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**SOVEREIGN STATES DRUG CONSORTIUM:**

**IOWA  
MAINE  
OREGON  
UTAH  
VERMONT  
WEST VIRGINIA  
WYOMING**

Response to Request for Proposal (RFP) # VT0341011001:  
Services to Procure Medicaid Supplemental Drug Rebates and  
Other Medicaid Pharmacy Benefit Rebates

**PROGRAMMATIC/TECHNICAL PROPOSAL  
COPY**



**Sovereign  
States  
Drug  
Consortium**



*Small Company. Big Results.  
Quality Partnerships.*

**Goold Health Systems**  
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PO Box 1090  
Augusta Maine, 04332-1090

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Submitted on January 31, 2011  
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This proposal has been formatted for double-sided printing.

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## II. TRANSMITTAL LETTER

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January 28, 2010

Kate Jones, Contracts Administrator  
Department of Vermont Health Access  
312 Hurricane Lane, Suite 201  
Williston, Vermont 05495

Dear Ms. Jones:

On behalf of Goold Health Systems (GHS), I am pleased to present the Sovereign States Drug Consortium (SSDC) and your office, specifically, with our response to the Request for Proposals (RFP) # VT0341011001 for Services to Procure Medicaid Supplemental Drug Rebates and Other Medicaid Pharmacy Benefit Rebates.

GHS is a privately-held company with 36 years of experience in healthcare management, primarily focused on State Medicaid pharmacy issues. We are the incumbent vendor to the SSDC and have performed these services for the last four (4) years. It is our objective to continue providing the SSDC with leading-edge technology and professional support services that will provide Member States the means by which they can effectively control pharmaceutical costs for their State's Medicaid program.

As Chief Executive Officer of GHS, I am authorized to negotiate on behalf of GHS and shall be responsible for the overall management of any potential contract. As an officer of this company, my signature has the authority to bind any contract that may result from negotiations. I will also serve as the primary point of contact for all RFP-related communications between State staff and GHS.

I certify that I am the GHS representative responsible for the prices contained in the proposal and I certify that the price was arrived at without any conflict of interest. I have read and accept the RFP and contract terms found in the Appendices. I agree to a retainage of ten percent (10%) of the total contract amount.

Our approach is built upon a transparent business model, rather than a proprietary business model, recognizing the importance of State autonomy, clarity and quality decision-making. We take great pride in working collaboratively with the Member States and look forward to continuing our relationship as the best possible partner for the SSDC.

We thank you for your time and consideration of our proposed services. We look forward to answering any questions you might have and providing any other information you might request.

Sincerely,

James A. Clair  
Chief Executive Officer

**A. Bidder Information Sheet**

<b>Goold Health Systems Bidder Information Sheet</b>	
<i>Name of company or individual</i>	<i>Goold Health Systems</i>
<i>Mailing address</i>	<i>P.O. Box 1090 Augusta, ME 04332-1090</i>
<i>Street address (for FedEx or other mail delivery service)</i>	<i>45 Commerce Drive, Suite 5 Augusta, ME 04330</i>
<i>Company Federal ID Number</i>	<i>01-0475134</i>
<i>Name and title of the company contact person / authorized signatory</i>	<i>James A. Clair, Chief Executive Officer</i>
<b>Contact Sheet: Key Personnel Named in the Proposal</b>	
<i>Contact Name</i> <ul style="list-style-type: none"> <li>• <i>Direct Telephone Number</i></li> <li>• <i>Fax Number</i></li> <li>• <i>Email Address</i></li> </ul>	<i>Jim Clair, CEO</i> <ul style="list-style-type: none"> <li>• <i>800-832-9672 x1127</i></li> <li>• <i>207-623-5125</i></li> <li>• <i>jclair@ghsinc.com</i></li> </ul>
<i>Contact Name</i> <ul style="list-style-type: none"> <li>• <i>Direct Telephone Number</i></li> <li>• <i>Fax Number</i></li> <li>• <i>Email Address</i></li> </ul>	<i>Tim Clifford, MD, Lead Negotiator</i> <ul style="list-style-type: none"> <li>• <i>800-832-9672 x1126</i></li> <li>• <i>207-623-5125</i></li> <li>• <i>tclifford@ghsinc.com</i></li> </ul>
<i>Contact Name</i> <ul style="list-style-type: none"> <li>• <i>Direct Telephone Number</i></li> <li>• <i>Fax Number</i></li> <li>• <i>Email Address</i></li> </ul>	<i>Laureen Biczak, DO, Associate Medical Director</i> <ul style="list-style-type: none"> <li>• <i>800-832-9672 x1143</i></li> <li>• <i>207-623-5125</i></li> <li>• <i>lbiczak@ghsinc.com</i></li> </ul>
<i>Contact Name</i> <ul style="list-style-type: none"> <li>• <i>Direct Telephone Number</i></li> <li>• <i>Fax Number</i></li> <li>• <i>Email Address</i></li> </ul>	<i>John Grotton, R.Ph., Executive Vice President</i> <ul style="list-style-type: none"> <li>• <i>800-832-9672 x1125</i></li> <li>• <i>207-623-5125</i></li> <li>• <i>jpgrotton@ghsinc.com</i></li> </ul>
<i>Contact Name</i> <ul style="list-style-type: none"> <li>• <i>Direct Telephone Number</i></li> <li>• <i>Fax Number</i></li> <li>• <i>Email Address</i></li> </ul>	<i>Roger Boissonneau, Project Manager</i> <ul style="list-style-type: none"> <li>• <i>800-832-9672 x 1102</i></li> <li>• <i>207-623-5125</i></li> <li>• <i>rboissoneau@ghsinc.com</i></li> </ul>
<i>Contact Name</i> <ul style="list-style-type: none"> <li>• <i>Direct Telephone Number</i></li> <li>• <i>Fax Number</i></li> <li>• <i>Email Address</i></li> </ul>	<i>Rossi Rowe, Manager of Rebate Services</i> <ul style="list-style-type: none"> <li>• <i>800-832-9672 x1369</i></li> <li>• <i>207-623-5125</i></li> <li>• <i>rrowe@ghsinc.com</i></li> </ul>

<b>Contact Sheet: Key Personnel Named in the Proposal, continued</b>	
<p><i>Contact Name</i></p> <ul style="list-style-type: none"> <li>• <i>Direct Telephone Number</i></li> <li>• <i>Fax Number</i></li> <li>• <i>Email Address</i></li> </ul>	<p><i>Jason Rushing, Data Analyst Team Lead</i></p> <ul style="list-style-type: none"> <li>• 800-832-9672 x1307</li> <li>• 207-623-5125</li> <li>• jrushing@ghsinc.com</li> </ul>
<p><i>Contact Name</i></p> <ul style="list-style-type: none"> <li>• <i>Direct Telephone Number</i></li> <li>• <i>Fax Number</i></li> <li>• <i>Email Address</i></li> </ul>	<p><i>Dr. Alex Atayev, Senior Clinical Analyst</i></p> <ul style="list-style-type: none"> <li>• 207-318-2871</li> <li>• 207-623-5125</li> <li>• aatayev@ghsinc.com</li> </ul>
<p><i>Contact Name</i></p> <ul style="list-style-type: none"> <li>• <i>Direct Telephone Number</i></li> <li>• <i>Fax Number</i></li> <li>• <i>Email Address</i></li> </ul>	<p><i>Sally Griffith-Onnen, Senior Rebate Specialist</i></p> <ul style="list-style-type: none"> <li>• 617-879-0219</li> <li>• 877-853-8533</li> <li>• sgriffithonnen@ghsinc.com</li> </ul>
<p><i>Contact Name</i></p> <ul style="list-style-type: none"> <li>• <i>Direct Telephone Number</i></li> <li>• <i>Fax Number</i></li> <li>• <i>Email Address</i></li> </ul>	<p><i>Shelley-Lynn Kelley, Senior Rebate Specialist</i></p> <ul style="list-style-type: none"> <li>• 800-832-9672 x1160</li> <li>• 207-623-5125</li> <li>• skelley@ghsinc.com</li> </ul>
<p><i>Contact Name</i></p> <ul style="list-style-type: none"> <li>• <i>Direct Telephone Number</i></li> <li>• <i>Fax Number</i></li> <li>• <i>Email Address</i></li> </ul>	<p><i>Shari Martin, Senior Rebate Specialist</i></p> <ul style="list-style-type: none"> <li>• 800-832-9672 x 1375</li> <li>• 207-623-5125</li> <li>• smartin@ghsinc.com</li> </ul>

### **III. BUSINESS ORGANIZATION**

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*State the full name and address of the Bidder/Bidder organization and, if applicable, the branch office or other subordinate element that will perform, or assist in performing, the work described in the bid.*

Work will be performed by Goold Health Systems from the corporate headquarters in Augusta, Maine.

*Indicate whether the Bidder operates as an individual, partnership, or corporation; if as a corporation, include the state in which it is incorporated.*

Goold Health Systems (GHS) is an independent, privately-owned corporation incorporated in the State of Maine.

*If appropriate, state whether it is licensed to operate in the SSSDC states or agrees to be licensed in the event the Bidder is selected as the prevailing Bidder.*

GHS is presently licensed to do business in the States of Iowa, Maine, Vermont, West Virginia and Wyoming. We are in the process of obtaining licenses in the States of Oregon and Utah should that be a requirement for this contract. GHS agrees to obtain licenses in any additional states as may be required in the future.

*List all subcontractors: include firm name and address, contact person, and complete description of work to be subcontracted. Include descriptive information concerning subcontractor's organization, abilities, and commitment to the contract period.*

GHS is not proposing the use of any subcontractors in the performance of work contained in this proposal.

*Provide annual audited financial reports for the past three (3) years for the Bidder and any subcontractor.*

GHS is in sound financial condition and has the financial resources necessary to carry out the contractual obligations associated with this RFP. Copies of our audited financial statements for the most recent three years begin on the following page of this proposal.

Identify all owners and subsidiaries that own more than five (5) percent of the organization.

<b>Owner</b>	<b>Board Position</b>	<b>Percentage of Ownership</b>
Victoria Waldron Mulkern	President/Treasurer	50%
William G. Waldron, Jr.,	Chairman of the Board	50%

If the Bidder is an affiliate of another organization, submit the financial information for the parent company and describe the relationship.

GHS is an independent corporation. Our financial information begins on the next page of this proposal.

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## IV. LOCATION

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*Indicate the site or sites from which the Bidder will perform the relevant tasks embodied in this proposal. While it is not required, it is possible that the Contractor may wish to change the site(s) for some of these tasks during the contact term. Please describe the Bidder time line in this regard if applicable. Specifically identify where activities will take place.*

The vast majority of the tasks described in this proposal will be performed at GHS' headquarters located in Augusta, ME. SSDC members have complete access to the personnel working at this facility. The Augusta office is GHS' headquarters and serves as the base for the management, clinical, technical and administrative staff members who support the services and technology provided to the SSDC. The one exception for the location of services is the SSDC "annual meeting," where GHS will continue to support functions at the meeting at the location of the Member States' choosing

GHS' staff of clinicians, project managers, rebate specialists and rebate analysts in Augusta supports supplemental rebate solicitation, negotiations, all general, administrative functions and report production and distribution activities associated with the SSDC contract.

GHS houses all system components and communications in our state-of-the art data center on-site in Augusta, Maine. The dedicated technical staff who work in support of the SSDC project, its associated applications and data requirements are located on-site to ensure on-going support. Our data center is comprised of current technology. The Augusta location allows the flexibility for future expansions if needed to meet the growing storage and performance demands over the expected life of this project.

The clinical staff that leads the negotiations and supports SSDC presentations, reporting and analytics are also located in the Augusta facility. The majority of our clinical staff is co-located within this office and is available to provide support and consultation as needed. Executive and program leadership staff, including the SSDC Project Manager and the Executive Vice President of Pharmacy, is located in Augusta. They provide executive and day-to-day oversight, respectively, for the SSDC program.

GHS does not anticipate changing the location for any of these tasks during the contract term. Should this change over the course of the contract, GHS will provide the SSDC Member States with timely notice of the change, as well as a detailed timeline and an analysis of any potential impact to the project.

## V. AFFILIATIONS

The State of Vermont requires that any Contractor shall report to the State all affiliations that may affect the performance of its duties under its contract. This report shall occur as the Contractor enters into any such affiliation during any portion of the term of the Contract. In addition, Title 33 V.S.A § 2001 requires in connection with Vermont's pharmacy best practices and cost containment program, that DVHA shall not enter into a contract with a Contractor where the Contractor has entered into an agreement or engaged in a practice described here unless the Commissioner of DVHA determines and certifies in a required fiscal report to the Vermont General Assembly, that such agreement or practice furthers the financial interests of Vermont, and does not adversely affect the medical interests of Vermont beneficiaries:

- Any agreement with a pharmaceutical manufacturer to favor the manufacturer's products over a competitor's products, or to place the manufacturer's drug on the State's preferred list or formulary, or to switch the drug prescribed by the patient's health care provider with a drug agreed to by the Contractor and the manufacturer;
- Any agreement with a pharmaceutical manufacturer to share manufacturer rebates and discounts with the Contractor, or to pay "soft money" or other economic benefits to the Contractor;
- Any agreement or practice to bill Vermont health benefit plans for prescription drugs at a cost higher than the Contractor pays the pharmacy;
- Any agreement to share revenue with a mail order or internet pharmacy company;
- Any agreement to sell prescription drug data concerning Vermont beneficiaries, or data concerning the prescribing practices of the health care providers of Vermont beneficiaries; or
- Any other agreement of the Contractor with a pharmaceutical manufacturer or with wholesale and retail pharmacies affecting the cost of pharmacy benefits provided to Vermont beneficiaries.

This requirement applies to any contractor that provides pharmacy benefit manager related services. Since Vermont's participation in the SSDC is under Vermont's pharmacy best practices and cost containment program, this requirement applies to this procurement.

Describe all affiliations or ownership relationships with potential suppliers of pharmaceuticals or retail pharmacy services to any state or territory in the United States of America, including:

- Retail pharmacy services
- Mail order pharmacy services
- Drug manufacturing
- Drug distribution
- Drug repackaging

GHS has no affiliations of any kind with pharmaceutical manufacturers or retail pharmacies that affect the performance of our contractual duties. Our approach to rebate negotiation on behalf of the SSDC is completely transparent. GHS is not a party to the rebate agreements we negotiate for the SSDC or any State. GHS has no agreements with any Vermont health plans or pharmacies. GHS has no agreements with any mail or internet company. GHS does not "own" any of the data we maintain on behalf our of SSDC and State clients. GHS does not sell or disclose any data at anytime other than for the specific purpose for which we have been contracted to provide. GHS has no affiliations or ownership relationships with any Retail pharmacy or mail order pharmacy services or drug manufacturing, distribution or repackaging facilities.

Describe drug rebate activities performed on behalf of any other entity, including but not limited to states, insurers, and hospitals. Identify the entity or entities. Describe all subcontractor relations that will pertain to work required by this contract.

GHS is well positioned to provide cost-effective drug rebate services for the SSDC. We are the incumbent vendor for the SSDC and have been providing drug rebate services to the SSDC since its inception in 2005. We currently provide full CMS, supplemental and J-code rebate services for the States of Georgia, Iowa and Wyoming. We provide supplemental and support services for the States of Maine and West Virginia. In addition, we provide State Pharmacy Assistance Program (SPAP) and Aids Drug Assistance Program (ADAP) rebate services for the States of Maine and Wyoming.

