Template A

Cover Letter and Executive Summary

RFP # 03410-127-14

catamaran

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1.0 Submission Cover Letter

The Vendor must include a cover letter and executive summary stating the Vendor's intent to bid for this RFP. The Vendor's response must include a transmittal (cover) letter; table of contents; executive summary; Vendor contact information and locations.

Instructions: The Vendor must include the following cover letter provided and, an individual authorized to legally bind the Vendor must sign the cover letter in ink and include it in the labeled "Original Proposal".

Provide the following information regarding the person responsible for the completion of the Vendor response. This person should also be the person the Department of Vermont Health Access (DVHA) should contact for questions and/or clarifications.

Name	Jeff Gottlieb	Phone	215-284-9980
Address	1600 McConnor Parkway	Fax	224-231-1904
	Schaumburg, IL 60173-6801	E-mail	jeff.gottlieb@catamaranrx.com

Subject to acceptance by the State, the Vendor acknowledges that by submitting a response AND signing in the space indicated below, the Vendor is submitting a formal offer to meet the requirements and intent of the RFP and should a contract result of this RFP with said vendor, the vendor shall be contractually obligated to comply with all items in this Request for Proposal (RFP), including Vermont Agency of Human Services (AHS) Attachments C, E, F. While the Vendor is directed to list exceptions on the Exception Summary form in Template B, all such exceptions shall be subject to State acceptance and/or further negotiation. If no exceptions are noted, none will apply. Vendors who sign below may not later take exception to any point during contract negotiations.

Failure to sign the Submission Cover Sheet or signing it with a false statement shall void the submitted response or any resulting contracts.

_____ / 1/28/2014

Original signature of individual authorized to legally bind the Company / Date

Name (typed or printed)	Dan Hardin
Title	Segment President, Public Sector
Company name	Catamaran, LLC
Physical address	1600 McConnor Parkway
	Schaumburg, IL 60173-6801
State of Incorporation	Texas

2. Proposed solution for the Project meets all the requirements of this RFP.
3. The Vendor will comply with all federal and state laws, rules, and regulations that are in force currently or anytime during the term of a resulting Contract.
4. The company represented here is an authorized dealer in good standing of the products/services included in this response.
5. The Vendor and its principals are eligible to participate in this transaction and have not been subjected to suspension, debarment, or similar ineligibility determined by any federal, state or local governmental entity and that Respondent is in compliance with the State of Vermont statutes and rules relating to procurement and that Vendor is not listed on the federal government's terrorism watch list as described in Executive Order 13224. Entities ineligible for federal procurement are listed at http://www.epls.gov.

Please note that Catamaran has proposed exceptions to the Standard State Provision for Contracts and Grants. These exceptions are documented in Template B Vendor Experience, Section 6, Exceptions.

2.0 Submission Cover Sheet

Instructions: Along with the Cover Sheet, the Vendor must also provide the following information:

A statement regarding the Vendor's legal structure, federal tax identification number, and principal place of business and attach applicable W-9 forms (http://www.irs.gov/pub/irs-pdf/fw9.pdf)

- A list of the people who prepared the Vendor's Proposal, including their titles
- A list of all subcontractors, if any, that the Vendor will use on the Project, if the State selects the Vendor to do the work
  - For each proposed subcontractor, the Vendor must attach a letter from the subcontractor, signed by an individual authorized to legally bind the subcontractor, with the following included in the letter
    - The subcontractor's legal status, tax identification number, and principal place of business address
    - The name, phone number, fax number, email address, and mailing address of a person who is authorized to legally bind the subcontractor to contractual obligations
    - A description of the work the subcontractor will do
    - A commitment by the subcontractor to do the work if the Vendor is selected
    - A statement that the subcontractor has read and understood the RFP and will comply with the requirements of the RFP
    - A statement that the subcontractor will maintain any permits, licenses, and certifications required to perform its portion of the work

Response:

Legal Structure

Catamaran LLC is a limited liability company, which began its corporate life in the State of Texas on January 25, 1995 under the name SystemsXcellence USA, Inc., a Texas corporation.

Federal Tax Identification Number

Catamaran's Federal Tax Identification number is 75-2578509.

Principal Place of Business

Catamaran LLC is located at:

1600 McConnor Parkway
Schaumburg, IL 60173-6801

W-9 Form

Catamaran's W-9 form is provided in Attachment A.

People Involved in Proposal Preparation

The following individuals prepared Catamaran LLC's proposal.

Confidential, Proprietary, and Trade Secret Information of Catamaran.

[redacted]

Subcontractors

Catamaran LLC proposes the University of Massachusetts Medical School (UMMS), Clinical Pharmacy Services (CPS) as our clinical call center / prior authorization subcontractor for this

contract. CPS will operate a clinical call center, support and staff the prior authorization program, assist in developing and adhere to clinical criteria documents, provide monthly reports, and support the Catamaran Clinical Account Team.

The University has provided the required subcontractor letter, offered in Attachment B.

Catamaran is also proposing CaptureRx as our 340B claims clearinghouse that normalizes all 340B data and facilitates retrospective adjudication in order to eliminate the risk of duplicate discounting as well as maximize appropriate savings within a gain share model.

CaptureRx has provided the required subcontractor letter, also offered in Attachment B.

3.0 Table of Contents

Instructions: This section must contain a Table of Contents. This should include all parts of the proposal, including response forms and attachments, and should be identified by volume and page number. The Table of Contents should identify all sections, figures, charts, graphs, etc.

Catamaran has prepared a Table of Contents for each proposal Template, located at the beginning of each. Following is a master Table of Contents for the entire proposal response.

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4.0 Executive Summary

Instructions: This section should be a brief (three- (3) to five- (5) page) summary of the key aspects of the Vendor's Technical Proposal. The executive summary should include an overview of the Vendor qualifications, approach to deliver the services described in the Request for Proposals (RFP), time frame to deliver the services, proposed team, and advantage to the State.

Response:

Catamaran has crafted this proposal thoughtfully and conscientiously, while keeping the goals and objectives of the State of Vermont in mind. As the incumbent pharmacy benefit management (PBM) partner for the Department of Vermont Health Access (DVHA), we have been extremely diligent in our efforts to articulate our understanding of the State's project goals, as well as the requirements and performance standards outlined in the RFP. We trust that our straightforward responses clarify our understanding of the State's needs and our dedication to its program. Furthermore, we have proposed low-risk solutions that offer the State the ability to modernize Vermont's pharmacy benefit management program without significant modifications to our existing technology, RxClaim Suite®.

Qualifications

Catamaran is a comprehensive PBM company serving the industry since 1981. As the fourth largest PBM in the United States, we currently touch more than 32 million lives and process more than 1.5 billion pharmacy claims annually. Catamaran manages six State Medicaid fee-for-service (FFS) programs, covering more than five million Medicaid FFS lives. We oversee 17 Managed Medicaid contracts, covering more than four million managed Medicaid lives. None of this experience qualifies Catamaran for the job at hand more than the fact that we have served the State of Vermont as its PBM vendor for its publicly funded healthcare programs since 2006. However, we do not rest on this knowledge. As forward thinkers and industry leaders, we offer solutions that enable Vermont to move to the level of maturity it seeks in its new Health Services Enterprise.

As DVHA's incumbent PBM partner, we have enjoyed working as a blended team with State personnel to provide point-of-sale pharmacy claims processing, prior authorization and clinical services, a specialty pharmacy program, drug utilization review, and state supplemental rebate administration. Over the course of the last eight years, Catamaran has consistently modified our services and support model to ensure appropriate strategic alignment with the State's goals and objectives. We have collaborated with the State to address high-priority regulatory and legislative issues, budgetary issues, changing market dynamics, and high-profile trends in drug prescribing and consumption. Through these efforts, it is our sincere hope that we have clearly demonstrated our commitment as a business partner and our dedication to delivering a customized and effective pharmacy benefit management program for Vermont.

We are committed to providing innovative, flexible tools to our clients and their beneficiaries in order to provide cost effectiveness as well as optimal healthcare delivery options. The transformation of the healthcare system depends on new and innovative ways to leverage data and technology to achieve dramatic change in health and wellness. Our history as a technology leader and innovator is central to the way we operate. We are building on our rich legacy of innovation in the pharmacy industry with a comprehensive approach to reimagining our healthcare future. Innovation is a company-wide effort at Catamaran. A dedicated space for innovation sets the stage for fruitful collaboration with a variety of stakeholders and healthcare

leaders. A space to engage, interact and collaborate, Catamaran's Innovation Center in Chicago provides a powerful and compelling way for our guests to experience the transformational advances we are bringing to the pharmacy benefit industry. At the center, we showcase the pathway we are forging to better health through the marriage of analytics and insights with technology. Interactive technology, with multimedia and informal gathering spaces, sets the stage for dynamic and collaborative idea generation.

Approach to Service Delivery

We understand the State's desire to implement contemporary PBM services that are supported by modern technology, supporting MITA 3.0 processes, and that meet the CMS Seven Standards and Conditions for Enhanced Federal Funding. We have a long and unique history with the State, which affords us an intimate insight into the program. We understand that all components of this RFP are significant and necessary to move the program to a more modern state. However, we also understand that there are service components of this RFP that are key to its ongoing success. In the pages that follow, we briefly describe our approach to service delivery by highlighting new or expanded "key" services we offer the State.

Point of Sale Claims Processing (RxClaim Suite®) – Our point of sale system processes millions of pharmacy claims every day, including Vermont's, and supports virtually every type of pharmacy benefits program currently utilized in the marketplace. The system architecture incorporates MITA principles and aligns well with the CMS Seven Standards and Conditions for Enhanced Federal Funding. RxClaim Suite is a modern suite of modular components that efficiently supports all of the business functions required by the State with minimum customization required.

Prior Authorization (RxAuth®/ SilentAuth) – The Vermont PA program is currently deployed through our RxAuth module. The tool is a flexible, efficient prior authorization (PA) management solution that leverages the power of RxClaim to automate the PA process from end to end. Clinical Pharmacy Services (CPS), a division of the University of Massachusetts Medical School, our clinical call center provider, will continue to utilize RxAuth to facilitate PA management. However, Catamaran recognizes the State's continued need to control escalating drug costs while also easing the administrative burden of the paperwork, documentation requirements, and reporting challenges associated with prior authorization. Therefore, we are offering RxAuth access to providers via the RxProvider Portal Web interface. This portal provides an online, real-time interface for prescribers to submit and manage prior authorizations requests. Interactions between RxProvider Portal and RxAuth are dynamic with multiple data exchanges happening in real-time.

New to Vermont, Catamaran's SilentAuth application will work behind the scenes, at the point of sale, facilitating real-time prior authorization decisions based on the pharmacy and medical history data associated with the beneficiary. The "submission" of a PA request will be part of the POS adjudication process and largely invisible to the provider submitting the claim unless the system flags the claim for additional information. The incorporation of medical data (ICD-9/10 and CPT codes) allows real-time, objective decisions to the extent that they can be based on the submitted claims history.

Dashboard Reporting (RxTrack Connect) – Catamaran's RxTrack Connect Web-based application is a new offering for the State. Replacing RxTrack, it enables users to generate powerful reports from claims data easily and conveniently. Using this application, authorized State personnel can view Vermont's program data online via the RxTrack Dashboard. RxTrack Connect is user friendly and a readily accessible data access tool that empowers the end users

to produce standardized and parameter driven reports and data files; and to obtain transactional level detail. The users can print professional reports ranging from things as simple as mailing labels to as complex as utilization reports, or bring the data into their desktop applications.

Drug Rebate Administration (RxMax®) – Our rebate management system, RxMax, is a flexible, scalable rebate management system that empowers users to manage and track contractual arrangements with pharmaceutical manufacturers at their desktops. Utilized by our rebate team for Vermont today, RxMax provides all the functionality required by State and Federal regulations. RxMax utilizes both CMS and NCPDP rebate standards as its foundation, allowing it to support the entire rebate process for Medicaid rebates authorized under Section 1927 of the Social Security Act, Medicaid supplemental rebates, and State-only rebates

Preferred Drug List Development (RxBuilder™) – Catamaran proposes to enhance its work maintaining the State's Preferred Drug List (PDL). We will utilize our Web-based formulary management offering, RxBuilder. The application is a comprehensive, rules-based PDL management solution that meets the challenge of accurately creating, maintaining, and sharing the PDL. The rules-based capabilities of RxBuilder create efficiencies in PDL maintenance and in application of PDL and benefit characteristics.

Provider Access (RxProvider Portal™) – Introduced above, RxProvider Portal is a Web-based provider interface that allows physicians and pharmacists easy access to beneficiaries' plan information from RxClaim, to provide more accurate and cost-efficient prescription medications. It gives physicians the ability to search a specific prescription number and view details of that claim, remittance advice, forms and contracts, and beneficiary eligibility information. The portal also offers an online, real-time interface for prescribers to submit and manage prior authorizations requests.

Medication Therapy Management Suite – Catamaran proposes our Retrospective DUR and Medication Therapy Management suite of programs to address the State's need to take these services to the next level. Our proposal features innovative technology and customizable clinical rule sets to drive evidenced-based clinical solutions and enable the State to target areas of greatest concern.

Management of Physician Administered Drugs – Catamaran recognizes the State's desire to manage all drugs, paid under any benefit (Pharmacy or Medical) and administered at any site of service and we are offering a comprehensive solution to do just that. We propose a collaborative process with the State that begins with understanding recent medical benefit drug utilization patterns driving the majority of drug spend. We will then deploy a multi-faceted consistent approach to drug management in both the pharmacy and medical benefit. The process will include medical benefit drug evaluation, prior authorization, medical benefit drug claims processing and payment rules, data integration, utilization review, drug rebate, and additional clinical initiatives. This model offers the same level of oversight and management for all outpatient drugs whether provided to the beneficiary by retail pharmacy or specialty pharmacy for home administration, or provided through the medical benefit for administration to the member in the home, physician office, and freestanding infusion clinic or outpatient hospital.

Specialty Pharmacy – Catamaran is proposing a specialty growth strategy to manage this changing environment in a proactive way through our wholly owned specialty pharmacy, Briova. One of the unique components of Catamaran's strategy and one that differentiates our specialty pharmacy strategy from other vendors is our consultative approach to managing specialty patients. We are the only specialty pharmacy offering video consultations (Briova Live) with

patients. Most pharmacies offer either a consultation at the retail counter, over the phone, through written communication, or a home health nurse. Our approach is personalized through video, creating a direct connection between a specialty pharmacist and patient without the patient feeling overwhelmed by having someone physically in their home. This is just one component of our specialty approach to assisting the State in controlling drug spend associated with high cost specialty medications used to treat complex and chronic diseases, which require intensive therapy management.

Time Frame

The State is very clear in requiring a January 01, 2015 go-live and Catamaran believes this is an attainable goal. Our knowledge of the current systems and business processes presents the least risk to the schedule of any other solution. Since data conversion, interfaces, and the incumbent working relationship are the three highest risk items in every implementation, we have essentially eliminated those risks to the project. The gaps we have identified between the to-be and the as-is state have been evaluated and work required to close those gaps has been found to be within tolerance for implementation on the date requested.

Proposed Account Management Team

Catamaran's Account Management Team assigned to Vermont today, and proposed for the ongoing engagement, is intimately familiar with the State's plans, its goals, and the opportunities for the modernization of the program. Nancy Miner, Account Manager and Diane Neal, Clinical Services Manager are both dedicated to this project and have been for the last seven years. Ms. Miner is a Certified Pharmacy Technician with 13 years of experience in retail pharmacy. Ms. Neal is a Registered Pharmacist licensed in Vermont with 30 years of experience in a combination of PBM and hospital settings.

Michelle Sirois, Client Services Manager, has been dedicated to the project for the last three years. She is an additional proposed resource who will serve as one of the State's Key Personnel. Ms. Sirois is a Registered Pharmacy Technician in the State of Vermont and has 17 years of experience in a long-term-care pharmacy setting.

Providing data analytics support to the program for the last three years is Jacquelyn Stager. Ms. Stager has 13 years of experience in project management and data analytics and holds a Six Sigma yellow belt certification.

These key individuals committed to managing the Vermont program possess institutional knowledge that allows Catamaran to continue providing a proactive, extremely personalized account management approach for the State.

We have also proposed a highly experienced account management professional, Craig Boon, as the dedicated Account Director. Mr. Boon is a PMI certified Professional Project Manager (PMP) with over 20 years of experience in healthcare administration, specifically account and project management, and has been dedicated to some of Catamaran's most complex program implementations including Indiana, Nevada, and Virginia.

Mr. Boon and the Account Management Team will be supported by a robust staff including implementation resources, pharmacists / clinical personnel, systems and network staff, rebate experts, and a seasoned group of call center personnel. They are also backed by Catamaran's Senior Director of Account Management, Susan McCreight. Ms. McCreight has a twenty-year history in account management and most recently oversaw Catamaran's contract with Georgia

Medicaid. Finally, the Vermont contract is a Key Account for which our Public Sector Segment President, Dan Hardin, has direct oversight and accountability.

Advantage to the State

The State seeks a partner who will provide a flexible and comprehensive PBM program. By contracting with Catamaran, the State will retain such a partner that is equally vested in its success. Through our incumbent knowledge, industry-leading solutions, client first mentality, and innovation, Catamaran is the lowest risk PBM for this opportunity.

- As the incumbent PBM partner, no organization has the historical knowledge and established relationships that our dedicated Vermont Account Management Team offers.
- As the incumbent PBM partner, our dedicated Account Management Team is already on the ground today in Vermont and committed to the program's success.
- As the incumbent PBM partner, core system data such as claims, Prior Authorizations, MAC pricing, etc., are simply moved from the current environment used for the program today, to the new environment dedicated to Vermont without the traditional development efforts. The overall data conversion risk is considerably minimized for the State.
- As the incumbent PBM partner, Catamaran has proven its financial stability. We have significant cash reserves to weather the strongest storms and we have no parent organization driving changes in our mission.
- As the incumbent PBM partner, the State knows we meet our commitments, we implement the best solutions in the industry, and we are committed to exceeding your expectations.

Ultimately, Catamaran's success is measured on our customer satisfaction scores. To that end, Catamaran deployed a strategic program called "Clients for Life". This program is a representation of our corporate philosophy and direction that has meaning to every Catamaran employee from our Chairman and CEO on down. It is our goal to ensure the State of Vermont is a "Client for Life." We achieve this goal by excelling in three areas: first, by striving for operational excellence. We implement the tools, processes, and procedures that allow the State to obtain the best products and service available in the industry. Second, by striving for 100% client satisfaction, we do what is right for the State within the constraints of the business. Lastly, we focus on our employees that serve our clients. By investing in our employees, we ensure that each has the knowledge and resources necessary to support the State. When we are successful in executing each of these initiatives, we achieve our Catamaran mission:

> ***"To build loyal client relationships based upon an intimate understanding of our customer's business. Leveraging our adaptable technology and domain expertise, we will architect customized solutions that create a game-changing impact on their healthcare outcomes and costs."***

"Clients for Life" is not just a belief or fancy words; it is institutionalized in our training, operations, and employee compensation. Catamaran lives by the slogan, "Deeds, not words."

5.0 Vendor Contact Information

Instructions: Complete the following information regarding the Vendor's headquarters, and primary contact for any questions pertaining to the Vendor's responses to this RFP, payment address to which the State should send payments under the Contract, and Legal Notice Address to which the State should send legal notices under the Contract.

Respondents are not to change any of the completed cells in the following Table 1. Any changes to the completed cells in the following table could lead to the disqualification of a respondent.

Table 1 Vendor Contract Information

COMPANY HEADQUARTERS INFORMATION:	
Company Name:	Catamaran LLC
Address:	1600 McConnor Parkway
City, State & Zip Code:	Schaumburg, IL 60173-6801
Company Type (Check One):	☐Private ☒Public
Company Size:	3,500+ (Total Number of Employees)
Annual Revenue:	$10 billion

PRIMARY CONTACT INFORMATION:			
Name:	Jeff Gottlieb	Title:	Director, Public Sector Sales
Address:	1906 Castle Green Circle		
City, State & Zip Code:	Mount Airy, MD 21771		
Phone:	215-284-9980	Fax:	224-231-1904
E-mail:	jeff.gottlieb@catamaranrx.com		
REGIONAL OR LOCAL OFFICE INFORMATION:			
Company Name:	Catamaran will open a local office in Vermont. The exact location is under consideration.		
Address:	To be determined.		
City, State & Zip Code:	To be determined		
Primary Contact:	Nancy Miner, Vermont Account Manager		
Phone:	802-879-5638	Fax:	802-879-5651
E-mail:	nancy.miner@catamaranrx.com		

5.1 Subcontractor Contact Information (If applicable)

Instructions: Complete the following information regarding the Subcontractor's contact information. If more than one Subcontractor is proposed, add more pages as necessary.

Respondents are not to change any of the completed cells in the following Table 2. Any changes to the completed cells in the following table could lead to the disqualification of a respondent.

Table 2 Subcontractor Contact Information

COMPANY INFORMATION:	
Company Name:	University of Massachusetts Medical School
Address:	55 Lake Avenue North
City, State & Zip Code:	Worcester, MA 01655
Company Type (Check One):	☐Private ☒Public
Company Size:	6579 (Total Number of Employees)
Annual Revenue:	$844,907,000

PRIMARY CONTACT INFORMATION:			
Name:	Timothy Cummins, RPh, MBA	Title:	Executive Director–CPS
Address:	333 South Street		
City, State & Zip Code:	Shrewsbury, MA 01545		
Phone:	774-455-3440	Fax:	877-208-7428
E-mail:	Timothy.Cummins@umassmed.edu		

Table 3 Subcontractor Contact Information

COMPANY INFORMATION:	
Company Name:	NEC Networks, LLC dba CaptureRx
Address:	10100 Reunion Place, Suite 700
City, State & Zip Code:	San Antonio, TX 78216
Company Type (Check One):	☒Private ☐Public
Company Size:	55
Annual Revenue:	$15 million

PRIMARY CONTACT INFORMATION:			
Name:	Cinthya Pillot-Olive	Title:	VP of Operations
Address:	10100 Reunion Place		
City, State & Zip Code:	San Antonio, TX 78216		
Phone:	2105873486	Fax:	2105760420
E-mail:	cinthya@capturerx.com		

6.0 Minimum Mandatory Qualifications

Instructions: Complete the following information regarding the Vendor's ability to meet the Minimum Mandatory Qualifications. The State reserves the right to ask for any additional clarification relating to the minimum requirements.

Respondents are not to change any of the completed cells in the following Table 3. Any changes to the completed cells in the following table could lead to the disqualification of a respondent.

The Vendor agrees to meet the following Minimum Mandatory Qualifications.

