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EXECUTIVE SUMMARY

MedMetrics is delighted to bring the State of Vermont an innovative approach to meet the goals of the Pharmacy Benefit Management (PBM) Request for Proposals (RFP). MedMetrics hopes to assist the State of Vermont to:

- Continue to increase access to, and quality of, PBM services available to individuals enrolled in drug programs offered by the State;
- Control expenditures for pharmaceuticals in provided to public beneficiaries;
- Decrease program administrative costs; and,
- Help uninsured individuals access the medications they need at low cost.

Ultimately, MedMetrics' goal is to help Vermont generate sufficient savings to maintain current levels of drug coverage for current and future beneficiaries, including individuals that will ultimately be covered by Medicare Part D.

MedMetrics Value Proposition

MedMetrics is a private, non-profit, full-service PBM, featuring a business model that aligns its financial incentives with our clients' needs to more effectively manage drug spending while delivering quality clinical care. As a non-profit PBM with a primary focus on public sector clients, MedMetrics proposes to work in partnership with Vermont to better control drug expenditures while providing state-of-the-art clinical programs developed in partnership with the University of Massachusetts Medical School.

Critical to our ability to meet our mutual goals is MedMetrics' unique compensation model. Our business model embraces transparency in pricing, including full disclosure of all financial transactions, including pharmaceutical rebates, as well as pass-through pricing on all components of the drug management program. Because MedMetrics does not imbed hidden revenue streams in our pricing, MedMetrics seeks to be compensated by a separate, identifiable per member per month administrative fee. We believe this compensation model best aligns our mutual incentives by identifying the true costs

of the Vermont program, and providing full information for Vermont to make to informed and cost-effective decisions on all aspects of their program, including benefit design, PDL, and clinical programs.

This financial alignment supports a partnership between MedMetrics and Vermont that serves our mutual desire to control drug spending and, ultimately, to meet the needs of Vermonters. One of MedMetrics’ core beliefs is that only after our financial incentives are fully disclosed and aligned can we jointly focus on true net drug cost management, which we believe is superior to a potentially misleading focus on rebates and retail discounts.

MedMetrics will continuously work with the state of Vermont to reduce overall programmatic and administrative costs throughout the term of the contract. Although MedMetrics will seek to control administrative costs, the significant savings for Vermont will be realized by reducing net drug costs, drug trend and programmatic costs. MedMetrics is committed to providing full information to meet this mutual goal. MedMetrics’ innovative decision analysis tool will link up all cost data, including rebate and pharmacy discounts by drug, down to the NDC level. Only with this complete data can fully informed management decisions be made.

MedMetrics Business Model

Traditional PBM	New Model
<ul style="list-style-type: none"> ❖ Competing priorities <ul style="list-style-type: none"> ◆ Payment structure rewards <u>increasing</u> drug costs ◆ As drug spending increases, so do PBM revenues ❖ Hidden revenue streams <ul style="list-style-type: none"> ◆ Confidential deals with pharmacies, manufacturers ◆ Manipulation strategies increase PBM revenue ❖ Bundled service and payment arrangements <ul style="list-style-type: none"> ◆ Intentionally removes sponsor from full information ◆ May negotiate aggressive terms on one component, but replaces with alternate fee ❖ PBM retains information and control <ul style="list-style-type: none"> ◆ PBM provides client with limited information on drug cost components ◆ PBM controls formulary decisions in effort to maximize own revenue streams ❖ Non-responsive client service <ul style="list-style-type: none"> ◆ Provide cookie-cutter reports; limited information ◆ Provide limited service to clients and members 	<ul style="list-style-type: none"> ❖ Shared Priorities <ul style="list-style-type: none"> ◆ Payment incentivizes cost control and management ◆ Not paid based on client's increased drug spending ❖ Transparent financial relationships <ul style="list-style-type: none"> ◆ Financial deals are shared with client ◆ Client's business is not leveraged in secret deals ❖ Unbundled service and payment arrangements <ul style="list-style-type: none"> ◆ Relationship is based on full information ◆ Creative strategies are used to minimize costs for the benefit of the client ❖ Client is given all critical information <ul style="list-style-type: none"> ◆ Client is provided with important net drug cost information to make appropriate decisions ◆ Client has input on formulary decisions and other decisions to maximize own revenue ❖ Superior client service <ul style="list-style-type: none"> ◆ Comprehensive reporting for full information review ◆ Full-service for clients and members

MedMetrics comes to the State of Vermont with an impressive track record and experience that is primarily focused on public programs. MedMetrics’ mission is to assist public entities to

improve healthcare delivery and programs. MedMetrics maintains a primary focus on serving vulnerable populations with diverse experiences including, but not limited to: Medicaid consumers, the uninsured, elders, among others. With our best-in-class business partners, the MedMetrics Team has experience in multiple public sector programs including:

- On-going responsibility for managing the Drug Utilization Review (DUR) program for the Commonwealth of Massachusetts, including the evaluation and selection of preferred drugs and the prior authorization services for non-preferred drug approvals.
- The Senior Pharmacy Contract for the Commonwealth of Massachusetts. MedMetrics coordinated the preferred Medicare-endorsed Discount Pharmacy program for the State SPAP, and managed the coordination to ensure that members maximized the new federal transitional assistance benefit in a near-seamless manner. MedMetrics is currently assisting Massachusetts to define and implement a coordination of benefits program for Medicare-eligible members in 2006, when the Medicare Part D drug benefit becomes fully operational. MedMetrics is developing the infrastructure and capacity to implement this program for Massachusetts.
- Acting as the PBM for Neighborhood Health Plan, a mostly Medicaid Managed Care Organization (MCO) in Boston, Massachusetts. Under this contract, MedMetrics is responsible for both efficient administration of NHP's drug benefit coverage and providing expertise and support for managing NHP's drug spend and trend.
- The 340B pharmacy program where senior leadership at MedMetrics has provided technical assistance to state administrators and has participated in numerous statewide committees regarding this issue. MedMetrics has developed a comprehensive care management program that provides a state of the art medical assessment to high cost and high utilizing individuals, while providing access to the preferred 340B pricing.

Staff members at MedMetrics also have extensive experience serving Medicaid consumers.

MedMetrics manages multiple Medicaid-related initiatives, such as servicing persons with disabilities, managing drug utilization review (DUR) programs, and administering a community case management program for Medicaid consumers.

Having been previously employed by Medicaid agencies, numerous MedMetrics' staff are intimately familiar with Medicaid recipient needs, providers, operations, and regulations.

MedMetrics is the only PBM in the industry that has a solid, working relationship with a medical school – the University of Massachusetts – at the core of its organizational resources.

Specifically, MedMetrics affiliation with the University of Massachusetts Medical School provides Vermont:

- Unparalleled clinical resources upon which to draw;
- Unbiased clinical programs with a focus on appropriate utilization, including overutilization and well as the more popular adherence programs.

MedMetrics utilizes a “Best-in-Class” business relationship model in all of our subcontractor relationships. MedMetrics brings to the State of Vermont a philosophy and the capability to establish strong and effective working relationships with business partners and critical stakeholders, including pharmaceutical companies. MedMetrics prides itself on strong relationships and a reputation as an honest and dependable business partner – both in contracting and sub-contracting with service delivery partners.

MedMetrics believes that consolidating certain operational components from qualified experts and bring such expertise to a team, under the leadership of MedMetrics, delivers the best of all worlds for the State of Vermont. Our lead Best-in-Class partners for Vermont include SXC, CPS and Walgreens. The “Best-in-Class” features of our partners organizations are now embedded within MedMetrics’ structure for all of our clients to delivery the very best the market has to offer in a seamless manner.



May 20, 2005

Ann Rugg
Deputy Director
Office of Vermont Health Access
312 Hurricane Lane, Suite 201
Williston, VT 05495

Dear Ms. Rugg:

On behalf of MedMetrics Health Partners (MedMetrics), a non-profit, full service pharmacy benefit manager (PBM), wholly owned by Public Sector Partners (PSP) and affiliated with the University of Massachusetts Medical School and University of Massachusetts Memorial Medical Center, I am pleased to submit the enclosed response for the Vermont Pharmacy PBM RFP. MedMetrics is delighted to offer the State of Vermont an innovative approach that will exceed the State of Vermont's goals outlined in the Pharmacy Benefit Management (PBM) Request for Proposals (RFP). If awarded the contract, MedMetrics will ensure that the State of Vermont is successful in its efforts to:

- Continue to increase access to, and quality of, PBM services available to individuals enrolled in drug programs offered by the State;
- Control expenditures for pharmaceuticals provided to public beneficiaries;
- Decrease program administrative costs; and,
- Help uninsured individuals to decrease their drug costs.

As described throughout this RFP response, MedMetrics offers significant value to the State of Vermont through our value proposition, that consists of:

- A focus on net cost, rather than a potentially misleading focus on rebates and retail discounts;
- A relationship with the University of Massachusetts Medical School, bringing significant and unique clinical resources to the State;
- A single focus on low-income populations with strong, experienced managers that know and understand the needs of Medicaid and other vulnerable populations; and,
- A team of "Best in Class" partners that promises to bring the State of Vermont outstanding value for your purchasing dollars.

Ms. Ann Rugg
May 20, 2005

In the event that the State of Vermont issues a contract to MedMetrics, I am authorized to bind MedMetrics to all of the requirements of the State of Vermont in the RFP in this letter. Further, MedMetrics accepts all terms and conditions in the Bidders' Library, and agrees to a retainage of ten percent (10%) of operational costs of the third year of the contract, as required in the Request for Proposal. Finally, I wish to certify that MedMetrics arrived at a price for this bid without any conflicts of interest.

We look forward to a strong and positive working relationship with the State of Vermont. Please do not hesitate to contact me if you have any questions regarding this bid.

Sincerely,

Robert D. Wakefield, Jr.
Chairman

RDW/jg

Bidder Information Sheet

Company Name & Address MedMetrics Health Partners, Inc.
100 Century Drive
Worcester, MA 01606

Federal ID Number 20-1031924

Authorized Signatory Robert D. Wakefield, Jr.
Chairman
Phone (508) 793-1182
Fax (508) 793-1199
Email: Robert.Wakefield@umassmed.edu

Company Contact Person Patricia Norton
Business Development
Phone (508) 793-1182
Fax (508) 793-1199
Email: Pat_Norton@medmetricshp.com

Key Contacts To be issued at contract signing

II.B. Business Organization

The bidding organization is MedMetrics Health Partners, Inc. (MedMetrics), a non-profit PBM founded by Public Sector Partners, Inc. (PSP). PSP is a non-profit organization created by, and affiliated with, the University of Massachusetts Medical School (UMMS) and the University of Massachusetts Memorial Medical Center in Worcester, Massachusetts, with representatives from both organizations sitting on PSP's board of directors.

Established in 2001, PSP is a health care management organization that offers a full array of program management and consulting services to public sector clients. PSP's mission is to work with states and municipalities to support public sector health care initiatives, to optimize program efficiency and effectiveness, and to add value to the quality of the provision of health care services. PSP's senior management team has over 100 years of combined direct public sector experience.

Founded by PSP, MedMetrics has a unique relationship with UMMS. The relationship is formalized by a contract with PSP, but the entities function as partners in many respects. PSP provides administrative, management and technical support to UMMS in a variety of areas including, but not limited to, program and project management, product and marketing management services, and education and training. In turn, UMMS offers a depth of clinical expertise and experience that allows PSP and MedMetrics to enhance the quality of health care services for its clients. The collaboration between MedMetrics and UMMS is strengthened by the co-location of MedMetrics and UMMS staff in offices in Worcester, Massachusetts.

The bidder is incorporated in Massachusetts and is located at 100 Century Drive, Worcester, MA 01606. MedMetrics is an independent, non-profit corporation; as such, no other organization own any portion of MedMetrics.

MedMetrics has applied for a license to do business in the State of Vermont.

MedMetrics is fully responsible for meeting all requirements of any contract resulting from this RFP, including the work performed by sub-contractors. The sub-contracted firms that will perform work associated with a contract awarded to MedMetrics, all of whom have agreed to commitments associated with the RFP for the full contract period required, are as follows:

Sub-Contractor	Key Contact/Address	Description of Sub-Contracted Work
SXC Health Solutions, Inc. (the American subsidiary of Systems Xcellence, Inc.)	Mike Bennof Senior Vice President 2505 South Finley Road Suite 110 Lombard, Illinois 60148	<ul style="list-style-type: none"> • Claims processing, management • Data warehousing • Retail Network Management
University of Massachusetts Medical School Clinical Pharmacy Solutions (CPS)	Timothy Cummins, PharmD Director, CPS 100 Century Road Worcester, Massachusetts 01606	<ul style="list-style-type: none"> • Prior Authorization • Drug Utilization Review
Walgreens Mail Service	Michele Pence Account Manager 1417 Lake Cook Road #L457 Deerfield, Illinois	<ul style="list-style-type: none"> • Mail • Specialty Pharmacy

MedMetrics has solid relationships with its partners, having selected “Best in Class” organizations to ensure outstanding service delivery and highly flexible systems. MedMetrics seeks to exceed client expectations. The “Best-in-Class” features of our partners organizations are now embedded within MedMetrics’ structure for all of our clients to delivery the very best the market has to offer in a seamless manner.

For example, the SXC claims processing platform is currently used by 40 organizations that serve over one hundred eight (108) million lives. In total, nearly 1 billion transactions are processed annually through SXC systems for both its licensed and data center applications, representing 1 in every 5 pharmacy claims processed in the United States each day.

Likewise, Walgreens Mail Service, our mail partner, offers tremendous experience with proven, reliable services to our customers. MedMetrics has also partnered with Walgreens to provide our specialty pharmacy programs and services.

In addition, CPS, a division of the University of Massachusetts Medical School, is MedMetrics' clinical arm that manages concurrent and retrospective drug utilization review programs. This relationship brings opportunities for clinical research and innovation. The strength of this partnership, combined with the clinical expertise within the University, offers new opportunities to study and manage pharmacy and health in a manner that has never been done before.

Audited financial statements for the past three years for Public Sector Partners and our sub-contracted partners are included in the Financial Statements Attachment. MedMetrics financial statements will undergo an audit in July 2005.

A complete State disclosure statement is included as an Attachment.

II-C. Location

In order to achieve economies of scale, the bidder will perform relevant tasks embodied in this proposal from multiple sites as follows:

Activity	Location
Systems activity including claim processing	Lombard, Illinois
Data analysis	Worcester, MA
Rebate negotiation	Worcester, MA
Member and provider services	Worcester, MA
Project/account management	Worcester, MA
Specialty pharmacy services	Worcester, MA
Mail order services	Tempe, Arizona

II-D. Affiliations

MedMetrics is affiliated with the UMMS and the University of Massachusetts Memorial Medical Center. MedMetrics does not have affiliations or ownership relationships with

suppliers of pharmaceuticals or retail pharmacy services to the state including: retail pharmacy services; mail order pharmacy services; drug manufacturing; and, drug distribution.

MedMetrics will leverage our “Best In Class” sub-contractor relationships to maximize value to the State of Vermont, as is the case with our other clients. Our sub-contractors are listed below.

Subcontractor	Role
SXC Health Solutions, Inc	<ul style="list-style-type: none"> • Claims processing, management • Information Technology • Retail Network Management
Walgreens	<ul style="list-style-type: none"> • Mail order fulfillment • Specialty Pharmacy
CPS	<ul style="list-style-type: none"> • Prior authorization • Drug Utilization Review

All appropriate business agreements required by HIPAA are current and are updated on an ongoing basis to ensure legal compliance. Agreements are available for audit by the State.

MedMetrics requires sub-contractors to report any potential conflicts of interest and informs our clients of potential conflicts as they arise. At present, MedMetrics is unaware of any conflicts of interest with sub-contractors in Vermont or generally.

II-E Relevant Experience

MedMetrics has significant experience with all of the sub-populations that will be served under the Vermont Pharmacy programs, as described in the Vermont PBM RFP:

Medicaid: Senior management and staff at both PSP and MedMetrics have extensive experience working within the Medicaid environment. Several personnel held executive positions at the Massachusetts Medicaid agency and are intimately familiar with the needs of Medicaid recipients and providers. More importantly, our staff understands the needs of state governments. PSP and MedMetrics are also involved in multiple Medicaid-related

initiatives, such as providing services for individuals with disabilities, managing drug utilization review (DUR) programs, and administering a community case management program.