GHS will not be using any sub-contractors for work related to this contract.

*Indicate whether all appropriate business associate agreements required by HIPAA are current and available for audit by the State of Vermont.*

GHS is committed to protecting the confidentiality, integrity, privacy and physical security of Protected Health Information (PHI), confidential information, data information, personnel, and supporting technological information resources created, obtained by, and provided to the organization. GHS has all appropriate business associate agreements in place as required by the Health Insurance Portability and Accountability Act (HIPAA). These agreements are current and available for audit by the State of Vermont.

*Explain how the Bidder can assure the SSDC that any such relationships will not create a conflict of interest with the SSDC current or potential Member States Complete the required State of Vermont disclosure statement as described in Appendix A5.*

As the incumbent vendor, GHS takes pride in our commitment to transparency. As such, GHS does not and will not have relationships that will create a conflict of interest with current or potential SSDC Member States. As part of this commitment to transparency GHS does not and will not be a party to any agreement for rebates with pharmaceutical manufacturers. GHS views each Member State as our customer and thus views our role as supporting the States participating in the SSDC through clinical, technical and administrative support functions outlined in this Request for Proposals. GHS has controls and safeguards in place to assure all activities are performed with integrity and completed accurately, professionally and on-time. As part of this

process GHS will assure that potential new SSDC members complete the State of Vermont Disclosure Statement in a timeframe required by the SSDC.

*Explain how the Bidder can assure the SSDC that manufacturer specific pricing and rebate information obtained in the course of the delivery of SSDC Medicaid supplemental drug rebate bid procurement services will be kept confidential as required by the conditions of Section 1927 of the Social Security Act (42 U.S.C. 1396r-8) which apply to Medicaid supplemental rebates as well as federal OBRA'90 rebates. Describe the assurance the Bidder can provide the SSDC that this pricing and rebate information will not be used in the course of any other activity in which the Bidder is engaged.*

GHS has established safeguards to ensure the confidentiality of manufacturer-specific pricing and rebate information obtained in the delivery of our services to the SSDC. As the incumbent vendor we understand the sensitivity of the data. Our proactive activities to maintain safeguards include protecting against anticipated threats or hazards to the security or integrity of covered data and information as well as protecting against unauthorized access to or use of covered data and information. We also have mechanisms to identify and assess risks that may threaten covered data and information maintained by GHS employees. We develop written policies and procedures to manage and control these risks. This plan is reviewed on a regular basis and adjusted to reflect any changes in technology, the sensitivity of covered data and information as well as internal or external threats to information security.

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## VI. RELEVANT EXPERIENCE AND REFERENCES

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GHS has managed Maine pharmacy benefits for over twenty years with reliable, innovative and effective service. GHS has assisted the State of Maine in electronic administration of pharmacy programs since 1991, accepting claims data for online adjudication for Maine's Low Cost Drugs for the Elderly and Disabled (DEL) program. In the earliest years of the DEL contract, starting in 1974, the system relied exclusively on paper claims. In 1991, GHS implemented real time Point of Sale (POS) claims adjudication, resulting in significant cost savings for the State, while greatly improving pharmacy satisfaction.

In December 1995, GHS implemented the Point of Sale (POS) claims adjudication system (MEPOP) for the Maine Medicaid Program. The advantages of real time POS provided a host of new controls that are now known as pharmacy benefit management. The services we now provide as part of the MEPOP contract include Pharmacy POS claims adjudication, PA, PDL maintenance, drug rebate management, pharmacy/provider Help Desk, and other related services. The PDL was successfully implemented in 2003. GHS implemented an electronic PA work flow system (ePAs) to compliment the data-driven PDL management system, allowing us to easily accommodate the increased volume in prior authorizations and related clinical edits. GHS was instrumental in implementing the MaineCare Part D program and began operating a Part D Help Desk in 2005. We recently re-competed and were awarded a new five-year contract to continue providing these services to the State of Maine.

GHS has grown to become a vendor of selected pharmacy services to ten other states. In Iowa, we have been a full service PBM for the Iowa Medicaid Enterprise (IME) since 2005. Our services include PDL, PA, Supplemental Rebate, and POS claims adjudication services. GHS was awarded a new 5 year contract for the clinical portion of this work in 2010.

GHS is the incumbent rebate negotiation vendor to Medicaid's highly successful multi-state drug rebate pooling cooperative, the Sovereign States Drug Consortium (SSDC). In the fall of 2005, GHS assisted Iowa, Maine and Vermont in the design of this multi-state drug rebate pooling program. This pool currently represents approximately 2 million lives.

GHS began providing Wyoming Medicaid with Supplemental Rebate services in October 2007. In 2009, GHS began providing the full set of PBM services for the State of Wyoming, including POS claims adjudication, POS fiscal agent activities, PA services, and TPL recovery. The GOOLD RX (6.0) POS system in Wyoming was certified (back to the first day of operations) by CMS in January 2010 using the Medicaid Enterprise Certification Toolkit certification process.

Since 2007 GHS has provided West Virginia Medicaid with clinical and administrative support, managed their Preferred Drug List, and administered their Supplemental Rebate and SMAC programs. Since assuming duties for the PDL and SMAC programs in 2007 GHS has provided a return on investment (ROI) of over 90:1, saving the State over \$70 million while providing a clinically effective PDL.

In 2009, GHS began providing the full suite of CMS Medicaid, J-Code and Supplemental Pharmacy Rebate services for the Georgia Medicaid Program and began managing the Medicaid SMAC program in Illinois. In 2011 GHS added Managed Care Organization (MCO) rebate administration to the suite of services provided to the State of Georgia.

References have been listed on the following page.

<b>Project:</b>	Maine Low Cost Drugs For The Elderly And Disabled Program (DEL) Program – Rebate Negotiation and Administration
<b>Client Reference:</b>	Jennifer Palow Director of Pharmacy Department of Health and Human Services Office of MaineCare Services 11 State House Station 442 Civic Center Drive Augusta, ME 04330 (207) 287-2705 jennifer.palow@maine.gov
<b>Contract Period:</b>	1991 - present
<b>Project Description:</b>	Perform rebate negotiation and administration for the Maine Low Cost Drugs For The Elderly And Disabled Program (DEL) Program which provides supplemental prescription drug benefits for elderly and disabled people whose household income does not exceed specified limits.

<b>Project:</b>	State of Georgia, Department of Community Health – Medicaid and Supplemental Drug Rebate Program
<b>Client Reference:</b>	Adrian Washington, Pharm.D., MBA Director of Pharmacy Services Georgia Department of Community Health 2 Peachtree Street Atlanta, GA 30303-3159 (404) 657-9092 awashington@dch.ga.gov
<b>Contract Period:</b>	2009 – present.
<b>Project Description:</b>	Provide the full suite of rebate negotiation, invoicing and administration for the Georgia Medicaid program, including OBRA '90, Supplemental and Managed Care rebates.

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## VII. CONTRACTOR ORGANIZATION AND STAFFING

GHS realizes our commitment to provide the proper resources to continue operating the applications, program and systems described in this RFP. GHS has assembled a staff of extremely talented, competent, and capable employees who, collectively, have decades of experience in Medicaid rebate operations. All of the staff members below are based out of our Augusta, Maine headquarters. Our expert staff is available at a moment's notice to answer questions, provide technical support, address concerns and assist with legislative requests. Named staff is available to attend meetings via teleconference or online meetings and for travel to attend meetings in person as appropriate.

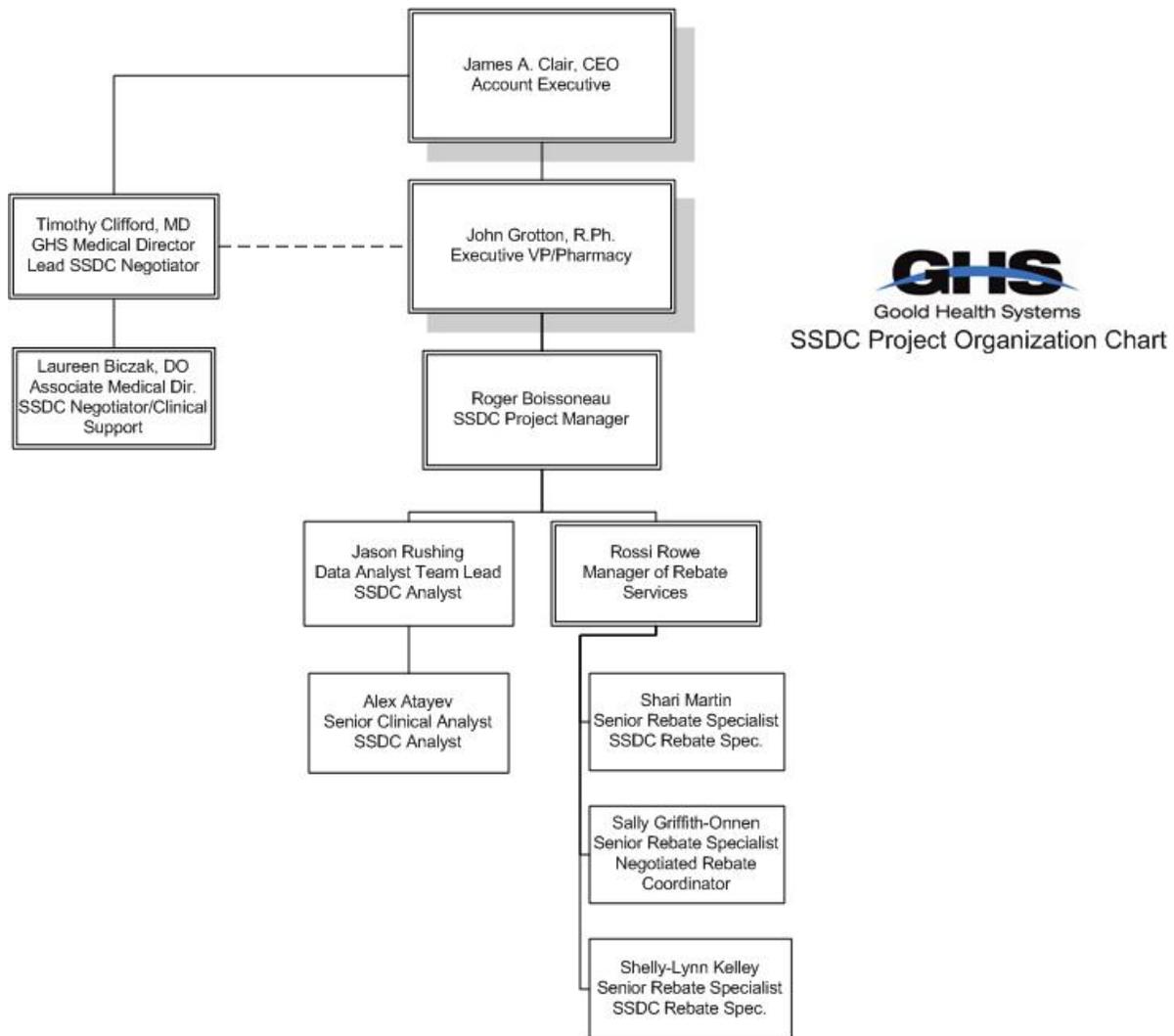


Figure 1: GHS Project Organization Chart

## **A. Brief Job Descriptions**

### **Account Executive**

Jim Clair, Chief Executive Officer, will serve as the Account Executive. Jim oversees day-to-day operations at GHS as well as all strategic issues. As CEO, he is authorized to negotiate and sign any contract document related to this project. Jim's responsibilities include:

- Contract management:
- Conflict resolution: and
- Change management review and approval.

### **Executive Vice President of Pharmacy**

John Grotton, R.Ph., is the Executive Vice President of Pharmacy at GHS. John provides Executive Oversight for day-to-day pharmacy operations, including Medicaid Drug Rebate Operations.

### **GHS Medical Directors**

GHS has two full-time physicians on staff who manage our Medicaid and Supplemental Rebate negotiations process. The lead negotiator for all GHS clients is Timothy Clifford, M.D. He will work closely with the Data Analysis Team to design, update and QA all clinical and financial analyses. Dr. Clifford will negotiate supplemental rebates with manufacturers. He is also available for meetings and presentations to the SSDC.

Another professional involved in negotiations and, in particular, offer reviews is Laureen Biczak, D.O. She takes the primary role in evaluating all drug reviews, both clinically and financially. She will assist in negotiating and implementing SSDC supplemental rebates. She is also available for meetings with the SSDC.

### **SSDC Project Manager**

Roger Boissonneau serves as the SSDC Project Manager. His project responsibilities include:

- Project management: Scope verification, Change management, and Contract support;
- JAD session participant;
- Serve as subject matter expert on existing operations and client needs; and

- Document and enforce business rules for the project.

### **Rebate Services Manager**

Rosemary (Rossi) Rowe is responsible for day to day operations and oversight of the GHS Rebate Team. Some of her responsibilities include:

- Project coordination including: project tracking; manage project scope, stakeholder communication;
- Insure contract management process is timely and accurate;
- Lead dispute resolution process; and
- Training lead.

### **Senior Drug Rebate Specialist**

Shari Martin, Shelley-Lynn Kelley and Sally Griffith-Onnen are all Senior Drug Rebate Specialists assigned to the SSDC project. Their overall responsibilities include:

- Supplemental Rebate contracting;
- Supplemental Rebate negotiations;
- Rebate Calculation Accuracy;
- Invoicing;
- Maintenance of manufacturer contact information;
- Communication with manufacturers;
- Collections;
- Resolution/tracking of disputes; and
- Check entry / account balancing.

### **Reporting/Data Coordination**

The design lead for SSDC reports is Jason Rushing, Data Analyst Team Lead. Jason oversees the work of the Data Analyst Team whose responsibilities include:

- Report generation / customization; and
- Data QC.

Dr. Alex Atayev serves as the Senior Clinical Analyst and works in support of the SSDC contract. Dr. Atayev works closely with Dr. Clifford and Dr. Biczak to study and define new cost saving and quality of care strategies, financial modeling scenarios and impact analyses. Dr. Atayev also works in support of PDL design and enhancement for the states of Maine, Iowa and West Virginia.

### **Additional Support Staff**

GHS will provide other support staff as needed during the development and operational phases of the project. These include, but are not necessarily limited to:

- Administrative support staff; and
- Technical and networking support staff.

### **B. Staff Qualifications**

Qualifications for the proposed staff named in this proposal are included below. Resumes can be provided upon request.

#### **James Clair – Chief Executive Officer**

Jim oversees day-to-day operations at GHS and is responsible for guiding the company's future. Jim joined the GHS team in 2001 to work on strategic planning, finances, operations and business development initiatives. Under Jim's leadership, the company has more than doubled in size over the last 6+ years, but GHS only takes on work that allows us to "grow smartly." Jim brings nearly two decades of policy analysis, budgeting and operations experience from a number of non-partisan staff capacities at the Maine State House. He was most recently the Executive Director of the legislative staff, having operating and administrative responsibility for the organization's annual budget of \$20 million.

Jim holds an MPA from Syracuse University and an MS concentration in planning from the State University of New York. He is a member of the Maine Cancer Foundation Board of Directors, the Maine Children's Growth Council, the HealthReach Network Board of Directors, the University of New England's President's Roundtable, Maine's Business Roundtable on Early Childhood Investment, the Kennebec Valley Community College General Advisory Council, and the NFIB/Maine Leadership Council.