Table 3 Minimum Qualifications

#	Qualification Item	Vendor Agrees to Meet?		Reference to Proposal Response Section
1	The bidder must have at least five years' experience with projects of similar size and scope to the State's that include design, development, implementation, and operation of a Medicaid POS pharmacy claims processing system in compliance with all federal and State regulations, which includes eligibility verification, POS edits and transmission messaging, PA, DUR, reimbursement, benefit design, and reporting	YES ☒	NO ☐	Template B – Vendor Experience
2	The PBM Solution proposed by the Vendor must have been previously implemented successfully in a State Medicaid environment. A successful implementation is defined as one in which providers can submit claims and the PBM system adjudicates claims and generates payments accurately. In addition, operational programs and services such as DUR, prior authorization, and utilization management have been implemented and are operating successfully.	YES ☒	NO ☐	Template B – Vendor Experience Template I – Non-Functional Requirements Approach
3	The PBM vendor must have three years' experience administering Part D drug benefits and supporting Part D drug plans or, at the time of the Duals Demonstration Project Implementation, will subcontract with a vendor that does have this experience.	YES ☒	NO ☐	Template B – Vendor Experience Template G – Functional Requirements Approach: 1.3.5 Dual Eligible Demonstration

#	Qualification Item	Vendor Agrees to Meet?		Reference to Proposal Response Section
4	The PBM vendor must have three years' experience administering Part D drug benefits and supporting Part D drug plans or will subcontract with a vendor that does have this experience	**YES** ☒	**NO** ☐	Template B – Vendor Experience Template G – Functional Requirements Approach: 1.3.5 Dual Eligible Demonstration
5	The bidder must have three project references	**YES** ☒	**NO** ☐	Template C – Vendor References
6	The bidder's PBM solution must be able to function independently from the MMIS, interface to the current MMIS system, and interface with the new Core MMIS system chosen at a later date	**YES** ☒	**NO** ☐	Template G – Functional Requirements Approach: 1.1.1 Point –of-Sale Claims Processing System Template H - Non-Functional Requirements
7	The bidder must agree that they will be responsible to make any system modifications necessary to comply with all Federal and State regulations and mandates, as described herein, which include (but are not limited to) eligibility verification, POS edits and drug monitoring, prior authorization, drug utilization review, billing and reimbursement, and to meet the deadlines imposed for such changes for the duration of this contract	**YES** ☒	**NO** ☐	Template H - Non-Functional Requirements Template I – Non-Functional Requirements Approach

Template B

Vendor Experience

RFP # 03410-127-14

catamaran

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1. Vendor Organization Overview

The Vendor must include details of the Vendor's Experience in this section. The details must include Vendor organization overview; corporate background; Vendor's understanding of Medicaid and Medicaid pharmacy operations.

Instructions: Provide all relevant information regarding the general profile of the Vendor.

Respondents are not to change any of the completed cells in the following table. Any changes to the completed cells in the following table could lead to the disqualification of a respondent.

Vendor Organization Profile

Company Name	Catamaran LLC
Name of Parent Company	Catamaran Holdings I, Inc., a Delaware company
Industry (NAICS) **(North American Industry Classification System)**	524292, 44611, 511210
Type of Legal Entity	Limited Liability Corporation
Company ownership **(i.e., private/public, joint venture)**	Publicly Traded
Number of full time employees	3,500 +
Last Fiscal Year Company Revenue	$9,940,120,000
Last Fiscal Year Company Net Income	$116,658,000
% of revenue from State and Local Government clients in the United States	10%
% of revenue from IT Design and Implementation Services	< 1%
Number of years in business	30
Number of years Vendor has been providing the type of services specified in the RFP	30
Number of Employees providing the type of services specified in the RFP	3,500+ employees provide and support the services specified in the RFP
Headquarters in the USA	Schaumburg, Illinois
Locations in the USA	50 +
Office Servicing this Account	This account will be supported by a local office in and Catamaran LLC's corporate headquarters is Schaumburg, Illinois.

1.1 Subcontractor Organization Overview (If applicable)

Instructions: If the proposal includes the use of Subcontractor(s), provide all relevant information regarding the profile of that Subcontractor. This section may be duplicated in its entirety and page each used per subcontractor included.

Respondents are not to change any of the completed cells in the following table. Any changes to the completed cells in the following table could lead to the disqualification of a respondent.

Subcontractor Organization Profile

Subcontractor Name	University of Massachusetts Medical School (UMMS)
Type of Legal Entity	Public university–The University is a public university created by the legislature of the Commonwealth of Massachusetts under statue M.G.L. ch. 75. The University's enabling statue can be accessed at www.malegislature.gov/Laws/GeneralLaws/PartI/TitleXII/Chapter75
Company ownership (i.e., private/public, joint venture)	Public, university
Headquarters Location	55 Lake Avenue North, Worcester, MA
Date Founded	1962
Number of employees	6,579
Last Fiscal Year Company Revenue	$ 844,907,000
Last Fiscal Year Company Net Income	$ 38,699,000
Services to be provided	The University will: operate a clinical call center, support and staff a prior authorization program, assist in developing and adhere to clinical criteria documents, provide monthly reports, and support the Catamaran account manager.
Experience of Subcontractor in performing the services to be provided	Over 14 years of experience
Brief description of and number of projects that Vendor has partnered with this Subcontractor	Catamaran (vendor) has been working with UMMS/Clinical Pharmacy Services (CPS) since 2005. UMMS currently provides clinical call center support to four current Catamaran clients.
Locations where work is to be performed	333 South Street Shrewsbury, MA 01545

Subcontractor Organization Profile

Subcontractor Name	■ NEC Networks, LLC dba CaptureRx
Type of Legal Entity	■ LLC
Company ownership (i.e., private/public, joint venture)	■ Private
Headquarters Location	■ San Antonio, Texas
Date Founded	■ 1995
Number of employees	■ 55
Last Fiscal Year Company Revenue	■ 7.5 million
Last Fiscal Year Company Net Income	■ 920,000
Services to be provided	■ 340B claims clearinghouse that normalizes all 340B data and facilitates retrospective adjudication in order to eliminate the risk of duplicate discounting as well as maximize appropriate savings within a gain share model.
Experience of Subcontractor in performing the services to be provided	■ Subcontractor is the largest privately held 340B administrator, servicing over 300 covered entities and 8 million covered lives.
Brief description of and number of projects that Vendor has partnered with this Subcontractor	■ Multiple projects including but not limited to Texas 1915B Medicaid Waiver 340B gain share administration, 340B DSH administration and multiple Medicaid Managed Care initiatives.
Locations where work is to be performed	■ Vermont, Texas and Illinois

2. Vendor Corporate Background and Experience

This section details the Vendor's corporate background and experience. The section should include the following information:

2.1 Vendor Corporate Background

Instructions: Describe the Vendor's corporate background as it relates to projects similar in scope and complexity to the project described in this RFP.

Response:

As an experienced full service pharmacy benefit management (PBM) company serving the industry since 1981 and the Department of Vermont Health Access (DVHA) since 2006, Catamaran has the requisite systems, tools, and dedicated staff to continue supporting DVHA in its mission of assuring beneficiary access to safe, efficacious, and clinically appropriate drug therapies at the lowest cost possible. We offer the Department an established solution to meet the business and technical needs of its program, as well as the expertise to ensure a successful implementation of DVHA's health reform initiatives.

Catamaran Experience

- **30 years** of PBM experience
- **32 million lives** served company-wide
- **6 State Medicaid clients** providing Fee-for-service (FFS) benefit
- **> 5 million** Medicaid FFS lives
- **17 Managed Medicaid** contracts
- **> 4 million** managed Medicaid lives
- **4th largest** PBM
- **1.5 billion claims** processed annually with Catamaran systems

Catamaran is the **"power"** behind many of the largest PBMs in the industry because the industry acknowledges that our systems are the best in terms of functionality, reliability, and stability. This unrivaled technical competency is complemented by a business approach that focuses on the client and the delivery of exemplary clinical and administrative services. This singular focus on the delivery of superior PBM and administrative services is reflected by the fact that Catamaran has never had to apologize for failures of duty. Catamaran is a company whose legacy is defined by the successful development, deployment and operation of industry-leading technical solutions. As the industry's leading provider of transparent PBM services, it is not obliged to corporate parents whose primary business is mail or retail pharmacy or health plans, nor is it beholden by the pressures of the pharmaceutical industry.

Catamaran's background and experience provides a wealth of knowledge matched squarely to the mission of the Department. Our background provides evidence of well-developed functional skills in those very areas required for successful performance on the contract. It is a history that exemplifies an organizational culture and philosophy shaped by extensive experience serving government-sponsored health benefit programs with a CMS certified system.

2.2 Vendor's Understanding of Medicaid and Medicaid Pharmacy Operations

Instructions: Describe the Vendor's understanding of Medicaid, Medicaid pharmacy operations, and the State of Vermont's Medicaid pharmacy operations. Discuss the Vendor's strategies and areas of focus related to this service. Discuss key trends affecting Pharmacy Benefits Management in the next three to five years and how this perspective will translate into benefits for Vermont.

Response:

Catamaran's team has significant experience with State Medicaid programs, and the State of Vermont's Medicaid pharmacy operations specifically. Our systems are currently operational in six state Medicaid programs providing a fee-for-service benefit where Catamaran has management responsibilities. We also support seventeen Managed Medicaid contracts covering more than four million managed Medicaid lives.

Catamaran has fostered lasting relationships with our State Medicaid clients and we have developed an intimate understanding of the stakeholders, business environments, and unique challenges inherent in State Medicaid accounts. Some of these challenges include the demand for coordination of and buy-in from a disparate group of stakeholders and vendors, the need to react quickly to new and changing State and Federal mandates, and meeting the evolving needs of program beneficiaries. These challenges require a partner who can facilitate long-term flexibility and portability, minimizing inert tools and processes in a constantly changing healthcare landscape.

From the beginning of our relationship with Vermont, we showed our understanding of your needs. Effective January 1, 2006, Catamaran (as MedMetrics Health Partners) transitioned your operations from your previous vendor to our claims processing and PBM services. We simultaneously implemented your plans for benefits for Vermont Medicare beneficiaries coordinated with Medicare Part D that became available that same day. Immediately it was apparent that there were significant problems with Part D, and your Legislature and Administration authorized the reinstatement of the State's pre-Part D coverage. With that, we designed new plans for our systems - your December 2005, pre-Part D benefits; which we had never administered - and implemented them that same week so that Vermonters with Medicare and eligible for the Vermont benefits would not be turned away by pharmacies while Medicare resolved their Part D problems.

Today, as an industry-recognized service integrator known for delivering an innovative mix of market expertise, information technology, clinical capability, scale of operations and specialty pharmacy offerings, Catamaran delivers Medicaid specific solutions for PBM services that meet these challenges. Our broad range of pharmacy management tools from our CMS certified, MITA 3.0 compliant pharmacy benefit management system suite, RxClaim Suite, to our experienced and dedicated account team, to our deep familiarity with highly regulated Medicaid programs, enable us to improve upon the solutions in place in Vermont today and further meet the State's unique needs.

Understanding of Vermont's Medicaid Pharmacy Operations

We currently process approximately 2.1 million transactions per year for the State's 170,000 beneficiaries. The services Catamaran provides today are listed below. With minimal

modifications, they can meet the future needs of the State including a number of the requirements set forth in this RFP as expansions of services or new initiatives.

- Pharmacy claims processing
- Custom interface integration with MMIS
- Provider technical and clinical call center services
- On-site Account Management support
- Clinical analytics support, including reporting and therapeutic class reviews
- DUR Board and P&T Committee support
- RetroDUR
- Access to pharmacy systems including RxClaim and RxTrack
- State rebates for diabetic supplies
- Supplemental rebate offer evaluation
- Supplemental rebate contracting, invoicing and reporting
- Pharmacy outreach and support
- State MAC rate management
- ePrescribing support
- Specialty Pharmacy
- eCOB (enhanced Coordination of Benefits)

Vermont's operations are quite distributed in comparison to some of our clients. An important reminder we note is that planning significant coordination, development, and testing time is essential when changes must be made that span multiple organizations with multiple responsibilities and priorities. For example, under the existing contract, Catamaran has worked with Hewlett Packard Enterprise Services (HPES) which is the MMIS vendor/Fiscal Agent for Vermont Medicaid. Catamaran's involvement with HPES focused on PBM integration, including pharmacy and prescriber eligibility file transfers from HPES to Catamaran and pharmacy claims file transfers from Catamaran to HPES. Together, we developed a custom claim extract for these transfers and we modify it when there are changes that affect any data element that must be loaded into the MMIS. But we both would say that we needed to learn to make adjustments and accommodations to make things work for our mutual client.

We believe that this knowledge will be critical going forward as the State invests in and transitions to a Health Service Enterprise strategy.

Industry Trends

In this section, we explore major industry trends that impact Medicaid, including the impact of healthcare reform, the prevalence and impact of obesity on healthcare spend, the rising cost of prescription medications, and drug shortages. We delve into drug trend and examine its drivers, providing an assessment of the industry, a view into both traditional and specialty trend and our outlook on future trends.

The Impact of Healthcare Reform

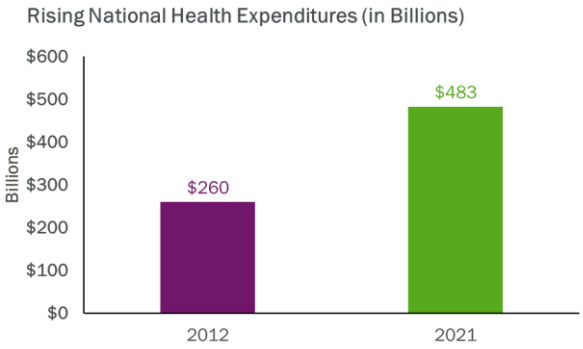
The Affordable Care Act expanded coverage to more than 30 million Americans on January 1, 2014, raising national health expenditures on prescription drugs from $260 billion in 2012 to an estimated $483 billion by 2021[1].

The health system overhaul aims to achieve three important goals:

1. Better organized health insurance purchasing
2. Improved efficiency of healthcare delivery
3. Improved access to care for long-lasting quality outcomes

While national prescription drug expenditures are expected to grow at a rate of 8.8% annually, in part due to reform provisions, Catamaran's expertise, our flexible technology and our ability to manage complex markets and programs will deliver value in addressing these goals for our clients[1].

Figure 1



Organizing Health Insurance Purchasing and Procurement

Health Insurance Marketplaces (formerly exchanges) are designed to solve a series of challenging market and consumer issues. The network of federally facilitated, federal-state partnership and state-managed exchanges is intended to address a fragmented marketplace, unite a sizable risk pool to optimize health insurance risk and introduce more transparency in the process of selecting among consumer health plan options.

The Patient Protection and Affordable Care Act passed implementation details to federal regulatory agencies, resulting in a vast number of regulations on guidance. As the centerpiece of the Act, every state in the union offered their own health insurance exchange or a federal option for consumers to access, compare and purchase health plans. Insurers were to obtain certification for "Qualified Health Plans" (QHPs) and all plans were to be ready for open enrollment in October 2013 and match state-designated benchmarks. Things did not go as well as planned.

Catamaran has the commercial expertise to help counsel Vermont in regard to plans should it be useful. If ever it should be needed we would be able to structure an offering for any exchange. We are working with both current clients and new clients to develop consumer-friendly and cost-effective plan designs and we are supporting their efforts to implement a pharmacy essential health benefit that meets benchmark requirements. As we move beyond implementation, Catamaran will be working with these clients to evolve from benchmark to "signature" offerings. Our flexible model gives these clients the capacity to create a compelling and competitive model for pharmacy management.

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[1] Centers for Medicare & Medicaid Services, *National Health Expenditure Projections 2011-21,* accessed 5/21/2013, http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/Proj2011.pdf.

Catamaran supports the private exchange marketplace with a member-centric approach and flexible program design.

As employer groups seek to offset rising healthcare costs, private health insurance exchanges are emerging to fill gaps in the insurance marketplaces. These exchanges are being designed to facilitate employee coverage through defined contribution plans with the intent of lowering company costs and offering employees more flexibility in health plan choices. Catamaran supports the emerging private exchange marketplace with our unique, member-centric approach and flexibility in program design. This makes us uniquely knowledgeable in the intricacies of private health insurance today. We believe that this knowledge may help the State in their efforts to coordinate publicly funded benefits with insurance coverage in these times.

Improve Efficiency of Healthcare Delivery

Accountable Care Organizations (ACOs) are attracting more attention in health care administration as a integrated care and payment model that creates incentives for healthcare providers to work together to treat patients across the delivery system. The intention is to improve care management and foster a community approach to care delivery while controlling costs.. At the same time, the goal of coordinated care is to ensure that patients, especially the chronically ill, receive the right care at the right time, while avoiding unnecessary duplication of services.

This model holds promise in delivering care to those with the greatest need. The Centers for Medicare and Medicaid Services have established a Medicare Shared Savings Program, which is designed to reward ACOs that lower their growth in healthcare costs while meeting performance standards on quality of care.

Catamaran is well-versed in and already partnering with existing ACOs, where our tools and clinicians are often embedded as part of the ACO. Clinical tools and risk-scoring at an individual level enhance coordination and pinpoint where providers need to focus their resources toward the best possible outcome. Catamaran has the tools and the flexible approach to align well with this area of reform, providing better access and coordination and improving quality.

Should Vermont consider the ACO approach for service delivery for portions of its beneficiaries, Catamaran could offer considerable help in administering and managing the pharmacy benefit. A somewhat negative note, though, is the ACO-related final ruling which excludes Medicare Part D expenditures from ACO cost benchmarks. This is a significant development for states like Vermont that supplement Part D coverage. Since Medicare Part D will not count toward the cost of care in a ACO, this exclusion is likely to result in increased Medicare beneficiary drug utilization and Part D spending. For states like Vermont that assist beneficiaries with their costs under the Part D benefit, this exclusion is likely to increase state spending.

Achieving Long-Lasting Quality Outcomes through Improved Access to Care

As the nation gravitates toward greater upfront investment in preventive care, government is leading the charge in a shift from a healthcare system that rewards volume to one which focuses on wellness and prevention. According to Health and Human Services estimates,

approximately 105 million Americans have already benefited from preventive services coverage improvements in the Affordable Care Act[1].

The Affordable Care Act requires non-grandfathered health plans and policies to provide coverage for "preventive care services" without cost sharing (such as coinsurance, deductible or copayment) when using a network provider. Services can include screenings, immunizations and other types of care, as recommended by the federal government.

Catamaran believes that an interpretation to be considered is that the integration of prescription and prescribed over-the-counter (OTC) medications can play a valuable part in managing preventive treatment for patients. The regulation references preventive care services with an A or B rating as outlined by the United States Preventive Services Task Force and covers a range of drug-related products such as aspirin and specific vitamin and mineral supplements. Our claims processing systems support our clients, including DVHA, in the coverage of such OTC.

In addition, Catamaran's claims processing systems fully support reimbursement for client specified immunizations and their administration. In Vermont, currently influenza vaccine can be administered in pharmacies.

While the Affordable Care Act will improve quality outcomes, Catamaran believes that managing at a beneficiary level to better outcomes is more critical than ever today as medications become extraordinarily expensive. Catamaran helps and will continue to help our clients improve quality and cost outcomes through a personalized approach to health management, proactively using patient risk scores to influence wellness and lifestyle.

We believe that Catamaran's pharmacy benefit management expertise will be needed more than ever to understand the new pharmaceutical agents, including the increasing specialty pipeline and formulary implications, and to manage the cost curve for purchasers of healthcare. And, as we enter an era of the post generic wave, savings in the pharmacy benefit area will depend on knowledge, innovation and improvements in linking the cost of pharmacy benefits to outcomes of care.

Through its Office of Government Relations, Catamaran is positioned to work with its State clients like Vermont to identify strategic opportunities to develop best-in-class offerings, to increase the efficiency of healthcare delivery and to improve health.

A Growing Epidemic

In 2012, the Centers for Disease Control (CDC) released a study detailing the growing obesity epidemic in the United States. As of 2010, more than 78 million adult Americans and approximately 12.5 million children were classified as obese.[2] This represents 35.7% of the adult population and 17% of those aged 2 to 19. The American Journal of Obesity reports that 15 million Americans were at least 100 pounds overweight in 2010, an increase of 70% over 2000 levels. Approximately one in 15 Americans (6.6%) is now considered severely obese.

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[1] U.S. Department of Health & Human Services, *Affordable Care Act Extended Free Preventive Care to 71 Million Americans with Private Health Insurance,* http://www.hhs.gov/news/press/2013pres/03/201303a.html, March 18, 2013.

[2] CL Ogden, MD Carroll, BK Kit, KM Flegal, *Prevalence of Obesity in the United States, 2009-2010, http://www.cdc.gov/nchs/data/databriefs/db82.pdf, U.S. Department of Health and Human Services, centers for Disease Control, No. 82, January 2012.*

The Rising Cost of Obesity-Related Conditions

The CDC reports that obesity-related conditions are among the leading causes of preventable death, including heart disease, stroke, type 2 diabetes and certain types of cancer. Figure 2 shows the correlation between diabetes and increased body weight in addition to projected healthcare costs due to obesity-related health conditions.

According to a study at Emory University, if current obesity trends continue, obesity-related healthcare spending will quadruple to $344 billion by 2018[1].

New Drugs for Obesity

In 2012, the FDA approved two new treatments for obesity, the first approvals in 13 years. Eisai's Belviq and Vivus' Qsymia were approved by the FDA in June and July 2012, respectively. However, Belviq has not been launched due to awaiting DEA scheduling which was announced in May 2013 (C-IV)[2]. With relatively few therapeutic options proven to be safe and effective, there is potential for rapid growth in the anti-obesity category. Valued at $1.4 billion in 2009, the global Anti-Obesity Market is projected to grow at a Compound Annual Growth Rate (CAGR) of 11.7%, reaching $3.1 billion by 2016[3].

> Real-time risk scoring enables Catamaran to identify and intervene with plan members at-risk for worsening conditions.

Catamaran clinical consultants work with our clients, providing advice on coverage decisions for all new drugs including these. In addition, we develop and implement utilization management guidelines to prevent unsafe and/or inappropriate usage. Finally, through our risk-scoring engine, we identify members at-risk for worsening conditions for further intervention. These measures help to ensure that members who are most at-risk stay on the right track to avoid progression of disease.

