/policies-issued-bythe-cto.aspx). The Vendor will provide IT support at no additional charge to the State. At the expiration of the contract, all hardware provided by the Vendor will be returned to the Vendor. The Vendor shall be responsible for all fees associated with return of hardware upon expiration of contract.

Change Healthcare will meet this requirement as written, provided the information required is included in the transfer of data to our organization for input into our system.

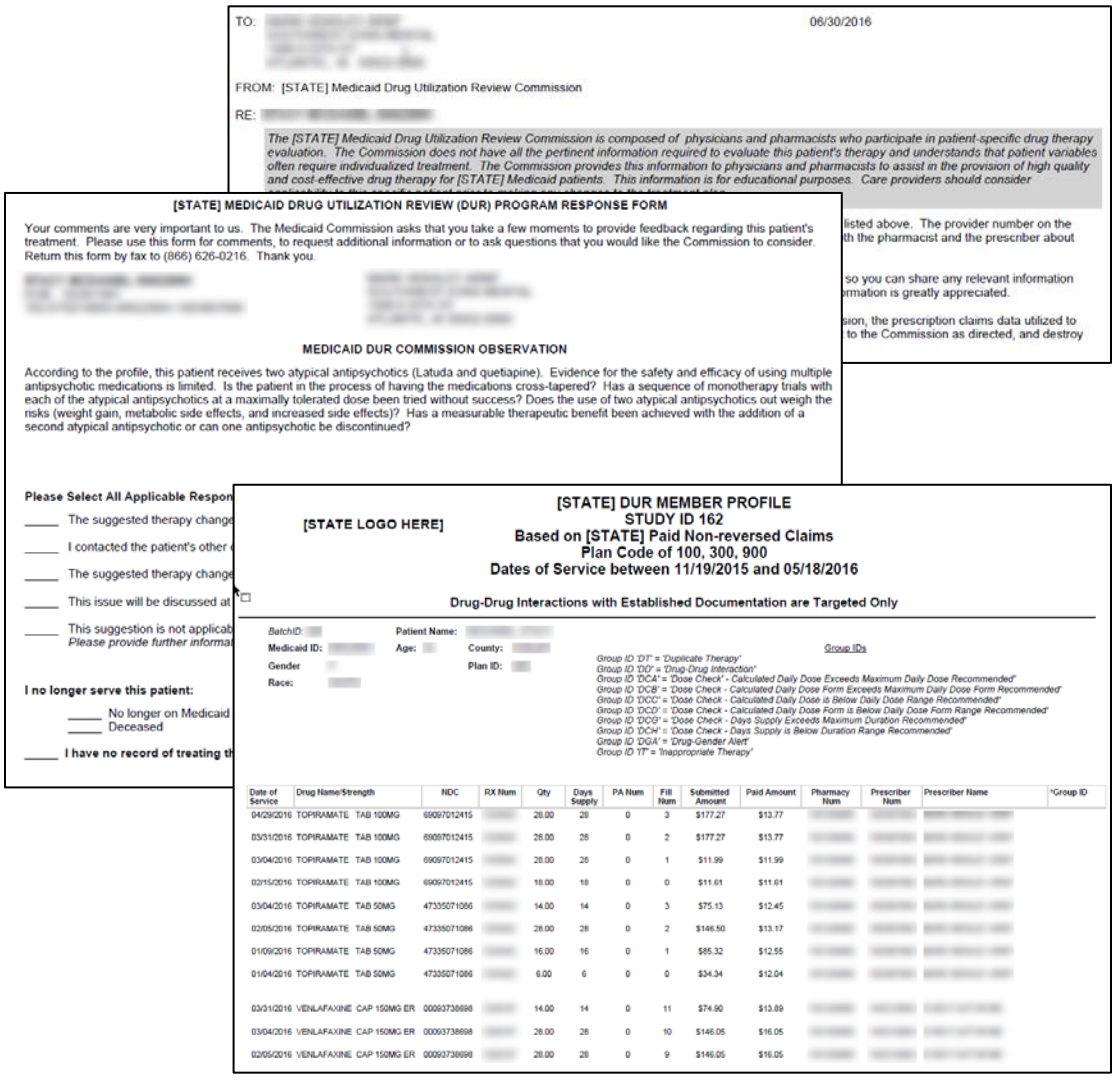
Intervention Letters

4.2.15 The Vendor's system shall not limit the ability of the RetroDUR committee to request an intervention letter to be sent for any clinical issue identified during profile review.

Change Healthcare pharmacists and physicians are experienced in all aspects of DUR programs including DUR Board presentations, DUR criteria creation and management and

interventions / outcomes. Drawing from our many years of experience in the industry and knowledge from implementing and operating other commensurate state programs, our clinical staff will be able to provide a unique insight into the clinical implications and fiscal information necessary to assist DUR Board members in their deliberations and selection of RetroDUR interventions. As we do for our other RetroDUR clients, we will work with the Bureau in developing the intervention letters as part of the RetroDUR program. We have expert staff that will provide clear, concise guidance and recommendations for inclusion in the letters.

We will work with the Bureau to develop the templates that will be used to generate the letters to the prescribers and pharmacies to ensure that all communications are approved by the Bureau. For one of our client states, we include with each letter a copy of the recipient's most recent six (6) months of claims history as a reference and a survey that we request they return to us with feedback on the result of the recommended intervention. The recipient's pharmacy can be copied on the letter, as we have found that many positive outcomes are initiated by the recipient's pharmacist. Our solution can facilitate the use of standard or custom language or a combination of both for intervention letters. The following figures depict such an intervention letter with accompanying information relevant to the intervention:


TO: 06/30/2016

FROM: [STATE] Medicaid Drug Utilization Review Commission

RE:

The [STATE] Medicaid Drug Utilization Review Commission is composed of physicians and pharmacists who participate in patient-specific drug therapy evaluation. The Commission does not have all the pertinent information required to evaluate this patient's therapy and understands that patient variables often require individualized treatment. The Commission provides this information to physicians and pharmacists to assist in the provision of high quality and cost-effective drug therapy for [STATE] Medicaid patients. This information is for educational purposes. Care providers should consider

[STATE] MEDICAID DRUG UTILIZATION REVIEW (DUR) PROGRAM RESPONSE FORM

Your comments are very important to us. The Medicaid Commission asks that you take a few moments to provide feedback regarding this patient's treatment. Please use this form for comments, to request additional information or to ask questions that you would like the Commission to consider. Return this form by fax to (866) 626-0216. Thank you.

listed above. The provider number on the th the pharmacist and the prescriber about

so you can share any relevant information rmation is greatly appreciated.

sion, the prescription claims data utilized to to the Commission as directed, and destroy

MEDICAID DUR COMMISSION OBSERVATION

According to the profile, this patient receives two atypical antipsychotics (Latuda and quetiapine). Evidence for the safety and efficacy of using multiple antipsychotic medications is limited. Is the patient in the process of having the medications cross-tapered? Has a sequence of monotherapy trials with each of the atypical antipsychotics at a maximally tolerated dose been tried without success? Does the use of two atypical antipsychotics out weigh the risks (weight gain, metabolic side effects, and increased side effects)? Has a measurable therapeutic benefit been achieved with the addition of a second atypical antipsychotic or can one antipsychotic be discontinued?

Please Select All Applicable Respon

____ The suggested therapy change

____ I contacted the patient's other

____ The suggested therapy change

____ This issue will be discussed at

____ This suggestion is not applicab
Please provide further informa

I no longer serve this patient:

____ No longer on Medicaid
____ Deceased

____ **I have no record of treating th**

[STATE LOGO HERE]

[STATE] DUR MEMBER PROFILE
STUDY ID 162
Based on [STATE] Paid Non-reversed Claims
Plan Code of 100, 300, 900
Dates of Service between 11/19/2015 and 05/18/2016

Drug-Drug Interactions with Established Documentation are Targeted Only

BatchID:
Patient Name:
Medicaid ID:
Age:
County:
Gender
Plan ID:
Race:

Group IDs

Group ID 'DT' = 'Duplicate Therapy'
Group ID 'DD' = 'Drug-Drug Interaction'
Group ID 'DCA' = 'Dose Check' - Calculated Daily Dose Exceeds Maximum Daily Dose Recommended'
Group ID 'DCB' = 'Dose Check - Calculated Daily Dose Form Exceeds Maximum Daily Dose Form Recommended'
Group ID 'DCC' = 'Dose Check - Calculated Daily Dose is Below Daily Dose Range Recommended'
Group ID 'DCD' = 'Dose Check - Calculated Daily Dose Form is Below Daily Dose Form Range Recommended'
Group ID 'DCG' = 'Dose Check - Days Supply Exceeds Maximum Duration Recommended'
Group ID 'DCH' = 'Dose Check - Days Supply is Below Duration Range Recommended'
Group ID 'DGA' = 'Drug-Gender Alert'
Group ID 'IT' = 'Inappropriate Therapy'

Date of Service	Drug Name/Strength	NDC	RX Num	Qty	Days Supply	PA Num	Fill Num	Submitted Amount	Paid Amount	Pharmacy Num	Prescriber Num	Prescriber Name	*Group ID
04/29/2016	TOPIRAMATE TAB 100MG	69097012415		28.00	28	0	3	$177.27	$13.77				
03/31/2016	TOPIRAMATE TAB 100MG	69097012415		28.00	28	0	2	$177.27	$13.77				
03/04/2016	TOPIRAMATE TAB 100MG	69097012415		28.00	28	0	1	$11.99	$11.99				
02/15/2016	TOPIRAMATE TAB 100MG	69097012415		18.00	18	0	0	$11.61	$11.61				
03/04/2016	TOPIRAMATE TAB 50MG	47335071086		14.00	14	0	3	$75.13	$12.45				
02/05/2016	TOPIRAMATE TAB 50MG	47335071086		28.00	28	0	2	$146.50	$13.17				
01/09/2016	TOPIRAMATE TAB 50MG	47335071086		16.00	16	0	1	$85.32	$12.55				
01/04/2016	TOPIRAMATE TAB 50MG	47335071086		6.00	6	0	0	$34.34	$12.04				
03/31/2016	VENLAFAXINE CAP 150MG ER	00093738698		14.00	14	0	11	$74.90	$13.89				
03/04/2016	VENLAFAXINE CAP 150MG ER	00093738698		28.00	28	0	10	$146.05	$16.05				
02/05/2016	VENLAFAXINE CAP 150MG ER	00093738698		28.00	28	0	9	$146.05	$16.05				

Figure 7: Sample Intervention Letter

Confidentiality

4.2.16 The Vendor's system shall maintain patient and provider confidentiality in all aspects of developing and handling patient history profiles, as well as all input claims history date. The Vendor shall handle and store claims data and patient and provider profiles in accordance with 42 Code of Federal Regulations part 431, Subpart F, included in https://www.ecfr.gov/cgi-bin/text-idx?SID=10b4393ea7e6cacba7ed18c6bd7531aa&mc=true&node=sp42.4.431.f&rgn=div6 regarding confidentiality of information concerning applicants and beneficiaries of public assistance, and 42 Code of Federal Regulations Part 2, included in https://www.edfr.gov/cgi-bin/text-idx?rgn=div5;node=42%3A1.0.1.1.2, regarding confidentiality of alcohols and drug abuse patient records .

Our system, staff and company as a whole will maintain patient and provider confidentiality in all aspects of developing and handling patient history profiles as well as the input of any claims history we obtain as a component of this RetroDUR contract. We comply with all of the Federal Regulations depicted in this requirement and ensure our methodology to maintain confidentiality. We provide insight to our standard approach to confidentiality and the handling of PHI in the section that follows.

Change Healthcare follows standard Health Insurance Portability and Accountability Act of 1996 (HIPAA) and protected health information (PHI) practices. Our standards of performance align with client, state and federal guidelines and comply with applicable industry technical standards. We are committed to protecting the confidentiality, integrity, privacy and physical security of the PHI entrusted to us by our clients. We will ensure that any products and applications utilized for this scope of work maintain these standards. Per our organization's internal policies, all new staff undergoes HIPAA training as part of the contingent hire process and all existing staff members are required to participate annually in HIPAA training.

Our organization will maintain the confidentiality of beneficiary information at all times. We ensure the security and confidentiality of covered data, information, personnel and supporting technological resources. We protect against any anticipated threat to the security or integrity of covered data / information including unauthorized access or use. We have mechanisms in place that identify and assess risks to confidentiality that are defined in written policies and procedures and practiced in the management / control of these risks. Our policies and procedures are reviewed regularly to ensure they are up-to-date with industry trends, technological advancements and regulatory changes. As we find it necessary, we amend our policies and procedures to reflect these changes. Our team performs a series of audits and reviews on a regular basis to ensure we are effective in our efforts and compliant with the specific Business Associates Agreement (BAA) with each of our state clients. West Virginia will likewise benefit from this process to ensure protection of beneficiary information.

We maintain physical / facility infrastructure security through the use of an electronic card access system (ECA) that requires issuance of proximity cards that permit access to only the locations necessary to perform essential duties. Each secured room in our facilities is secured with an RF reader / access point and each time a proximity card is used to pass through one of these points, the employee's card is recorded and reported into our security system. Our facilities are also equipped with alarm systems and motion sensors that are monitored by a qualified third-party vendor during non-business hours. Additionally, all personnel are issued a Change Healthcare photo badge that is to be worn at all times in our facilities, making our employees an accountable line of defense in terms of access to the facility as well as data kept on site or electronically.

Among our access controls, we have individual, auditable accounts for each person who accesses our systems. Each user must meet specific, complex requirements for passwords that include length, character requirements and regular updates. We also enforce a timeout policy

that requires the user to log back in after a defined period of inactivity. Employees are required to lock their screens any time they leave their desks and must repeat password entry to regain screen access.

Our organization has a full understanding of the necessity to protect against disclosure. All Change Healthcare employees – including those who will service this contract – are in possession of written policies specific to HIPAA and PHI security. Employees are required to acknowledge receipt and prove their understanding of policy content. Policies of this nature are applied to the following:

- Email
- Facsimile transactions
- Mail
- Paper destruction
- Caller verification
- Visitor
- Physical transport of PHI
- Electronic transport of PHI
- Enrollment

Computer system access permissions (internal and external)
Should an employee violate any of these policies, a corrective action plan will be enacted based on severity of violation to include, but not be limited to, access restriction, additional compliance trainings, discipline, reassignment or dismissal. Our organization's approach to thorough employee training and systems security protocols minimize any risk of unauthorized disclosure of confidential information.

Our organization and the solution we offer to West Virginia are in full compliance with HIPAA and other state and federal regulations. We ensure that we will remain up-to-date, promptly addressing and applying any changes enacted during the contract term.

PATIENT PROFILE REVIEWS (RFQ SECTION 4.3)

4.3 The Vendor shall communicate the results of patient profile reviews within twenty-eight (28) calendar days by letter to prescribers and/or pharmacy providers for all members. The cost of mailing shall be included in the Vendor's quotation and should account for at least 850 letters per month. All letters to Medicaid prescribers and pharmacy providers must be signed by the Vendor's medical director. The Vendor's retrospective DUR program shall provide ongoing interventions for physicians and pharmacists targeted toward therapy problems or individual patients identified in the course of DUR review activities.

Change Healthcare will generate patient profiles, conducting reviews and communicating results via letters to prescribers and / or pharmacy providers within 28 days. We understand the cost associated with this task is to be incorporated into our pricing proposal, which we have done, and should account for at least 850 letters per month, signed by our medical director. Our solution accounts for ongoing interventions for physicians and pharmacists that target therapy issues or individual patients identified during DUR review activities.

POPULATION-BASED INTERVENTIONS (RFQ SECTION 4.4)

4.4 The Vendor shall design at least six (6) educational population based interventions or other targeted provider interventions to be modifiable per the Bureau and DUR Board's requirements per year. The Vendor shall make any such modifications to wording or formats, specified by the BMS Pharmacy program and DUR Board, within twenty-eight (28) calendar days of the request by the Bureau at the Vendor's expense. The total cost of mailing these interventions to targeted prescribers or pharmacy providers shall be included in the Vendor's quote. There are 18,374 active prescribers and 859 pharmacy providers currently enrolled in the West Virginia Medicaid Program.

Our RetroDUR approach includes the capability to meet the population-based intervention requirements as defined in this scope of work. We understand the Bureau's specification that a minimum of six (6) educational, population-based interventions (or other targeted provider

interventions) will be applied per calendar year. We will present recommendations based on profile reviews and analysis of standard and specific issues currently occurring amongst the Medicaid community in West Virginia and will seek approvals from the DUR Board before enacting recommended interventions, incorporating changes or adjustments the Board requests. We will make these modifications within 28 calendar days of the request, subsequently mailing intervention letters to the targeted population.

Problem-focused reviews narrow the emphasis of review to a specific issue that has been determined to be an area where a targeted educational effort to providers may be valuable. Topics for review are selected from the findings of patient-focused reviews and medical literature reviews. Educational materials are disseminated to providers caring for members who may benefit from intervention. Providers are encouraged to voluntarily respond to the educational initiative. The current member profile is typically generated six (6) to nine (9) months after the initial review to determine the impact rate of the intervention, along with any fiscal considerations.

PHARMACY LOCK-IN PROGRAM (RFQ SECTION 4.5)

4.5 The Vendor shall establish and maintain a Pharmacy Lock-in Program for Medicaid beneficiaries who utilize multiple pharmacies and/or prescribers for controlled substances within two (2) months of the contract award. The Vendor's system must be compatible with all West Virginia Medicaid specific lock-in criteria as defined at the following address: http://www.hddr.wv.gov/bms/BMS%20Pharmacy/Documents/DUR/Lock%20In%20Criteria%202016%20ver.9.pdf included in EXHIBIT B.

We understand the requirements for the Pharmacy Lock-in Program for Medicaid beneficiaries who utilize multiple pharmacies and / or prescribers for controlled substances and the two (2) month time frame required for implementation. We have reviewed Exhibit B, which further explains the State's lock-in criteria and expectations for this program.

As outlined in the West Virginia Medicaid Lock-in Criteria (Exhibit B), we understand that all members with prescription drug utilization meeting the State's lock-in criteria collect their prescriptions for controlled substances from one (1) pharmacy and that, based on meeting certain criteria, the RetroDUR Committee may lock in members to one (1) pharmacy for up to 12 months. It is customary and important to regularly review these members and consistently analyze for new members for adherence to the lock-in program. Change Healthcare will operate the proposed RetroDUR solution to help the State achieve success in the management of this program, ensuring enhanced coordination of care for members who may be at risk for adverse effects due to the potential of overutilization of controlled substances.

Our solution for the lock-in program compliance consists of a combination of two (2) applications currently utilized in several of our client states: the Change Healthcare RetroDUR tool and the Change Healthcare Med Management tool. It is through the RetroDUR tool that we will generate the required profiles; however, Med Management will allow us to house the medical and pharmacy claims histories of West Virginia's Medicaid members and apply groups that facilitate specific reports that will be designed according to the lock-in criteria. Therefore, we can efficiently apply the State's lock-in criteria to create full listings (or new member-specific) listings of members eligible for the lock-in program. We look forward to JAD session discussions regarding the format and frequency of the transfer of medical and pharmacy claims data so that we meet the expectations of the State regarding this program.

It is our understanding that the following is the current list of lock-in criteria, based on Exhibit B, and may exclude cancer patients determined on a case-by-case basis. We inform the State that

we have a flexible solution for this program that can account for potential changes made to the criteria.

- **High Average Daily Dose**: greater than / equal to 50 morphine milligram equivalents per day over the past 90 calendar day
- **Overutilization**: Filling of greater than / equal to five (5) claims for all controlled substances in the past 60 calendar days.
- **Doctor / Pharmacy Shopping**: greater than / equal to three (3) prescribers or greater than / equal to writing / filling claims for any controlled substance in the past 60 days.
- **Use with a History of Dependence / Overdose**: any use of a controlled substance in the past 60 days with at least one (1) occurrence of a medical claim for substance abuse, dependence or overdose in the past 720 calendar days
- **"Frequent Flyer"**: greater than / equal to three (3) emergency department visits in the last 60 calendar days
- **Cash Payments**: review of the controlled substance automated prescription program (CSAPP) report indicates cash purchases of controlled substances covered by Medicaid
- **Positive Drug Screen**: report by medical provider of abnormal or unexpected drug screen result.

Drug Therapy Management

4.5.1 The purpose of the Lock-In Program shall be to improve patient care by coordinating the activities of various health care providers, to integrate the pharmacist into the drug therapy management process, and to improve patient outcomes.

Change Healthcare understands the necessity and benefit of a well-managed lock-in program, especially as it coordinates activities across pharmacies and physicians to improve patient outcomes through the drug therapy management process. We will work with the State's MMIS vendor to coordinate the lock-in program with the existing PBM model.

Lock-In Profile Generation

4.5.2 The Vendor shall generate monthly lock-in profiles for review within five (5) working days of any meeting by the RetroDUR Committee. The Vendor shall generate no less than 85 member-profiles for lock-in review per calendar month unless fewer than 85 members are identified. Members shall be identified as potential lock-in candidates by application of the Vendors utilization algorithm and West-Virginia specific clinical criteria, included in Exhibit B. The Vendor must produce these profiles in either hard or electronic format for RetroDUR review.

Our staff will generate monthly lock-in profiles for review within five (5) working days of any RetroDUR Committee meeting. We will generate a minimum of 85 member profiles for this lock-in review each calendar month unless there are fewer members identified. Profile generation will occur within our RetroDUR tool (please see our response to the RetroDUR Computer System (RFQ Section 4.2) for details on this tool) and will incorporate utilization algorithms as well as the West Virginia-specific clinical criteria from Exhibit B and acknowledged in our response at the opening of this section. Our RetroDUR tool has the capability to generate profiles that include all criteria together or be individualized to each category of lock-in criteria. We will ensure the Committee receives electronic or hard copy profiles for review.

Review and Selection for Lock-In

4.5.3 The RetroDUR committee shall review these profiles and direct the Vendor to process selected members for pharmacy lock-in:

4.5.3.1 The Vendor shall contact the eligible member who will then be required to select one provider for pharmacy services. The Vendor will inform the member that Medicaid will deny claims for pharmacy services submitted by any other pharmacy provider.

