CHANGE HEALTHCARE

Medicaid Enterprise Systems (MES)
CRFI BMS2200000001

Collaborating on your Medicaid Enterprise Systems Modernization Roadmap

Proposal for the State of West Virginia

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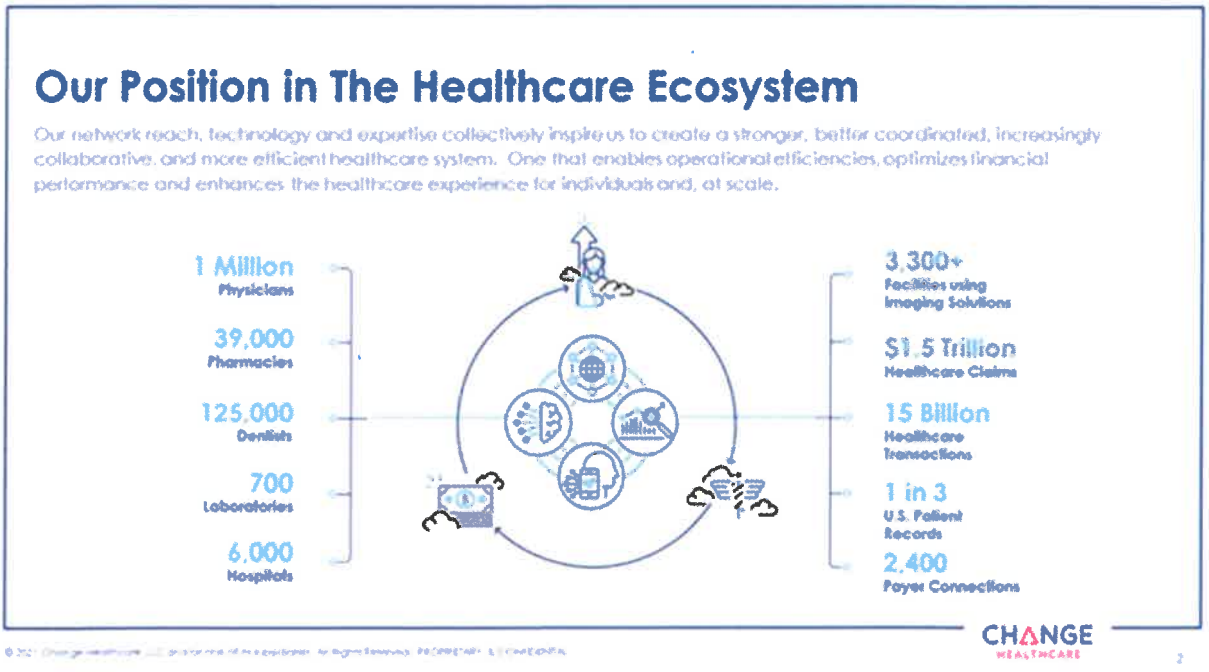
Executive Summary

The State of West Virginia Bureau for Medical Services is currently engaged in an effort to create a Medicaid Enterprise Systems roadmap and is seeking vendors to provide you with innovative healthcare solutions to support your Medicaid Enterprise modernization efforts.

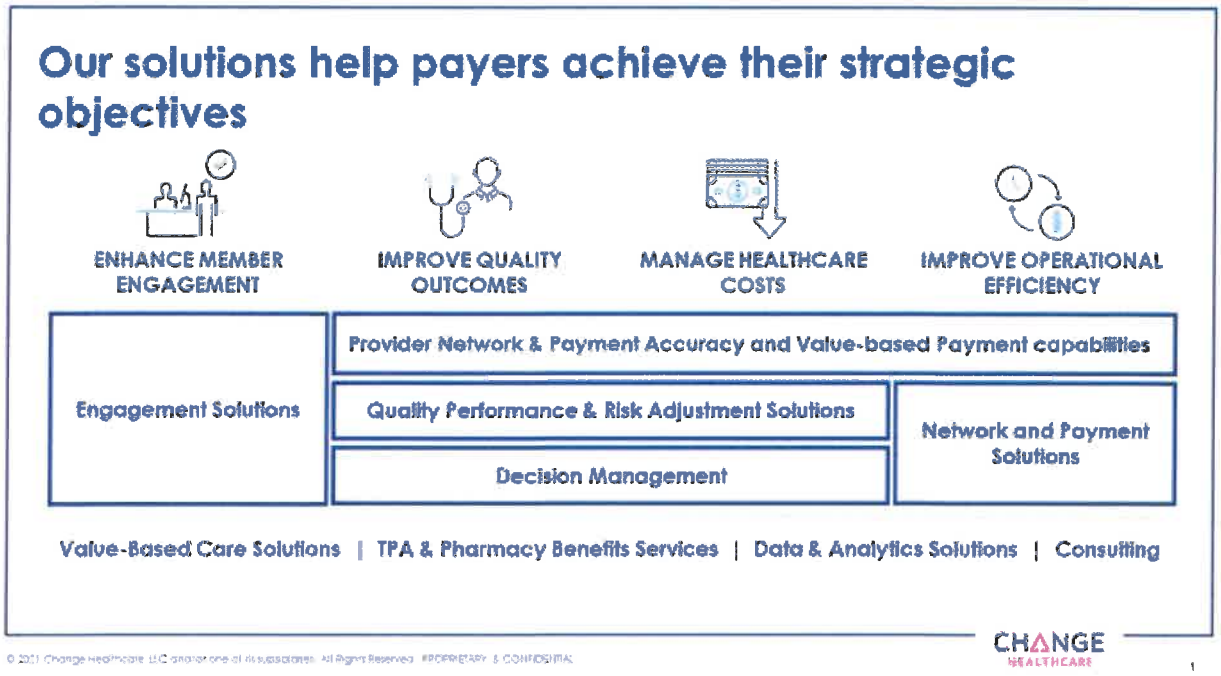
More specifically, you are looking for an innovative and modular approach to aid BMS in meeting several of its identified Medicaid Information Technology Architecture (MITA) capability goals, such as:

- Improving the State's effectiveness and efficiency
- Improving operational efficiency and reducing costs in the healthcare system
- Promoting an environment that supports flexibility, adaptability, and rapid response to changes in programs and technology
- Promoting an enterprise view that supports enabling technologies that align with Medicaid business processes and technologies
- Improving the management of member and provider data so that it is timely, accurate, usable, and easily accessible to support analysis and decision-making for healthcare management and program administration.

Change Healthcare is a trusted advisor in the healthcare ecosystem and one of our primary goals is creating a stronger, more efficient healthcare system. From our interconnected position at the center of healthcare, we are uniquely suited to support policy makers working on complex issues for the American healthcare system. Our solutions are designed to improve clinical decision making, simplify billing, collection and payment processes and enable a better patient/consumer experience.



Key areas of expertise include **supporting interoperability, enabling value-based care, promoting member engagement and transparency, and increasing payment accuracy**. We offer software and analytics, network solutions, and technology-enabled services to create a stronger more collaborative healthcare system. We help deliver measurable value, not only at the point of care, but also before, after, and between care episodes.



Additionally, through collaboration of these solutions, Change Healthcare is embracing the CMS vision for healthcare system redesign and its Triple AIM for delivery reform:

- Improving the quality of care by focusing on safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity
- Improving health by addressing root causes of poor health e.g., poor nutrition, physical inactivity, and substance use disorders
- Reducing per capita costs

Change Healthcare's RFI Response Approach for West Virginia BMS

The objective in preparing this response is to inform the State of Change Healthcare solutions that would result in measurable benefits to the Medicaid program and that should be considered in the Medicaid Enterprise Systems roadmap and potential procurement. Change Healthcare is also proud to highlight our existing relationship with the State though our partnership with Gainwell and the long-term use of ClaimCheck, our claim editing solution that delivers measurable medical savings to BMS.

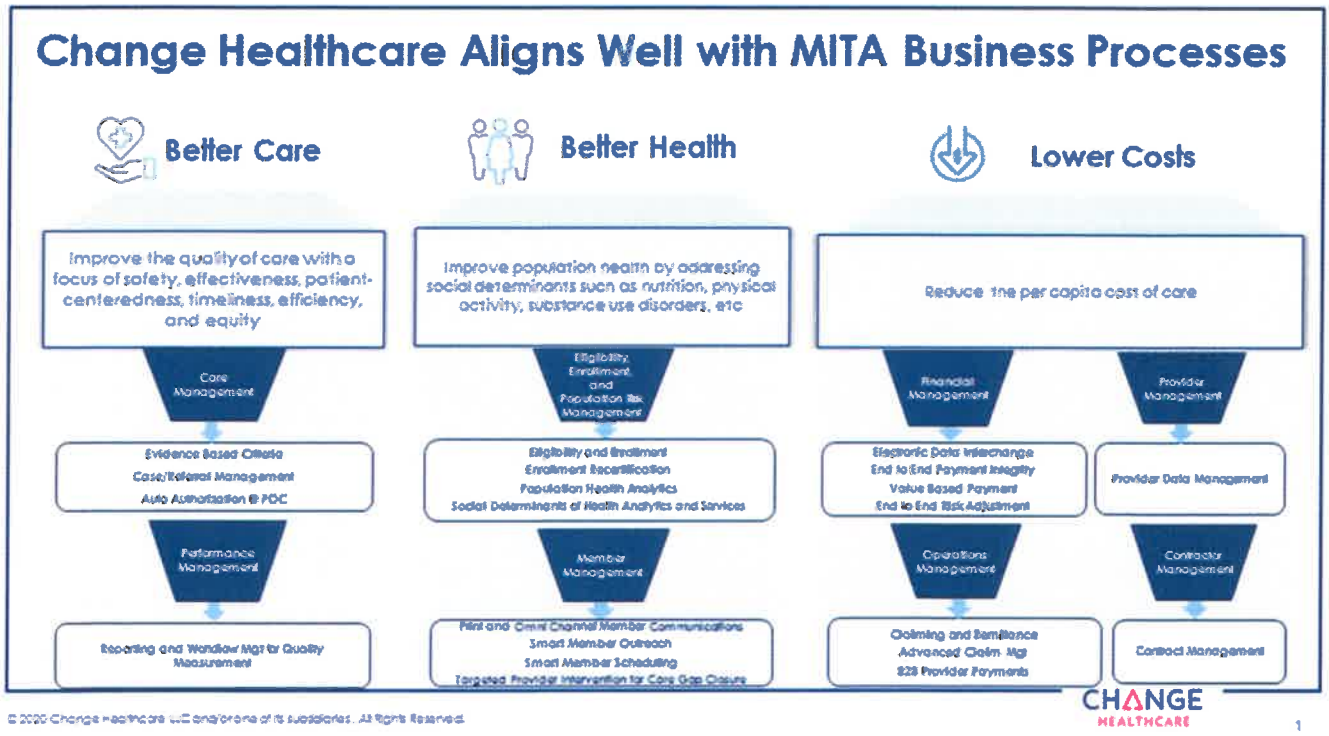
Change Healthcare delivers results in West Virginia

Change Healthcare knows the West Virginia market through our collaborations with key stakeholders over the last couple of decades. We conduct business with the State, and our various solutions are used by commercial health plans that represent close to one million covered lives in West Virginia.