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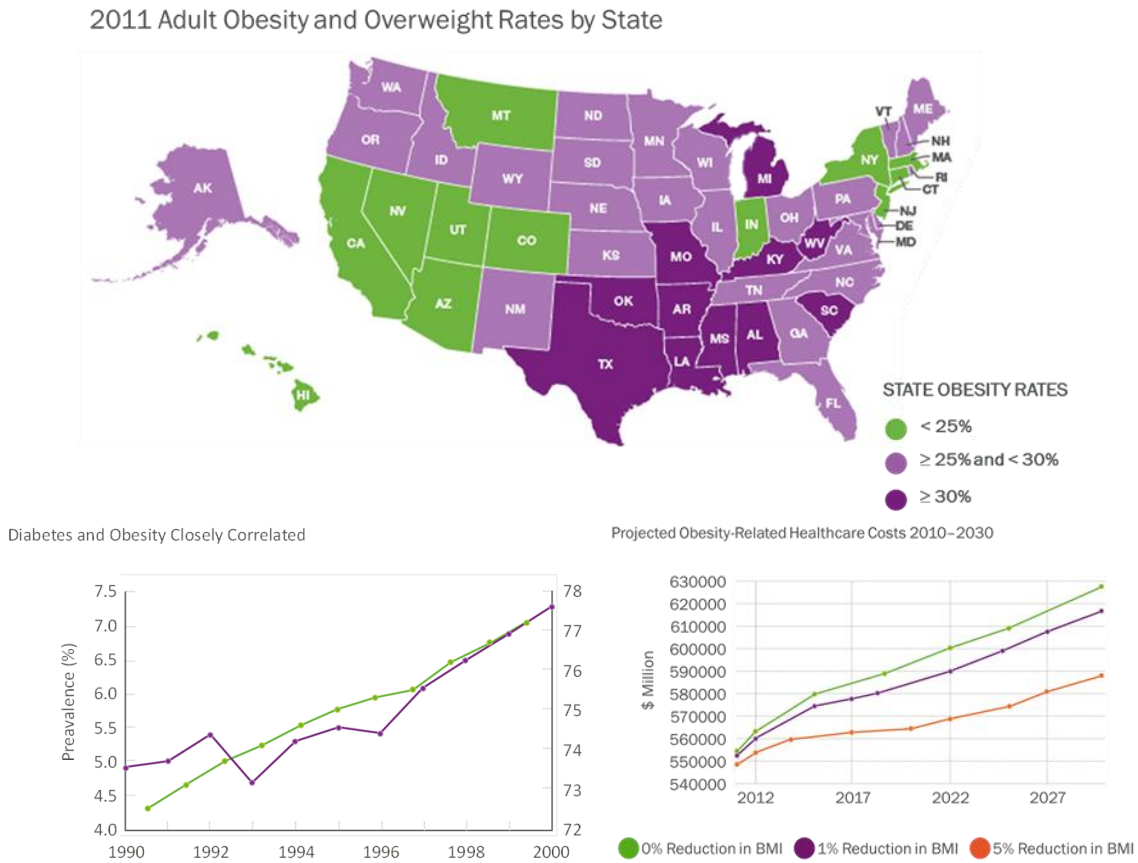
[1] CBS News, *Study: 40% of U.S. May be OBses by 2018, accessed 12/26/2102,* http://www.cbsnews.com/2100-204_162-5683256.html

[2] First Word Pharma, *Spotlight On: FDA approvals to date in 2012, accessed 1/15/2013,* http://www.firstwordpharma.com/node/1000898.

[3] Global Data market Research, *Anti-Obesity Drug Pipeline Analysis and Market Forecasts to 2016,* accessed 1/11/2013, http://www.prlog.org/10483087-antiobesity-drug-pipeline-analysis-and-marjket-forecasts-to-2016.thml.

Figure 2



State of Vermont's Obesity Initiative

In support of the Obesity Initiative underway in the State of Vermont, we believe that Catamaran can bring a number of key capabilities to the table that can assist the State in driving success with this initiative.

1. At minimum, through Catamaran's Central Drug Intelligence team, we can easily identify a routinely-updated list of drug therapies that may predispose individuals to metabolic issues driving weight gain and metabolic syndrome.
2. Through our advanced analytics capabilities, we have the ability to further supplement activities underway within the State to mine existing datasets and stratify members based upon risk and need for this type of intervention.
3. We can work with the State to utilize our highly flexible and advanced claims adjudication systems, as well as current contracts with external partners (e.g., cloud-based gamification vendors) to assist in devising and deploying the State's incentive models.
4. Lastly, we also have the ability through our central Clinical Outreach Call Center, to supplement efforts of the Vermont Chronic Care Initiative and BluePrint for Health to better coach and support individuals enrolled in this programming through our pharmacists, nurses and technicians.

Catamaran welcomes the opportunity to sit down with the key stakeholders from the State to determine a mutually-beneficial collaboration in this area, should we be fortunate enough to retain the State business on a go-forward basis.

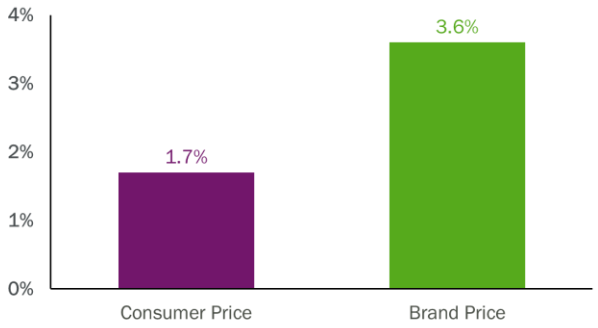
The Rising Cost of Prescription Medications

Once again in 2012, the price of branded prescription medications rose at levels exceeding general inflation rates and the overall cost of healthcare. The invoice price of patent-protected brands increased 3.6% in 2012, about twice the general inflation rate of 1.7% in 2012[1]. Brand prescription inflation outpaced all other categories of healthcare spending, including:

- Physician services at 1.3%
- Non-prescription drugs at 0.7%
- Medical instruments at 0.1%

Figure 4

Consumer Inflation Rate vs. Brand Drug Inflation



Price increases account for 145% of growth in the U.S. pharmaceutical sales in the past five years. [2]

The widespread increases in the price of branded medications have offset cost savings from increased generic utilization, impacting the growth of overall spending on prescription drugs in the United States. As generic utilization rates continue to climb, industry analysts note that major pharmaceutical companies are increasing brand prices in an effort to offset losses.[2] As reflected in average wholesale price (AWP) increases, spending on protected brands increased by 9.5% in 2011, compared to 8.8% in 2010. Price increases account for 48% of growth in U.S. pharmaceutical sales since 1980 and 145% of growth in U.S. pharmaceutical sales in the past five years, even while volume has decreased.[3]

As we have indicated, Catamaran believes that its approach to managing at a beneficiary level to achieve better outcomes is more critical than ever today as medications become more expensive. We believe that it is important to target the least expensive options that can meet a patient's needs.

Increasingly Common Drug Shortages

During the years from 2005 through 2011, the number of prescription medications in short supply increased more than four-fold, from 61 to more than 250.[4] In response to the crisis, both Congress and the Obama administration put forth new measures 2012. The focus of both

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[1] U.S. Department of Commerce, Bureau of Economic Analysis, *Industry Data,* http://www.bea.gov/iTable/iTable.cfm?ReqID=5&step=1#reqid=5&step=2&isuri=1&403=1.

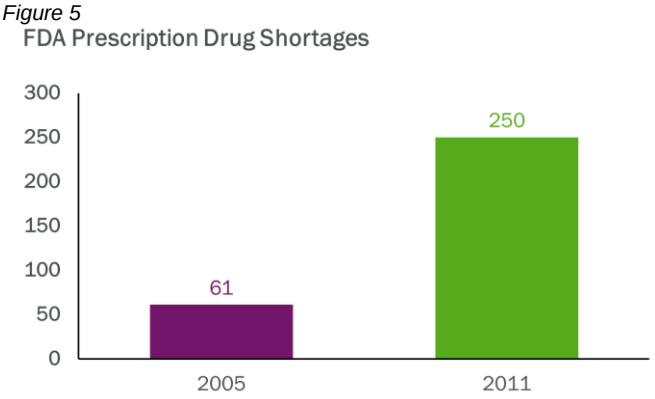
[2] Seeking Alpha, *Cramer's Mad Monody-Big Pharma is One Big Graveyard for Stocks,* http://seekingalpha.com/article/253706-cramer-s-mad-money-big-pharma-is-one-big-graveyard-for-stocks-2-17-11, February 17, 2011.

[3] Mathew Herper, *Why Big Pharma's Constant Price Increases Could Backfire,* Forbes, http://forbes.com/sites/matthewherper/2012/03/21/will-the-drug-industries-shocking-reliance-on-price-increases-come-to-an-end/, March 21, 2012.

[4] Policy and Medicine, *Prescription Drug Shortags: FDA Clarifies Congressional Report,* http://www.policymed.com/2012/08/prescription-drug-shortages-fda-clarifies-congressional-report.html, August 1, 2012.

federal efforts was to reduce drug shortages through earlier warnings, better tracking and improved coordination between the Food and Drug Administration (FDA) and pharmaceutical manufacturers.

Figure 5



The federal initiatives, coupled with the voluntary actions of pharmaceutical manufacturers, have had a positive effect. According to the FDA, in the six months following President Obama's executive order, there was a six-fold increase in early notifications from manufacturers. The FDA claims that the industry was able to prevent 128 drug shortages and new shortages in 2012 were running at less than half the levels of 2011[1]. Initiatives started under executive order were strengthened on July 9, 2012, with the enactment of the Food and Drug Administration Safety and Innovation Act (FDASIA) of 2012. In the new law, Congress provided the FDA with new authorities to combat shortages of drug products in the United States and imposed new requirements on manufacturers regarding early notification of issues that could lead to a potential shortage or disruption in the supply of a product.

Buoyed by its newfound authorities, the FDA was able to resolve more than 60 drug shortages in 2012[4]. Close to 300 medications, however, remain on the FDA Drug Shortage Index[3].

The Ameridose Impact

Those working to ensure an adequate supply of generic injectables will face a new challenge in 2013. The voluntary shutdown of Ameridose in October of 2012, coupled with the recall of Ameridose products, may affect supplies of certain life-saving drugs for some healthcare systems. In fact, six Ameridose products were already on the FDA critical shortage list prior to the recalls. These include:

- Sodium Bicarbonate Injection
- Succinylcholine Injection
- Atropine Sulfate Injection
- Bupivacaine Hydrochloride Injection
- Lidocaine Hydrochloride Injection
- Furosemide Injection

The FDA reports that it is working to identify other manufacturers willing to initiate or increase production, and will expedite reviews of pending applications. They are also facilitating efforts to safely import these medications from foreign manufacturers.

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[1] U.S. Food and Drug Administration, *FDA's Work on Drug Shortages,* accessed 12/30/2012, http://blogs.fda.gov/fdavoice/index.php/2012/05/six-monoth-check-up-fdas-work-on-drug-shortages/.

The Impact of Drug Shortages

It is important to be aware that while the FDA works to reduce the drug shortages, patient care is impacted. As prices of products in short supply typically rise, Catamaran is committed to keeping our clients and their members informed of new drug shortages. Our drug intelligence team gathers information regarding product shortages and market withdrawals from a variety of professional and industry sources. We address drug shortages by:

- Communicating to clients through our RxHighlights clinical publication
- Working with manufacturers to ensure an adequate supply
- Communicating with members in writing for large-scale shortages and individually by phone for smaller scale shortages
- Assisting specialty patients in obtaining an emergency supply of medication
- Contacting the physician for alternative therapy for patients utilizing our home delivery channel.

Future Trends

In the United States, spending is expected to grow, largely due to the higher costs of caring for an aging population, higher prevalence of chronic diseases and increased utilization of expensive new specialty treatments. These growth rates, however, will stay near their historical lows due to the high number of top-selling drugs losing patent protection.

Generic utilization reached 80% in the U.S. for the first time in 2012[1], and is expected to climb to 87% by 2015 [2]. Though 2013 represented somewhat of a lull, the wave of patent expirations will continue at least through 2016. According to the IMS Institute for Healthcare Informatics, patent expirations will reduce U.S. brand spending by $127 billion through 2016. Factor in the cost of generics and this yields a five-year "patent dividend" of $106 billion [1]. Comparatively modest savings are projected for biosimilars, which are still likely to account for less than 2% of spending in 2016.

Figure 6

U.S. Spending and Growth on Medications, 2007-2016

Overall Forecast

The predominant trends of the last five years are expected to persist for the next five. On a relative basis, spending

[1] JM Hoffman, E Li, F doloresco, L Matusiak, RJ Hunkler, ND Shah, LC Vermeulen, GT Schumock, *Projecting Future Drug Expenditures – 2012,* accessed 1/9/2013, American Journal of Health System Pharmacy, Vol. 69, 2012, http://www.ajhp.org/site/Projecting_future_drug_expenditures_2012.pdf

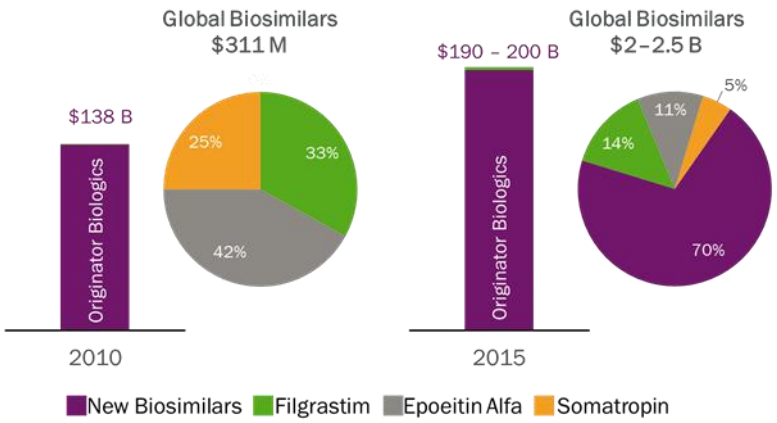
[2] Doug Long, *Looking Back and Looking Ahead,* IMS Health, http://fmi.org/docs/2012-health-wellness-conference-presentations/doug-long---the-us-pharmaceutical-market.pdf?sfvrsn=r, March 20, 2012.

continues to move away from traditional branded medications toward traditional generics and specialty drugs; one trend lowering the overall cost of prescription drugs and the other driving it upward. Overall, the IMS Institute for Healthcare Informatics projects growth of 1–4% in annual medication spend for each of the next four years[1]. Additional generic launches and the impact of low-cost generic alternatives will affect lower spending growth over the next few years. Impact of health insurance reforms will drive growth in 2014, with the majority of the impact seen in the retail setting. Brand price increases above the consumer price index will continue, although they should be offset by additional generic launches. New brand drugs contributing to spending will increase slightly to $10-12 billion per year as the number of approvals increases[1]. Specialty drugs will continue to grow, driven by novel mechanisms and targeted therapeutic approaches, improved efficacy and safety, and increased patient populations.

Biosimilars Growing Rapidly with Modest Impact

The global biosimilar market is expected to at least quadruple over the next four years, expanding from $693 million in 2011 to a projected $4-6 billion by 20161. While an impressive proportional increase, biosimilars are still expected to account for less than two percent of the global market in specialty medications in 2016. Even if biosimilars were to reach the same levels of utilization as traditional generics, similar savings would not likely result. Citing higher facility, manufacturing and other costs, the Congressional Budget Office estimates a suggested discount of up to 40% for biosimilars, compared to nearly 80% for small molecule (or traditional) generic products26.

Figure 7



Catamaran Forecast

Over the next several years, Catamaran projects overall trend to range between 2.2% and 6.3% based on generic launches, utilization rates, specialty pipeline, price inflation and other factors influencing drug trends. With some of the largest blockbuster generic launches occurring between 2013-2015, drug mix will have a less significant impact in offsetting some of the increasing trends such as price inflation. The following figure forecasts Catamaran's overall, traditional and specialty trend for the three years beginning with 2013 (figures now being finalized).

[1] IMS Institute for Healthcare Informatics, *The Global Use of Medicines: Outlook through 2016,* July 2012.

Figure 8

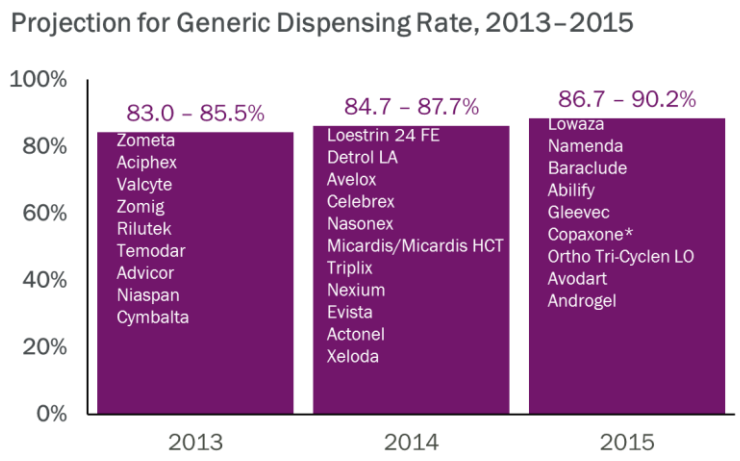
Trend Forecast, 2013-2015

	Overall	Traditional	Specialty
2013	2.2 – 5.2%	-2.8 – -0.3%	18.5 – 21.5%
2014	2.9 – 5.9%	-2.4 – 0.2%	20.5 – 23.5%
2015	3.3 – 6.3%	-2.8 – 0.2%	22.5 – 25.5%

Generic Drugs Taking Over

Drugs with more than $80 billion in sales are expected to go off-patent through 2016, with 2015 lining up to be a particularly eventful year. By helping our clients take advantage of these exceptional opportunities, we expect the Generic Dispensing Rate (GDR) for the Catamaran book of business to reach record levels surpassing 90% by 2015. The Figure 9 shows our estimated GDR forecast, along with the key blockbuster drugs expected to lose patent protection. This figure includes 2013, while the actual numbers are being finalized.

Figure 9



2.3 Customers Served in the Medicaid Pharmacy Operations Space

Instructions: Describe the customers you have served in Medicaid pharmacy operations and, to the extent possible, the nature of those relationships in terms of services provided and duration of the relationship. Provide data on vendor performance on same or similar contracts, grants, and collaborative activities.

Response:

As mentioned above, Catamaran currently manages six state fee-for-service Medicaid programs covering more than five million lives and supports seventeen Managed Medicaid contracts covering more than four million lives. A few excellent examples of the nature and duration of these relationships, as well as the services provided, are included in the following client overviews.

Georgia DCH, Division of Medicaid

An excellent example of Catamaran's experience and ability with operation, service, and maintenance of a State Medicaid PBM program is the support we provide for the Georgia DCH Fee-For-Service and PeachCare for Kids programs, collectively referred to as "Medicaid". The project has been in operation since January 1, 2007 (over 6 years) and the system was certified by CMS in May 2008. In fact, it was the first a standalone pharmacy system certified with CMS. At that time, Xerox was the State's MMIS vendor. The DCH transitioned to Hewlett Packard Enterprise Services (HPES) for MMIS services on November 1, 2010. HPES was required to mirror Xerox's interfaces for the Catamaran PBM component of their implementation. There were no new requirements for Catamaran to implement due to the transition to a new MMIS vendor. Catamaran's involvement was primarily focused on thorough interface file testing (e.g. eligibility, COB and pharmacy) and file transfers testing with HPES prior to their go-live.

Catamaran processes approximately 12 million transactions per year for Georgia's combined 440,000 fee-for-service and PeachCare for Kids recipients. Services include or have included the following:

- Pharmacy claims processing
- Custom interface integration with MMIS
- Data conversion services
- Provider technical and clinical call center services
- Account Management support
- Clinical analytics support, including reporting and therapeutic class reviews
- DUR Board and P&T Committee support
- RetroDUR
- Provider payment and remittance advice
- Access to pharmacy systems including RxClaim and RxTrack
- State rebates for diabetic supplies
- Provider relations
- State MAC rate management

Indiana Family and Social Services Administration

Although Catamaran just recently implemented PBM services for the State of Indiana in May 2013 (9 months), it is an example of a comprehensive program where Catamaran is responsible for the technical operation and maintenance of the State's program. HPES is Indiana's MMIS vendor and was the legacy PBM claims processing vendor. In addition, Xerox provided prior authorization, clinical services, and drug rebate administration. During the initial phase of the implementation, the State was in the process of determining the award for a new MMIS vendor. The contract was subsequently re-awarded to HPES. We are currently preparing for system certification by CMS with the review scheduled for Spring, 2014.

Catamaran anticipates processing approximately 12 million claims each year for the State's 1.1 million recipients. Services include the following:

- PBM Operations
  - Technical and clinical call center
  - PDL development and maintenance
  - OTC PDL – adult and pediatric
  - Pharmacy prior authorization management
  - DUR Board and P&T Committee support
  - RetroDUR
  - Rebate Administration
- Claims processing and payment
- eCOB (electronic coordination of benefits)
- ePrescribing support
- State MAC administration
- Pharmacy provider auditing

State of Washington Medicaid

Catamaran provides pharmacy benefit management services, including technical operation and maintenance services, for the State of Washington's Medicaid program. The project has been in operation since March 2005 (over 8 years). On July 19, 2011, CMS certified the State of Washington MMIS system, including pharmacy. This certification was retroactive to October 2008 for our PBMS component. Catamaran processes approximately 15 million transactions per year for the program's 1.2 million recipients. Services include the following:

- Pharmacy benefit applications hosting
  - Claims processing
  - Prior Authorization
  - Rebate Management
- Custom interface integration with MMIS

State of Vermont, Department of Vermont Health Access

As previously indicated, Catamaran has provided has provided pharmacy benefit management services to DVHA since January 1, 2006 for benefits in Medicaid. Vermont's Medicaid program is a managed care program by virtue of an 1115 Demonstration Waiver to Title XIX of the Social

Security Act. However, the pharmacy benefit largely operates like a traditional fee-for-service benefit.

We currently process approximately 2.1 million transactions per year for the State's 170,000 Medicaid and other state and publicly funded program recipients. The services Catamaran provides today are listed below.

- Pharmacy claims processing
- Custom interface integration with MMIS
- Provider technical and clinical call center services
- On-site Account Management support
- Clinical analytics support, including reporting and therapeutic class reviews
- DUR Board and P&T Committee support
- RetroDUR
- Access to pharmacy systems including RxClaim and RxTrack
- State rebates for diabetic supplies
- Supplemental rebate offer evaluation
- Supplemental rebate contracting, invoicing and reporting
- Pharmacy outreach and support
- State MAC rate management
- ePrescribing support
- Specialty Pharmacy
- eCOB (enhanced Coordination of Benefits)

2.4 Customers Served in the Public Sector

Instructions: Describe the customers you have served in the public sector. Describe the nature of those relationships in terms of services provided and duration of the relationship. Describe vendor's experience working with DVHA, if applicable.

Response:

As indicated in the previous sections, in addition to Medicaid, Catamaran's experience extends into other government programs and includes background with Medicare, the Department of Defense (DoD), Veterans Affairs, and state employee health benefits programs. Catamaran also has a successful history with the DoD having supported TRICARE's pharmacy benefit in ten of the twelve Military Health System (MHS) regions prior to the TRICARE Retail Pharmacy (TRRx) program. Further, Catamaran supports eight state employee programs and 10 of the 22 Consumer Operated and Oriented Plan (CO-OP) Programs called for under the Affordable Care Act.

A few excellent examples of the nature and duration of our public sector client relationships, as well as the services Catamaran provides, are included in the following client overviews.

State of Ohio, Bureau of Workers Compensation

Catamaran implemented the Ohio BWC's pharmacy program in November, 2009, partnering with the client to achieve a complete implementation in 110 days. Ohio law requires employers to obtain workers compensation insurance for all employees and employers are either state-funded or self-insured. State funded employers pay an insurance premium to BWC. In turn, BWC pays compensation benefits directly to the injured worker. Self-insured employers pay workers' compensation benefits directly to their employees. Ohio BWC is the largest state-fund insurance system in the nation, serving more than 250,000 Ohio employers and processes 1.4 million annual transactions. The number of covered lives fluctuates as their enrollees are short term.