**John Grotton, R.Ph. – Executive Vice President of Pharmacy**

John Grotton, R.Ph., was named Executive Vice President in 2006. He is responsible for direct oversight of GHS' pharmacy operations. His 20-plus years in the pharmaceutical industry provide him with unique insights into GHS services. John is a graduate of the college of pharmacy at Northeastern University and is a licensed pharmacist in two states. He has worked as a district supervisor for two large retail pharmacy chains and as a pharmacy intern in a large metropolitan hospital. John is the past president of the Maine Board of Pharmacy and is a member of the Maine Pharmacy Association.

**Timothy Clifford, M.D. – GHS Medical Director**

Dr. Timothy Clifford, M.D. is the full-time physician serving as Medical Director for Goold Health Systems.

Dr. Clifford has 25 years experience as a physician, 24 of those in Maine. He is a graduate of Boston College, Tufts University School of Medicine and the Maine- Dartmouth Family Practice Residency Program. Before joining GHS, and in addition to private practice, he served as the Medical Director for Maine's Department of Health and Human Services. While at DHHS, Dr. Clifford was the chief clinical consultant for the Medicaid program. He provided considerable input into the development of the Medicaid Decision Support System and served on a wide variety of work groups and committees whose purpose it was to improve the well being of Maine residents. His tenure at DHHS allowed him to develop an understanding for and keen insight into the objectives of DHHS in its administration of State-sponsored healthcare programs.

While in that position he chaired the Drug Utilization Review Committee and the Pharmacy Advisory Group. He designed and implemented the Physicians Directive Drug Initiative and was instrumental in the design and operation of the Healthy Maine Prescription Program and Maine Rx. He is an active member of the American Association of Family Practice and the Maine Medical Association. He still practices Family Medicine, on a part-time basis, at Bucksport Regional Health Center and is board certified by the American Academy of Family Physicians.

At GHS, Dr. Clifford focuses his attention on the Drug Utilization Review system, the Prior Authorization program, Preferred Drug List, generic pricing, program integrity and clinical consultation. These efforts have contributed to saving the States of Iowa and Maine tens of millions of dollars while not compromising the health of Medicaid recipients. Dr. Clifford is the lead negotiator for the Sovereign States Drug Consortium.

**Laureen Biczak, D.O. – Associate Medical Director**

Prior to joining the GHS team in March of 2007, Dr. Laureen Biczak spent over 6 years as the Medical Director for Maine’s Medicaid program, MaineCare, at the Department of Health and Human Services. She has had extensive experience in all aspects of the Maine Medicaid Program. Dr. Biczak is Board Certified in both Internal Medicine and Infectious Diseases. Her continued part-time clinical practice provides her with a unique view of pharmacy issues as seen from both the State’s and the provider’s perspective. She is a member of the American College of Physicians, the Maine Medical and Maine Osteopathic Societies as well as several professional Infectious Disease Societies. She previously 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.

**Roger Boissonneau – Project Manager**

Roger has been with GHS since September of 2009 and brings over 7 years of project management experience with a technology focus. While at GHS he has worked on multi-state platform rebates processing and supplemental rebates, including the SSDC bid offer system (eROMS). Roger has focused his SSDC efforts on improving communication with the SSDC Member States while improving both the eROMS product and internal processes. Roger’s previous experience includes five years in the Vermont state government where he managed the \$9 million dollar DMV modernization and created the No Child Left Behind programs used by the Department of Education.

**Jason Rushing, Data Analyst Team Lead**

Jason Rushing has served as the Data Analyst Team Lead at GHS since 2004. He brings nearly 20 years of experience in information systems analysis and data analysis. Jason is integral to the

continuing operations of the GHS Data Analyst Team, providing guidance and training to other analysts in performance of their regular duties. Jason draws on his extensive experience to prioritize projects and implement and enforce adherence to standards.

**Alex Atayev, Senior Clinical Analyst**

Dr. Alex Atayev has gained extensive exposure to the public healthcare sector and the Medicaid Drug Rebate Services GHS provides as the Senior Clinical Analyst in support of the SSDC as well as PDL design and enhancement for the states of Maine and Iowa. Prior to joining GHS Dr. Atayev spent four years as a healthcare analyst in both the private and public sector where he performed extensive data and statistical analysis for clients in public and commercial health plans.

**Rossi Rowe – Manager of Rebate Services**

Rosemary (Rossi) Rowe supervises rebate administration duties and is responsible for ensuring contract compliance for all of GHS’ rebate clients. Rossi has over twenty years of experience in the administration and management of large benefit recovery programs during which she has gained extensive knowledge of Medicaid programs, policies and procedures, as well as Medicaid medical and pharmacy claims processing, third party coordination of benefits and recovery, and drug rebate collections.

Prior to joining GHS, she was the Director of the Division of Third Party Liability for the State of Maine where she provided strategic leadership in an agency providing healthcare services to more than 250,000 Maine citizens. She managed and provided oversight for the development, implementation, and evaluation of the division’s policies and programs. Rossi leverages her extensive experience in problem resolution and trouble-shooting for large, complex benefit recovery programs and her experience working in collaborative project manager/contractor relationships to ensure that all of GHS’ rebate accounts are effective, efficient and responsive to our clients’ needs.

**Shari Martin, Senior Rebate Specialist**

Shari joined the GHS Rebate Services Team in July of 2008. She brought with her 7 years experience working with Maine's Bureau of Medical Services Pharmacy Help Desk, Managed Care Provider Enrollment and Provider Relations. Shari was also held the position as Team Lead responsible for Reporting and Member Data Feeds during the 6 year Maine Claims Management System (MECMS) design and implementation. Here at GHS, Shari supports multiple rebate contracts with a focus on Supplemental and Diabetic Rebates. She coordinates SSDC contract negotiation efforts which include administrative duties, manufacturer offer submission education, manufacturer correspondence and help desk support, and participates in the eROMS upgrade design sessions. She manages the diabetic supply offer process, reporting and State specific negotiations for the SSDC Member States. Shari's previous experience includes several years in the pharmaceutical industry where she served as a Pharmacy Purchasing Manager after serving for several years as a Pharmacy Technician.

**Shelley-Lynn Kelley, Senior Rebate Specialist**

Prior to joining GHS in 2001, Shelley-Lynn Kelley held a variety of positions in the retail pharmacy industry, including pharmacy technician, training coordinator and pharmacy scheduler for a large national retail pharmacy chain. Shelley has performed a variety of duties during her ten (10) years with GHS and has been involved with the SSDC project since its inception in 2005. Shelley works closely with Dr. Clifford in support of rebate solicitation, negotiation and bid presentation and has extensive working knowledge of the SSDC and its myriad requirements, procedures and business rules.

**Sally Griffith-Onnen, Senior Rebate Specialist**

Sally has been with GHS since March 2009 and has two and a half years of state contract administration and business documentation experience. While at GHS she has worked on testing upgrades to the SSDC bid offer system (eROMS) and supporting states and manufacturers through the bidding and contracting process. She also updated the eROMS user guides. Sally's previous experience includes working for the state of Western Australia's Department of Industry and Resources, where she assisted in the management of state agreements and drafted briefing notes and memos.

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## VIII. METHODOLOGY AND APPROACH

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### A. General Supplemental Drug Rebate Activity Requirements

1. *Describe any rebate activity experience.*

GHS is well-positioned to provide cost-effective drug rebate services for the SSDC. We are the incumbent vendor for the SSDC and have been providing drug rebate services to the SSDC since its inception in 2005. We currently provide full CMS, supplemental and J-code rebate services for the States of Iowa and Wyoming. We provide supplemental rebate (SR) and support services for the States of Maine and West Virginia. We provide full supplemental rebates services as a stand-alone solution for the State of Georgia. In addition, we provide SPAP and ADAP rebate services for the States of Maine and Wyoming.

2. *Describe the related entities that they are or have been a part of including any pooling or comparative program they manage or of which they are or have been a part.*

GHS has worked with the States of Iowa, Vermont and Maine to support the SSDC multi-State drug purchasing pool since its inception in 2005. Since then, the States of Oregon, Utah, West Virginia and Wyoming have joined the pool such that the present aggregate negotiations strength is based on the approximate 2 million covered lives of the 7 Member States. We have performed 6 annual SSDC pool negotiations. GHS, as the incumbent SSDC vendor, does not have separate pooling contracts with each participating state. GHS is not a signing party to the contracts each state signs with manufacturers. The rebate contracts are between each participating state and the manufacturer(s) alone. GHS also does not provide or maintain supplemental rebate unit price as a “proprietary” function. GHS understands the significance of this distinction – although we are the current SSDC vendor we are clear that it is not “our” pool, but rather the pool of the states within the SSDC. We have been honored to provide administrative support at the pool’s discretion.

3. *Where rebate activities are involved, Bidders should describe in general the framework, conditions and processes used in negotiating rebates and/or in evaluating the rebate value in relation to the drug product utilization mix of a customer or customers. Where comparative activities are involved, Bidders should describe how those activities compare.*

GHS realizes that an important goal of the SSDC is to make it as state-centric as possible, as opposed to vendor-centric. At the same time, we need to maintain the “purchasing power” concept of pooled Medicaid lives. One of the driving principles behind our approach is to form a

partnership with each of the SSDC participating states. GHS strives to create and maintain excellent working relationships with all of the pharmaceutical manufacturers as well. GHS has been working closely with pharmaceutical manufacturers since 2003 when the MaineCare Program – Maine’s Medicaid Program – first implemented its Preferred Drug List (PDL). GHS ensures that every manufacturer is afforded the same opportunity to present its drug in the best clinical and economic light possible. GHS has maintained positive, effective, transparent relationships with pharmaceutical manufacturers for over 7 years.

GHS performs two 6 month cycles of SR negotiations annually. GHS encourages manufacturers to be responsive, creative, and flexible in their offers. Our agreed-upon process allows manufacturers to bid based on different tiers. At present, manufacturers can bid on being exclusively preferred, one of two preferred, one of three preferred and one of four or more preferred drugs. Manufacturers may also bid on being the exclusively “preferred” after clinical PA, one of two “preferred after clinical PA, one of three “preferred” after clinical PA or one of four or more “preferred” after clinical PA. The latter approach works perfectly for drug classes where it is vital to be certain that approved indications exist, such as EPO agents, GH drugs, insulin pens and many other expensive biological drugs. Going forward, with SSDC review and approval, GHS may propose to streamline this bidding process by reducing the number of tiers available to manufacturers.

We allow companies to make bids contingent on specifically excluding a competitor’s drug. We allow step-therapy bids where certain pre-conditions of online “preferred” adjudication are negotiated. We will consider different PDL status for different age groups if the SSDC states desire that approach. GHS will provide complete financial modeling scenarios for the therapeutic categories identified for discussion. The models will include separately, identified CMS and supplemental rebates and the resultant net drug costs. The model will demonstrate the financial impact to the class and allow for changes in drug mix, pricing assumptions and market share shifts. We will provide recommendations to the SSDC states that were derived from the financial modeling results.

Most PDL categories do not require complex pharmaco-economic modeling. When comparator drugs are already available, similar in terms of daily dosing and similar in terms of expected

outcomes (no proven inferiority or superiority) then the model is simple and only requires net cost calculations involving actual net costs of established drugs and estimated net costs of new drug entries lacking historical CMS rebate data or SR offers. If on the other hand a new drug appears clinically stronger than existing competitors then we have to anticipate erosion of existing drug utilization and the potential deflective strengths of proposed PA criteria (assuming non-preferred status will be recommended for this example.)

Comparisons need to be both fair and useful. Ophthalmics and topicals are best compared using net costs per prescription or per day rather than per ml or gram. Growth hormones need to be assessed per mg, pancreatic enzymes per 10,000 units of lipase activity and MS agents per month or per day. Many other categories such as inhalers also require specialized comparison conversions. It is a lot of work to create these fair comparisons but it is very worthwhile.

Some drug categories are more important than others by virtue of their fiscal significance. The mental health drugs and the antidiabetic classes are two examples of drug categories that warrant close attention all the time. These two areas required special models recently. Initially we created a model using large scale pool data to determine comparative savings. We then took this model and customized it with state-specific data. An individual state's savings scenarios may differ due to varying PA criteria, baseline drug utilization differences and generic SMAC pricing. We have included the following two sample models.

The first pharmaco-economic model, shown in Figure 2 concerns the TZD class. Actos has always displayed disproportionate variations in CMS rebates across its three strengths. Over time the Actos 15mg tab has become much cheaper per mg than the two higher strengths. Recognizing this anomaly, we modeled out the potential savings that might result from only preferring the use of the Actos 15 mg strength. This required identifying all the drugs that could be substituted with Actos 15 mg or multiples thereof and then calculating the net costs using CMS rebates only versus accepting TZD supplemental rebates and resulting savings. As you can see from examining this model, the net savings in excess of those resulting from just taking supplemental rebates on the TZD drugs was \$1.1 million annually. This type of analysis is

crucial in developing accurate net cost savings projections that can be used to guide committee recommendations and State decisions.

ACTOS 15 MG STRATEGY PDL EXHIBIT									
ONLY ACTOS 15MG PREFERRED W/O SR									
Drug Name	Utilization (1q09)	Converted Actos 15 mg	Actos 15 net*	(Combo) net w/o sr*	Metformin costs	Extra Disp fee/day	Q1 Actos 15 savings	Actos 15 savings/yr	Vs SR savings/yr
Actos Tab 15 MG	11,304	11,304	\$0.28	\$ 0.28			\$ -	\$ -	\$ -
Actos Tab 30 MG	21,596	43,192	\$0.28	\$ 3.35			\$ 119,346	\$ 477,384	\$ 81,638
Actos Tab 45 MG	21,967	65,901	\$0.28	\$ 3.67			\$ 182,910	\$ 731,640	\$ 237,405
Avandia Tab 2 MG	480	480	\$0.28	\$ 1.83			\$ 740	\$ 2,960	\$ 314
Avandia Tab 4 MG	6,300	12,600	\$0.28	\$ 1.85			\$ 16,372	\$ 65,488	\$ 25,351
Avandia Tab 8 MG	3,747	11,241	\$0.28	\$ 4.35			\$ 38,969	\$ 155,876	\$ 44,481
AVANDAMET 2-1000MG	960	960	\$0.28	\$ 2.05	\$ 0.080	\$ 0.153	\$ 1,489	\$ 5,956	\$ 3,741
AVANDAMET 4-1000MG	1,374	2,748	\$0.28	\$ 3.37	\$ 0.080	\$ 0.153	\$ 6,842	\$ 27,368	\$ 9,795
AVANDAMET 2-500MG	2,643	2,643	\$0.28	\$ 1.65	\$ 0.070	\$ 0.153	\$ 2,941	\$ 11,764	\$ 5,586
AVANDAMET 4-500MG	1,725	3,450	\$0.28	\$ 2.67	\$ 0.070	\$ 0.153	\$ 6,262	\$ 25,048	\$ 10,778
ACTOPLUS MET15/500MG	3,530	3,530	\$0.28	\$ 1.87	\$ 0.070	\$ 0.153	\$ 4,643	\$ 18,572	\$ 7,148
ACTOPLUS MET 15/850MG	8,541	8,541	\$0.28	\$ 1.87	\$ 0.050	\$ 0.153	\$ 11,363	\$ 45,452	\$ 15,819
								<b>\$ 1,567,508</b>	<b>\$ 442,056</b>

Savings Potential	
Actos 15 Mg Only Preferred	<b>\$ 1,567,508</b>
Take All TZD SR	<b>\$ 442,056</b>
Actos 15 Mg Net Savings Incr.	<b>\$ 1,125,452</b>

\* Actos 15 mg and other brand nets altered, not factual

**Figure 2: TZD Exhibit 2010**  
**Actual numbers have been changed to protect confidential CMS and SR information.**

We can also perform financial modeling that shows the recent utilization with all CMS rebates, supplemental rebates and net costs clearly identified. Then we demonstrate how these variables might change under different sets of assumptions and their probabilities. In a number of categories this involves comparing rebated brands to each other and then possibly to non-contracted brands and/or generics potentially affected by SMACs/FULs. To the extent that data is available, we use other states’ utilization changes after they adopted a similar PDL category design. An additional example of our pharmaco-economic models (concerning the Serotonin Norepinephrine Reuptake Inhibitors [SNRIs]) is provided in Appendix 1 of this proposal.