For example, our payment accuracy solutions are delivering reduced costs by connecting, sequencing, delivering, and managing a more thoughtful and efficient approach to paying claims accurately. Capabilities are integrated into the provider and payer workflows to enable our clients to proactively configure and automate policies to pay claims accurately and as early as possible in the claim lifecycle. We have automated the West Virginia-specific Medicaid payment policies to enable accurate billing and payment. Medical cost savings and administrative efficiencies are currently being achieved with these solutions by West Virginia state Medicaid and MCO plans. Further, we are recognized as the industry leader in the pre-pay claim editing market, with more than 100 health plans representing 185+ million covered lives. These health plans comprise 13 out of the 15 largest health plans in the U.S., numerous multi-state, and regional Blue Cross Blue Shield plans, as well as Managed Medicaid and Medicare Advantage organizations. Our payment accuracy tools are used to support 13 state Medicaid programs in addition to four large national multistate Managed Medicaid and 12 West Virginia health plans.

Helping you Align with Medicaid Infrastructure Technology Architecture Business Processes

Change Healthcare recommends the State consider the following approach to address the Triple AIM in alignment with MITA requirements. (Question 4.2.1)



Improving Care Experience

To meet the goal of improving quality of care for West Virginia consumers, we offer:

Care Management (Question 4.2.39)

InterQual Criteria/InterQual Coordinated Care/InterQual Connect

The Bureau for Medical Services (BMS) wants to control costs better while delivering appropriate care to members. Your ideal solution would leverage rigorously developed evidence-based criteria and care plans for complex cases with your care management system (which has clinical and business rules, protected health information, and automatic authorization determination functionality) to automate medical reviews and simplify authorization requests. To help you shift from a manual, reactive process to an automated, proactive process – where evidence-based clinical guidance is integrated throughout – we recommend our long-standing decision support suite solutions, InterQual® Criteria and Coordinated Care delivered via InterQual® Connect. Our InterQual® suite of solutions is currently being used by 14 state Medicaid plans to support their decisions about what care is appropriate and effective for their members.

InterQual® Criteria Portfolio

- **Level of Care Criteria** assesses the safest and most efficient care level for more than 95% of reasons for admission. The condition-specific format presents evidence-based interventions that are specific to the condition, helping to cost-effectively improve outcomes. The unique Episode Day structure helps clinicians evaluate if a patient is responding as expected, recommends interventions in the event of complications or a slower-than-expected response to treatment, or next steps for early responders. Our novel approach evaluates severity of illness along with intensity of service, providing a clinically specific approach to stay determinations. And only InterQual has incorporated management of comorbid conditions upon admission, along with continued stay.
- **Behavioral Health Criteria** help clinicians manage the delivery of mental health and substance use care, including initial and continued stay level-of-care decisions. The depth of criteria supports care managers in the consideration of behaviors, symptoms, level of function, social risks, and support systems, while the comprehensive range of level-of-care alternatives allows for movement across the continuum of care. The evidentiary content development process for the Behavioral Health Criteria is the same as for our medical/surgical products. Additionally, criteria for behavioral services, procedures, tests, and medications are included for such key interventions as ECT, TMS, and Applied Behavioral Analysis, among others. InterQual proprietary Benchmark LOS and percent paid as observation benchmarks are included where appropriate.
- **Ambulatory Care Planning Criteria** identifies the appropriateness of ambulatory interventions including imaging studies, procedures, durable medical equipment, molecular diagnostic tests/test panels, specialty pharmacy medications, and specialty referral consultations, and assure the appropriate sequencing of care alternatives according to the evidence. InterQual proprietary Benchmark LOS data is included where appropriate.
- **Powered by InterQual** is third-party industry content criteria in your familiar InterQual workflow to improve review efficiency and consistency. Content from CMS and others is converted into our easy-to-use Q&A format. Policies that are cumbersome to navigate or stored in disparate sources are streamlined and structured. Content powered by InterQual can be incorporated seamlessly into your existing workflow via InterQual technology solutions.

InterQual Coordinated Care

InterQual® Coordinated Care is an integrated, software as a service (SaaS) solution designed to help manage high-risk conditions and complex cases. Explicitly developed to address cases in which members have more than one condition, InterQual Coordinated Care relies on the same rigorous, evidence-based process that has made InterQual the gold standard of decision support. By merging assessment components for all relevant conditions, InterQual Coordinated Care enables the creation of a single, blended care plan. This inclusive approach is more efficient than multiple redundant plans, which can absorb staff time and increase patient

frustration. The solution's comprehensive member/patient assessment takes a holistic approach to co-assess applicable medical, behavioral, and social determinants of health. As care managers are better informed about the patient's full circumstances, they can more easily improve outcomes and prevent readmissions. InterQual Coordinated Care is accessed from within the case management workflow systems, increasing care manager efficiency. InterQual Coordinated Care provides assessments in a simple Q&A format. The Primary Assessment addresses common care barriers, including social determinants of health. The case manager has the flexibility of adding one or more of 40 patient conditions to create a patient specific assessment in real time. The assessment also includes complex case management, special needs, ADL screening, IADL screening, cognitive screening, and caregiver needs, among many others. In addition to the Primary Assessment, the solution includes a Palliative Care Assessment, High Risk Neonate and Caregiver Discharge Assessment, Screening Tool Assessment, Long-Term Services and Support Assessment, and a Readmission Reduction Assessment to help mitigate avoidable readmissions within 30 days of hospital discharge.

InterQual Connect

InterQual® Connect is an integrated medical review and connectivity solution for payers and providers that enables the automation of prior authorization requiring a medical review within existing workflows.

Medical Review Service provides immediate access to the most current, cloud based InterQual criteria with a modern, user-friendly interface for conducting medical reviews. Efficiency is improved with provider access to the Medical Review Service within the existing UM/CM system via the plan's provider portal. Plans can publish unique policies for provider access as they conduct medical reviews to ensure transparency in the prior authorization process.

Authorization connectivity enables providers to transmit an authorization request across our authorization gateway, complete with an InterQual medical review, directly to the plan. The plan can then apply business rules and the InterQual criteria to this request and instantly deliver an automated authorization determination status back through the gateway to the provider. Providers can receive quicker authorization approvals for most requests. That means the plan only needs to touch the exceptions that cannot be approved automatically. The result is no more duplicative medical reviews or wasting of precious staff time on routine authorizations.

Integration partners enable us to connect to the authorization gateway to provider portals, care management, and EHRs. The authorization gateway is proven and secure and currently supports thousands of authorization transactions per week between connected payers and providers. No other company has as large of an EHR footprint, nor the same connectivity backbone as Change Healthcare. This allows us to keep providers in their workflows while supporting collaborations, communications, and complete transactions. Our unique footprint includes 40+ healthcare technology companies and all the leading EHR vendors (e.g., Epic, Cerner, MEDITECH).

Performance Management

To address the performance management business area which involves the assessment of program compliance related to utilization and performance, Change Healthcare offers Compliance Reporter and Risk Manager.

Compliance Reporter

Compliance Reporter is our full-service solution for quality measurement reporting. Our analytics and reporting platform is built on the NCQA-certified Quality Rules Engine and simplifies the full HEDIS review process — from the generation of samples through the creation of NCQA and CMS data submission files.

Compliance Reporter supports all aspects of the HEDIS reporting process including:

- Production and analysis of HEDIS administrative rates
- Collection and creation of the HEDIS hybrid rates
- Generation of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) sample frame files
- Creation of the CMS Patient Level Detail (PLD) file for submission to CMS
- Creation of the XML-based Interactive Data Submission System (IDSS) files for submission to NCQA's IDSS
- Support of the medical record review process -- including sample creation, chase logic, and associated workflow support
- Full HEDIS measure reporting including the ability save reports as PDF, TXT, or XLS-based files
- Full client access to the underlying hosted MSSQL database

Compliance Reporter lets you easily create the sample for CAHPS survey measures for your members, sample your membership for HEDIS hybrid metrics, and generate the NCQA IDSS file and CMS PLD file for final submission. Key features include a central data repository of claims, membership, enrollment, lab data, pharmacy data, and scanned charts. The platform also has productivity summaries for all measures, reviewers, and members; standard reports for required certification; and an audit tool to generate completed chart samples. Additionally, the platform includes live, in-line recalculation of rates. Therefore, you have access to the latest results within minutes.

Risk Manager

Risk Manager is a population risk management tool that provides comprehensive and actionable risk, cost, utilization, quality, and efficiency intelligence.

Plan provided data is processed through the risk engine which includes groupers, clinical quality rules (HEDIS and procedural), and hierarchies to provide analytics, reporting and outreach tools. Dashboards and standard reports are available for medical directors, practice managers, informatics directors, analysts, providers, provider relations, care coordinators, and more.

Population and Quality Analysis Provided

- Stratifies and identifies populations
- Who are my sickest patients?
- What conditions are driving risk?
- Concurrent – prospective risk models
- Commercial, Medicare, Medicaid populations
- Likelihood of hospitalization

Cost and Utilization Analysis

- ED visits (PMPM; visits per 1000; avg cost; 'frequent fliers'; low acuity visits)
- Inpatient stays (PMPM; admits per 1000; average cost; readmits; in-vs-out of network)
- Outpatient Imaging
- Office visits

Physician Profiling

- Compare physician performance
- Risk-adjusted PCP utilization analysis
- Specialist profiles (episode-based)
- Cost and utilization-based reporting
- PCP/group dashboards

Pharmacy Analysis

- Identify top drugs, top prescribers
- Utilization analysis (generics; cost; volume)
- Identify equivalent, more cost-effective prescription drugs
- Letter generation for outreach
- Pharmacy dashboard; reports; cube

Improving Health (Question 4.2.25)

West Virginia's population faces multiple high health needs and limited access to care. To meet the goal of improving population health, we recommend that West Virginia consider solutions that specifically target at risk members, get them to care, and close care gaps. In addition to the population risk analytics and personalized care planning described above, Change Healthcare offers solutions that assist in identifying high potential for eligibility and to facilitate enrollment, assist in identifying and addressing social determinants of health, and facilitate targeted member and provider interventions for gap closure.