Catamaran provides the following PBM services in support of the Ohio BWC program:

- Claims processing
- ProDUR
- Data Warehousing
- Network Management
- Reporting
- Data Analysis
- Benefit Design Consulting

Department of Veterans Affairs

Catamaran has provided pharmacy benefit management services to the Veterans Health Administration Center (now known as Purchased Care at Health Administration Center) since 2008 and was award the contract again via the procurement process. The Department of Veterans Affairs (VA) Health Administration Center (HAC) processes claims for three health benefits programs administered by the VA. The programs covered are:

- **Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA): a** health benefit program for dependents of permanently and totally disabled veterans, survivors of veterans who died from service-connected conditions, or who at the time of death, were rated permanently and totally disabled from a service-connected disability.
- **Spina Bifida Health Care (SB):** a federal health benefit program administered by the Department of Veterans Affairs for Vietnam veterans' birth children who have been diagnosed with Spina bifida (except Spina bifida occulta).
- **Children of Women Vietnam Veterans Healthcare (CWVV):** a federal health benefits program administered by the Department of Veterans Affairs for children with certain birth defects born to women Vietnam veterans.

Catamaran processes 6.2 million transactions per year on behalf of the program. Other services we provide, in addition to POS claims processing, are reporting and call center support for members and providers.

State of Vermont, Department of Vermont Health Access

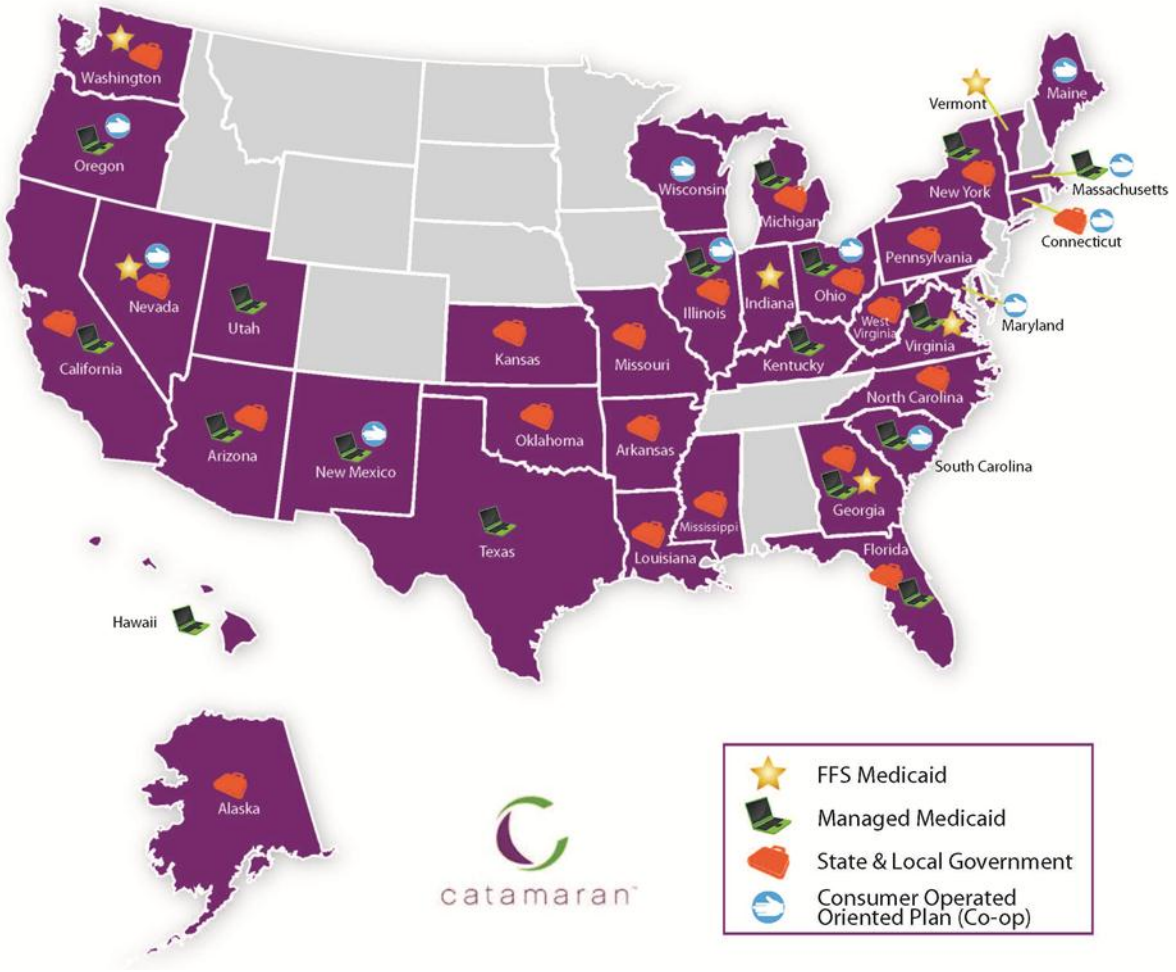
As previously indicated, Catamaran has provided has provided pharmacy benefit management services to DVHA since January 1, 2006 for benefits in Vermont's other state and publicly funded programs.

We currently process approximately 2.1 million transactions per year for the State's 170,000 program recipients. The services Catamaran provides today are listed below.

- Pharmacy claims processing
- Custom interface integration with MMIS
- Provider technical and clinical call center services
- On-site Account Management support
- Clinical analytics support, including reporting and therapeutic class reviews
- DUR Board and P&T Committee support
- RetroDUR
- Access to pharmacy systems including RxClaim and RxTrack
- State rebates for diabetic supplies
- Supplemental rebate offer evaluation
- Supplemental rebate contracting, invoicing and reporting
- Pharmacy outreach and support
- State MAC rate management
- ePrescribing support
- Specialty Pharmacy
- eCOB (enhanced Coordination of Benefits)

This map indicates the States in which Catamaran has current contracts for FFS Medicaid, Managed Medicaid, State & Local Government, and Consumer Oriented & Operated Plan (Co-Ops).

Figure 10



2.5 Vendor's Work Locations

Instructions: The Vendor Key Project Personnel (including but not limited to the Account Director, Account Manager, and Clinical Pharmacist Manager) must be available to participate in-person during PBM-related meetings as scheduled by the State during normal business hours, 8:00 AM until 4:30 PM Eastern Time, Monday through Friday except State of Vermont holidays. The State will not provide facilities for Vendor Key Project Personnel.

Vermont expects that no more than 10% of all staff, including both prime and subcontractor, shall be performing the work on a valid working visa issued by the United States government. The State will not permit project work or business operations services to be performed offshore. At no time shall the vendor maintain, use, transmit, or cause to be transmitted information governed by privacy laws and regulations outside the United States and its territories.

Describe the locations where the Vendor proposes performing work associated with this RFP. Indicate the site or sites from which the Vendor will perform the relevant tasks identified in this proposal. If the site(s) for a specific task change during the contract term, please provide a time line reflecting where the task will be performed during each time period.

Specifically identify where the services identified in RFP Section 2.2 will take place.

Specifically identify where the Key Project Personnel identified in RFP Section 2.5 will be physically located for the duration of the contract.

List any call centers, their related contract responsibilities, and the city and state where they will be physically located for the duration of the Contract.

For each of the deliverables identified in RFP Section 2.7, provide the percentage of work to be done in Vermont.

Response:

Catamaran's Key Personnel, including Nancy Miner, Account Manager; Diane Neal, Clinical Pharmacist Manager; Jackie Stager, Data Analyst; Michelle Sirois, Client Services Manager; and our proposed Account Director, Craig Boon are available to participate in face-to-face meetings with the Department as required.

Catamaran ensures that no more than 10% of all prime and subcontractor personnel are participating in this project via a work visa. Catamaran meets all State requirements with respect to the off shoring of work and transmission of information outside the United States and its territories.

In the next three tables, we have provided the locations where all work/operations specified in the RFP are to be performed, including:

- Location for services specified in RFP Section 2.2
- Location of Key Project Personnel
- Call Center Locations

In the fourth table, we have indicated the percent of work that will be performed in Vermont, relative to the deliverables outlined in RFP Section 2.7.

Location for the Provision of Services Outlined in RFP Section 2.2

The following table lists the location where the services and systems specified in RFP Section 2.2 are to be managed or provided.

Service	Location
Claims Processing and Operational Support	
Point-of-Sale (POS) claims processing system	Elk Grove, IL Denver, CO
Automated Coordination of Benefits (COB)	Elk Grove, IL Phoenix, AZ
Post Payment Claims Management	Schaumburg, IL Burlington, VT
Provider Network Support, Call Center, and Portal	Lisle, IL Phoenix, AZ Orlando, FL Worcester, MA

E-Prescribing and E-Prior Authorization	Schaumburg, IL
Pharmacy Benefit Management and Clinical Programs	
Utilization Management Programs	Schaumburg, IL
Prior Authorization Program	Worcester, MA Burlington, VT
Drug Utilization Review	Schaumburg, IL Burlington, VT
State Maximum Allowable Cost (SMAC) Program and the Federal Upper Limit (FUL)	Schaumburg, IL Burlington, VT
Specialty Pharmacy	Jeffersonville, VT
Medication Therapy Management	Schaumburg, IL Burlington, VT
Benefit Design and Consultative Support	Burlington, VT
Management of Physician-Administered Drugs	Schaumburg, IL Worcester, MA Burlington, VT
Reporting and Analytics	Schaumburg, IL Burlington, VT
Quality Assurance	Schaumburg, IL Burlington, VT
Dual Eligible Demonstration	Burlington, VT
Medication Therapy Management	Schaumburg, IL Burlington, VT
Financial Management	
Management of State and CMS Drug Rebate Programs	Alpharetta, GA
Support of Multistate Supplemental Rebate Consortium	Alpharetta, GA
340B Program Management	Schaumburg, IL Alpharetta, GA, Burlington, VT San Antonio, TX
Additional Services	
Single Payer Considerations	Burlington, VT

Physical Location of Key Project Personnel

The following table identifies Catamaran's Key Project Personnel and their physical location for the duration of this contract.

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[redacted]

Call Center Locations

The following table lists the locations and responsibilities for all call centers Catamaran will utilize for this program.

Call Center	Contract Responsibility	Location
Catamaran Call Centers	Call center services excluding Prior Authorization	Phoenix, AZ Orlando, FL Lisle, IL
The University of Massachusetts Medical School, Clinical Pharmacy Services (CPS)	Prior Authorization / Clinical Services	Worcester, MA

Location of Work Relative to Section 2.7 Deliverables

The following table indicates the percent of work that will be performed in Vermont, relative to the deliverables outlined in RFP Section 2.7.

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[redacted]

[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
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[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]

2.6 Existing Business Relationships with Vermont

Instructions: Describe any existing business relationships the Vendor or any of its affiliates and proposed Subcontractors has with Vermont.

Response:

Catamaran's relationship with the State of Vermont began when the Department awarded this contract to MedMetrics Health Partners, the full-service PBM subsidiary of Public Sector Partners, Inc. effective January 2006. Catamaran acquired MedMetrics in June, 2011 and, therefore, assumed responsibility for the contractual relationship with the Department.

Key members of the core account team have supported DVHA for much of our eight-year engagement with the State. Nancy was initially employed as a Provider Representative from November 2006 to July 2010 and was promoted to Account Manager in August 2010. Diane began her tenure as Clinical Pharmacist Manager in July 2006. Jackie Stager joined the team as a Data Analyst in November 2009.

Our clinical services subcontractor, the University of Massachusetts Medical School, Clinical Pharmacy Services program (CPS) has been responsible for significant portions of the prior authorization components of this contract from day one. Catamaran's account team and CPS personnel assigned to Vermont are intimately familiar with the history and nuances of the Department's pharmacy benefit management program.

The University of Massachusetts Medical School currently provides services to the State of Vermont in the following areas:

- Expert witness services to State of Vermont Office of the Attorney General
- Medicaid administrative claiming for the Vermont Department of Health
- Evaluation Research Services for the Vermont Department of Disabilities, Aging and Independent Living (DAIL)
- Newborn screening services for State of Vermont, Department of Health, Division of Maternal and Child Health, Children with Special Needs
- Project management of the various components of SIMS for the State of Vermont
- Through a subcontract with UHealthSolutions, Inc., it operates the clinical call center and provides pharmacy clinical support and formulary management for the Vermont Medicaid program

CaptureRx currently has relationships with nine covered entities in the State of Vermont.

2.7 Medicaid Pharmacy Operations Projects Completed in the Last Five Years

Instructions: Provide a listing and contact information for all implementations and/or services contracts/clients in the Medicaid pharmacy operations space for the last five (5) years, and denote any that are pending litigation or Terminated for Cause or Convenience and associated reasons. If Vendor uses Subcontractors, associated companies and consultants that will be involved in any phase of this project, each of these entities will submit this information as part of the response.

Table 3 Projects completed in the last five years - Catamaran

Ref #	Project Name	Customer Name	Customer Contact	Project Duration	Business Dispute?
1.	Medicaid Pharmacy Benefit Management Program	Georgia Department of Community Health (GA-DCH)	Linda Wiant, Pharm.D., Director of Pharmacy	1/2007 – 6/2016 (with option yrs)	**YES** ☐ **NO** ☒
2.	Indiana Medicaid	Indiana Medicaid FSSA/Office of Medicaid Policy & Planning	Chris Johnson, Director of Pharmacy	5/2013-5/2017	**YES** ☐ **NO** ☒
3.	Nevada Medicaid	Nevada Division of Health Care	Coleen Lawrence, Chief of Program Services, DHCFP	12/2011 – 12/2016	**YES** ☐ **NO** ☒

4.	State of South Dakota	State of South Dakota, Department of Social Services	Mike Jockheck	6/2008 – 10/2013	**YES** ☐ **NO** ☒
5.	Vermont Health Access	Department of Vermont Health Access	Nancy Hogue, Pharm.D., Director of Pharmacy Services	1/2006 – 12/ 2014	**YES** ☐ **NO** ☒
6.	Virginia Medicaid Drug Rebate Services	Virginia Department of Medical Assistance Services	Donna Proffitt, R.Ph., Pharmacy Program Manager	4/2009 – 6/ 2014 Four (4) additional State option years remain.	**YES** ☐ **NO** ☒
7.	Washington Medicaid	State of Washington Healthcare Authority	Renee Morgan, Information Technology Specialist	3/2005 – 6/2021	**YES** ☐ **NO** ☒
8.	TennCare	Bureau of TennCare	Casey Dungan	6/2008 – 5/2013	**YES** ☐ **NO** ☒

Table 3 Projects completed in the last five years – Subcontractor: The University of Massachusetts Medical School, Clinical Pharmacy Services (CPS)

Ref #	Project Name	Customer Name	Customer Contact	Project Duration	Business Dispute?
1.	Drug Utilization Review	MassHealth	Paul Jeffrey	1999- present	**YES** ☐ **NO** ☒
2.	Clinical Call Center Support	Department of Vermont Health Access	Nancy Hogue	2006- present	**YES** ☐ **NO** ☒
3.	Pharmacy and Therapeutics Meeting Support	TennCare	Leslie Pittman	2008- 2013	**YES** ☐ **NO** ☒
4.	Clinical Call Center Support	Nevada Medicaid	Carl Jeffrey	2011- present	**YES** ☐ **NO** ☒
5.	Pharmacy and Therapeutics Meeting Support	Alabama Medicaid	Kelli Littlejohn	2012- present	**YES** ☐ **NO** ☒

Table 4 Projects completed in the last five years – Subcontractor: CaptureRx

Ref #	Project Name	Customer Name	Customer Contact	Project Duration	Business Dispute?
1.	340B Administration and Implementation	New York City Health and Hospital Corporation	Vincent Biambanco	Ongoing	YES ☐ NO ☒
2.	340B Administration and Implementation	Valley Health	Dave Wiseman	Ongoing	YES ☐ NO ☒
3.	340B Administration and Implementation	Temple University	Gerry Oetzel	Ongoing	YES ☐ NO ☒
4.	340B Administration and Implementation	Shasta Community	Dean Germano	Ongoing	YES ☐ NO ☒
5.	340B Administration and Implementation	Ar Care	Talmage Whitehead	Ongoing	YES ☐ NO ☒

2.8 Business Disputes

Instructions: Provide details of any disciplinary actions and denote any that are pending litigation or Terminated for Cause or Convenience and associated reasons. Also denote any other administrative actions taken by any jurisdiction or person against the Vendor. List and summarize all judicial or administrative proceedings involving your sourcing activities, claims of unlawful employment discrimination and anti-trust suits in which you have been a party within the last five years. If Vendor is a subsidiary, submit information for all parent companies. If Vendor uses Subcontractors, associated companies and consultants that will be involved in any phase of this project, each of these entities will submit this information as part of the response.

Catamaran Response:

As a public company in a highly regulated industry, Catamaran occasionally subject to claims or litigation, none of which has had, or do we believe will have, a material adverse impact on the company. Any material litigation is disclosed in our annual report, Form 10K.

Subcontractor Response:

The University of Massachusetts Medical School, Clinical Pharmacy Services

The University is a public institution of higher learning authorized by the legislature of the Commonwealth of Massachusetts. As such, it is a defendant in various lawsuits and is subject to various contractual matters, however, University management is of the opinion that the ultimate outcome of any investigations, litigation, or potential contractual obligations will not have a material effect on the operations, financial position, financial results, or cash flows of the University, nor raise any material issue about the University's qualifications as a contractor.

CaptureRx

CaptureRx has no disciplinary actions that are pending litigation, no administrative actions taken by any jurisdiction or person, and has not been Terminated for Cause or Convenience.

3. Financial Stability

The following questions pertaining to Financial Stability must be answered.

3.1 Dun & Bradstreet (D&B) Ratings

Instructions: The Vendor must provide the industry standard D&B Ratings that indicates the firm's financial strength and creditworthiness, assigned to most US and Canadian firms (and some firms of other nationalities) by the US firm Dun & Bradstreet (D&B). These ratings are based on a firm's worth and composite credit appraisal. Additional information is given in credit reports (published by D&B) that contain the firm's financial statements and credit payment history.

Response:

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Catamaran's Dun & Bradstreet ratings are as follows:

[redacted]

A complete D&B Report is offered in Attachment C.

3.2 Financial Capacity

Instructions: The Vendor must supply evidence of financial stability sufficient to demonstrate reasonable stability and solvency appropriate to the requirements of this procurement. Vendors must submit the most recent audited financial statement including all supplements, management discussion and analysis, and actuarial opinions. At a minimum, such financial statements and reports shall include: balance sheet; statement of income and expense; statement of changes in financial position; cash flows; and capital expenditures. If the Vendor is a corporation that is required to report to the Securities and Exchange Commission, it must submit its two most recent SEC Forms 10K, Annual Reports. If any change in ownership is anticipated during the twelve (12) months following the proposal due date, the Vendor must describe the circumstances of such change and indicate when the change is likely to occur.

Response:

Catamaran's most recent 10K filing and annual report is provided in Attachment D. No change of ownership is anticipated during the next 12 months.

In the following table, please list credit references that can verify the financial standing of your company.

Confidential, Proprietary, and Trade Secret Information of Catamaran.

Credit References

Institution	Address	Phone Number
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]

3.3 Corporate Guarantee

Instructions: If the Vendor is substantially owned or controlled, in whole or in part, by one or more other legal entities, the Vendor must submit the information required under the "Financial Capacity" section above for each such entity, including the most recent financial statement for each such entity. The Vendor must also include a statement that the entity or entities will unconditionally guarantee performance by the Vendor of each and every obligation, warranty, covenant, term and condition of the contract. If the State determines that an entity does not have sufficient financial resources to guarantee the Vendor's performance, the State may require the Vendor to obtain another acceptable financial instrument or resource from such entity, or to obtain an acceptable guarantee from another entity with sufficient financial resources to guarantee performance.

Response:

Catamaran LLC unconditionally guarantees its performance of each obligation, warranty, covenant, term and condition of the contract as executed.

4. General Assumptions

Document the assumptions related to vendor experience in the following table. Vendor may add rows as necessary to the response table.

Vendor Experience Assumptions

Item #	Reference (Section, Page, Paragraph)	Description	Rationale
1.	NA	NA	NA
2.			
3.			

5. Certifications and Other Required Forms

Instructions: Vendors must submit the following required forms with their proposals

- Application Information Sheet
- Certification and Assurances
- Vermont Tax Certificate and Insurance Certification
- Nondisclosure (to be created as needed by Vendor)
- Federal Lobbying Disclosure (to be created as needed by Vendor)
- Certification of Insurance (provided by Vendor)

The required forms are located at the end of this Template (B). The State encourages Vendors to carefully review all of these forms and submit questions regarding their completion prior to the deadline for submitting questions.

Response:

The required forms are included, as specified, in the pages that follow.

6. Exceptions

Instructions: Please return the Proposal Exception Summary Form at the end of this section with all exceptions to items in any Section of this RFP listed and clearly explained or state "No Exceptions Taken." If no Proposal Exception Summary Form is included, the Vendor is indicating that he takes no exceptions to any item in this RFP document.

The State of Vermont expects the vendor to agree to the State and Agency Customary Contracting Provisions outlined in Attachments C, E and F of this RFP (Section 1.5.5) Exceptions to Attachments C, E and F shall be noted in the bidder's cover letter and further defined by completing the Proposal Exceptions Summary Form in this Section. Exceptions shall be subject to review by the Office of the Attorney General.

Failure to note exceptions will be deemed to be acceptance of the Standard State Provision for Contracts and Grants as outlined in Attachment C, E and F of the RFP. If exceptions are not noted in the RFP but raised during contract negotiations, the State reserves the right to cancel the negotiation if deemed to be in the best interests of the State of Vermont.

The State reserves the right to reject any proposals, including those with exceptions, prior to and at any time during negotiations.

1. Unless specifically disallowed on any specification herein, the Vendor may take exception to any point within this RFP, including a specification denoted as mandatory, as long as the following are true:
    a. The specification is not a matter of State law;
    b. The proposal still meets the intent of the RFP;
    c. A Proposal Exception Summary Form is included with Vendor's proposal; and
    d. The exception is clearly explained, along with any alternative or substitution the Vendor proposes to address the intent of the specification, on the Proposal Exception Summary Form.
2. The Vendor has no obligation to provide items to which an exception has been taken. The State has no obligation to accept any exception. During the proposal evaluation

and/or contract negotiation process, the Vendor and the State will discuss each exception and take one of the following actions:

a. The Vendor will withdraw the exception and meet the specification in the manner prescribed;

b. The State will determine that the exception neither poses significant risk to the project nor undermines the intent of the RFP and will accept the exception;

c. The State and the Vendor will agree on compromise language dealing with the exception and will insert same into the contract;

d. None of the above actions is possible, and the State either disqualifies the Vendor's proposal or withdraws the award and proceeds to the next ranked Vendor.