If selected as the successful bidder GHS will continue to provide supplemental rebate negotiations and saving analyses of specific drugs/drug categories to the SSDC states. We will present estimated savings in a manner agreeable to the SSDC. This will involve estimations based on both current and projected utilization. Depending on the SSDC’s state’s preference, we

can present a simple summary version of estimated savings within each class, reflecting shifts in market share utilization, average blended net cost per unit, and supplemental rebates. These summaries can accompany the more complex analysis that incorporates all the utilization, including that of minor drugs.

## **B. Member State's Utilization Data Compilation**

1. *Describe their experience in compiling data sets of the sort described.*

GHS has been performing services for the SSDC, as outlined in the RFP, since 2005. Since this time, several states have been added to the SSDC, each time requiring the collection of claims data from the state's and / or their other vendors. GHS also performs collection and maintenance of claims and other data sets in support of other contracts, not related to SSDC. Therefore, GHS has the experience necessary to continue receiving, processing and maintaining claims data from SSDC Member States.

2. *Describe how that data would be compiled.*

GHS receives claims data from all SSDC states and/or their business partners. Claims data is received in a standard format agreed to by GHS and SSDC Member States; all fields necessary to perform SSDC operations and analysis are included in this format. Data is compiled in a specific database established for SSDC operations within GHS's Data Warehouse. Data from each SSDC Member State is identified and maintained separately. All new data is validated before it is migrated to a production database.

3. *Describe in what formats it would be made available for the review of Member States, manufacturers, and others that the Member States might specify.*

Data will be made available to SSDC Member States through the SSDC user interface and through the use of standardized production reports. Unless otherwise directed by the SSDC, GHS will continue to use the reporting and data extract specifications that are presently implemented. Ad-hoc reports and data extracts can also be generated as needed to support ongoing analysis and new scope of services.

- |    |   |
|----|---|
| 4. | <i>Describe how these formats will facilitate ready review.</i> |
| 5. | <i>Provide examples where appropriate.</i>                      |

Using a standardized data format ensures that possible data errors are minimized, speeding the availability of data for reporting and analysis. One example of this is the Marketshare Report, a sample of which can be found in Appendix 2 of this proposal.

### **C. Rebate Bid Solicitation**

1. *Describe their experience in working with multiple differing entities to develop a positive group strategy.*

GHS has been successfully performing this duty since the origination of the SSDC. Every year seems to acquire a different theme. The first year of the pool was about convincing manufacturers to participate. The second year theme was about Medicare Part D and losing lives and potentially some leverage. We especially had to work hard to convince manufacturers to submit bids on “elderly” drugs like Alzheimers and bladder agents. We had to provide data on members over age 65 to convince many manufacturers to continue their participation. Last year was all about Health Care Reform and losing rebates to the federal government.

We had to identify likely line extension drugs and calculate what their net cost would be adjusted by CMS’ guidance on rebate offsets. We also had to estimate what the 8% AMP rebate (minimum rebate raised from 15.1% to 23.1% AMP) losses would do to drug offers. Another problem was convincing manufacturers to continue offering SR in the face of having to increase their minimum CMS rebate. We had to sit with many of the drug companies and show them how the Health Care Reform law would either positively or negatively affect our perception of their net costs and relative value. Some drugs that were previously net priced the same became separated in net price due to varying degrees of rebate losses due to the new law. In the end we were able to obtain the same level of support from the manufacturers. Supplemental rebates have become more important since what is lost to the federal government are largely segments of the CMS rebate. Line extension drugs on the other hand are much trickier to do business with since most SR contracts are GNP and any large increase on the CMS rebate component will erode the value of the SR component. We provided a special analysis of these drugs this year for the SSDC states which is included in Appendix 3 of this proposal.

GHS recommends different approaches for different manufacturers. Some of the large companies have specific Medicaid rebate contracting teams. With guidance from the SSDC Member States, GHS works diligently with manufacturers to ensure a successful bid process. For new manufacturers, GHS staff goes the extra mile to ensure they understand the process and can successfully participate in the process. We have provided tutorials on how to bid, explained basic PDL concepts, and participated in face-to-face meetings, which are granted as often as time allows during the busy bidding schedule. GHS is proactive during the bidding process to ensure that our state clients receive the maximum value. It is important to note the SSDC members determine the composition of their own PDLs. SSDC members do not have to adopt the same PDLs as other members. GHS, on behalf of the pool, negotiates prices and conditions, but each state within the SSDC has full control over contracts to accept or reject offers. In most cases, the states in the pool reach consensus and in our experience act in unison, but there are several PDL categories where one state wanted to pursue a much more or less aggressive approach than other partners. Maintaining this autonomy is crucial to the long term success of the pool.

2. *Describe their experience in working with drug manufacturers or other entities in securing concessions of this sort.*

GHS has worked hard to develop and maintain partnerships between our client and SSDC States and the manufacturers that are beneficial to both parties over the years. These transparent relationships have continued to flourish over the last 7 years with the growth of the SSDC.

GHS is experienced at leveraging the purchasing power of the SSDC as well as recommending innovative criteria that encourage manufacturers to offer significant supplemental rebates. Our ability to support flexible offers on multiple tiers with variable criteria allow bids to be presented that offer the best opportunity for both the States and the manufacturers. We are able to work directly with the rebate staff of many manufacturers to work out details of offers or secure a concession that is favorable to the SSDC or a Member State. Many concessions have more to do with conditions rather than pricing. Some states want generic first edits such as allowing simvastatin before a preferred brand statin (success). Some states wanted to require the use of ACEI before allowing ARBs (success). Every year we negotiate or renegotiate offers with various conditions attached similar to those just listed. Nearly thirty offers involved substantial preconditions.

GHS strongly supports the member States determination of their own PDLs and is able to continue to secure significant rebates even given the occasional variability in these PDLs. In our 6 rounds of negotiations performed on behalf of the SSDC, GHS has solidified these relationships and proven the value of these partnerships over time and despite an ever changing landscape including the changes brought about by the Affordable Care Act.

3. *Describe their experience in soliciting drug rebates.*

GHS has worked with the States of Iowa, Vermont and Maine to support the SSDC multi-State drug purchasing pool since its inception in 2005. Since then the State's of Oregon, Utah, West Virginia and Wyoming have joined the pool representing nearly 2 million lives. We have performed 6 annual pool negotiations. In addition to providing drug rebate services to the SSDC, GHS has been providing rebate services to the State SPAP and ADAP Programs for Maine and Wyoming. In addition, GHS provides "stand-alone" rebate negotiations for the State of Georgia.

4. *Describe how they would notify drug manufacturers of the start of the bid procurement process.*

Annually, GHS sends letters out to all manufacturers. The purpose of this letter is to inform the manufacturers that the Member States of the Sovereign States Drug Consortium (SSDC) are opening solicitation and negotiations for their multi-state supplemental rebate pool for the rebate calendar year. GHS also informs the manufacturers that we are the vendor which will act on behalf of the SSDC for the bid process.

5. *Describe what would be required of the manufacturers.*

GHS directs manufacturers to the SSDC website ([www.rxssdc.org](http://www.rxssdc.org)) for them to register, complete and submit any Supplemental Rebate Offer using the GOOLD eROMS application. GHS further assures the manufacturers that rebate amounts are confidential and cannot be disclosed in accordance with Section 1927(b)(3)(D) of the Social Security Act. We encourage manufacturers to review each individual Member State's Supplemental Rebate Agreement (SRA) posted on the [www.rxssdc.org](http://www.rxssdc.org) website prior to submitting offers. We inform manufacturers that offers should be made with the understanding that the terms and conditions of the posted SRAs apply. We also inform manufacturers that if they make an offer with a proposal for a modification to a SRA or SRAs, the proposal may be summarily rejected by an affected Member State. We also remind Manufacturers with existing multi-year contracts extending

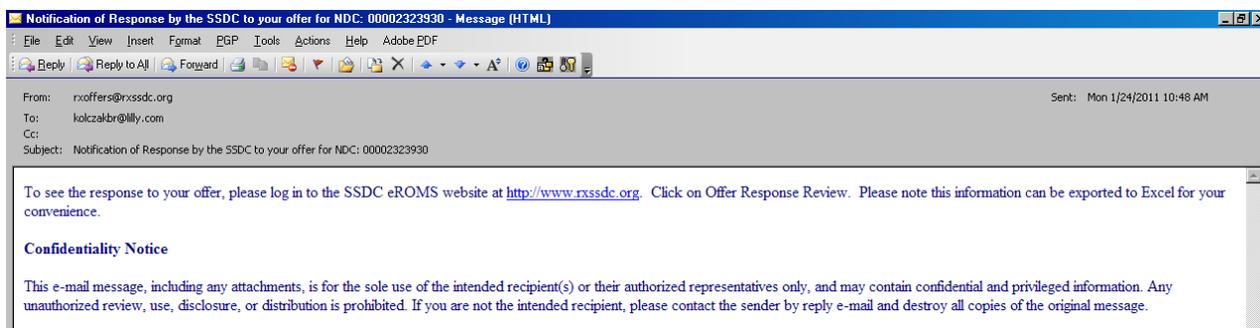
through or beyond the end of appropriate calendar year do not need to re-submit initial offers though manufacturers may opt to improve their current offers if they wish. It is also important to emphasize that offers will only be reviewed from companies that are currently in good standing with respect to rebate payments to Member States. GHS also provides a timeline (once approved) by SSDC Member States for the annual bid and Best and Final Offer (BAFO) process.

6. *Describe what vehicle(s) might be used to solicit bids.*

GHS employs standard purchasing practices utilized in the private and public sectors in regards to its rebate negotiation services. All rebate offers are entered into our secure web-based offer entry system eROMS. eROMS stands for Electronic Rebate Offer Management System. It is a secure, online system developed by GHS to allow manufacturer bidding and state responses to be managed in an efficient and accountable manner through a secure website. Before being granted access to eROMS, manufacturers go through a 3 point check that verifies the identity of the user and negates the risk of fraud and abuse. Each manufacturer is given a unique user ID and password, making it impossible for that user to see offers made by other manufacturers. All email correspondence generated during the use of eROMS is warehoused, giving GHS and the state users a complete audit trail of manufacturer's actions. Authorized State users have 24/7 access to eROMS, where they can view all offers, monitor the course of negotiations, and retrieve historical offer data as needed. We have found that the use of a secure web portal facilitates a smooth and transparent process for manufacturers to use and allows SSDC Member States to log-in at their convenience to monitor the offer solicitation process. Furthermore, based on the experience of a manufacturer renegeing on a substantial offer so late in the process that many states were injured, it also provides the members considerable protection and readily available documentation for legal action in the future if such a need should arise.

7. *Describe how it is envisioned that any identified vehicle facilitates the process for the manufacturers.*

eROMS allows for manufacturers to submit offers on-line. The system allows for electronic responses to manufacturers for immediate email notification as to the status of their offer i.e. accepted, rejected, counter offer, as well as allows for access to reports to view the status of each of the NDC's for which that manufacturer is bidding. Figure 3 shows an example of a manufacturer notification.



**Figure 3: Manufacturer Notification of Offer Status**

8. Describe how the Member States can access or will be provided information while the solicitation process is underway so that they can assess the progress of the solicitation process.

GHS' eROMS system allows immediate access to our Member States to view offers entered into the system by manufacturers as they are occurring. Authorized State users have 24/7 access to eROMS, where they can view all offers, monitor the course of negotiations, and retrieve historical offer data as needed. Some of the State users typically check on how many manufacturers have submitted bids and whether they are in line with existing contracts, especially in key budget categories like stimulants and biologicals.

9. Describe timeliness standards in making information available to SSDC Member States while the solicitation process is underway so that the states can consider potential impact on their PDLs. Provide examples where appropriate.

As described above, eROMS allows for immediate access by SSDC Member States to the bid solicitation process. As the incumbent vendor for the SSDC, GHS has been compiling Member State-specific data since its inception. GHS updates eROMS to bring the offers into the appropriate drug category as well as comparing non-offers in the category and the impact on each state's PDL, estimate potential savings and estimate market shift. State members can check on offers or for that matter non-offers from any location or any time day or night to see how things are going or to potentially consider budget effects if the existing offers remain unchanged and are accepted.

## D. Bid Presentation

1. Describe their experience in compiling data sets of the sort described.

GHS processes and validates all offers submitted from the manufacturers. Over the past 6 rounds of managing offers submitted to the SSDC pool GHS has developed effective tools to compile and present detailed data to the Member States. eROMS provides a precise, organized tool for

States to view all bids received, potential savings by drug and what PDL tiers the offers were made in, as well as other collected data. GHS staff review and analyze the data and provide feedback to SSDC Member States.

2. *Describe their experience in assessing the impact of factors/conditions on the drug rebate bids; e.g., federal Medicaid drug rebate policy research and analysis; alternative drug development tracking; related litigation research and analysis; etc.*

Included in our answer to question A3 in Section VIII GHS performs a series of pharmacoeconomic modeling analysis. In addition, GHS has been providing and will continue to provide the SSDC Member States with technical expertise as it relates to Healthcare Reform. GHS remains committed to assisting the SSDC with maintaining its effective use of SR's despite the changes to Medicaid rebates included in this reform. In order to assist the States to continue their efforts at maintaining an affordable prescription drug benefit, GHS will continue to monitor and recommend strategies to minimize adverse effects to Medicaid pharmacy budgets as Healthcare Reform is implemented. GHS also monitors potential litigation to be able to provide clinical/technical advice and expertise to SSDC members. We stay apprised to changes in the market place, drug availability, movement of Brand name drugs off patent to generics and will continue to analyze changes in federal policy and its impact on the SSDC Member States.

3. *Describe their experience in integrating compiled data sets with varied other data.*

As the SSDC incumbent vendor GHS has a successful history of accurately compiling data and aligning offers submitted by manufacturers with that of OBRA 90 CMS rebates to arrive at "dead net" drug cost for each of the SSDC Member States. GHS provides recommendations and scenarios that would potentially result in greater savings and a more expansive drug benefit to Medicaid beneficiaries is also provided.

4. *Describe how that data would be compiled.*

For a complete description of this process please see our response to Section VIII.B of this proposal.

5. *Describe in what formats it would be made available for the review.*

It has been our experience that providing data in an excel format is typically the most effective means of making data available to SSDC Member States. GHS will work with the SSDC to re-confirm that this is the desired method of delivery or if other formats may be preferred.

6. *Describe how these formats will facilitate ready review.*

The use of an excel spreadsheet promotes ease of use for the user. Excel allows for ease of data filtering, allows for summarizing data by drug category as well as comparing across drug classes/categories. There are many different offer tiers to consider and at times the prices can vary depending on whether or not a specified condition is in effect. Then there are the adjustments in prices needed to reflect the anticipated Health Care Reform rebate losses. There are so many variables potentially relevant that Excel has proven so far to be the most flexible and efficient.