More specifically, CPS, MedMetrics' clinical arm at UMass Medical School, has performed drug utilization review services for the Massachusetts Medicaid program since 1997 to over 650,000 individuals. The Drug Utilization Review (DUR) program was established by CPS in response to the requirements of the Omnibus Budget and Reconciliation Act of 1990 (OBRA '90). The main goal of the Massachusetts DUR program is to ensure that Medicaid recipients are receiving appropriate, medically necessary prescription drug therapy. To achieve this goal, two programs have been implemented including Prospective DUR and Retrospective DUR. Our approach to these activities is described within this RFP response.

For our DUR activities, a DUR Board acts in an advisory capacity. The Board assists in the development of clinical guidelines to be used in the DUR Program. Meeting quarterly, the Board is comprised of a minimum of twelve members representing physicians and pharmacists of various specialties of the medical community.

HIV/AIDS: MedMetrics currently serves a commercial and managed Medicaid HMO with a significant HIV/AIDS population. MedMetrics and CPS track pipeline and new-to-market HIV/AIDS medications, consult with HIV/AIDS specialists regarding new-to-market drugs and/or therapies and assemble, coordinate and/or facilitate expert panel discussions to determine best practices regarding HIV/AIDS medications. For example, MedMetrics formed an expert panel to review clinical findings and develop recommendations regarding a very costly, but important, drug for HIV/AIDS patients: enfuvirtide (Fuzeon). MedMetrics conducts prior authorization for this drug, among others, as a result of this review.

Based on our experience with HIV/AIDS patients, MedMetrics pays careful attention to:

- Timely review and formulary/preferred drug decision-making to ensure HIV/AIDS patients have access to the most effective treatments;

- Concurrent DUR to ensure HIV/AIDS drugs are dispensed without risk of drug interactions or complications;
- Retrospective DUR to identify potential negative drug use patterns, such as poor compliance with chronic antiretroviral therapy;
- Prior authorization and specialty programs to ensure expensive biotech drugs used to treat HIV/AIDS and their complications are prescribed, dispensed and used correctly;
- Disease management & educational programs to provide targeted education and wellness information to the HIV/AIDS population.

State Defined Beneficiaries: MedMetrics' "parent", Public Sector Partners (PSP), was selected in 2000 through a competitive procurement process conducted by the Commonwealth of Massachusetts to provide all day-to-day operations for its State Pharmacy Assistance Program (SPAP), Prescription Advantage. Prescription Advantage is a prescription drug insurance plan for Massachusetts residents age 65 and older, and younger individuals with disabilities who meet the program's income and employment guidelines. PSP is specifically responsible for all third party administrative functions including eligibility, enrollment, billing, consumer education, call center, member services, data and reporting, and appeals. Essentially, PSP performs all key functions for Prescription Advantage. This program is managed under the Massachusetts Executive Office of Elder Affairs and was developed with PSP's expertise and continues to thrive as a successful SPAP program.

Emergency Needs Populations: MedMetrics serves a population with emergency needs for Neighborhood Health Plan, a commercial and managed Medicaid HMO. Due to the nature of Medicaid eligibility (and, to some extent, the commercial marketplace), MedMetrics is often called upon to provide immediate eligibility and benefits to NHP members. MedMetrics is pleased to state that our systems and staff are more than flexible enough to handle the needs of individuals who are classified in Vermont as having "emergency needs."

The Uninsured: Through PSP, MedMetrics runs a Medicare-approved drug discount card program. The company has enrolled over 90,000 members nationwide. Through the operations of the Medicare Discount Card and the Prescription Advantage Plan, MedMetrics staff has strong expertise in serving populations without sponsors and is accustomed to providing the level of education and member services that is required in an uninsured population.

II-F. Contractor Organization and Staffing

MedMetrics agrees to provide all resources necessary to develop, implement and operate the system as specified in this RFP. Notwithstanding the general requirements, MedMetrics will commit to the dedicated staff resources outlined in the RFP. That dedicated staff that will act as a single point of contact for Vermont.



Technical Response

RFP Section III

III-A. BIDDER RESPONSE TO RFP

MedMetrics is delighted to bring the State of Vermont an innovative approach to meet the goals of the Pharmacy Benefit Management (PBM) Request for Proposals (RFP). MedMetrics hopes to assist the State of Vermont to:

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III-B. Claims Processing and Systems

Discussion and Overview

MedMetrics offers the State of Vermont a smooth transition for systems and claims processing through our technology partnership with SXC Health Solutions, Inc. (SXC). This partner, a key player in claims adjudication and data warehousing, will work closely with MedMetrics staff to invisibly create an organized implementation and transition.

MedMetrics' previous implementations have been successful, timely, and according to plan.

We are confident that our implementation philosophy will allow us to be successful in an implementation with the state of Vermont. Essentially, we begin our process by developing a cross-functional project plan. The implementation plan attached to this proposal is the beginning of the process, but the business needs analysis phase of the development is key to customizing the implementation plan for each client's specific needs. Our philosophy focuses on developing a plan and managing that plan throughout the implementation period, managing the scope as well as the tasks and timeline involved in the plan. We offer an experienced Project Manager and cross-functional Implementation Team to perform a coordinated system setup and review. It is important at MedMetrics that we respect the time and efforts of the staff of the client and require only the time and attention necessary to assist with the implementation. We leverage a proven implementation methodology with daily activity on our part and weekly status meetings of both MedMetrics staff and the client to ensure that the conversion is organized and smooth for the client. Lastly, we offer full onsite implementation support as early and as late in the implementation as is necessary for the client to feel comfortable with our systems and communication strategies.

Clearly, key to implementation process and the ongoing maintenance of any account is our ability to test and offer quality assurance to any systems coding. Essentially, as indicated by our draft implementation plan, the process of bringing a new client to our systems involves one third assessment, one third coding, and one third testing. The testing phase is as important as the other two and is given equal attention. On an ongoing basis, with smaller, more manageable and measurable coding changes, we offer a specific and documented test process for each benefit design change requested and made. Our ability to make coding changes immediately, on-line and real-time, gives us the flexibility to perform

extensive testing on the change prior to signing off to the client. Our ability to respond immediately to benefit design requests is clearly one of the differentiators we bring to the state of Vermont.

The MedMetrics team believes our experience, combined with the experience of our partner, SXC Health Solutions, stands as testament to our fundamental ability to provide exceptional claims processing services, and further, that the remainder of our offering reflects our ability to exceed your basic requirements and provide capabilities beyond those of our competitors.

MedMetrics employs a proprietary software solution for claims processing designed by SXC. SXC was one of the first companies to bring to market a claims processing system designed exclusively for on-line, real-time claims adjudication of prescription drug claims. SXC introduced and implemented this system in 1991 and called it RxCLAIM[®] Online Transaction Processing system. Over the past 12 years, RxCLAIM[®] has supported virtually every type of Medicaid and commercial pharmacy benefit program that has been introduced to the marketplace. RxCLAIM[®] is an extremely flexible product that integrates drug coverage design with an eligibility system by utilizing eligibility, drug, and benefit systems to adjudicate claims for appropriate coverage. Point of sale, batch, and paper claims are all adjudicated through this same system.

RxCLAIM[®] is designed for flexibility, speed, high availability and scalability. The system provides our clients with an infinite array of solutions for adjudication of third-party pharmacy claims at the point of service. System performance is incomparable in the marketplace due to menu-driven, user-friendly screens and table-driven applications that are not hard-coded. RxCLAIM[®] offers nearly 1,000 edits to be used within the adjudication of a claim, and advanced DUR edits are table-driven and definable by plan. Further, true flexibility is guaranteed through the ability to update benefit, price, member, provider, and drug details **real-time, on-line at any time**. Our clients have the capability to access their data and manipulate plans and pricing at their discretion and on their timeline.

Alternatively, our clients can request that MedMetrics staff make changes and those changes can be undertaken and completed within the day in most circumstances, and many times within the hour.

The RxCLAIM[®] platform is currently used by 40 organizations, serving nearly one hundred eight (108) million pharmacy lives. In total, more than one billion transactions are processed annually through a

version of the RxCLAIM[®] application, representing 20%, or one-fifth, of all pharmacy claims processed in the United States.

MedMetrics offers the ability to perform a drug search by eligible beneficiary with a myriad of capabilities. As a sample, claims can be viewed in the following ways:

- By pharmacy by fill date by Rx number by refill number
- By authorization number
- By member ID
- By carrier for pharmacy for submit date
- By carrier / account / group for submit date (reverse chronological)
- By member by fill date (reverse chronological)
- By member by submit date (reverse chronological)
- By member by pharmacy
- By member by prescriber by fill date (reverse chronological)
- By member by drug by fill date (reverse chronological)
- By member for claim status by fill date (reverse chronological)

RxCLAIM[®] has an extremely powerful search function with search parameters that can be customized to accommodate this requirement. Information about beneficiaries, their benefit, pricing, and claims history are all available for inquiry by users. Eligibility screens are automatically updated, online, real-time when eligibility is updated or when changes are made to benefit plan and pricing edits. Information on pharmacy claims can be viewed in any of the following ways:

Claims Processing System

The MedMetrics Team can meet or exceed the state's claims processing requirements, as follows:

POS, On-Line, 24/7 Capability:

RxCLAIM[®] provides real-time, 24 hours/day, 7 days/week claims adjudication and reversal of pharmacy claims.

Retail pharmacies submitting to the claims processing system are able to transmit member claims electronically and receive a claim response in less than two seconds. In 2002, the data center's internal response time was just over .60 seconds and the average external response time (as measured by business partners like NDC and ENVOY) was just over 1.0 seconds.

Reversals within a claims payment cycle are netted out against paid claims within the cycle using Rx number, pharmacy ID, and dates-of-fill as the key parameters. RxCLAIM[®] fully tracks out-of-cycle reversals, deducting the reversal from the payee's next payment. Reversals are viewed in the same manner as paid or rejected claims, and each is designated by a different claim status so that the user can quickly determine the status of the claim as reversed. Partial recoveries are available (that is, if the reversal is for \$125 and the payee is owed only \$75, the remaining \$50 outstanding from the reversal will carry forward to the next payment cycle). Generally, pharmacies do not provide a specific reason for reversals. Analysis of paid and reversed claims by the pharmacy and the number of days between a paid and a reversed claim can be utilized to identify "return to stock" activity.

Paper or Batch Claims Processing

RxCLAIM[®] provides support for paper and batch claims processing. Paper and batch claims are also adjudicated through RxCLAIM[®], which provides complete data for review and reporting and ensures consistency of DUR for clients and their members. The ease of use of the RxCLAIM[®] system means that paper or batch claims can be entered into the system by state staff if so desired.

Claims Capture System During Downtime / Disaster Recovery

The RxCLAIM[®] system processes claims 24-hours a day, 7 days a week. Our claims processing system was online 99.9% in the past five years.

Regardless of this outstanding uptime statistic, MedMetrics recognizes the importance of having our adjudication system available 100% of the time. The MedMetrics team has identified all single points of failure within our operations and provided for backup and/or redundant systems to allow for continuous operation of our services in the event of a hardware/equipment failure.

A comprehensive Business Continuity Plan (BCP) defines the policies and procedures that are used to minimize potential risks and recover from unexpected interruptions. The redundant systems include:

Claims Processing Servers; Prescriptions Processing Servers; Terminal Servers; Print Servers; Web and Portal Servers. Databases for claims processing and prescription processing are kept synchronized by data replication software that operates over our Wide Area Network (WAN), keeping the secondary systems' data current with the primary systems' data within seconds of any transaction. Further, an alternate "Hot-Site" processing facility in Scottsdale, Arizona houses redundant computer systems for our claims processing and web-based services.

Our BCP allows our services to continue to operate out of the alternate facility even if the primary facility is completely disabled. The BCP allows for transition to the alternate facility in less than an hour during an unscheduled outage and in seconds if the switch is performed in a scheduled manner. The alternate site is tested and operations verified at least once per month and we actually operate production activity out of that site during the exercise. The fail-over operations are transparent to MedMetrics' clients and will not require any reconfiguring of the network for either scheduled or unscheduled switches.

Scheduled downtimes occur during non-peak hours, so no disruptions are made to claims being processed. The average number of minutes per month the system is unavailable is 90 minutes. Scheduled downtimes are used to test and process disaster recovery switches, for approximately 30 minutes each month, and to install monthly updates to the system, for approximately 60 minutes each month. These tests and updates are typically performed at 5:00 a.m. four to six times a month, lasting for about 10-20 minutes on average.

RxCLAIM[®] has experienced short unscheduled downtimes over the past two years; however, most unscheduled downtimes were related to either direct communication lines being dropped by national switches, network issues, or power issues. Because of our extensive BCP, none of the unscheduled downtimes caused an adverse affect on the processing of claims.

Below is a table by month that identifies the amount of scheduled and unscheduled downtime for 2004 – 2005, in minutes:

	Scheduled 2004	Unscheduled 2004	Scheduled 2005
January	90	13	90
February	90	30	90
March	90	0	90
April	90	7	90
May	90	9	90
June	90	0	90
July	90	0	90
August	90	0	90
September	90	0	90
October	90	0	90
November	90	0	90
December	90	0	90

The MedMetrics team takes disaster recovery planning very seriously and goes to great lengths to ensure that all systems are operational 24/7.

As part of the BCP, we operate completely redundant “Hot-Backup” claims processing systems and have a separate site for back-up and archiving. The primary processing center is in Chicago, Illinois. The alternate site is in Scottsdale, Arizona. The archive site is in Phoenix, Arizona.

All locations are protected from a power outage with battery back-up and generator services. If for any reason the primary system is taken off-line, the back-up system can be activated in less than one hour.

A contract is in place with a national data recovery service vendor that maintains multiple recovery sites at several locations throughout the United States. The contract guarantees access to a disaster recovery site in the event of a disaster and provides for computing resources equal to or greater than existing capacity. The plan provides restoration of full online processing services, batch processing services, and communications with the national pharmacy claim switching vendors, help desk services, and other professional services. The claims processing data is backed up daily and stored off-site in a facility maintained by a national data storage services vendor. The off-site data is stored in an environmentally

controlled, secured-premises facility. Computer media (tapes, diskettes, etc.) are picked up and delivered daily.

Compliance with HIPAA Requirements

Among its key benefits as a technology partner is the fact that SXC was among the first system suppliers to offer HIPAA-enabled transactions for drug benefit management systems to the marketplace, well in advance of the October 16, 2003 deadline. MedMetrics has a HIPAA compliance team and HIPAA compliance officer who are responsible for the corporate oversight of HIPAA compliance. The HIPAA compliance team monitors compliance with HIPAA regulations, coordinates any required system and procedural changes within the organization, and performs ongoing audits to verify successful implementation and ongoing compliance. As a result, the MedMetrics Team can focus on leveraging the new standards and transaction sets to the best advantage of Vermont.

The MedMetrics Team also continues to follow HIPAA developments for transaction standards in related healthcare fields and the developments of standard identifiers.

Compliance With NCPDP Standards.

RxCLAIM[®] is a robust production system and is fully compliant with the NCPDP HIPAA Release 5.1.

Lock-In Functions

RxCLAIM[®] will allow the state to lock a beneficiary into specific pharmacy or pharmacies, prescriber(s), or both. The system includes lock-in functions to lock a beneficiary into up to two pharmacies and/or three prescribers, including the ability to perform multiple lock-in functions.

Syntax Editing

The claims history load follows the NCPDP standard. Validation checks are built in to ensure alpha-numeric and numeric fields are in check, that required fields are supplied, and that the data provided in each field meet the definition for the specific field.

Eligibility Verification

RxCLAIM can interface with Vermont's eligibility system ACCESS.

Each client has different methods for maintaining eligibility; most common is for clients to perform daily eligibility updates with update files and to provide a full file refresh on a regularly scheduled basis (i.e., quarterly).

The claims processing system can process at least 100,000 new members or updated members per hour, when normal eligibility update procedures are exercised (using a single update process). If processing rates higher than this are required, multiple update processes can be utilized to meet this requirement.

Eligibility updates are received on a continuous basis. The updates are batch files, typically received electronically. Once the file is received, the updates are applied to the live file. The system supports a standard eligibility format to update the eligibility file. A standard eligibility format is one in which the file provided contains field lengths that are identical to the field lengths to be populated. Eligibility data also can be accepted in a non-standard format and converted into a standard format.

In addition, RxCLAIM[®] allows each authorized user the ability to perform eligibility updates on-line, real-time from the user's desktop. Updates can be performed anytime, allowing the flexibility to be performed based on day-to-day changes in enrollment.