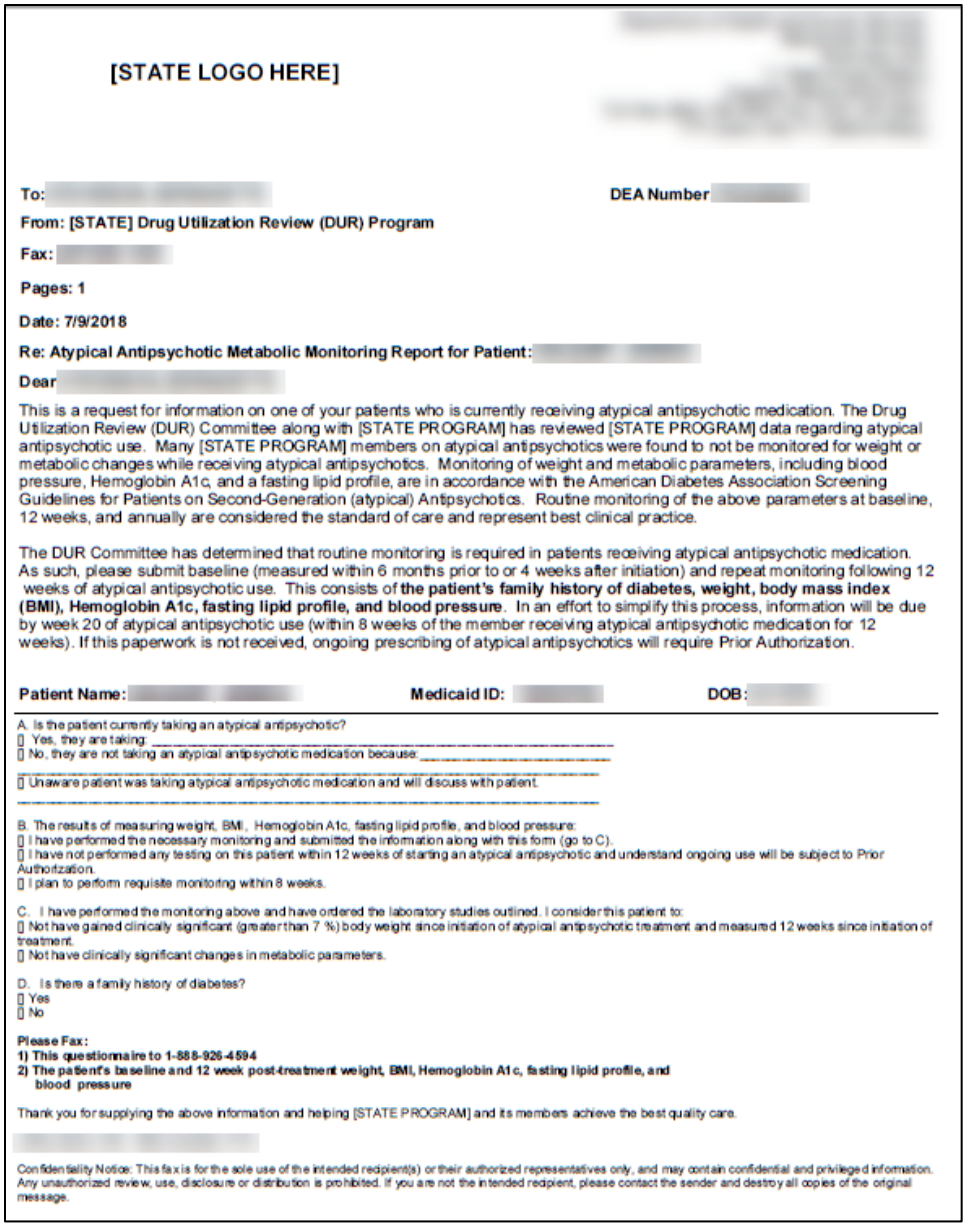
4.5.3.2 The Vendor shall then call the Pharmacy Provider the member has chosen, explain the Lock-In Program and obtain their agreement to participate as the lock-in Pharmacy provider for the member.

4.5.3.3 Pharmacy lock-ins must be completed by the Vendor within 28 calendar days of request. If the member fails to choose a pharmacy within twenty-eight (28) calendar days, the Vendor shall lock the member into the last pharmacy of record and inform the member via mail of their right to request a change. Instructions for requesting a lock-in pharmacy will be included in notification.

Change Healthcare acknowledges that the RetroDUR Committee will make the final decisions regarding the profiles we provide for review to determine which members will be selected for lock-in. The minimum 85 profiles will be generated in our RetroDUR application tool and provided to the Committee for their approvals. We will also feed the profiles presented to the Committee into our med management tool where we manage the members. Upon receipt of the Committee's determination, we will apply the lock-in to only the selected members, causing them to be "active" in the system while ensuring the member profiles not selected by the Committee for lock-in are tagged as "inactive." This method ensures an audit trail of generated profiles and that only approved members are locked in for their specific criteria.

Our help desk staff will be responsible for carrying out the subsequent communications required once Committee decisions are made. Our preferred method of communication is to generate a letter directly from our med management tool to be sent to the eligible member. This communication will include the relevant information to inform the member of the lock-in, explain their responsibility to select one provider for pharmacy services, the time frame for making this selection and inform the member that their claims for pharmacy services will be denied by Medicaid should they be submitted through any other pharmacy provider. The following figure is a sample of such a letter we currently provide for another state client. We will tailor the letter template specific to West Virginia and gain approval from the Bureau prior to implementation. Please note that all PHI has been blurred from this sample letter.

Should the member fail to make a selection for the lock-in pharmacy within 28 days, Change Healthcare will select a pharmacy for the member based on the last pharmacy of record. At this time, we will generate a second letter from the med management tool informing the member of the selected pharmacy, including informing the member of his or her right to request a change as well as instructions for how to do so. Our help desk staff will also communicate via telephone to inform the selected pharmacy of the lock-in, explaining the program and obtaining their agreement to participate as the lock-in pharmacy provider for the member. Should a change be requested through the proper channels, we will follow up with the pharmacy providers as necessary.



[STATE LOGO HERE]

To: DEA Number

From: [STATE] Drug Utilization Review (DUR) Program

Fax:

Pages: 1

Date: 7/9/2018

Re: Atypical Antipsychotic Metabolic Monitoring Report for Patient:

Dear

This is a request for information on one of your patients who is currently receiving atypical antipsychotic medication. The Drug Utilization Review (DUR) Committee along with [STATE PROGRAM] has reviewed [STATE PROGRAM] data regarding atypical antipsychotic use. Many [STATE PROGRAM] members on atypical antipsychotics were found to not be monitored for weight or metabolic changes while receiving atypical antipsychotics. Monitoring of weight and metabolic parameters, including blood pressure, Hemoglobin A1c, and a fasting lipid profile, are in accordance with the American Diabetes Association Screening Guidelines for Patients on Second-Generation (atypical) Antipsychotics. Routine monitoring of the above parameters at baseline, 12 weeks, and annually are considered the standard of care and represent best clinical practice.

The DUR Committee has determined that routine monitoring is required in patients receiving atypical antipsychotic medication. As such, please submit baseline (measured within 6 months prior to or 4 weeks after initiation) and repeat monitoring following 12 weeks of atypical antipsychotic use. This consists of **the patient's family history of diabetes, weight, body mass index (BMI), Hemoglobin A1c, fasting lipid profile, and blood pressure**. In an effort to simplify this process, information will be due by week 20 of atypical antipsychotic use (within 8 weeks of the member receiving atypical antipsychotic medication for 12 weeks). If this paperwork is not received, ongoing prescribing of atypical antipsychotics will require Prior Authorization.

Patient Name: Medicaid ID: DOB:

A. Is the patient currently taking an atypical antipsychotic?
[] Yes, they are taking: _____
[] No, they are not taking an atypical antipsychotic medication because: _____
_____
[] Unaware patient was taking atypical antipsychotic medication and will discuss with patient.
_____

B. The results of measuring weight, BMI, Hemoglobin A1c, fasting lipid profile, and blood pressure:
[] I have performed the necessary monitoring and submitted the information along with this form (go to C).
[] I have not performed any testing on this patient within 12 weeks of starting an atypical antipsychotic and understand ongoing use will be subject to Prior Authorization.
[] I plan to perform requisite monitoring within 8 weeks.

C. I have performed the monitoring above and have ordered the laboratory studies outlined. I consider this patient to:
[] Not have gained clinically significant (greater than 7 %) body weight since initiation of atypical antipsychotic treatment and measured 12 weeks since initiation of treatment.
[] Not have clinically significant changes in metabolic parameters.

D. Is there a family history of diabetes?
[] Yes
[] No

Please Fax:
1) This questionnaire to 1-888-926-4594
2) The patient's baseline and 12 week post-treatment weight, BMI, Hemoglobin A1c, fasting lipid profile, and blood pressure

Thank you for supplying the above information and helping [STATE PROGRAM] and its members achieve the best quality care.

Confidentiality Notice: This fax is for the sole use of the intended recipient(s) or their authorized representatives only, and may contain confidential and privileged information. Any unauthorized review, use, disclosure or distribution is prohibited. If you are not the intended recipient, please contact the sender and destroy all copies of the original message.

Figure 8: Sample Lock-In Letter

AUTOMATED LOCK-INS (RFQ SECTION 4.6)

4.6 The Vendor shall maintain the member lock-in beneficiary and provider list and supply a file of this information to the BMS Fiscal Agent MMIS vendor daily for an automated lock-in process. The Vendor shall work with the Fiscal Agent BMS MMIS vendor to coordinate file layouts and transfer of files through a secure FTP site. All costs associated with transfer of files will be the expense of the Vendor as DHHR/BMS will not incur these charges.

We will maintain the member lock-in beneficiary and provider list, supplying this file to the MMIS vendor on a daily basis to ensure the automated lock-in process continues seamlessly. Our staff will coordinate with the MMIS regarding file layouts and transfer of files through a secure FTP site. We look forward to establishing the expectations regarding these file transfers during JAD sessions to include information shared in both directions from both parties. We make the assumption that the MMIS will send us a daily claims file inclusive of the appropriate pharmacy and medical claims history required for us to run the daily report that identifies any new

members eligible for automatic lock-in. Provided we have the up-to-date histories for Medicaid members, we will provide either full listings or new member listings via the secure FTP site to the MMIS on a daily basis. We understand that costs associated with the transfer of files is the responsibility of our organization.

PRIMARY MANGEMENT OF CONTRACT (RFQ SECTION 4.7)

The Vendor shall provide a list of every office director, owner, partner, key employees, or other person with primary management or supervisory responsibilities, and any person who has a critical influence on or substantive control over a transaction with the State of West Virginia, whether or not employed by the Vendor. The list shall include full names, including maiden names and first and middle names where applicable, and Medicaid Identification Numbers. Additions or deletions to the list of names shall be reported voluntarily and automatically to the Pharmacy Program within one month of the change or addition. The Vendor shall not employ or contract with any individual or entity named on the federally excluded provider list, which can be found at http://exclusions.oig.hhs.gov/.

Dan Hardin, Change Healthcare's Senior Vice President and General Manager of the Medicaid pharmacy solutions division is the executive sponsor for this contract with the State of West Virginia. He is the main point of contact for any critical influences and / or substantive control over this scope of work. Change Healthcare empowers each of our account managers with the daily oversight of each contract. Brent Breeding will have the ability to make daily operational decisions in support of the Bureau's contract. When topics or issues arise that Brent is not able to resolve or answer on his own, our process is for Brent to seek assistance from his supervisor, Chad Bissell. This escalation process assures the Bureau that there is a clear path for resolving questions and concerns in a timely manner. If neither Chad nor Brent are able to make a decision on the Bureau's request, they will seek input from Dan for a final determination and solution for the Bureau.

In the following table, we depict the names and titles of the primary management personnel for this contract in the order of which the Bureau would contact them. During project implementation, our team will seek advice from the Bureau to make sure this approach meets the needs of your programs. Any changes to the contacts in this table will be updated and provided to the Bureau within one (1) month of the change or addition.

Change Healthcare Employee	Title
1. Brent Breeding, PharmD	West Virginia Account Manager
2. Chad Bissell, PharmD, MBA	Regional Pharmacy Director
3. Dan Hardin, RPh, MBA	SVP and GM

Table 2: Change Healthcare Contacts for West Virginia Contract

Notifications of Staffing Changes (RFQ Section 4.7.1)

The Vendor shall submit to the Bureau notification and resumes for any proposed staffing changes to clinical and management positions directly serving the West Virginia account within 30 calendar days of the change. The Bureau shall have the right to review and determine whether the proposed staffing change is acceptable. If the Bureau finds that the proposed staffing change no longer meets the needs of the program, the Vendor must provide an acceptable alternative for BMS approval. No key position (see section 3.1) shall remain vacant for longer than 60 calendar days.

The Bureau will find we have included resumes for key and support staff for the West Virginia RetroDUR scope of work in our Supplemental Attachments. We agree to support the requirement to notify the Bureau in the event that any of this key staff identified in RFQ requirement 3.1 changes. This notification will come within 30 days of the change and, as always, we will seek the Bureau's review and input of any new personnel proposed to support this program.

Our organization has an excellent approach to recruiting new team members. In the event that a key position becomes vacant, we will work closely with the Bureau and our recruiting team to find a suitable replacement candidate to fill an open position within the 60-calendar day timeframe.

FINANCIAL AND TECHNICAL SUPPORT (RFQ SECTION 4.8)

The Vendor shall provide financial and technical support for a RetroDUR Committee that will evaluate member profiles generated by the Vendor. The Committee, made up of healthcare professionals selected by the Bureau, shall consist of four (4) members designated by the Bureau for renewable one year terms. The support must include training for four (4) Committee members and financial reimbursement per monthly meeting not less than $400 per member.

Change Healthcare agrees to provide the RetroDUR Committee members reimbursement per monthly meeting. In our support of several DUR Boards and P&T Committees across the country, we are familiar with this requirement and will provide the Bureau and its Committee members the support they need. In terms of technical and educational support, our talented staff will be available to assist the members with their meeting needs. Further details of this requirement can be further discussed during the implantation phase to assure Change Healthcare's understanding of the expectations are within reason of the Bureau.

REPORTS (RFQ SECTION 4.9)

4.9 REPORTS - The Vendor shall establish a reporting system producing the standard periodic reports for the Bureau as described below:

Regular self-assessment of the RetroDUR program is paramount to ensure it remains effective and relevant. In addition to the regular updates required via the specified formal reports as well as updates during meetings, we will regularly assess the RetroDUR program for financial impact that encompasses cost savings / avoidance and clinical outcomes achieved through RetroDUR efforts. By comparison with updated peer reviewed literature, we have the ability to update and summarize the clinical relevancy of RetroDUR edits to ensure they follow best practice guidelines being used by providers. This is an effort that encompasses our entire account management team, working together to ensure the best possible reporting and analytics for our state clients.

Change Healthcare provides comprehensive standard management reports and advanced analytics to our state clients that are tailored to the specific needs and requirements of their specific programs – in this instance, West Virginia's RetroDUR program. Our robust technology platforms, applications, health informatics resources and clinical subject matter expertise are fully leveraged to deliver the most accurate and timely reporting and analytics services to West Virginia to achieve effective and efficient management of its RetroDUR program.

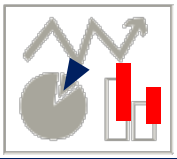
Change Healthcare's Reporting Solutions for West Virginia 	Provides pre-defined inquiries into pharmacy reference and support data.
	Allows our Analysts access to multiple sources of data, such as Oracle, Microsoft SQL Server and Microsoft Excel to provide detailed levels of data visualization.
	Microsoft SQL database hosting solution.

Table 3: Reporting Solutions

We understand that reporting, whether scheduled, ad-hoc or parameterized is a critical element in managing the pharmacy benefit on an ongoing basis regarding performance requirements, tracking the results of quality of care / cost savings initiatives and other State program goals. At the summary level, our analytics solution supports the following key categories of reports:

- ***Standardized*** – Reports with a pre-approved format, structure, content and frequency that are automatically produced and distributed on a regular schedule based on pre-defined specifications. Reports have been designed to be requested to date or based on certain periods of time and can be configured to meet the Bureau's requirements. Although weekly, monthly, quarterly and annual schedules are common, we will work with the State to define the frequency of standardized reporting.
- ***Ad hoc*** – Reports developed to research or address a specific issue or initiative as defined at the time of request. These are run one (1) time or for a limited duration and may also be referred to as "custom" reports. Our experienced staff can both generate requested reports to be provided as well as train State staff to navigate and operate the reporting tool themselves.

We propose a combination of our RetroDUR tool and Microsoft SQL Server Reporting Services (SSRS) to meet the reporting requirements outlined in this RFQ. Our RetroDUR tool (explained in our responses to the RetroDUR Computer System section and in several report samples that follow in this section) is designed as an analysis tool. Though many report functions are available within our RetroDUR tool, we will also be utilizing SSRS. SSRS is a server-based report generation software system that compliments the Microsoft SQL Server suite of products. It provides a unique interface into Microsoft Visual Studio so that developers as well as SQL administrators can connect to SL databases and use SSRS tools to format SQL reports in many complex ways. Access to reports for designated State employees will be delivered through our selected secure web portals.

Our proposed Database Analyst for the West Virginia RetroDUR contract is Mr. Rick Erickson, who brings more than 20 years of experience in relational database development, design, reporting and data analysis. He has been with Change Healthcare for over 14 years and has immense experience in pharmacy / medical claim reporting and analysis, MS SQL Server and SSRS to support multiple Medicaid state agency programs within a wide range of requirements. He will bring extensive analytical experience from our other state partners specific to RetroDUR programs – notably, he developed the entire RetroDUR reporting suite deployed for our largest Medicaid state. He collaborates extensively and effectively with the other members of our in-house analytics team, sharing business knowledge, ideas, specialized areas of interest / skill and to lend / obtain professional support. Rick exemplifies the Change Healthcare standard collaborative approach of information sharing to ensure we maintain industry-wide expertise that applies across the nation, thus providing services above and beyond what our state partners expect.

DUR Reports

Change Healthcare's RetroDUR solution offers multiple applications that have the functionality to report on individual DUR program functions. Our clinical team will have desktop analytic tools available for them to generate a variety of commonly requested reports. When more complex reports are necessary, our designated West Virginia analyst will work in conjunction with the West Virginia account management team to provide such reports as necessary to facilitate requests, DUR forecasting and cost savings analyses.

We provide our clients with robust, flexible and scalable reporting services that include standard and ad hoc reports. Effective reporting is crucial to the services we provide. We use reporting to assure that we are carrying out all of our responsibilities effectively. Reporting allows state policy makers to evaluate the impact of policy decisions on program operations and closely track expenditures. It is useful in the identification of issues of policy that require remediation and opportunities for cost savings and quality improvement. Our team of highly trained data analysts will work with key stakeholders to identify those special reports required to meet the needs of the Bureau. We look forward to discussing the State's ad hoc reporting needs during JAD sessions, further defining the frequency and number of reports typically requested. We recommend an Excel format for the speed and flexibility it offers and because it works well for the dynamic content of requests, but will deliver reporting in the manner of the Bureau's choosing, with layouts specific to the State's needs.

Monthly Reports

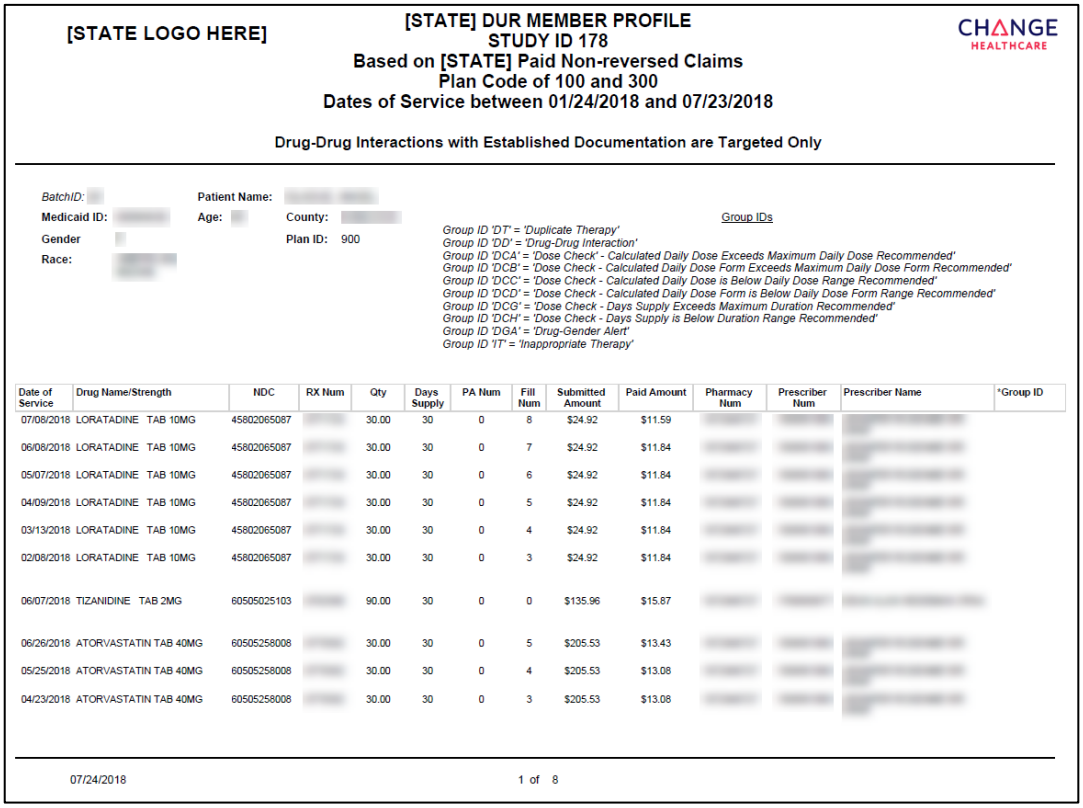
4.9.1. Monthly reports .. The Vendor shall provide the following RetroDUR summary reports monthly, at least three (3) calendar days prior to the RetroDUR Committee meeting, to the Pharmacy Services Program for review and approval. These reports shall be mailed to the Bureau for inclusion in the RetroDUR Committee members' monthly meeting packets. The content fields of the Vendor's summary reports shall be mutually identified and agreed upon. Monthly reports are to include, but not be limited to:

- ***4.9.1.1. Provider response log updates;***
- ***4.9.1.2. Provider profiling (physician and pharmacy provider);***
- ***4.9.1.3. Profile review outcome summary;***
- ***4.9.1.4. Case summary;***
- ***4.9.1.5. Statistical activity summary report to include but not be limited to distribution of beneficiaries, number of cases reviewed, number of letters generated, summary of distribution of cases by problem types and follow up data;***
- ***4.9.1.6. Monthly summary of new member lock-ins as well as the total number of members currently locked into a pharmacy;***
- ***4.9.1.7. Report of outlier and errant claims by pharmacy providers;***
- ***4.9.1.8. RetroDUR Estimated Savings Report (including the vendors methodology***

We will provide all monthly RetroDUR summary reports as depicted in this requirement at least three (3) calendar days prior to the RetroDUR Committee meeting, to the Pharmacy Services Program for review and approval. Our account management staff will ensure timely mailing of these reports to the Bureau for inclusion in the RetroDUR Committee's meeting packets.