7. *Describe how this data might be presented; for example, in meetings, e-mail, or web-based presentations or other means.*

GHS hosts a web-based presentation via GoToMeeting.com for secure, confidential review. GHS utilizes an excel spreadsheet – this allows for ease of use in reviewing drug classes. If Member States would like to have access directly to the data GHS will be reviewing – a password protected copy is sent directly to the member state requesting the data.

8. *Describe how this data may be made available to SSDC Member States in a timely fashion so that staff can adequately prepare for presentations.*

GHS works with SSDC Member States to review and implement a timeline that is agreeable. The use of eROMs – our on-line offer management system – allows for direct and immediate access to supplemental rebate offers submitted by pharmaceutical manufacturers. In addition, GHS will submit a copy of the master spreadsheet directly to Member States who request this information prior to the web-meeting in a password protected email.

9. *Describe what is believed to be the most effective means of presentation and why.*

GHS encourages the SSDC Member States to continue with an annual on-site meeting to review offers, policies, etc. This facilitates an environment where states can share information, their approach to managing different PDL classes, their experience with clinical criteria and allows for

the sharing of best practices and success stories and lessons learned in each member state. At various points during the day it also allows us (during breaks) to clarify problems or explain in greater detail to individual states without holding up the progress of the entire group. Even though more drugs are reviewed each year, the efficiencies of the current meeting process have allowed the States to conclude their business progressively faster.

10. *Describe what is believed to be the least effective means of presentation and why.*

An individual phone call to each state separately creates an environment that is somewhat counterintuitive to the creation of a multi-state pool. Group phone calls are even less effective. The group interaction is vital. Less experienced members benefit from the wise veterans and the more experienced older states learn to question and reevaluate their established practices based on questions from the new-PDL states.

11. *Provide examples where appropriate.*

In the previous answer we mentioned group phone calls. We tried this for several years in reviewing counteroffers. It was very slow and wasted state staff time since many issues discussed were pertinent to one state but none of the others. This recurred over and over during the PDL category review. This was not acceptable to the member states and, as a result, was subsequently discontinued.

## **E. Rebate Bid Negotiation**

1. *Describe in detail the framework, conditions and processes used in negotiating rebates in this specific sense including in evaluating the rebate value in relation to the Member States' drug product utilization mix.*

Please refer to our response to Question A.3 in Section VIII regarding our approach to negotiating supplemental rebates and how GHS analyzes and evaluates offers in relation to member state's PDL.

2. *Describe how they would envision gathering information from Member States and their staff to perform the negotiations.*

Prior to the annual negotiations with the manufacturers GHS hosts teleconference meetings with the SSDC Member States to discuss the overall approach and strategize with members states. We review changes in state regulations that could affect their individual PDLs, discuss the impact of changes on the federal level and discuss potential new drugs coming into the market place as

well as the movement from Brand name drugs to their generic versions. We review the bid process with any new SSDC members. We review with SSDC Member States what has and has not worked well over the previous year to continuously strive to improve upon the process. We provide bidding examples, explain how competitive bids will be simulated and then maximized with subsequent counteroffers by setting conditions to better prepare states for the bid review process. Annual training is also offer as needed.

3. *Describe how they will identify, schedule, and coordinate all meetings with the designated manufacturers on behalf of the Member State(s).*

Once the timeline has been approved by SSDC Member States GHS provides notification to the pharmaceutical manufacturers. The timeline is driven by the need to have draft PDLs ready for presentation to individual state drug committees in the fall. The notification includes the schedule/timeline for offers to be submitted and allows for manufacturers to set up in person/telephone/ or web-based meetings to discuss specifics relating to the drug/criteria and offer that they will be submitting.

4. *Describe how they will evaluate the results to determine what proposals are most appropriate clinically and financially for the Member State(s) and provide the Member State(s) with options.*

GHS will provide financial/clinical modeling scenarios. It is important for the model to emphasize that the sum of SR dollars or the percent of the drug budget that they represent are not necessarily the best indicators of success. The best indicator is net cost. The SSDC Member States should judge the success of the PDL design and strategies by how well its net cost trends are controlled over time. Accepting big SRs on very expensive drugs may give an extremely misleading impression of how well the negotiator has done. Overpriced drugs need to give oversized rebates just to reach price parity with best-priced drugs in many classes. The financial models will try to highlight these situations to the drug review committees.

At a detailed level, the cost analyses are performed to arrive at comparisons of net costs. We take state-specific pharmacy reimbursement rate(s), FULs, and SMACs and then subtract out CMS rebates (and eventually supplemental rebates) to arrive at net costs. We then compare drug net costs within PDL classes to help decide best values. Most drugs, especially the one unit per day drugs, are then easily compared. Other drugs require adjustments in order to arrive at fair comparisons. For example, we judge inhalers, nose sprays and eye drops by actual utilization

data. We apply a net cost value to the average number of units used per day supply by the entire state Medicaid population. Another example concerns antibiotics. We determine the most frequently prescribed courses of therapy and model out net costs to arrive at net cost per course of therapy.

The last major component of the cost analysis relates to market share. The committee members need to know how many scripts/people are on (tentatively) preferred and non-preferred drugs. They also need to know if any data exists that would help predict the probability of success if drug A was made preferred and drug B non-preferred. This data assists in making sound decisions. In the more complex analysis, we use a predictive pricing approach to estimate the final budget impact of PDL decisions after accounting for all rebates, prescribing alterations, and offsetting administrative costs. We have attached the initial step of this methodology in Appendix 4.

Health Care Reform has had a tremendous effect on financial analyses for state Medicaid programs. We have had to incorporate potential rebate losses to the Federal government due to this bill in order to help state clients accurately forecast true PDL savings. We have access to AMP pricing for most drugs and for the others used WAC as a proxy to estimate brand rebate losses. When Best Price was available we used it to reduce the state's potential obligation to the federal government. As an example, in Appendix 4 we have also included a financial model created and provided to the SSDC regarding the impact on the BPH class.

5. *Describe how they would coordinate their activities with Member States and their staff.*

GHS will host teleconferences to discuss and coordinate schedules. Email is used for the approval process of letters and timelines. Training is made available to both SSDC Member States and manufacturers on the use of the eROMS system.

6. *Describe timeliness standards in making information available to SSDC Member States while the negotiation process is underway so that the states can assess the progress of the process and consider its potential impact on their PDLs.*

Authorized State users have 24/7 access to eROMS, where they can view all offers, monitor the course of negotiations, and retrieve historical offer data as needed. As soon as state members

register and are verified as “authorized” users they will have immediate access to the eROMS system.

- |    |  |
|----|--|
| 7. | <i>Describe how they would communicate the results of the negotiations to the Member States.</i> |
| 8. | <i>Provide examples where appropriate.</i>   |

In addition to secure 24x7 access to the eROMS system, the annual bid review meeting is the primary vehicle for communication of bid offers to the SSDC Member States. Conference calls are set up as necessary to communicate any identified issues during the rebate solicitation process. Examples of update materials sent to Member States have been included in Appendix 5.

## **F. Bid Selection Notification**

1. *Describe how the notification materials will be available to the Member States or their agents for their review prior to release.*

The current approved SSDC process is to send all materials to the SSDC contract manager for review and distribution to SSDC Member States. GHS does not release any information to manufacturers on behalf of the SSDC without first obtaining prior approval.

2. *Describe their experience in compiling sensitive information for distribution.*

GHS manages over a dozen accounts and process data extracts and loads on both a regular and ad hoc basis. We currently manage over 20 major databases and manipulate over 2 million records per day. We maintain segregation of customer data to ensure integrity and security. Unlike some of our closest competitors, GHS has never experienced a breach in security or confidentiality, thanks to our robust security, confidentiality and auditing procedures.

3. *Describe in what formats this data will be presented to manufacturers.*

GHS’ eROMs system allows manufacturers to view compiled SSDC Member States data by NDC, number of units and status of offer.

4. *Describe how the notification materials as sent to manufacturers will be available to the Member States or their agents.*

GHS notifies manufacturers on the status of their offers via eROMS. The system notifies manufactures via email on decisions by SSDC Member States. In addition, any changes in the bid solicitation process timeline are also communicated via eROMS. Member states have 24/7 access to the eROMS system to view offer status.

5. *Describe how they will communicate the results of the final supplemental rebate agreements and the appropriate contacts to the Member States.*

SSDC Member States have 24/7 access to the eROMS system. The final agreed-upon results of all Supplemental Rebate offers are accessible at any time. Member States have two options for this report. GHS supplies a standard “Offer Accepted Report” which is produced and distributed upon request. The second option is a self-serve report available through GHS’ Business Objects/Business Intelligence portal for Member States that currently have, or wish to purchase, a license. Optional pricing for this license has been included in our separate cost proposal.

6. *Describe what safeguards will be utilized to assure that information is not inadvertently and inappropriately disseminated to parties that should not have access to it.*

We use database replication for performance and security purposes to support our developers and analysts in their own environment. GHS applies at least 128 bit encryption for all data sets transferred electronically to and from our business partners. We also use 1024 bit DSA SSH Version 2 encryption for any data sets transmitted by means other than a secure web interface. This will also apply to all claims data sets sent to and from GHS’ data center through our enterprise Extract Transfer Load (ETL) system. Authentication for our ETL system is provided by a public key / private key authentication method. For more detailed information please see GHS’ Security Policy, included in Appendix 6.

## **G. General Administrative Functions**

1. *Describe their experience in developing and maintaining a website.*

GHS has developed and maintained numerous websites for our clients. These include websites in support of full pharmacy benefit services functions in Maine, Iowa and Wyoming, clinical support services in West Virginia as well as web-based prescription monitoring programs. We designed, developed and are currently maintaining the SSDC website [www.rxssdc.org](http://www.rxssdc.org).

In addition, we managed four years of supplemental rebate negotiations through web-based applications for the State of Maine and solicited supplemental rebates for Iowa’s successful first negotiation year using a web-based application. Subsequently, we designed and developed the GOOLD electronic Rebate Offer Management System (eROMS), which is a web-enabled application used to manage Supplemental Rebate negotiations. GOOLD eROMS is currently

deployed and maintained in support of the SSDC and Georgia accounts. For more detail, please see GHS' Security Policy, included in Appendix 6.

2. *Describe their experience in operating customer service type support and managing and responding to telephonic, written, and e-mail inquiries in a timely and accurate manner.*

GHS has been providing a wide range of help desk services to physicians, pharmacists, and members for over 19 years. We presently operate help desks for 6 states, serving provider, prescriber and member populations in Colorado, Maine, Illinois, Iowa, West Virginia and Wyoming. Our staff provides timely and accurate responses by telephone, mail and e-mail while maintaining the confidentiality of information. Our staff has consistently demonstrated a culture of being "responsive, helpful and courteous" when responding to inquiries received from customers, providers, prescribers and members. Communications planning is designed to ensure that all project participants, both DHHS and GHS staff, and senior executives are kept fully informed of all project activities, and have communication channels to ensure that needed information is tracked and reported effectively. A key element of the GHS communications strategy is to ensure that GHS and DHHS lines of authority and communications interfaces, including formal meetings and reports and impromptu meetings and messaging follow a "chain of command" structure that ensures the effectiveness of communications. The GHS Project Manager will serve as the primary point of contact for SSDC-related inquiries to ensure consistent, clear communications. SSDC Member States, however, will have complete access to our Augusta staff working on this project.

3. *Describe their experience and standards in the use of varied "mailing" options.*

GHS believes that communication that takes place early and often, in both formal and informal processes, is critical to ensuring the on-going timely and effective operation of a project. GHS uses varied communication methods to ultimately create a solid foundation for implementation and operations based on keeping stakeholders informed. Established communication methods include website postings, newsletters, fax blasts, listservs, Email distribution lists, and mass mailings via the USPS.

4. *Describe what the communication vehicle will be to relay issues in an accurate manner to SSDC members including their staff and agents.*

When issues have come up that were identified by GHS in the past, we have immediately reached out to the effected members and contract administrator through phone and email. We prefer there to be an email/documentation chain. When working through an issue we provide supporting data and screen shots to make our response both thorough and easy to understand. Some issues may affect only a subset of the Member States. In those instances we work directly with the affected members and the SSDC contract administrator. If an issue is found by a Member State, they begin by contacting the SSDC contract administrator or GHS Project Manager, as appropriate, by either phone or email.

5. *Describe timeliness standards in relaying issues to SSDC Member States and their staff and agents.*

GHS' standard business practice is to respond to all inquiries within 1 business day of receipt. In the event of an issue effecting one of our clients, GHS staff would attempt to establish communications immediately and would ensure that notification was successful within 1 business day of becoming aware of the problem. Upon discovery of a problem, the GHS team begins analysis immediately and makes it the top priority for the SSDC team. Once we have an understanding of the issue and any potential impacts, we immediately engage the SSDC contract manager and the effected states, or the entire pool as appropriate. We take our responsibilities to customer service very seriously.

6. *Describe their experience in developing user materials and training staff.*

GHS has approved documentation for the SSDC systems and processes currently in place. GHS maintains and updates this documentation regularly and in accordance with all applicable customer terms and regulations. All documentation is release-driven and made available to all end users of the system. Developing well-written, clear materials and proper training is a requirement of all of our pharmacy contracts. GHS staff members will review current documentation as part of the implementation and make any needed revisions to ensure that the standard documentation accurately reflects all functionality, including any new configuration or customization that results from this RFP process.

7. Describe their experience in providing various reports of the type which would be requested by SSDC Member States in an SSDC approved format.

GHS offers robust reporting services to all of our clients and has been providing reporting services to the SSDC Member States throughout the term of the current contract. GHS is prepared to review the reporting requirements with project stakeholders in detail upon contract award to ensure that our existing reporting services continue to meet the Member States' needs.

8. Describe their experience in compiling data sets of the sort described.  
 9. Describe how that data would be compiled.  
 10. Describe in what formats it would be made available for the review.  
 11. Describe how these formats will facilitate ready review.  
 12. Describe how this data might be presented; for example, in meetings, e-mail, or web-based presentations or other means.

Please see Section VIII.B of this proposal for a complete description of data set compilation, experience, methods, formats, review and presentation.

13. Describe how this data may be made available to SSDC Member States in a timely fashion.

GHS has multiple methods for communicating data to SSDC Member States, depending on the context. The most frequently used are described below.

Method	Comment
<b>Self-Serve Report:</b>	The Rebate Bid Report can be made available to any Member State that has, or chooses to purchase, the optional Business Objects license. This report was built to address the needs of states for analyzing bids for supplemental rebate. It allows the user to query by drug name, PDL category (when feed is available) or company name and to see information on a drug's PDL status, utilization and bidding information (if applicable). This report can be exported to Excel, allowing the user to analyze the data as they wish.
<b>Phone and email:</b>	We generally turn around specific data requests within 48 hours via phone or email.
<b>Reports:</b>	Custom or standard reports can be generated and emailed within an agreed upon timeframe. Reports are scheduled to be available to states to coincide with, and support, SSDC milestones. All reports that contain confidential information are password-protected prior to distribution. Standard modes of transmission include email, telephone, FTP, USPS or web portal.

14. Describe a process for accurate reporting and monitoring of negotiated supplemental rebates in an SSDC approved format.