3. Should the State and the Vendor reach a successful agreement, the State will sign adjacent to each exception which is being accepted or submit a formal written response to the Proposal Exception Summary responding to each of the Vendor's exceptions. The Proposal Exception Summary, with those exceptions approved by the State, will become a part of any contract on acquisitions made under this RFP.

4. An exception will be accepted or rejected at the sole discretion of the State.

5. The State desires to award this RFP to a Vendor or Vendors with whom there is a high probability of establishing a mutually agreeable contract, substantially within the State General Provisions included herein. As such, Vendors whose proposals reflect a substantial number of material exceptions to this RFP may place themselves at a comparative disadvantage in the evaluation process or risk disqualification of their proposals.

In the following table, please list and clearly explain any exceptions, for all RFP Sections, Supplements and Exhibits, in the table below. The Vendor may add rows as appropriate.

Proposal Exceptions Summary Form

Confidential, Proprietary, and Trade Secret Information of Catamaran.

State of Vermont RFP Reference	Vendor Proposal Reference	Brief Explanation of Exception	State of Vermont Acceptance (sign here only if accepted)
(Reference specific [redacted]	[redacted]	[redacted]	
[redacted]	[redacted]	[redacted]	

[redacted]	[redacted]	[redacted]	
[redacted]	[redacted]	[redacted]	
[redacted]	[redacted]	[redacted]	

[redacted]		[redacted]	
[redacted]	[redacted]	[redacted]	
[redacted]	[redacted]	[redacted]	
[redacted]	[redacted]	[redacted]	
[redacted]	[redacted]	[redacted]	

[redacted]			
[redacted]	[redacted]	[redacted]	
[redacted]	[redacted]	[redacted]	
[redacted]	[redacted]	[redacted]	
[redacted]	[redacted]	[redacted]	

[redacted]			
[redacted]	[redacted]	[redacted]	
[redacted]	[redacted]	[redacted]	

[redacted]			
[redacted]	[redacted]	[redacted]	
[redacted]	[redacted]	[redacted]	

[redacted]	[redacted]	[redacted]	

Application Information Sheet
DEPARTMENT OF VERMONT HEALTH ACCESS

APPLICANT INFORMATION SHEET

(To be included in the proposal packet)

**NOTE: This information sheet must be included as the cover sheet of the application being submitted. Be sure to complete this form in its entirety. Please fill out and attach a W-9 to this form signed by the duly appointed signing official for your company.

Applicant Organization: Catamaran LLC

Contact Person: Jeff Gottlieb

Title: Director, Public Sector Sales

Mailing Address: 1600 McConnor Parkway

Town, State, ZIP: Schaumburg, IL 60173-6801

Telephone: 215-284-9980 Fax #: 224-231-1904

E-mail Address: jeff.gottlieb@catamaranrx.com

Fiscal Agent (Organization Name): Catamaran LLC

FY Starts: January FY Ends: December

Financial Contact Person: John Martino, V.P. Finance- Corporate Controller

Mailing Address: 1600 McConnor Parkway

Town, State, ZIP: Schaumburg, IL 60173-6801

Telephone: 224-231-1846 Fax #: 224-231-1904

E-mail Address: john.martino@catamaranrx.com

Federal Tax ID Number: 75-2578509

Whom should we contact if we have questions about this application?

Name Jeff Gottlieb Phone Number 215-284-9980

Certification and Assurances

CERTIFICATIONS and ASSURANCES

I/we make the following certificates and assurances as a required element of the bid or proposal to which it is attached, understanding that the truthfulness of the facts affirmed here and the continuing compliance with these requirements are conditions precedent to the award or continuation of the related contract(s):

1. The prices and/or cost data have been determined independently, without consultation, communication or agreement with others for the purpose of restricting competition. However, I/we may freely join with other persons or organizations for the purpose of presenting a single proposal or bid.
2. The attached proposal or bid is a firm offer for a period of 120 days following receipt, and it may be accepted by the DVHA without further negotiation (except where obviously required by lack of certainty in key terms) at any time within the 120 day period.
3. In preparing this proposal or bid, I/we have not been assisted by any current employee of the State of Vermont whose duties related (or did relate) to this proposal, bid or prospective contract, and who was assisting in other than his or her official, public capacity. Neither does such a person nor any member of his or her immediate family have any financial interest in the outcome of this proposal or bid. (Any exceptions to these assurances are described in full detail on a separate page and attached to this document).
4. I/we understand that the DVHA will not reimburse me/us for any costs incurred in the preparation of this proposal or bid. All proposals or bids become the property of DVHA.
5. I/we understand that any contract(s) awarded as a result of this RFP will incorporate terms and conditions substantially similar to those attached to the RFP. I/we certify that I/we will comply with these or substantially similar terms and conditions if selected as a Contractor.
6. I hereby certify that I have examined the accompanying RFP forms prepared by: Rebecca Weisberg for the funding period beginning May 1, 2014 and ending April 30, 2017 and that to the best of my knowledge and belief, the contents are true, and correct, and complete statements prepared from the books and records of the provider in accordance with applicable instructions, except as noted.

Signature: _____ Date: 1/28/2014

Title: Segment President, Public Sector

Vermont Tax Certificate and Insurance Certification

REQUEST FOR PROPOSAL

Pharmacy Benefits Management Services

This form must be completed and submitted as part of the response for the proposal to be considered valid.
The undersigned agrees to furnish the products or services listed at the prices quoted and, unless otherwise stated by the vendor, the Terms of Sales are Net 30 days from receipt of service or invoice, whichever is later. Percentage discounts may be offered for prompt payments of invoices; however, such discounts must be in effect for a period of 30 days or more in order to be considered in making awards.

VERMONT TAX CERTIFICATE AND INSURANCE CERTIFICATE

To meet the requirements of Vermont Statute 32 V.S.A. subsection 3113, by law, no agency of the State may enter into extend or renew any contract for the provision of goods, services or real estate space with any person unless such person first certifies, under the pains and penalties of perjury, that he or she is in good standing with the Department of Taxes. A person is in good standing if no taxes are due, if the liability for any tax that may be due is on appeal, or if the person is in compliance with a payment plan approved by the Commissioner of Taxes, 32 V.S.A. subsection 3113. In signing this bid, the bidder certifies under the pains and penalties of perjury that the company/individual is in good standing with respect to, or in full compliance with a plan to pay, any and all taxes due to the State of Vermont as of the date this statement is made.

Bidder further certifies that the company/individual is in compliance with the State's insurance requirements as detailed in section 21 of the Purchasing and Contract Administration Terms and Conditions. All necessary certificates must be received prior to contract issuance. If the certificate of insurance is not received by the identified single point of contact prior to contract issuance, the State of Vermont reserves the right to select another vendor. Please reference this RFP# when submitting the certificate of insurance.

Insurance Certificate: Attached X Will provide upon notification of award: (within 5 days)

Delivery Offered (to be mutually determined by Catamaran and the State) Days After Notice of Award Terms of Sale (to be mutually determined by Catamaran and the State)

Quotation Valid for 180 Days_____ Date: July 30, 2014

Name of Company: Catamaran LLC Telephone Number: 215-284-9980

Fed ID or SS Number: 75-2578509 Fax Number: 224-231-1904

By: _____ Name: Dan Hardin
Signature (Bid Not Valid Unless Signed) (Type or Print)

This is NOT AN ORDER

All returned quotes and related documents must be identified with our request for quote number.

catamaran

Schedule D Related Party Disclosure

Please identify all related party relationships including cost purpose and approval process.

Catamaran has proposed two subcontractors to support this contract, including the University of Massachusetts Medical School, Clinical Pharmacy Services (CPS) and CaptureRx. Contracts and Business Associate Agreements currently exist between Catamaran and these subcontractors. Any work proposed or performed by the entities in support of the Vermont contract will be approved by the State.

Nondisclosure

Catamaran's nondisclosure letter is offered below.

Confidential, Proprietary, and Trade Secret Information of Catamaran.

catamaran

January 24, 2014

Department of Vermont Health Access
312 Hurricane Lane
Williston, VT 05495

CONFIDENTIAL
Contains Confidential, Proprietary, and Trade Secret Information

Re: Confidential, Proprietary, and Trade Secret Information of Catamaran LLC contained in Catamaran's Proposal (the "Proposal") in response to the Pharmacy Benefits Management Solution Design, Development, and Implementation ("RFP").

To whom it may concern:

[redacted]

1600 McConnor Parkway | Schaumberg, IL 60173

catamaran

[redacted]

[redacted]

[redacted]

Regards,

Jay Pickard

Jay Pickard
Legal Counsel

1600 McConnor Parkway | Schaumberg, IL 60173

Federal Lobbying Disclosure

Response:

Catamaran has no Federal lobbying activities to disclose.

Certification of Insurance

Catamaran's Certificate of Insurance is provided in Attachment E.

Template C

Vendor References

RFP # 03410-127-14

catamaran

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1.0 Vendor's References

Instructions: Include at least three (3) references from projects performed within the last five (5) years that demonstrate the Vendor's ability to perform the Scope of Work described in the RFP and demonstrate the Vendor's ability to meet the qualifications listed in Table 3 in Template A. Include project description, contract dates and contact information (customer points of contact, address, telephone number and email address). The Vendor must explain whether it performed the work as a prime contractor or subcontractor.

Respondents are not to change any of the completed cells in the following table. Any changes to the completed cells in the following table could lead to the disqualification of a respondent.

Table 1 Reference 1

Confidential, Proprietary, and Trade Secret Information of Catamaran.

Vendor Information	
Vendor Name: Catamaran LLC	Vendor Contact/Name: [redacted]
Project Dates: [redacted]	Vendor Contact Phone: [redacted]
Customer Information	
Customer Organization: [redacted]	Customer Contact Name: [redacted]
	Customer Phone: [redacted]
Customer Address: [redacted]	Customer Fax: [redacted]
Project Information	
Total Vendor Staff:	[redacted]

Project Objectives:

[redacted]

- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]

Project Description:

[redacted]

Vendor's Involvement:

[redacted]

- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]

Project Benefits:

[redacted]

Key Personnel	
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]

Project Measurements:			
[redacted]	[redacted]		
[redacted]	[redacted]		
[redacted]			
[redacted]	[redacted]		
[redacted]			
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]

[redacted]
[redacted]

Table 2 Reference 2

Confidential, Proprietary, and Trade Secret Information of Catamaran.

Vendor Information	
[redacted]	[redacted]
[redacted]	[redacted]
Customer Information	
[redacted]	[redacted] [redacted] [redacted]
[redacted] [redacted] [redacted] [redacted] [redacted]	[redacted] [redacted]
Project Information	
[redacted]	[redacted]
[redacted] [redacted] [redacted] - [redacted] - [redacted] - [redacted] - [redacted]	
[redacted] [redacted]	

Vendor's Involvement:

[redacted]

- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]

[redacted]

Key Personnel	
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]

Project Measurements:	
[redacted]	[redacted]

[redacted]	[redacted]
[redacted]	
[redacted]	[redacted]
[redacted]	
[redacted]	[redacted] [redacted] [redacted]
[redacted]	[redacted] [redacted] [redacted]
[redacted]	
[redacted]	

Table 3 Reference 3

Confidential, Proprietary, and Trade Secret Information of Catamaran.

Vendor Information	
[redacted]	[redacted]
[redacted]	[redacted]
Customer Information	
[redacted]	[redacted]
	[redacted]
[redacted]	[redacted] : [redacted]
Project Information	
[redacted]	[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

Key Personnel	
[redacted]	[redacted]
[redacted]	[redacted]

Project Measurements:	
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	
[redacted]	[redacted]

[redacted]			
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]			
[redacted]			

Table 4 Reference 4

Confidential, Proprietary, and Trade Secret Information of Catamaran.

Vendor Information	
[redacted]	[redacted]
[redacted]	[redacted]
Customer Information	
[redacted]	[redacted]
	[redacted]
[redacted]	[redacted]
Project Information	
[redacted]	[redacted]
[redacted]	

[redacted]

[redacted]

[redacted]

- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]

[redacted]

[redacted]

Key Personnel	
Name: [redacted]	Role: [redacted]
Name: [redacted]	Role: [redacted]

Name: [redacted]	Role: [redacted]
Name: [redacted]	Role: [redacted]
Project Measurements:	
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	
[redacted]	[redacted]
[redacted]	

[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]

[redacted]
[redacted]

Table 5 Reference 5

Confidential, Proprietary, and Trade Secret Information of Catamaran.

Vendor Information	
[redacted]	[redacted]
[redacted]	[redacted]
Customer Information	
[redacted]	[redacted]
	[redacted]
[redacted]	[redacted]
Project Information	
[redacted]	[redacted]
[redacted]	
[redacted]	

[redacted]

[redacted]

- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]

[redacted]

[redacted]

Key Personnel	
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
Project Measurements:	
[redacted]	[redacted]

[redacted]	[redacted]
[redacted]	
[redacted]	[redacted]
[redacted]	
[redacted] [redacted]	[redacted] [redacted] [redacted]
[redacted] [redacted]	[redacted] [redacted] [redacted] [redacted]
[redacted]	
[redacted]	

1.1 Subcontractor References (If applicable)

Instructions: If the proposal includes the use of Subcontractor(s), provide three references for each.

Respondents are not to change any of the completed cells in the following table. Any changes to the completed cells in the following table could lead to the disqualification of a respondent.

The references provided in the following section pertain to Clinical Pharmacy Services (CPS) and the services they provide as a clinical call center.

Table 1 Subcontractor Reference 1

Confidential, Proprietary, and Trade Secret Information of Catamaran.

Subcontractor Information	
[redacted]	[redacted]
[redacted]	[redacted]
Customer Information	
[redacted]	[redacted]
	[redacted]
[redacted]	[redacted]
Project Information	
[redacted]	
[redacted]	
[redacted]	
[redacted]	
Key Personnel	
[redacted]	[redacted]
[redacted]	[redacted]
Project Measurements:	
Operating [redacted]	[redacted]
[redacted]	[redacted]

[redacted]			
[redacted]	[redacted]		
[redacted]			
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]			

Table 2 Subcontractor Reference 2

Confidential, Proprietary, and Trade Secret Information of Catamaran.

Subcontractor Information	
[redacted]	[redacted]
[redacted]	[redacted]
Customer Information	
[redacted]	[redacted]
	[redacted]
[redacted]	[redacted]
Project Information	
[redacted]	
[redacted]	

[redacted]

[redacted]

Key Personnel	
[redacted]	[redacted]
[redacted]	[redacted]

Project Measurements:	
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	
[redacted]	[redacted]
[redacted]	

[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

[redacted]

[redacted] [redacted]

[redacted]

[redacted]	
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	
[redacted] [redacted]	[redacted] [redacted]
[redacted] [redacted] [redacted]	[redacted]
[redacted]	
[redacted] [redacted] [redacted]	
[redacted] [redacted]	
[redacted] [redacted]	
[redacted] [redacted] [redacted]	
Key Personnel	
[redacted]	[redacted]
[redacted]	[redacted]
Project Measurements:	
[redacted]	[redacted]
[redacted]	[redacted]

Table 1 Subcontractor Reference 1

Confidential, Proprietary, and Trade Secret Information of Catamaran.

Subcontractor Information	
Customer Information	
Project Information	

[redacted]

[redacted]

[redacted]

- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
  - [redacted]
  - [redacted]
  - [redacted]
  - [redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

Key Personnel	
[redacted]	[redacted]
[redacted]	[redacted]

Project Measurements:	
[redacted]	[redacted]

[redacted]	[redacted]
[redacted]	
[redacted]	[redacted]
[redacted]	
[redacted] [redacted]	[redacted] [redacted] [redacted]
[redacted] [redacted]	[redacted] [redacted] [redacted]
[redacted]	

Table 2 Subcontractor Reference 2

Confidential, Proprietary, and Trade Secret Information of Catamaran.

Subcontractor Information	
[redacted]	[redacted]
[redacted]	[redacted]
Customer Information	
[redacted]	[redacted]
	[redacted]
[redacted]	[redacted]
Project Information	

[redacted]

[redacted]

- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
  - [redacted]
  - [redacted]
  - [redacted]
  - [redacted]

[redacted]

[redacted]

[redacted]

Key Personnel	
[redacted]	[redacted]
[redacted]	[redacted]

Project Measurements:	
[redacted]	[redacted]

[redacted]	[redacted]
[redacted]	
[redacted]	[redacted]
[redacted]	
[redacted] [redacted]	[redacted] [redacted] [redacted]
[redacted] [redacted]	[redacted] [redacted] [redacted]
[redacted]	

Table 3 Subcontractor Reference 3

Confidential, Proprietary, and Trade Secret Information of Catamaran.

Subcontractor Information	
[redacted]	[redacted]
[redacted]	[redacted]
Customer Information	
[redacted]	[redacted]
	[redacted]
[redacted]	[redacted]
	[redacted]
Project Information	

[redacted]

[redacted]

- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
  - [redacted]
  - [redacted]
  - [redacted]
  - [redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]	
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	
[redacted]	[redacted]

[redacted]	[redacted]
[redacted]	
[redacted]	[redacted]
[redacted]	
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	

Template D

Project Organization and Staffing

RFP # 03410-127-14

catamaran

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7. Staff Retention 28
8. Use of Vermont Staff 30
9. Time Commitment 30
10. Project Organization and Staffing Assumptions 32

The Vendor must include a narrative of the Vendor's proposed organization and staffing approach. This response template must include the proposed approach to: organization plan; organization chart; key staff; Subcontractors; staff contingency plan; staff management plan; staff retention and the Vendor's approach to working with the State project staff.

1. Project Organization Plan

Instructions: The Vendor must describe the integrated staffing organizational plan required to execute the proposed approach and create the deliverables required in the project. The staffing plan should be a balanced complement of Vendor and State project resources. This section includes details regarding the State's team, proposed use of approved Subcontractors, and the Vendor's expectations of State project resources.

The Vendor must provide a staffing plan detailing the number of personnel, level, roles and responsibilities, and team reporting relationships and identify the approach to providing "shoulder-to-shoulder" links for key staff roles between Vendor staff and State staff. This plan will show proposed Vendor personnel hours by phase, by personnel level and by role for the entire project. The Vendor must identify all Key Project Personnel for the Vendor and key personnel for the State and their proposed project role. Key Project Personnel cannot be replaced without prior State approval during the life cycle of the project.

Refer to RFP sections 2.4 and 2.5 for Vermont's proposed approach to the staffing plan.

Response:

Confidential, Proprietary, and Trade Secret Information of Catamaran.

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

Personnel	Role / Responsibility	Implementation Hours *(Contract Award to Effective Date 5/1/14 to 1/1/15)*	Ongoing PBM Management Hours *(Base Contract 3 Years starting 1/1/15)*	Contract Extension Hours *(Two additional Years following Base Contract Period)*
Executive Oversight				
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Key Personnel				
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Personnel	Role / Responsibility	Implementation Hours *(Contract Award to Effective Date 5/1/14 to 1/1/15)*	Ongoing PBM Management Hours *(Base Contract 3 Years starting 1/1/15)*	Contract Extension Hours *(Two additional Years following Base Contract Period)*
	[redacted]			
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Personnel	Role / Responsibility	Implementation Hours *(Contract Award to Effective Date 5/1/14 to 1/1/15)*	Ongoing PBM Management Hours *(Base Contract 3 Years starting 1/1/15)*	Contract Extension Hours *(Two additional Years following Base Contract Period)*
	retrospective [redacted]			
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Personnel	Role / Responsibility	Implementation Hours *(Contract Award to Effective Date 5/1/14 to 1/1/15)*	Ongoing PBM Management Hours *(Base Contract 3 Years starting 1/1/15)*	Contract Extension Hours *(Two additional Years following Base Contract Period)*
	[redacted]			
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Offsite Support Personnel				
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Personnel	Role / Responsibility	Implementation Hours *(Contract Award to Effective Date 5/1/14 to 1/1/15)*	Ongoing PBM Management Hours *(Base Contract 3 Years starting 1/1/15)*	Contract Extension Hours *(Two additional Years following Base Contract Period)*
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	[redacted]			
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Personnel	Role / Responsibility	Implementation Hours *(Contract Award to Effective Date 5/1/14 to 1/1/15)*	Ongoing PBM Management Hours *(Base Contract 3 Years starting 1/1/15)*	Contract Extension Hours *(Two additional Years following Base Contract Period)*
	[redacted]			
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Personnel	Role / Responsibility	Implementation Hours *(Contract Award to Effective Date 5/1/14 to 1/1/15)*	Ongoing PBM Management Hours *(Base Contract 3 Years starting 1/1/15)*	Contract Extension Hours *(Two additional Years following Base Contract Period)*
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

[redacted]

Shoulder-to-shoulder links between the State and the Key Personnel at Catamaran assigned as dedicated personnel to oversee the continued success of the State's PBM program are depicted in the chart below.

[redacted]

Use of State-Approved Subcontractors

At the discretion of the State, Catamaran will continue to use CPS as a subcontractor to this program. The primary responsibilities of CPS include clinical call center services and ensuring the proper review and resolution to questions of a clinical nature. As with any contractor with whom we subcontract services, CPS will be held to strict service level agreements and undergo periodic audits to ensure that we continue to maintain our commitment to providing the State with high quality service.

We will also engage with CaptureRx to coordinate the 340B program and maximizing savings associated with 340B claims.

2. Project Organization Chart

Instructions: The Vendor must provide a proposed organization chart showing both the Vendor staff and State staff. The organization chart must denote in the chart, all the key Vendor personnel and State project personnel for this project, and a summary of each key member's high level responsibilities. Vendor Key Project Personnel are to be full-time and dedicated solely to the Vermont Medicaid account unless the Vendor provides alternative solutions that meet with the State's approval. No Key Project Personnel can be added or removed without the State's permission. The Vendor must also identify members of the company's Board of Directors.

Response:

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[redacted]

[redacted]

Members of Catamaran's Board of Directors include the following:

Name	Year Joined Catamaran BOD	Employed At
Mark Thierer, Chairman of the Board	2006	Catamaran Corporation
Steve Cosler	2007	Water Street Healthcare Partners
Peter J. Bensen	2011	McDonald's Corporation
William J. Davis	2007	Blackboard
Steven B. Epstein	2012	Epstein Becker & Green, P.C.,
Betsy D. Holden	2012	McKinsey & Company
Karen Katen	2012	Essex Woodlands Healthcare Venture Capital and Growth Equity
Harry M. Jansen Kraemer, Jr.	2012	Madison Dearborn Partners
Anthony Masso	2007	Consortium Health Plans Inc.

3. Vendor Key Personnel

Instructions: The Vendor must identify Key Project Personnel for the project including:

- Name
- Position in Vendor organization
- Proposed role on project
- Experience in the proposed role
- Qualifications for the proposed role
- Role in the last three projects
- Percentage of time the person is committed for the entire project (if not, start and end dates must be provided)

Confidential, Proprietary, and Trade Secret Information of Catamaran.