Sample Provider Profiling Report (4.1.9.2)

The following two (2) screenshots are a sample report of profiles that have been run for RetroDUR review based on targeted criteria on drug:drug interactions. From these profiles, members are selected for intervention and will be sent provider letters. We are able to tailor the presentation of this report as well as its contents to the needs of the Bureau. Please note that all PHI has been blurred from these samples.



[STATE LOGO HERE]

[STATE] DUR MEMBER PROFILE
STUDY ID 178
Based on [STATE] Paid Non-reversed Claims
Plan Code of 100 and 300
Dates of Service between 01/24/2018 and 07/23/2018

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Drug-Drug Interactions with Established Documentation are Targeted Only

BatchID: [redacted] Patient Name: [redacted]
Medicaid ID: [redacted] Age: [redacted] County: [redacted]
Gender [redacted] Plan ID: 900
Race: [redacted]

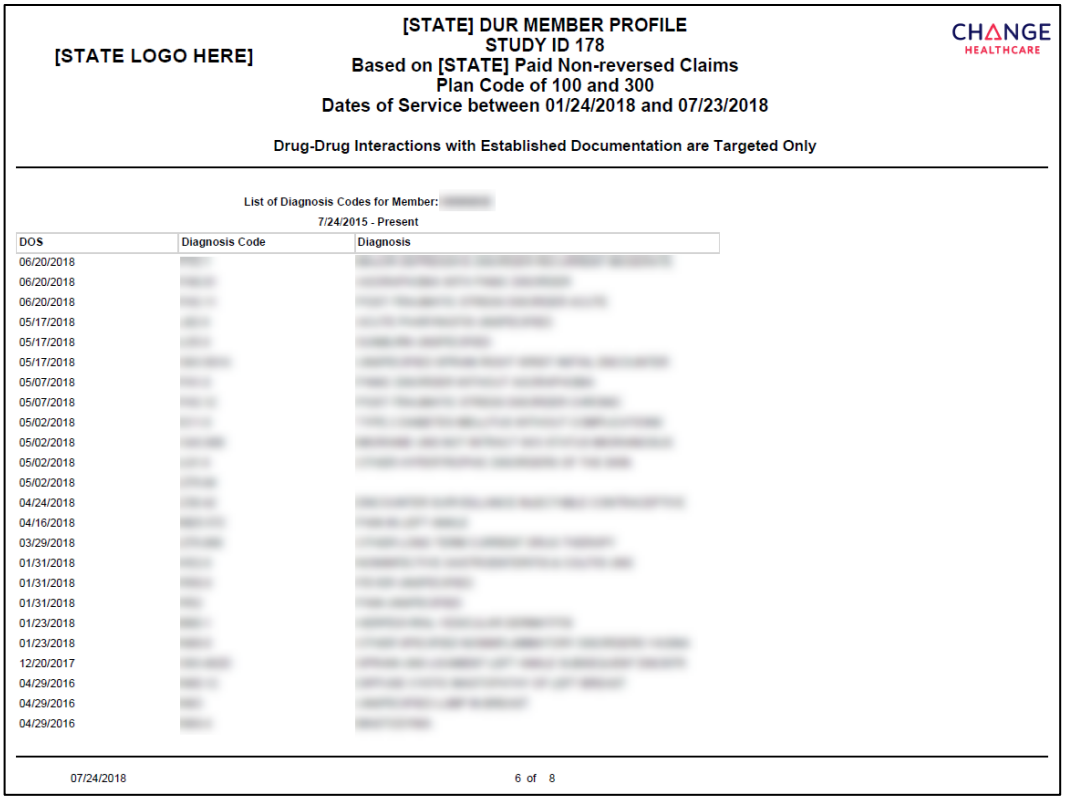
Group IDs

Group ID 'DT' = 'Duplicate Therapy'
Group ID 'DD' = 'Drug-Drug Interaction'
Group ID 'DCA' = 'Dose Check' - Calculated Daily Dose Exceeds Maximum Daily Dose Recommended'
Group ID 'DCB' = 'Dose Check - Calculated Daily Dose Form Exceeds Maximum Daily Dose Form Recommended'
Group ID 'DCC' = 'Dose Check - Calculated Daily Dose is Below Daily Dose Range Recommended'
Group ID 'DCD' = 'Dose Check - Calculated Daily Dose Form is Below Daily Dose Form Range Recommended'
Group ID 'DCG' = 'Dose Check - Days Supply Exceeds Maximum Duration Recommended'
Group ID 'DCH' = 'Dose Check - Days Supply is Below Duration Range Recommended'
Group ID 'DGA' = 'Drug-Gender Alert'
Group ID 'IT' = 'Inappropriate Therapy'

Date of Service	Drug Name/Strength	NDC	RX Num	Qty	Days Supply	PA Num	Fill Num	Submitted Amount	Paid Amount	Pharmacy Num	Prescriber Num	Prescriber Name	*Group ID
07/08/2018	LORATADINE TAB 10MG	45802065087	[redacted]	30.00	30	0	8	$24.92	$11.59	[redacted]	[redacted]	[redacted]	
06/08/2018	LORATADINE TAB 10MG	45802065087	[redacted]	30.00	30	0	7	$24.92	$11.84	[redacted]	[redacted]	[redacted]	
05/07/2018	LORATADINE TAB 10MG	45802065087	[redacted]	30.00	30	0	6	$24.92	$11.84	[redacted]	[redacted]	[redacted]	
04/09/2018	LORATADINE TAB 10MG	45802065087	[redacted]	30.00	30	0	5	$24.92	$11.84	[redacted]	[redacted]	[redacted]	
03/13/2018	LORATADINE TAB 10MG	45802065087	[redacted]	30.00	30	0	4	$24.92	$11.84	[redacted]	[redacted]	[redacted]	
02/08/2018	LORATADINE TAB 10MG	45802065087	[redacted]	30.00	30	0	3	$24.92	$11.84	[redacted]	[redacted]	[redacted]	
06/07/2018	TIZANIDINE TAB 2MG	60505025103	[redacted]	90.00	30	0	0	$135.96	$15.87	[redacted]	[redacted]	[redacted]	
06/26/2018	ATORVASTATIN TAB 40MG	60505258008	[redacted]	30.00	30	0	5	$205.53	$13.43	[redacted]	[redacted]	[redacted]	
05/25/2018	ATORVASTATIN TAB 40MG	60505258008	[redacted]	30.00	30	0	4	$205.53	$13.08	[redacted]	[redacted]	[redacted]	
04/23/2018	ATORVASTATIN TAB 40MG	60505258008	[redacted]	30.00	30	0	3	$205.53	$13.08	[redacted]	[redacted]	[redacted]	

07/24/2018 1 of 8

Figure 9: Provider Profile Sample Report



[STATE LOGO HERE]

[STATE] DUR MEMBER PROFILE
STUDY ID 178
Based on [STATE] Paid Non-reversed Claims
Plan Code of 100 and 300
Dates of Service between 01/24/2018 and 07/23/2018

CHANGE HEALTHCARE

Drug-Drug Interactions with Established Documentation are Targeted Only

List of Diagnosis Codes for Member: [redacted]
7/24/2015 - Present

DOS	Diagnosis Code	Diagnosis
06/20/2018	[redacted]	[redacted]
06/20/2018	[redacted]	[redacted]
06/20/2018	[redacted]	[redacted]
05/17/2018	[redacted]	[redacted]
05/17/2018	[redacted]	[redacted]
05/17/2018	[redacted]	[redacted]
05/07/2018	[redacted]	[redacted]
05/07/2018	[redacted]	[redacted]
05/02/2018	[redacted]	[redacted]
05/02/2018	[redacted]	[redacted]
05/02/2018	[redacted]	[redacted]
05/02/2018	[redacted]	
04/24/2018	[redacted]	[redacted]
04/16/2018	[redacted]	[redacted]
03/29/2018	[redacted]	[redacted]
01/31/2018	[redacted]	[redacted]
01/31/2018	[redacted]	[redacted]
01/31/2018	[redacted]	[redacted]
01/23/2018	[redacted]	[redacted]
01/23/2018	[redacted]	[redacted]
12/20/2017	[redacted]	[redacted]
04/29/2016	[redacted]	[redacted]
04/29/2016	[redacted]	[redacted]
04/29/2016	[redacted]	[redacted]

07/24/2018 6 of 8

Figure 10: Provider Profile Sample Report 2

Sample Provider Review Outcome Summary (4.9.1.3) and Sample Monthly Case Summary (4.9.1.4)

The following sample report depicts a per study review of provider responses typically used in focus studies. We also provide similar reports for patient studies. All reports for West Virginia will be tailored to meet the needs of the State in terms of parameters, layout, information included, etc.

[STATE] DUR
Problem - Focused Review

Study ID: 160

Initial Review Date	**December, 2014**			
Re-Review Date	**May, 2015**			
Patient Profiles Reviewed	**23**			
Patient Profiles Available for Evaluation	**23**			
Intervention Letters Sent				
Prescribers	**38**	60.32%	Overall Response Rate	34.92%
Pharmacists	**25**	39.68%	Prescriber Response Rate	39.47%
Total	**63**		Pharmacy Response Rate	28.00%
Responses Received				
Prescribers	**15**	68.18%		
Pharmacists	**7**	31.82%		
Total	**22**			

Responses Received by Month

Month Received	Total Responses	Pharmacy Response	Prescriber Response
Oct 2015	20	7	13
Nov 2015	1	0	1
Dec 2015	1	0	1
	22	7	15

Figure 11: Provider Review Outcomes Sample Report

[STATE] DUR
Problem - Focused Review

Study ID: 161

Initial Review Date	**December, 2014**			
Re-Review Date	**May, 2015**			
Patient Profiles Reviewed	**12**			
Patient Profiles Available for Evaluation	**12**			
Intervention Letters Sent				
Prescribers	**20**	55.56%	Overall Response Rate	19.44%
Pharmacists	**16**	44.44%	Prescriber Response Rate	15.00%
Total	**36**		Pharmacy Response Rate	25.00%
Responses Received				
Prescribers	**3**	42.86%		
Pharmacists	**4**	57.14%		
Total	**7**			

Responses Received by Month

Month Received	Total Responses	Pharmacy Response	Prescriber Response
Oct 2015	5	3	2
Nov 2015	2	1	1
	7	4	3

Figure 12: Provider Review Outcomes Sample Report 2

Sample Lock-in Summary Report (4.1.9.6)

The following report sample we provide is a sample of the lock-in summary for one of our current client states. It includes the members' names, card holder number ID, age, unique pharmacy count and unique prescriber count. The Bureau will note that the sample report provided is presented as an annual report with the aforementioned criteria included; however, we can easily alter the date and content parameters to meet the needs of West Virginia. In other words, we can tailor this report as a monthly analysis, it can include all lock-in members or only the new member lock-ins added in the specified time frame and other relevant lock-in information. Please note that all PHI has been blurred from the following sample report:

[STATE LOGO HERE]

[STATE] Lockin

Report Period: 1/1/2017 to 12/31/2017

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Cardholder ID	Cardholder Name	Cardholder Age	Unique Pharmacy Count	Unique Prescr Count
[redacted]	[redacted]	28	2	2
[redacted]	[redacted]	9	2	5
[redacted]	[redacted]	15	2	3
[redacted]	[redacted]	13	2	2
[redacted]	[redacted]	34	2	2
[redacted]	[redacted]	48	2	4
[redacted]	[redacted]	30	2	4
[redacted]	[redacted]	55	3	4
[redacted]	[redacted]	50	3	6
[redacted]	[redacted]	20	2	3
[redacted]	[redacted]	12	2	3
[redacted]	[redacted]	33	3	8
[redacted]	[redacted]	57	2	2
[redacted]	[redacted]	46	2	2
[redacted]	[redacted]	37	2	3
[redacted]	[redacted]	35	2	2
[redacted]	[redacted]	37	2	2
[redacted]	[redacted]	41	4	4
[redacted]	[redacted]	48	2	2
[redacted]	[redacted]	34	2	2
[redacted]	[redacted]	46	2	4
[redacted]	[redacted]	25	2	2
[redacted]	[redacted]	11	2	2
[redacted]	[redacted]	38	2	4
[redacted]	[redacted]	9	3	4
[redacted]	[redacted]	45	2	4
[redacted]	[redacted]	40	3	5
[redacted]	[redacted]	16	2	4
[redacted]	[redacted]	58	3	5
[redacted]	[redacted]	56	2	2
[redacted]	[redacted]	15	2	2
[redacted]	[redacted]	28	2	3
[redacted]	[redacted]	61	3	3
[redacted]	[redacted]	35	2	2

9/5/2018 3:48:04 PM [STATE]-1164 Page 1 of 37

Confidential and Proprietary

Figure 13: Annual Lock-in List Sample Report

Sample RetroDUR Savings Report for Selected Study (4.9.1.8)

The following is a sample RetroDUR Savings Report based on a selected study. The information depicted is a per study analysis of member and provider activity with pre- and post-intervention savings. This report can also be run to depict six- (6) month intervention results. Please note that the following image contains no PHI.

[STATE LOGO HERE]

[STATE] DUR FOCUS STUDY
Based on [STATE] Paid Non-Reversed Claims

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Duplicate Beta-Blockers

Follow-up on the unique members identified as taking two or more chemically distinct beta-blockers.

Number of unique members from original study	34
Number of unique members that changed therapy	17
Number of unique members that did not change therapy	15
Number of unique members who lost Medicaid eligibility since 2/1/2015	2

Number of surveys sent to prescribers	67	Number of surveys received from prescribers	27	Percent of surveys from prescribers	40.30%
Number of surveys sent to pharmacies	37	Number of surveys received from pharmacies	17	Percent of surveys from pharmacies	45.95%
Total number of surveys sent	104	Total number of surveys received	44	Percent of surveys received	42.31%

Costs (Pre-Rebate)	Original Costs (1/1/2015 - 1/31/2015)*	Costs After DUR Intervention (1/1/2016 - 1/31/2016)**	Cost Savings***	Annualized Cost Savings****
Total Dollars Federal	$672.74	$334.31	$338.42	$4,061.09
Total Dollars State	$247.79	$139.21	$108.59	$1,303.03
Total Dollars (State and Federal)	$920.53	$473.52	$447.01	$5,364.12

* **Federal FMAP: 0.5554 State: 0.4446**
** **Federal FMAP: 0.5491 State: 0.4509**
*** **IHAWP Federal FMAP: 1.0000 State: 0.0000**
**** **Annualized Cost Savings is based on the reported interval. Some savings may be due to changes in reimbursement from the original time period to the follow-up period.**

Figure 14: DUR Focus Study Savings Sample Report

Quarterly Activity Reports

4.9.2 Quarterly Activity Reports -The Vendor shall submit, by e-mail and hard copy, each quarterly report within 15 calendar days following the applicable quarterly period. The quarterly reports are to include, but not be limited to:

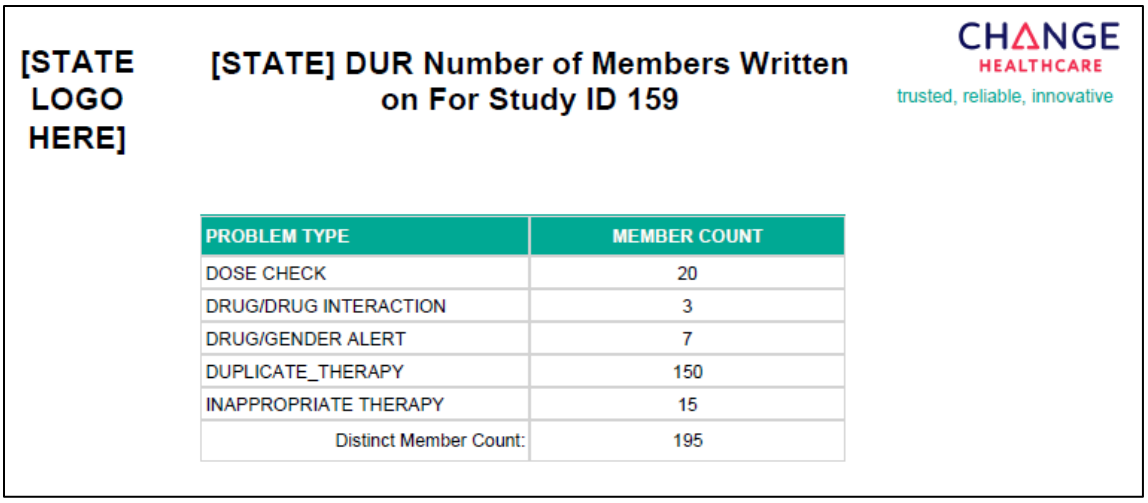
- ***4.9.2.1 Patient profiles review outcome reports by population***
- ***4.9.2.2 Activity statistical report;***
- ***4.9.2.3 Case distribution by problem type;***
- ***4.9.2.4 Trend summary of major therapeutic categories of interest;***
- ***4.9.2.5 Outcomes reports (six-month post intervention) - The Vendor shall provide an outcome report for review at DUR Board meetings;***
- ***4.9.2.6 Outcome reports (six-moth post intervention). The Vendor shall provide outcome reports of all population based educational interventions and present them at the appropriate quarterly DUR Board meeting;***
- ***4.9.2.7 Quarterly estimated savings reports with methodology***

Change Healthcare will provide the Bureau with the quarterly activity reports as outlined in this requirement. We will deliver these reports via email and hard copy within 15 calendar days following the applicable quarterly period.

Sample Case Distribution by Problem Type Report (4.9.2.3)

We include the following sample report provided for the RetroDUR program for another of our state partners. This particular report pertains to the Case Distribution by Problem Type report

(4.9.2.3). It depicts the number of state Medicaid members who have been selected for review by the problem type.



[STATE LOGO HERE]

[STATE] DUR Number of Members Written on For Study ID 159

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PROBLEM TYPE	MEMBER COUNT
DOSE CHECK	20
DRUG/DRUG INTERACTION	3
DRUG/GENDER ALERT	7
DUPLICATE_THERAPY	150
INAPPROPRIATE THERAPY	15
Distinct Member Count:	195

Figure 15: Case Distribution by Problem Type Sample Report

Annual Reports

4.9.3 Annual Reports -The Vendor shall electronically submit to the Bureau the following, (but not limited to), data by May 1 of each calendar year for CMS annual reports:

4.9.3.1 Outcomes and utilization summary reports
4.9.3.2 Population-based intervention outcomes
4.9.3.3 Annual savings generated by the RetroDUR Program (methodology must be described).
4.9.3.4 All requirements specified by the Centers for Medicare and Medicaid (CMS) Annual Report no later than May 1 of each year to comply with Section 1927 (g)(3)(d) of the Social Security Act, included in https://www.ssa.gov/OP Home/ssact/title19/1927.htm, that requires each state to submit an annual report to CMS on the operation of its Medicaid DUR Program. Per subsection (D) Annual report, each State shall require the DUR Board to prepare a report on an annual basis. The State shall submit a report on an annual basis to the Secretary which shall include a description of the activities of the Board, including the nature and scope of the prospective and retrospective drug use review programs, a summary of the interventions used, an assessment of the impact of these educational interventions on quality of care, and an estimate of the cost savings generated as a result of such program. The Secretary shall utilize such report in evaluating the effectiveness of each State's drug use review program. The Vendor shall include all necessary data for the descriptions of the nature and scope of the RetroDUR program, a summary of the interventions used and an assessment of the education programs, and an assessment of the RetroDUR program's impact on quality of care, as well as any cost savings generated in the program. Additionally, the Vendor shall assist the Bureau in a description of DUR Board activities as it pertains to RetroDUR activities. The report format must be such that the Bureau will be able to add other sections to the electronic report in order to complete the document according to CMS specifications at no additional cost to the Bureau.

We will prepare and provide electronically, the reports outlined in this requirement regarding the CMS annual report no later than May 1 of each calendar year.

In support of the RetroDUR programs in all of our client states, we provide assistance for and / or complete the Medicaid Drug Utilization Review Annual Report. As an organization with extensive experience providing Medicaid pharmacy services across 16 client states, our expertise in managing and monitoring utilization, prescribing habits, cost savings and other innovative practices in alignment with federal and state regulations have instilled confidence in our state partnerships that we are reliable and accurate in our reporting. This uniquely positions us to assist with provision of reporting and other relevant information required to ensure the Medicaid Drug Utilization Annual Report is accurate and timely for CMS.

In our client states of Ohio, Utah and Wyoming, our clinical staff prepares data and reports that the pharmacy directors or other state designee consults to respond to the survey. In our client

states of Maine, Iowa and Vermont, our staff complete the full survey specific to those accounts. As the vendor for full PBM services in these states, our staff is well-versed in the clinical and financial goals of each, providing reporting and analytics on the many components of the Drug Utilization Report to include, but not be limited to ProDUR / RetroDUR initiatives, pharmacy lock-in, DUR Board activities, physician-administered drugs, cost savings / avoidance, FWA, e-Prescribing, prescription drug monitoring programs and opioid / morphine equivalency. Although we understand our participation in West Virginia will be limited to RetroDUR activities, we detail our experience to assure the Bureau we are well-qualified to assist in the preparation of this report.

To ensure accurate tracking and auditing of our solution, our clinical team, comprised of doctors and pharmacists, works with data analysts, data administrators and developers to establish and regularly review indicators, pharmacy and medical profiles and outcomes that are captured through reporting and analytics. This effort facilitates not only the achievement of an effective and efficient program, but also allows our staff to provide accurate and timely response to CMS' Drug Utilization Report. Change Healthcare is able to offer support as required by West Virginia.

Sample Annual Savings Generated by RetroDUR Report (4.9.3.3)

As an example of our reporting capabilities, we offer the Bureau a glimpse at an annual savings report (similar to that of what is requested from the Annual Savings Generated by RetroDUR, 4.9.3.3). We recommend presentation in Excel format as there are multiple tabs for display of the various components; however, we can provide it in PDF format as well. Included are the overall summary, month-month, impact-assessment, comment-type, savings-by-template and comment-type-percentages. Overall, this report provides a yearly overview of the program as a whole and it will be tailored to meet West Virginia's needs. The following screenshots are samples of the Statistical Activity Summary Report as it is presented to another of our state partners. Please note that all PHI has either been removed or blurred from these images.