Eligibility and Enrollment Management

Community Advocate, Recert Complete, Part D Complete

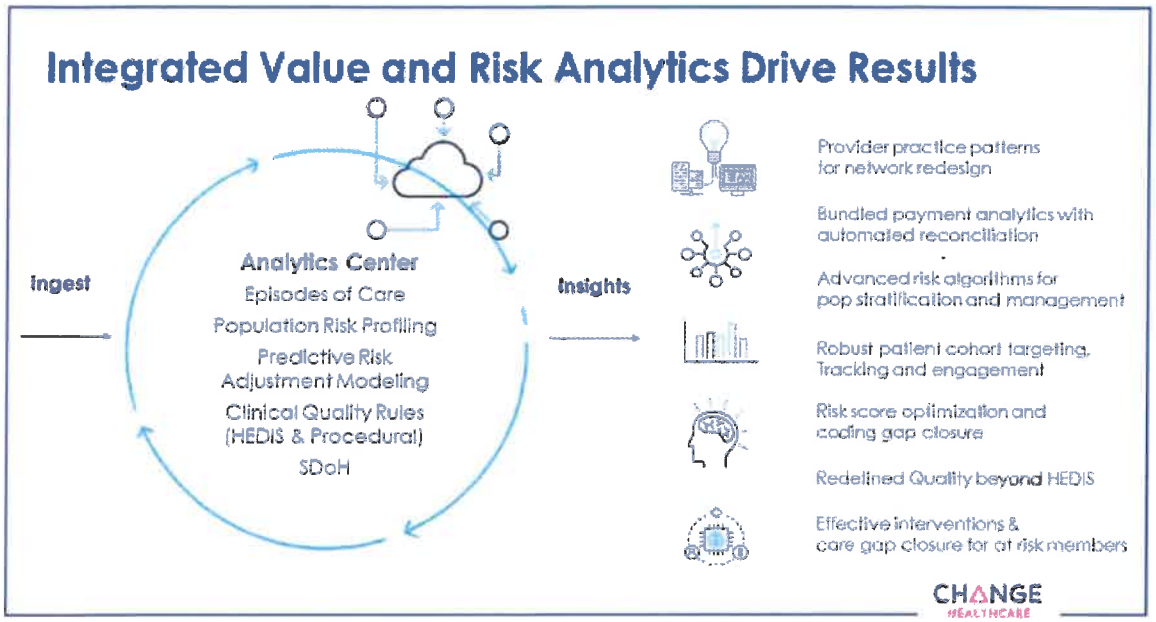
Eligibility and Enrollment solutions provide services that help to identify and support financially vulnerable patients through payment counseling and program enrollment. These solutions include:

- **Community Advocate™ (CA)** provides members access and enrollment support to thousands of public and private programs that help address Social Determinants of Health (SDOH)
- **Recert Complete™ (Recert)** engages members to complete the Medicaid recertification applications to help ensure dual eligibility status is maintained.
- **Part D Complete™ (LIS)** identifies eligibility and helps members apply for Low Income Subsidy (LIS) assistance for prescription drug benefits

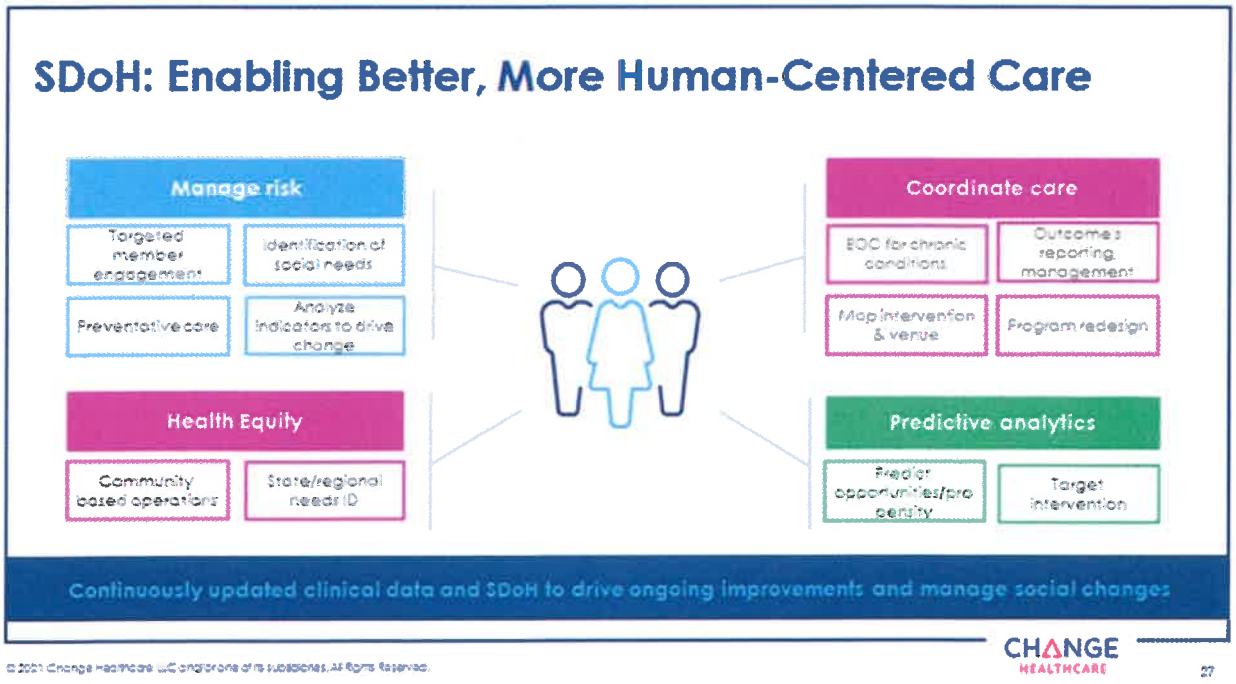
Population Risk and Social Determinants of Health Analytics

Risk Manager and SDoH Analytics Engines

As described above in performance management, Risk Manager provides business intelligence to manage a population's risk. Change Healthcare offers modular analytics engines to provide insights generated across the continuum of care, Thus, in addition to stratifying and identifying populations, actionable intelligence can be used to drive behavioral change.



Social Determinants of Health analytics predict propensity of members at risk and target interventions for social needs, preventive care, drivers for change, health equity, and care coordination services.



Member Management

Connected Consumer Health (Question 4.2.7)

Change Healthcare's Connected Consumer Health™ suite provides free interoperability APIs for Centers for Medicare and Medicaid Services (CMS) compliance and patient access requirements.

The solution offers payers secure, standards-based application programming interfaces (APIs), enabling rapid data access for members. These APIs – bolstered by robust security, consent, and identity management – help payers achieve compliance quickly.

We offer two options to access Connected Consumer Health that meet CMS requirements. One option is for payers to provide data files which Change Healthcare would then host. The other option is for payers to provide FHIR HL7 public compatible APIs to access the data that they host, and Change Healthcare would then augment with security, consent, and identity management.

Meeting Legislative and Policy Mandates

Connected Consumer Health provides members with access to their own patient records, directly or through third-party applications. The CMS patient access rule, called CMS-9115-F, mandates standard, open APIs to provide that access.

Access and interoperability also must exist between payers so they can exchange data. All payers must meet the requirement to allow members to request the transfer of their records for up to five years if they change plans.

Where the mandates apply:

- Medicare Advantage Organizations
- Medicaid Managed Care Organizations
- State Medicaid Agencies (for FFS)
- CHIP Agencies
- CHIP Managed Care Entities
- Qualified Health Plans on Federally Facilitated Exchanges

The interoperability APIs within Connected Consumer Health provide members with access to their medical information and gives members the ability to release their data with consent to other payers.

The Change Healthcare network connects data between different payer systems, and we operate the API marketplace and manage security so that the payer doesn't need to track members' consent or interact with third-party developers. The data access provided by Connected Consumer Health, paired with Change Healthcare consulting services, helps payers source, access, and integrate the required data they need.

Increase Member Engagement

Connected Consumer Health not only helps payers with CMS compliance, it also provides the infrastructure for payers to expand member-facing capabilities. Eventually, members will have their entire healthcare journey at their fingertips. Connected Consumer Health will provide payers with the opportunity to increase engagement and build stronger provider networks.

Change Healthcare Value and Differentiators

Choosing Change Healthcare means you are choosing a dedicated partner for the long-term with differentiators such as:

Transformational partner. Change Healthcare is truly a platform strategic partner for many payers, providers, and health IT vendors. Approximately 50% of our business is helping payers and 50% is helping providers. Change Healthcare is unique with respect to having a "two-sided" platform and network that is operating at scale. Many other vendors are one-sided point solutions (a payer or provider solution but not both), attempting to solve your Interoperability and patient access compliance.

The primary question facing our clients is: can a one-sided point solution vendor with much less connectivity, data, and solutions provide you with as much initial and long-term value and relief for achieving Interoperability and patient access compliance across the overall consumer journey enablement and digital experience, as Change Healthcare can?

Provide the Connected Consumer Health application to increase engagement. With a shared identity, we can deliver data to power and combine workflows to produce increased digital member engagement for your providers and members. We are permitting health plans to rebrand our Connected Consumer Health app that functions as an application platform. It includes extensions for meaningful member-facing functions such as cost transparency, member payment (included for free), and provider scheduling that are among other functions Change Healthcare is pursuing. The Change Healthcare API marketplace (https://marketplace.changehealthcare.com/) also will host these solutions as premium APIs for third-party adoption. Please see Figure 1 below to visualize our workflow.

Interoperability Hosted API Connector™ Solution

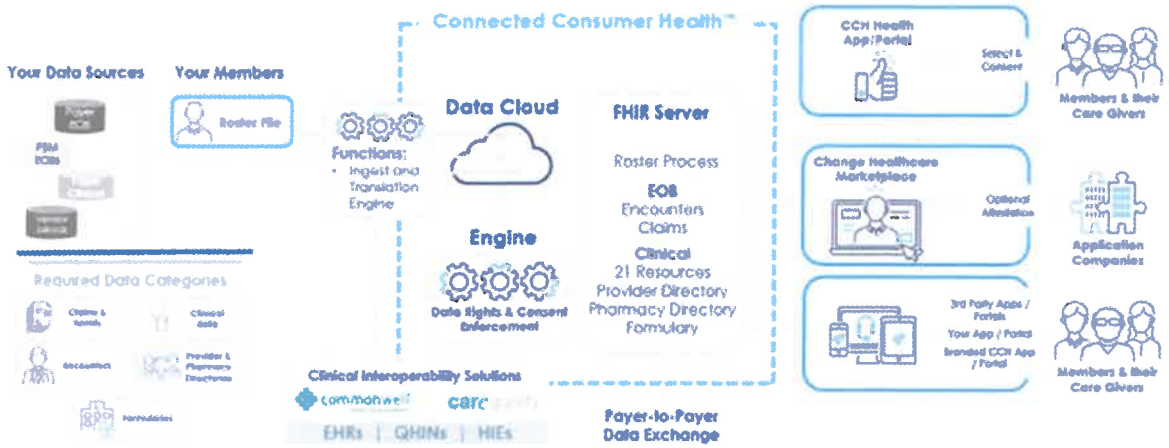


Figure 1: Connected Consumer Health offers connectivity allowing it to be more economical and faster with one implementation

Consulting Services. Our consulting team understands the implications of the recently released CMS and ONC rules and their impact on your operations and information technology architecture. Change Healthcare's consulting services are singularly focused on the healthcare market and are ranked by KLAS as the #1 Payer Consultancy based on its 2019 client survey. We see ourselves as a catalyst to accelerate the journey toward improved lives and healthier communities by providing clinical, compliance, operations, and technology consulting services to payers. Our consultants have extensive health plan experience, with an average of more than 15 years in the industry. We have current and relevant experience in all product lines (e.g., HMO, PPO, EPO and ASO), as well as all lines of business [e.g., large group, small group, individual (on and off exchange), Medicaid, Medicare, and employee retirement programs].