Table 1. Vendor Key Project Personnel

Please see the table below for the requested information regarding the Key Personnel proposed by Catamaran for managing the State's PBM program.

Name	Position in Organization	Experience in Proposed Role (Years)	Qualifications for Proposed Role	Role in Last 3 Projects	% Committed for Entire Project?
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Name	Position in Organization	Experience in Proposed Role (Years)	Qualifications for Proposed Role	Role in Last 3 Projects	% Committed for Entire Project?
[redacted]	[redacted]		[redacted]	[redacted]	
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]n	[redacted]

Name	Position in Organization	Experience in Proposed Role (Years)	Qualifications for Proposed Role	Role in Last 3 Projects	% Committed for Entire Project?
			[redacted]		
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Name	Position in Organization	Experience in Proposed Role (Years)	Qualifications for Proposed Role	Role in Last 3 Projects	% Committed for Entire Project?
			[redacted]	[redacted]	
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Name	Position in Organization	Experience in Proposed Role (Years)	Qualifications for Proposed Role	Role in Last 3 Projects	% Committed for Entire Project?
			[redacted]		

3.1 Subcontractors (If Applicable)

Instructions: The Vendor must identify the Subcontractor key staff for the project including:

- Name
- Proposed role on project
- Experience in the proposed role
- Qualifications for the proposed role
- Role in the last three projects
- Percentage of time the person is committed for the entire project (if not, start and end dates must be provided)

Confidential, Proprietary, and Trade Secret Information of Catamaran.

Table 2. Subcontractor Key Staff

Name	Position in Organization	Experience in Proposed Role (Years)	Qualifications for Proposed Role	Role in Last 3 Projects	% Committed for Entire Project?
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

			software solution		
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

4. Staff Contingency Plan

Instructions: The Vendor must provide a contingency plan that shows the ability to add more staff if needed to ensure meeting the project's deliverable due dates and go-live dates.

Response:

Catamaran's project organization capitalizes on our technical expertise, quick implementation capabilities, and extensive State Medicaid pharmacy program experience. We offer the Department an outstanding array of system features and the stability of proven solutions. However, we recognize that a successful program requires more than just hardware and software. Catamaran complements the systems capabilities with experienced leadership, knowledgeable staff, effective management procedures, and a dedication to quality. We have designated a comprehensive team to perform all responsibilities outlined in the RFP.

Our team is structured for depth as well as breadth, which means that qualified backup and contingency personnel from over 3,000 employees in all areas of the organization already exist for each project role including: testing personnel, validation analysts, systems documentation staff, systems development staff and project management, to ensure that all program deadlines and needs are met regardless of unplanned events. The Department will be supported by all parts of our organization including software development, network services, operations, industry relations, quality assurance, business analysis, clinical services, and human resources / recruiting. The design of our organizational structure meets the objectives of the Vermont program, providing for efficient service delivery whether during development, implementation, or ongoing operations and enhancement periods.

Our staffing model is the result of years of experience implementing and operating very large PBM programs. Our operations currently serve 5.3 million Medicaid fee-for-service and 4.8 million Medicaid MCO beneficiaries. We have never had to apologize for failures of agency duty. Our operations are implemented and maintained with sufficient personnel and corporate support to ensure that we meet the Department's requirements. The references we have included in this proposal will attest to Catamaran's ability to meet the State's PBM program staffing demands.

To ensure that we meet the project's deliverable due dates and go live dates, we are committed to supplementing the Key Staff Personnel identified within this section with necessary staff from across our company. Catamaran understands the State reserves

the right to interview and approve any proposed Key Staff Personnel replacements and/or modifications.

5. Staff Management

Instructions: Describe internal standards, policies and procedures regarding hiring, professional development and human resource management.

Response:

Catamaran's highly skilled recruiters worked with sales and the Senior Director of Account Management to identify the appropriately skilled and experienced professionals to staff the project plan for the State. The process described in the following paragraphs is followed when recruiting account management teams for any new client engagement. Critical components of our internal standards, policies and procedures regarding hiring, professional development and human resource management are outlined in detail in the discussion below.

Policies and Procedures for Hiring Staff

The description below highlights our standard hiring policies and procedures. However, we do not anticipate a need to hire any new resources from outside of the company in order to meet the staffing needs for managing the Department's program. The current staff assigned to the Department's account has consistently scored "satisfied" or "very satisfied" on client satisfaction surveys. We are proposing to continue to provide account management services to the Department by maintaining the Account Management team in their current roles as key personnel.

Our search for candidates to staff new contracts always begins internally and our approach was no different when recruiting for this engagement. Catamaran employs over 3,500 highly skilled professionals throughout the country. Many have the capacity and desire to grow within the organization by taking on new roles as we implement new contracts, such as the State's with its new requirements.

Catamaran recruiters also collaborate with external career resource organizations to identify appropriately skilled and experienced candidates including LinkedIn, CareerBuilder, Dice, and Americas Job Exchange (AJE) for diversity recruitment and compliance. It is through these avenues that we would identify any key staff required to help manage the pharmacy benefits program on behalf of the Department, should the need arise.

Catamaran is judicious when considering personnel to support our client contracts. This is especially true for external candidates who do not have a proven performance history within our organization. Our interview process is extensive, including multiple layers of management and staff. Once the interview process has identified a candidate, our recruiters conduct an extensive background examination of the individual including the following research conducted by our partner, Orange Tree.

Social Security Trace: The Social Security Number Trace provides information about the names and addresses associated with a given Social Security Number when supplied to the Credit Agencies. In addition to providing name and address information

for comparison against what the candidate provided on their application, a Social Security Number Trace is used to derive addresses in order to conduct the personal history information search.

Statewide Criminal Search: A statewide criminal record search obtains criminal records from various sources depending on each state system (i.e. state repositories, state agencies, and any unified all-county databases). Statewide searches are done on an "as available" basis, as not all states have a publically accessible repository or provide timely access, or full and accurate records. These searches look for and report all available felony and misdemeanor records that the statewide repository makes available, including; deferred, pending, fail to appear and warrant information in accordance to the Fair Credit Reporting Act (FCRA). Information searched will be for a minimum of 7 years (as available) and include jurisdictions where the candidate lived for the last seven years and any other names or aliases used during that period.

Education Verification: This verification confirms the degree, diploma or certificate obtained or attended, as reported by the applicant. In addition, attendance dates, graduation date and major may be verified.

Employment Verification: This verification confirms the information provided by the candidate regarding their past employment history. In addition to confirming employment, the verification includes provided dates of employment and title for the last seven years.

Fraud and Abuse Control Information System- Level III: A search is conducted of a proprietary database consisting of public records of sanctions and adverse actions taken in the healthcare field. There are three levels of search, FACIS Level 1, FACIS Level 2 and FACIS Level 3. A FACIS level 1 search meets the federal requirements outlined in the Office of Inspector General Compliance Program Guidance. A FACIS Level 2 search includes the information contained in the FACIS Level 1 search plus records contained in the database for a single specified state. A FACIS Level 3 search includes information contained in the FACIS Level 1 search plus records contained in the database for all state sources.

Federal Criminal Search: A federal criminal search is completed by Orange Tree Screening researchers using the same online repositories utilized by court clerks. Researchers report all available felony and misdemeanor records that the court has available, including deferred, pending, fail to appear and warrant information in accordance to the Fair Credit Reporting Act (FCRA). Federal criminal records are cases brought by the Federal Government and can include, but not limited to, cases of stolen goods, bank robbery, embezzlement, counterfeiting, terrorism, weapons violations and drug trafficking. Searches are conducted in jurisdictions where the candidate lived for the last seven years and any other names or aliases used during that period.

Drug Testing: Drug screening is required of all candidates and is conducted via a Certified-Third Party Administrator (C-TPA) programs. Catamaran's thorough recruitment and candidate screening processes are to ensure that we employ the most competent, qualified people to implement and support our clients' programs. We are confident the key personnel assigned to the State's program consist of highly qualified,

professional individuals with in-depth State Medicaid experience and recognized expertise in the major functional areas of this project.

Professional Development and Human Resource Management

We are interested in building and maintaining the brightest and most motivated staff within the PBM industry. Specific to account management, we discourage turnover of team members by continually evaluating the necessity for additional staff to ensure our Account Management Team is fully-staffed and has the necessary resources to properly service our accounts. We value our employees' experience and knowledge and welcome their input into all corporate decisions. In addition, we instill a team atmosphere throughout our organization, enhancing job satisfaction and performance.

As outlined in further detail in response to Section 6. Training Policies and Procedures, we have a robust curriculum of courses that is used to promote the ongoing training and professional development of our employees. Within Catamaran University, our Web-based portal for online training and development, we have dedicated a specific training module entirely to Professional Development. Ongoing training is a critical component of our employees' performance and documented annually as part of the performance evaluation process. At Catamaran, we are highly committed to investing in the continued growth and development of our staff.

6. Training Policies and Procedures

Instructions: Describe Vendor's policies and processes for training and ongoing education of its personnel.

Response:

Catamaran employs a comprehensive training program for newly hired and existing personnel in all of our engagements. The training methods and plans described below were utilized for all Catamaran personnel when we originally implemented the State of Vermont as well as Georgia, Nevada, Washington, and most recently, Indiana. In fact, these methods are applied throughout our book of business. However, the training content is customized for each contract to encompass program specific rules, regulations, benefits and policies.

Annual Training

Upon hire and on an annual basis thereafter, Catamaran requires all employees to complete the following curriculum, regardless of the contract they are assigned to serve. These training modules ensure our compliance with State and Federal requirements and accrediting bodies.

Catamaran Annual Training Curriculum
Catamaran Employee Orientation *(New Employees Only)*
Compliance Courses Catamaran Compliance Training HIPAA Training False Claims Act Training CMS Fraud Waste and Abuse Training
URAC Accreditation Training
Compliance Policy Training Code of Business Conduct and Ethics Compliance Program Conflict of Interest Policy and Procedure HIPAA Associate Confidentiality Agreement Whistleblower Policy Employee Handbook

Catamaran University

Catamaran University is a Web-based classroom where all employees access required and supplemental training. The Catamaran University catalogue incorporates hundreds of training events and eLearning courses ranging from general skills and competencies to product/technical proficiency to leadership development.

Catamaran University is a component of My Career Gateway, which is the site utilized to manage each employee's annual goals, objectives and performance plans. The courses each employee completes via Catamaran University are automatically documented in their performance plan.

While Catamaran University/ My Career Gateway is the vehicle for executing the company's Annual Training, it is also a resource for individual departments to disseminate department specific, role based, and contract based curricula. Managers use the site to assign training courses to their teams. Individual employees are also able to access the hundreds of courses available to support their independent learning objectives.

The table below is a sample of the training categories and associated curricula available via Catamaran University.

Catamaran University Training Catalog – Sample Courses	
Category	**Sample Topics/Courses**
Technical Products (RxClaim Suite)	*RxClaim Basic Training* *RxClaim Claims Research* *RxAuth User Training* *RxAuth System Overview* *RxTrack Core Reporting* *RxTrack Advanced Reporting*
Brown Bag Sessions	*Managing Your Career* *Contract Management Review* *Project Management*
Professional Development	Communication Skills *Communicating Across Cultures* Finance *Planning and Controlling Budgets* Interpersonal Skills/ Team Work *Succeeding Through Teamwork* Negotiation *Finding Resolution Through Negotiation* Project Management *Project Time Management*
Customer Service	*Customer Service Via Phone and Email* *Excellence in Technical Customer Service* *Building Strong Customer Relationships*
Technical Training	Adobe Products Cisco Products Microsoft Products Novell Products Oracle Products E-commerce
Clinical Products	*Drug Intelligence* *Fraud, Waste and Abuse*

Catamaran University Training Catalog – Sample Courses	
Category	**Sample Topics/Courses**
	Pharmacy & Therapeutics
Clinical Analytics	*2013 Trend Training*
Management & Leadership	*Change Management* *Conflict Management* *Emergency Management* *Harassment Awareness*

Contract and Role Specific Training

During a new contract implementation, the nuances of the program including benefit plan designs, policies and procedures, State regulations, and special processes are documented by our DDI Manager, our Account Team, and the client. This documentation is provided to the Training Department so that the necessary training modules can be customized. Typically, all personnel assigned to an account receive the following client-specific training, as appropriate for their individual roles.

- Client-specific products, services, and systems
- Privacy and confidentiality policies - all employees handling sensitive data (i.e., health claims data) are educated regarding the importance of data security and confidentiality
- Information within our call centers as shared on a need-to-know basis and only with approved staff, providers, and client-sanctioned staff
- An overview of the client's performance requirements
- Any client-specific legal statutes, policies, and processing requirements
- Detailed claims processing edits and covered drugs and services
- Cross training on additional duties, as appropriate

Role specific training is also provided for the Account Management Team, call center, and clinical personnel assigned to the project. This training approach is utilized in our Georgia, Vermont, and Indiana operations, as well as all other programs where call center services are provided. As an example of role specific training, following is an overview of the training plan for our pharmacy service representatives.

Catamaran Representative Training as a Training Example

Our comprehensive MSR training program includes specific client and cultural immersion, system education and professional etiquette. We ensure that representatives are well equipped with the knowledge, tools, and information needed to resolve inquiries in a timely and satisfactory manner. Prior to employment as a Catamaran, applicants are required to have a minimum of two years' experience in a call center and/or

telecommunication environment and possess excellent oral communication skills. In addition, associates are required to successfully complete classroom training prior to handling inquiries.

Our newly hired representatives participate in six weeks of training consisting of three weeks of classroom instruction. Following the completion of their classroom hours, representatives also participate in an additional three-week mentoring program with a tenured MSR. This mentoring period is extended if the MSR is not ready to handle calls independently.

All call center staff must attend detailed call training that covers call center policies and procedures specific to their assigned client, ensuring that calls received into the call center are managed appropriately, expeditiously and accurately. We prepare training materials that serve to reinforce topics covered in training classes, and the manuals double as reference guides that trainees use while performing their jobs.

Some of the tools available to the call center personnel to assist them in answering calls regarding claims processing, prescription coverage issues, and Medicaid policy questions include, but are not limited to, the following:

- Department-specific procedures documents
- Resource materials
- RxClaim system access
- RxClaim user manual
- RxMax system access
- RxMax user manual
- RxAuth user manual
- Internet access
- Web links to State Medicaid (Georgia, Nevada, Washington etc.) specific information
- CMS links to Medicaid information.

Classroom training techniques include formal presentations, simulated production activities, and exercises to develop skills in using resource materials, equipment, and desktop applications. Hands-on training and realistic system application test scenarios included in our training classes cover the following areas:

- Telephone system procedures and proper response to telephone inquiries
  - Appropriate greeting is provided
  - Clear speaking voice
  - Appropriate closing
- Customer service skills and telephone etiquette
  - Staying calm under adverse conditions

- Knowledge of the specific program's requirements
  - Ability to disseminate information received
  - Ability to accurately answer callers' questions
- Training on the different components of the call center system
- Use of Microsoft Word
- Use of email and facsimile
- Use of the system files and online screens
  - Communication log appropriately reflects call
- Confidentiality policies.

As client program changes are identified, Catamaran schedules small group training sessions with all key staff, including representatives, to review the updated procedure document to ensure their understanding of the plan.

We ensure our representatives are providing accurate and up-to-date information to callers by performing routine call monitoring. We test representatives regularly throughout the training program and following course completion to ensure knowledge retention.

7. Staff Retention

Instructions: Describe Vendor's process and methodology for retaining Vendor personnel and ensuring that Key Project Personnel are available noted in Section 2.5 of the RFP.

Response:

Catamaran has several programs in place to measure employee engagement and increase employee retention. Catamaran measures employee engagement annually and uses the results to create engagement plans in an interactive process with employees and managers. Catamaran has several reward and recognition programs, such as the Catamaran Cup described below, where employees can be recognized by management or peers for living the Catamaran values, going the extra mile, and overall outstanding work. Additionally there is a Milestone award program, which rewards longevity in the organization. Catamaran has progressive performance management and compensation practices designed to recognize and reward exceptional performance. The company also supports a social responsibility program, which engages and supports the employees in their efforts to give back.

- **Catamaran Cup:** The Catamaran Cup award and recognition program includes multiple awards that are distributed on a recurring basis to recognize employee achievements. The purpose of this program is to identify and reward employees who uphold the Catamaran values of developing Clients for Life, maintaining accountability and delivering on our promises, building relationships with coworkers and clients, and fostering engagement throughout the workplace to enhance employee's ongoing learning and

development, while delivering world class customer service. This recognition program is comprised of three components:

- **Champion of Excellence:** This award is for employees that do what it takes to exceed customer's (both external and internal) needs while treating co-workers with respect. Champions achieve their goals through collaboration, while delivering on promises.
- **Captains Award:** This award is for any level of management (supervisors and above) that are great coaches, mentors and role models. Captains do what it takes to engage their team members through effective mentoring and development.
- **Everyday Heroes:** This peer recognition program gives all employees the opportunity to recognize fellow employees who go above and beyond to help get the job done.

Maintaining a Desirable Workplace Environment

In addition, to rewarding employees for outstanding performance, we strive to maintain a desirable workplace environment. We are proud to offer our employees comprehensive medical, dental and prescription coverage; long-term financial planning including life and disability insurance coverage; a competitive 401k contribution plan and an employee stock purchase plan; tax savings programs like Medical Flexible Spending (MFS), Dependent Care and Transit Reimbursement accounts; and confidential and free 24-hour access to Health Advocate services for assistance with leveraging benefits.

We promote a healthy workplace that is smoke free, harassment free, and offers an Employee Assistance Program (EAP) with face-to-face counseling sessions, professional assessment and action plan development available. Lastly Catamaran is committed to the growth and development of our employees as supported by our Tuition Reimbursement Program in support of continued academic achievement and Catamaran University, which offers a robust catalogue of training. We are an Equal Opportunity Employer, M/F/D/V and operate in a corporate culture with a strong belief in cultivating talent and promoting from within Catamaran. Our total compensation package sets us apart in the industry and allows Catamaran to attract and retain highly qualified individuals.

Ensuring Key Personnel are Available

Catamaran will work collaboratively with the Department and seek and obtain State approval before hiring or replacing any Key Project Personnel. In the event that we do need to hire or replace any staff on the Key Project Personnel team for the Department, following an initial screening by our internal recruiters at Catamaran, we will provide the State with an opportunity to participate in the candidate selection process. As requested by the State, we will abide by the parameters outline in Section 2.5 Vendor Key Project Personnel Roles, including:

- developing a formal plan for the replacement of Key Project Personnel within two weeks of the request for their removal
- providing the State with written notification within two business days of receiving an employee's resignation notice, Vendor's notice to terminate an individual, or the position is otherwise becoming vacant

- providing the State with a status update report every 30 days on finding an appropriately qualified replacement candidate
- helping to ensure that a qualified candidate is successfully placed in role within 90 calendar days of the last date of employment of the departing Key Project Personnel

Additionally, we will provide the first 30 days of a replacement resource with equivalent skill at no additional charge.

8. Use of Vermont Staff

Instructions: Describe the required staffing of business and technical resources the State must provide to support the creation of all deliverables. The staffing plan will include the number of resources (both business and technical), anticipated role and responsibilities, level of participation (e.g., part time, full time) and necessary capabilities / skills.

The State may not be able or willing to provide the additional support the Vendor lists in this part of its Proposal. The Vendor therefore must indicate whether its request for additional support is a requirement for its performance. If any part of the list is a requirement and if the State is unable or unwilling to meet the requirements, the State may reject the Vendor's Proposal.

Response:
Based on the new requirements outlined in the RFP and the need to implement new and/or enhanced programs for the State, we anticipate the need for a number of pharmacy and technical resources. At this time we do not foresee the need for significant additional business resources from the State to support the creation of all new deliverables.

We have made every effort to develop our plans so as to have a minimal impact on State staff and their workloads beyond their current involvement with our operations. Prior to implementation, we will work collaboratively with the State to review plans and ensure that these plans meet the State's expectations. We will encourage State participation throughout the implementation process; we envision virtually every unit and division in the State as well as staff in other State Departments will or may have an interest in participation. However, in working with the State we will look to managers to have them identify who they want involved and to what extent. We will then work with the State to formalize a mutually agreed upon implementation plan clearly documenting roles and responsibilities, including any resources that we may agree are needed from the State.

9. Time Commitment

Instructions: Please submit a statement and a chart that clearly indicate the time commitment of the proposed Key Project Personnel and the Vendor's proposed team members for the work. Please include a statement indicating to what extent, if any, the Key Project Personnel may work on other tasks or assignments unrelated to the project during the term of the Contract. Also, please state other potentially conflicting commitments that shall be concurrent with the proposed project.

The State may reject any proposal that commits the proposed Key Project Personnel or any proposed personnel to other assignments during the term of the Contract, if the State believes that any such commitment may be detrimental to the Vendor's performance.

Response:

Confidential, Proprietary, and Trade Secret Information of Catamaran.

[redacted]

[redacted]

[redacted]

Key Personnel	Role	Time Commitment
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]

10. Project Organization and Staffing Assumptions

Document the assumptions related to the project organization and staffing in the following table. The Vendor may add rows as appropriate.

Table 3. Project Organization and Staffing Assumptions

Item #	Reference (Section, Page, Paragraph)	Description	Rationale
1.	1.0 Project Organization Plan, chart appearing on pages 3 through 10.	During the implementation and operation of the State's program, outside of committed resources, we may elect to adjust the number hours for a particular resource in order to most effectively meet the State's program requirements.	Our staffing model is based on input from the RFP, the responses to the clarification questions submitted by Vendors and our expert judgment based on our experience implementing Medicaid programs of similar size and scope.
2.			
3.			

Template E

Staff Experience

RFP # 03410-127-14

catamaran

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2.0 Resumes 17

1.0 Staff Experience

The Vendor must provide a completed Staff Experience reference form for each proposed Key Project Personnel (includes both the Vendor and Subcontractor staff).

Instructions: For each project experience listed, indicate the client name and client contact information, whether the project was for a public sector agency, project name, start and end dates the team member performed the role, duration of the experience and whether the project included software and/or services implementation / configuration. The Vendor may duplicate Table 1 in its entirety, once each per Key Project Personnel.

Respondents are not to change any of the completed cells in the following table. Any changes to the completed cells in the following table could lead to the disqualification of a respondent.

Staff Experience

Confidential, Proprietary, and Trade Secret Information of Catamaran.

Staff experience for the Key Project Personnel from Catamaran is outlined below.

[redacted]

2.0 Resumes

Instructions: The Vendor must complete this section and attach resumes of all proposed Key Project Personnel to this section of the proposal. Each person identified in Section 1 of this template should be included in this section.

Each resume must demonstrate experience germane to the position proposed. Resume should include work on projects cited under the Vendor's corporate experience, and the specific functions performed on such projects.

List of Resumes

[redacted]

Response:

On the pages that follow, please find the resumes of the Key Personnel being proposed to manage the State of Vermont PBM program from Catamaran and CPS.