Patient - Focused Reviews
FFY 2013

	077 thru 091	
Initial Review Date	**January 2012 - December 2012**	
Re-review Date	**November 2012 - September 2013**	
Patient Profiles Reviewed	1,800	
Profiles Selected for Intervention	1,288	
Intervention Letters Sent		
Prescribers	1,597	53.43%
Pharmacists	1,392	46.57%
Total	**2,989**	
Responses Received		
Prescribers	575	53.24%
Pharmacists	505	46.76%
Total	**1,080**	
Total Number of Suggestions		
Therapeutic	1,321	98.00%
Cost-Sav		
T		
Total Number of Chan		
Therape		
Cost-Sav		
Positive Impact C		
T		

Overall Response Rate	**36.13%**
Prescriber Response Rate	36.01%
Pharmacy Response Rate	36.28%
Impact Rate	**5.93%**

Figure 16: Annual Savings Generated by RetroDUR - Summary Page Sample

Patient - Focused Review
Month by Month Breakdown
FFY2013

	077	080	082	084	087
Initial Review Date	**Feb-12**	**Apr-12**	**Jun-12**	**Aug-12**	**Oct-12**
Evaluation Date	**Nov-12**	**Jan-13**	**Mar-13**	**May-13**	**July-13**
Profiles Reviewed	300	300	300	300	300
Profiles Available for Evaluation	238	220	216	212	195
Total Number of Suggstions Made	252	236	230	222	200
Therapeutic	245	233	230	221	193
Cost Saving	7	3	0	1	7
Total Number of Changes Made	19	16	14	6	12
Therapeutic	19	16	14	6	11
Cost Saving	0	0	0	0	1
Positive Impact Only	0	0	0	0	0
Total Dollars Saved - Therapeutic	$7,970.48	$80,885.87	$27,571.09	$49,476.58	$23,873.48
Total Dollars Saved - Cost Saving	$2,119.79	($2,091.59)	$0.00	($1,313.78)	$5,764.83
Total Dollars Saved on Medication*	$10,090.27	$78,794.28	$27,571.09	$48,162.80	$29,638.31
Total Dollars Saved per Profile	$42.40	$358.16	$127.64	$227.18	$151.99

Figure 18: Patient-Focused Review Month by Month Breakdown Sample Report

Medicaid DUR Impact Assessment Report
Patient-Focused Reviews
FFY2013

	77	80	82	84	87	91		
Initial Review Date	Feb-12	Apr-12	Jun-12	Aug-12	Oct-12	Dec-12		
Evaluation Date	Nov-12	Jan-13	Mar-13	May-13	Jul-13	Sep-13	**Total**	
Profiles Reviewed	300	300	300	300	300	300	**1,800**	
Profiles Evaluated	238	220	216	212	195	207	**1,288**	
Letters Sent	555	527	517	481	451	458	**2,989**	100.00%
Prescribers	295	283	278	254	242	245	**1,597**	53.43%
Pharmacy	260	244	239	227	209	213	**1,392**	46.57%
Responses Received	195	180	158	185	182	180	**1,080**	100.00%
Prescribers	98	100	83	100	96	98	**575**	53.24%
Pharmacy	97	80	75	85	86	82	**505**	46.76%
Total Number of Templates Mentioned	252	236	230	222	200	208	**1,348**	100.00%
Therapeutic	245	233	230	221	193	199	**1,321**	98.00%
Cost-Saving	7	3	0	1	7	9	**27**	2.00%
Total Number of Changes Made	19	16	14	6	12	13	**80**	100.00%
Therapeutic	19	16	14	6	11	12	**78**	97.50%
Cost-Saving	0	0	0	0	1	1	**2**	2.50%
Positive Impact Only	0	0	0	0	0	0	**0**	0.00%
Total Dollars Saved - Therapeutic Changes	$7,970.48	$80,885.87	$27,571.09	$49,476.58	$23,873.48	$14,706.90	**$204,484.40**	97.62%
Total Dollars Saved - Cost Saving Changes	$2,119.79	($2,091.59)	$0.00	($1,313.78)	$5,764.83	$516.55	**$4,995.80**	2.38%
Total Dollars Saved on Medication*	$10,090.27	$78,794.28	$27,571.09	$48,162.80	$29,638.31	$15,223.45	**$209,480.20**	100.00%
Total Dollars Saved Per Profile Evaluated	$42.40	$358.16	$127.64	$227.18	$151.99	$73.54	**$162.64**	

***Savings reported are pre-rebate, total dollars**

Figure 17: DUR Impact Assessment Sample Report

Comment Type
Patient Focused Reviews
FFY2013

	77		80		82		84	
Initial Review Date	**Feb-12**		**Apr-12**		**Jun-12**		**Aug-12**	
Evaluation Date	**Nov-12**		**Jan-13**		**Mar-13**		**May-13**	
Template Classification	**Suggestions**	**Changes**	**Suggestions**	**Changes**	**Suggestions**	**Changes**	**Suggestions**	**Changes**
Adverse Drug Reaction	0	0	1	0	1	0	0	0
Drug-Disease Interaction	0	0	1	0	1	0	0	0
Drug-Drug Interaction	26	2	26	3	18	0	14	1
High Cost Drug	0	0	0	0	0	0	0	0
Innapropriate Billing	1	0	2	0	0	0	1	0
Missing Drug Therapy	0	0	0	0	0	0	0	0
Not Optimal Dosage Form	4	0	0	0	0	0	0	0
Not Optimal Dose	1	0	5	1	0	0	3	0
Not Optimal Drug	43	4	16	3	34	3	31	2
Not Optimal Duration	7	0	19	0	6	0	4	0
Patient Overuse	0	0	1	1	2	0	1	0
Patient Underuse	1	0	1	0	3	0	2	0
Potential Generic Use	2	0	1	0	0	0	0	0
Therapeutic Alternative	0	0	0	0	1	0	1	0
Therapeutic Duplication	165	13	163	8	161	11	165	3
Unnecessary Drug Therapy	2	0	0	0	3	0	0	0
Total	**252**	**19**	**236**	**16**	**230**	**14**	**222**	**6**

Figure 19: Comment Type Sample Report

Savings By Template Class
FFY2013

	77	80	82	84	87
Initial Review Date	Feb-12	Apr-12	Jun-12	Aug-12	Oct-12
Evaluation Dte	Nov-12	Jan-13	Mar-13	May-13	Jul-13
Template Classification					
Adverse Drug Reaction	$0.00	$24.94	($0.01)	$0.00	$0.00
Drug-Disease Interaction	$0.00	($53.70)	$7.79	$0.00	$0.00
Drug-Drug Interaction	$2,318.90	$1,701.13	$2,619.39	($1,266.55)	($26.37)
High Cost Drug	$0.00	$0.00	$0.00	$0.00	$0.00
Inappropriate Billing	$37.62	($2,425.76)	$0.00	($1,313.78)	$325.10
Missing Drug Therapy	$0.00	$0.00	$0.00	$0.00	$0.00
Not Optimal Dosage Form	$1,563.87	$0.00	$0.00	$0.00	$5,815.95
Not Optimal Dose	$166.28	($1,631.68)	$0.00	$3,138.91	$1,092.38
Not Optimal Drug	($3,275.46)	$9,252.74	($24,419.02)	$21,170.29	$2,465.39
Not Optimal Duration	$680.74	$411.99	$222.31	$171.12	$104.86
Patient Overuse	$0.00	$157.27	($212.84)	($86.74)	$140.83
Patient Underuse	$0.00	$0.00	$926.14	($172.51)	$284.28
Potential Generic Use	$518.30	$334.17	$0.00	$0.00	($376.21)
Therapeutic Alternative	$0.00	$0.00	$183.05	$1,880.23	$0.00
Therapeutic Duplication	$8,284.38	$71,023.18	$48,334.64	$24,641.84	$19,812.11
Unnecessary Drug Therapy	($204.37)	$0.00	($90.36)	$0.00	$0.00
Total	**$10,090.26**	**$78,794.28**	**$27,571.09**	**$48,162.81**	**$29,638.32**

Figure 20: Savings by Template Class Sample Report

Patient Focused Reviews
FFY 2013

Template Classification	Total Suggestions	Total Changes	% of Total Suggstions	% of Total Changes	% of Suggestions Changed	% Dollars Saved	
Adverse Drug Reaction	2	0	0.15%	0.00%	0.00%	0.01%	$24.93
Drug-Disease Interaction	2	0	0.15%	0.00%	0.00%	(0.02%)	($45.91)
Drug-Drug Interaction	106	7	7.86%	8.75%	6.60%	2.49%	$5,221.13
High Cost Drug	0	0	0.00%	0.00%	0.00%	0.00%	$0.00
Inappropriate Billing	6	0	0.45%	0.00%	0.00%	(1.61%)	($3,376.82)
Missing Drug Therapy	0	0	0.00%	0.00%	0.00%	0.00%	$0.00
Not Optimal Dosage Form				2.50%	14.29%	3.64%	$7,621.66
Not Optimal Dose				2.50%	11.76%	1.51%	$3,156.79
Not Optimal Drug				17.50%	8.64%	1.65%	$3,463.17
Not Optimal Duration				1.25%	1.92%	0.84%	$1,753.70
Patient Overuse				5.00%	44.44%	(0.00%)	($1.49)
Patient Underuse				2.50%	14.29%	0.99%	$2,070.07
Potential Generic Use				0.00%	0.00%	0.36%	$750.97
Therapeutic Alternative				0.00%	0.00%	0.98%	$2,063.28
Therapeutic Duplication				57.50%	4.89%	86.43%	$181,061.07
Unnecessary Drug Therapy				2.50%	13.33%	2.73%	$5,717.66
Total				100.00%	5.93%	100.00%	**$209,480.21**

Figure 21: Patient-Focused Reviews Template Classification Sample Report

QUARTERLY NEWSLETTER (RFQ SECTION 4.10)

4.10 The Vendor shall produce a quarterly newsletter detailing BMS pharmacy policy updates, Drug Utilization Review Board action, and any other pertinent drug information to prescribers and pharmacy providers. This newsletter must be available for posting electronically on the Bureau for Medical Services website at http://www.dhhr.wv.gov/bms/Pharmacy/Pages/default.aspx within 30 calendar days following the end of the quarter.

Change Healthcare has previous experience producing quarterly newsletters to update prescribers and pharmacy providers on policy updates, changes and initiatives. We will meet this requirement to execute a quarterly newsletter detailing BMS pharmacy policy updates, DUR Board actions and other relevant information, making this communication available on the BMS website within 30 calendar days following the end of each quarter.

Our proposed Account Manager, Brent Breeding, is experienced in managing the quarterly newsletter for the clinical services contract our organization oversees for West Virginia. On a quarterly basis, he compiles all of the information regarding changes and updates mandated by the P&T Committee, any additional information the State wishes to include and drafts a clinical article for publication based on a relevant topic. These topics range from PDL-related to Committee-related to cultural or timely topics. For example, in the fall quarterly newsletter he provided a clinical article with updates on available treatments for head lice, as it coincided the back-to-school time of year. In another newsletter, he addressed the opioid epidemic, specifically tailoring the statistics to West Virginia and including quotes from providers and prescribers within the State instead of addressing it from the national perspective. In the following screenshot, we provide an example of the West Virginia Pharmacy Program Quarterly Newsletter as prepared by Change Healthcare.

West Virginia Medicaid
Pharmacy Solutions

JUNE, 2016

West Virginia Medicaid Pharmacy Department

http://www.dhhr.wv.gov/bms/BMS%20Pharmacy

Provider Services

888-483-0793

888-483-0801 (Pharmacy)
304-348-3360
Monday – Friday
8:00 am until 5:00 pm

Pharmacy Help Desk& Pharmacy Prior Authorization (Rational Drug Therapy Program)

800-847-3859 (Phone)
800-531-7787 (Fax)
Monday – Saturday
8:30 am until 9:00 pm
Sunday 12:00 pm until 6:00 pm

Member Services

888-483-0797
304-348-3365
Monday – Friday
8:00 am until 5:00 pm

Preferred Drug List

For a copy of the most recent preferred drug list, visit:
http://www.dhhr.wv.gov/bms/BMS%20Pharmacy/Pages/Preferred-Drug-List.aspx

State Maximum Allowable Cost (SMAC)

SMAC Review Form:
http://www.dhhr.wv.gov/bms/BMS%20Pharmacy/SMAC/Pages/default.aspx
Please refer questions to Magellan at 1-800-763-7382 or e-mail to StateSMACProgram@magellanhealth.com

Use of Opioids and New CDC Guidelines

Opioid analgesic sales quadrupled from 1999 to 2010. Opioid-related deaths more than tripled from 1999 to 2012. In 2012, Alabama, Tennessee, and West Virginia had the highest prescribing of opioid pain relievers and benzodiazepines. In 2013, West Virginia had the highest number of drug overdose deaths in the United States. West Virginia providers were writing 137.6 opioid pain relieving prescriptions per 100 people in 2014. This was the third highest rate in the country, almost doubling the national average of 82.5 per 100 people.[1]

Broader availability of oxycodone—sold under the name OxyContin—starting in the mid-1990s is widely blamed for the rise of opioid abuse. When patients lose access to this drug, some who have become dependent on it switch to the chemically related drug heroin and illicitly produced fentanyl, and results can be deadly.[2]

Rates of opioid prescribing vary greatly across states in ways that cannot be explained by the underlying health status of the population, highlighting the lack of consensus among clinicians on the use of opioid pain medication.[2]

Responding to the growing epidemic of opioid and heroin abuse, the CDC issued a new guideline for doctors prescribing opioids for chronic pain. In 2012, healthcare providers wrote 259 million prescriptions for opioid pain medication, enough for every adult in the United States to have a bottle of pills. Primary care physicians account for nearly half of all opioid prescriptions and typically treat adults in outpatient settings.[2]

The CDC guidelines are targeted at primary care physicians and not those treating cancer patients, or those in palliative or end-of-life care. The guidelines emphasize both patient care and safety. The CDC developed the guidelines through extensive review of the best scientific evidence available along with input from a group of hundreds of leading experts and practitioners, federal agencies, patient advocacy groups and others.[3]

Three key principles underlie the guideline's 12 recommendations (see The CDC Opioid-Prescribing Guideline. First, non-opioid therapy is preferred for chronic pain outside the context of active cancer, palliative, or end-of-life care. Non-pharmacologic therapies can ameliorate chronic pain while posing substantially less risk to patients. In some instances, other therapies result in better outcomes than opioids. These therapies include exercise therapy, weight loss, psychological therapies such as cognitive behavioral therapy, interventions to improve sleep, and certain procedures.[3]

Second, when opioids are used, the lowest possible effective dose should be prescribed to reduce the risks of opioid use disorder and overdose. Overdose risk increases in a dose–response manner, at least doubling at 50 to 99 morphine milligram equivalents (MME) per day and increasing by a factor of up to 9 at 100 or more MME per day, as compared with doses of less than 20 MME per day. Clinicians should carefully reassess individual benefits and risks when increasing a dose to 50 MME or more per day. Doses of 90 MME or more should be avoided, or the decision to titrate above this level should be carefully considered and justified. When prescribing opioids, the rule of thumb is to "start low and go slow."[3]

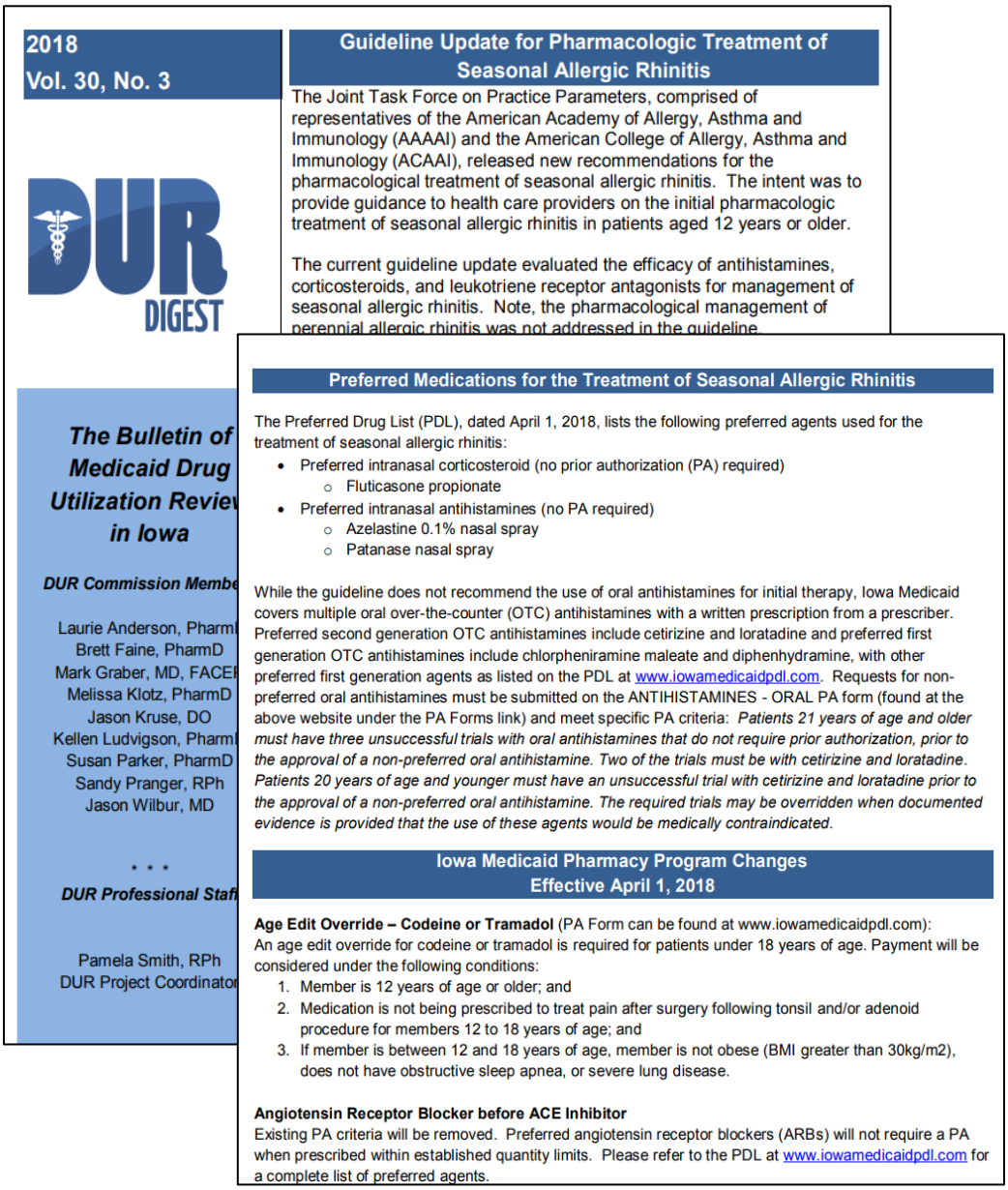
The link below is a link to an Opioid Dose Calculator for converting opioid doses to daily morphine equivalents. http://agencymeddirectors.wa.gov/mobile.html. Below is a chart comparing some commonly prescribed products and dosages to their daily morphine equivalent dose.

Figure 22: Sample Quarterly Newsletter – West Virginia Clinical Services

For our client state of Iowa, we create a scholarly newsletter each quarter that includes articles based on findings from Medicaid member data review, current literature, treatment guidelines and pharmacy program policies. Also included in the newsletter are relevant educational and policy-related information that includes, but is not limited to:

- Educational information;
- Prevalence information;
- Drug therapy information;
- Appropriate medication use guidelines; and
- Updates on policy initiatives and program changes.

The following screenshot is an example of the quarterly newsletter, DUR Digest, we prepare for the State of Iowa:



2018
Vol. 30, No. 3

DUR DIGEST

The Bulletin of Medicaid Drug Utilization Review in Iowa

DUR Commission Membe

Laurie Anderson, Pharm
Brett Faine, PharmD
Mark Graber, MD, FACE
Melissa Klotz, PharmD
Jason Kruse, DO
Kellen Ludvigson, Pharm
Susan Parker, PharmD
Sandy Pranger, RPh
Jason Wilbur, MD

* * *

DUR Professional Staf

Pamela Smith, RPh
DUR Project Coordinator

Guideline Update for Pharmacologic Treatment of Seasonal Allergic Rhinitis

The Joint Task Force on Practice Parameters, comprised of representatives of the American Academy of Allergy, Asthma and Immunology (AAAAI) and the American College of Allergy, Asthma and Immunology (ACAAI), released new recommendations for the pharmacological treatment of seasonal allergic rhinitis. The intent was to provide guidance to health care providers on the initial pharmacologic treatment of seasonal allergic rhinitis in patients aged 12 years or older.

The current guideline update evaluated the efficacy of antihistamines, corticosteroids, and leukotriene receptor antagonists for management of seasonal allergic rhinitis. Note, the pharmacological management of perennial allergic rhinitis was not addressed in the guideline.

Preferred Medications for the Treatment of Seasonal Allergic Rhinitis

The Preferred Drug List (PDL), dated April 1, 2018, lists the following preferred agents used for the treatment of seasonal allergic rhinitis:

- Preferred intranasal corticosteroid (no prior authorization (PA) required)
  - Fluticasone propionate
- Preferred intranasal antihistamines (no PA required)
  - Azelastine 0.1% nasal spray
  - Patanase nasal spray

While the guideline does not recommend the use of oral antihistamines for initial therapy, Iowa Medicaid covers multiple oral over-the-counter (OTC) antihistamines with a written prescription from a prescriber. Preferred second generation OTC antihistamines include cetirizine and loratadine and preferred first generation OTC antihistamines include chlorpheniramine maleate and diphenhydramine, with other preferred first generation agents as listed on the PDL at www.iowamedicaidpdl.com. Requests for non-preferred oral antihistamines must be submitted on the ANTIHISTAMINES - ORAL PA form (found at the above website under the PA Forms link) and meet specific PA criteria: *Patients 21 years of age and older must have three unsuccessful trials with oral antihistamines that do not require prior authorization, prior to the approval of a non-preferred oral antihistamine. Two of the trials must be with cetirizine and loratadine. Patients 20 years of age and younger must have an unsuccessful trial with cetirizine and loratadine prior to the approval of a non-preferred oral antihistamine. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.*

Iowa Medicaid Pharmacy Program Changes Effective April 1, 2018

Age Edit Override – Codeine or Tramadol (PA Form can be found at www.iowamedicaidpdl.com):
An age edit override for codeine or tramadol is required for patients under 18 years of age. Payment will be considered under the following conditions:

1. Member is 12 years of age or older; and
2. Medication is not being prescribed to treat pain after surgery following tonsil and/or adenoid procedure for members 12 to 18 years of age; and
3. If member is between 12 and 18 years of age, member is not obese (BMI greater than 30kg/m2), does not have obstructive sleep apnea, or severe lung disease.