There is typically no significant lag time for posting batch eligibility files to the system. Under normal conditions, eligibility files received by 6:00 pm will be applied that night. In addition, clients can provide future-dated eligibility information such that the eligibility is on file (but not yet effective) prior to the member's effective date.

As part of the adjudication process, the system performs eligibility checks on every claim using eligibility data as determined by our clients, including any of the following:

Member ID	Date of Birth
First Name	Person Code
Last Name	Relationship Code
Gender	

Combinations of the above are available and can be customized to meet Vermont's requirements. If eligibility cannot be found for a specific member, a reject code is sent back to the pharmacy informing them of the issue.

Reversal of Claims

In cases of retroactive eligibility where a beneficiary's benefit increases/decreases liability, MedMetrics shall instruct the provider to reverse the original claim, reimburse the beneficiary for any overpayment, and submit a new claim.

Benefit Tracking

RxCLAIM[®] has the ability to track variable benefit limits over any variety of time periods -- monthly, quarterly, annually, or lifetime.

Editing Eligibility Prior to Pricing Claims

RxCLAIM[®] offers nearly 1,000 edits, including editing for prescriber and pharmacy eligibility. These edits are applied prior to pricing claims. RxCLAIM[®] is capable of interfacing with the state's MMIS system and with third party liability carriers, and accepting provider and TPL updates as specified in this requirement.

Acceptance of Compound Prescription Claims

RxCLAIM[®] allows clients to drive the manner in which compounded prescriptions are adjudicated through the Compound option in each Plan. Compounds can be excluded entirely, can be marked to adjudicate as any other product, or can be marked to adjudicate specially as a compound. When pricing a compound, RxCLAIM[®] has the ability to have distinct pricing rules for compounds separate from any other claims.

Our efforts to become compliant with NCPDP 5.1 offers a fully-robust support for pricing compounds based on each ingredient used in the compound and a specific dispensing rate for each type of compound processed. Again, MedMetrics would work with the state of Vermont, to customize this pricing process for the labor related to compound medications.

PDL Support

RxCLAIM[®] offers a full suite of functionality and edits to support the state's PDL. In addition to the nearly 1,000 edits that RxCLAIM[®] offers in the adjudication of claims, the system maintains two types of preferred drug lists. MedMetrics' clients can maintain preferred drug lists either via NDC or via GPI. The Preferred Drug lists are used to educate and encourage pharmacies to dispense preferred drugs over other products.

Preferred drug lists can be used to require certain products be filled through the use of hard edits and rejected claims, or messaging can be used to communicate with pharmacies that a certain product is preferred by the state over another product. Maintenance of Preferred GPI and NDC lists are simple in our system and all changes can be made on-line, real-time with immediate availability for transaction processing.

Prior Authorization Support

RxCLAIM[®] provides full support for Prior Authorizations and has the ability to accept PAs entered directly into the system manually or by batch. Prior Authorizations are performed real-time and are available to interactive users and transaction processing as soon as the PA is entered or the update is performed. RxCLAIM[®] has very robust prior authorization capabilities.

Prior Authorizations are maintained at a member level with date ranges defined by submitted product code. The Prior Authorization can be as specific as an NDC or can be defined at a product or therapeutic class level. Only those specific parameters intended to be overridden are affected by the Prior Authorization, retaining control over most aspects of the benefit for our clients.

MedMetrics clinical call center offers full support of our Prior Authorization process, as defined in later in this Section. Clinical Call Center staff create and/or edit PAs by directly inputting the information into the system.

Further, RxCLAIM[®] has the ability to process a claim based on known conditions. Contingent therapy protocols used by RxCLAIM[®] to restrict or limit the use of a drug product or a therapeutic class of products based on prior or concurrent therapy with other product(s). We essentially maintain three

types of contingent therapies: prerequisite contingent therapy, inclusive contingent therapy, and exclusive contingent therapy:

- Prerequisite contingent therapy protocols restrict the use of a product or class of products until an outcome inefficacy has been determined with other specified products.
- Inclusive contingent therapy protocols restrict the use of a product or class of products unless another product is concurrent therapy.
- Exclusive contingent therapy restricts the use of a product of class of products is a predefined set of products is not present in the member's history.

The state of Vermont can use the protocols to determine prior authorizations or overrides in an automated fashion, or manual intervention is available, where a specific PA can be established and/or overridden for a particular member and drug.

Claims Processing Exceptions

RxCLAIM[®] allows for claims processing exceptions to specific benefit designs by a certain panel of providers or by location.

The claims processing system is based on a multi-tiered hierarchy that allows for a variety of plans to be set up within a client's account. Different groups can be established to accommodate benefit differences such as varying co-pay, between multiple sets of members. The benefit parameters, known as plans, are linked to the group's eligibility record. All of the members linked to that group generally have the same benefits. Individual members of a particular group, who require alternate benefits, can be accommodated by override plans specified by the member's eligibility record.

The claims processing system can support a virtually unlimited number of benefit design variations through a table-driven system. The system is capable of administering nearly 1,000 edits to deliver unparalleled plan flexibility. And, again, benefit designs can be changed on-line, real-time, anytime.

Benefit edits include, but are not limited to:

Eligibility Override	Refill Limits	Rx Restrictions
Member Eligibility	Over-the-Counter Meds	Pricing
Customer Location	Brand/Generic	Deductible / Max Benefit Limits
Pharmacy Network	Third Party Exception	DUR
Care Facility	DEA Class	Level of Service
Prescriber	Dosage Form	Preferred Formulary
Network	DESI Indicator	GPI List
DEA Validation	Maintenance	Max Days Supply/Qty
Prescriber Specialty	Packaging Exceptions	Therapeutic Category
Compounds	FDA Therapeutic Equivalents	NDC List

Acceptance of Claims History at Implementation

RxCLAIM[®] exceeds the requirement that the system have the ability to accept three years of claims history at implementation and retain at least three years in operations. In fact, the claims processing system has no practical limit to the amount of historical data that can be loaded in the system. This process will be part of the implementation plan and the amount of historical data to be loaded will be determined before the system is installed.

The paid amounts from the historical claims are loaded such in such a way that whatever dollar amounts were previously approved are also approved when reloaded. Rejected history claims are typically not loaded, and paid/reversal combinations are typically bypassed. Most standard edits are usually suspended when loading claims history based on the logic that because they were previously approved they should not be subsequently denied.

Systems Capacity to Adjudicate

RxCLAIM[®] adjudicates claims using claims history to verify formulary status, diagnosis, and approval or denial of claims. All contingent therapy protocols depend on this functionality, as do other benefit design requirements that the state may choose to implement. RxCLAIM[®] offers a full and robust capability in this area.

Support for Pricing Methodology

RxCLAIM[®] fully supports each of the pricing methodologies contemplated by the RFP.

MedMetrics' clients define the logic that they choose to use to price pharmacy claims. Separate pricing tables are available based on the formulary status of the product (preferred versus non-preferred) and for each product indicator within the formulary status (e.g., single-source brand, multi-source brand). Up to four cost types, including AWP, MAC, HCFA MAC, WAC, and the submitted drug cost can be compared within each of these pricing tables. Further, that comparison can be DAW-conditioned, e.g., MAC on DAW 5, but not on DAW 1. Additionally, MedMetrics offers further comparison to the usual and customary charge to ensure the state pay the lowest price available.

The system's power and flexibility allows virtually unlimited customization of cost-sharing arrangements, including:

- Deductible/coinsurance
- Multi-tiered coinsurance
- Multi-tiered copayments
- Multi-tiered copayments based on the cost of drug
- 4th tier lifestyle drugs
- Front-end drug deductibles
- Out-of-pocket maximum limits
- Charge coinsurance once an annual benefit limit is reached
- Maximum/minimum number of refills before mandatory mail
- 100% cash at retail/mail and integration with medical carrier for reimbursement

-
- Client-designed formulary or preferred drug list
 - Unique co-payment/co-insurance structure for specific drugs

Application of COB Edits

RxCLAIM[®] can apply COB edits for other insurance coverage in terms of benefits and cost-sharing to the extent possible according to NCPDP standards, as described above.

Current functionality in the claims processing system allows Coordination of Benefits (COB) through plan set-up design. If the client elects COB processing, when a member record ID is “flagged” to indicate that the member has alternate insurance, the other coverage code (OCC) submitted by the pharmacy determines if the claim is allowed or not allowed to adjudicate for that member. Additionally, if the OCC indicates the claim is primary, but the member ID submitted is secondary, the system attempts to locate the member's primary record on the system before rejecting the claim. Through plan set-up, the client also defines if alternate pricing member pay calculations should be performed on the claim processed as secondary.

Custom interfaces have been developed to track integrated deductibles. The staff at MedMetrics will work with the State of Vermont to determine the best method of coordinating this information. The updates can be real-time, daily, quarterly, or at any other desired frequency.

Application of COB Edits for Medicare Part D

RxCLAIM[®] fully meets the requirement to apply COB edits for Medicare Part D coverage, both in terms of benefits and cost sharing to the extent possible according to NCPDP standards, including formularies for each Medicare Part D Pharmacy Drug Provider (PDP) in the State's region; other coverage information billed using the Medicare Part D; and cost sharing details including deductibles, coinsurance, and the application of the coverage gap (“donut hole”).

As described above, because this system is based on a table-driven, multi-tiered architecture, it can accommodate virtually any combination of coverage, benefits, and cost-sharing categories, including edits on the SPAP wrap of the Medicare Part D formulary.

In the event that the pharmacy benefit is administered by a preferred PDP (as opposed to being coordinated with the PDP), the RxCLAIM® system is equipped to accept the transmission of crossover or crossover-like claims for payment of the balance under the SPAP coverage. Because SPAPs will be supplemental payers and will receive claims from pharmacies for “wrap” coverage, MedMetrics is prepared to implement all systems and interfaces, as well as all operational and administrative supports required to manage the wrap benefits (including the receipt of transmitted claims information and processing of all wrap claims). This includes:

- Processing all claims for “wrap” coverage for SPAP members enrolled in a PDP
- Performing extensive claims analysis to identify changes or trends in member drug utilization, potential net savings to the state, and other activities to monitor and improve the wrap benefit
- Transmitting all necessary information on SPAP enrollment to CMS to facilitate the coordination of benefits

Provider-Submitted TPL Overrides

RxCLAIM® has the ability to allow for provider-submitted TPL overrides when other benefits have been exhausted or partially exhausted. The carrier/plan name, client identifier, and member information shall be communicated to the provider using messaging information in the NCPDP response record. Multiple carrier/plan data shall be provided to the pharmacist as part of the cost avoidance override process.

NCPDP Values for COB/Other Payer Detail Reject Codes

RxCLAIM® has the ability to accept NCPDP values for COB/Other Payer Detail Reject Codes.

Voluntary Beneficiary Payments

RxCLAIM® has the ability to allow for voluntary beneficiary payments. As described above, the multi-tiered hierarchy allows for the establishment of different groups to accommodate benefit differences such as varying co-pay. This same approach can be applied to individualized circumstances such as voluntary payments.

Messaging of Pharmacy Providers

The MedMetrics team offers both system and customized messages to network pharmacies about a whole host of DUR issues, preferred drugs, quantity limits, or other benefit design components. This component may be customized in such a way that the response level may differ based on severity, onset, and documentation. For example, a major severity of interaction with a rapid onset and established documentation conflict could result in a “hard reject,” while a moderate severity with delayed onset and established documentation conflict results in a “message response.”

MedMetrics’ current clinical edits include a full suite of interactions and incompatibilities as described below:

Drug-to-Age Conflict: This check may be customized to base the conflict on the indication (primary versus secondary) as well as the level of contraindication.

Drug/Pregnancy Contradiction: A diagnosis can be inferred based on the presence of drugs in the member’s history or a diagnosis can be retrieved from the member’s health profile. For example, the presence of prenatal vitamins infers the member is pregnant. If the incoming claim/drug conflicts with a pregnant state then the pharmacy is alerted.

Early Refill: The percentages can vary based on days supply (e.g. 95% of a 100 days supply, 85% of a 50 days supply, 75% of a 30 days supply).

Duplicate Prescriptions: Through MedMetrics’ online DUR the following are edits performed to determine duplicate claims:

- Duplicate Therapy/Duplicate Rx Checking
- Duplicate Therapy
- Duplicate Product Equivalent

Therapeutic Duplication: This check may be customized to allow for a number of days overlap and to further report only on duplications that exceed documented thresholds.

Ingredient Duplication: This check may be customized to allow for a number of days overlap based on either a percentage or a set number of days.

Drug-to-Diagnosis Conflict: This check may be customized to base the conflict on the level of contraindication.

Inferred Diagnosis Conflict: This check may be customized to base the conflict on the indication (primary versus secondary) as well as the level of contraindication.

Drug-to-Gender Conflict: This check may be customized to base the conflict on the indication (primary versus secondary) as well as the level of contraindication.

Drug-to-Allergy Conflict: This check may be customized to base the conflict on the cross sensitivities.

Dosage-to-Age Conflict: This check may be customized to use alternate dosage information if applicable dosage information is not available for age (e.g., use adult dosage information if geriatric dosage information is not available).

Acute Versus Maintenance Dosing Conflict: This check may be customized by specifying against which products the edit should be performed.

Under Usage Conflict: This check may be customized by specifying the minimum number of days supply on products for which the edit should be performed.

Refill Too Soon: This edit screens for potential overuse stemming from greater medication use than required to treat the disease. Early refills can suggest the possibility of increased consumption and possible adverse effects. Not every early refill indicates overuse; physicians occasionally increase dosage, which results in a clinically warranted rise in consumption.

PA To Expire: RxCLAIM[®] has the capacity to send messages to pharmacy providers when a new PA is required within 30 days or less of the date of service.

Systems Interface

All necessary interfaces between RxCLAIM[®] and Vermont's MMIS will be established to facilitate the transfer of information as specified in this requirement.

III-C. Specialty Pharmacy

MedMetrics partners with Walgreens Specialty Pharmacy to offer a highly efficient operation with multiple points of service -- giving our members choice, convenience, access, and flexibility.

Approximately 4,700 Walgreens retail pharmacies cover 44 states and Puerto Rico, over 1,400 of which are open on a 24-hour basis. Members may also select mail delivery during enrollment and order intake. Our Specialty Pharmacy Center will contact and coordinate delivery with the patient, provide clinical support and follow-up each order to its destination.

MedMetrics is a single-source provider for almost all medications and supplies; both mail and retail facilities can assist the member in procuring virtually any medication needed. If a member requires a “traditional” medication along with their specialty pharmacy prescription, our pharmacy staff will coordinate dispensing and delivery of both. And, because our Specialty Pharmacy Center pharmacists review prescriptions before retail or mail drug utilization review, a “second level” of pharmacy verification is performed.

When members use MedMetrics for all their prescription needs, our pharmacy staff can review a patient’s entire profile and identify potentially harmful - and costly - drug interactions and incompatibilities that may otherwise result from using more than one pharmacy. If necessary, our pharmacy staff will initiate an intervention with the prescriber to evaluate the therapy.

There are many vivid examples of how such screening capabilities provide truly comprehensive care. For example, an interaction when Rebetol is combined with Retrovir and Zerit yields increased risk of Lactic Acidosis and inhibition of intracellular viral activity. Further, a Zofran combination with Akosyn can cause profound hypotension and loss of consciousness. Our screening system was designed to block these potentially harmful interactions through state-of-the-art screening and logic edit capabilities.

Walgreens Specialty Pharmacy continually develops new programs and enhances current programs. We are currently expanding our hepatitis C and multiple sclerosis programs to include phone surveys (such as quality of life, adherence surveys, disease state survey), and regular patient profile updates and follow-ups. These features could decrease the costs associated with complex care.

III-D. Auditing

MedMetrics is committed to implementing controls to ensure the integrity of the pharmacy program. These controls include a comprehensive auditing program designed to ensure that participating pharmacies are in compliance with all relevant program rules and regulations.

We understand that while random audits are important to ensure the integrity of the pharmacy program, targeted auditing procedures – those that focus on specific activities or characteristics that may be indicative of a problem – are likely to yield more cost-effective results. Thus, we believe that a combination of these approaches is necessary.

The auditing program described below is comprehensive, and has proven to be highly effective.