Secure Cloud Platform. Our cloud is a secure and scalable data repository that uses our patient identification services to create a longitudinal patient view based upon a set of defined primary use and secondary use rights. We are also HITRUST CSF® Certified, Federal Information Security Management Act (FISMA) compliant and EHNAC HNAP-EHN accredited, we also maintain compliance with a number of federal requirements and have an industry-recognized employee training on HIPAA including security awareness, and fraud, waste, and abuse. We are fully aware of, monitor, and maintain data security and regulatory compliance to safeguard our clients' information.

Industry-Leading Innovation. Our innovations are backed by collaborations with organizations like CommonWell Alliance, Adobe, Microsoft, Google Cloud, and others - to help us leverage artificial intelligence, machine learning, and analytics to transform healthcare and the member's experience. For example, our payments experience, connectivity, and leadership in payer-to-provider payments led to us developing one of the first production health plan offerings for consumer (member) electronic bill presentment and payments to providers and a Connected Consumer Health experience. Additionally, it should be noted that Change

Healthcare is the technology service provider for the CommonWell Health Alliance whose mission is to provide a vendor-neutral platform supporting secure, ubiquitous access to healthcare data & information.

Member Correspondence Advocate

This solution offers you a customizable communication product for health plans and administrators that want to improve member engagement through printed, telephonic, and electronic correspondence.

With Member Correspondence Advocate, you can improve communications with your health plan members by:

- **Transforming member communication** into meaningful, interactive engagement channels. Capture attention and compel action with targeted information relevant to each member's well-being.
- **Creating a differentiated member experience** through personalized, timely, omnichannel communications. Work to improve retention and foster trust with high-quality, customizable content.
- **Converting paper-based correspondence to digital content** to align with select member preferences. Reduce administrative costs related to printing and postage.
- **Increasing member communications** through multiple channels, including printed, telephonic (IVR), and electronic correspondence.

The solution features customized member kits, ID cards, and regulatory communications, member-friendly EOBs, and a wide array of correspondence options that can be customized to meet your needs.

Smart Connect™

Smart Connect is part of a suite of member management solutions that includes Smart Appointment Scheduling™. These solutions offer a member engagement platform for payers that want to improve consumer engagement in healthcare by encouraging proactive involvement in their health and well-being.

Using data-driven insights, we deliver targeted messaging to encourage members to take actions that can improve their clinical, economic, and administrative behaviors. By promoting healthy lifestyle choices, sending reminders for wellness checks, providing disease education, and much more, our solution can help facilitate healthy choices and actions on an individual member level. We do not just rely on plan-supplied data, single variable testing, trigger-based interventions, or engagement level metrics with a one-size-fits-all approach. We use advanced analytics to evaluate member data and provide key insights that can help build targeted member campaigns. In addition, we can help minimize client effort by leveraging existing infrastructure already available associated with closed-loop outcomes measurement.

Our knowledge-driven member engagement strategies help:

- Inform your member engagement strategies to deliver the right message to the right members at the right time with sophisticated analytics and centralized big data, including your existing claims data.
- View all member touch points across your enterprise with a consumer engagement platform that offers a vendor agnostic, integrated reporting dashboard that allows you to manage SMART Connect campaigns, and other communication programs.
- Provide consumer engagement tools to allow your members to select what works best for them from multi-channel, multi-language communication options including IVR, email, SMS text, web portal, live advocates, and more.

The solution uses sophisticated analytics and centralized big data, including the client's existing claims data, to inform communication strategy and build targeted campaigns (e.g., the right message to the right member(s) at the right time) to:

- Deliver targeted messaging to promote actions that can help improve health outcomes
- Improve engagement rates over time with demonstrable results
- Provide a vendor agnostic, integrated reporting dashboard to view all member touch points across the organization; manage Smart Connect campaigns as well as information from other communication programs across your organization
- Support a variety of communications outreach including IVR, fax, email, print, web portal, Android and iPhone apps, SMS text, and live member advocates
- Enable warm transfers from plan care managers to Change Healthcare live advocates to enhance engagement and improve the member experience
- Leverage behavior science to optimize outreach and engagement, and recommend alternative methods for hard-to-reach populations
- Offer 85 languages across all channels

Smart Appointment Scheduling

Part of our suite of member management solutions that includes Smart Connect™, Smart Appointment Scheduling helps you:

- Identify members and send targeted member education materials with dynamic, integrated analytics using our health engagement platform.
- Coordinate and schedule provider appointments via live member advocates that directly contact members.
- Help ensure members keep their appointments with direct mail and digital reminders, which can help to close care and risk gaps.

Care Gap Advisor

Care Gap Advisor is part of Change Healthcare's innovative advisor solution portfolio that address gaps directly in care and billing workflows. Care Gap Advisor focuses on targeted interventions to address gaps in care directly at the point of care for the member. The solution leverages API proprietary technology that Change Healthcare obtained through the acquisition of NDSC. Their API technology will allow connectivity to the majority of EMR solutions on the market, leading with Epic and Cerner.

Reducing Costs (Question 4.2.25)

To reduce your per capita cost of care, we offer:

Financial Management

Medical Network EDI

Change Healthcare has been providing healthcare clearinghouse transaction services for over 35 years. We are the market leader in healthcare claims communications and payment services facilitating connectivity between 2,400 payers, 6,000 hospitals, and over 1,000,000 providers, including more than 125,000 dental providers

Last year, our Intelligent Healthcare Network™ processed and delivered 15 billion healthcare transactions and we are positioned to lead the adoption of electronic medical and dental attachments because of our vast network connectivity. Change Healthcare is continuously developing and deploying modern technologies and tool sets to enhance the user experience for our clients. Our clearinghouse has the capacity to manage all aspects of your electronic claim workflow to maximize your investments, standardize payer and provider support tools and services, and minimize provider abrasion.

- Our Medical EDI Network provides electronic data interchange for all HIPAA transactions: 837, 270/271, 276/277, and 835s.
- Our Dental EDI Network provides electronic data interchange for all HIPAA transactions: 837, 270/271, 276/277, and 835s.

Both networks help payers and providers increase clean claim submissions, expedite credentialing, minimize paperwork, and reduce costs. Our Dental EDI Network transactional platform is the largest dental clearinghouse in the nation and both networks are part of our Intelligent Healthcare Network, which helps expedite claims processing while lowering administrative costs for the healthcare industry. Through our exclusive relationships with over 100 channel partners, including Henry Schein, Patterson, and Carestream, Change Healthcare's Dental Network processes over 300 million transactions annually from more than 125,000 dental providers.

Within our EDI networks, we recommend these services:

- **Hosted and direct real-time eligibility.** Our hosted solution supports real-time healthcare transaction exchanges in HIPAA-compliant formats; it enables automated eligibility and benefit verification between you and our network of 1,000,000+ providers. As a data hosting resource, it eliminates the need for expensive upgrades in systems and technology.
- **EFT.** We manage the provider enrollment process for clients, tracking and auditing payment delivery and adding the trace number (TRN) to the 835 transactions for compliance.
- **Electronic Remittance Advice (ERA).** Clients can partner with Change Healthcare for ERA via the HIPAA-standard ASC X12N format, supporting ERA (835). It supports alternative technology platforms and format options, so you can select the best fit.

- **Enrollment services.** We have a variety of EFT and ERA enrollment options, ranging from online tools to paper enrollment forms. By processing EFT and ERA, we help you maintain the Council for Affordable Quality Healthcare (CAQH) CORE III requirement for EFT and ERA delivery timeframes. We also integrate the ACH payment information (via the trace number) into the ERA contents to ease electronic reconciliation.

Providing Measurable Value

260M	100M+	4M
dental transactions annually	dental eligibility transactions per year	dental payments processed each year

- **Claims testing and validation.** We provide the ability to validate and report data content errors back to providers. For channel partner and product customers, rejects are communicated electronically. For scanned paper claims, we offer a reject letter service (with payer branding) to return a rejected claim back to the billing provider's address via USPS.

Change Healthcare offers experience and expertise in clearinghouse services

Through our Intelligent Healthcare Network, you can also benefit from our Medical Claims Attachments service to streamline claims processing by enabling required documents to be submitted electronically, maximizing efficiency for both providers and payers. With our expansive network — including nearly all government and commercial payers — we can send most claims/attachments to their final destination without rerouting. Industry experts estimate that payers save $1.74 per attachment while providers will save on average $5.25 per attachment. Dental Claim Attachments services simplify the submission of supporting documentation and streamline the claims adjudication process. Providers are paid faster, and clients run more efficiently and cost effectively by converting to electronic claims. You can reduce administrative and material costs associated with paper-based attachments.

Our EDI helps to enhance clients' claims processing, giving them cleaner claims with improved accuracy and consistency that ultimately drives shorter pay cycles and increased collections.

Payment Accuracy: Provider Education, Claims Editing, Medical Record Review, TPL Services, and Post Pay Audit and Recovery (Question 4.2.39)

Our experience in the market is unparalleled. We have developed payment accuracy solutions for nearly 40 years. Historically, after a claim had been paid, auditors would review hundreds of medical record pages searching for overpayments. Managing record requests, recoveries, and collections cause high administrative expenses for payers and providers, provider abrasion, and confusion for consumers. Audit and recovery, while still necessary, have not been the panacea; taking proactive steps across the entire payment continuum — from pre-submission to post-payment — is a better way to surpass current performance and reduce payment errors.

We have listened to our government and commercial payers; to address their pain points, we developed our end-to-end payment accuracy solution suite, which is central to reducing healthcare costs. Our expanded end-to-end payment accuracy suite of solutions is intentionally designed to efficiently connect, sequence, deliver, and manage a more thoughtful and efficient approach to paying claims accurately. Our approach and capabilities are integrated into the provider and payer workflows to enable our clients to proactively configure and automate medical and payment policies, guidelines, regulations, and contract requirements to accurately pay a claim the first time through the process.

As discussed in the previous section (Medical Network EDI), our end-to-end payment accuracy strategy begins with our Intelligent Healthcare Network (IHN), which provides us the opportunity to expand beyond the payment accuracy continuum from traditional pre-payment and post-payment solutions to a pre-emptive (pre- submission) capability. This unique pre-submission platform allows us to integrate domain knowledge and advanced analytics directly into the claim submission process; data insights from paid claim data identify areas of inconsistencies in the claim and medical record while also identifying outliers, billing, and coding errors. By applying these insights at the earliest points in the payment continuum, we proactively help providers fix coding and billing errors before they enter the claim payment system for adjudication.