State of Vermont - Pharmacy Benefits Management
Template F - RFP Functional Requirements Response

RFP Vendor Instructions

This workbook contains Functional Requirements for the system desired by State of Vermont HHS. The response codes below should be used by Responders to indicate the fit of their solution to the State of Vermont HHS Requirements specified in this workbook.
This template must be completed and submitted as an MS Excel file as part of the response to this RFP.

Responses	Definition
Response Code: How will this Functional Requirement be met by your solution?	**Please note that all requirements must be met by one of the possible solution options described below.**
	Indicate if the requirement will be met by selecting either: **Yes Comply or Not Comply:**
	Y = Comply - The State of Vermont HHS Requirement will be met by the Vendor solution.
	N = Not Comply – The State of Vermont HHS Requirement will not be met by Vendor's solution. Please indicate in the Vendor Response Comments colunm the reason that requirement cannot be satisfied.
Vendor Response Comments	Provide comments as necessary in regards to specific requirements using this response template. For more details regarding the approach for meeting a requirement, or combination of requirements, or overall functional area, use the template provided in Response Template H. Also, provide a reference to the appropriate RFP Req. #(s) in this template.
Description of Other Fields	**Below describes the information fields provided for each requirement and their usage.**
	RFP Req #: Identification number for requirement. This should be used to refer to requirements in correspondence.

ID	Section Title	
FR1	Claims Processing	
FR2	Pharmacy Benefits Management	
FR3	Financial	

State of Vermont - Pharmacy Benefits Management
Template F - RFP Functional Requirements Response

Req. #	Requirement	Response Code (Y or N)	Vendor Response Comment(s)
Point-of-Sale (POS)			
FR1.1	The Vendor's POS claims processing system must support online, real-time operations for receipt, adjudication, and notification to billing providers regarding the disposition of a claim (e.g., as payable, denied, or requiring more information).	Y	
FR1.2	The Vendor's POS claims processing system must adhere to the most current version of the National Council for Prescription Drug Program (NCPDP) Implementation Guide functionality for Governmental Programs to allow appropriate reimbursement and coordination of a beneficiary's benefits.	Y	
FR1.3	The Vendor's POS claims processing system must support NCPDP Multi-Ingredient Compound functionality to process compounded claims in accordance with current Department policy and procedures.	Y	
FR1.4	The Vendor must support implementation and ongoing support of providers' interaction with the Vendor's POS systems including, but not limited to, the following	Y	
	1. Establish testing procedures	Y	
	2. Coordinate with network vendors to ensure smooth operation of the POS system	Y	
	3. Certify provider practice management systems (e.g., service bureaus, switches, etc.) as compatible and ready to interface with the Vendor's POS system	Y	
FR1.5	The Vendor's POS claims processing system must be capable of adding, changing, or removing adjudication rules, edits, and customized transmission messages to accommodate Department-required changes for its current and future pharmacy programs.	Y	
FR1.6	The Vendor's POS claims processing system must support, at a minimum, the following:	Y	
	a. The ability to track and report on the specific adjudication rule in effect by date of service and date of payment, and the date the rule was changed, added or deleted	Y	
	b. Adjudication rules customized for each of the Department's programs by category codes within Medicaid, eligibility status, beneficiary attributes (e.g. age, sex, medical condition, etc), ambulatory, long-term care, hospice or other residential setting, drug or drug class (e.g. brand/generic status, drug coverage status, preferred drug list status or other attributes), Medicare-Medicaid dual eligible status and other criteria specified by the Department.	Y	
	c. The ability to look up the PDL status of a drug at a claim and NDC level	Y	
	The Vendor's POS claims processing system must support unique edit and claims processing logic as specified by the Department for each of its individual programs including, at a minimum, the following:	Y	
	a. Prescriber Validation – Validate the prescriber entry on the claim using either a National Provider (NPI) check digit or an HCIdea National Provider Identifier/DEA Lookup from the NCPDP, and/or the Department's Master Provider Index as specified by the Department.	Y	
	b. Co-Payments – Calculate different co-payment amounts for different pharmacy programs, for different drugs, and for beneficiaries based on age or any other specifications provided by the Department.	Y	
	c. Prior Authorization (PA) Requirements – Edit for drugs requiring PA or bypass PA requirements when authorization is granted for the date of dispensing or automated authorization is allowed based on pharmacy or medical claims history files. In particular, system must be capable of displaying expiration dates of prior authorizations at POS.	Y	

Req. #	Requirement	Response Code (Y or N)	Vendor Response Comment(s)
FR1.7	d. Diagnosis-Specific Requirements – Edit for drugs requiring submission of specific diagnosis codes.	Y	
	e. Age-Specific Requirements – Edit for drugs requiring specific beneficiary age restrictions	Y	
	f. Other Reference Files – Apply Department-specified payment criteria based on First DataBank, Medi-Span, or other reference files approved for use by the Department.	Y	
	g. Preferred Drug List and Other Formulary Requirements – Deny payment for drugs requiring PA, non-preferred, non-covered drugs or drug classes not covered by a beneficiary's pharmacy program and notify the provider through an online, real-time response. Exceptions must be allowed when approved by the Department or based on Department-approved criteria.	Y	
	h. Authorized Providers – Limit payment for selected drugs, classes, or specific Department programs to authorized prescribers as designated by the Department. For example, limit certain dosage forms of buprenorphine to prescribers with an X-DEA number.	Y	
	i. Compounded Drugs – Capture, edit, and adjudicate compounded drug claims as specified by the Department. Must be able to apply edits at ingredient level detail	Y	
	j. Quantity, Days Supply, and Frequency of Service – Validate claims to assure that the quantity of services is consistent with the Department's policy (i.e., verify drug specific minimum and maximum quantity limitations are followed including any days supply limitations and frequency limitations).	Y	
	k. Benefit Restrictions – Impose pharmacy benefits restrictions that apply to a given recipient including, but not limited to: benefit restrictions based on the lock-in program, living arrangements (e.g., ambulatory versus long-term care settings), and eligibility for the Department's different pharmacy programs.	Y	
	l. Approved Manufacturers – Deny payment for drugs distributed by manufacturers not participating in the federal manufacturer drug rebate program, except as directed by the Department for specific pharmacy programs or products.	Y	
	m. Proposed Less-Than-Effective Drugs – Deny payment for drugs that the federal government has identified as proposed less-than-effective under the Drug Efficacy Study Implementation (DESI) program and as identical, related, or similar to such drugs.	Y	
	n. Other CMS-Restricted Drugs – Deny payment for any drug that CMS identifies as restricted.	Y	
	o. Sanctioned Providers – Deny payment for sanctioned providers (e.g., pharmacies or prescribers) designated by the federal government and the State.	Y	
FR1.8	The Vendor's POS claims processing system must provide NCPDP standard messages in addition to customized transmission response messages as specified by the Department for its current or future programs including, but not limited to, the following:	Y	
	a. Bill [Health Plan] and [phone number]	Y	
	b.Bill Medicare Part B	Y	
	c. Bill Medicare Part D [name] and [phone number]	Y	
	d.Program has no pharmacy benefit	Y	
	e.Bill as Medical Supplier	Y	
	f. PA expires on [date]	Y	
	g. Drug not covered – included in long-term care per diem rate	Y	

Req. #	Requirement	Response Code (Y or N)	Vendor Response Comment(s)
	h.Doctor not authorized, pharmacy not authorized, doctor/NDC not authorized, or pharmacy/NDC not authorized related to the Lock-In Program (message must return authorized pharmacy)	Y	
FR1.9	The Vendor must be able to process POS, batch electronic claims (e.g. batch adjustments), and paper claims. Paper claims to be processed by the Vendor within 14 days of receipt	Y	
FR1.10	The Vendor must create electronic imaged copies of all paper claims and attachments within 24 hours of receipt.	Y	
FR1.11	The Vendor must notify the Department staff of any and all claims that have been erroneously processed by the claims processing system, and present a corrective action plan to the Department within five business days. The Vendor must initiate corrective actions, at no additional cost to the Department, only after the written approval of the Department.	Y	
FR1.12	The Vendor must analyze probable erroneous payments that have been brought to the Department's attention by providers or that have been identified through the Department's evaluation of paid claim samples.	Y	
FR1.13	The Vendor must base its POS transmissions and batch electronic transmissions on NCPDP and other required transactions and code sets. As additions and updates are available, the Vendor must continue to be in compliance and, at no additional cost to the Department, the Vendor must:	Y	
	a. Implement new and updated NCPDP and other required transactions and code sets	Y	
	b. Maintain compatibility with pharmacies using the previous version data elements and those providers using the updated version(s), according to the timeline approved by the Department	Y	
FR1.14	The Vendor must adjudicate primary, secondary, and tertiary pharmacy claims for the Department's current programs and any future programs consistent with the Department's coverage and reimbursement policies and procedures specified in the Vermont Provider Manual, the Pharmacy Provider Manual, Department PDL, the VT Medicaid State Plan, and other Department documentation. The Department's current programs are:	Y	
	a. Medicaid	Y	
	b. Dr. Dynasaur	Y	
	c. VPharm	Y	
	d. Healthy Vermonters	Y	
	e. VMAP(Ryan White HIV MA program)	Y	
	f. Dual Eligibles	Y	
	g. General Assistance	Y	
	h. Long Term Care	Y	
FR1.15	The Vendor must provide automated audit trails to document, identify, and track chronological records and transactions throughout the Vendor's systems including, but not limited to, additions, deletions, and changes to PDL and formulary maintenance	Y	
FR1.16	Vendor's System must be capable of recording the PDL status of a drug on an NDC level, and capable of a look-up or query of PDL status of a drug on an NDC level.	Y	
FR1.17	Vendor's must maintain detailed electronic documentation outlining the specific benefit design structure that supports and represents the Department's pharmacy benefits in the Vendor's system	Y	

Req. #	Requirement	Response Code (Y or N)	Vendor Response Comment(s)
FR1.18	The Vendor must provide functionality to apply different reimbursement logic or benefit coverage as specified by the Department including, but not limited to, the following:	Y	
	a. Ingredient Cost and Dispensing Fee Payments based on pharmacy network for compounded drugs, 340B drugs, specialty drugs, and other	Y	
	b. Based on program, category code or other program specifications, beneficiary age, drug or drug class, Medicare-Medicaid dual eligibility, beneficiaries residing in a nursing facility, and other	Y	
	c. . DVHA "lower of" reimbursement logic as outlined in the Vermont Medicaid State Plan included in the Procurement Library	Y	
Coordination of Benefits (CoB)			
FR1.19	The Vendor must validate claims to determine whether there is a liable third party (or parties) that must be billed prior to billing the Department's programs including, but not limited to, the following:	Y	
	a. Denying payment for claims when a beneficiary is covered by one or more carriers until the billing provider indicates the claim has been fully adjudicated (paid or denied) by the other payer(s)	Y	Catamaran can provide validation that the submitted Other Payer matches but this is currently limited to 'one' of the Other Payers must match.
	b. Utilizing the Department's, vendor's or external sources of TPL data and eligibility records to ensure that all payment opportunities are exhausted	Y	Per item FR1.19a above, Catamaran can provide validation that the submitted Other Payer matches but this is currently limited to 'one' of the Other Payers must match.
	c. Processing claims where multiple third parties are liable, at a minimum, must be able to correctly process claims where either the Department or an external insurer is the tertiary payer. Must be able to identify and/or assign multiple funding sources depending on the payer, if the payer is an Agency program.	Y	
	d. Overriding COB editing as specified by the Department	Y	
	e. Maintaining indicators to identify Medicare Part B drugs and process the claim balance remaining after subtracting the Medicare Part B payment for beneficiaries dually enrolled in Medicare and any of the Department's programs	Y	
	f. Coordinating benefits automatically with all primary payers including capturing and storing the primary payer's data	Y	Catamaran captures and stores all NCPDP COB Submitted data elements.
	g. Obtaining maximum cost avoidance and reimbursement for beneficiaries covered by third parties	Y	
	The Vendor must report TPL plan information to billing providers when another payer is primary (or available) including, but not limited to:	Y	

Req. #	Requirement	Response Code (Y or N)	Vendor Response Comment(s)
FR1.20	a. Payer names, identifiers, addresses, phone numbers	Y	Catamaran can provide all NCPDP COB Response data elements based on the data being available but this currently does not include Payer names and addresses.
	b. The payer's Bank Identification Number (BIN) and Processor Control Number (PCN).	Y	
FR1.21	The Vendor must be able to support the Department's current COB process for mail order pharmacy coverage from another insurer.	Y	Catamaran recognizes that the current COB process in this area is labor intensive. The problem occurs when a primary pharmacy coverage plan requires members to utilize a mail order pharmacy company that is unwilling to enroll in Vermont Medicaid. It is not clear if the company is unwilling to enroll because Vermont's enrollment requirements are difficult, the company does not wish to coordinate the benefit with another insurance, or the Vermont Medicaid reimbursement rate is not to their liking. No provider of any type can be made to participate in the program or to comply with its requirements. No Medicaid claims processor, pharmacy or otherwise, can process claims for payment from a provider that is not enrolled in that state's Medicaid program. It is unrealistic to pay some providers differently.
Provider Support			

Req. #	Requirement	Response Code (Y or N)	Vendor Response Comment(s)
FR1.22	The Vendor must maintain telephone support for technical and business operations. The Vendor must maintain call center services and help lines to respond to providers about questions and issues including, but not limited to, general eligibility questions, claims inquiries, prior authorizations, operational questions and problems, clinical/drug inquiries, and general provider support. The Vendor must supply all required information systems, telecommunications, and personnel to perform these operations. Each of the following help lines must be available through a designated telephone number:		
	a. Pharmacy Support Services Help Line available toll-free 24x7x365 to respond to questions on coverage, claims processing, pricing, reimbursement and other pharmacy-related issues. .	Y	
	b. Prescriber Support Services Help Line (including toll-free telephone and toll-free fax access) available 24X7X365, to handle PA requests from prescribers, drug dispensing questions, or other requests from providers.	Y	
FR1.23	The Vendor must provide operational and customer service that is scalable to meet the Department's future needs and includes, but is not limited to, the following:		
	a. An automated call distribution voice-response system;	Y	
	b. Capacity to handle all telephone calls at all times including times of peak call volume and to meet the Department's needs and performance expectations with acceptable call completion and abandonment rates	Y	
	c. Management tracking and reporting capabilities	Y	
	d. A Quality Assurance program that includes call sampling and follow up to confirm efficient handling and caller satisfaction	Y	
	e. Language translation services	Y	
	f. Call response from individuals with hearing or visual impairments	Y	
	g. Access to a pharmacist consultant 24 hours a day		
	h. A reference document with guidelines on how to handle caller inquiries	Y	
	i. A backup system available to operate in the event of line trouble or other problems	Y	
FR1.24	The Vendor must implement and maintain a provider contact and problem resolution tracking and document management system which, at a minimum, documents and tracks contacts with providers, identifies issues and describes the problem resolution. The Vendor must prepare an analysis of the issues which must be reviewed with Department staff at regularly scheduled meetings at the Department's discretion.	Y	
FR1.25	Vendor must prepare and distribute (subject to the Department's approval) all provider communications including but not limited to, provider notices, newsletters, operational, programmatic, or system changes of any type that impact providers , and clinical notices such as changes to drug coverage. Communications must be distributed in a variety of formats including, but not limited to direct mail, Vendor web portal, DVHA website, email, fax, phone.	Y	
FR1.26	The vendor must interface with the State of Vermont's Master Provider Index database in order to maintain a database of current contact information for providers. The Vendor must research any undelivered provider communication and make reasonable attempts to identify a new address for such providers.	Y	

Req. #	Requirement	Response Code (Y or N)	Vendor Response Comment(s)
FR1.27	The Vendor must design, develop, and implement customized provider portals for the Department that support the needs of the pharmacy programs. Vendor must support, update, and maintain the portals to meet the needs of the Department. The vendor must guarantee any data exchange on its website between the Vendor and the Department and/or providers will be secure.	Y	Catamaran provides a Provider Portal, that allows for providers to login with user specific credentials and see the membership information and content the client specifies. Information posted to the site comes directly from RxClaim & RxAuth in real time.
FR1.28	The Vendor must update its portals, maintained for the Department, after the content of such updates has been approved by the Department. The Vendor's postings to its website must include, but not be limited to:		
	a. Important communications and alerts to providers	Y	
	b. Drug Utilization Review (DUR) Board meeting schedules, meeting agendas and notices, policies, meeting minutes, member contact information	Y	
	c. Other Department-designated committee activities.	Y	
	d. Provider forms and reference policies or links to forms and policies, if applicable.	Y	
	e. Drug information including the Vermont Preferred Drug List (PDL), special drug policies, Maximum Allowable Cost (MAC) policies and prices, frequently asked questions from manufacturers or providers.	Y	
	f. Manuals including the Pharmacy Claims Processing Manual and links to the Vermont Medicaid Provider Manual.	Y	
	g. Special provider policies and requirements including e-prescribing support.	Y	
	h. Web-based PA requests.	Y	
	i. Other documents as specified by the Department	Y	
FR1.29	Vendor must keep current electronic versions of Department-approved Pharmacy Provider Manual which must include payer sheets, instructions on POS, batch, and paper claims processing. The Vendor must post the Manual(s) on the provider portals and/or website and, on an on-going basis, maintain and update these manuals. Any modifications must be submitted to the Department for approval prior to implementation of revisions.	Y	
E-Prescribing			
FR1.30	The Vendor must provide electronic prescribing companies (e.g., SureScripts-RxHub) access to the data for the Department's various programs including, but not limited to:	Y	
	a. Beneficiary eligibility	Y	
	b. Preferred Drug List including drug's PDL status, alternative choices within the class and their PDL status	Y	
	c. Beneficiary drug claims history	Y	
	d. Other Department specified data.	Y	
FR1.31	The Vendor must work with the Department to meet the Department's goals for electronic prescribing and for providing information to prescribers and pharmacies promoting electronic prescribing	Y	

Req. #	Requirement	Response Code (Y or N)	Vendor Response Comment(s)
FR1.32	The Vendor must provide, at a minimum, monthly reporting on e-Prescribing activities such as number of e-prescriptions, number of requests for eligibility, medication history, or PDL inquiries, and any technical or operational issue identified during the specified time period. Vendor must have quality assurance process in place to assure system integrity and display of required information.	Y	

State of Vermont - Pharmacy Benefits Management
Template F - RFP Functional Requirements Response

Req. #	Requirement	Response Code (Y or N)	Vendor Response Comment(s)
Prior Authorization Program			
FR2.1	The Vendor must manage and operate a prior authorization (PA) program and procedures for the Department that encompasses drugs processed through the pharmacy benefit and physician-administered drugs processed through the medical benefit. Components of the program will include, but not be limited to:		
	1. Implementation of the operational processes to support drug coverage decisions for all clinical and non-clinical criteria	Y	
	2. Operation of a provider call center staffed with appropriate clinical personnel	Y	
	3. Notifications of decision to providers and beneficiaries	Y	
	4. Compliance with all Department PA rules, regulations, and policies	Y	
	5. Support of the grievance and appeal process	Y	
	6. Detailed reporting and analysis on all aspects of the PA program	Y	
FR2.2	The Vendor must comply with all Department PA requirements including, but not limited to, providing a telephone call center which must:		
	1. Be accessible 24x7x365 – except for Vendor downtime approved in advance by the Department	Y	
	2. Support PA processing through toll-free telephone, toll-free facsimile, mail, and web-based requests through provider portal	Y	
	3. Be compatible with real-time electronic editing of medication requests based on current paid claims history, beneficiary eligibility, provider eligibility, and reference medical data supplied to the Vendor	Y	Under the assumption that medical data relates to ICD9/10 and CPT codes.
	4. Be staffed with appropriate technical and clinical personnel including clinical pharmacists	Y	
FR2.3	The Vendor must have functionality to automatically override PA requirements during POS processing based on data available from pharmacy claims paid by the Vendor and on medical claims history files provided by the Department to the Vendor.	Y	
FR2.4	The Vendor must include a review of the beneficiary's eligibility record as part of their PA processing to retrieve the information needed for PA determinations including, but not limited to:		
	a. Program eligibility	Y	
	b. Existence of authorized prescribers	Y	
	c. Existence of program coverage restrictions	Y	
	d. Existence of alternative insurance (ex. Part B or primary commercial coverage)	Y	
	d. Other elements specified and approved by the Department	Y	As mutually agreed upon by the Department and Catamaran.
FR2.5	The Vendor's PA process must allow determinations based on various data elements identifying drug products including, but not limited to, the following:		
	a. The first 9-digits of a product's NDC	Y	
	b. First DataBank, Medispan, or equivalent, therapeutic classification system	Y	
FR2.6	The Vendor must send required notifications to the beneficiary and provider when PA is approved or denied. Notifications must include the required components as outlined by the State.	Y	

Req. #	Requirement	Response Code (Y or N)	Vendor Response Comment(s)
FR2.7	The Vendor must coordinate and provide support to the Department and other State personnel who oversee the appeals process if an appeal results from a denied PA.	Y	
FR2.8	The vendor must interface with the State of Vermont's Master Person Index database in order to maintain a database of current contact information for beneficiaries. The Vendor must research any undelivered beneficiary communication and make reasonable attempts to identify a new address for such beneficiaries.	Y	
FR2.9	The Vendor must allow for the dispensing of at least a 72-hour supply (or other Department-approved amount) of a drug product in an emergency situation as specified by the Department, except for non-covered drug classes or products.	Y	
FR2.10	The Vendor must maintain an electronic version of a PA policies and procedures manual, including, but not limited to:		
	a. Clinical criteria	Y	
	b. Department-approved product protocols	Y	
	c. Criteria for PA processing	Y	
	The information will be available on DVHA's website and/or the provider portals	Y	
FR2.11	The Vendor must provide a PA system, accessible to designated state staff and providers, which maintains and allows the query of all pertinent information about PA requests and determinations including, but not limited to, the following:		
	a. Requesting provider name	Y	
	b. Date and time of request	Y	
	c. Beneficiary identifiers	Y	
	d. Requested drug name, strength, form, and quantity	Y	
	e. Program eligibility of the beneficiary	Y	
	f. Request status (i.e., approved, pended, denied)	Y	
	g. Reason for denial or exception	Y	
	h. Authorization begin and end dates	Y	
	i. Date and time of action on the request	Y	
	j. Authorization of a 72-hour emergency drug supply	Y	
	k. Comprehensive and flexible "free-text" notation functionality.	Y	
FR2.12	The Vendor's PA system must have flexible administrative reporting and include functionality to retrieve and track PA determinations using multiple search fields including, but not limited to: pharmacy program, beneficiary name, beneficiary unique identification number, provider name or ID, drug, date of authorization, and authorization status	Y	
	FR2.16 The Vendor's system must include functionality to support the Team Care and Pharmacy Home (Prescriber/Pharmacy Lock-In) programs including, but not limited to, the following:		
	a. Implement claims processing customized edits and transmission messages	Y	