Angiotensin Receptor Blocker before ACE Inhibitor
Existing PA criteria will be removed. Preferred angiotensin receptor blockers (ARBs) will not require a PA when prescribed within established quantity limits. Please refer to the PDL at www.iowamedicaidpdl.com for a complete list of preferred agents.

Figure 23: Quarterly Newsletter Example: Iowa's, DUR Digest

DUR BOARD MEETING SUPPORT (RFQ SECTION 4.11)

4.11 The Vendor must provide support for quarterly DUR Board meetings including, but not limited to:
4.11.1 Meeting attendance by a clinical representative;
4.11.2 Presentations regarding completed population-based educational interventions;
4.11.3 Quarterly pharmacy profile review outcome reports;
4.11.4 Estimated savings reports;
4.11.5 Recommendations for potential population-based educational interventions based on BMS therapeutic criteria exceptions and other relevant data;
4.11.6 The Vendor shall also provide DUR Board meeting minutes, by e-mail, within 10 calendar days of each quarterly meeting.

Our pharmacists are available to attend Committee meetings as requested and to provide valuable clinical information that ultimately influences Committee decisions.

At Change Healthcare, we recognize that a strong, successful program is contingent upon a dedicated, supportive DUR Board. Our selection for West Virginia Account Manager, Brent Breeding, RPh has extensive experience with the West Virginia DUR Board and Clinical Pharmacist, Ashleigh Holeman, PharmD, has worked in multiple states to support RetroDUR programs and their respective Boards and Committees. They, along with our Medical Directors and other clinical experts will be available to consult with the State and remain available as requested to provide valuable clinical information that ultimately influence Board decisions. Trusted staff providing clinical and financial expertise to the Board include, but are not limited to the key personnel as outlined in the key personnel as outlined in the RFQ:

- Account Manager: Brent Breeding, RPh
- Clinical Pharmacist: Ashleigh Holeman, PharmD
- Medical Director: Jacquelyn Hedlund, MD, MS
  - Supported by: Laureen Biczak, DO and Jeffrey Barkin, MD, DFAPA
- Analyst: Rick Erickson
- Operational Account Coordinator: Jennifer Seymour

Ashleigh, in her role as Clinical Pharmacist, will be available to present completed population-based educational interventions and any other relevant information to the DUR Board at their quarterly meetings. She will receive support from our Medical Directors in the preparation and evaluation of these completed interventions. Ashleigh has extensive experience presenting at DUR Board / P&T Committee meetings, always presenting evidence-based analyses in a professional and thorough manner. A RetroDUR initiative she brought to another client state regarded an FDA release stating that children under two (2) years of age should not be prescribed codeine due to respiratory depression. She brought this update to that state's DUR Board, gained approval to act. She ran profiles, conducted analyses, distributed DUR letters, obtained provider responses and conducted a pre / post comparison of data. Presenting the outcomes of this intervention analysis, she was able to make recommendations for PA criteria, advise on further intervention ideas and spark productive discussion amongst the Board members. This is experience and a proven approach she will bring to West Virginia in the recommendation, completion and post-analysis presentation of population-based education interventions.

We have found that a pharmacist / physician team ensures valuable perspectives and expertise are included in analysis that directly and positively influences engagement of the Board members during clinical discussion post-presentation. Should the State find it beneficial, our

Medical Director can be available over the phone to consult and provide additional insight during these meetings.

In his current capacity as Account Manager for the West Virginia clinical services contract, Brent has attended DUR Board meetings for several years. He is familiar with the Board members and their preferred method of procedure. His presence in that capacity is largely to answer any questions the Board may have and intervene in the event a Board decision to enact certain criteria could jeopardize a supplemental rebate agreement. Subsequent to meetings, he incorporates Board-approved changes into the PDL document for posting on the Bureau's website. He will bring this crossover knowledge and experience to the RetroDUR contract DUR Board support requirements as he works with Ashleigh, enabling a seamless and cohesive approach to this service component.

Our collaboration helps us to understand that the DUR Board primarily relies on evidence-based guidelines and not the more subjective clinical experience, expert opinions, professional relationships or other sources when making determinations. Our staff works to thoroughly research and uniquely edit our clinical analyses to provide the DUR Board with recommendations for therapeutic criteria and various interventions. Extensive analysis of intervention outcomes will be presented and evaluated for efficacy, followed by recommendations for amendments or additional interventions forecasted to continue improving the program.

Current Support of P&T Committee and DUR Boards

- **Maine → since 1995**
- **Iowa → since 2005**
- **West Virginia → 2008 – 2011 and re-procured in 2014**
- **Mississippi → since 2011**
- **Delaware → since 2015**
- **Pennsylvania → since 2015**
- **Ohio → since 2016**

We currently provide DUR Board / P&T Committee meeting schedules, agenda material and follow-up documentation of meeting minutes and action items for our client states of Delaware, Iowa, Maine, Mississippi, Ohio, Pennsylvania and West Virginia. We understand and will comply with West Virginia's requirement of the 10-day timeline to present meeting minutes via email in a State-approved format and layout. We ensure provision of services required to support the DUR Board in a professional and thorough manner that meets or exceeds the State's expectations.

Our typical approach to the support of DUR Boards and P&T Committees is to solicit information regarding utilization analysis, study or reporting preferences the Board may have interest in exploring. It has been our experience that pursuing ideas of mutual interest is extremely beneficial to the long-term success of our partnerships with our client states as well as State and Medicaid member benefit. It is essential to simulate and maintain the intellectual interest of each Board member. **Taking the time and effort to provide data can greatly reassure Board members of the appropriateness of their decisions.**

Our clinical expertise allows us to provide various support services specific to the DUR program of each. We will bring this expertise to West Virginia as well, to include, but not be limited to:

- Developing and conducting analyses of significant cost savings generated by RetroDUR implementations;
- Studying and defining new cost saving and quality of care strategies;
- Developing and publishing quarterly newsletters for the West Virginia Medicaid stakeholders;

- Developing RetroDUR algorithms and focus studies including duplicate therapies, drug:drug interactions, drug:disease contraindications, drug:age and drug:gender alerts and adherence to prescribed therapies;
- Provisioning relevant reporting and information for the annual CMS DUR Report; and
- Providing standard and ad hoc reporting.

The clinical support we provide to our state partners, the expertise gleaned across this experience and our collaborative approach are benefits we will bring to West Virginia's in support of the DUR Board. Our successes in other states have helped our state partners to develop and modify therapeutic criteria that helps to improve the therapeutic, clinical effectiveness and cost savings goals of each program. At all times, we take a holistic view of the program to consider not only the potential cost savings of our recommendations, but also the broader impact of recommendations to providers, Medicaid recipients and other stakeholders.

CHANGE MANAGEMENT PROCESS (RFQ SECTION 4.12)

4.12 Change Management Process - The Vendor shall design and maintain a change management process involving (at minimum) a once-monthly quality-assurance meeting conducted with the Bureau by teleconference. Meetings shall occur at an agreed upon date during normal business hours 9:00 am to 5:00 pm ET, Monday through Friday. These meetings shall serve the purpose of assessing operational status and as an opportunity for the Bureau to request changes or adjustments to the system. The Vendor shall have 7 calendar days to review the request and present an implementation plan to the Bureau. If actionable, the Vendor has by default 30 calendar days to complete the change. Implementation time may be extended by the Bureau on request. Critical changes required for full system functionality must be completed within seventy-two (72) hours or risk Vendor default.

Change Healthcare has a tried and true change management process already in place for our 16 client states. Although we have found measurable success by following the process described in the pages that follow, we are open to amendment based on the specific needs of this contract and preferences of the Bureau. We understand and will comply with the specifications set forth in this requirement to include at a minimum:

- Once monthly quality assurance meeting conducted via teleconference with the Bureau;
  - To be set at a mutually agreed upon date during normal business hours (9am – 5pm ET, Monday – Friday)
  - To serve the purpose of assessing operational status and provide opportunity for the Bureau to request adjustments;
  - Enact a seven (7) calendar day time frame for the review of request(s) and presentation of an implementation plan to the Bureau
  - Comply with the 30-day implementation window should the request and plan be actionable unless reasonable request is made for extension; and
  - Compliance with a 72-hour time frame for implementation of critical components.

By consciously following the process for each change request, a project can successfully accommodate and implement change and avoid the chaos unconsidered changes can inflict upon a project.

Software development projects are dynamic processes that change frequently over time. Change occurs perpetually during the planning phase of a project while planning documents are being developed. Once these documents are finalized, however,

Change Healthcare Understands the Purpose of Change Management is to:

- **Record** requested changes to approved plans
- **Determine** and **evaluate** the **impact** of those requested changes
- Employ a **systematic approval** process
- **Implement** approved changes
- **Record decisions** made and reasons for them
- **Communicate** those decisions

and the baseline scope of work has been established, further changes can present problems if expectations are not clearly established.

Change requests are defined as **new or changed requirements**, which affect the system baseline, as represented by the project scope of work. Approved project artifacts (project deliverables) are considered the project baseline. Change requests are unique from requests made to support operations, such as ad-hoc reporting, analysis requests and ongoing maintenance. The change management process is intended to address more substantial changes that warrant more rigorous management practices. In general, these changes will result in enhancements or adjustments to the baseline scope of work performed by Change Healthcare.

We propose that, in collaboration with the Bureau, Change Healthcare will follow a formal change management process during DDI, which is aligned with the Project Management Body of Knowledge® (PMBOK) Guide. The change management process will be enforced once the project baseline has been established and fully defined in the project work plan. We will update this plan prior to the operations and maintenance phase of the project to incorporate West Virginia processes and procedures.

Our Change Management process for the West Virginia RetroDUR solution will draw upon the expertise of our knowledgeable project and account managers to ensure we thoroughly identify and track open issues and requested modifications throughout the life of this project. We have an experienced technical staff dedicated to the operation and support of this contract. Their functions include change management, system maintenance, enhancement coding, testing, quality control, file maintenance, upgrades, issue resolution and reporting. We use our documented change control process in support of operations and project management, which encompasses application support task orders. This process aligns with PMI standards and facilitates the tracking of source code, documentation, problem logs, change requests, approvals, decisions, and implemented changes for both operational and in-development modifications.

For any project, we formally document our change management process in a Change Management Plan, which will include business processes, ongoing operational activities and system changes to ensure requests for changes are responded to in a timely manner as required. We use a formal Change Management Process that aligns with the PMBOK Guide. The change management process documents the activities and processes to:

- Request a change;
- Assess the impact of a change to the scope, budget and timeline;
- Approve, deny or defer a change;
- Take action to implement an approved change;
- Record and retain necessary change request documentation; and
- Communicate the change.

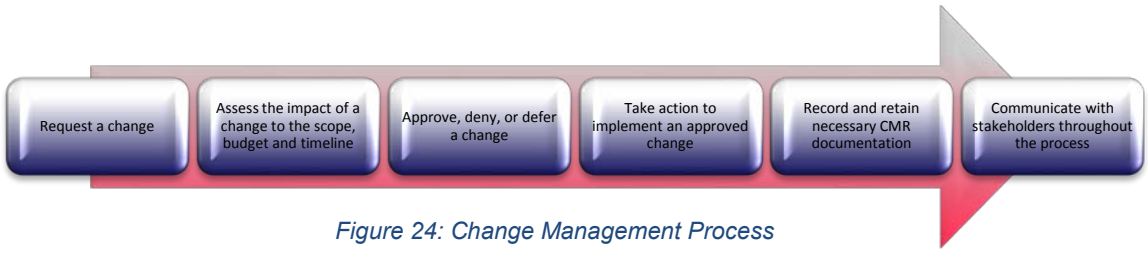


Figure 24: Change Management Process

There are many events that may trigger a change request. Most changes requested after the planning documents are approved generally arise because of:

- Changes to state or federal policy;
- Change in industry standards;
- Changes to data sets or systems maintained by our business partners;
- Additional functionality is identified as necessary;
- A key requirement is incorrect or incomplete and must be modified or deleted;
- Information was incorrectly recorded in a project plan and not caught until after the plan was approved and has a significant impact on key dates or deliverables; or
- Circumstances change and activities in an approved project plan are no longer possible.

Any project stakeholder may request a change; however, not every requested change may be desirable or align with the PBM product vision. Prior to initiating any change request, our designated Project Manager (or her designee) reviews the request for applicability and may escalate the issue to the Bureau to avoid any unnecessary work and planning.

If a desired change means additional requirements, revised requirements or deleted requirements after the project baseline has been approved, a formal change request is necessary**. It is important to note that not every desired change actually means a change to the baseline project scope.** The type of change, size of change and stage of software development or other pertinent activity, determine whether a formal change request is necessary. If, at any time, the person desiring the change is unsure whether it requires submission of a formal change request, our Project Manager, Account Manager or other appropriate designee will happily discuss the request.

We evaluate each change to the system and communicate with all stakeholders the risk it may pose to the overall solution. Should our staff recognize the need for change, we will consult with

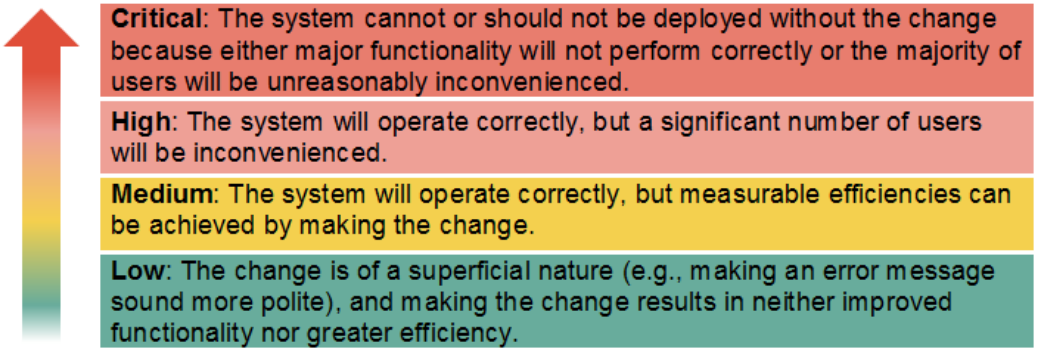


Figure 25: Change Management Escalation

the Bureau prior to making any alterations to the approved solution. We want to assure the Bureau that because our systems run independently, production issues that occur with another client do not affect any other client. The following list demonstrates the standard flow that our team follows for our projects. Upon contract award and during JAD sessions, we will review this process with the Bureau to ensure our standards are in line with those of West Virginia.

From time to time, the need to perform a minor wording correction or add clarifying text to an approved document will arise. The following list include some typical examples of such situations:

- To clear up an otherwise ambiguous sentence, someone requests that a term be replaced with a more specific term;
- Correction of typos that do not impact the already understood meaning of the text;
- Addition of background context to a functional design;
- Insertion of a missing reference in one functional design to another; or
- Insertion of minor instructions that do not change the overall activity and provide the implementers with details that will aid them.

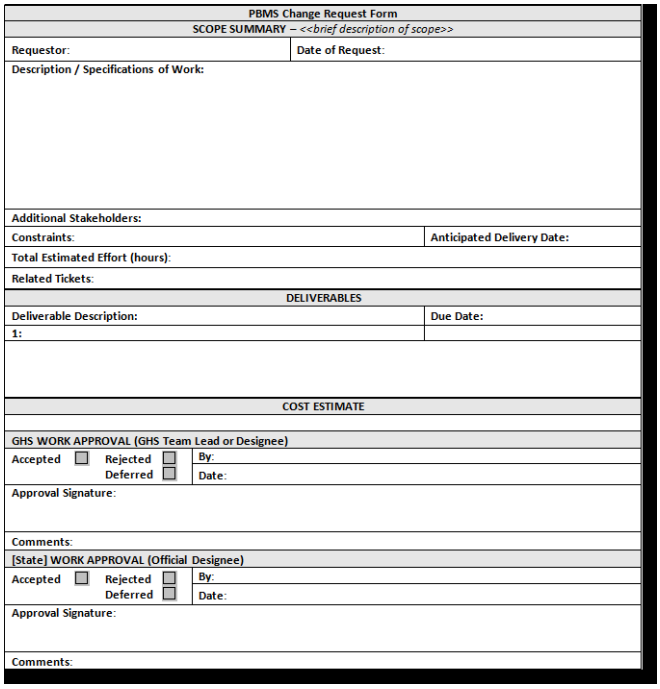
For these very minor changes, a change request must be submitted for tracking purposes, but can be immediately approved by the Change Healthcare Project Manager (or her designee) and the documents updated. The change request form will be forwarded to the Bureau.

A process will be determined and documented during the DDI phase of the project for how timely processing of data to and from the Bureau will be managed. The documented process will include the provision of technical assistance and contacts in support of the process. We will commit to providing resources to support the associated service level agreements and meeting those agreements.

Our internal process for priority-based problem identification and resolution will be provided to the Bureau during the DDI phase of the project and it will be reviewed with Bureau staff for approval and sign-off. Tracking of issues will be managed by either project management staff during implementation or by the account manager during operations to ensure the process is followed and issues are resolved in a timely manner.

Measurement of performance against service level agreements will be maintained and reviewed with the Bureau on a regular basis. Our project management team facilitates the change management process by the following third-party software tools, which collectively form our change tracking system and version control software:

- **Jama** – This tool provides a complete suite of requirement management and tracking feature;
- **Atlassian Jira** – Our change management and control tool provides ticketing for deliverables, activities, and other actionable items, with integration into Jama; and
- **Subversion and Source Anyway** – Provides source code management and version control.



PBMS Change Request Form	
SCOPE SUMMARY – *<<brief description of scope>>*	
Requestor:	Date of Request:
Description / Specifications of Work:	
Additional Stakeholders:	
Constraints:	Anticipated Delivery Date:
Total Estimated Effort (hours):	
Related Tickets:	
DELIVERABLES	
Deliverable Description:	Due Date:
1:	
COST ESTIMATE	
GHS WORK APPROVAL (GHS Team Lead or Designee)	
Accepted ☐ Rejected ☐ Deferred ☐	By: Date:
Approval Signature:	
Comments:	
[State] WORK APPROVAL (Official Designee)	
Accepted ☐ Rejected ☐ Deferred ☐	By: Date:
Approval Signature:	
Comments:	

Figure 26: Sample Change Request Form

Change Healthcare has protocols in place for problems that may occur with our systems. Our team is equipped and trained to handle all types of problems that may arise. All system issues are addressed and evaluated promptly to ensure that the level of service interruption is as minimal as possible and that costs are not incurred whenever possible in order to maintain a high level of customer satisfaction.

All requests for change will be responded to promptly. Processes for change requests will be documented in the Change Management Process documentation which will be developed during the DDI phase of the project. The Account Manager will be the point of contact to initiate this process and assure timely handling of all results. To ensure the project remains on track and in support of rapid development, the West Virginia RetroDUR project will be implemented utilizing an Agile approach run by a dedicated sprint team. Tools and methodology will include:

- Establishing backlog
- Sprint planning sessions
- Daily stand-ups
- Sprint retrospectives

Throughout the life of the contract, we will remain a committed partner to the Bureau to provide the best project management solutions for the RetroDUR program. At the foundation of our project management approach is a commitment to transparency, flexibility and responsiveness that ensures “seamless” operations and project administration. Our project management team along with our other supporting teams will work continuously with the Bureau to monitor performance during the contract and warranty period by recommending specific metrics to be used for performance monitoring using a performance scorecard. Additional metrics may include:

- Conditions
- Milestones
- Requirements
- Timetables
- Service
- Quality

Change Healthcare has provided project management for all the contracts we maintain, both large and small. We are prepared to bring a stable partnership to the Bureau by managing our proposed solution, all project activities and supporting you in the completion of the project management responsibilities. Our organization is always looking for ways to enhance our systems and processes and gladly accept suggestions from our state partners on ways to improve the quality, value and delivery of our services. Likewise, we may offer the Bureau suggestions to improve the solution based on industry standards.

Contract Award (RFQ Section 5)

Change Healthcare has built our pricing based on our more than 40 years of experience in the pharmacy industry in addition to our long history of partnership with the State of West Virginia. The Bureau and State staff have come to trust and rely on the insightful input that the clinical team, in particular, at Change Healthcare provide on a regular basis. We look forward to continuing this trusting partnership.

In the following section we provide a brief response for RFQ requirements 5.1 and 5.2.

CONTRACT AWARD (RFQ SECTION 5.1)

The Contract is intended to provide Agency with a purchase price for the Contract Services. The Contract shall be awarded to the Vendor that provides the Contract Services meeting the required specifications for the lowest overall total cost as shown on the Pricing Pages.

The purchase price Change Healthcare provides is inclusive of all requirements outlined in the RFQ scope of work. Experience tells us that the needs of our clients can change throughout the course of a contract and our team is available to the assist the State in the event the scope of work changes. We offer a flexible and reasonable change management process for our clients and will always seek input from the State should changes be necessary. Please refer to our response to RFQ section 4.12 (Change Management) for details on how we work with our state clients through this change process.

PRICING PAGE (RFQ SECTION 5.2)

Vendor shall complete the Pricing Page by providing the monthly and annual cost for each service (data collection, lock-in program) and deliverable (reports and educational programs for providers) indicated in the table in Exhibit A. The Vendor shall also provide the total annual cost of all four services and deliverables combined that are listed in the table. All mailing costs and monthly amounts paid to RetroDUR Committee members shall be included in the Vendor's price quotation. No costs can be passed on to the Bureau outside the Vendor's submitted quote for RetroDUR services. Vendor should complete the Pricing Page in full as failure to complete the Pricing Page in its entirety may result in Vendor's bid being disqualified. Notwithstanding the foregoing, the Purchasing Division may correct errors as it deems appropriate. Vendor should type or electronically enter the information into the Pricing Page to prevent errors in the evaluation.

Change Healthcare's price proposal takes into consideration the total cost for the services and deliverables outlined in the RFQ document and the pricing page inclusive of data collection, member profiles, educational materials, reports and the lock-in program. The State will find we provide the pricing page in the exact format provided in the RFQ with costs for each service.

We have completed the pricing page with annual, not-to-exceed costs for the combined program requirements for the four (4) years of the contract. This is inclusive of all general and administrative staff, travel, supplies, etc. Furthermore, the Change Healthcare team understands that all mailing costs and other requirements contained in the RFQ are included in our fixed fee.

Performance (RFQ Section 6)

Vendor and Agency shall agree upon a schedule for performance of Contract Services and Contract Services Deliverables, unless such a schedule is already included herein by Agency. In the event that this Contract is designated as an open-end contract, Vendor shall perform in accordance with the release orders that may be issued against this Contract.