The components of our payment accuracy suite are tailored to each customer's requirements and places decisions as early as possible in the payment process. They can be implemented together, or as point solutions to address specific issues. Please see Figure 2 for a high-level depiction of the components and where they are typically implemented in the end-to-end claim workflow.

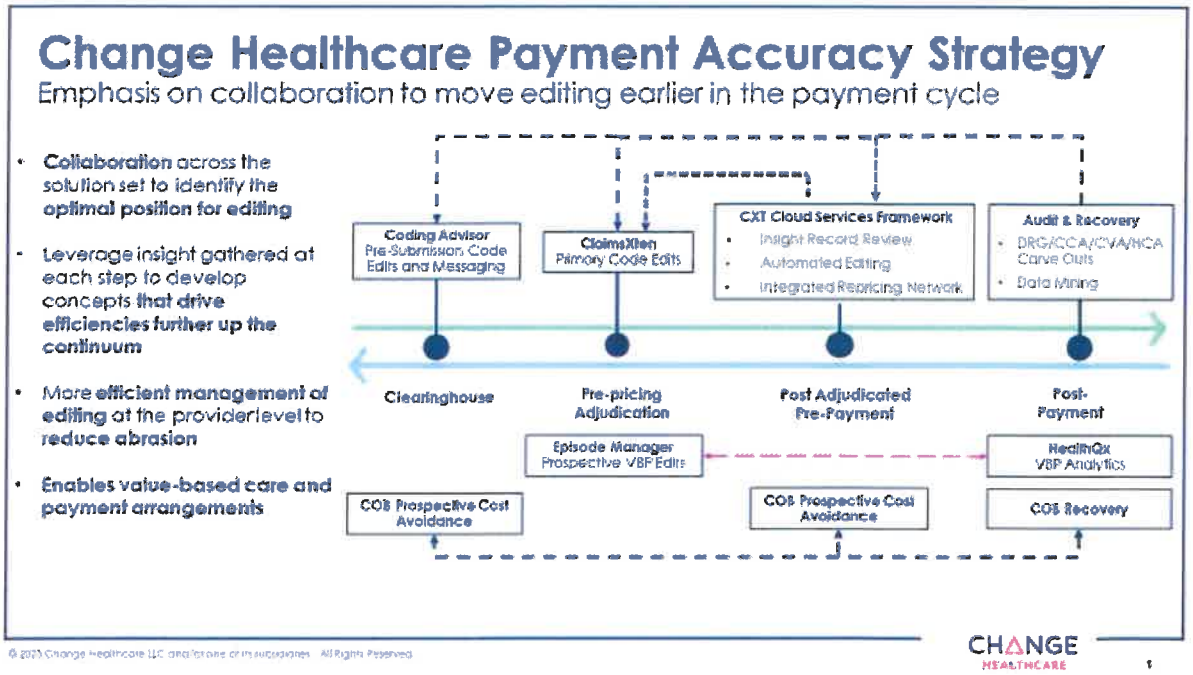


Figure 2: Our payment accuracy strategy includes pre-submission edits and messaging, prospective and retrospective TPL coordination of benefits, primary code editing, automated secondary code editing, pre-pay insight and record review, audit and recovery services, and value-based payments.

Applying claim editing as early as possible in payment cycle mitigates payment errors

The thoughtful sequencing of our solutions at each stage of the payment continuum permits us to evaluate the metrics and identify trends that enable us to develop the rules and modules that drive savings opportunities earlier in the payment process, so claims are paid accurately the first time. Communication between pre-submission, pre-adjudication, pre-payment, and post payment solutions and services is accomplished by our ability to view claims in the beginning of the submission process, allowing us to monitor provider behavior across all points of the continuum. We leverage advanced analytics including artificial intelligence and machine learning to identify new overpayment concepts and target claims that are most likely to be inaccurately billed. This proven approach is how we drive greater cost savings for our customers with the least amount of abrasion, and further facilitates the continuous development of process improvements.

By applying these insights at the earliest points in the payment continuum, we proactively deliver one consistent message and help providers fix coding and billing errors before they enter the claim payment system for adjudication — avoiding multiple messages from multiple vendors and reducing provider abrasion. Providing clients with better outcomes aligns with our mission to inspire a better healthcare system by reducing administrative cost in the healthcare system.

Provider Education with Coding Advisor

Beginning on the left of the Figure 1 diagram, even before claim submission, Coding Advisor is an innovative, outreach based, provider engagement solution that **works to positively alter provider billing behaviors and reduce overpayment for high-volume, low-dollar claims, for which other payment accuracy initiatives have proven to be cost prohibitive.** The goal is to reduce the number of up-coded evaluation and management and other "intensity of service" claims from being entered in the first place. After benchmarking providers, those with the greatest percentages of high E&M claims, are notified in a nonconfrontational way that they are outliers. Change Healthcare's advanced degree personnel reach out to educate the providers and their staff on appropriate coding of E&M claims. Detailed metrics are captured on a periodic basis to determine which providers have improved their coding approach and those that have not and should possibly be subject to further review. Our Coding Advisor customers today **save an average $2-4 PMPY**.

Powerful Primary Editing

Once a claim enters the system, **ClaimsXten**, our primary claim editing solution, is the core application in our payment accuracy suite. It integrates in real-time to a payer's claim adjudication systems at an enterprise level to manage the medical and payment policy rules for multiple lines of business including Managed and FFS Medicaid, Medicare Advantage, and commercial claims. The high-performance payment rules engine leverages regularly updated clinical rationale with comprehensive sourcing justification to facilitate accurate payments and provider education using payment rules tailored to the state's policies. We use natural language processing to ingest national and local coverage determination policies (NCD/LCD), state guidelines, and payer medical and payment policies. Insights from payment history are also used to accurately process the claim.

Your fiscal agent will soon begin migrating BMS from using Change Healthcare's legacy ClaimCheck claims editing to our current, more powerful ClaimsXten primary editor to provide more comprehensive and flexible editing capability for your FFS claims.

The growth in Medicaid enrollment under the Accountable Care Act, Medicaid programs, and Medicaid managed care operations are increasingly challenging you to not only address the health care needs of your members, but to streamline administrative efficiencies and identify medical cost savings.

To support this growth, Change Healthcare has developed a state specific Medicaid service offering that leverages our widely used ClaimsXten primary claims editing solution and is designed to support Managed Medicaid and/or state Medicaid lines of businesses through the delivery of state specific policies using natural language processing and clinical expertise to better manage costs.

We have extensive experience maintaining edits for our millions of lives across the country from national Managed Medicaid payers and direct relationships with state Medicaid programs. Our experience includes keeping our clients up to date with ongoing changes in their state fee

schedules, manuals like those of BMS and the extensive CMS mandatory edits in NCCI and MUE editing, plus handling quarterly CMS updates. Our experience and background are why Change Healthcare provides claim editing services for more than 185 million lives.

This service offers three key components:

- **Content/Policy Development.** The foundation of the service is the state Medicaid content and policy development, based on a review of the state website to clearly define and understand published guidelines. Based on the review, Change Healthcare has identified and developed state guidelines that fall within the existing ClaimsXten editing functionality using our Content Framework. For the State of West Virginia, we reviewed numerous publications, including provider manuals, bulletins, etc., and we offer more than 200 West Virginia Medicaid-specific policies for consideration.

  The state Medicaid guidelines, embedded into the ClaimsXten workflow, indicate a denial when state-specific claims lack – or include an inappropriate – age, diagnosis code, modifier, gender, place-of-service (POS) code, or if the frequency limits are exceeded.

  The guidelines also indicate a denial of certain claims that exceed frequency limits. Frequency edits audit the providers as the guidelines dictate. Code combinations are also audited to deny a claim line when another procedure code is found. Furthermore, certain policies will deny a current claim line when another code is required in the member's claim history and is not present.

  The service also includes editing for combinations of the scenarios described above. Currently, when the conditions are true, the policy recommends denial of the claim.

  To ensure ongoing accuracy, the guidelines are monitored and maintained by Change Healthcare, including any state-issued updates to the default guideline/policy.

  We currently offer this service to 13 states, including West Virginia. In fact, one of your MCO partners recently went live with our ClaimsXten Medicaid Services Offering to enable them to process claims more consistently with BMS policies.

- **Consulting Services.** Reports and documentation outlining the editing release content are available for each state. The consulting services team, including a Medicaid state consultant, will review the reports and documentation to facilitate identification of medical policies that are necessary to support editing to be consistent with state policies.

- **Implementation.** Implementation services oversee the following:

  - Implementation of the guidelines to ensure customizations are implemented correctly
  - Acceptance and deployment of the default policies
  - User acceptance testing (UAT)

We are currently developing natural language processing capabilities to automate ongoing content development and data mine policies and regulations to reduce the development timeframe and increase the accuracy of our claim editing content.

Pre-Payment Medical Record Review

We offer a **Pre-Pay Insight and Record Review** solution which uses claim flagging techniques to pend claims that have been fully adjudicated, but not yet paid. It identifies those claims with a high likelihood that there will be inconsistencies between the claim and the underlying clinical records. We use artificial intelligence and machine learning to identify these claims on a pre-pay basis. To reduce false positives, those flagged claims are then further reviewed by trained Change Healthcare personnel to significantly reduce false positives and only request records when there is a high likelihood of uncovering inaccuracies. Our experience is that approximately 85% of the claims that are ultimately selected have findings once the medical records have been reviewed. Our current clients see **an average of about 1% savings** of all outpatient and professional claims yet records are typically only requested for .1% to .2% of the claims. The combination of the low claim selection rate coupled with the high likelihood of accurate identification of problematic claims reduces provider abrasion.

Additionally, our network size and commitment to drive adoption of electronic attachments positions us to deliver both solicited and unsolicited attachments on a large scale. Reducing provider friction, accelerating the provider's revenue cycle, and reducing paper attachments costs for your providers will provide value for a variety of use cases. For example, you could streamline management of supporting documents, speed claim adjudication, eliminate orphaned documents, reduce document-management costs, and improve provider satisfaction.

TPL/Coordination of Benefits

We have provided payer-to-payer eligibility solutions for more than 10 years to plans serving 5,000 to 5 million+ members. Our data lake contains **over 1.9 billion commercial eligibility records,** and we refresh over 1.2 billion of them monthly. These represent over **262 million covered lives**. FFS state Medicaid plans as well as MCOs depend on the quality of our COB information for medical, pharmacy, dental, and vision policies which is **over 99% accurate** due to our proprietary matching algorithm coupled with manual verification when required. We focus on cost avoidance through ongoing policy identification to prevent inappropriate claims payment in the first place, but we can also provide TPL recovery services if a claim has already been paid for which another payer is in fact responsible. Our TPL capabilities can operate in any pass position if BMS desires to stack TPL vendors.