However, we understand that the specific needs of the State of Vermont may be different from those of other public-sector programs we have supported. MedMetrics is committed to working with State Program Integrity staff in all aspects of the auditing program to provide a truly customized solution. Such collaboration may include areas such as the identification of data reporting/capturing that may be responsible for erroneous fraud, waste and abuse detection; referral of cases (as deemed appropriate by the state) to state program integrity unit staff, developing criteria for special audit processes and directives, and implementing requirements (e.g. specific desk-audit criteria) developed by the state.

MedMetrics' Auditing Solution

The MedMetrics Team uses a combination of internal and external resources to perform a comprehensive audit process to detect and prevent network pharmacy fraud and abuse. 100% of all claims are reviewed and analyzed using RxTRACK[®], MedMetrics' online reporting tool. RxTRACK[®] allows MedMetrics staff to analyze each pharmacy's performance in key areas, and compares these to established norms. Pharmacies that display questionable activities or patterns are selected for desk audit.

To ensure the integrity of the auditing process itself, MedMetrics retains all qualitative and quantitative statistics on substantiated cases and compiles reports and maintains documentation of findings and recoveries as applicable.

Desk Audits

SXC's Pharmacy Auditing Team analyzes the prescription data to search for any inconsistencies or unusual activity. Statistical analysis is utilized to create pharmacy scores based on standard deviations across various criteria. Pharmacies with unusual activity are identified and may be subject to an on-site field visit for further investigation. Measured criteria include:

- Total claims volume
- DAW percentages
- Generic dispensing rates
- Average dollar amount per claim
- Average number of claims per member
- Percentage of claims reversed
- U & C prices
- Compounded Rx activity

These indicators identify pharmacies to be targeted for desk audit, on-site field audit, or both.

Pharmacies may also be audited based on random selection, or based on information provided by plan sponsors, members, or governmental agencies.

Percentage of Pharmacies Audited

Our standard procedure is to perform desk audits on 2% - 10% of participating pharmacies, and on-site audits of those pharmacies for which the analysis recommends such. Desk audits are performed annually at MedMetrics' expense, while on-site audits are charged at a per diem rate. On-site audits generally offer substantial recovery amounts that adequately cover the per diem costs. We feel strongly that audits are important for both the practical aspects of the audit itself and for the "sentinel" effect on the remainder of the network. Consequently, our pharmacy network is aware that we are constantly reviewing claims data to identify pharmacy outliers and potential issues. Often, the effect of this vigilance is that fewer on-site audits become necessary. However, if our audit rate is not deemed satisfactory by the state of Vermont, MedMetrics will work with the state to arrive at a mutually-agreed upon number or percentage of pharmacies to be audited.

Types of Desk Audits

To ensure program integrity, MedMetrics performs three types of desk audits: Claims Review Audits, Controlled Substance Audits, and Compound Audits.

Claims Review Audit

Through claims level review, the audit program identifies documents and reports questionable, erroneous, potentially fraudulent or fraudulent practices. Items subject to review include:

- Compliance with the usual and customary price provision;
- Average prescription billed;
- Average amount paid;
- Average quantity per prescription;
- Accuracy of days supply information;
- Frequency of fill;
- Low generic utilization and dispensing;
- Amount of controlled substance drugs per prescription;
- Accuracy of physician identification; and
- Frequency of denial

Based on these factors, the claims review auditing program identifies:

- Quantity errors,
- Early refills,
- High number of refills,
- Early dispensing under separate prescription numbers for the same drug product,
- Quantities greater than benefit supply,
- High number of claims for controlled drugs,
- High volume of prescriptions per visit,
- High dollar volume per prescription,
- High number of prescriptions per DEA number/provider number, and
- High number of DAW prescriptions.

Controlled Substance Audits

Using both administrative and clinical algorithms, RxCLAIM[®] is able to identify the potential candidates for Controlled Substance Audits. These audits are used to identify members that are obtaining a multiplicity of medications that lend themselves to potential abuse from more than one provider. This claims level audit also identifies members using a number of different pharmacies to obtain controlled substances. Further, the audit identifies providers that are prescribing a statistically significant number of controlled substances to the provider's patients.

Compound Audits

Compounded products are some of the most expensive claims adjudicated and, due to the complexity of the product and different pricing strategies, are priced incorrectly by the pharmacy provider. The compound audit program analyzes all compound claims by compound identification codes and verifies the claim for appropriate ingredient cost and contracted rate. MedMetrics regularly reaches out to compounding pharmacies to discuss our reimbursement processes and rates. We believe that we have achieved a basic level of understanding and satisfaction on this issue with our high-volume compounders. Nevertheless, consistent vigilance in reviewing claims has proven to be an excellent tool in managing this specific area of pharmacy benefits.

Parameters that trigger a desk audit

As discussed above, the Pharmacy Auditing Team analyzes claims data to search for inconsistencies or unusual activity. Statistical analysis is utilized to create pharmacy scores based on standard deviations across various criteria. Pharmacies with unusual activity are flagged for a desk audit, and may be subject to an on-site field visit for further investigation. For each outlier pharmacy, MedMetrics opens a file on that pharmacy. The file remains open until an investigation of the discrepancies results in a resolution of the issues. MedMetrics ensures that all such discrepancies and their resolution is appropriately documented in the file.

Participant Response Auditing

MedMetrics' Pharmacy Auditing Team sends a letter, as well as a list of the medications which should have been received, to members. Members are asked to review the list to ensure that the appropriate drug was received, and any discrepancies are to be noted. The participant is then asked to sign and date the letter and return the information to MedMetrics in a pre-addressed stamped envelope.

Criteria used to trigger an on-site audit

If any statistically significant outliers are identified through the Desk Audit process, an on-site audit is triggered.

Identification of Statistically Significant Outliers

Identification of outliers is based upon algorithms that recognize aberrant practices, deviating from a standard or pattern. Each pharmacy is given a grade based upon the number of standard deviations away from the median of the identified standard or pattern. The further the deviation from the standard, the higher the grade and the greater the possibility of a potential problem.

The following are examples of outlier patterns identified by the auditing program:

- Unusual increases in dollar volume at a network pharmacy,
- Unusual increases in prescription volume,
- High dollar utilization for a member, and
- Unusually high brand name medications dispensed by a network pharmacy

On-Site Pharmacy Audits

On-site audits are used for pharmacy outliers for whom a desk audit produces questionable results and require an on-site review. On-site pharmacy audits include:

- Claims verification – including DAW code 1 “Brand Medically Necessary” certification, controlled substance prescription verification, and compounded prescription verification,
- NDC verification,
- Usual and Customary Pricing verification,
- Electronic records consistent with written prescriptions,
- Medication signature logs, and

-
- Compliance with state and federal law requirements and licensing.

The process for conducting on-site audits is described more fully below.

Impact of: Suspected "short-counts"; partially filled prescriptions; under-stocked drugs; scripts that are not picked up are reversed in a timely fashion and other.

Again, MedMetrics' regular analysis of pharmacy claims give us an indication of those pharmacy that are playing games with prescription fills or adjudication timing. We also identify these pharmacies through member complaints and comments. Any pharmacy suspected of irregular practices is immediately contacted in addition to being subjected to a desk audit.

Characteristics of those performing desk audits

The Pharmacy Audit process is overseen by our Network Management Department. Desk Audits are conducted by internal staff with pharmacy education or equivalent experience.

Characteristics of those performing on-site audits

On-site audits are conducted only by auditing staff with extensive experience in pharmacy processes. Consequently, on-site audits are typically conducted at the pharmacy location by independent contractors.

Process for On-Site Audits

During the Field Audit, the Auditor reviews submitted claims data and on-site pharmacy records to uncover discrepancies or non-compliance in the following areas:

- Missing prescriptions
- Different-drug billed
- Brand-billed / Generic-dispensed
- Returned-to-stock prescriptions
- Over billed quantities
- Unauthorized quantities
- Unauthorized refills
- DAW compliance

-
- Signature log
 - Check inventory for package-size as billed
 - Check for current valid licenses

The Auditor also visually inspects the premises relative to cleanliness, procedures, and level of service, and reports his/her observations.

Process of Calculating Settlements

The MedMetrics Team uses a combination of internal and external resources to perform a comprehensive audit process to detect and prevent network pharmacy fraud and abuse.

On-Site and Desk Audit Recoveries

Amounts that have been paid to a pharmacy, for which the pharmacy cannot produce appropriate documentation, may be charged back. Charge backs may be billed directly to the pharmacy, debited to the pharmacy by reprocessing the applicable claims, or debited as line-item deductions from future pharmacy payments. Net recoveries are passed to MedMetrics' clients as invoice credits.

Our Pharmacy Auditing Team may visit any pharmacy that has been identified in the desk audit to physically check the pharmacy records. Questionable prescriptions are checked against pre-determined criteria to verify accuracy. In addition to verifying prescriptions, our Pharmacy Auditing Team also inspects the pharmacy to assess the overall facility and its staff. The auditor also checks for current valid licenses issued by the State Board of Pharmacy.

Pharmacies are subject to charge-back for payments applied to undocumented or discrepant claims that are due to fraud or error. Based on audit results, we may recommend that pharmacies be terminated from the state's pharmacy Network.

Reporting

Once the on-site field audit is complete, the Pharmacy Auditing Team will compile a report summarizing its findings, as well as provide the pharmacy with recommendations on how to improve or correct any problem areas that were discovered. This report will be made available to state program staff.

III-E. Analysis and Reporting

As our company name implies, MedMetrics firmly believes that “if you don’t/can’t measure it, you can’t manage it.” Our company focuses on strong reporting, analysis, and management decision-making tools to provide the insight that is necessary to effectively manage your pharmacy benefits. The cornerstone of MedMetrics’ clinical and utilization management programs is the accurate measurement, analysis, data-driven decision making and re-measurement of relevant information to assess results. This is critically important to our mission and integral to how we evaluate and share information to manage drug cost trend for our clients.

Consistent with our philosophy regarding transparency of data and information, at the core of our product is our ability to make information readily available and accessible to our clients.

Whenever possible, our approach features the use of electronic data, in order to both increase accessibility and to decrease paper and waste. MedMetrics further embraces the concept that data is only as good as the manner in which it is used to manage our PBM services.

The MedMetrics’ team is pleased to provide comprehensive reporting system to the State of Vermont that offers services that are flexible, proactive, and responsive to your needs, both in terms of standard and ad-hoc reporting as well as an advanced analytical and query support system for online reporting.

MedMetrics’ program offers a standard report portfolio of 75 individual unique reports that are accessible at Vermont’s option. As part of the contract implementation phase, MedMetrics will work closely and collaboratively with the State of Vermont to design a standard set of reports that specifically meet the State’s needs, based on the State’s parameters (e.g., weekly, monthly, quarterly, etc.).

MedMetrics will offer the State of Vermont user-friendly, summary level management reports that include highlights regarding costs, utilization and membership. Often referred to as “Dashboard Indicators,” MedMetrics will provide a quarterly report of key performance indicators to help provide a clear understanding of the State’s drug spend and cost trends.

MedMetrics will meet all reporting requirements documented in the Vermont PBM RFP. We will provide the State of Vermont with all of the reports required, and will offer others as well, using our standard report package, including:

- Utilization (e.g., high cost/utilization ranking reports at the member level and therapeutic duplication, drug-drug interactions, prior-auth reports)
- Financial (e.g., DUR savings, MAC savings, rebate reports)
- Provider (drilled down by specialty, high cost/utilization ranking)
- Provider Auditing (e.g., compounded drugs, generic dispensing, DAW rates)
- PDL (e.g., use of PDL, therapeutic class detail, high cost/utilization ranking)
- Claims Processing (e.g. claim detail, claim volume ranking); and,
- COB Reports.

In addition, MedMetrics will provide the State of Vermont with:

- A rebate administration system that generates detailed product-specific rebate amounts and net-of-rebate analysis.
- Leading-edge financial decision modeling software to determine the prospective overall financial impact from changing formulary preferred drugs, market share performance, including generic: brand ratio, mail-order penetration, drug manufacturer contract terms and member cost share contributions.
- A comprehensive clinical call center activity report package that documents and analyzes all call center activity, including call volume, call response efficiency, types of calls, outcomes, etc. This type of reporting helps document the cost-benefit of prior-authorizations.

A sample of standard management reports is attached.

In addition to the wealth of information provided by MedMetrics' standard reports, the online analytical decision support tool, RxTrack[®] allows any number of Vermont State Staff (or designated individuals) to query and analyze data based on the State's specific business needs. Online reporting gives Vermont staff the ability to customize reports easily and conveniently. The data elements can be graphically

queried using pre-built report templates, or the client can create their own customized reports. Vermont State staff has the flexibility to select the data elements, drill down to plan level analysis, and create visually appealing graphic reports. The online system allows managers to select a number of combinations of products, costs, and utilization within an array of time periods. At every level, the State's management staff can visualize and measure all the factors that drive costs and drug trend. Additionally, RxTrack[®] provides the capability to create data extracts to be used in conjunction with other analytic tools and statistical software packages, like SPSS and SAS.

RxTrack[®] gives Vermont's managers the ability to generate powerful custom reports from their claims data as it is required, making it an effective and efficient ad hoc reporting capability.

Therefore, MedMetrics' staff rarely find the need to run ad hoc reports; however, MedMetrics is fully prepared to offer custom ad hoc reports on an as-needed basis to meet the State of Vermont's needs.

In addition to these standard reporting options, MedMetrics' system provides online reporting and financial modeling from a manufacturer contract management system. This allows the client to generate the following reports:

- Amount of rebate dollars invoiced to specific manufacturers
- Amount of rebate dollars received from manufacturers
- Rebate dollars at a drug product level
- Net-of-rebate drug costs

MedMetrics' system has the ability to create HEDIS Outpatient Pharmacy Reporting. The data warehouse has built-in HEDIS standards, such as HEDIS age bands, to enable the client to perform this reporting on their own; however, MedMetrics' resources are available to assist in developing and analyzing reports. In addition, through RxTrack[®], the data can be viewed by any reportable field including group, member, network, etc.

III-F. Drug Coverage and Management

MedMetrics is fully able to meet all of the requirements listed in the State of Vermont PBM RFP for both Drug Coverage Processes and the Medicaid Preferred Drug List (PDL), including implementation of the drug coverage parameters established with the DUR Board. At MedMetrics, we place an emphasis on managing *net* drug costs in a comprehensive and integrated fashion, using data, intelligent analysis, results-oriented execution and re-measurement of results.

Clinical Account Management

First and foremost, the MedMetrics Team provides outstanding clinical account management that will be available to the State of Vermont. For this contract, MedMetrics will assign a dedicated clinical pharmacist as the single point of contact. At the center of our service delivery model is the clinical management team, who will be lead by the dedicated clinical pharmacist. This individual provides a critical communication link between the various components of our delivery system to ensure smooth operations and strong customer service to all stakeholders.

MedMetrics will recruit from a set of top candidates, some of whom are currently interviewing for a variety of jobs within our corporation, a dedicated clinical pharmacist with a RPh or Pharm D degree, and a minimum of 5 years of practical experience in managing drug benefits. The successful candidate that MedMetrics will recommend to the State will have a strong knowledge of the types of sub-populations served in Vermont, as well as knowledge of service delivery issues in rural areas. For the Vermont PBM contract, this individual will:

- Actively support the DUR Board and other relevant groups or individual stakeholders
- Serve as the liaison between the Vermont program and the clinical resources and drug benefit management expertise at MedMetrics
- Collaborate with clinical resources to analyze data and materials on drug use and further develop recommendations for changes in approach and program administration, including the University of Massachusetts Medical School
- Supervise coverage file updates completed by staff
- Attend all DUR Board meetings and present the Board with written information including, but not limited to: the previous quarter's pharmacy claims, recommendations for additions or changes in drug coverage and prior authorization, dispensing limitations, generic substitution

protocols and other relevant or innovative suggestions; and, supportive clinical research, documentation, financial impact analysis and recommendations for newly approved therapies and indications to the DUR Board for consideration.

Drug Information Management

One of MedMetrics' greatest strengths lies in our dedicated drug information management resource center – made available to all of our clients, including the State of Vermont. As the foundation of our information management capabilities, the center:

- Houses clinical information, drug data and pricing sources
- Provides information to support monthly maintenance of the MAC list
- Supports the monitoring, maintenance, and accuracy of the claims processing system on an ongoing basis through a review of both weekly and ad-hoc reporting. For example, weekly reports specifically support the identification of changes made to the drug file including new dosage forms, strengths, generic formulations, and product codes and prices. These changes are coded into the claims processing system and QA tested for accuracy
- Leverage sophisticated clinical information to inform, analyze and make recommendations for changes to the formulary preferred drug list (PDL) and other drug program policies such as prior-authorization, step therapy guidelines, medication quantity limits and clinical call center exception process content

Custom Clinical Guideline Development

For one client, MedMetrics recently reviewed and developed clinical guidelines and prior authorization criteria for expensive biotech drugs to treat arthritis and psoriasis, given significant increases in utilization. Based on data analysis and review, staff from the drug resource center consulted with clinical specialists, brought data-driven recommendations to the P&T Committee for approval and implemented the criteria in the clinical call center.