As the State's partner, we will always seek input on program decisions. During the project implementation phase, the Change Healthcare team will collaborate with the Agency's staff to seek input on the schedule for performance. In the event the Agency has a schedule already created, our knowledgeable team is happy to provide the stakeholders input based on our experience providing similar programs in other states. If the Agency determines this contract to be an open-ended contract, our team agrees to perform in accordance with the release orders within mutually agreeable terms.

Payment (RFQ Section 7)

Agency shall pay a flat fee as shown on the Pricing Pages, for all Contract Services performed and accepted under this Contract. Vendor shall accept payment in accordance with the payment procedures of the State of West Virginia.

Change Healthcare has reviewed and understands the Agency's payment methods outlined in the RFQ. Our team agrees that the Agency will pay a flat fixed fee, as outlined in the pricing pages, billed on a monthly basis for the program services.

Travel (RFQ Section 8)

Vendor shall be responsible for all mileage and travel costs, including travel time, associated with performance of this Contract. Any anticipated mileage or travel costs may be included in the flat fee or hourly rate listed on Vendor's bid, but such costs will not be paid by the Agency separately.

The Change Healthcare team understands that we are responsible for all mileage and travel costs, including travel time, associated with performance of this contract. Anticipated mileage and travel costs are included in the price quotation of this RFQ.

Facilities Access (RFQ Section 9)

Performance of Contract Services may require access cards and/or keys to gain entrance to Agency's facilities. In the event that access cards and/or keys are required:

PRINCIPAL SERVICE PERSONNEL (RFQ SECTION 9.1)

Vendor must identify principal service personnel which will be issued access cards and/or keys to perform service.

Change Healthcare understands we may be required to comply with Agency facility access requirements. Upon contract award, and prior to our staff onsite visits, we will provide the Agency with a list of Change Healthcare staff that will be onsite so that access cards can be issued to the appropriate personnel.

CONTROLLING CARDS AND KEYS (RFQ SECTION 9.2)

Vendor will be responsible for controlling cards and keys and will pay replacement fee, if the cards or keys become lost or stolen.

Our organization operates our facilities with strict security access to all locations. We are familiar with the need to control access cards and keys to the appropriate staff. For personnel serving the West Virginia contract, Change Healthcare agrees to be responsible for access cards as necessary for onsite visits to State facilities.

ACCESS NOTIFICATIONS (RFQ SECTION 9.3)

Vendor shall notify Agency immediately of any lost, stolen, or missing card or key.

Our employees recognize the importance of keeping Change Healthcare property and property issued by our clients secure. Change Healthcare follows a similar protocol for when our staff misplaces or loses an access badge and we will put similar policies in place for staff working on the West Virginia contract. Upon contract award, our team will ensure our policies are in-line with those of the Agency and seek input from State stakeholders as necessary.

SECURITY PROTOCOL AND PROCEDURES (RFQ SECTION 9.4)

Anyone performing under this Contract will be subject to Agency's security protocol and procedures.

Change Healthcare agrees that the staff performing work on this contract will be subject to the Agency's security protocols and procedures. Upon contract award, Change Healthcare will share the security protocols and procedures that our organization follows and we may find similarities.

Due to the nature of our business in the healthcare space, Change Healthcare operates with an emphasis on security, following standard Health Insurance Portability and Accountability Act of 1996 (HIPAA) and protected health information (PHI) practices. Our standards of performance align with client, state and federal guidelines and comply with applicable industry technical standards. We are committed to protecting the confidentiality, integrity, privacy and physical security of the PHI entrusted to us by our clients. We will ensure that any products and applications utilized for this scope of work maintain these standards. Per our organization's internal policies, all new staff undergoes HIPAA training as part of the contingent hire process and all existing staff members are required to participate annually in HIPAA training.

SHARING OF PROCEDURES (RFQ SECTION 9.5)

Vendor shall inform all staff of Agency's security protocol and procedures.

Upon contract award, the Change Healthcare project staff will collaborate with the Agency to share these security protocols and procedures. Our organization is committed continually meeting these requirements of our clients. The Agency's information will be shared with all staff working on the State's programs under this contract. The assigned Change Healthcare Account Manager for this program will be the liaison to share information between our State partners and Change Healthcare staff.

Vendor Default (RFQ Section 10)

DEFAULT (RFQ SECTION 10.1)

The following shall be considered a vendor default under this Contract.

10.1.1. Failure to perform Contract Services in accordance with the requirements contained herein.
10.1.2. Failure to comply with other specifications and requirements contained herein.
10.1.3. Failure to comply with any laws, rules, and ordinances applicable to the Contract Services provided under this Contract.
10.1.4. Failure to remedy deficient performance upon request.

Change Healthcare has reviewed the reasons outlined in requirements 10.1.1 through 10.1.4 for a contract to be considered default and affirm our understanding of the Agency's guidelines.

REMEDIES (RFQ SECTION 10.2)

The following remedies shall be available to Agency upon default.

10.2.1. Cancellation of the Contract.
10.2.2. Cancellation of one or more release orders issued under this Contract.
10.2.3. Execution of penalties detailed in the Service Level Agreements.
10.2.4. Any other remedies available in law or equity.

Upon default of a contract, Change Healthcare understands that the Agency reserves the various remedies as outlined in requirements 10.2.1

Miscellaneous (RFQ Section 11)

CONTRACT MANAGER (RFQ SECTION 11.1)

During its performance of this Contract, Vendor must designate and maintain a primary contract manager responsible for overseeing Vendor's responsibilities under this Contract. The Contract manager must be available during normal business hours to address any customer service or other issues related to this Contract. Vendor should list its Contract manager and his or her contact information below

During the performance of the contract with West Virginia, Change Healthcare has designated the following as the Contract Manager. We will maintain a primary contact responsible for overseeing our responsibilities under the contract as a result of this RFQ.

Contract Manager: *Dan Hardin, RPh, MBA*

Telephone Number: *(800) 832-9672*

Fax Number: *(207) 623-5125*

Email Address: dhardin@changehealthcare.com

STAFFING CHANGES (RFQ SECTION 11.2)

The Vendor must submit for review and approval any proposed staffing changes to key positions within 10 days of the change. The Bureau reserves the right to request a change to current or proposed staff in these positions: Clinical Account Manager, Contract Manager and Lock-In Manager.

We view our partnership with the Agency as extremely important and conduct our daily operations with continuous input from our clients. This valuable input strengthens the trust between Change Healthcare and our clients as well as our solutions for the Medicaid members we serve. Although Change Healthcare includes highly talented individuals to support our pharmacy solutions, we seek our clients input with all staffing decisions that affect our contracts directly.

The staff identified in the RFQ document for the Medical Director, Account Manager, Clinical Staff Pharmacist and Data Analyst are considered the key positions for this contract. Change Healthcare will seek review and approval from the Agency for any key staff changes within 10 days of a change.

EXHIBIT A: PRICING SHEET

On the following page, the Bureau will find the completed Exhibit A: Pricing Sheet. With an understanding of the scope of work provided in the RFQ for this RetroDUR solution for West Virginia, Change Healthcare has priced our solution as sharply as possible. The Bureau has asked for features and applications within this solution that have a direct drive on the overall cost of a RetroDUR program. In particular, the use of the RetroDUR tool that Change Healthcare is proposing in order to meet the requirements of this RFQ will be a great benefit to the State resulting in measurable cost avoidance in the pharmacy program for years to come.

We look forward to continuing our partnership with the Bureau and the effective management of the Medicaid pharmacy program.

Exhibit A
Pricing Sheet

Cost information below as detailed in the Request for Quotation. Cost should be clearly marked. Cost must be broken out by the following categories. This will be a fixed cost contract, based on a per year basis. Vendor shall not alter cost sheet. YEAR 2,3,4 are optional renewals

Description of Services	YEAR 1 (2 Months Startup + 10 Months Operations)	OPTIONAL RENEWAL YEAR 1 (12 Months)	OPTIONAL RENEWAL YEAR 2 (12 Months)	OPTIONAL RENEWAL YEAR 3 (12 Months)
Start-up Costs (4.1, 4.2, 4.5, 4.9). Total not to exceed 2- Month Implementation.	$ 303,296.30	xxxxxx	xxxxxx	xxxxxx
Data Collection (4.9)	$ 44,681.54	$ 54,958.29	$ 56,332.25	$ 57,740.55
Member Profiles (4.2.11, 4.8)	$ 67,022.30	$ 82,437.43	$ 84,498.37	$ 86,610.83
Educational Programs for Providers (Newsletters, Educational Population-Based Interventions, Member Profile Review Letters (4.3, 4.4, 4.10)	$ 156,385.38	$ 192,354.01	$ 197,162.86	$ 202,091.94
Retrospective Drug Utilization Review Reports (4.9)	$ 111,703.84	$ 137,395.72	$ 140,830.62	$ 144,351.38
Lock-In Program (including letters to members, prescribers and pharmacy providers) and Help Desk (4.5, 4.6)	$ 67,022.30	$ 82,437.43	$ 84,498.37	$ 86,610.83
Totals	(A) $ 750,111.66	(B) $ 549,582.88	(C) $ 563,322.47	(D) $ 577,405.53
GRAND TOTAL (NOT TO EXCEED 4 YEAR PRICE) (A+B+C+D) $ 2,440,422.54				
Notes:				

1.) The Vendors Total Not to Exceed Cost will include all general and administrative staffing (secretarial, clerical, etc.), travel, supplies and other resource costs necessary to perform all services within the scope of this procurement.
2.) The cost bid will be evaluated on the Total Not to Exceed Cost of Contract for the four (4) year period.
3.) Vendor will not be eligible to invoice any operational or programmatic costs while invoicing for start-up costs.
4.) Program services shall be invoiced monthly in arrears.
5.) The number of months in the operational base year one has been determined to be ten (10) months to allow for 2-month implementation. Year One (1) Cost for these items are to be based on ten (10) months of service while optional renewal years are to be based on twelve (12) months of service

Change Healthcare	Company
Dan Hardin, SVP and GM	Representative Name, Title
800-832-9672	Contact Phone/Fax Number
9/24/2018	Date

SUPPLEMENTAL ATTACHMENTS

Addendum Acknowledgement Form

On the following page, we provide our signed Addendum Acknowledgement form noting our receipt and review of Addendum #1, which served to return the State's responses to vendor questions as well as announce the extension date of proposal submission.

ADDENDUM ACKNOWLEDGEMENT FORM
SOLICITATION NO.: CRFQ 0511 BMS1900000001

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. 2
- [ ] Addendum No. 3
- [ ] Addendum No. 4
- [ ] Addendum No. 5
- [ ] Addendum No. 6
- [ ] Addendum No. 7
- [ ] Addendum No. 8
- [ ] Addendum No. 9
- [ ] 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.

Change Healthcare Pharmacy Solutions, Inc.
Company

Authorized Signature

9/18/2018
Date

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

Revised 06/08/2018

Designated Contact / Certification and Signature

On the following page, we provide our signed Designated Contact / Certification and Signature form for the State's records.

DESIGNATED CONTACT: Vendor appoints the individual identified in this Section as the Contract Administrator and the initial point of contact for matters relating to this Contract.

Dan Hardin, RPh, MBA
(Name, Title)
Senior Vice President and General Manager
(Printed Name and Title)
45 Commerce Drive, Suite 5, Augusta, ME 04332
(Address)
800.832.9672 / 207.623.5125
(Phone Number) / (Fax Number)
dhardin@changehealthcare.com
(email address)

CERTIFICATION AND SIGNATURE: By signing below, or submitting documentation through wvOASIS, I certify that I have reviewed this Solicitation in its entirety; that I understand the requirements, terms and conditions, and other information contained herein; that this bid, offer or proposal constitutes an offer to the State that cannot be unilaterally withdrawn; that the product or service proposed meets the mandatory requirements contained in the Solicitation for that product or service, unless otherwise stated herein; that the Vendor accepts the terms and conditions contained in the Solicitation, unless otherwise stated herein; that I am submitting this bid, offer or proposal for review and consideration; that I am authorized by the vendor to execute and submit this bid, offer, or proposal, or any documents related thereto on vendor's behalf; that I am authorized to bind the vendor in a contractual relationship; and that to the best of my knowledge, the vendor has properly registered with any State agency that may require registration.

Change Healthcare
(Company)

(Authorized Signature) (Representative Name, Title)

Dan Hardin, RPh, MBA, Senior Vice President and General Manager
(Printed Name and Title of Authorized Representative)

September 18, 2018
(Date)

800.832.9672 / 207.623.5125
(Phone Number) (Fax Number)

Revised 06/08/2018

Required Insurance

On the following page, we provide our Certificate of Insurance in the Standard Acord form, in compliance with the RFQ insurance requirements. Should the State require any further evidence or policy information, we will work with the State to provide such information.

ACORD

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 09/05/2018

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER MARSH USA, INC. TWO ALLIANCE CENTER 3560 LENOX ROAD, SUITE 2400 ATLANTA, GA 30326 Attn: Atlanta.CertRequest@marsh.com Fax: 212-948-4321 CN118528062-EMDEO-E&O-18-19	CONTACT NAME: PHONE (A/C, No, Ext): FAX (A/C, No): E-MAIL ADDRESS:
	INSURER(S) AFFORDING COVERAGE — NAIC # INSURER A : AFB Lloyd's Syndicate INSURER B : INSURER C : INSURER D : INSURER E : INSURER F :
INSURED Change Healthcare Pharmacy Solutions, Inc. 3055 Lebanon Road Nashville, TN 37214	

COVERAGES **CERTIFICATE NUMBER:** ATL-004851247-06 **REVISION NUMBER:** 4

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	COMMERCIAL GENERAL LIABILITY						EACH OCCURRENCE	$
	☐ CLAIMS-MADE ☐ OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$
							MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$
	☐ POLICY ☐ PRO-JECT ☐ LOC						PRODUCTS - COMP/OP AGG	$
	☐ OTHER:							$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	☐ ANY AUTO						BODILY INJURY (Per person)	$
	☐ OWNED AUTOS ONLY ☐ SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	☐ HIRED AUTOS ONLY ☐ NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	$
								$
	☐ UMBRELLA LIAB ☐ OCCUR						EACH OCCURRENCE	$
	☐ EXCESS LIAB ☐ CLAIMS-MADE						AGGREGATE	$
	☐ DED ☐ RETENTION $							$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y / N						☐ PER STATUTE ☐ OTH-ER	
	ANYPROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? N (Mandatory in NH)	N / A					E.L. EACH ACCIDENT	$
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$
							E.L. DISEASE - POLICY LIMIT	$
A	PROFESSIONAL LIABILITY			B0509FINPB1800012	03/01/2018	03/01/2019	Limit	1,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)
Cyber coverage is included in Professional Liability.

CERTIFICATE HOLDER	CANCELLATION
Change Healthcare Pharmacy Solutions, Inc. 3055 Lebanon Road Nashville, TN 37214	SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS. AUTHORIZED REPRESENTATIVE of Marsh USA Inc. Stephen R. Earp

ACORD 25 (2016/03) The ACORD name and logo are registered marks of ACORD

Key Personnel Resumes

On the following pages we present resumes for the key personnel required in the RFQ. Please refer back to our responses to Key Personnel (RFQ Section 3.1) and Support Personnel for the West Virginia Project for additional staffing and personnel-related information.

BRENT BREEDING, RPH

West Virginia Account Manager

SUMMARY OF EXPERIENCE

Mr. Brent Breeding joined the Change Healthcare team in 2015 and has since been a valued member of the clinical team, helping to oversee the clinical solutions for Pennsylvania and West Virginia. In his role for account oversight, he is accountable for the daily activities for the pharmacy benefits solutions. He brings almost 30 years of pharmacy experience to Change Healthcare's clients with a wide array of knowledge including retail pharmacy and management. His past experiences working with various states allow him to bring a unique multi-state and multi-industry perspective to the states he works with.

EMPLOYMENT

2015 – Present **Regional Pharmacy Account Manager**
Change Healthcare

- Accountable for contract compliance
- PDL drug file maintenance
- Identify potential areas of savings for assigned clients
- Develop P&T meeting materials
- Present P&T meeting materials and status recommendations at committee meeting
- Prepare post committee meeting materials
- Conduct regular client status meetings
- Develop strong business relationship with assigned clients
- Ensure all Service Level Agreements (SLA) are met
- Be aware of and informed of new government regulations
- Demonstrate the value of pharmacy solutions (unit cost, utilization management and patient care enhancement)
- Identify opportunities for additional services that address unmet customer needs

2014 – 2015 **Arkansas Medicaid Pharmacy Account Manager**
Magellan Health

- Accountable for contract compliance
- Complete drug file maintenance
- Develop and implement drug formulary
- Ensure all revenue goals are met
- Develop strong business relationship with Arkansas Medicaid Pharmacy Unit
- Ensure all Service Level Agreements are met
- Be aware of and informed of new government regulations
- Demonstrate the value of pharmacy solutions (unit cost, utilization management and patient care enhancement)
- Identify opportunities for additional services that address unmet customer needs
- Participate as Subject Matter Expert for DDI phase of contract

2013 – 2014 **Arkansas Medicaid Pharmacy Account Manager**
Hewlett Packard

- Accountable for contract compliance
- Complete drug file maintenance
- Develop and implement drug formulary

- Ensure all revenue goals are met
- Manage account team
- Project Manager for transition of account to new pharmacy vendor
- Develop strong business relationship with Arkansas Medicaid Pharmacy Unit
- Ensure all Service Level Agreements are met
- Be aware of and informed of new government regulations
- Demonstrate the value of pharmacy solutions (unit cost, utilization management and patient care enhancement)
- Identify opportunities for additional services that address unmet customer needs

2013 – 2013 Clinical Pharmacist
Magellan Health

- Evaluate PA requests for approval/denial based on clinical criteria
- Provide clinical consultations and recommendations to call agents and providers

2010 – 2013 Clinical Pharmacist
Hewlett Packard

- Evaluate PA requests for approval/denial based on clinical criteria
- Provide clinical consultations and recommendations to call agents and providers
- Perform Desk Audits to ensure provider compliance with Medicaid Policies and Procedures
- Maintain drug formulary file
- Project Manager for procurement process of Medicaid Contract

1998 – 2010 Senior Executive Clinical Specialist
Glaxo-Smith-Kline

- Provide clinical information to physicians, nurses and pharmacists within FDA guidelines
- Act as a liaison between GSK marketing and GSK clients
- Create and present analytical reports of territory sales performance
- Successfully develop, implement and execute business plans for assigned accounts
- Associate Sales Trainer for three years
- Facilitate training at district, regional and national meetings
- Won Winner's Circle for top level performers (top 10%) 3 times
- Won Winner's Circle for top level performers (top 20%) 1 time
- Successfully launched Advair (top 2 in region)
- Successfully launched Lamictal for bipolar disorder (top 2 in nation)

1989 – 1998 Pharmacy Manager
Wal-Mart

- Managed pharmacy inventory and payroll
- Interviewed, hired, trained and coached pharmacy staff
- Managed all pharmacy operations within state and federal laws and regulations

EDUCATION

University of Arkansas College of Pharmacy, Little Rock, Arkansas

- B.S. in Pharmacy

University of Central Arkansas, Conway, Arkansas

- Pre-pharmacy curriculum

ASHLEIGH HOLEMAN, PHARMD

Clinical Pharmacist

SUMMARY OF EXPERIENCE

Ms. Ashleigh Holeman joined the Change Healthcare clinical team in 2016 in support of our client's clinical services. Prior to joining our team, Ashleigh worked in a similar role as a clinical pharmacist for Xerox. She brings our clients more than 10 years of relevant Medicaid pharmacy experience with focus as a clinical pharmacist. Her extensive knowledge on the state pharmacy programs make her a trusted contributor for preferred drug list (PDL) solutions, state maximum allowable cost (SMAC) initiatives, retrospective drug utilization review (RDUR) criteria and interventions, as well as prior authorization (PA) support and contribution.

As the Clinical Pharmacist, Ashleigh is closely involved in the implementation of programs for our clients, as well as supports programs throughout operations. She acts as a liaison for clinical matters between our client states and Change Healthcare stakeholders, ensuring clinical matters are communicated effectively and properly, always keeping the client's best interest in mind. For the Minnesota program, she will be the day-to-day contact for operations included in this scope of work. She brings this solution her clinical expertise to support the State's clinical matters with support from our expert clinical team.

EMPLOYMENT

2016 – Present Regional Account Manager
Change Healthcare, Morton, Mississippi

Pennsylvania

- PDL Services
  - Process weekly, annual and as-needed PDL file updates
- RDUR
  - Serve as clinical and operational resource for state RDUR program in both implementation and operational phases
  - Work with the state to develop RDUR criteria and potential RDUR interventions
  - Ensure necessary reports are accurate and delivered on time

Delaware

- PDL Services
  - Process weekly, annual and as-needed PDL file updates

Minnesota

- SMAC Services
  - Ensure SMAC reports (weekly, monthly, quarterly and annual) are produced accurately and provided on time
  - Serve as clinical and operational liaison between the state and Change Healthcare stakeholders

North Dakota

- SMAC Services
  - Ensure SMAC reports (weekly and ad hoc) are produced accurately and provided on time
  - Serve as clinical and operational liaison between the state and Change Healthcare stakeholders
  - Facilitate bimonthly meetings between state and Change Healthcare staff to discuss issues relevant to scope of work

New Jersey

- SUL Services
  - Ensure SUL reports (weekly, monthly, quarterly and annual) are produced accurately and provided on time
  - Serve as clinical and operational liaison between the state and Change Healthcare stakeholders
  - Facilitate bimonthly meetings between state and Change Healthcare staff to discuss issues relevant to scope of work

Mississippi

- Provide back-up coverage for prior authorization review staff

2014 – 2016 Clinical Pharmacist
Xerox State Healthcare, Morton, Mississippi

- Compose and maintain clinical documents, including flowcharts, decision logic and drug/diagnosis tables, for electronic prior authorization system
- Compose and maintain clinical interventions for retrospective drug utilization based on current literature and/or clinical guidelines
- Assist with development and testing of clinical interventions for electronic health record
- Maintain library of clinical documents for all electronic prior authorization and retrospective drug utilization clients
- Update rubrics in rules engine based on new or updated interventions

2013 – 2014 Regional Consultant Pharmacist
Wexford Health Sources, Pearl, Mississippi

- Supervise distribution of medications to inmates in state prison system
- Served as clinical liaison between dispensing pharmacy and individual prisons
- Monitored high-cost, high-risk patients to promote compliance with medication regimen, including HIV patients enrolled in 340B program
- Conducted inspections of medication areas to ensure cleanliness, organization, inmate privacy and security of medications

2007 – 2013 Clinical Pharmacist, Pharmacy Support Services
Health Information Designs, Inc., Jackson, Mississippi

- Managed RDUR program activities
- Facilitated DUR Committee meetings
- Provided DUR Board support
- Managed PA program activities
- Served as clinical advisor to PA call center staff
- Managed academic detailing program
- Created educational and interventional materials for providers
- Coordinated and facilitated ongoing clinical training for HID clinical and support staff
- Produced deliverables on scheduled and as needed basis

2005 – 2007 Clinical Pharmacist
McKesson Health Solutions, Broomfield, Colorado

- Helped design and implement pharmacist intervention component of disease management program
- Reviewed patient charts for drug interactions, duplicate therapies, and inappropriate medications for specific disease states and / or patient populations

- Contacted physicians or other health care providers regarding problems or concerns found with patients' medication regimens to provide alternative therapies or other advice as needed
- Provided drug information for telephonic and field-based disease management nursing staff
- Assisted in training of pharmacists for new disease management programs implemented in other states

EDUCATION

1996 – 2002 University Of Mississippi, School of Pharmacy

- Doctor of Pharmacy (2002)
- Bachelor of Science, Pharmaceutical Sciences (2000)

DR. JACQUELYN A. HEDLUND, MD, MS

West Virginia Medical Director

SUMMARY OF EXPERIENCE

Dr. Jacquelyn Hedlund joined the Change Healthcare clinical team in 2015 and brings more than 27 years of relevant experience to our clinical team. She also currently holds the position of Assistant Medical Director at Community Health Options, one of the original not-for-profit health insurance cooperatives born out of the ACA.