Change Healthcare's payment accuracy summary experience and expertise

Claim editing solutions

We are recognized as the industry leader in the pre-pay claim editing market, with more than 100 health plans representing 185+ million covered lives. These health plans comprise 13 out of the 15 largest health plans in the U.S., numerous multi-state, and regional Blue Cross Blue Shield plans, as well as Managed Medicaid and Medicare Advantage organizations. Our claims editing tools are used to support 13 state Medicaid programs in addition to four large national multistate managed Medicaid organizations.

Pre-pay solutions

We have 43 active Pre-Pay Insight and Record Review customers located in 23 states, including three large multi-state Blue plans. Our clients include plans serving 25,000 to 5+ million members.

Post-pay solutions

Our Post-Payment Audit and Recovery services are provided to over 30 payer customers. We operate in major market segments, including nine BCBS plans covering 24 states, large national commercial payers, regional health plans, Medicaid and Medicare MCOs, third-party administrators.

In terms of tenure, many customers have used our services for more than 15 years and most for more than five years. We attribute this strong retention to our continued innovation in practices that are acceptable to providers and lead to maximum savings.

Data Mining

All our payment accuracy solutions and services integrate robust tools and processes to mine data effectively to support our services. Data mining is an integral part of our post payment audit and recovery service effectiveness. A variety of sophisticated data mining routines help us identify claims with the highest potential for reimbursement issues. This process is done without medical records review and truly little abrasion to the provider community. The data mining takes into account the state's specific policies. We are constantly reviewing and re-reviewing data to make ensure we maximize the data mining concepts for our clients.

A MARKET LEADER

As of 2020, our payment accuracy solutions were embedded in the workflow of 19 of the 20 largest U.S. commercial payers based on covered lives.

Our national market presence includes:

- 92% of top 25 health plans in the country license at least one of the solutions
- 23 clients who license at least two solutions
- Six clients who license at least three solutions

Health plans covering over 200 million members, including all the top ten U.S. health plans based on covered lives, used our payment accuracy products at the start of 2020.

Data mining is most often used in the post-pay phase. However, Change Healthcare is working to use information learned through data mining earlier in the claim payment continuum, moving editing concepts into a pre-payment position. Our data mining has been particularly effective in auditing for Specialty Rx. We have been providing this service for more than 25 years with a client base that includes many of the top plans in the country.

We are one of the nation's largest service providers for payers, particularly for payment integrity services. Overall, we provide data mining to nearly half of all the U.S. Blue plans, including large and small Blue plans nationwide.

Value Based Programs *(Question 4.2.39)*

Alternative-payment models have been proven to drive clinical transformation, resulting in improved care at a lower cost. Industry estimates indicate these models are achieving an average 5% in medical cost savings.[1] However, these programs can be challenging to implement at scale. Change Healthcare's value-based payment strategy is focused on improving the continuum of care. Our industry-leading analytic engines are the foundation for our value-based capabilities. Sophisticated analytics allow payers and providers to identify and evaluate payment models that deliver results—both retrospectively and prospectively.

Change Healthcare offers a comprehensive suite of solutions for value delivery in Medicaid programs.

To support your value-based payment program, we have a proven platform that offers episode-based analytics to optimize your organization's performance. We also offer solutions that can analyze the quality of care delivered by your provider networks and provide insights for cost optimization. These solutions can be used to fully automate an end-to-end episode-based payment process through a set of individual components to help clients develop, manage, and scale an efficient bundled payment program while reducing administrative burden and improving clinical outcomes. Notably, our clients have achieved:

- $250 million in retrospective shared savings payments
- 9% improvement on hip and knee costs
- 4% savings on pregnancy costs
- 7% reduction in inpatient hospitalization

Our collaborative processes along with the technology support value delivery in Medicaid programs.

- Understand how Medicaid dollars are spent with industry standard content and our extensive experience
- Member, provider, and network insights allow you to assess and compare, identify potentially avoidable complications, and implement new care delivery models
- Address Medicaid member needs with data and engagement by tracking total continuum of care, analyzing, and addressing social determinants, and targeting early member engagement for mother/baby programs
- Build components as needed for success by adopting solution components and programs as needed or as a whole

We work with clients at every stage their episode of care journey. A current client has 26 active episode programs, which include procedural, acute, and chronic bundles. Another client has seen ROI of approximately $145M using episodes to support their ACO programs. Other clients

[1] Internal Change Healthcare data representing all value-based payments customers for calendar year 2019.

are using our analytics to build their provider networks and phasing in episodes that target their goals.

For episode grouping, our solution offers PROMETHEUS Analytics®, which is designed to support payers in the transition to value-based payment models. PROMETHEUS episodes are designed to identify unwarranted variations of care across similar episodes that allow payers and providers to create unique analytic insights that help improve provider performance and provide consumers more value from their health care experience.

Health plans and payers use PROMETHEUS Analytics to optimize their provider networks. With our analytics, you can create unique analytic insights that help improve provider performance and deliver a better care experience to your members. PROMETHEUS Analytics is integrated into HealthQx®, our retrospective value-based program solution. As owner of the industry standard PROMETHEUS Analytics, Change Healthcare will support and enhance this standard methodology to support your PROMETHEUS episodes. We will be positioned to explore innovative ways to reduce cost, increase quality, and improve outcomes, driving the acceleration of value-based care in your commercial, Medicare, and Medicaid markets.

Value-based care solution components include our HealthQx and Episode Manager products described in Table 1.

Table 1: Change Healthcare offers value-based solution components for customers at any stage within the value-based care journey.

Module	Description
HealthQx® Episode Insights	Used to increase the speed of the delivery and flexibility of analytic intelligence, this module allows you to identify value-based opportunities across your provider network through an analysis of historic claims grouped into episodes. This analysis, in conjunction with consultative services, helps payers and providers to identify, design, and scale value-based opportunities, driving physician adoption and supporting ongoing growth and scale. Episode Insights delivers customized drill-down dashboards so the HealthQx team can partner with your team for program planning, as well as the comprehensive reporting for provider partner education.
HealthQx® Strategic Insights	Provides a targeted analysis, user interface and workflow to increase medical savings by presenting insights into physician behavior and the cost of care delivery within clinical episodes to support automating and scaling episode of care programs. We recommend that clients start out with Episode Insights and consider implementing Strategic Insights as part of a bundled payment program as future needs develop.
HealthQx® Budget and Reconciliation Module	To automate and monitor provider contract obligations at scale, we offer this module, allowing the HealthQx product team to prioritize provider contracting enhancements for Healthfirst. This module will increase your options for analytic exploration of your data in terms of modeling out provider financial relationships. The budget and reconciliation module is a key component of a robust value-based payment program, but it is possible to implement this in a later phase of your value-based care program if you begin to contract with providers for episodes of care.

HealthQx® Consulting services	To help you with program administration after implementation.
Episode Manager	For scaling a prospective payments program via Change Healthcare's ClaimsXten™ rules engine.

A solution that meets and exceeds your needs

Change Healthcare provides our customers with comprehensive tools to understand specific, clinically valid episode of care opportunities and the insights to help them focus their efforts on the key metrics that drive program success. Once implemented, we assist in the development of plans that identify and drive members to those preferred providers that deliver optimal care quality and lower costs.

Our value-based program solutions offer clients benefits, including:

Expertise. Change Healthcare was among the first certified partners for the PROMETHEUS methodology, and we have been highly successful in supporting our clients to use it. Our leadership position was further enhanced when we acquired PROMETHEUS Analytics in 2020. Our highly developed subject matter expertise has allowed us to make it simple to use. Our knowledge of how to apply the model exceeds others in the industry, proven by the fact that we run it for 70+million members; our clients have successfully contracted with thousands of physicians across the country to deliver value-based payments.

We have the greatest depth of understanding the bundled payments methodology; the way we help customers apply it and how we administer payments in the market is unparalleled.

Operationalize at scale. Change Healthcare is the only vendor who can operationalize episode of care programs at scale for clients who are ready. This requires specialized, innovative technology that enables the standardization of episode definitions coupled with subject matter expertise that enables flexible provider contracting. We adapt to the unique operating environments of national payers. We have multiple clients with provider contracts in place for a multitude of episode types.

Flexible and customer-focused service delivery. Unlike other vendors, the PROMETHEUS episode methodology also supports analysis of care variation and clinical transformation opportunities, identifying high performing providers, PCPs, and specialist overlays for medical neighborhood analysis. Clients have told us that HealthQx data results offer some of the most comprehensive views of the continuity of care within their systems. This is the kind of value we deliver. HealthQx episode of care data is leveraged in derivative initiatives that measure provider network performance.

Transparency. Change Healthcare built our PROMETHEUS engine from the ground up, which allows us a great degree of control of it. As such, we stay updated on industry coding changes more rapidly than our competitors, and we leverage existing clinical coding expertise within Change Healthcare. As the owner of the PROMETHEUS methodology, we standardize episodes of care to better understand complex care patterns, cost, and quality.

Operations Management

PCS Advanced Claim Management and Attachments

Payer Connectivity Services is a claim administration, routing, and first-pass adjudication system for payers that want to consolidate and manage their inbound and outbound transaction streams at a single connection point.

The service is designed to enable high-quality, effective transaction management and provides:

A single transaction workflow solution

- Providing a single connection point for transactions, helping enable industry standard and payer-specific business rules and compliance with legislative mandates.
- Simplifying the claims administration process, consolidating submitters, and reducing administrative complexity so it is easier for providers and payers to work together.
- Improving claims routing accuracy and reduces claim rework. With the ability to route transaction data to the appropriate processing path, you can simplify transactional workflows - even one with multiple claims systems and lines of business.

Advanced claims edits and routing

- Applying advanced claims edits and presents edit errors directly to submitters to catch errors up-front in processing so claims can be made cleaner before routing for processing.
- Simplifying compliance with federal regulations, HIPAA, and CORE Phase I, II and III for ACA Operating Rules.
- Reducing administrative waste stemming from low first-pass rates and claim rework due to incorrect routing across multiple adjudication systems.

Settlement Advocate

Our provider payment solution, Settlement Advocate, handles routing of payments via Change Healthcare's Intelligent Healthcare Network according to providers' preferred payment method. We leverage a collaborative approach to help you minimize payment distribution costs by offering providers multiple options to maximize electronic payments. We provide consolidated payments and reconciliation across all payment types and funding sources. The solution includes access to an ever-growing network of providers accepting electronic payments.

Settlement Advocate consolidates drawdown, reconciliation, and IRS 1099 processes for all payment types while driving electronic payment adoption. It enables you to submit a single payment file to a turnkey system that handles all payment fulfillment activities, eliminating worries over downstream processes. It handles routing of payments through a large provider network using each provider's preferred payment method, streamlining the reconciliation process across all funding sources. Settlement Advocate offers:

Why Change Healthcare?