GHS allows monitoring of the bidding process in three ways. Firstly, all states are able to review the most recent offers for each NDC through the Offer Review Screen in SSDC eROMS. States are also select in individual NDC through the NDC lookup screen and drill down to see all offers associated with an NDC. Secondly, Member States may opt to receive additional automation

services through GHS' Business Objects Solution. Finally, GHS provides Member States with reports to their specifications at predetermined times during the bidding cycle. The timing of the reports will coincide to support SSDC milestones in an agreed upon format.

15. *Describe their experience in assessing the impact of factors/conditions on the drug rebate bids; e.g., federal Medicaid drug rebate policy research and analysis; alternative drug development tracking; related litigation research and analysis; etc.*
16. *Provide examples where appropriate.*

GHS has extensive experience in assessing the impact of outside factors/conditions on drug rebate bids. Our financial modeling experience and expertise is more completely described in section VIII.A.3 of this proposal. One example of the kinds of analysis GHS produces is the impact of Health Care Reform. Health Care Reform has had a tremendous effect on financial analyses for state Medicaid programs. We have had to incorporate potential rebate losses to the Federal government due to this bill in order to help state clients accurately forecast true PDL savings. We have access to AMP pricing for most drugs and for the others used WAC as a proxy to estimate brand rebate losses. When Best Price was available we used it to reduce the state's potential obligation to the federal government. Samples of financial analyses and impact analyses have been included in our response to Section VIII.A.3 and Appendices 5 and 6 of this proposal.

#### **H. Required Reports**

GHS offers our clients robust, flexible and scalable reporting services that include both standard and ad hoc reports. Effective reporting is a critical function of GHS' proposed solution. GHS uses reporting to monitor our performance and to assure that we are carrying out all our responsibilities effectively. Reporting allows Member State policymakers to evaluate the impact of decisions as well as opportunities for cost savings and quality improvement. Reporting is also critical to the SSDC's ability to hold GHS accountable for performance of our contractual obligations.

GHS presently provides the SSDC with standard and ad hoc reporting on a pre-determined and pre-approved schedule. We have the experience and competence necessary to meet the reporting requirements as outlined in this RFP. While we presently provide many of the reports being requested, we recognize that some new reports and updates are being requested. Our team of data analysts, clinicians and support staff – our “integrated clinical data teams” – will work with key

stakeholders upon contract award to document new reports or updates to existing reports that are needed to meet RFP requirements and customer service expectations. Print-ready reports will be delivered electronically using Microsoft Word or Excel, unless other specified.

### **I. Staffing and Time Requirements**

GHS recognizes our responsibility to provide sufficient staffing to ensure that the majority of the SSDC's Medicaid supplemental drug rebate bid procurement services are completed during the Spring, Winter and Fall of a given year so that agreements are effective January 1 of the following year. GHS has been providing these services to the SSDC for the last 6 consecutive rounds of negotiation and will maintain the timeline currently in place, unless changes are requested by the SSDC Member States. As a result, GHS has the staffing, experience and procedural knowledge in place to ensure that the 6 Medicaid supplemental drug rebate bid procurement services requested in this RFP continue without disruption into the next contract period.

Roger Boissonneau is GHS' proposed SSDC Project Manager for the upcoming engagement. He will continue to serve as both the Transition/Implementation Manager and Project/Account Manager for this project. Roger will act as the single point of contact representing GHS throughout the life of the contract. Roger will ensure that all communications flow efficiently and effectively between GHS staff, SSDC Member States and any other designated project stakeholders.

All SSDC Member States have equal and complete access to GHS and our staff. Roger, as the primary point of contact, will coordinate all communication between GHS and the SSDC Members. A complete contact list of the key staff named in the proposal was included in Tab 2 of this proposal, along with the transmittal letter. GHS will continue to provide updated contact lists in accordance with the RFP requirements.

The GHS staff included in the proposed staffing plan are uniquely qualified to continue providing the services requested. As the incumbent vendor, our staff is familiar with the current processes, business rules and operating procedures. Our experience staff will ensure consistency

and stability in the provision of the 6 services requested. Individual staff qualifications are described in greater detail in Section VII of this proposal.

#### **J. Post Implementation**

GHS provides all routine procedural support and systems maintenance required for the SSDC activities and production applications. Our skilled technical staff is available to address any questions or problems related to the operation of our systems between the hours of 7:00 a.m. and 6:00 p.m. EST and our clinical and administrative staff is available during regular business hours to any SSDC member to address questions, resolve issues or provide updates. GHS will maintain our current high level of service and support under any new contract resulting from this procurement process, ensuring that the SSDC members experience no interruption in the supplemental rebate services and applications provided. Any future changes to GHS operations that may impact SSDC services will be submitted to the SSDC Member States for review and prior approval.

#### **K. Disaster Recovery**

GHS maintains robust system protection processes and procedures for the work we conduct, including work related to the SSDC project. These procedures are described in greater detail in subsequent paragraphs and meet or exceed the requirements outlined above.

GHS has an enterprise-wide Disaster Recovery and Business Continuity Plan in place. This plan will be provided to the SSDC for review and approval after contract award. GHS' disaster recovery policies and procedures include detailed information on risks, impacts and mitigation of potential disaster events, priorities regarding business and service delivery function to be restored in response to a disaster event, a communications matrix to be used from the onset to conclusion of a disaster event, criteria used to activate contingency plans, exit criteria to be used to determine the successful resumption of business and service delivery functions, procedures for testing and procedures for periodic changes and updates to the Disaster Recovery Plan.

To mitigate physical and logical disaster, GHS takes state-of-the-industry steps at all levels. We maintain a secure, off-site co-location facility where mission critical data is replicated. Border network security is protected by dual firewalls. Firewall activity is monitored and Intrusion

Detection Systems (IDS) lock out IP addresses if hack attempts occur. Our firewall logs are monitored and audited regularly. Our servers are protected by anti-malware software. Anti-virus definitions are updated at least once daily. Operating systems are patched on a regular basis to ensure known exploits are mitigated.

To mitigate system fault our systems are back-ended on a redundant SAN (Storage Area Network), database servers are run in high-availability clusters with automatic fail-over, our web and application servers run on virtual machines configured in high-availability mode. All network infrastructure connected to the servers and storage has redundant (multi-homed) connections.

To alleviate storage fault, we also replicate all data to a secondary SAN. All systems and data are backed up on a weekly full and nightly incremental or differential cycle. Tapes are moved off-site and retained in a secure storage facility that is only accessible by GHS Network Services staff. All Network Services staff members are trained in backup, recovery, and secure tape storage procedures.

Recent upgrades to our data center have moved us from a Tier 2 to a Tier 3 data center as defined by the Uptime Institute. We feature dual redundant cooling, dual redundant UPS' powering each rack and each server power supply. We also have a backup generator that can run for 72 hours on load with contingency contracts in place with fueling companies for any potential scenario requiring extended use of the generators.

#### **L. End of Contract Transition Plan**

All electronic or hard-copy documentation maintained by GHS will be transferred to any subsequent vendor as directed by the SSDC. Any electronic data will then be permanently removed from GHS's data warehouse at pre-determined amount of time after contract termination. The data retention timeframe must be dictated by the SSDC.

The following is an excerpt of a typical Table of Contents from a transition plan for data and rebate services:

1. Introduction
2. Approach to Transition
3. Resource Requirements
  - a. Staffing
4. Definition of Scope
  - a. SSDC and Member State Responsibilities
  - b. GHS Responsibilities
  - c. New Contractor Responsibilities
5. Services Terminated / Transitioned
  - a. SSDC offer submission portal (eRebs Application)
  - b. Data feeds to / from GHS / SSDC partners
  - c. SR contract negotiations
  - d. Transfer of paper and electronic documents
6. Transition Schedule and Deliverables
  - a. Schedule
  - b. Deliverables
  - c. Timeline
7. Contingency Planning

### M. Performance Standards

GHS proposes the penalties listed in column three of the table below. In aggregate, the maximum liquidated damages for any month would be equal to 10% of the total admin fee for that month.

Service Performance Standards	Guarantee	Description of Penalty/Liquidated Damages and Frequency
1. <b>Member States' utilization data compilation</b>	Produce compilations: <ul style="list-style-type: none"> <li>• By April 1 of the year prior to the rebate calendar year bid year unless otherwise approved by the Member States</li> <li>• Within 2 work weeks of request in the case of potential Member State</li> </ul>	GHS proposes penalties/liquidated damages equal to 1% of that month's admin fee to GHS if found to be out of compliance with these performance guarantees.
2. <b>Rebate bid solicitation</b>	<ul style="list-style-type: none"> <li>• Initiate solicitation no later than April 1 of the year prior to the rebate calendar year bid year unless otherwise approved by the Member States</li> <li>• Provide a vehicle to allow manufacturers to submit bids in a minimum 30-day time frame</li> </ul>	GHS proposes penalties/liquidated damages equal to 1% of that month's admin fee to GHS if found to be out of compliance with these performance guarantees.
3. <b>Rebate bid presentation</b>	Provide Member States with a bid presentation no later than: <ul style="list-style-type: none"> <li>• Weekly unless otherwise approved during rebate calendar year bid year cycle</li> <li>• 10 days after the close of the bid solicitation</li> <li>• 10 days after receipt for mid-year proposals</li> </ul>	GHS proposes penalties/liquidated damages equal to 1% of that month's admin fee to GHS if found to be out of compliance with these performance guarantees.
4. <b>Rebate bid negotiation</b>	Complete negotiations no later than 14 days after the Member State bid presentation	GHS proposes penalties/liquidated damages equal to 1% of that month's admin fee to GHS if found to be out of compliance with these performance guarantees.
5. <b>Bid selection notification</b>	Notify manufacturers of the final disposition of their supplemental rebate offers no later than 7 days after the Member State acceptance/rejection	GHS proposes penalties/liquidated damages equal to 1% of that month's admin fee to GHS if found to be out of compliance with these performance guarantees.
6. <b>General Administrative Functions</b>	<ul style="list-style-type: none"> <li>• Establish and maintain a SSDC specific web page subject to the approval of the Member States or their agent</li> <li>• Provide timely response to Member State contacts within 2 business days</li> <li>• Provide timely response to manufacturers contacts within 2 business days</li> <li>• Provide necessary process training to Member State staff and agents no later than 15 days after the rebate calendar year bid year solicitation</li> <li>• Produce Member State SSDC supplemental rebate program reports within agreed upon time frames</li> <li>• Provide a disaster recovery and business continuity plan during the implementation phase of the contract</li> <li>• Perform weekly information and data backups</li> <li>• Comply with the terms and conditions of the agreed upon end of contract transition plan</li> </ul>	GHS proposes penalties/liquidated damages equal to 5% of that month's admin fee to GHS if found to be out of compliance with these performance guarantees.

# IX. Appendix 1

## SNRI Pharmaco-Economic Model

<<State>> Medicaid Pharmacy  
**New Generation Antidepressants- SNRI ONLY Modeling**  
**For Entire Year**  
Based on Q1 CY2009 Utilization and Supplemental Rebate Offers

**Current Status A: Supplemental rebate offers are not taken yet**

	PDL Status	# Units	# Scripts	Weighted Avg Pre-Rebate Ingr \$/Unit	Weighted Avg CMS Rebate \$/Unit	Weighted Avg Supp Rebate \$/Unit	Weighted Avg Net \$/Unit	Total Pre-rebate \$	Total CMS Rebate	Total SR	Total Net \$	Weighted Avg Pre-rebate \$/Script	Weighted Avg Post-rebate \$/Script	Total Net Savings off Current		
EFFEXOR XR	NR	203,122	6,094	\$ 4.34	\$ 2.51	\$ -	\$ 1.93	\$ 880,658	\$ 509,443	\$ -	\$ 371,215	\$ 169.69	\$ 75.44			
PRISTIQ	N	17,585	598	\$ 3.80	\$ 0.84	\$ -	\$ 2.96	\$ 66,770	\$ 14,857	\$ -	\$ 51,912	\$ 112.44	\$ 87.72			
VENLAFAXINE ER	N	270	9	\$ 5.30	\$ 1.92	\$ -	\$ 3.49	\$ 1,432	\$ 518	\$ -	\$ 914	\$ 159.08	\$ 104.57			
CYMBALTA	NR	1,480,724	50,008	\$ 4.24	\$ 1.39	\$ -	\$ 2.87	\$ 6,279,469	\$ 2,063,321	\$ -	\$ 4,216,148	\$ 125.57	\$ 84.90			
SAVELLA	N	960	16	\$ 1.80	\$ 0.23	\$ -	\$ 1.55	\$ 1,724	\$ 223	\$ -	\$ 1,501	\$ 107.74	\$ 93.21			
EFFEXOR	P	13,216	244	\$ 0.58	\$ 1.56	\$ -	\$ (0.97)	\$ 7,604	\$ 20,606	\$ -	\$ (13,003)	\$ 17.26	\$ (29.22)			
VENLAFAXINE	N	5,502	94	\$ 0.58	\$ 0.02	\$ -	\$ 0.56	\$ 3,166	\$ 109	\$ -	\$ 3,057	\$ 24.99	\$ 24.17			
		<b>1,721,379</b>	<b>57,063</b>					<b>Current Spending:</b>	<b>\$ 7,240,822</b>	<b>\$ 2,609,077</b>	<b>\$ -</b>	<b>\$ 4,631,745</b>				<b>0</b>

**Scenario A 0: Supplemental rebate offers are taken, only EFFEXOR XR and Effexor Preferred**

	PDL Status	# Units	# Scripts	Weighted Avg Pre-Rebate Ingr \$/Unit	Weighted Avg CMS Rebate \$/Unit	Weighted Avg Supp Rebate \$/Unit	Weighted Avg Net \$/Unit	Total Pre-rebate \$	Total CMS Rebate	Total SR	Total Net \$	Weighted Avg Pre-rebate \$/Script	Weighted Avg Post-rebate \$/Script	Total Net Savings off Current		
EFFEXOR XR	P	203,122	6,094	\$ 4.34	\$ 2.51	\$ 0.23	\$ 1.70	\$ 880,658	\$ 509,443	\$ 47,095	\$ 324,121	\$ 169.69	\$ 66.37			
PRISTIQ	N	17,585	598	\$ 3.80	\$ 0.84	\$ -	\$ 2.96	\$ 66,770	\$ 14,857	\$ -	\$ 51,912	\$ 112.44	\$ 87.72			
VENLAFAXINE ER	N	270	9	\$ 5.30	\$ 1.92	\$ -	\$ 3.49	\$ 1,432	\$ 518	\$ -	\$ 914	\$ 159.08	\$ 104.57			
CYMBALTA	NR	1,480,724	50,008	\$ 4.24	\$ 1.39	\$ -	\$ 2.72	\$ 6,279,469	\$ 2,063,321	\$ -	\$ 4,216,148	\$ 125.57	\$ 84.90			
SAVELLA	N	960	16	\$ 1.80	\$ 0.23	\$ -	\$ 1.55	\$ 1,724	\$ 223	\$ -	\$ 1,501	\$ 107.74	\$ 93.21			
EFFEXOR	P	13,216	244	\$ 0.58	\$ 1.56	\$ -	\$ (0.97)	\$ 7,604	\$ 20,606	\$ -	\$ (13,003)	\$ 17.26	\$ (29.22)			
VENLAFAXINE	N	5,502	94	\$ 0.58	\$ 0.02	\$ -	\$ 0.56	\$ 3,166	\$ 109	\$ -	\$ 3,057	\$ 24.99	\$ 24.17			
		<b>1,721,379</b>	<b>57,063</b>					<b>Current Spending:</b>	<b>\$ 7,240,822</b>	<b>\$ 2,609,077</b>	<b>\$ 47,095</b>	<b>\$ 4,584,650</b>				<b>\$ 188,379</b>