Daily, she works closely with our Medical Directors and our clients, bringing innovative clinical expertise with her consultation to states including Iowa, Maine, Mississippi, Ohio, Pennsylvania, Vermont, and West Virginia. Her experience includes utilization management, prior authorization, PDL design and implementation, new drug evaluation, quality assurance, multidisciplinary program development and clinical trial implementation. Her industry knowledge, combined with real-world medical experiences benefit our Medicaid clients.

Jacquelyn is board certified in Internal Medicine and Hematology continues to be an active member in the clinical world. She has been in practice for 18 years, providing care to patient in Maine with benign and malignant hematologic conditions. She was the first Medical Director for the Maine Medical Center Cancer Institute and was instrumental in its conception and development. She continues her practice part-time at New England Cancer Specialists in southern Maine. She is a fellow of the American College of Physicians and a member of the American Society of Hematologists and the American Society of Clinical Oncologists.

She received her medical degree from the University of Vermont College of Medicine and a Master of Science in health policy and management from the Harvard School of Public Health. Jacquelyn frequently shares her insight and expertise with her medical peers through presentations and trainings. Her expertise as a Board-Certified Hematologist and Internist complements the clinical breadth of expertise already present.

EMPLOYMENT

2015 – Present **Associate Medical Director**
Change Healthcare, Augusta, Maine

- Provide clinical support to teams that develop and administer pharmacy benefits for Medicaid programs in several states, including conducting drug utilization reviews and staffing Pharmacy and Therapeutics committee meetings.
- For the state of Maine, provide oversight for management of DME and medical claims and contribute to development of policies such as coverage determination for genetic testing.

2016 – Present **Assistant Medical Director**
Community Health Options, Lewiston, Maine

- Provide medical oversight of utilization management and collaborate on development of clinical guidelines and quality assurance/compliance programs for the organization, a non-profit health insurance cooperative in Maine.

2016 – Present **Consultant**
New England Cancer Specialists, Maine

- Contracted to provide hematology/oncology care in an urgent care setting.

- Provide call coverage for the Hemophilia and Thrombosis Treatment Center.

PRIOR EMPLOYMENT

1985 – 1986	Consultant, Blue Cross Blue Shield, Massachusetts
1996 – 1997	Associate Medical Director, Coral Therapeutics, Inc. 1997-1998 Medical Director, Coral Therapeutics, Inc.
1998 – 2011	Consulting Medical Director, Coral Blood Services, Inc. 1998-2016 Physician Partner/Owner, New England Cancer Specialists
2015 – 2016	Consulting Physician, Martin's Point Health Care Plan

FACULTY APPOINTMENTS

1998 – 2009	Clinical Instructor, University of Vermont College of Medicine Clinical Instructor, Tufts University School of Medicine

HOSPITAL AND ADMINISTRATIVE APPOINTMENT

1985 – 1986	Teaching Assistant, Harvard School of Public Health, Statistical Methods for Health Policy and Management
1996 – 2004	Assistant Director, Maine Hemophilia Treatment Center
1998 – 1999	Transfusion Medicine Consultant, Maine Medical Center
1998 – 2007	Medical Director, Maine Medical Center Outpatient IV Therapy Room
2004 – 2008	Clinical Medical Director, Bone Marrow Transplant Program, Maine Medical Center
2004 – Present	Attending Physician, Maine Hemophilia Treatment Center Medical Director, Maine Medical Center Cancer Institute
2010 – Present	Medical Director, Gibson Pavilion Cancer Care Floor, Maine Medical Center
2012 – 2013	Service Line Physician Leader, Oncology Service Line, Maine Medical Center

EDUCATION

1990 **University of Vermont College of Medicine, Burlington, VT**

- Medicine Doctor

1986 **Harvard School of Public Health, Boston, Massachusetts**

- M.S. Health Policy and Management

1983 **Smith College, Northhampton, Massachusetts**

- A.B. Economics

POSTGRADUATE TRAINING AND FELLOWSHIP APPOINTMENTS

1990 – 1993	Internal Medicine Residency, Maine Medical Center, Portland, ME 1993-1994 Chief Medical Resident, Maine Medical Center, Portland, ME
1994 – 1996	Hematology Fellowship, University of Washington, Seattle, WA 1995-1996 Transfusion Medicine Fellowship, Puget Sound Blood Center, Seattle, WA

ADDITIONAL TRAINING

2008	Harvard School of Public Health, Leadership Strategies for Evolving Health Care Executives, Boston, MA
2008 – 2009	MaineHealth, Physician Leadership Development Fellowship, Portland, ME
2009	Harvard School of Public Health, Intensive Seminar for New and Emerging Leaders. Boston, MA
2011	Maine Medical Center, Portland, ME, Clinical Microsystems Team Training

PROFESSIONAL LICENSES, CERTIFICATIONS AND MEMBERSHIPS

BOARD CERTIFICATION

- 1993 Internal Medicine
- 1997 Hematology
- 2003 Internal Medicine Recertification
- 2007 Hematology Recertification
- 2014 Internal Medicine Recertification

LICENSURE

- Maine [redacted]
- Massachusetts [redacted]

COMMITTEE MEMBERSHIPS

1991 – 1994	Health and Public Policy Committee, Maine Chapter of the American College of Physicians
1991 – 1993	National Council of Associates, American College of Physicians, Steering Committee
1992 – 1993	American College of Physicians Access to Health Care Reform
1998 – 2004	Transfusion Committee, Maine Medical Center
1999 – 2002	Clinical Advisory Committee, Maine Medical Center
1999 – 2003	Medical Audit Committee, Maine Medical Center
2002 – 2004	Medical Executive Committee, Maine Medical Center
2002 – 2013	Pharmacy & Therapeutics Committee, Maine Medical Center
2007 – 2012	Performance Improvement Committee, Maine Medical Center
2007 – 2013	Chair, Maine Medical Center Oncology Steering Committee
2007 – 2009	Research Strategic Plan Steering Committee, Maine Medical Center
2008 – 2013	Technology Assessment Committee, Maine Medical Center
2008 – 2013	MaineHealth Oncology Leadership Team
2008 – 2013	Chiefs' Committee, Maine Medical Center
2008 – 2013	Leadership Team, Maine Medical Center
2009 – 2011	Co-Chair, Maine Health Oncology Quality Committee
2011 – 2013	MaineHealth Oncology Quality Committee
2011 – 2013	Clinical Applications Steering Committee EPIC Shared Health Record Implementation: MMC

PROFESSIONAL SOCIETIES

1990 – Present	American College of Physicians
1994 – Present	American Society of Hematology
1996 – 2006	American Society for Aphaeresis
1996 – 2012	American Association of Blood Banks
1998 – 2013	International Society for Hemostasis and Thrombosis

2006 – Present	American Society of Clinical Oncology (ASCO)
2007 – 2013	Association of Community Cancer Centers, Delegate

COMMUNITY SERVICE

2004 – 2007	Member, Board of Directors, Maine Cancer Foundation
2010 – 2015	Member, Board of Directors, United Way Greater Portland
2013 – 2016	Member, Board of Directors, Piper Shores Continuing Care Retirement Community (non-profit)
2013 – 2016	Chair, Memory Care Work Group, Piper Shores
2013 – 2014	Member, Strategic Planning Work Group, Piper Shores

RICK ERICKSON

Database Analyst

SUMMARY OF EXPERIENCE

Rick Erickson has more than 20 years of experience in relational database development, design, reporting, and data analysis, and been with Change Healthcare over 14 years. He has experience in pharmacy/medical claim reporting and analysis, using MS SQL Server and SSRS, and Crystal Reports to support multiple Medicaid State Agency programs within a wide range of reporting and analysis. He also has experience in database design including data warehousing design and ETL. These include implementation of Medi-Span MDDB (Master Drug Database) v2.5 daily incremental database, the weekly FDB drug database. He also served as developer of the Drug Formulary, PDL (Preferred Drug List), and feeds automation to and from multiple trading partners. He also developed a Medicaid Drug Rebate application supporting supplemental rebate pricing.

Rick currently is the primary reporting analyst for the Iowa State reporting suite, and the Retrospective Drug Utilization Review program (RDUR). He collaborates with two Iowa account manager registered pharmacists, who work directly with Iowa State management. He has also developed the Illinois Medicaid RDUR reporting suite. Rick interacts with analyst team members, through sharing of business knowledge, ideas, specialized areas of interest and skill, and personal support. This team focuses on techniques in writing MS Transact-SQL queries, view, function, stored procedures and deploying and maintaining SSRS reports.

EMPLOYMENT

2014 – Present **Strategic Reporting Analyst III**
Change Healthcare, Augusta, ME

- Primary support for analysis and reporting Iowa Medicaid reporting suite, written in SSRS. These reports are both scheduled and on-demand, and extend to financial, therapeutic, and system reporting. A second common class of reports, ad-hoc, are typically rendered in Excel.
- Primary support for analysis and reporting for the Iowa Retrospective Drug Utilization Review program (RDUR). He collaborates with two Iowa account managers registered pharmacists, who work directly with Iowa State management.
- Implementation of the RDUR reporting suite for Illinois Medicaid.
- Automation of the quarterly processing of the Mississippi Complex Pharmaceutical Care (CPC) program from a legacy process, using stored procedures and SSRS.
- Assisted in development of suite of operational reports for Pennsylvania Medicaid, using SSRS, as well as a high-level Drug Rebate dashboard report.
- Development of parameterized stored procedure to return pharmacy claim data from Illinois paid claims. This procedure is used by the analysts as an opportunity to provide conformity and increase efficiency in querying this large data set.

7/2014 – 10/2044 **Senior Data Developer**
Vets First Choice, Portland, ME

- MySQL OLTP development with Pentaho on Open Source stack

2011 - 2014 **Analyst / Programmer**
University of Maine, System Office, Bangor, ME

- Oracle database and page development in PeopleSoft ERP Financials.

2000 – 2011 System Developer
Goold Health Systems (now Change Healthcare), Augusta, ME

- Implementation of Medi-Span MDDB (Master Drug Database) v2.5 daily incremental database.
  - Utilize MDDB implementation best practices. All ETL processes are managed by meta-data and dynamic SQL for increased automation and reliability.
  - Exhaustive auditing of historical changes for every attribute is efficiently maintained by SQL procedures for audit querying, while maintaining primary data sources for general purpose querying and reporting.
  - Developer for comprehensive MDDB pricing history (WAC / AWP / DP / FUL) and history of other selected attributes.
  - Collaboration with Change Healthcare POS team to implement very flexible file layout of regularly scheduled drug formulary feeds which support zero gap effective dated history, while also supporting on-demand retroactive history changes.
- Design and implementation of Supplemental Rebate (SR) database application to manage drug rebate SR NDC unit prices for multiple Medicaid client states.
  - Driven by a menu of dynamically generated SR formulas tailored to client specifications.
  - On a separate but related project, he supervised a .Net contract developer of an Iowa drug rebate application.
- Developer for Medicaid drug formulary database rules engine.
  - A multi-state database supplying regularly scheduled feeds to the OLTP POS claim adjudicator.
  - Support for internal reporting and querying.
- Collaborated with team members to import pharmacy internal pharmacy claim feeds and related files (client / eligibility / TPL, provider, etc.) from corporate POS to SQL Server data warehouse.
- Collaborate with trading partners for import/export of various automated file transfers, including the Maine Medicaid medical claim feeds.

1995 - 1999 Programmer / Programmer Analyst
State of Maine, Bureau of Medical Services, Augusta, ME

- General purpose Medicaid medical querying and reporting from Oracle data warehouse for medical director and business analysts.
  - Write Oracle SQL queries and PL / SQL procedures on claim and data.

EDUCATION

University of Maine, Orono, Maine

- Computer Science, BA

TECHNICAL SKILLS PROFILE

Programming Languages:

- Microsoft T-SQL
- Crystal Syntax
- VB

Database:

- SQL Server 2000/2005/2008
- Access

Development Environments:

- SQL Server Management Studio
- MS Visual Studio
- Tibco Spotfire
- SQL Server Reporting Services
- Crystal Reports
- MS Access

Support Staff Resumes

On the following pages, we provide the resumes for the additional support staff and subject matter experts who will lend their time and expertise to the West Virginia RetroDUR contract and account management staff on an as needed basis.

DAN HARDIN, RPH, MBA

Senior Vice President and General Manager
Executive Sponsor

SUMMARY OF EXPERIENCE

Dan is an executive with strong management skills, excels at strategic planning, has an extensive background and experience in areas involving Profit and Loss, unparalleled leadership skills, ability to facilitate new business development and skill in integrating new companies and products into existing infrastructure. He has demonstrated the ability to grow revenues and to cross-sell across divisions. With a proven track record in managing, establishing and leading sales teams, Dan is able to deliver high win rates and superior margins. His ability to formulate plans, provide sound market data analysis and effectively communicate in executive meetings has established him as an exemplary people-manager as well as business manager. With thirty 30 years of mid and upper-level management experience in health care involving pharmacy benefit management, sales and account management, retail pharmacy, clinical services, human resources, healthcare management programs, program development and public sector, Dan's experience crosses a breadth of realms.

EMPLOYMENT

2016 – Present SVP and GM, Pharmacy Benefit Solutions
Change Healthcare, Augusta, ME

- Accountable for P&L, operations, sales, marketing, proposal development, implementation, clinical operations, account management, implementation activities, and consultant strategy in State Medicaid, Commercial Pharmacy Benefit Administration programs.
- Responsible for driving top and bottom line growth
- Strategic planning and execution to enhance profitability, productivity, and efficiency throughout the company's operations
- Responsible for developing and executing policies, plans, and programs to meet anticipated organizational needs in the areas of functional responsibility and ensure compliance with corporate policies and guidelines
- Responsible for the design and execution of product and service offerings

2007 – 2015 Segment President and Chief Services Officer – Employer, Labor & Trust, State Employee, TPA / Hospital, Public Sector and Pharmacy Technology Services
Catamaran Corporation

- Accountable for P&L, operations, sales, marketing, proposal development, implementation, clinical operations, account management, implementation activities, and consultant strategy in Employee Groups, State Medicaid, State Employees, TPA/Hospital, Labor & Trust, Federal programs, and Canadian provincial programs
- Responsible for driving top and bottom line growth
- Strategic planning and execution to enhance profitability, productivity, and efficiency throughout the company's operations
- Responsible for developing and executing policies, plans, and programs to meet anticipated organizational needs in the areas of functional responsibility and ensure compliance with corporate policies and guidelines
- Responsible for the design and execution of product and service offerings

- Produced annual Client Advisory, Client Management, and Consultant Advisory Meetings

2006 – 2007 Vice President, Business Development – Public Sector
SXC Health Solutions, Inc.

- Accountable for positioning and leading efforts involving State Medicaid Fee-for-Service and State Employee procurements
- Created sales pipeline, including all PBM and related State Medicaid opportunities to improve top-line revenue
- Developed sales and marketing strategies and activities for public sector clients
- Worked to re-brand public sector marketing image
- Identified Merger / Acquisition candidates to expand markets, products, and services
- Sourced and hired support staff
- Responsible for developing corporate pricing strategies

2005 – 2006 Vice President, Business Development
ACS Government Healthcare Solutions

- Responsible for the management and execution of all Sales and Marketing activities including existing markets and exploiting new market activities
- Identified strategic growth opportunities to continue expected growth rates
- Maintained pricing strategies to achieve margin and profitability goals consistent with forecasts and corporate goals
- Hired and trained sales personnel involving selling methods and marketing promotions
- Interfaced with new product development staff
- Led client presentations
- Restructured marketing department to focus on strategic customers required to grow revenue and profits

2004 – 2005 Vice President, Clinical Services and Account Management
ACS State Healthcare Solutions

- Provided strategic planning and oversight for the Clinical Services department
- Directed the development of innovative clinical products saving clients millions of dollars in annual drug spend
- Coordinated efforts among cross-functional areas to provide solutions to clients
- Responsible for development of clinical systems enhancements
- Coordinated HIPAA security and privacy activities for PBM
- Managed the development, implementation, and execution of ACS clinical programs
- Directed the development and maintenance of ACS's National Formulary
- Directed the development of disease state management protocols, therapeutic interchange programs, and PA criteria/protocols
- Responsible for managing contractual relationships with vendors providing pricing, electronic drug information, and clinical pharmacology services for integration in utilization management programs
- Directed the Drug Utilization Review (DUR), Clinical Call Centers, Case Management, and Academic Detailing programs
- Responsible for Clinical Pharmacy Analytics department

2003 – 2004 Director, Sales and Product Development
ACS State Healthcare Solutions

- Led acquisition and due diligence efforts of PBM group
- Directed sales personnel including selling methods and marketing promotions
- Provided senior management with a strategic business plan for the sales segment of the business including forecasting sales, as well as expected profit from realized sales Analyzed growth and provided accurate, complete, and timely submission of required progress reports, forecasts, quotations, budgets, and rates
- Established divisional standards for sales methodology, documentation, and operating procedures, to ensure effective and consistent business development operations and to safeguard client resources

2001 – 2003 Associate Vice President, Pharmacy Programs, Sales and Marketing
Keystone Mercy Health Plans / PerformRx

- National Sales and Marketing Director responsible for selling new pharmacy benefit management program to state Medicaid programs and Medicaid MCOs
- Increased covered pharmacy lives by 500%
- Implemented pipeline tool to evaluate marketplace opportunities and efficiently utilize resources
- Developed presentations for potential clients emphasizing value added services
- Reviewed and approved all pharmacy customer proposal responses
- Negotiated all contracts
- Responsible for implementation efforts for all new lines of business
- Developed marketing and business plans for new operating entity, PerformRx, LLC

2001 – 2001 Pharmacist Account Executive, Government / Commercial Clients
First Health Services Corporation

- Created and sold the first Medicaid Supplemental Rebate Program for Michigan that led to the development of the National Medicaid Pooling Initiative (NMPI)
- Provided business and clinical support to Michigan and South Carolina (largest accounts)

1999 – 2001 Director, Pharmacy Product Marketing
First Health Services Corporation

- Led due diligence efforts to acquire new pharmacy claims processing system
- Evaluated Electronic Prescribing Service vendors for integration into multiple claims processing platforms (mainframe, client server, data warehouse)
- Re-designed corporate website including clinical content and presentation
- Responsible for analyzing the PBM industry and associated markets including product life cycles and exploration of new technology and products
- Developed discount senior prescription drug program involving retail and mail order pharmacies
- Strategically involved in updating all business lines to ensure HIPAA compliance
- Business owner of First Rebate™, a new Medicaid Rebate Administration/Dispute Resolution program utilizing client server and data warehouse technology
- Provided sales training and presentation support across business units
- Participated in industry forums and standard setting bodies to influence direction and gain recognition for First Health Services products in the industry

- Participated in support of sales activities to prospective clients including on-site visits, presentations, product demonstrations, and tradeshows

1997 – 1999 Pharmacist Account Manager, Drug Rebate Programs
First Health Services Corporation

- Performed dispute resolution involving OBRA 1990 rebate program with pharmacy manufacturers involved in the Medicaid drug rebate program
- Returned in excess of $250 million to clients during FFY 1998
- Developed efficient rebate dispute resolution programs for State Medicaid agencies Developed drug rebate policy and procedures manual
- Implemented automated drug rebate system in multiple clients
- Implemented CMS approved dispute resolution program
- Responsible for production and support of data products supplied to pharmaceutical manufacturers and government agencies
- Increased revenues for this product sector by 68%

1997 – 1997 Pharmacist Account Manager
First Health Services Corporation

- Provided business and clinical support
- Prepared and monitored individual client budgets
- Provided specific account drug utilization review (DUR), provider profiling, clinical programs involving drug use and review, formulary management, prior authorization, drug rebate administration, and clinical pathways/disease management programs
- Implemented medical and prescription program for Georgia Baptist Hospital

1995 – 1999 Pharmacist Development Manager
Rite Aid Corporation

- Developed, promoted, hired, trained, compensated, and scheduled pharmacy personnel in this newly created position following company reorganization

1991 – 1995 Regional Pharmacy Division Manager
Rite Aid Corporation

- Chief Operating Officer for pharmacy operations in Mid-Atlantic States
- Managed pharmacy operations including human resources, marketing, purchasing, third party contracts, and government affairs
- Increased sales by 118%
- Responsible for strategic planning and implementation of business plan
- Total P&L and general ledger responsibilities
- Approved all salary increases
- Devised and implemented marketing programs
- Negotiated exclusive mail order services for State of Virginia employees
- Successfully negotiated exclusive pharmacy services contracts with Virginia's largest private employer and also the largest hospital system in east Tennessee
- Represented NACDS/VACDS before Virginia legislature
- Purchased 26 independent pharmacies and 15 nursing homes
- Negotiated agreements with local businesses to provide fee-for-service pharmacy services
- Developed a network alliance to provide pharmacy services to Champus subscribers

- Negotiated contracts with 65 long-term care facilities

1987 – 1991 Director of Professional Placement and Human Resources
Rite Aid Corporation

- Total human resource responsibilities for over 1,100 FTEs including benefit administration, interviewing, hiring, firing, exit interviews, and position promotions
- Coordinated recruitment efforts and led staffing efforts
- Designed and implemented successful training and succession programs for Pharmacists,
  Pharmacy Supervisor candidates, and pharmacy technicians.
- Refined and implemented a performance-based merit review system for all associates
- Decreased employee turnover from 116% to less than 12% annually
- Coordinated all advertising and marketing efforts
- Negotiated benefit and compensation packages on behalf of Rite Aid Corporation and UFCW representing Rite Aid Staff Pharmacists

1984 – 1987 Pharmacy District Supervisor
Rite Aid Corporation

- Interviewed, hired, and trained Pharmacists and ancillary personnel for Baltimore, MD based sales district
- Purchased and integrated 10 independent pharmacies
- Doubled sales while reducing employee turnover to less than 10% on an annual basis
- Grew district sales to 2nd highest sales district in corporation
- Trained all new Pharmacy District Supervisors for the entire corporation

1979 – 1981 Pharmacist / Manager
Hardin's Drug

- Managed independent pharmacy
- Increased total store sales by 150%

EDUCATION

1997 Duke University, Durham, NC

- MBA Health Care Management - with honors (GPA 3.57 / 4.00) at the Furqua School of Business

1979 University of South Carolina, Columbia, SC

- BS Pharmacy (GPA 3.33 \ 4.00)

PROFESSIONAL LICENSES, CERTIFICATIONS AND MEMBERSHIPS

Pharmacy State Board Licenses in North Carolina and Virginia

DR. LAUREEN BICZACK, DO

Medical Director

SUMMARY OF EXPERIENCE

As Medical Director, Dr. Biczak oversees all clinical aspects of Change Healthcare's programs. She has extensive experience working on the clinical and fiscal aspects of the pharmacy benefits for the Medicaid Agencies in multiple states. Prior to joining our team, she spent more than six (6) years as the Medical Director for Maine's Medicaid program, MaineCare, at the Department of Health and Human Services. She brings to the table extensive experience in all aspects of Medicaid Programs, including PDL design and implementation, drug evaluations, prior authorizations and in-depth knowledge of policy and regulatory issues. She also has worked extensively with the medical prior authorization program for Maine Medicaid.