- **We take a collaborative, strategic approach**
- **Our customers have access to an ever-growing network of providers accepting electronic payments**
- **We are a leader in payment solutions with:**
  - **26.6 million electronic payments processed annually representing over $50 billion in payment value**
  - **More than 1,000,000 providers accessible on network**
  - **2.5 billion images fulfilled annually representing over $100 billion in payment value**

- **Multiple Payment Types.** Change Healthcare provides a breadth of payment types including EFT, Virtual Card (VC), Closed Network Automated Clearing House (ACH) and paper check. Each provider chooses the payment type that best suits their business processes and improves their satisfaction and goodwill will with the payer.
- **Payment Preference Management.** Change Healthcare manages the payment preferences for all providers receiving payments from the Settlement Advocate solution. Providers can change the payment preference or request support at any time by calling our Change Healthcare managed call center.
- **Consolidated ACH Drawdown.** Change Healthcare conducts one daily ACH drawdown for all payment types which reduces banking fees and simplifies the reconciliation process thus improving operational efficiency.
- **Online Payer Portal.** Change Healthcare provides clients with an online payer portal providing online access to disposition of all payments. You can also void, change and re-issues payments providing efficient self-service improving operational performance.
- **Automated 1099 Reporting.** Since the Settlement Advocate solution handles all payment types, Change Healthcare can create and report 1099's to the IRS. This will allow the State to improve compliance, re-allocate operational staff and realize significant cost savings.

Beyond the financial benefits related to virtual card payments, the Settlement Advocate solution also drives ACH adoption, where we have seen as much as a 40% uptick in ACH TIN enrollment as providers fine tune their payment preferences away from paper payments, a client case study on Group Management Services, clearly shows the value and success that you can attain through the Settlement Advocate solution.

Change Healthcare offers experience and expertise in provider payment services

As one of the largest health IT companies in the industry, no other company provides greater real-time connectivity to payers, patients, and providers to transform your path to payment and journey to value-based care.

Change Healthcare's modern and scalable solutions and growing network connect over 2,400 commercial and government payers to 6,000 hospitals including 1,000,000 clinicians. Last year, we processed 15 billion financial transactions valued at more than $1.5 trillion.

Change Healthcare Consulting

Change Healthcare Consulting has led over a hundred digital transformation projects and we have helped many health care organizations launch new service lines (Medicaid, Medicare, DSNP, ACA, and commercial). We use a nimble yet disciplined approach that engages executive management, staff, and key stakeholders to work together to achieve mutual success. Using our iterative Project Management Institute (PMI)-based framework, we lead and motivate our project teams, proactively manage activities, ensure the timely completion of deliverables, and rapidly mitigate risk and issues.

Change Healthcare Consulting focuses on integrating business processes, people, culture, and technology to optimize effectiveness, improve performance, increase scalability, and simplify infrastructure and operations. We apply proven methodologies and best practices to help our clients realize measurable performance improvements and the greatest return on their investments. This approach has provided our clients with a highly structured and dependable foundation from which their strategic plans can be executed.

Ranked by KLAS as the #1 Payer Consultancy for two of the last three years based on its client surveys, Change Healthcare Consulting provides reality-based consulting services that help health care organizations innovate, solve problems, and optimize business performance. Our consultants have extensive healthcare experience, with an average of more than 15 years in the industry. We have current and relevant experience in all product lines (HMO, PPO, EPO, ASO, etc.), as well as all lines of business (large group, small group, individual (on and off exchange), Medicaid, Medicare, DSNP, and employee retirement programs).

Our consultants have deep domain knowledge in healthcare operations and technology. They have worked with large to mid-size healthcare payers, and they have expertise in all aspects of payer administration including claims, enrollment, clinical operations, quality management, compliance, member acquisition and growth, customer service, provider maintenance, and system administration. We offer a wide range of services in seven distinct focus areas, described below and shown in Figure 2:

- **Government Programs:** Leading efforts to enter new markets, ensuring compliance and optimize performance for Medicaid, Medicare, and ACA lines of business.
- **Population Health:** Working with clients to develop and deploy care models and care coordination that ensure the highest quality outcomes.

Figure 2: Change Healthcare Consulting offers seven distinct focus areas.

- **Value-based Healthcare:** Partnering with payers and providers to develop a roadmap that moves from volume to value.
- **Healthcare Consumerism:** Putting the consumer first by developing products that are designed specific for the population served, creating multi-channel engagement programs, and enhancing the overall customer experience.
- **Analytics & Insights:** Working with clients to develop data strategy and governance programs that turn data into actionable insights and tangible results.
- **Process & System Modernization:** Helping clients optimize their business through re-engineered workflows and strategic use of technology.
- **IT Risk Management:** Providing privacy, security, and compliance reviews to help you increase your enterprise resiliency leveraging SOC2, HITRUST, and FedRAMP frameworks.

Change Healthcare Consulting is focused on helping our clients drive innovative transformation. We do this by working collaboratively with our clients, rolling up our sleeves, and doing the challenging work required to facilitate change. Our engagements range from complex, multi-year projects, to concise, efficient remediations. Our services include:

- Strategic planning and road mapping
- Regulatory compliance and guidance
- Product development and market entry
- Enrollment and benefit design
- Provider network contracting and development
- Delegation oversight
- Clinical care model design
- Enterprise system modernization
- Business process optimization
- Program planning and execution
- Security and organizational resiliency
- Interim staffing

As a leader in the healthcare industry, we are committed to supporting market evolution that improves efficiency, drives transparency, and increases quality of care. With increasing cost pressures, consumer empowerment, technical innovations, and legislative reform at both the state and national level, the role of all players on the health delivery eco-system is evolving quickly. Change Healthcare Consulting is at the forefront of this industry-wide transformation, working with clients across the country to improve lives and well-being.

Change Healthcare's return on investment for consulting services

Please click on the link below to read a Change Healthcare Consulting case study and learn more about the value we bring to our clients.

https://info.changehealthcare.com/consulting-services/driscoll-health-plan-case-study

Conclusion

Change Healthcare knows the West Virginia market through our collaborations with key stakeholders and through our various solutions that are used by commercial health plans representing nearly one million covered lives in West Virginia. We have innovative healthcare solutions to meet several of your identified Medicaid Information Technology Architecture (MITA) capability goals. Our solutions are designed to be implemented and integrated with those provided by other vendors, allowing BMS significant flexibility to pick and choose those that best meet your needs. We welcome the opportunity to expand our relationship with BMS and work with your fiscal agent to deliver measurable value before, after, and between care episodes, as well as at the point of care.

We look forward to participating in the next steps in your process to identify and assess vendors and solutions to meet your objectives for modernizing and advancing the BMS Medicaid Enterprise System.

Request for Information
CRFI BMS2200000001
Medicaid Enterprise System (MES)

By signing below, I certify that I have reviewed this Request for Information in its entirety; understand the requirements, terms and conditions, and other information contained herein; that I am submitting this response for review and consideration on behalf of my organization.

Change Healthcare

(Company)

Pete Titas, Vice President

(Representative Name, Title)

phone 216-402-5295; no fax number

(Contact Phone/Fax Number)

January 7, 2022

(Date)

	Department of Administration Purchasing Division 2019 Washington Street East Post Office Box 50130 Charleston, WV 25305-0130	**State of West Virginia** **Centralized Request for Information** **Info Technology**

Proc Folder: 964162 **Doc Description:** REQUEST FOR INFORMATION-MEDICAID ENTERPRISE SYSTEM (MES) **Proc Type:** Request for Information			**Reason for Modification:** ADDENDUM 1 TO PROVIDE ANSWERS TO VENDOR QUESTIONS
Date Issued	**Solicitation Closes**	**Solicitation No**	**Version**
2021-12-13	2022-01-07 13:30	CRFI 0511 BMS2200000001	2

BID RECEIVING LOCATION

BID CLERK
DEPARTMENT OF ADMINISTRATION
PURCHASING DIVISION
2019 WASHINGTON ST E
CHARLESTON WV 25305
US

VENDOR

Vendor Customer Code:

Vendor Name :

Address :

Street :

City :

State : **Country :** **Zip :**

Principal Contact :

Vendor Contact Phone: **Extension:**

FOR INFORMATION CONTACT THE BUYER
Crystal G Hustead
(304) 558-2402
crystal.g.hustead@wv.gov

Vendor Signature X **FEIN#** **DATE**

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

ADDITIONAL INFORMATION

REQUEST FOR INFORMATION:

THE WEST VIRGINIA PURCHASING DIVISION IS ISSUING THIS REQUEST FOR INFORMATION FOR THE AGENCY, WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES (DHHR), BUREAU FOR MEDICAL SERVICES (BMS), FOR THE PURPOSE OF GATHERING INFORMATION TO DEVELOP SPECIFICATIONS FOR A MEDICAID ENTERPRISE SYSTEM (MES) MODERNIZATION. INFORMATION PROVIDED WILL ASSIST THE WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES IN DEVELOPING SPECIFICATIONS AND WILL ASSIST IN THE PROCUREMENT PROCESS.

QUESTIONS REGARDING THE SOLICITATION MUST BE SUBMITTED IN WRITING TO CRYSTAL.G.HUSTEAD@WV.GOV PRIOR TO THE QUESTION PERIOD DEADLINE CONTAINED IN THE INSTRUCTIONS TO VENDORS SUBMITTING BIDS

ONLINE RESPONSES FOR THIS SOLICITATION ARE PROHIBITED

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
1	Medicaid Enterprise System (MES) Modular				

Comm Code	Manufacturer	Specification	Model #
93151507			

Extended Description:
Medicaid Enterprise System (MES) Modular

SCHEDULE OF EVENTS

Line	Event	Event Date
1	VENDOR QUESTION DEADLINE	2021-12-06

SOLICITATION NUMBER: CRFI BMS2200000001
Addendum Number: 1

The purpose of this addendum is to modify the solicitation identified as ("Solicitation") to reflect the change(s) identified and described below.

Applicable Addendum Category:

[ ] Modify bid opening date and time

[ ] Modify specifications of product or service being sought

[✓] Attachment of vendor questions and responses

[ ] Attachment of pre-bid sign-in sheet

[ ] Correction of error

[ ] Other

Description of Modification to Solicitation:

1. To provide answers to vendor questions

No other changes

Vendor responses to the Request for Information remains 01/07/2022 at 1:30 PM ET

Additional Documentation: Documentation related to this Addendum (if any) has been included herewith as Attachment A and is specifically incorporated herein by reference.