MedMetrics conducts re-measurement activities to determine the effectiveness of this process and opportunities to improve are addressed.

- Provide the State with the ability to review changes in national drug codes' or GCN Seq's supporting data on a weekly basis including changes to GC3 or DF. MedMetrics also reviews reports of new generic sequence numbers added to FDB file, which is generated weekly and taken to the DUR Committee to consider for inclusion into the Medicaid PDL.
- Keep the Vermont DUR Board up to date with new pharmacological products in the pipeline and those near FDA approval.

All of the information housed within the center is leveraged to monitor and manage all aspects of MedMetrics service delivery. Data is continuously used to identify the State and our other stakeholders of relevant information and to further identify and act on opportunities to improve the delivery of our products and services.

Quality Management

MedMetrics has a well-defined process for ensuring prescription claims adjudicate for the defined benefit package. There is an emphasis placed on initial set-up and testing to make sure coverage is accurately administered and a log of these changes and testing is sent to the client. MedMetrics will provide the State of Vermont with weekly reports of new drug products on the market with verification of the claims processing status of each product. For example, drug coverage changes are coded into the claims adjudication system by one individual and are then tested to ensure the claim processes correctly with any defined on-line messages to the pharmacy.

Administration

MedMetrics performs a variety of administrative functions for existing clients that we will also perform for Vermont. As discussed earlier, the MedMetrics Team has an exceptional claims adjudication system & software, providing a leading industry capability to meet all requirements to support unique and variable drug coverage parameters, program coding, reimbursement methodologies, on-line DUR and reporting requirements.

Specifically, for the State of Vermont, the MedMetrics Team will:

- Maintain the ability to accept electronic files from other insurers that identify the insurers formulary and coverage conditions and would be used in COB activities and claims processing.
- Provide a product that integrates drug coverage design with eligibility systems and POS/batch/paper adjudication edits.
- Update drug prices and other supporting drug data on a weekly basis using Medispan, one of the leading sources for accurate drug data and pricing. MedMetrics will utilize this vendor to further update the Federal Upper Limit (FUL) weekly.
- Apply the current reimbursement methodology for the State's programs, including the ability to apply any exempts from the PDL that the State identifies.

Medicaid PDL

Knowing that Vermont currently uses a PDL strategy for cost containment, we are confident that the MedMetrics Team can provide incremental, additional financial improvement in the application of a PDL across the Vermont Medicaid population, through expanded therapeutic classes and efficient execution of PDL protocols. The result will be a corresponding incremental savings in drug spend and greater control over drug cost trend over time.

MedMetrics' partner, UMMS/CPS has significant experience in developing, implementing, and maintaining a PDL for the State of Massachusetts. UMMS/CPS was instrumental in the development and implementation of the initial MHDL in 2002. During the first two years of operation, the MHDL, and UMMS/CPS' contributions to that effort saved the state of Massachusetts approximately \$120 M. Subsequently, the Centers for Medicare & Medicaid Services (CMS) chose the MHDL as one of two examples of successful state Medicaid drug lists in issuing guidelines on formularies for the new Medicare drug benefit.

In addition to having a major role in the development of the MassHealth PDL, for Massachusetts, UMMS/CPS:

- Prepares and coordinates the updates to the list for the paper and electronic documents, as well as for other databases, such as Epocrates.
- Reviews and presents new drugs, formulations and generics at regularly scheduled policy meetings (three times monthly) and advises MassHealth on how to manage these new products.

For Vermont, the MedMetrics Team will maintain a PDL for select classes. We will propose additions or changes to the list and identify preferred choices within therapeutic classes for particular diseases and conditions including generic alternatives. Through our Pharmacy and Therapeutics (P&T) Committee, MedMetrics will employ clinical data to determine which drugs are equivalent, within therapeutic classes, on the basis of clinical efficacy and safety. MedMetrics will make recommendations to the State DUR Board for review and approval.

In making and/or recommending formulary decisions, MedMetrics uses an innovative and sophisticated net drug cost modeling and management software product. This software allows MedMetrics to

accurately evaluate the cost and cost savings associated with (a) different pricing discount contract arrangements (b) PDL choices and optimizing the number of preferred drugs in a therapeutic class (c) market share mix of different products in a therapeutic class and (d) beneficiary cost sharing. It represents a powerful tool to support cost-effective decision-making and management of Vermont's PDL.

MedMetrics builds on its industry knowledge and experience and strong relationships and ensures that interests of stakeholders are heard and attended to, whenever possible, and maximizes opportunities for individuals and groups to comment on changes in the preferred drug list prior to such changes being made.

In addition, MedMetrics agrees that:

- The dedicated pharmacist, working with the drug resource center, will provide all required materials and analysis for the DUR Board
- The MedMetrics team will customize electronic messages to network pharmacies regarding preferred drugs, quantity limits, and any other benefit restrictions, as for other clients. Messages can be informational only or associated with a reject edit that requires an action on the part of the pharmacist.
- Pharmacists in the clinical call center will provide the capability to authorize coverage for medical necessary products and services.
- The drug information resource center will be responsible for generating Preferred Drug marketing material, such as printed lists & guidelines, prior auth forms, etc. for dissemination to physicians and patients as described below.

III-G. Network, Formulary, and Rebates for the Uninsured

Marketing and Outreach to Consumers

One of the most challenging aspects of delivering a prescription drug discount card is effectively reaching the uninsured and those without drug coverage and ultimately assisting them to enroll in a benefit plan. The senior management of MedMetrics has significant experience in working with these populations and in designing marketing and outreach programs aimed at reaching the broadest population. MedMetrics proposes to assist in conducting various targeted community outreach events at local organizations, developing print advertisements, and assist in educating various public agencies and non-profit organizations about the benefits of the program. MedMetrics will assist the State of Vermont to develop public service announcements for television and radio featuring state officials advertising the program.

In order to provide assistance to as many uninsured as possible, MedMetrics will provide several enrollment options, including mail, telephone, and web applications.

Pharmacy Network

MedMetrics currently operates a funded benefit pharmacy network and a discount card network in Vermont for our clients and the Medicare-approved Discount Card. However, the operation of the state's Healthy Vermonters benefit will require that we re-contract with the network based on this particular Discount Card benefit. The nature of the Medicare-approved Card is such that we specifically contracted on its behalf.

Therefore, in many ways, MedMetrics will solicit an entire discount card pharmacy network on behalf of the state. Nevertheless, MedMetrics has existing relationships with most of the pharmacies in the state and recruiting those pharmacies to join a discount card network for the Healthy Vermonters program will not be exceptionally difficult. Soliciting and recruiting new pharmacies is a practice that MedMetrics undertakes with each new client and has had significant success. We will initially reach the pharmacies with a letter and network contract from us indicating that the state has chosen us to manage the Healthy Vermonters benefit, as well as the other Medicaid plans. The letter will briefly describe (and remind) the pharmacies of MedMetrics' business model and corporate structure. The letter will be followed up by

individual phone calls to each pharmacy that hasn't responded to the initial outreach. MedMetrics will take follow-up with a series of possible arrangements to recruit all Vermont pharmacies into this Discount Card network.

Relationships with Providers

MedMetrics believes part of the solution to enhanced pharmacy relationships lies in pay-for-performance contracts (P4P) with pharmacy providers. Under such a system, MedMetrics establishes performance metrics for both clinical and financial performance to encourage improvement in patient care and financial outcomes. Such metrics will be integral to our approach to provide outstanding service and cost-effectiveness to the State of Vermont.

Formulary and Rebate Arrangements

MedMetrics will provide standard rebate discount arrangements for the Healthy Vermonters Program. The rebates are directly related to formulary preferred drug listing and market share performance. : MedMetrics strongly believes that rebate guarantees represent a sub-optimal financial relationship with a PBM. Rebate guarantees evolved from an environment of non-disclosure and do not reflect an intelligent approach to net drug cost management. At MedMetrics, we carefully evaluate and optimize the impact rebates have on your net drug costs. Under our innovative model, MedMetrics will work with the State of Vermont to ensure that rebates are optimized and that higher rebates do not result in increased overall costs. MedMetrics can estimate the rebates for the uninsured program would be approx. \$4.00 per brand Rx.

MedMetrics is excited to work closely with the DUR Board to align and optimize formulary preferred drug decision-making with rebate contracting to optimize the management of net drug cost for the State of Vermont.

MedMetrics strategy to optimize rebates in the Healthy Vermonters Program is to align this program with other state drug benefit programs. MedMetrics proposes to run the Healthy Vermonters Program with the same Preferred Formulary Drug List decision-making process, the same manufacturer and the same beneficiary and provider marketing communication strategies. Ultimately, this will allow the State

of Vermont to effect greater leverage or influence over preferred drug utilization, thereby increasing Vermont's negotiating leverage with manufacturers.

Another strategy we suggest is to develop a program with direct involvement from drug manufacturers. Drug manufacturers are interested in the uninsured population; many are developing their own discount programs. Based on our overall collaborative and cooperative approach to business relationships, MedMetrics believes that collaborating with manufacturers, particularly those with whom MedMetrics has strong relationships, could yield innovative solutions for improved discounts for uninsured individuals. For example, MedMetrics proposes to work closely with the many manufacturers who provide free or deeply discounted drugs to qualifying lower-income beneficiaries to help facilitate and access these drugs for Vermonters who qualify.

The rebate administration system used by MedMetrics will calculate and electronically invoice manufacturers within one business week after the end of the quarter. Payments come to MedMetrics from the manufacturers 60-90 days after they receive the invoice and data (depending on the terms agreed upon in the contract). MedMetrics will immediately pass the rebate payments on to the State of Vermont when they are received, so the State can expect to receive payments within 65-95 days post-quarter.

Enrollment and Card Production

MedMetrics will work with the state of Vermont to develop an enrollment process for the program. If the state wishes for MedMetrics to develop an eligibility system to determine eligibility for the program, we will work also with the state to do so.

With a relatively simple eligibility and enrollment process, MedMetrics is able to quickly enroll members into the Healthy Vermonters program. The RxCLAIM[®] system allows on-line, real-time enrollment of members into the program on an immediate basis. Further, RxCLAIM[®] transmits the information necessary to produce ID cards. The ID cards are NCPDP-compliant and will have toll-free phone numbers listed for members and pharmacies to get assistance on claims processing and answers to questions.

Member Services Support

MedMetrics has significant experience in running a call center for Discount Card members. With nearly 90,000 members of our Medicare-approved Discount Card, we field and handle a substantial volume of member service calls. Reasons for calls range from simple pharmacy locator calls to more complex pricing and clinical issues.

As opposed to most legacy claims processing systems, RxCLAIM[®] allows our Member Service representatives to run test claims on behalf of Discount Card members to accurately quote the price that will be charged the member at a pharmacy. Our representatives are able to fully respond as to the price of the product, the dispensing fee, and any rebate that may be available on that drug at the point of sale.

III-H. Medicaid (OBRA'90) Supplemental and State only Rebates

Relationships with Drug Manufacturers

MedMetrics personnel has more than twenty years combined experience dealing with drug manufacturers, in contracting, formulary management and rebate administration. MedMetrics has strong, established relationships with key pharmaceutical companies. For example, in 2004-2005, MedMetrics worked closely with Merck, Novartis, Wyeth, J&J, Abbott, Lilly and Pfizer to wrap these seven company's special post-\$600 "full reimbursement" programs into the MedMetrics Medicare Drug Discount Card. This allowed qualifying Medicare beneficiaries' uninterrupted and seamless access to "free goods" as a part of their drug discount card program. This type of administrative integration and cooperation with manufacturers was not typical.

Recognizing that manufacturers are critical stakeholders who share responsibility for providing affordable drug benefits to Vermonters, MedMetrics has a variety of strategies to control costs at the manufacturer level. Specifically, MedMetrics:

- Embraces open, positive relationships across the industry.
- Is focused on manufacturer-oriented activities and business practices that provide financial benefit to the client and their members, not the PBM and drug company. For example, we do not collect undisclosed funding from manufacturers or manipulate the ratio of rebates vs. non-rebate manufacturer fees. Rebates and other potential sources of revenue from manufacturers are fully disclosed to our clients and 100% of all rebates are credited to the client.

Additionally,

- MedMetrics proposes to work closely with the many drug manufacturers who provide free or deeply discounted drugs to qualifying low-income beneficiaries to help facilitate and access these drugs for Vermonters who would qualify.
- MedMetrics will hold drug manufacturers accountable to provide outcomes-based evidence for the PDL inclusion and use of their drugs, particularly new & expensive drug approvals.
- MedMetrics will seek grants from drug manufacturers that want to work closely to research or study innovative approaches to delivering drug benefits.

Experience Processing Rebates

MedMetrics utilizes a new proprietary web-based rebate management system that provides efficient and accurate administration and accounting for Medicaid-OBRA'90 rebates. The system calculates rebates, electronically sends invoices and validation data to manufacturers and generates a series of standard financial reports that support tracking and reconciliation of invoiced versus received payments. In addition, MedMetrics system will meet all accounting requirements listed in this RFP, such as maintaining historical rebate data, calculating interest on late payments, supporting procedures for prior period adjustments and providing detailed NDC-level financial reporting.

The technology and design of the rebate administration system allows for instant calculation and electronic data submission, resulting in faster rebate payments. The result is 100% recovery rate and fewer manufacturer data discrepancies. MedMetrics maintains quarterly unit rebate amount data from CMS dating back to 1991.

All accounting functions required by the RFP will be included in our system including, but not limited to, preparing and submitting manufacturer invoices quarterly with all required data elements listed on page 49 of the RFP and procedures for prior period adjustments for manufacturers. If claims are reversed after invoicing a manufacturer for the rebate, State staff can view transaction data including the initial payment, the reversal, and the subsequent re-bill, if relevant. In this manner, State staff can verify that the transaction was correct and appropriate. Invoices will be issued within sixty (60) days after each rebate period for all Medicaid beneficiaries.

MedMetrics employs a dispute resolution function for the drug rebate program that will be utilized for the State of Vermont. This function includes research and resolution of discrepancies between the State and manufacturers. Any interest or over payments identified through the dispute resolution system, or other means, due to the state will be calculated according to CMS guidelines.

Posting processes offered by MedMetrics include:

- Quarterly data on reconciliations of invoices from manufacturers and transmittal reports to the State of payment receipts
- Prior quarter adjustment statements

- Quarterly and annual reporting to CMS, in both electronic and paper formats

Per the requirements of the RFP, MedMetrics processes pharmacy claims submitted for obsolete NDC's for at least two years beyond the obsolete date to allow for its shelf-life. Pharmacies that submit beyond this deadline will receive an on-line message indicating that the denial is due to "NDC Obsolete".

The VScript Expanded program and any other developing SPAP can be easily incorporated into the rebate administration function described above.

Other Information Requested

MedMetrics has business relationships with over 50 pharmaceutical manufacturers, including all the top tier companies, numerous mid to small companies and biotech firms. Our strongest relationships with manufacturers include:

- | | | |
|------------|------------|-----------------------|
| • Abbott | • Andrx | • Alza |
| • Berlex | • BMS | • AstraZeneca |
| • Allergan | • Alcon | • Boeringer Ingleheim |
| • EISAI | • GSK | • Sanofi-Aventis |
| • Lilly | • J&J | • Wyeth |
| • Novartis | • Pfizer | • Merck |
| • TAP | • Schering | • NovoNordisk |
| • Forest | • Roche | • 3M |
| • Sankyo | • Seprecor | • Solvay |
| • KOS | • Purdue | • Takeda |
| • Organon | • Monarch | • Dura |
| • P&G | • Otsuka | • Schwarz |
| • Roberts | • Amgen | • Genentech. |

Drug companies reimburse MedMetrics for two line items: rebates and occasional administrative fees. Both are fully disclosed to the client. One hundred percent of all rebates are passed through to our clients, including any future contracts with the State of Vermont, and the administrative fee is paid to MedMetrics by the manufacturers for maintaining and providing access to appropriate utilization records and other contractually required information. This administrative fee is retained by MedMetrics.