Dr. Biczak is Board Certified in Internal Medicine and Infectious Diseases. Her continued part-time clinical practice offers Change Healthcare a unique view of pharmacy issues – from both the State and provider perspective. Dr. Biczak is a member of the American College of Physicians, the Maine Medical and Maine Osteopathic Societies, and several professional Infectious Disease Societies. She has in the past served as a gubernatorial appointee to the Maine Quality Forum Advisory Committee, which is devoted to not only improving the quality of healthcare in Maine but also the transparency of that quality for Maine citizens.

She received her Doctor of Osteopathy from the University of New England College of Osteopathic Medicine.

EMPLOYMENT

2012 – Present Medical Director
Change Healthcare, Augusta, Maine

- Transition of company ownership in 2013 to Emdeon, roles and responsibilities fundamentally unchanged;
- Actively host regular contacts between CHC's clinicians, disseminate clinical information, and encourage clinical interaction with updates on best practices, new drug reviews, and evidence-based learning;
- Maintain an atmosphere of evidence based clinical excellence and client centered service at all times; and
- Provide clinical, fiscal and policy input as needed on all aspects of Medicaid or commercial activities by serving as a subject matter expert, attending meetings and providing written or oral input.

2007 – 2012 Associate Medical Director
Change Healthcare, Augusta, Maine

- Oversaw clinical aspects of the pharmacy benefits for the Medicaid Agencies in multiple states
- Recommended both pro-DUR and retro-DUR criteria and oversees clinical prior authorization activities
- Oversaw clinical and fiscal aspects of PDL design including supplemental rebate negotiation, and integration with State Maximum Allowable Cost activities
- Oversaw development of clinical therapeutic class and drug reviews
- Actively participated in the P & T and DUR meetings in multiple states

- Oversaw clinical aspects of pharmacy benefit care management services for Maine Medicaid including narcotic restriction programs and high cost specialty pharmacy management
- Oversaw all clinical activities at CHC, including the medical and radiology benefit management services

2005 – 2007 Maine Medicaid MMIS Remediation Project Lead
Maine Department of Health and Human Services, Augusta, Maine

- Medical Director for the Maine Bureau of Medical Services (Medicaid Program).
  - Served as a voting member of the Drug Utilization Review Committee
  - Participated in clinical and fiscal aspects of PDL design and management activities
  - Participation in medical and pharmacy clinical determinations including fair hearings
  - Participated as a member of the Senior Management Team and was actively involved in all aspects of health care management activities including benefit design, including the pharmacy benefit, pay for performance initiatives, budgetary issues, interpretation of Federal Medicaid law, and quality projects
  - Consultant for coverage and medical necessity determinations, prior authorization and development of agency rules
  - Consultant for policy development, as well as coding and reimbursement determinations, including pharmacy policy
  - Served as the medical expert in the development of waivers
  - Communicated frequently with CMS and other States on a wide range of issues regarding MaineCare including pharmacy issues
  - Served as the liaison for the Department with professional associations, often publicly speaking at meetings and conventions on the Department's behalf
  - Responded on behalf of the Commissioner of Health and Human Services and the Governor to concerns and complaints from providers, legislators, and members
  - Testified at legislative hearings when requested by the Commissioner
  - Developed reports to support quality and programmatic activities
  - Participated in multiple quality related workgroups and committees
- Chaired Covered Services Team
  - Reviewed new services for coverage determinations and budgetary implications
- Created Code Committee which oversaw decision analysis around new or changed codes and dealt with complex coding issues

1996 – Present Infectious Disease Teaching Service

- Actively involved in teaching students, interns, residents and fellows (including Infectious Disease Fellows) in the clinical setting
- Direct patient care for hospitalized patients with infectious disease problems at three hospitals

1990 – Present Clinical Practice

- Infectious Diseases and Travel/Tropical Medicine direct patient care
  - Inpatient and outpatient settings

EDUCATION

1988 – 1990 University of Connecticut, Farmington, CT

- Clinical and Research Fellow, Infectious Disease Program
- Program Director: Sam T. Donta, MD

1986 – 1988 Osteopathic Hospital of Maine, Portland, ME
- Internal Medicine Residency
- Program Director: David A Weed, DO

1985 – 1986 Osteopathic Hospital of Maine, Portland, ME
- Rotating Internship
- Program Director: Jon Karol, DO

1981 – 1985 University of New England College of Osteopathic Medicine
- Doctor of Osteopathy
- Appointed to Sigma Sigma Phi (Osteopathic Honor Society)

1978 – 1981 University of Maine at Orono
- B.A., Zoology, Summa cum Laude
- Appointed to Phi Beta Kappa

PROFESSIONAL LICENSES, CERTIFICATIONS AND MEMBERSHIPS

State of Maine, License [redacted] Expiration 07/31/16
American Osteopathic Board of Internal Medicine, Certificate [redacted]
Internal Medicine, 03/1990
Infectious Disease, 1991
American College of Physicians
Maine Osteopathic Association
American Osteopathic Association
Maine Medical Association
Infectious Disease Society of America
HIV Medicine Association
Northern New England Infectious Disease Society
Southern Maine Osteopathic Medical Group

PROFESSIONAL APPOINTMENTS

- Chief of Staff, 1995-1997, *Brighton Medical Center*
- Chief of the Department of Medicine, 1993-1995 *Brighton Medical Center*
- Institutional Review Board, 1993-1995, *Brighton Medical Center*
- Staff Executive Committee, 1993-1997, *Brighton Medical Center*
- Chair, Infection Control Committee, 1990-1997, *Brighton Medical Center*
- Chair, Medical Quality Review Committee, 1995-1997, *Brighton Medical Center*
- Clinical Monitoring Committee, 1990-1997, *Brighton Medical Center*
- Chair, Antibiotic Agents Subcommittee, 1990-1993, *Brighton Medical Center*
- Library Monitoring Committee, 1996-1997, *Maine Medical Center*
- Physician's Information Services Committee, 1998-1999, *Maine Medical Center*
- Pharmacy and Therapeutics Committee, 1998-2002, *Maine Medical Center*
- Maine Quality Forum Advisory Committee, 2005-2007

DR. JEFFREY BARKIN, MD, DFAPA

Associate Medical Director

SUMMARY OF EXPERIENCE

Dr. Barkin has been employed as an Associate Medical Director with Change Healthcare since 2010. He has maintained a private and forensic psychiatry practice since 1991, treating individuals with a variety of mood, anxiety, and psychotic disorders. Dr. Barkin has special expertise in clinical trial design and analysis and is especially interested in applying evidence based best practices in administrative and legal settings. Prior to his current position, he served as Chair of the Maine Medicaid DUR Committee and Chair of the Psychiatric Work Group. He is currently President of TriCounty Mental Health Services, Immediate Past President of the State of Maine Association of Psychiatric Physicians and is on the board of the Maine Medical Association.

In his five years working with the Change Healthcare team, he has undertaken medical director responsibilities for Medicaid pharmacy programs in Maine, Vermont, Ohio, Iowa, Mississippi, West Virginia and has been involved in all clinical programs related to Medicaid at Change Healthcare, and actively participates in the development of clinical therapeutic class and drug reviews. He also has multiple years of experience in interpreting clinical trial data to help inform placement of products on preferred drug lists, as well as application of research methods and outcomes in numerous settings including administrative and legal. Dr. Barkin is also an active member of clinical team which oversees pharmaceutical utilization for multiple client states, multi-state drug negotiation pool, and high cost (specialty) pharmacy services.

EMPLOYMENT

2009 – Present Associate Medical Director
Change Healthcare, Augusta, ME

- Oversees clinical aspects of Medical PA services for Maine Medicaid;
- Provides medical director guidance to client states pharmacy clinical programs;
- Participates in development of clinical therapeutic class and drug reviews;
- Provides input to pharmacy and therapeutics and drug utilization review committees;
- Recommend both ProDUR and RetroDUR criteria and oversee clinical prior authorization activities;
- Five years of experience with medical director responsibilities for Medicaid pharmacy programs in Maine, Vermont, Ohio, Iowa, Mississippi, and West Virginia;
- Involved in all clinical programs related to Medicaid at Change Healthcare;
- Multiple years of experience in interpreting clinical trial data to help inform placement of products on preferred drug lists.
- Application of research methods and outcomes in numerous settings including administrative and legal;
- Ongoing work in developing other (non-pharmacy) Medicaid programs;
- Capable of applying medical analytics to assess population impact of pharmacy management strategies;
- Developed a dose consolidation program for high cost antipsychotics for multiple client states which demonstrated robust cost savings with no deleterious impacts on adherence or compliance and has presented results at national conferences;
- Developed geographic modeling assessing differential utilization of opiates employing Dartmouth Atlas methodology; and

- Active member of clinical team which oversees pharmaceutical utilization for multiple client states, multi-state drug negotiation pool, as well as high cost (specialty) pharmacy services.

2004 – Present **Private Practice**
Portland, ME

- Clinical & Forensic Psychiatry;
- Health Care Policy;
- Complex healthcare Analysis;
- Consultation to Business; and
- Teaching.

2000 – 2004 **Partner, Neurology Associates of Eastern Maine**
Bangor, Maine

1998 – 1999 **Acadia Hospital/Eastern Maine Medical Center**
Bangor, Maine

1994 – 1998 **Department of Psychiatry**
The Medical Center of Central Massachusetts, Worcester, Massachusetts

1993 – 1994 **Addiction Psychiatrist**
Adcare Hospital Worcester, Massachusetts

1992 – 1993 **Attending Psychiatrist**
Charles River Hospital, West Chicopee, Massachusetts

1992 – 1993 **Mediplex Psychiatric Nursing Home Holyoke, MA**
Center for Human Development West Springfield, MA
Private Practice Springfield, MA

1991 – 1992 **Therapeutic Associates Longmeadow, MA**

1989 – 1991 **On-Call Services**
Griffin Hospital Derby, Connecticut

1989 – 1991 **On-Call Services**
Silver Hill Hospital, New Canaan, Connecticut

EDUCATION

- 1988 – 1991 Residency in Psychiatry – Yale University New Haven, CT
- 1987 – 1988 Internship, Internal Medicine – University Hospital Boston, MA
- 1983 – 1987 M.D. – Yale University School of Medicine New Haven, CT
- 1979 – 1983 B.A. – Swarthmore College, Swarthmore, PA
- Graduated with Distinction – Phi Beta Kappa, Sigma Xi

PROFESSIONAL LICENSES, CERTIFICATIONS AND MEMBERSHIPS

Licensed physician in the States of Maine, Massachusetts, and Connecticut.
1996 Added Certification – Geriatric Psychiatry Certificate #[redacted]

1993 Board Certified in Psychiatry Certificate [redacted]
1998 State of Maine Certificate [redacted]
1991 State of Massachusetts Certificate [redacted]
1989 State of Connecticut Certificate [redacted]
1988 Diplomate NBME

- **President, Maine Association of Psychiatric Physicians**
- **Board member, Maine Medical Association**
- **Board member, Tricounty Mental Health**
- Chairman, Maine Psychiatric Work Group
- Chairman, Drug Utilization Review Board – State of Maine
- American Psychiatric Association
- American Society of Clinical Psychopharmacology
- American Neuropsychiatric Association
- Maine Medical Association
- Member, Maine State Board of Bar Examiners
- Founder, Maine Women's Mental Health list serve
- Founder & Director, Maine Psychiatric Journal Club

LASHAWNA MORGAN TYE, PMP

Project Manager

SUMMARY OF EXPERIENCE

Ms. Lashawna Tye has honed skills related to leadership, strategic planning, compliance, communication, and strategic relationship building over the course of her career, with the last six years being within the healthcare industry.

Lashawna has experience in building and maintaining good working relationships with CMS at both the regional and national office levels, possesses wealth of knowledge and experience in federal regulatory compliance specifically related to the Medicaid Information Technology Architecture, Medicaid Enterprise Certification Lifecycle, and Federal Financial Participation regulations. She is well versed in federal and state procurement, contracting, budgeting, and accounting rules and processes as well as regulatory reporting requirements for healthcare information technology projects.

In her former position with the State of Colorado's Department of Health Care Policy and Financing, she was responsible for supervision of the Project Management Unit tasked with overseeing projects such as ICD-10 and the implementation and certification of legacy Medicaid Management Information System (MMIS) component replacement projects for the claims processing and adjudication system, business intelligence and data management system, and pharmacy benefits management system. She recently joined Change Healthcare in September 2018.

EMPLOYMENT

Sept. 2018 – Present **Project Manager**
Change Healthcare, Augusta, Maine and Grand Prairie, Texas (remote)

- Develop detailed project plan to monitor and track progress for Pharmacy Benefit Management System implementations;
- Resource planning, risk analysis, schedule control and monitoring;
- Create and maintain comprehensive project documentation;
- Assist in the definition of project scope and objectives by contributing information and recommendations to strategic plans and reviews; preparing and completing action plans; implementing production, productivity, quality and customer-service standards; resolving problems; completing audits; identifying trends; determining system improvements; implementing change; and
- Help remove barriers to timely and cost-effective project completion.

July 2012 – Aug. 2018 **Project Manager**
Colorado Medicaid Management Innovation & Transformation Project (COMMIT)

- Actively managing a portfolio of programs to implement replacement of a legacy Medicaid Management Information System over a period of 8 years. This program has state-wide impacts to Providers, Hospitals, Payer Organizations and Insurance Plan Members. Three major components of the replacement system (Claims Processing, Pharmacy Benefits Management, and Business Intelligence & Data Management) were implemented in the first quarter of 2017 and are transitioning into ongoing operations, prior to Federal system certification.

Oct. 2012 – Oct. 2015 Project Manager
International Classification of Diseases 10 Implementation (ICD-10)

- Successfully implemented this nation-wide initiative to improve collection and reporting of medical diagnosis data within the Health Care Industry with extensive impacts to Providers, Hospitals, Payer Organizations, and Clients on time and within approved budget and schedule.

2013– 2018 Program Manager
2012– 2013 Project Management Team Lead
State of Colorado, Department of Health Care Policy & Financing
Health Information Office, Provider Payment Division, Project Management Unit

- Supervisor of the Project Management Unit comprised of six full time employees and three contract staff, four of whom are Project Management Professionals.
- Responsible and accountable for leading, guiding, advising, and directing activities of the unit as well aligning vendors and other Department staff to ensure business objectives are met as well as ensuring project tasks and activities are completed within the constraints of time, budget, resources, and quality expectations.
- Ensures project and program portfolio compliance with state and federal laws, policies, regulations, and guidance related to Medicaid Information Technology Architecture standards, and reporting requirements for projects and programs related to the upgrade, modification, and/or enhancement to the State of Colorado's Medicaid Management Information System (MMIS).
- Consults with Centers for Medicare and Medicaid Services (CMS), the Governor's Office of Information Technology (OIT), other agencies, partners, contractors, and vendors to coordinate cross team integration activities to meet regulatory compliance and strategic business goals.
- Responsible for gathering requirements and technical specifications to complete the solicitation, procurement, and contracting process to obtain goods and services for the programs and projects in accordance with Federal and State rules and guidelines.
- Submits State budget requests and Advanced Planning Documents to secure Federal Financial Participation funding in accordance with strategy and objectives related to Medicaid and Child Health Plan Plus (CHP+) program administration and implementation within Colorado.
- Maintains the Programs $406 million-dollar budget to ensure both State and Federal funding procedures and requests are completed in a timely fashion in accordance with applicable policies, rules, and regulations.
- Formulates Department responses to Federal requests for additional information, State requests related to legislative proceedings, and audit findings.
- Addresses issues related to non-compliance in policies and/or deferrals/disallowances of funding claims.

EDUCATION

2010 Colorado Technical University
Master of Science in Management Colorado Springs, CO

1997 University of Colorado
Bachelor of Arts in Spanish Boulder, CO

PROFESSIONAL LICENSES, CERTIFICATIONS AND MEMBERSHIPS

Project Management Institute, PMP Certification

JENNIFER SEYMOUR

Operational Account Coordinator

SUMMARY OF EXPERIENCE

Ms. Jennifer "Jenn" Seymour joined our organization in 2007. During her tenure, she has gained a full understanding of the healthcare industry and currently provides project coordination and support for several of our clinical and PBM client solutions. She is involved with our projects during all stages, beginning with the implementation phase all the way through to ongoing, operational support. Her involvement with each project ensures she has a thorough understanding of each project and client's needs.

Jenn is experienced in providing communication between several stakeholders, including P&T Committees and DUR Boards. Her professional, trustworthy demeanor make her an asset in handling client-facing communications and all aspects of project coordination, including weekly meeting agendas, status reports, clinical support, and billing. Her detail-orientated work ethic and proven time management make Jenn essential to the success of the projects she contributes.

EMPLOYMENT

2007 – Present Operational Account Coordinator
Change Healthcare Pharmacy Solutions, Augusta, Maine
Provide project support for multiple projects across the Medicaid pharmacy landscape for Change Healthcare. Working closely with the Project Managers and state stakeholders, providing project support and coordination activities as needed. Projects supported to date include:

06/2017 – Present Operational Account Coordinator Maine

- Involved during DDI and operations phase;
- Provide communications and support with administrative coordination for Pennsylvania programs;
- Documentation management and Account Management support

05/2016 – Present Operational Account Coordinator Pennsylvania

- Involved during operations phase;
- Provide communications and support with administrative coordination for Pennsylvania programs;
- Documentation management, production and assemble all clinical meeting materials for biannual P&T meeting; and
- Provide clinical staff support for biannual P&T meetings.

04/2016 – Present Operational Account Coordinator West Virginia

- Involved during operations phase;
- Provide communications and support with administrative coordination for West Virginia programs;
- Documentation management, production and assemble all clinical meeting materials for quarterly P&T meeting;
- Manage and disseminate weekly meeting agendas and status reports; and
- Provide clinical staff support for quarterly P&T meetings and monthly billing.

01/2016 – Present Operational Account Coordinator Mississippi

- Involved during operations phase;
- Provide communications and support with administrative coordination for Mississippi programs;
- Documentation management, production and assemble all clinical meeting materials for quarterly P&T meeting;
- Manage and disseminate weekly meeting agendas and status reports; and
- Provide clinical staff support for quarterly P&T meetings and monthly billing.

09/2015 – 12/2015 Administrative Assistant II

- Responsible for maintenance of office operations;
- Execute weekly time reporting for CapEx eligible employees in Jira for the payroll department, which requires extensive communication efforts and attentive follow-through;
- Create monthly Wage Allocation Reports in Excel for all employees based on time logged for each calendar month, which requires extensive communication efforts and attentive follow-through;
- Bi-weekly monitoring of Kronos to ensure management approvals and sign-offs have been completed accurately for all employees in preparation for payroll;
- Kronos Administrator, responsible for entering pager times for Provider Services, adjusting inaccurate punches and monitoring GL Codes for accuracy;
- Completing office supply ordering for Maine and Vermont offices, assigning appropriate GL Codes for all line items and ensuring timely delivery;
- Work in Travizon to establish FedEx labels and set up pickups, managing deliveries based on urgency;
- Maintain public calendars;
- Security monitoring with provisions of temporary badges or visitor badges based on need, granting access only to appropriate individuals with extensive communication with operations as necessary;
- Meet and greet all incoming visitors;
- Provide exemplary customer service over the phone as the main point-of-contact for the general line; and
- Provide as-needed support to management staff on tasks ranging from updating spreadsheets, taking meeting minutes, large-scale mailing projects.

09/2014 – 09/2015 Administrative Assistant I

- Responsible for maintenance of office operations;
- Execute weekly time reporting for CapEx eligible employees in Jira for the payroll department, which requires extensive communication efforts and attentive follow-through;
- Completing office supply ordering for Maine, Vermont and Ohio offices, assigning appropriate GL Codes for all line items and ensuring timely delivery;
- Work in Travizon to establish FedEx labels and set up pickups, managing deliveries based on urgency;
- Maintain public calendars;
- Security monitoring with provisions of temporary badges or visitor badges based on need, granting access only to appropriate individuals with extensive communication with operations as necessary;
- Meet and greet all incoming visitors;

- Provide exemplary customer service over the phone as the main point-of-contact for the general line; and
- Provide as-needed support to management staff on tasks ranging from updating spreadsheets, taking meeting minutes, large-scale mailing projects.

01/2012 – 09/2014 Scanning Specialist /Data Entry Specialist

- Prep and batch claims / non-claims for scanning;
- Scan all documents, ensure TCN imprinting on all paperwork;
- Work documents down through repair functions and KE; and
- Accurately enter all data fields on claims / non-claims.

07/2007 – 01/2012 Data Entry Specialist / MR Clerk

- Prep and batch claims / non-claims for scanning;
- Work documents down through repair functions and KE; and
- Accurately enter all data fields on claims / non-claims.

EDUCATION

1993 – 1997 Cony High School Augusta, ME

- Diploma