**Scenario A 1: Supp rebate offers are taken, VENLAFAXINE ER becomes Preferred and take 90% from EFFEXOR XR,**

	PDL Status	# Units	# Scripts	Weighted Avg Pre-Rebate Ingr \$/Unit	Weighted Avg CMS Rebate \$/Unit	Weighted Avg Supp Rebate \$/Unit	Weighted Avg Net \$/Unit	Total Pre-rebate \$	Total CMS Rebate	Total SR	Total Net \$	Weighted Avg Pre-rebate \$/Script	Weighted Avg Post-rebate \$/Script	Total Net Savings off Current		
EFFEXOR XR	N	20,042	609	\$ 4.34	\$ 2.51	\$ -	\$ 1.93	\$ 86,894	\$ 50,267	\$ -	\$ 36,628	\$ 169.69	\$ 75.44			
PRISTIQ	N	17,585	6,083	\$ 3.80	\$ 0.84	\$ -	\$ 2.96	\$ 66,770	\$ 14,857	\$ -	\$ 51,912	\$ 112.44	\$ 87.72			
VENLAFAXINE ER	P	183,350	9	\$ 5.30	\$ 1.92	\$ 2.24	\$ 1.24	\$ 972,213	\$ 351,464	\$ 411,333	\$ 209,417	\$ 207.52	\$ 48.61			
CYMBALTA	NR	1,480,724	50,008	\$ 4.24	\$ 1.39	\$ -	\$ 2.72	\$ 6,279,469	\$ 2,063,321	\$ -	\$ 4,216,148	\$ 125.57	\$ 84.90			
SAVELLA	N	960	16	\$ 1.80	\$ 0.23	\$ -	\$ 1.55	\$ 1,724	\$ 223	\$ -	\$ 1,501	\$ 107.74	\$ 93.21			
EFFEXOR	P	13,216	244	\$ 0.58	\$ 1.56	\$ -	\$ (0.97)	\$ 7,604	\$ 20,606	\$ -	\$ (13,003)	\$ 17.26	\$ (29.22)			
VENLAFAXINE	N	5,502	94	\$ 0.58	\$ 0.02	\$ -	\$ 0.56	\$ 3,166	\$ 109	\$ -	\$ 3,057	\$ 24.99	\$ 24.17			
		<b>1,721,379</b>	<b>57,063</b>					<b>Current Spending:</b>	<b>\$ 7,417,839</b>	<b>\$ 2,500,847</b>	<b>\$ 411,333</b>	<b>\$ 4,505,660</b>				<b>\$ 504,340</b>

**Figure 4: SNRI Modeling**  
**Actual numbers have been changed to protect confidential CMS and SR information.**

The SNRI antidepressants cost over \$7 million annually for this sample client, or nearly 3% of this example state’s drug budget. In this example, the State Legislature had placed restrictions on this class, making it difficult to curb expensive chemically unique antidepressants. Since Venlafaxine ER is the same chemical as Effexor XR the State was then able to capture some savings when significant SR offers were made on both drugs. In this model, which incorporated all pre-rebate costs, CMS and potential SRs, savings were modeled out on the most recent quarter’s utilization. The Excel sheet model allows us to vary assumptions concerning expected utilization changes along with different mixes of preferred and non-preferred drugs. In this

model it became very clear that one drug's offer was superior and that a high success rate was probable. Taking the lower offer would provide \$188,000 of new savings and not require any switching while accepting the higher offer would result in almost a three-fold higher annual savings of \$504,000 but require a one-time massive switch. In this scenario we also examined the benefit of consolidating multiple strength scripts into a single strength script. In other iterations (not included in the RFP for the sake of brevity) of the model we also examined what would happen if Savella was made preferred or preferred only with step edit criteria to encourage appropriate utilization in fibromyalgia.

## X. Appendix 2

SSDC Marketshare Report Q4 2009															
PDL CATEGORY		Iowa		Maine		Oregon		Utah		Vermont		West Virginia		Wyoming	
Drug Name	Brand or Generic	Scripts	% Mktshr	Scripts	% Mktshr	Scripts	% Mktshr								
<b>ACE AND THIAZIDE COMBO'S</b>															
<b>Benazepril &amp; Hydrochlorothiazide</b>															
Benazepril & Hydrochlorothiazide	G	105	5.60%	108	3.22%	24	5.37%	0	0.00%	11	2.30%	234	4.82%	0	0.00%
<b>Captopril &amp; Hydrochlorothiazide</b>															
Captopril & Hydrochlorothiazide	G	7	0.37%	18	0.54%	0	0.00%	0	0.00%	0	0.00%	21	0.43%	3	1.60%
<b>Enalapril Maleate &amp; Hydrochlorothiazide</b>															
Enalapril Maleate & Hydrochlorothiazide	G	62	3.31%	157	4.68%	7	1.57%	46	4.47%	28	5.43%	242	4.99%	10	5.35%
VASERETIC	B	0	0.00%	4	0.12%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%
<b>Fosinopril Sodium &amp; Hydrochlorothiazide</b>															
Fosinopril Sodium & Hydrochlorothiazide	G	1	0.05%	3	0.09%	2	0.45%	0	0.00%	0	0.00%	0	0.00%	0	0.00%
MONOPRIL HCT	B	1	0.05%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%
<b>Lisinopril &amp; Hydrochlorothiazide</b>															
Lisinopril & Hydrochlorothiazide	G	1,678	89.49%	2,987	89.11%	400	89.49%	954	92.71%	436	91.02%	4,296	88.54%	174	93.05%
ZESTORETIC	B	4	0.21%	3	0.09%	3	0.67%	0	0.00%	0	0.00%	0	0.00%	0	0.00%
<b>Moexipril-Hydrochlorothiazide</b>															
Moexipril-Hydrochlorothiazide	G	0	0.00%	46	1.37%	3	0.67%	21	2.04%	3	0.63%	0	0.00%	0	0.00%
UNIRETIC	B	17	0.91%	2	0.06%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%
<b>Quinapril-Hydrochlorothiazide</b>															
ACCURETIC	B	0	0.00%	3	0.09%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%
Quinapril-Hydrochlorothiazide	G	0	0.00%	21	0.63%	8	1.79%	8	0.78%	3	0.63%	59	1.22%	0	0.00%
<b>ACE INHIBITORS</b>															
<b>Benazepril HCl</b>															
Benazepril HCl	G	493	4.13%	808	2.57%	82	1.86%	57	2.07%	35	0.97%	906	3.37%	28	2.01%
LOTENSIN	B	0	0.00%	8	0.03%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%
<b>Captopril</b>															

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PDL CATEGORY		Iowa		Maine		Oregon		Utah		Vermont		West Virginia		Wyoming	
Drug Name	Brand or Generic	Scripts	% Mktshr	Scripts	% Mktshr	Scripts	% Mktshr								
<b>ACE INHIBITORS</b>															
Captopril	G	166	1.39%	337	1.07%	25	0.57%	8	0.29%	10	0.28%	323	1.20%	33	2.37%
<b>Enalapril Maleate</b>															
Enalapril Maleate	G	1,759	14.73%	3,591	11.40%	340	7.72%	280	10.19%	364	10.13%	3,456	12.86%	131	9.42%
VASOTEC	B	0	0.00%	8	0.03%	0	0.00%	0	0.00%	2	0.06%	3	0.01%	0	0.00%
<b>Enalaprilat</b>															
Enalaprilat	G	1	0.01%	0	0.00%	0	0.00%	8	0.22%	0	0.00%	0	0.00%	0	0.00%
<b>Fosinopril Sodium</b>															
Fosinopril Sodium	G	174	1.46%	280	0.89%	31	0.70%	3	0.11%	21	0.58%	64	0.24%	3	0.22%
MONOPRIL	B	0	0.00%	5	0.02%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%
<b>Lisinopril</b>															
Lisinopril	G	8,771	73.43%	25,613	81.32%	3,717	84.42%	1,965	71.51%	3,077	85.66%	20,169	75.08%	1,141	82.09%
PRINIVIL	B	0	0.00%	7	0.02%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%
ZESTRIL	B	0	0.00%	20	0.06%	0	0.00%	0	0.00%	2	0.06%	6	0.02%	0	0.00%
<b>Moexipril HCl</b>															
Moexipril HCl	G	3	0.03%	65	0.21%	9	0.20%	11	0.40%	2	0.06%	4	0.01%	0	0.00%
UNIVASC	B	3	0.03%	68	0.22%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%
<b>Perindopril Erbumine</b>															
ACEON	B	4	0.03%	5	0.02%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%
<b>Quinapril HCl</b>															
ACCUPRIL	B	0	0.00%	6	0.02%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%
Quinapril HCl	G	74	0.62%	287	0.91%	50	1.14%	154	5.60%	31	0.86%	483	1.80%	14	1.01%
<b>Ramipril</b>															
ALTACE	B	8	0.07%	11	0.03%	0	0.00%	0	0.00%	2	0.06%	0	0.00%	0	0.00%
Ramipril	G	488	4.09%	370	1.17%	118	2.68%	258	9.39%	46	1.28%	1,448	5.39%	40	2.88%
<b>Trandolapril</b>															
MAVIK	B	0	0.00%	1	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%
Trandolapril	G	0	0.00%	6	0.02%	31	0.70%	6	0.22%	0	0.00%	3	0.01%	0	0.00%
<b>ACE INHIBITORS AND CA CHANNEL BLOCKERS</b>															
<b>Amlodipine Besylate-Benazepril HCl</b>															
Amlodipine Besylate-Benazepril HCl	G	10	1.46%	285	79.83%	38	70.37%	0	0.00%	62	92.54%	1,630	99.51%	39	78.00%
LOTREL	B	618	89.93%	64	17.93%	9	16.67%	0	0.00%	5	7.46%	1	0.06%	8	16.00%

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## XI. Appendix 3

Included below is the special analysis exhibit referenced in Section VIII.C.1 of this proposal.

Form Line Extension Drug Summary

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Drug	LE Rebate Penalty % (diff between total rebate %s)	Best Price (BP) Helps? 8% AMP rebate at risk	Potential Total Rebate Loss	SRO available?	Prefer on PDL?
Abilify ODT	5%	No 8% lost	13%	Yes	No
Aricept ODT	0%	Yes 3% to 8% kept	0% to 5%	Yes	Yes
Depakote ER	23% to 32%	No 8% lost	31% to 40%	No	No
Detrol LA	13% to 14%	No 8% lost	21% to 22%	Yes	No
Effexor XR	11%	No 8% lost	19%	No	No
Focalin XR	33% but only on 30, 40 mg (but two 20mg still > 40mg net)	Yes 7/8 kept on old strengths	1% old str. 40% to 41% new	Yes	Yes
Keppra XR	43% to 45%	Yes 3% to 4% kept	47% to 50%	Yes	No
Lescol XL	4%	Yes 8% kept	4%	Yes	Yes
Maxalt MLT	0%	Yes 8% kept	0%	Yes	Yes
Opana ER	1% to 2%	Yes 8% kept	1% to 2%	Yes	Maybe Yes if you liked it...
Paxil CR	5% except 0% on 37.5 mg	Yes 8% kept	5%	No	No
Sanctura XR	34%	Yes 8% kept	34%	Yes	No
Seroquel XR	28% to 44%	No 8% lost	36% to 52%	Yes	No
Tegretol XR	0%	Mixed	0% to 8%	No	Toss up ? Generic SMAC

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## XII. Appendix 4

### Predictive Pricing Approach

The first step involves analyzing whether a specific PDL decision will result in less or more savings than another scenario. This requires us to make market share assumptions, then examine, and quantify the results. To do this, we use prior experiential claims data on similar drugs or drug classes that have already been incorporated within PDLs. In Figure 5 we model several assumptions on the statin class to estimate the final budget impact of PDL decisions. We vary market shares and net unit costs to arrive at potential savings. We then compare the outcomes of these scenarios to projected and actual Lipitor net prices. The models are reviewed with the States to arrive at a best fit.

<i>Exhibit IV c. Cholesterol - HMG COA + Inhibitors</i>		Baseline *	Scenario A	Scenario B	Scenario C	Scenario D
<i>Pure Statins</i>		<i>No Mktshr Chg</i>	<i>No Mktshr Chg</i>	<i>No Mktshr Chg</i>	<i>Mktshr Chg</i>	<i>Mktshr Chg</i>
<b>Simvastatin</b>						
	Avg Units/Script	30	30	30	30	30
	Avg Unit Cost	\$2.00	\$1.00	\$0.50	\$1.00	\$0.50
	Avg Script Cost	\$60.00	\$30.00	\$15.00	\$30.00	\$15.00
<b>LIPITOR</b>						
	Avg Units/Script	30	30	30	30	30
	Avg Unit Cost	\$2.20	\$2.20	\$2.20	\$2.20	\$2.20
	Avg Script Cost	\$66.00	\$66.00	\$66.00	\$66.00	\$66.00
* Baseline = Maine mktshr						
	<b>Baseline MarketShare</b>	<b>Baseline *</b>	<b>Marketshare Cost</b>	<b>Marketshare Cost</b>	<b>Marketshare Cost</b>	<b>Marketshare Cost</b>
	<b>Mktshr</b>					
	<b>Scripts</b>					
<b>Simvastatin</b>	19.0%	19.0%	19.0%	19.0%	66.9%	66.9%
	6,974	6,974	6,974	6,974	24,607	24,607
		\$418,440	\$209,220	\$104,610	\$738,215	\$369,107
<b>LIPITOR</b>	63.0%	63.0%	63.0%	63.0%	15.0%	15.0%
	23,147	23,147	23,147	23,147	5,514	5,514
		\$1,527,702	\$1,527,702	\$1,527,702	\$363,914	\$363,914
		\$1,976,264	\$1,767,044	\$1,662,434	\$1,132,250	\$763,143
			Change from Baseline			
			(\$209,220)	(\$313,830)	(\$844,014)	(\$1,213,121)
			% chg			
			-10.59%	-15.88%	-42.71%	-61.38%

Figure 5: Predictive Pricing Approach

One limitation with the financial model is that it only represents the choices being presented to the Committee (i.e. SR amounts of potential marketshare changes.) The model does not account for what you had last year compared to this year. It is simply focused on facilitating the choice of the best savings option present within an individual drug class.

### BPH Class Financial Model

In the tables below we have illustrated a series of financial models in the BPH class that we recently provided to the SSDC. The CSN is the CMS rebate net price of the drug. The OSN is the net price offered after being reduced by the supplemental rebate. The ADJ OSN is the net price as adjusted by the calculated rebate loss to the federal government. The important points to make are that no PDL decisions can be made presently without the inclusion and consideration of this data. Waiting for CMS to provide these “EQROA”s (estimated quarterly rebate offset amounts) will result in poor interim decisions and significant lost state savings. PBM vendors need to aggressively pursue these rebate offset methodologies in order to best position their clients to avoid rebate losses. GHS has been providing these analyses proactively to our clients to ensure they are well positioned to avoid potential losses.