MedMetrics has several suggestions to control costs at the manufacturer level for Medicaid and the uninsured. Two key recommendations for controlling costs at the manufacturer level are:

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- Placing an emphasis on complete, accurate and efficient rebate administration. MedMetrics' rebate administration system, considered best practice in the industry, ensures fast and complete billing and collection of rebates, resulting in increased savings of the State of Vermont.
 - A focus on administrative efficiency primarily accomplished through a single manufacturer contract across all applicable lines-of-business or groups. Specifically, MedMetrics' rebate administration system has the capacity to maintain different contract terms for different groups, so we simply calculate the appropriate rebate amounts and report them back to the State broken out by the population.

Supplemental Rebates

The strength of the MedMetrics' rebate management system is its capability to manage multiple types of contract arrangements across different groups with different benefits, formularies and utilization controls. The same rebate processing proficiency and accounting functions described with Medicaid-OBRA'90 rebates apply to the administration of Supplemental Rebate contracts.

MedMetrics personnel have the knowledge and expertise to negotiate Supplemental Rebate Agreements on behalf of the State of Vermont. We have deep industry experience with manufacturer contracting, preferred drug list development and rebate administration. For example, our Vice President of Clinical Services has over 15 years experience working in the managed health care pharmacy environment, with rich experience in P&T Committees and drug manufacturer relations. Our manufacturer contracting and rebate administrator has over 20 years experience with various managed care organizations.

As previously introduced, MedMetrics utilizes a unique, leading-edge proprietary software product that supports the evaluation, analysis and financial impact of rebate contract offers. The system supports the production of information for rebate negotiations specifically in relation to the State's drug product utilization mix. The system considers several factors, including manufacturer list price, formulary Preferred Drug selection, product utilization mix and beneficiary co-pays. This is a powerful and industry-leading capability that MedMetrics brings to the State of Vermont.

In Vermont, MedMetrics will continue our tradition of strong, collaborative and effective, relationships with manufacturers, resulting in our ability to help Vermont control costs. Consequently, we are able to

offer the State outstanding manufacturer management including coordination, preparation and input for all required meetings with drug manufacturers.

At present, MedMetrics does not:

- Perform Supplemental Rebate contracting. At the same time, we are confident that, based on our track record and capabilities, we have the ability to meet requirements for this task for the State of Vermont. MedMetrics will work closely and collaboratively with staff from the State of Vermont to secure a template following contract award.
- Pool multiple states or other clients together for formulary management or rebate negotiation.

MedMetrics will meet all additional requirements pertaining to Supplemental Rebates as described under OBRA rebates, above.

III-I DRUG UTILIZATION REVIEW & FEDERAL DUR REQUIREMENTS

Utilization management is a key cornerstone to MedMetrics' business model. It is the belief at MedMetrics that there are significant opportunities to improve pharmaceutical care and to ensure appropriate utilization of medication dispensed to members of MedMetrics. MedMetrics strategies focus on both a comprehensive and customized approach to managing (or assisting MedMetrics in managing) utilization challenges. MedMetrics' relationship with the University of Massachusetts Medical School (UMMS) gives us a significant advantage in developing clinical solutions that are practical, clinically sound and objective, and quantifiable.

General Requirements

Based on MedMetrics' extensive experience, we are prepared to comply with, and exceed, the requirements established by the State and Vermont with regard to DUR activities. Our dedicated clinical pharmacy manager will play a critical role in coordinating all DUR activities and will be responsible for:

- Ensuring compliance with all OBRA '90 and PL 104-91 requirements.
- Daily oversight of the pharmacy programs. This individual will manage the analysis of clinical information and provide guidance to the DUR Board.
- Coordination with the DUR Board.
- Developing and presenting an annual DUR plan to the DUR Board for review and approval. Such a plan will include a profile of all proposed DUR programs, dates for execution and expert advice regarding standards for pharmacist counseling of members.
- Evaluating and documenting performance to the DUR plan including a description of DUR activities, an assessment of performance and clinical impact and estimated savings as a result of such activities.
- Attend DUR meetings and present, as required, issues identified by the State, the Board or other stakeholders.
- Providing face-to-face clinical detailing, based on detailed criteria provided by the State.

Prospective DUR

MedMetrics provides drug utilization review and management across the three defined phases of drug use; Prospective DUR (before patient receives drug), Concurrent DUR (when patient purchases drug)

and Retrospective DUR (data analysis after patient received drug.) In many cases Prospective and Concurrent DUR are defined and described the same way. For example, point-of-service clinical edits and messages to the pharmacist can be either for a patient with a new prescription or ones they are currently taking. So, for purposes of explication, the MedMetrics Prospective DUR program will be described in terms of the point-of-service and clinical call center DUR service capabilities.

Concurrent DUR

MedMetrics' advanced systems capabilities meet or exceed the requirements outlined in the RFP, including the ability to accommodate:

- Table with day supply limits by drug
- Quantity limits by drug
- A dual tracking system for early refills that tracks both current and cumulative usage
- Age and gender edits

The MedMetrics approach to concurrent DUR, including systems capabilities, is described in detail in Section III-L Prior Authorization.

Retrospective DUR

MedMetrics' Retrospective DUR program takes a multi-level approach to identifying, communicating, and resolving questionable therapeutic drug regimens based on analysis of utilization patterns.

All levels of the retrospective DUR process – including the development of the clinical review criteria, the content of the alert letters, and the clinical monographs and questionnaires – are produced by the MedMetrics Team, including the UMMS's in-house professional staff and registered pharmacists.

Research and compilation of data are reviewed and approved by consensus of MedMetrics' Pharmacy and Therapeutics Committee (P&T) and by an advisory panel of physicians and health care experts and clinicians within the UMMS system representing various specialties and practice settings. MedMetrics analyzes pharmacy and non-pharmacy claims on an ongoing basis and presents recommendations quarterly for additions or changes to the Retrospective DUR programs and interventions.

MedMetrics has the capacity to profile and rank members for retrospective DUR interventions on a continuous basis. The utilization of every member is electronically ranked according to predetermined utilization criteria and reporting on a monthly management report. This ranking report is analyzed by the DUR staff to select the candidates for intervention. Approximately 20% of the entire population are potential candidates for review. From this group of candidates, at least 5% (ranked by significance of criteria) are selected for an intervention annually.

A significant proportion of MedMetrics' retrospective DUR interventions involve:

- Inappropriate (long-term) utilization of sedatives/hypnotics
- Concurrent utilization of more than one drug in the same therapeutic class
- Prolonged administration of narcotic analgesics
- High daily maintenance dose of anti-ulcer medication
- High-cost drugs where lower-cost alternatives may be appropriate

Clinical or Therapeutic Approach

This review process focuses on the application of predetermined pharmacologic and epidemiologic standards to a member's medication profile. Member drug profiles that exceed these standards are flagged for review and physician contact is limited. Some of the standards applied in this phase include:

- Appropriate daily dose, specific to drug
- Appropriate duration of therapy, specific to drug
- Dose or duration of therapy, specific to drug and member age
- Multiple drugs within the same therapeutic category or similar therapeutic category used concurrently
- Drug-drug interactions
- Drug-disease interactions
- Drug-age incompatibilities
- Drug-sex incompatibilities
- Multiple physicians and/or pharmacies
- Overutilization

- Underutilization

Cost-Effective Therapeutic Alternative

MedMetrics' Retrospective DUR Program also addresses cost containment. Needlessly expensive drug regimens are identified and physicians are encouraged to change the therapy to an equally appropriate but more cost-effective protocol. The specific DUR modules include therapeutic categories of drugs that contain a large number of agents from which a physician can select an appropriate therapeutic alternative. These categories may include, but are not limited to: the histamine antagonist anti-ulcer agents, antibiotics, nonsteroidal anti-inflammatory analgesics, antihyperlipidemic drugs, antihypertensive agents, antidepressants, and inhaled asthma products. The retrospective DUR program features written, oral, and electronic reminders containing specific information (either for a beneficiary or about a specific drug) to influence prescribing patterns.

MedMetrics' Physician Analysis (advanced prospective DUR) is designed to be flexible enough to identify physician resource utilization and patterns of care from multiple perspectives. Applying one or more of the various detailed MedMetrics' management reports, a typical utilization analysis can be performed at the client level, practice site level, physician specialty level, and at the individual physician level.

Once the initial analysis is performed and a questionable pattern of care is identified, the physician intervention process is initiated. The intervention methodology relies on targeted communications to the physician via written, verbal, or on-site exchange of clinical information. The primary reporting tool used in the communication to the physician includes the Prescribing Physician Profile (report card), intervention letter, and supporting documentation excerpted from current medical literature. The overall objective of the process is to provide the physician with all the information necessary to make a more rational prescribing choice in the future and to alter physician prescribing practices to achieve positive member care and economic outcome.

Our experience shows that if you provide meaningful information to physicians, support the intervention with evidence-based data, and suggest a specific action (such as prescribing drug X instead of drug Y), you can effectively change physician behavior and prescribing habits, resulting in documentable savings.

Fraud and Abuse

MedMetrics' programs support methods and strategies to identify potential fraud and abuse by prescribers, pharmacies and beneficiaries. Both systems and manual methods are used to review and intervene on fraud and abuse situations.

Retrospective DUR focuses on identification of potential fraud and abuse situations by prescribers, pharmacists or members. Prescribers and pharmacies and members are selected for review based on predetermined ranking criteria. For example, prescribers or members who rank high in number of prescriptions, percent of controlled substances, and number of pharmacies used may be candidates' for over-utilization or fraud/abuse review modules.

Once a member, prescriber or pharmacy is "flagged" for a DUR intervention, the DUR case management team at MedMetrics initiates a specialized process. The cornerstone of the process is communication. This communication may involve written material or telephone contact. The tools used to communicate the utilization issue include:

- An alert letter explaining the specific problem(s) that has (have) been identified
- An excerpt from current medical literature that further defines and supports the perceived issue,
- The member's drug history profile sent to the prescriber.

Once a member, prescriber or pharmacy has been flagged as an active case and the review process has been initiated, retrospective follow-up outcomes studies are conducted to determine whether any positive, negative, or neutral outcome has been achieved. These outcomes are totaled and the figures are reported to the client.

Educational Programming

MedMetrics has developed strong educational programs and materials for use in its pharmacy benefit management activities. Historically, our educational programs have successfully changed, and optimized, prescribing patterns. For example, MedMetrics recently eliminated the costly topical combination product Benzamycin from its formulary, replacing it with the recommendation to use the separate products erythromycin solution and benzoyl peroxide cream. We communicated to physicians the cost differential and the suitability of such a change. The change was accepted with little objection and an average cost savings of over \$50 per Rx was achieved.

Specifically, MedMetrics will provide educational materials, at least quarterly, to key stakeholders in Vermont. Such materials will include supportive clinical research, protocols, financial analyses for newly approved therapies and indications to the DUR Board for consideration. Once approved by the DUR Board, these materials will be included as part of the Retrospective DUR Program to targeted physicians and other prescribers.

In addition, the MedMetrics' DUR programs integrate with edits and provide communications and education to pharmacies that are not appropriately complying with these edits, including encouraging pharmacists to counsel members on DUR findings.

III-J UTILIZATION MANAGEMENT

At MedMetrics, we regard drug utilization management as a comprehensive and integrated set of processes, including prospective/concurrent and retrospective review, evidence-based comparative analysis of utilization, education and communication strategies and measurement for improvement documentation. All utilization management is described in other sections, such as Concurrent DUR, Retrospective DUR, Educational Programs, Fraud and Abuse, Formulary Management, Prior Authorization, Reporting and Analysis and Disease Management.

The MedMetrics team plans to provide clinical cost management programs to address specific identified needs for the state of Vermont. MedMetrics uses a programmatic approach that relies on established quality improvement methodologies. For example, MedMetrics identifies and seeks input from key stakeholders and experts, identifies the problem and its root causes, and implements specific improvement strategies that can be measured. Effective clinical cost management usually requires collaborative improvement strategies. For example, to change prescribing behavior for a specific drug may require the P&T Committee to develop treatment guidelines, member and physician educational marketing efforts, retrospective DUR or member case reviews, prior authorization procedures, or even benefit design changes.

The following are specific customized clinical cost improvement programs that the MedMetrics team intends to make available to Vermont as appropriate:

Controlled Substance Program

This program addresses the prescribing, dispensing, and member usage patterns of highly utilized controlled substances (OxyContin, other narcotic analgesics, amphetamine stimulants, etc.) to determine if overutilization is a problem. The MedMetrics Team offers to assemble a work group to gather and analyze information, identify the cause(s) of the problem, and implement improvement strategies, including but not limited to: (1) case reviews of high-risk members, (2) provision of medication histories of high-risk members to providers, (3) dispensing controls, and (4) physician educational marketing. In addition, MedMetrics incorporates resources and strategies from manufacturers. For example, Purdue Pharmaceuticals has a risk management program for OxyContin. The intended result of this program is a measurable reduction in utilization and cost of controlled substance prescriptions.

Sample Target Drug Program - Singulair

This program addresses the proper role and utilization of the leukotriene inhibitor, montelukast (Singulair) for treatment of seasonal allergic rhinitis. Singulair ranks high in NHP utilization/cost (5th most costly drug overall); The absence of Singulair in the NHP non-sedating antihistamine step therapy protocol may have contributed to its overuse. The goal of this program is to determine if Singulair is being overused before first-line agents such as OTC loratadine or inhaled nasal steroids. . After a thorough review of utilization patterns and clinical guideline content, the improvement strategies may include: (1) online step therapy adjudication, where the claim would require authorization unless the member's medication history contained anti-asthma drugs or the required first line agents for allergic rhinitis, (2) retrospective DUR to identify patterns of concomitant drug therapies with Singulair, (3) physician educational marketing, (4) targeted member coupons to encourage OTC loratadine use, and (5) incorporation of Singulair into current step therapy protocol for non-sedating antihistamines.

The intended result of this program is a measurable reduction in utilization and cost of Singulair.

Sample Target Drug Program - Neurontin

This program addresses the appropriate prescribing of the anticonvulsant, gabapentin (Neurontin). Neurontin is a drug commonly prescribed for off-label indications, most notably for chronic pain conditions, in a wide range of dosages and with inconsistent effectiveness. Neurontin ranks high in NHP utilization/cost (8th most costly drug overall). The goal of this program is to determine if

Neurontin is being overused in off-label situations where more optimal treatments may be indicated. This program will require very careful review and analysis of prescriber patterns, indications, dosages, member usage patterns, and alternative treatments. Improvement strategies may include: (1) development of evidence-based treatment guidelines for conditions where off-label Neurontin is used, (2) case reviews to assess effectiveness of Neurontin therapy, and (3) physician educational marketing.

III-K DISEASE MANAGEMENT

Patient Health Management is a unique set of programs offered by MedMetrics. These programs focus on improving member health and controlling overall client expenditures across the entire spectrum of health care services. They are designed to address not only the treatment of specific conditions or diseases, but also to promote prevention, member education, long-term complications, and co-morbidities in an effort to integrate and optimize total care of the member.

The four major areas in MedMetrics' programs are: *Risk Assessment*, *Wellness and Preventative Care* (via member education and empowerment), *Interventions* (via guideline implementation, drug use evaluation, physician education and product selection) and *Outcomes and Quality of Life*. Following is a description of each of these areas as MedMetrics intends to implement in the State of Vermont:

1. *Risk Assessment*: MedMetrics meets with key personnel from Vermont to determine which health concerns are foremost among the programs' members. Once these concerns are identified, members are provided with an opportunity to self-assess their health status and understanding of their disease state. The information obtained from these assessments is used to stratify members according to the severity of their disease, with the most severely ill members given highest priority within the program. The team at MedMetrics proposes to also use this self-reported data to assess the members' current medical care and their opinions about the quality of the medical care they receive.
2. *Wellness and Preventative Care*: Staff at MedMetrics is committed to going far beyond token efforts to help change members' behaviors. In this portion of the program, wellness and the maintenance of a healthy lifestyle are promoted through various educational venues which include, but are not be limited to: quarterly educational reading materials, intense small group instructions, and health fairs. All of MedMetrics' educational materials are highly focused and concentrate on teaching such self-management skills, as weight reduction and stress management.
3. *Interventions*: Through personal evaluation of the member's current therapy, MedMetrics staff can determine whether the drug protocols used by a physician are optimal or if a member is non-compliant with his/her drug regimens. When other drugs or therapies are more effective or equally effective and less costly, a MedMetrics representative intervenes by contacting the member's physician and alerting him/her to the appropriate alternatives. If non-compliance with a drug regimen is detected, staff at MedMetrics will alert both the member and his or her physician to this problem. The communication to the physician includes the presentation of alternative modes of treatment and suggestions for increasing

member awareness of the importance of keeping the proper regimen. The intervention to the member consists of a monthly "refill reminder" to encourage him/her to refill his/her prescriptions on time.