Terms and Conditions:

1. All provisions of the Solicitation and other addenda not modified herein shall remain in full force and effect.

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ATTACHMENT A

Vendor Question ID	RFI Section	Page Number	Vendor Question	State Response
Q001	General	N/A	Will the State please provide estimated timing for new MMIS modernization RFPs.	The State is using this Request for Information (RFI) to help inform future, potential modular procurements and implementations. The State makes no guarantees that an RFP will be issued as a result of this RFI. However, tentative estimates for a potential RFP currently are winter of 2022.
Q002	General	N/A	Will DHHR please provide a link to the current Gainwell contract.	Requesting copies of previously awarded contracts, other solicitations, or documents related to previous contracts through the question and answer process included in this solicitation is not appropriate. Requests for documentation of this nature can be obtained by interested parties through a Freedom of Information Act request
Q003	General	N/A	Is there flexibility in the Gainwell contract to reduce Gainwell scope as the State implements new MMIS functionality.	The State will consider solutions that support the seamless implementation of modules for the State's modernized Medicaid Enterprise.
Q004	Q 4.2.3	5	In order to support recommendations for how to best proceed with developing a future state MES modernization roadmap, would the State share a view of the current state of your Medicaid Enterprise services and systems?	The State's current Medicaid Enterprise is evolving. At present, business functional areas include: member management, care management, provider management, financial management, program integrity, performance/quality management, and plan management.

Q005	General	N/A	Is it the Department's ultimate intent to send out multiple RFPs for functionality that is now under an enterprise model, such as management of claims, TPL, care, provider performance, and compliance?	The State is using this RFI to help inform future, potential modular procurements and implementations.
Q006	General	N/A	Does BMS currently receive clinical and quality data from HIE(s) or other provider clinical sources?	Yes, The Bureau for Medical Services (BMS) currently receives clinical and quality data from various entities including, but not limited to, Health Information Exchanges (HIEs) and other provider data sources.
Q007	General	N/A	Are there any services currently performed by the MCOs (COB, TPL, etc.) that BMS would like to incorporate into a module?	The State currently does not anticipate any Managed Care Organization (MCO) duties being altered or amended.
Q008	General	N/A	Are there any functions currently performed by a different agency or department within the State of West Virginia that might be incorporated into a module?	The State currently does not anticipate any duties of other agencies being altered or amended.
Q009	General	N/A	How does this RFI and subsequent RFPs effect the relationship and functionality with the U.S. Virgin Islands?	The State is using this RFI to help inform future, potential modular procurements and implementation timelines, as well as potential opportunities with US territories and states.
Q010	General	N/A	If a vendor is selected as the system integrator, would that vendor be precluded from bidding on integrated modules?	The State is utilizing the RFI process to gain insight into best practices in modular Medicaid Enterprise development. The State's goal is to encourage competition and innovation among bidders. The State has not made a determination regarding this question at this time.

Q011	General	N/A	Does the state consider Data Governance part of the system integrator responsibility?	Data Governance is a key initiative of the State. The State is looking for insight into Data Governance standards and practices within responses to this RFI.
Q012	4.2.31	8	Question 4.2.3.1 of the RFI asks about the System Development Lifecycle and only refers to "waterfall" and "agile." Does the state support the deployment of a SaaS solution?	The State is looking for insight and recommendations regarding System Development Life Cycle (SDLC) approaches such as waterfall and agile, and would be interested in information related to other methodologies, including Software as a Service (SaaS) solutions.
Q013	General	N/A	Is BMS considering a care management platform?	The State is using this RFI to help inform future, potential modular procurements and implementations. The State has not determined which modules will be procured at this time.
Q014	1.1	1	In Section 1.1 of the RFI, the State indicates an intent to focus on reuse with other states and multi-state planning. Is the model you are referring to as NASPO, 2390-F, the current arrangement that you have with the U.S. Virgin Islands, or something else?	The State is using this RFI to help inform future, potential modular procurements and implementation timelines, as well as potential opportunities with US territories and states. The State would welcome information on specific experience with National Association of State Procurement Officials (NASPO) 2390-F.
Q015	General	N/A	Is it the State's intent to merge claims and clinical data into a singular uniform repository?	The State is utilizing the RFI process to gain insight into best practices and welcomes any information on merging claims and clinical data into a singular uniform repository.

Q016	General	N/A	Will Interoperability for Member and Provider (not Interoperability of Systems and Systems Functionality) be part of the anticipated RFP or will that be a separate and distinct function?	The State is using this RFI to help inform future, potential modular procurements and implementations. The State would welcome information on interoperability across different functional areas.
Q017	General	N/A	When do you anticipate releasing the RFP or RFPs for the Modular MES?	The State makes no guarantees that an RFP will be issued as a result of this RFI. However, tentative estimates for a potential RFP currently are winter of 2022.
Q018	General	N/A	Is it anticipated that there will be a Systems Integrator overseeing the Modular MES?	The State is using this RFI to help inform future, potential modular procurements and implementations. The State has not determined whether a Systems Integrator will be procured at this time.
Q019	4.2.43	10	Does the state anticipate moving toward a Value-based Administration Model (Pay for Performance), and if so, when?	The State has not determined payment model(s) for anticipated procurements at this time. The State is looking for insight and recommendations regarding payment models within responses to this RFI. Please refer to RFI Section 4.2.43 to provide additional insight to the State.
Q020	General	N/A	Does the state anticipate developing a model that will hold MCOs accountable for their performance and outcomes?	The State is using this RFI to help inform future, potential modular procurements and implementations that support the State's Mountain Health Trust and Mountain Health Promise managed care programs.

ADDENDUM ACKNOWLEDGEMENT FORM
SOLICITATION NO.: BMS2200000001

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

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

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

Change Healthcare
Company

Authorized Signature

1/7/2022
Date

NOTE: This addendum acknowledgement should be submitted with the bid to expedite document processing.
Revised 6/8/2012

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

State of West Virginia
Centralized Request for Information
Info Technology

Proc Folder: 964162			**Reason for Modification:**
Doc Description: REQUEST FOR INFORMATION-MEDICAID ENTERPRISE SYSTEM (MES)			ADDENDUM 2 TO CORRECT METHODS OF RESPONDING AND EXTEND THE OPENING DATE
Proc Type: Request for Information			
Date Issued	**Solicitation Closes**	**Solicitation No**	**Version**
2022-01-05	2022-01-11 13:30	CRFI 0511 BMS2200000001	3

BID RECEIVING LOCATION

BID CLERK
DEPARTMENT OF ADMINISTRATION
PURCHASING DIVISION
2019 WASHINGTON ST E
CHARLESTON WV 25305
US

VENDOR

Vendor Customer Code:

Vendor Name :

Address :

Street :

City :

State : **Country :** **Zip :**

Principal Contact :

Vendor Contact Phone: **Extension:**

FOR INFORMATION CONTACT THE BUYER
Crystal G Hustead
(304) 558-2402
crystal.g.hustead@wv.gov

Vendor Signature X **FEIN#** **DATE**

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

ADDITIONAL INFORMATION

REQUEST FOR INFORMATION:

THE WEST VIRGINIA PURCHASING DIVISION IS ISSUING THIS REQUEST FOR INFORMATION FOR THE AGENCY, WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES (DHHR), BUREAU FOR MEDICAL SERVICES (BMS), FOR THE PURPOSE OF GATHERING INFORMATION TO DEVELOP SPECIFICATIONS FOR A MEDICAID ENTERPRISE SYSTEM (MES) MODERNIZATION. INFORMATION PROVIDED WILL ASSIST THE WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES IN DEVELOPING SPECIFICATIONS AND WILL ASSIST IN THE PROCUREMENT PROCESS.

QUESTIONS REGARDING THE SOLICITATION MUST BE SUBMITTED IN WRITING TO CRYSTAL.G.HUSTEAD@WV.GOV PRIOR TO THE QUESTION PERIOD DEADLINE CONTAINED IN THE INSTRUCTIONS TO VENDORS SUBMITTING BIDS

ONLINE RESPONSES FOR THIS SOLICITATION ARE PROHIBITED

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
1	Medicaid Enterprise System (MES) Modular				

Comm Code	Manufacturer	Specification	Model #
93151507			

Extended Description:
Medicaid Enterprise System (MES) Modular

SCHEDULE OF EVENTS

Line	Event	Event Date
1	VENDOR QUESTION DEADLINE	2021-12-06

SOLICITATION NUMBER: CRFI BMS2200000001
Addendum Number: 2

The purpose of this addendum is to modify the solicitation identified as ("Solicitation") to reflect the change(s) identified and described below.

Applicable Addendum Category:

[✓] Modify bid opening date and time

[ ] Modify specifications of product or service being sought

[ ] Attachment of vendor questions and responses

[ ] Attachment of pre-bid sign-in sheet

[✓] Correction of error

[ ] Other

Description of Modification to Solicitation:

1. To correct section 5.2.7 Response Submission, emailed submission was included by mistake. Responses should be submitted by fax, mail, or drop off in person.

2. To extend the response date to January 11, 2022 at 1:30 PM ET

No other changes

Additional Documentation: Documentation related to this Addendum (if any) has been included herewith as Attachment A and is specifically incorporated herein by reference.

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ATTACHMENT A

To modifiy section **5.2.7 Response Submission**

Methods for responding are as follows:

*Fax to 304-558-3970

*Mail or drop off in person to :

2019 Washing Street East

Charleston, WV 25305

Emailed responses are not acceptable

ADDENDUM ACKNOWLEDGEMENT FORM
SOLICITATION NO.: BMS2200000001

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Change Healthcare
Company

Authorized Signature

1/7/2022
Date

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Revised 6/8/2012

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

State of West Virginia
Centralized Request for Information
Info Technology

Proc Folder: 964162			**Reason for Modification:**
Doc Description: REQUEST FOR INFORMATION-MEDICAID ENTERPRISE SYSTEM (MES)			ADDENDUM 3 TO CORRECT MAILING ADDRESS TO WASHINGTON STREET
Proc Type: Request for Information			
Date Issued	**Solicitation Closes**	**Solicitation No**	**Version**
2022-01-05	2022-01-11 13:30	CRFI 0511 BMS2200000001	4

BID RECEIVING LOCATION

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PURCHASING DIVISION
2019 WASHINGTON ST E
CHARLESTON WV 25305
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VENDOR

Vendor Customer Code:

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Principal Contact :

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crystal.g.hustead@wv.gov

Vendor Signature X **FEIN#** **DATE**

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Extended Description:
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SCHEDULE OF EVENTS

Line	Event	Event Date
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SOLICITATION NUMBER: CRFI BMS2200000001
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[ ] Attachment of vendor questions and responses

[ ] Attachment of pre-bid sign-in sheet

[✓] Correction of error

[ ] Other

Description of Modification to Solicitation:

1. To correct mailing address for responses to:
2019 Washington Street East
Charleston, WV 25305

No other changes

Additional Documentation: Documentation related to this Addendum (if any) has been included herewith as Attachment A and is specifically incorporated herein by reference.

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ATTACHMENT A

To correct the mailing address to

*Mail or drop off in person at:

2019 Washington Street East

Charleston, WV 25305

Emailed responses are not acceptable

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