BPH CLASS FINANCIAL MODELING								
* CMS rebates altered to change net prices, not factual								
Scenario 1: Current BPH Preferreds, PRE-HCR								
	PDL Status	% Marketshare	# Units	CSN*	OSN	SMAC	Total Net \$	Total Net Savings off Current
AVODART	P	15.2%	10,327	2.09			\$ 21,583.43	
FINASTERIDE	P	4.5%	3,063			0.87	\$ -	
PROSCAR	N	0.0%	30	1.79			\$ 53.70	
UROXATRAL	P	4.7%	3,207	1.45			\$ 4,650.15	
FLOMAX	N(P)	75.5%	51,304	1.29			\$ 66,182.16	
TAMSULOSIN	P	0.0%	22			0.65	\$ -	
		100.0%	67,953				\$ 92,469.44	

Figure 6: BPH Class Financial Modeling Scenario 1

Scenario 2: Current BPH Preferreds, POST-HCR								
	PDL Status	% Marketshare	# Units	CSN*	ADJ CSN	SMAC	Total Net \$	Total Net Savings off Current
AVODART	P	15.2%	10,327	2.09	2.30		\$ 23,752.10	
FINASTERIDE	P	4.5%	3,063			0.87	\$ 2,664.81	
PROSCAR	N	0.0%	30	1.79	1.94		\$ 58.20	
UROXATRAL	N	4.7%	3,207	1.45	1.64		\$ 5,259.48	
FLOMAX	N(P)	75.5%	51,304	1.29	1.51		\$ 77,469.04	
TAMSULOSIN	P	0.0%	22			0.65	\$ 14.30	
		100.0%	67,953				\$ 109,217.93	\$(16,748)

Figure 7: BPH Class Financial Modeling Scenario 2

Scenario 3: Current BPH Preferreds, POST-HCR, Post Flomax shift into tamsulosin									
	PDL Status	% Marketshare	# Units	CSN*	ADJ CSN	SMAC	Total Net \$	Total Net Savings off Current	
AVODART	P	15.2%	10,327	2.09	2.30		23,752.10		
FINASTERIDE	P	4.5%	3,063			0.87	2,664.81		
PROSCAR	N	0.0%	30	1.79	1.94		58.20		
UROXATRAL	N	4.7%	3,207	1.45	1.64		5,259.48		
FLOMAX	N	0.1%	90	1.29	1.51		135.90		
TAMSULOSIN	P	75.4%	51,236			0.65	33,303.40		
		100.0%	67,953				65,173.89	\$ 27,295	

Figure 8: BPH Class Financial Modeling Scenario 3

Scenario 4: Assume taking SR deals on Avodart and Uroxatral w/o share change from current										
	PDL Status	% Marketshare	# Units	CSN*	ADJ CSN	OSN	ADJ OSN	SMAC	Total Net \$	Total Net Savings off Current
AVODART	P	15.2%	10,327	2.09	2.30	1.59	1.84		\$ 19,001.68	
FINASTERIDE	P	4.5%	3,063					0.87	\$ 2,664.81	
PROSCAR	N	0.0%	30	1.79	1.94				\$ 58.20	
UROXATRAL	P	4.7%	3,207	1.45	1.64	0.83	1.08		\$ 4,425.66	
FLOMAX	N	0.1%	90	1.29	1.51				\$ 135.90	
TAMSULOSIN	P	75.4%	51,236					0.65	\$ 33,303.40	
		100.0%	67,953						\$ 59,589.65	\$ 32,879

Figure 9: BPH Class Financial Modeling Scenario 4

Scenario 5: Assume NP Avodart and Uroxatral, each lose 80% shares										
	PDL Status	% Marketshare	# Units	CSN*	ADJ CSN	OSN	ADJ OSN	SMAC	Total Net \$	Total Net Savings off Current
AVODART	N	3.0%	2,066	2.05	2.30	1.59	1.84		\$ 3,801.44	
FINASTERIDE	P	16.7%	11,324					0.87	\$ 9,851.88	
PROSCAR	N	0.0%	30	1.71	1.94				\$ 58.20	
UROXATRAL	N	0.9%	644	1.38	1.64	0.83	1.08		\$ 888.72	
FLOMAX	N	0.1%	90	1.21	1.51				\$ 135.90	
TAMSULOSIN	P	79.2%	53,799					0.65	\$ 34,969.35	
		100.0%	67,953						\$ 49,705.49	\$ 42,764

Figure 10: BPH Class Financial Modeling Scenario 5

In the BPH model scenarios provided it should be noted that the Health Care Reform induced rebate losses caused an 18% increase (from \$92,469 to \$109,469) in the net cost of the drug category, assuming supplemental rebates are not involved. In Scenario 4, where it is assumed that SR deals are taken on the brands, the net cost declines to \$59,570 thus saving \$32,879. The best savings opportunity, Scenario 5, assumes only generic drugs are preferred and therefore most brand drug rebate losses are avoided, resulting in a total net savings of \$42,764. In summary, we cannot overemphasize how vital rebate losses (offsets) are to developing accurate, useful financial models to state decision makers.

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## XIII. Appendix 5

Included below are samples of updates provided to SSDC Member States during the bidding process.

Hello everyone,
You can read the following "cheat sheet" summary before or after perusing the initial bids. If you are pressed for time you may want to concentrate on the categories where issues have been noted below. At the very least, everyone better read the GI PPI section before showing up Monday. See you soon.
Tim
Summary Scorecard
1. Alzheimer's – about same initial bids as last year so will c/o as before.
2. Androgens – Androgel looks good again.
3. Analgesics – Cephadyn forgettable.
4. Anaphylaxis – Twinject interesting alternative to Epipens.
5. Antiasthmatics – need to counter-offer (c/o) many drugs especially inhaled steroids and combos. Albuterol hfas about same as last year. Nasal steroids similar. Irritating starter pack NDCs need to be controlled.
6. Antibiotics misc.– forgettable bid on Adoxa (doxycycline mono)
7. Anticoagulants – mostly better than last year
8. Anticonvulsants – need to c/o Lyrica and Carbatrol. New Vimpat bid but still expensive adjunctive drug. New bids on Lamictal odt's and XR's.
9. Antidepressants – sizable decrease in Lexapro is interesting. SNRIs complicated with Savella entering much less expensive than others, and yoked bid for Effexor XR and Pristiq.
10. Antiemetics – Emend similar to last year and new but insufficient bid for Sancuso.
11. Antihistamines – Xyzal still unappealing but can have otc/generic step edit. Astelin/Astepro very aggressive bids to boot Patanase out.
12. Antiparkinson agents – Stalevo the same. Mirapex slightly higher on lower doses but moderately lower on higher doses. Requip XL still overpriced for states with good ropinirole smacs.
13. Antipsoriatics – Enbrel needs c/o. Tazorac better but Differin needs to be nonpreferred.
14. Antipsychotics – Geodon needs c/o. Invega improved but still not risperidone pricing. Fazaclo's close to generic clozapine for some states. Seroquel XR ok.
15. Antispasmodics long acting – Detrol LA needs big c/o and Vesicare a small one. Rest ok.
16. ARBs and ARB combos – A few drugs need c/o on single strengths but all are in position for status quo next year.
17. Beta blockers etc – Coreg CR and Bystolic overpriced and nonessential.
18. Beta lactams – Augmentin XR needs c/o but still decent deal compared to generic pricing on amox/clav 500s and 850s.
19. BPH – Avodart needs c/o. Proscar free to very cheap most quarters. Uroxatral better deal than Flomax for those wanting a more selective alpha adr. blocker.
20. CCB – Cardizem LA bid worth looking at if diltiazem smacs high on upper strengths.
21. CCB-LIPID – Caduet needs c/o.
22. Cephalosporins – Omnicef bid close to last year. Some states have higher smacs on cefdinir and should consider this. Suprax rejectable.
23. Cholesterol therapies – Tricor/Trilipix lawsuits by some states complicate these bids. The Tricor bid is 5% better than last year if you take Trilipix, too. We obtained a guarantee that if the Tricor generic becomes available prior to Trilipix that the Trilipix total rebate would grow to 80% of WAC. Lovaza needs c/o. Lipitor needs c/o. Lot of different scenarios to consider- do you want one, two or three potent brand statins? Some of the lesser statins need small c/o.
24. Cough and Cold – Number of bids but states can easily get by with limited number of generic choices with average script prices ranging between \$5 to \$15.
25. Cox-2 – about same. Need to clarify conditions. In past they have accepted long standing DUR edits.
26. Diabetic therapies – Insulins similar. Many Lilly insulins look good w/o bids (free due to big CMS rebates). Novo's close to last year but a few need c/o. Symlin and Byetta remain expensive pains in the neck. TZD and their combos need c/o.
27. Diabetic supplies – Mind numbing variety of choices. Most strips within pennies of same net. Three states now have Abbott and Lifescan preferred. One has Bayer and Lifescan. Pretty safe to go with whichever two already have greatest utilization in state.
28. Direct rennin inhibitor- Tekturma c/o to ARB price.

## c/o Summary Scorecard

1. Alzheimer's – Exelon came down a bit but some states will want to keep it or make it nonpreferred. Small share. Namenda did not budge.
5. Antiasthmatics – Advair came down and can be accepted. AZ nonresponsive on Symbicort so we should BAFO them with rejection and get ready to toss off the PDL. Proair did not come down but still close enough to accept. Same with Serevent. Xopenex came in with late bids that at exclusive level are consistent with other choices. Nasal steroids- Nasacort responded higher but its daily cost is similar to Veramyst if you want a second or third brand. Nasonex and Veramyst did not budge but most will still want Nasonex at least. Nobody moved on the inhaled steroids so we should BAFO here and kick one or two off if necessary from Flovent, Pulmicort and Asmanex. Alvesco had late bid which looks rejectable.
7. Anticoagulants – mostly better than last year but Lovenox did not budge on c/o. Little leverage so should accept now.
8. Anticonvulsants – Most should reject Lyrica. Carbatrol nearly met c/o so accept. Reject Vimpat still.
9. Antidepressants – Effexor XR came down 2% but did not lower Pristiq so reject both. Lexapro held steady. SNRIs complicated still with Savella entering less expensive than others, and then lowering it another nickel. Savella looks good if you are not blocking Lyrica and/or if you cannot manage the SNRIs by limiting use to just Effexor XR (lining up for generic). Wellbutrin XL came down more for Vermont.
10. Antiemetics – Emend came down a pittance, better off to manage access. Still insufficient bid for Sancuso.
11. Antihistamines – Ignore these- really just resubmitted same offers on initial rejections.
13. Antipsoriatics – Enbrel nonresponsive so will BAFO and if needed some states will only prefer the 25mg injections with the better CMS rebates. Tazorac met counters. Humira met us halfway so looks acceptable and better than Enbrel.
14. Antipsychotics – Geodon and Invega did not change. Fazaclo's improved and close to generic clozapine for some states.
15. Antispasmodics long acting – Vesicare met c/o and can be accepted. Detrol LA did not lower their gross overpricing and should BAFO with rejection to send message. Reject Toviaz too.
16. ARBs and ARB combos – Cozaar and Hyzaar nonresponsive and still problems. Avalide still high. Micardis HCT still high. Azor now good.
17. Beta blockers etc – Sectral rejectable as is Ranexa..
18. Beta lactams – Augmentin XR no lower after c/o but still decent deal compared to generic pricing on amox/clav 500s and 850s for some states. Moxatag lower but not acceptable.
19. BPH – Avodart came down some. Proscar free to very cheap most quarters. Uroxatral better deal than Flomax, which did not budge, for those wanting a more selective alpha adr. blocker.
21. CCB-LIPID – Caduet rejectable.
23. Cholesterol therapies – Lipofen better but most will stick with Tricor. Lipitor unchanged so needs BAFO and a few states might prefer it with splitting and w/o contract if needed until generic. Vytorin and Zetia lower. Crestor nonresponsive.
25. Cox-2 – no different.
26. Diabetic therapies – Novo's close to last year but nonresponsive to c/o. Lantus unchanged. Avandia unchanged so should reject Avandia combinations and get their attention.
28. Direct renin inhibitor- Tekturna unchanged but Tek hct looks good, maybe we can only prefer the combo...
33. GI – Apriso c/o good at T3 now. Better than Lialda. Reject Asacol HD. PPIs are the most complicated and financially dangerous problem this year. Prevacid goes generic in November and only Teva has a tentative approval right now. An exclusive generic's prices would likely be much higher than the current net on the brand. Teva won't do a deal on their authorized generic, probably unaffordable considering what they have to pay Takeda. Takeda will not offer an SR on the old brand, unless it is during a transition period to Kapidex this year, because they are desperately trying to shift share to their "new" aggressively rebated brand Kapidex, the enantiomer of Prevacid. States having 30-50% of their PPI use on Prevacid will potentially take an enormous but hopefully short term (? 6 months) financial beating if they keep these people on the brand or move them prematurely onto the generic. But the beating could last years if the generic price declines at the same rate as we saw with omeprazole. There is a generic 15 mg Prevacid expected but most people take 30 mg a day so this would not help financially either. We have a lot of scenarios to discuss and no easy choices. Protonix is stable, Nexium higher and Prilosec OTC available for less than some state's smacs. Panc enzymes still

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## XIV. Appendix 6

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### GHS Security Policy

As a minimum standard, we require usernames and passwords for access to web-based services to be at least 8 characters each, with the password containing variations of upper and lower case letters and / or numbers and at least 1 special character. Currently accounts are set to lock users out after three failed login attempts after which only authorized administrators can unlock the account. We can also provide functionality to delete or suspend accounts after a pre-determined timeframe of inactivity. Passwords can be set to expire periodically, in accordance with State-established criteria.

Password requirements and time out functionality has all been designed to be flexible and easily configured to meet the needs of our State clients. GHS will review all of this functionality with DHHS upon contract review to ensure that the system is configured appropriately to meet the needs of the State now and in the future.

The different levels of security form a system of access control. The security setup is based on the principle of least privilege granting the user only the privileges needed to perform their job function. Access control decisions are determined by the roles individual users perform as part of an organization. Roles are created for the various job functions in an organization. Users are then assigned roles based on their responsibilities and qualifications.

There are five (5) primary role categories:

- Operating Systems and Network Administrators, who have the responsibility for setting up and maintaining the security for the operating systems, network, and firewalls.
- Web and Application Administrators, who have the responsibility for configuration and maintenance of the security for web servers.
- Database Administrators, who have the responsibility for controlling access to data entry screens, programs, files, and databases. They are responsible for setting up user security access with the roles defined to perform their job functions.

- Developers, whose roles on production systems are limited to the privileges needed for data integrity purposes to research questions and issues, resolve and fix production problems, and generate end-user reports.
- Users, whose roles are defined during the implementation process. As part of the system setup, users are defined along with the roles needed to perform their job functions. These user job definitions are mapped to the appropriate role definition(s) and the user is assigned the appropriate role or roles required to complete their daily tasks. As the user's job responsibility changes, the user's profile is updated to remove and/or add the roles.

Data access is restricted at both the application and file/database layers. At the application layer, a user can be restricted to viewing only data for the services that the user supports. Data access restrictions at the file/database level can also limit a user to viewing and modifying only certain groups of data within specific services.

Security and privacy are important to us. To that end GHS employs secure, role-based permissions, multi-factor authentication, and secure, encrypted connectivity. To provide convenient communication options to providers, clients and beneficiaries the websites GHS hosts include a variety of communication methods including e-mail forms, newsletters and toll-free numbers.

GHS has a full time web developer on staff who is responsible for maintaining the web site and web pages developed for our customers. Our web developer is proficient in W3C standards, several web markup programming and markup languages, and has built and maintained multiple information web sites to client-mandated specifications.