4. *Outcomes and Quality of Life*: Important information, established at the inception of the program through the member's self-reported assessment, is reassessed periodically throughout the program to track improvement. These reassessments are thoroughly analyzed to measure actual disease improvement and the quality of the functioning of members within the program. After each reassessment, members are re-stratified as necessary and given the appropriate level of intervention.

The following PHM Programs are in development and are available to the State of Vermont:

The MedMetrics Airways (Asthma) Program is designed to improve asthma control through improved self-management skills and optimized therapy. The objective of this PHM is to control and/or reduce the need for emergency room visits and hospitalizations of asthmatic members.

The MedMetrics Balanced Lifestyles (Diabetes) Program is created to improve or maintain good glycemic (blood glucose) control while reducing the risk and/or delay of the progression of long-term complications of diabetes. The main goal of this program is to reduce the financial impact of treating members who suffer from diabetes.

The MedMetrics Lasting Relief (Ulcer and Related Diseases) Program is designed to enhance member awareness and knowledge of the role of H. pylori and ulcers, while improving member health by preventing or reducing the recurrences of ulcers. This program improves ulcer cure rates by optimizing drug therapy and diagnosis along with the minimizing of the overall financial impacts of treating gastrointestinal disease.

The Cholesterol Countdown (Hypercholesterolemia) Program is formed to improve unnecessary use of expensive cholesterol-lowering medications and to improve lifestyle modifications as the first line of ongoing therapy. A major initiative of this program is to reduce the risk and financial impact of cholesterol-related coronary heart disease to members.

The Take Control (Hypertension) Program is designed to improve compliance for blood pressure (BP) treatment to prevent or delay heart disease, while reducing the financial impact associated with uncontrolled BP and its long-term morbidity and mortality.

The Benign Prostatic Hyperplasia (BPH) Program is tailored to assist members in becoming more informed about BPH and its treatment options through member education and early screening.

The MedMetrics Joint Efforts (Arthritis) Program is designed to improve members comprehension of their condition and to improve quality of life. Further objectives of this program are to promote cost-effective treatments of arthritis and to eliminate inappropriate duplicate therapies.

The Women's Health (Osteoporosis) Program is designed to increase awareness and prevention of osteoporosis among young and post-menopausal women. A goal of this program is to improve adherence to medications to prevent fractures and recommends drug treatment (when appropriate) to combat bone loss. Further goals for Women's Health Program are to encourage weight bearing exercise and adequate calcium intake while assisting in reducing the costs associated with treatment of late stage osteoporosis.

The MedMetrics Clear Passages (Allergic Rhinitis) Program is created to improve member understanding and management of allergic rhinitis and reduces the severity and occurrence of symptoms through member education. Further initiatives of this PHM program are to decrease the overall cost associated with treatment by prescription medications for allergic rhinitis and to promote OTC allergic rhinitis medications as the first line of treatment.

The Changing Course (Depression) Program is designed to improve treatment and compliance with anti-depressant medications, improve member understanding and management of depression, and educate members about available treatment options. The main objective of this PHM program is to improve members' quality of life while reducing the usage/overall costs of medications and treatments.

III-L PRIOR AUTHORIZATION

MedMetrics employs a comprehensive Prior Authorization (PA) program designed to control utilization of medications exhibiting high potential for misuse and/or high cost. Prior

Authorization has become an increasingly important function given the continuous advancements in costly biotechnology drugs and drug therapies as well as increasingly complex and expensive treatments for such conditions as rheumatoid arthritis, organ transplantation, cancer, and infertility. Several types of recommended PA (prospective DUR) exist:

- Diagnosis required due to high degree of unlabeled use
- Diagnosis required to ensure appropriate use
- Override of plan guideline at client request
- Override of NDC block at member or physician request

Regardless of the type of prospective DUR, each request is handled in a systematic and standardized manner to ensure adherence to clinical and administrative protocols. Claims for medications requiring prior authorization that are transmitted to MedMetrics are blocked at the point of sale, with instructions to the pharmacist to contact MedMetrics' Prior Authorization unit. Upon receipt of the call from a pharmacy, a MedMetrics clinical pharmacist verifies the drug prescribed against a predetermined protocol, or attempts to contact the prescribing physician within 24 hours to verify diagnosis and any of the relevant information. If approved, the member will be notified, either by the pharmacist or by MedMetrics, that he or she may obtain the medication. The MedMetrics electronic claims system is then programmed to allow the claim to process. Subsequent prescriptions are processed for payment within the allowed approval period.

In cases where the treatment does not meet agreed upon clinical protocols or guidelines, the claim is denied and the pharmacy informs the member of alternative options or that he/she is responsible for the cost of the drug. A letter explaining the decision is sent to the member and the prescribing physician. Upon presentation of further information by the physician, the denial may be reconsidered.

The MedMetrics P&T Committee, in conjunction with the previously mentioned UMMS advisory board, develops the prescribing and clinical protocols on all drugs requiring prior authorization. The

prior authorization drug list and associated protocols can be customized to meet MedMetrics' specific needs.

Concurrent DUR

The effective management of concurrent DUR edits is an important utilization management service that MedMetrics will provide to the State of Vermont. Through concurrent edits, both eligibility and clinical issues are identified and addressed to improve the quality and cost effectiveness of drug benefits delivered to our members.

MedMetrics' system subdivides concurrent DUR edits into the following categories for easy classification, which are also applied to savings calculations:

- Administrative
- Clinical Edits
- Refill Too Soon

MedMetrics' utilization review services offer full customization and flexibility to the State of Vermont with regard to the type of response to the concurrent edits including the flexibility to treat edits as "hard edit" rejections, or "soft edit" messages. For the State of Vermont, the MedMetrics team recommends a configuration of concurrent edits as described below.

Administrative

Administrative edits are generally a function of health plan design and include, but are not limited to, edits such as: card not valid, dependant over age, duplicate claim, eligibility expired, NDC not allowed, member ineligible, and year to date maximum plan limits.

Clinical Edits

MedMetrics' clinical edits include a full suite of interactions and incompatibilities as described below:

This check may be customized in such a way that the response level may differ based on severity, onset, and documentation. For example, a major severity of interaction with a rapid onset and established documentation conflict could result in a "hard reject," while a moderate severity with delayed onset and established documentation conflict results in a "message response."

Drug-to-Age Conflict: This check may be customized to base the conflict on the indication (primary versus secondary) as well as the level of contraindication.

Drug/Pregnancy Contradiction: A diagnosis can be inferred based on the presence of drugs in the member's history or a diagnosis can be retrieved from the member's health profile. For example, the presence of prenatal vitamins infers the member is pregnant. If the incoming claim/drug conflicts with a pregnant state then the pharmacy is alerted.

Early Refill: The percentages can vary based on days supply (e.g. 95% of a 100 days supply, 85% of a 50 days supply, 75% of a 30 days supply).

Duplicate Prescriptions: Through MedMetrics' online DUR the following are edits performed to determine duplicate claims:

- Duplicate Therapy/Duplicate Rx Checking
- Duplicate Therapy
- Duplicate Product Equivalent

Therapeutic Duplication: This check may be customized to allow for a number of days overlap and to further report only on duplications that exceed documented thresholds.

Ingredient Duplication: This check may be customized to allow for a number of days overlap based on either a percentage or a set number of days.

Drug-to-Diagnosis Conflict: This check may be customized to base the conflict on the level of contraindication.

Inferred Diagnosis Conflict: This check may be customized to base the conflict on the indication (primary versus secondary) as well as the level of contraindication.

Drug-to-Gender Conflict: This check may be customized to base the conflict on the indication (primary versus secondary) as well as the level of contraindication.

Drug-to-Allergy Conflict: This check may be customized to base the conflict on the cross sensitivities.

Dosage-to-Age Conflict: This check may be customized to use alternate dosage information if applicable dosage information is not available for age (e.g., use adult dosage information if geriatric dosage information is not available).

Acute Versus Maintenance Dosing Conflict: This check may be customized by specifying against which products the edit should be performed.

Under Usage Conflict: This check may be customized by specifying the minimum number of days supply on products for which the edit should be performed.

Refill Too Soon: This edit screens for potential overuse stemming from greater medication use than required to treat the disease. Early refills can suggest the possibility of increased consumption and possible adverse effects. Not every early refill indicates overuse; physicians occasionally increase dosage, which results in a clinically warranted rise in consumption.

III-M. MEDICARE PART D

MedMetrics will not be seeking to participate in the CMS region as a PDP. MedMetrics is, however, uniquely qualified to support the state of Vermont in ensuring that none of its funded pharmacy program beneficiaries will be placed at a disadvantage resulting from the implementation of the Medicare Part D drug benefit, as well as in maximizing cost-savings from the state's many pharmacy assistance programs.

MedMetrics has recently entered into an agreement with the Commonwealth of Massachusetts to facilitate the coordination of its SPAP with Medicare Part D, and is in the process of enhancing its current functionality to meet the state's needs.

Beyond this, as PBM for Vermont's medical and pharmacy assistance programs, MedMetrics would be in a position to offer the state a full-service, seamless pharmacy benefit management solution for all of its publicly-funded program enrollees.

Among the benefits that MedMetrics offers for Medicare Part D include:

- Extensive staff knowledge of and experience with Medicare, Medicaid, and other pharmacy assistance programs from across the country
- Flexibility to respond to changing policies and changing needs.
- A state-of-the-art claims processing system that interface with the State of Vermont's eligibility and other information systems, as well with the designated regional PDP
- Call center staff already trained in Medicare Part D.
- Regular (sometimes daily) training of call center staff, designed to address changing policy and program needs.
- Extensive clinical and administrative resources through its relationship with the University of Massachusetts.

In the event that the SPAP benefit is only coordinated with the PDPs, MedMetrics will perform coordination of benefit activities, and editing against coverage and cost sharing conditions.

As described in Section III-B (Claims Processing), MedMetrics proposes a state of the art claims processing system, RxCLAIM[®] that provides extensive COB capabilities, including nearly 1,000 edits including edits against coverage and cost-sharing (including Medicare). Because this system is based on a table-driven, multi-tiered architecture, it can accommodate virtually any combination of coverage, benefits, and cost-sharing categories, including edits on the SPAP wrap of the Medicare Part D formulary.

In the event that the pharmacy benefit is administered by a preferred PDP, as opposed to being coordinated with, the RxCLAIM[®] system is equipped to accept the transmission of crossover or crossover-like claims for payment of the balance under the SPAP coverage.

In addition to a state-of-the-art claims functionality, MedMetrics proposes a comprehensive, seamless (to the member) approach to coordinating the Medicare Part D benefit for the State of Vermont. This approach is designed to address several key issues affecting states with the implementation of this new drug benefit, including:

- Eligibility and Enrollment Maximizing enrollment in Medicare Part D to reduce SPAP expenditures
- Administration of the Wraparound Benefit

Eligibility and Enrollment:

SPAP enrollees who enroll in Medicare Part D represent an opportunity for significant costs savings to the state. In keeping with CMS's requirement that SPAPs facilitate enrollment in Medicare Part D, Vermont is seeking to auto-enroll eligible SPAP members with the PDP.

MedMetrics offers a highly motivated and well-trained staff already conversant in the complexities of the Medicare Part D drug benefit. Through ongoing and just-in-time training, this staff will be equipped to address the information and enrollment needs of all members. Through its interface with the state's MMIS and other information systems, as well as interfaces with CMS and the Social Security Administration (SSA), MedMetrics will:

-
- Assist new SPAP members in selecting the most appropriate PDP for their needs , within CMS guidelines
 - Conduct CMS-approved auto-enrollment for those who do not select a PDP.
 - Assist current members with the enrollment and disenrollment process as their needs change.
 - Screen Medicaid and SPAP membership for Medicare Savings Plan (MSP) beneficiaries, who will be deemed eligible for the Low Income Subsidy (LIS).
 - Help all SPAP members eligible for Low Income Subsidy (LIS) to have applications processed by Social Security Administration (SSA) as soon as possible.

Support for Wraparound Benefits

Because SPAPs will be supplemental payers and will receive claims from pharmacies for “wrap” coverage, MedMetrics is prepared to implement all systems and interfaces, as well as all operational and administrative supports required to manage the wrap benefits (including the receipt of transmitted claims information and processing of all wrap claims). This includes:

- Processing all claims for “wrap” coverage for SPAP members enrolled in a PDP
- Providing SPAP member with ongoing information and guidance on their PDP benefits and SPAP wrap benefits.
- Tracking and reporting to the state the nature of calls from members, including those regarding claims denied by the PDP
- Assisting members in appealing denied PDP claims
- Conducting surveys or focus groups to gauge member’s experiences with PDPs and the wrap benefit.
- Performing extensive claims analysis to identify changes or trends in member drug utilization, potential net savings to the state, and other activities to monitor and improve the wrap benefit
- Transmitting all necessary information on SPAP enrollment to CMS to facilitate the coordination of benefits

Given the limited timeframe and the complexity of the Medicare Part D drug benefit, and particularly the interrelationship between this and SPAPs, MedMetrics is prepared to assist the state (to the extent

that it would be helpful) in the design and development of necessary program and operational features.

Key issues to be addressed include:

- State will need to finalize the wrap benefit as soon as possible.
- The wrap benefit will have to be defined in operational detail.
- Complexity of wrap design and complexity of interfaces with TrOOP Facilitator(s) and/or PDPs.
- The reimbursement logic will have to be programmed into the claims processing system.
- The logic must be shared (and tested) with the TrOOP Facilitator(s) (and PDPs) prior to implementation.

Because of these and other issues, it is critical that the Contractor for the Vermont PBM contract have the depth of knowledge and experience that can only come with having worked on design and implementation of the Part D benefit for another state. Through its relationship with the Commonwealth of Massachusetts, MedMetrics can offer just such experience.

III-N. BENEFICIARY AND PROVIDER TELEPHONE SUPPORT

MedMetrics offers excellent call center services, consistent with services provided to beneficiaries within the Prescription Advantage Program and our Medicare-Approved Drug Discount Card. Member Services will act as the single point of contact for ongoing customer services. Specifically, MedMetrics will provide the ability, within the system, to identify and inform members:

- Whether individual drugs are covered and any conditions of coverage;
- Why some drugs are not covered (e.g. rebates, non-covered benefit, etc.);
- Claims status information including reasons for denials that can be translated into beneficiary terms.

For the State’s publicly-supported health care programs and the Healthy Vermonter Program, MedMetrics will provide ongoing training and support to existing and new prescribers and providers. Network Providers will continue to be enrolled through the State’s fiscal agent. MedMetrics will provide provider with information on PBM program specifics and on claims filing preparation and will issue an up-to-date provider manual. MedMetrics will further offer provider education as program changes are implemented. MedMetrics will also handle all inquiries on these matters.

MedMetrics will also fulfill all requirements related to mail order options, in the event that the State elects to make a mail order program available.

MedMetrics’ performance for call center activities for existing clients is as follows:

Performance Measurement	2002	2003
Calls Offered	148,190	292,876
Calls Answered	147,524	289,033
Abandonment Rate	0.4%	0.7%
Calls Answered w/in 30 seconds	89.9%	83.18%

Average Handling Time	4:34 minutes	2:47 minutes
Ring Time	00:06	00:05
On Hold	1:04	00:17
Talk Time	3:03	2:08
Wrap Time	00:24	00:23

Measurement, tracking, and reporting:

Reports are generated from the call center software, Automated Call Distribution (ACD) program. The system is real time and can be reported in 15 minute increments. All reports are available daily, weekly, monthly, or annually. Information can be stratified by level of call, CSR, department, etc.

Statistics about the performance of the call center will be available to state program staff at any time upon request. Daily reports outlining the number of calls received and the average talk time are provided.

III-O. ID CARDS AND MEMBER MATERIALS

MedMetrics will utilize identification cards issued by the State of Vermont for its publicly supported health care programs and will further provide identification cards for other populations covered under the Vermont RFP. Any member identification cards issued by MedMetrics will conform to specifications issued by the National Council for Prescription Drug Programs (NCPDP). MedMetrics requires three days to produce identification cards prior to mailing them. MedMetrics can customize identification cards based on the needs and specifications of the State.

III-P. EDUCATIONAL AND PUBLIC RELATIONS FUNCTIONS AND OTHER FUNCTIONS

Educational Approach and Staffing

Educational activities, which are central to MedMetrics' approach to PBM service delivery, will be managed by a Director of Education. This individual will oversee, coordinate and integrate activities within member and network education through sophisticated data analysis and research on member and provider behavior. Data will be available through a number of resources to manage these activities. At MedMetrics, we believe such coordination is essential, given the synergies that must be addressed between member and provider behavior. This individual will manage at least one Program Representative, who will be responsible for executing educational activities for individual identified sub-groups of consumers and providers.

The Director of Education will lead the Education Unit within the MedMetrics Retail Network Education Program. Among the staff reporting to the Director of Education will be a Provider Program Representative and a Member Program Representative who, together, under the Director, will execute all communication strategies and training plans for MedMetrics. This individual will act as the point of contact for the provider community for both informational and other purposes.

MedMetrics will comprehensively educate network providers and members through a variety of educational strategies, each of which is designed to maximize how key stakeholders understand and utilize the pharmacy program and its requirements.

At the core of our strategy to ensure the success of the contract is our ability to develop and sustain strong relationships with stakeholders. MedMetrics will work with prescribers, pharmacies, associations, advocacy groups, members, families and other stakeholder groups to ensure a strong understanding of, and appreciation for, the PBM program. Specifically, MedMetrics will ensure:

- Direct involvement with physician prescribers and pharmacy providers. In particular, MedMetrics will educate these individuals and organizations about the intent of the program, the process that MedMetrics uses to determine the PDL, the PA process and issue resolution. Our goal is to ensure that providers feel as if they have a stake in the program, and that their direct involvement can have a true impact.

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- Direct involvement with stakeholders across the state that can have a true impact on making the program a success. At a minimum, stakeholders will include: the Vermont Pharmacy Association and the National Association of Chain Drug Stores (NACDS); medical groups such as the Vermont Medical Society; and other groups designated by the State. MedMetrics will also work with the State to strategize for Legislative Oversight Committee meetings, and will attend such meetings upon request to either educate legislators on issues related to the contract or address other issues as requested by the State.
 - Direct member involvement and feedback obtained through surveys, focus groups, and other mediums throughout the year.

Provider Education

Consistent with the requirements of the Vermont RFP, MedMetrics will educate prescribers and pharmacies on the details of the PBM program and its benefits, the PDL, the program's utilization review and prior authorization procedures and claim filing and adjudication processes and procedures.

MedMetrics will also initiate a comprehensive pharmacy communication and education campaign to ensure a seamless transition for Vermont pharmacy providers. To initiate this process, MedMetrics recommends that all prescribers and pharmacies receive an introduction letter from Vermont announcing MedMetrics as the new provider of pharmacy benefit management services for Vermont beneficiaries. The introduction letter presents a unique opportunity to highlight key plan features, along with other information that prescribers and pharmacies will find helpful. In addition, a PDL will be sent to all participating prescribers within 30 days of the completion of the list. Changes in the PDL will be communicated to prescribers prior to implementation.

Key strategies and methods that MedMetrics will use to educate network providers regarding these issues include:

- Written communications, via e-mail, fax, and mail that will include all information necessary for pharmacies to fully comply with the requirements of the program. Written communications will include copies of ID cards, BIN Numbers and Processor Control ID, electronic transmission instructions, and procedural changes, and will highlight significant plan design changes.
- A user-friendly, effective provider manual that will be continually reviewed and updated to

ensure current information on compliance issues. The provider manual will be consistent with other manuals within the State of Vermont and will be reviewed and approved by the State, prior to issuance. MedMetrics will pilot-test the contents of a manual to ensure a good response by pharmacists and other consumers of the information.

- All chains in Vermont, and all major national chains, will be contacted at their headquarters by both fax and by telephone by the MedMetrics Pharmacy Network Department regarding key announcements to the network. Independent pharmacies throughout the State will be contacted by e-mail or mail.
- Verbal communications conveyed by telephone, seminars and one-on-one visits to targeted pharmacies, when necessary.
- Use of the Pharmacy Help Desk as an additional available resource to provide information to pharmacy providers, and to assist them with any claim specific issues.

MedMetrics will collaborate with the State on the content and approach to all educational materials, and will further seek approval from the State prior to publishing or releasing any materials including printed documents and scripts.

Member Education

The philosophy that MedMetrics will apply to member education is consistent with that which will be applied to provider education. MedMetrics will educate members through a number of different vehicles. At a minimum, consumer education activities will include, but will not be limited to the development and distribution of: member handbooks for all beneficiaries, detailed information regarding drug benefits and the PDL and use of generics, prescription drug program announcement letters; a standard prescription drug program benefit brochure; and, patient profile forms (including pre-addressed envelopes).

The MedMetrics team recommends an introduction letter to Vermonters enrolled in the various pharmacy programs announcing MedMetrics as the new provider of pharmacy benefit management services for Vermont beneficiaries. The introduction letter presents a unique opportunity to highlight key plan features, along with other information members will find helpful.

As one example of our communication materials, MedMetrics produces an informational brochure that explains how to best utilize the pharmacy benefit. Based on Vermont's plan designs, MedMetrics will

furnish efficient member communication materials. As second example of our materials includes the standard member brochure. This user-friendly pamphlet explains the prescription fulfillment process, with simple, strategically placed graphics to reinforce written messages. A brief question-and-answer section is included to address members' most frequently asked questions, which we are aware of from extensive experience with low income populations. The materials communicate the key components of MedMetrics' integrated pharmacy benefit, including retail and mail service and clinical intervention programs, to ensure that members understand how these elements work together to provide added clinical and economic benefits.

A second standard piece of communication that will be sent to targeted members is a pocket PDL. This documentation will be mailed to enrollees that MedMetrics will identify, in collaboration with the State, within 30 days following agreement on a final PDL. On an ongoing basis, a pocket PDL guide will be sent to new enrollees with their ID card, if requested by the State. MedMetrics will coordinate with the State's fiscal agent, who issues member identification cards.

All of MedMetrics' communication materials are designed for individuals with low health literacy to be accessible to most members. Materials extensively use simple but effective graphics and examples to help members better understand the information. The MedMetrics team will also make materials available in languages other than English as may be required by the State of Vermont. Additionally, MedMetrics staff and Vermont State staff can work together to discuss how members with other communication challenges can best be served, including members who are visually or hearing impaired. Additionally, as part of our implementation process, the MedMetrics team, including a health literacy and communications professional, will be available to discuss the various communication options for members.

III-Q. STAFFING REQUIREMENTS

MedMetrics will meet the staffing requirements as established in the Vermont PBM RFP. Specifically, MedMetrics will identify and hire a full-time dedicated Project/Account or Implementation Manager who will act as the single point of contact representing the Contractor during the conversion and implementation phases of the contract. This individual will be fully accessible to State staff during working hours during the conversion and implementation phases and will further have the ability to commit MedMetrics' resources to all contractual obligations.

Staff will be located in Williston, Vermont and will, at a minimum, include:

- A Full-Time Equivalent (FTE) Account Manager, as described above. MedMetrics will seek out a candidate with a business degree, pharmacy-related experience, and strong knowledge of/experience in government.
- A FTE Clinical Manager that possesses either a RPh or a Pharm D to support all clinical, PDL and DUR functions and activities.
- A FTE Program Representative responsible for program support activities, performance review, development of consumer and provider education and communication strategies, training plans and provider relations.
- A FTE data manager who is responsible for all State data and reporting requirements including standard and ad-hoc reporting and decision support.

MedMetrics has a strong track record for contract transitions from other vendors. Based on successful experiences elsewhere, MedMetrics will make every effort to offer Vermont a seamless transition from the incumbent contract. One key strategy to accomplish this goal is to identify, at the outset, the strongest staff available through the incumbent's organization and retain that staff to continue with MedMetrics. MedMetrics will develop incentives for staff to join our team, following confirmation that the State wishes to retain individual staff members.

Following a determination regarding the qualifications of staff within the incumbents' organization, MedMetrics will conduct a thorough recruitment effort in the Northeast, and elsewhere in the country, to identify, hire and train the most qualified individuals to join the MedMetrics team. All hiring will be at the approval of the State.

Finally, MedMetrics will provide access to clinical and technical staff at our Vermont Office, which will be located in or near Williston. All key contacts and current information will be provided to the State and will be updated, as appropriate.

III-R. DISASTER RECOVERY

Our plans for disaster recovery are fully described in Section III-B of this RFP response. MedMetrics has a Business Continuity Plan (BCP) in place in the event of hacking or acts of terrorism to process claims. Our comprehensive Business Continuity Plan (BCP) defines the policies and procedures that are used to minimize potential risks and recover from unexpected interruptions. Our redundant systems include: Claims Processing Servers; Prescriptions Processing Servers; Terminal Servers; Print Servers; Web and Portal Servers. Databases for claims processing and prescription processing are kept synchronized by data replication software that operates over our Wide Area Network (WAN), keeping the secondary systems' data current with the primary systems' data within seconds of any transaction. Further, an alternate "Hot-Site" processing facility in Scottsdale, Arizona houses redundant computer systems for our claims processing and web-based services.

In any event, MedMetrics will present and discuss a disaster recovery plan to the state during the implementation phase of the contract.

III-S. POST IMPLEMENTATION

MedMetrics routinely monitors systems to ensure that deficiencies are addressed. MedMetrics will take action for routine system maintenance, or, in the event that an issue arises post-implementation, will be responsible for addressing such deficiencies. We understand that system changes can and should be made continually throughout the life of a contract to keep the benefit up-to-date. MedMetrics builds into our plans such maintenance.

MedMetrics understands that the cost of modifications will be subject to negotiation.

Implementation Plan

The MedMetrics Team has the resources, expertise, and real-world experience to meet the aggressive implementation schedule required by the State of Vermont.

Attached is a preliminary implementation timeline that maps out the key tasks and milestones for the Vermont PBM project. MedMetrics derived this implementation plan from its understanding of project requirements, and its own experience executing similar projects.

The preliminary project plan shows the tasks, subtasks, and activities – and the associated milestones – with respect to the following:

- Project Planning
- Human and Hardware Capacity Planning
- Connectivity and Security
- Eligibility Processes
- Program Analysis and Plan Development
- Training
- Batch Conversion Interfaces
- Pharmacy/Member Payment and Funding Procedures
- Information Outputs
- Review ID Card Requirements/Processes/Interfaces
- Pharmacy Network Management
- Formulary and Rebate Management
- Plan Administration Operational Procedures and Standards
- Pre-Go Live Planning and Activities
- Regression Testing and Review
- Post Go-Live Monitoring and Support

However, MedMetrics recognizes that every program is different and every project is unique; therefore, we consider this project plan to be only a starting point. Significant input from and collaboration with state program staff (provided through a workgroup structure established during the Project Planning phase) will be necessary to tailor the plan to meet the specific needs of the Vermont PBM program. If awarded the contract, MedMetrics staff will be eager to begin working with state staff to finalize a project plan that will ensure a successful implementation.



May 20, 2005

Ann Rugg
Deputy Director
Office of Vermont Health Access
312 Hurricane Lane, Suite 201
Williston, VT 05495

Dear Ms. Rugg:

MedMetrics Health Partners, Inc. ("MedMetrics") is pleased to provide the following Disclosure Statement pursuant to instructions in the Request for Proposal for Pharmacy Benefit Management Services.

- A. MedMetrics has not entered into 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 pharmacy benefit manager'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 pharmacy benefit manager and the manufacturer;
- B. MedMetrics has not entered into any agreement with a pharmaceutical manufacturer to share manufacturer rebates and discounts with the pharmacy benefit manager, or to pay "soft money" or other economic benefits to the pharmacy benefit manager;
- C. MedMetrics has not entered into any agreement or practice to bill Vermont health benefit plans for prescription drugs at a cost higher than the pharmacy benefit manager pays the pharmacy;
- D. MedMetrics has not entered into any agreement to share revenue with a mail order or internet pharmacy company;
- E. MedMetrics has not entered into any agreement to sell prescription drug data concerning Vermont beneficiaries, or data concerning the prescribing practices of the health care providers of Vermont beneficiaries; and
- F. MedMetrics has not entered into any other agreement of the pharmacy benefit manager with a pharmaceutical manufacturer, or with wholesale or retail pharmacies affecting the cost of pharmacy benefits provided to Vermont beneficiaries.

Sincerely,

Robert D. Wakefield, Jr.
Chairman



**Proposal to the State of Vermont
PBM RFP
Service Performance Standards**

Service Performance Standards	Guarantee	Description of Penalty and Frequency
Network Size (for Uninsured only)	MedMetrics intends to provide access to at least 90% of all plan members using the parameters of 2 pharmacies within 15 miles, following confirmation of availability of pharmacies across the state	Measure: GeoAccess survey of network providers relative to the population served Frequency: Annually Penalty: 1% of Administrative fee
File Updates	MedMetrics will perform required file updates – eligibility, provider, drug coverage, as required based on the frequency established by the state – with 99% accuracy. File updates will be confirmed for the State on a daily basis	Measure: # of errors/total file updates (including all individual updates) Frequency: Every six months Penalty: .5% of Administrative fee
Point-of-Sale Network System Downtime	MedMetrics agrees that unscheduled system downtime will be no greater than 2 hours per incident or no more than 1.5% on an annual basis	Measure: # of downtime incidents and duration of system downtime Hours system downtime/total system hours Frequency: Every six months Penalty: 1% of Administrative fee
Prior Authorization	MedMetrics agrees to act upon all requests for Prior Authorization within 72 hours of receiving the request	Measure: # of prior authorizations acted upon within 72 hours/total number of prior authorizations in a given month Frequency: Quarterly Penalty: 1% of Administrative fee
Retail Point-of-Sale Claims Adjudication Accuracy	MedMetrics agrees to a financial accuracy rate of at least 99% for all pharmacy claims processed at point of sale	Measure: # of accurate claims processed at POS/total claims processed at the POS Frequency: Annually Penalty: 1% of Administrative fee

MedMetrics Health Partners, Inc.
Service Performance Standards

Service Performance Standards, cont.	Guarantee	Description of Penalty and Frequency
Payment Accuracy	MedMetrics will have lead responsibility to ensure that erroneous payments from the MMIS are quickly identified, reported to OVHA and corrected to ensure that no overpayments or underpayments are made from State or Federal funds	Measure: No known unresolved overpayments Frequency: Annually Penalty: 1% of Administrative fee
Formulary Rebates	MedMetrics will, to the extent that it receives payments resulting from the formulary and rebate process, make all rebate reporting and payments within thirty days of the receipt, if any, of those rebates from drug manufacturers. Reporting will describes the sources of the rebates at the item level, and the date payment was received from the manufacturer	Measure: Date of rebates received and sent to the State within 30 days/total rebates received Frequency: Every six months Penalty: 2% of Administrative fee
Reporting Requirements	MedMetrics will provide all the reports specified in this RFP within the stated time periods, and to provide the query capability described in MedMetrics response	Measure: # of reports delivered within contractually required reporting times/total reports required. Frequency: Every six months Penalty: 1% of Administrative fee
On-Site Audits	MedMetrics agrees to perform on-site audits no the number of pharmacy providers specified by the state in each year of the contract	Measure: Total number of audits completed/total number of audits requested by the State Frequency: Annually Penalty: 1% of Administrative fee
Call Answering Time	MedMetrics agrees that at least 95% of all eligible persons' calls received will be answered within 30 seconds	Measure: Total number of calls answered within 20 seconds/total number of calls received Frequency: Every six months Penalty: 1% of Administrative fee

MedMetrics Health Partners, Inc.
 Service Performance Standards

Service Performance Standards, cont.	Guarantee	Description of Penalty and Frequency
Call Abandonment Rate	MedMetrics agrees that no more than 3% of all eligible persons' calls will be abandoned	Measure: Total calls abandoned/total calls received Frequency: Every six months Penalty: 1% of Administrative fee
ID Cards	MedMetrics will mail within ten business days of the receipt of any card file	Measure: Total number of cards mailed within 10 days of card file/total number of cards requested Frequency: Every six months Penalty: 1% of Administrative fee