Req. #	Requirement	Response Code (Y or N)	Vendor Response Comment(s)
FR2.13	b. Support beneficiary lock-in for a specific drug, drug class, drug DEA schedule, and other parameters as defined by the Department	Y	We will collaborate with the State to define and mutually agree upon other parameters to support beneficiary lock-in for a specific drug.
	c. Support the capability to lock members into one or more specific providers (pharmacies and/or prescribers).	Y	
	b. Support identification of potential Team Care eligible beneficiaries in the claims processing system using state defined criteria,	Y	As mutually agreed upon by the State and Catamaran.
	c. Provide detailed reporting information to the Department on program activities including, but not limited to, prescription utilization, cost per beneficiary, and parameters of the lock-in	Y	
FR2.14	The Vendor must comply with State and federal policies and procedures for beneficiary or provider appeals including, but not limited to, the following:		
	a. Notifying providers and beneficiaries of their appeals rights in accordance with the Department's policy	Y	
	b. Coordinating with State personnel who oversee the grievance and appeals process	Y	
	c. Preparing the appropriate reports and documents to support the Vendor's actions resulting in the request for an appeal from a beneficiary or provider	Y	
	d. Providing the services of a clinical pharmacist to engage in peer discussions with state Medical Director and other Department clinical personnel to address an appeal related to pharmacy benefit services	Y	
	e. Providing resources to address appeals related to claims disputes	Y	
	f. Complying with the mandates and timelines stipulated by the Department	Y	
FR2.15	The Vendor must continuously review and evaluate PA protocols and criteria, and the appropriateness of continued PA, suggestions for drugs appropriate for electronic or manual PA's. These reviews and evaluations must encompass drugs processed through the pharmacy benefit and physician-administered drugs processed through the medical benefit. The Vendor must analyze historical PA determinations and drug claims data and must provide quarterly recommendations and protocols for PA to the Department for review and approval.	Y	
FR2.16	The Vendor must provide detailed monthly operational, clinical, and financial reporting on all prior authorization activities, including but not limited to: number of PA's, denial/approval rates, number of electronic vs. manual PA's, drug and overall health care savings, and return on investment. Reports should be available by drug, drug class, beneficiary, provider, and other defined parameters.	Y	Catamaran performs all types of reporting outlined in the question, and would work with the Statet to implement total healthcare savings and various permutations/filters of the reporting where appropriate for the clinical program that is implemented.
FR2.17	The Vendor must, develop and maintain approved protocols and criteria for coverage of products		
	a. Not listed on the PDL	Y	

Req. #	Requirement	Response Code (Y or N)	Vendor Response Comment(s)
FR2.17	b. Typically not covered	Y	
	c. Exceeding the Department's SMAC rates	Y	
	d. Not meeting other clinical or technical criteria	Y	
Drug Utilization Review and Management			
FR2.18	The Vendor's RetroDUR management system must include data warehouse analytic/reporting tools, clinical rules, algorithms, and profiling including, but not limited to, identifying prescribing and utilization patterns which fall outside best practice guidelines.	Y	
FR2.19	The Vendor's RetroDUR management system must have functionality to merge medical service claims provided by the Department with pharmacy claims to identify and monitor drug usage including, but not limited to:		
	a. Overutilization	Y	
	b. Underutilization	Y	
	c. Therapeutic duplication	Y	
	d. Drug-disease contraindications	Y	
	e. Drug-drug interactions	Y	
	f. Incorrect drug, dosage, or duration of therapy	Y	
	h. Drug-induced illness	Y	
	i. Beneficiary clinical abuse and drug misuse	Y	
	j. Therapeutic appropriateness	Y	
	k. Other criteria identified by the Department or its DUR Board	Y	Catamaran maintains over 1,200 rules that can be implemented by the State.
FR2.20	The Vendor must conduct regular ProDUR and RetroDUR program activities that meet all state and federal requirements. Vendor must conduct regular program review, facilitate quarterly evaluations of criteria and interventions, recommend draft standards and criteria, and implement approved changes. RetroDUR activities must encompass drugs processed through the pharmacy benefit and physician-administered drugs processed through the medical benefit. Actions include, but are not limited, to the following:		
	a. Conduct clinical and financial analyses and literature reviews related to its ProDUR and RetroDUR activities and report findings to the Department and DUR Board regularly	Y	
	b. Assess the effectiveness of ProDUR and RetroDUR practices and provide clinical and financial summary reports at least quarterly	Y	
	c. Implement DUR Board recommended changes after Department approval	Y	
	d. Generate educational materials for prescribers, pharmacies, and beneficiaries to support Department-approved interventions	Y	
FR2.21	The Vendor must monitor and report on the outcomes of its DUR educational efforts quarterly or as otherwise specified by the Department.	Y	
FR2.22	The Vendor's RetroDUR management system must have clinical pharmacist oversight.	Y	
	The Vendor must draft and finalize, with support from the Department, the CMS annual DUR report as described in Section 1927(g)(3)(D) of the Social Security Act and the required cost savings analysis including, but not limited to, the following:		

Req. #	Requirement	Response Code (Y or N)	Vendor Response Comment(s)
FR2.23	a. Provide the draft CMS-required DUR Annual Report to the Department at least 30 days prior to the due date	Y	
	b. Incorporate any changes recommended by the Department into the CMS annual report	Y	
	c. Perform additional research requested by the Department	Y	
	d. Upload per CMS protocol the final CMS-required DUR Annual Report to the Department at least 10 days prior to the due date for Department approval and submission.	Y	
FR2.24	The Vendor must facilitate the DUR Board meetings and prepare Department-approved meeting materials including, but not limited to, the following:		
	a. Prepare, distribute, and post meeting agendas and materials to DUR Board members at least 14 days prior to the DUR Board meeting	Y	
	b. Present in person, all items on the agenda related to DUR activities, PDL recommendations, and drug related information at the DUR Board meetings.	Y	
	c. Record meeting minutes including all PDL changes and action items, and forward them to the Department within 3 days after the meeting for Department approval	Y	
	d. Post meeting minutes on the website 5 days after the DUR Board meeting.	Y	
	e. Assure that all DUR Board actions are implemented on a timely basis	Y	
FR2.25	The Vendor's designated (Key Personnel) Clinical Pharmacist must manage and direct the Department's DUR program and PDL activities and act as the Vendor's representative at the DUR Board meetings. During planned or unplanned absences, Vendor must provide replacement personnel to fill this role.	Y	
FR2.26	The Vendor's designated (Key Personnel) Clinical Pharmacist must proactively research, analyze, present findings, and advise the Department and/or the DUR Board on topics requested by the Department including, but not limited to:		
	a. PA requirements and clinical criteria	Y	
	b. Prescription spending trends focusing on the Department's programs and on national trends	Y	
	c. Cost containment strategies	Y	
	d. RetroDUR	Y	
	e. Educational materials for DUR	Y	
	f. POS claims processing	Y	
	g. Reimbursement strategies for product costs, dispensing fees, and beneficiary cost sharing	Y	
	h. ProDUR	Y	
	i. Reconsiderations and appeals	Y	
	Resources a – e must consider drugs processed through the pharmacy and physician-administered drugs processed through the medical benefit.	Y	
FR2.27	The Vendor must facilitate the DUR Board's use of clinical subject matter experts in reviewing various classes of drugs or individual drugs, if such expertise is needed.	Y	
FR2.28	The Vendor must maintain the drug coverage lists specific to the Department's programs as defined by the State. These include the Department's Preferred Drug List, clinical criteria document, covered OTC's, and other coverage lists.	Y	
State Maximum Allowable Cost Program (SMAC)			

Req. #	Requirement	Response Code (Y or N)	Vendor Response Comment(s)
FR2.29	The Vendor must administer the Department's MAC program, by setting rates on prescription and over-the-counter multiple-source generic and brand products. The Vendor's methodology for calculating the MAC must be available and transparent to the Department.	Y	
FR2.30	The Vendor must set MAC rates on all multiple-source drugs rated as therapeutic equivalents (A-rated) according to the FDA Approved Drug Products with Therapeutic Equivalence Evaluations, unless otherwise directed by the Department.	Y	
FR2.31	The Vendor must comply with the requirements explained at www.cms.hhs.gov/reimbursement for Federal Upper Limits and Medicaid Prescription Drugs under DRA (the Deficit Reduction Act of 2005). Updates to the FUL will be made on a timely basis.	Y	
FR2.32	The Vendor must monitor the Department's MAC rates to assure products are available at the MAC rates and are appropriate estimates of providers' actual acquisition costs.	Y	
FR2.33	The Vendor must publish weekly additions, deletions, and revisions to the MAC rates on the Vendor and/ or provider portals. The MAC list will be posted in a searchable and downloadable format	Y	
FR2.34	The Vendor must notify the Department at least ten business days prior to placing a MAC rate on a product, when a MAC has never been previously placed on that product.	Y	
FR2.35	The Vendor must ensure the Department's MAC rates, when compared with Federal Upper Limit (FUL) rates published by CMS, in aggregate, do not exceed FUL rates for CMS-specified products. This includes, but not limited to, taking the following actions:	Y	
	a. Monthly compare the Department's Medicaid expenditures and utilization on CMS-specified FUL products to what would have been paid if the FUL rates were used	Y	
	b. Prepare a monthly summary report of findings for the Department	Y	
	c. Prepare an action plan within ten business days of becoming aware that the Department's Medicaid expenditures exceeded, in aggregate, projected expenditures if the FUL rates had been used	Y	
FR2.36	The Vendor must provide regular reports on the operational status of the MAC program in addition to cost savings reports at least quarterly.	Y	Catamaran is willing to provide reporting on the MAC effective rate and overall generic effective rate specific to Vermont. However, these reports may be informational only and may not be considered as reporting of any related guarantee, unless established through the contracting process. We also may establish definitions of such terms or related criteria including, but not limited to, the methodology for such measurements and measurement period.

Req. #	Requirement	Response Code (Y or N)	Vendor Response Comment(s)
Reporting and Analytics			
FR2.37	The Vendor must provide management reports to the Department, on a schedule to be determined in negotiation with the State, to support PBM analytics. Examples of all current reports are included in the Procurement Library. The reports must include, but are not limited to:	Y	
	a. Utilization Reports	Y	
	b. Financial Reports	Y	
	c. Auditing Reports	Y	
	d. Preferred Drug List Reports	Y	
	e. Claims Processing Reports	Y	
	f. Coordination of Benefits (COB) Reports	Y	
	g. Net Cost Reporting	Y	
FR2.38	The Vendor's reporting system shall provide data dashboard capabilities to facilitate real time graphical display of key outcome and performance metrics with drill-down capability aligned with user's role and permissions	Y	
FR2.39	The Vendor's reporting system shall have the capability to generate and display population, program and client based dashboard reports.	Y	
	Population and program based dashboard reports may include but not be limited to:	Y	
	1. Characteristics of a population (e.g., Number and percentage of program participants by program type, Population distribution by eligibility or drug criteria, Participants enrolled in multiple programs / services, etc.)	Y	
	2. Program information (e.g., PA's received and status / disposition, referrals received, appeals with status, etc.)	Y	
	3. Solution performance and quality assurance reports (e.g., Solution performance according to agreed upon SLAs, Fraud, waste and abuse detection indicators)	Y	
FR2.40	The Vendor's reporting system shall allow the user to drill down in order to view more detailed information about a specific metric, where available	Y	
FR2.41	The Vendor's reporting system shall provide the capability to present data in graphical and/or GIS map format	Y	
FR2.42	The Vendor's reporting system shall provide the capability for reports to be automatically generated and distributed on a periodic basis	Y	
FR2.43	The Vendor's reporting system shall allow the user to configure report preferences	Y	
FR2.44	The Vendor's reporting system shall allow users to subscribe to reports so that they will be sent to them electronically upon periodic creation	Y	
FR2.45	The Vendor's reporting system shall allow the user to export information presented and underlying information with a granularity consistent with the user's access rights (jpg, pdf, xls, csv, etc.)	Y	
FR2.46	The Vendor's reporting system shall provide report formatted for printing on standard paper sizes	Y	
FR2.47	The Vendor's reporting system shall create an auditable list of all users that access reports and which reports they access	Y	

Req. #	Requirement	Response Code (Y or N)	Vendor Response Comment(s)
FR2.48	The Vendor's reporting system shall provide the ability to suppress data sets with a sample size of zero or a sample size that does not meet the threshold for de-identified/anonymous data	Y	
FR2.49	The Vendor's reporting system shall notify users of the estimated time required to run a report if it exceeds a predefined time limit	Y	
FR2.50	The Vendor's reporting system shall allow queuing of reports	Y	
FR2.51	The Vendor's reporting system shall include version control for all reports	Y	
FR2.52	The Vendor's reporting system shall provide a mechanism to archive and remove reports in order to prevent a proliferation of reports	Y	
FR2.53	The Vendor's reporting system shall have the capability to generate and display standard ("canned") reports as defined by the Department that users can view and export, but not customize	Y	
FR2.54	The Vendor's reporting system shall allow users specify "favorite" reports and will automatically identify frequently used reports	N	Our reporting system allows users to specify favorite reports; however, frequently used reports are not automatically identified. However, RxTrack report menu is sorted by client and displays last date and time each report was processed. Favorite reports can be scheduled to run automatically daily, weekly, monthly, etc. and delivered via email in PDF, Excel and other user-specific format.
FR2.55	The Vendor's reporting system shall display a list of standard reports available to the user. The list shall include, but is not limited to:		
	i. Report title	Y	
	ii. Last update date	Y	
	iii. Last run date	Y	
	iv. Planned run frequency	Y	
FR2.56	The Vendor's reporting system shall allow generation of reports with an 'as-of' date that may not be the same as the current date	Y	
FR2.57	The Vendor's reporting system shall display a list of parameter-based reports available to the user. Parameter based standard reports may include:	Y	
	i. Existing reports that are currently generated and published	Y	
	ii. Demographics, utilization, and other population based reports.	Y	
	iii. Beneficiary centric reports	Y	
	The Vendor's reporting system shall allow users to specify one or multiple parameters for the report. Parameters may include, but are not limited to:		
	i. Reporting period (last month, last quarter, customized date range, etc.)	Y	

Req. #	Requirement	Response Code (Y or N)	Vendor Response Comment(s)
FR2.58	ii. Population characteristics (age range, gender, program participation)	Y	
	iii. Geography (zip code, region, county, census)	Y	
	iv. Beneficiary or Provider -based analyses	Y	
	v. Threshold-based and exception reporting vi. Percent change reporting	Y	
	vii. Changes over time	Y	
FR2.59	The Vendor's reporting system shall allow for the user to sort and filter report data	Y	
FR2.60	The Vendor's reporting system shall provide the ability to upload a data set (e.g., list of beneficiary names or UID's) for use as a parameter	Y	
FR2.61	The Vendor's reporting system shall provide the option of saving the report parameters in order to re-run it another time	Y	
FR2.62	The Vendor's reporting system shall provide the ability to perform calculations (e.g., unique count, average, etc.)	Y	
FR2.63	The Vendor's reporting system shall provide the ability to compare the data from one reporting period to another	Y	
FR2.64	The Vendor's reporting system shall provide the ability to identify statistical outliers	Y	
FR2.65	The Vendor's reporting system shall provide the ability to build and save reports and report templates. These reports will have filtering capabilities and must be easy to build and modify by the user	Y	
FR2.66	The Vendor's reporting system shall allow the user to view and select available data sources for use in a query. Data sources may include, but are not limited to:	Y	
	a. Any data accessible within the Vendor solution	Y	
	b. Any data accessible through integration with other data systems	Y	
	c. Data from other external sources that may be imported for use in the query	Y	
FR2.66	The Vendor's reporting system shall provide a standards-based interface/integration capability which can be triggered by a user to request that data be obtained from The Vendor's reporting system and imported to other authorized systems (e.g. MMIS solution, integrated eligibility solution, program integrity solution)	Y	
FR2.67	The Vendor's reporting system shall allow the user to share the queries with other users	Y	
FR2.68	The Vendor's reporting system shall make timely, accurate, and complete decision support information available to authorized users through the application and standardized tools	Y	
FR2.69	The Vendor's reporting system shall provide for appropriate class of reporting and business intelligence tools for different type of users (e.g. executive, analyst, operations staff)	Y	
FR2.70	The Vendor's reporting system shall provide the ability to provide access via multiple formats (Portable Document Format (PDF), Microsoft Excel, Microsoft Access, HTML)	Y	
Quality Assurance			
FR2.71	The Vendor must develop and implement quality assurance processes and adopt best practices learned from other customer deployments, consistent with industry standards, principles, and processes including, but not limited to:	Y	
	a. Recurring process reengineering evaluation to ensure processes are aligned with best practices and opportunities for process improvement are realized.	Y	

Req. #	Requirement	Response Code (Y or N)	Vendor Response Comment(s)
FR2.71	b. Continuous performance measurement and improvement through the use of technical reviews, internal audits, and Vendor provider satisfaction surveys, or other assessment tools (e.g. reporting on operational metrics).	Y	
	c. Ongoing Vendor staff training.	Y	
	d. Implement Quality Improvement Processes for recurring processes.	Y	
FR2.72	The Vendor must conduct client Satisfaction Surveys at least biannually, or as specified by the Department. The Vendor's surveys must include, but are not limited to:	Y	
	a. Performance inquiries consistent with the duties and responsibilities of the Vendor and any SubVendor.	Y	
	b. Performance expectations and measurement criteria for managing the ongoing long-term business relationship with the Vendor and for monitoring performance.	Y	
	c. Inquiries on technology, quality, responsiveness, delivery, cost and continuous improvement.	Y	
	The Department, in its sole discretion, may modify these requirements.	Y	
FR2.73	The Vendor must immediately notify the Department of any system, program, or operational deficiencies or defects identified. The Department will establish the severity level and approve timelines for fixes or resolutions.	Y	
FR2.74	The Vendor must provide corrective action plans to the Department within 3 business days of the discovery of severe defects found through internal quality control reviews and identify options for corrective actions. The Vendor must initiate corrective actions plans, at no additional cost to the Department, only after the written approval of the Department.	Y	
FR2.75	The Vendor must provide audit trails to document, identify, and track chronological records and transactions throughout the Vendor's systems including, but not limited to, additions, deletions, and changes to:	Y	
	a. Master file data related to beneficiaries, providers, drugs, pricing, and other reference data	Y	
	b. Prior Authorizations	Y	
	c. Beneficiary Lock-Ins	Y	
	d. All edits encountered, resolved, or overridden	Y	
	e. POS transactions, including data submitted by providers and responses sent to the provider	Y	
FR2.76	The Vendor must sample and reconcile its claims processing system and files to ensure accurate and timely payments including, but not limited to, the following:	Y	
	a. Conduct a random sample of a minimum of 500 claims each quarter	Y	
	b. Stratify the sampling technique by variables, such as the Department's programs, reimbursement methodology, product type (e.g., sole-source, multiple-source, generics, etc.), or as specified by the Department for each reporting quarter	Y	
	c. Report quarterly review findings to the Department	Y	
	d. Provide an action plan to address processing errors	Y	
FR2.77	The vendor must implement a continuous process improvement program to reduce administrative burden on the Department, providers, and beneficiaries. This process must be regularly assesses and continue throughout the duration of the contract.	Y	

Req. #	Requirement	Response Code (Y or N)	Vendor Response Comment(s)
FR2.78	The Vendor must maintain a log of operational, clinical, programmatic, and claims processing issues which will be reviewed in weekly team meetings with Department staff. Each issue will be analyzed and a resolution determined on a timeline approved by the Department. Issues not resolved on a timely basis will be subject to penalty.	Y	
FR2.79	Upon the State's decision to proceed with implementation of the State's Dual Eligible Demonstration Program, the Vendor must comply with all federal and state rules, regulations, and CMS requirements related to the implementation of a pharmacy benefit program for Vermont's Dual eligible population. Vendor must also comply with all sections of the Part D Prescription Drug Benefit Manual (PDBM) found at: http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/PartDManuals.html in the delivery of PBM services in support of the Duals Program.	Y	
~~FR2.80~~	~~Upon the State's decision to proceed with implementation of the State's Dual Eligible Demonstration Program, the Vendor must meet all Department timelines and tasks related to the design, development, and implementation of the Duals Demonstration Pharmacy Benefit.~~	Y	Requirement deleted by the State.
FR2.81	Upon the State's decision to proceed with implementation of the State's Dual Eligible Demonstration Program, the Vendor must agree to provide adequate staff and systems for ongoing operational, clinical, and programmatic support of the Duals Demonstration Pharmacy benefit program.	Y	

State of Vermont - Pharmacy Benefits Management
Template F - RFP Functional Requirements Response

Req. #	Requirement	Response Code (Y or N)	Vendor Response Comment(s)
Drug Rebate Management			
FR3.1	The Vendor must manage the Department's manufacturer drug rebates for the following programs:		
	a. Federal OBRA'90 rebate program	Y	
	b. State supplemental rebate program	Y	
	c. State-only rebate program	Y	
	The requirements in this section apply to all of the Department's rebate programs	Y	
FR3.2	The Vendor must comply with the provisions explained at www.cms.hhs.gov/MedicaidDrugRebateProgram and Section 1927 of the Social Security Act.	Y	
FR3.3	The Vendor must maintain an electronic policies and procedures manual documenting all aspects of the Vendor's administration of the Department's manufacturer drug rebate programs.	Y	
FR3.4	The Vendor must not engage in any contracts or agreements during the Contract, and any renewal thereof, to receive direct compensation from pharmaceutical manufacturers (e.g., fees associated with data, rebates, rebate management, compliance, or clinical programs) which pertain to prescription claims data collected from the Department's programs.	Y	
FR3.5	The Vendor must conduct a review of rebate contracting and program performance at least quarterly with representatives from the Department.		
FR3.6	The Vendor must integrate the following Department claims data to calculate manufacturer rebates owed to the Department including:	Y	
	a. NDC claims data paid by the Vendor	Y	
	b. Practitioner and outpatient hospital claims data for physician-administered drugs paid by the Department and forwarded to the Vendor.	Y	
FR3.7	The Vendor must calculate the total rebate amounts due from each manufacturer based on:		
	a. The number of units paid per an NDC	Y	
	b. Unit rebate amounts applicable for the Department's programs, which are (1) distributed by CMS for the Federal Medicaid rebate program; (2) Supplemental unit rebate amounts as negotiated by the multi-state rebate pool; and (3) rebates required for participation in State-funded plans	Y	
FR3.8	The Vendor must invoice manufacturer rebates quarterly (or by other time periods specified by the Department or CMS) including, but not limited to, the following requirements:		
	a. Invoice 100% of participating manufacturers for Federal, State supplemental, and State-only rebates no later than 60 days after the end of the quarter, or in compliance with the timelines of the Federal government and the Department for generating manufacturer drug rebate invoices	Y	
	b. Submit the manufacturer rebate invoice summary for the Department's approval at least three business days prior to invoicing participating manufacturers.	Y	
FR3.9	The Vendor's rebate invoicing format and reported data elements must comply with CMS standards and with CMS policies and procedures for original invoices, for any needed prior period adjustments for previously invoiced quarters, and for interest on outstanding balances owed by a manufacturer.	Y	

Req. #	Requirement	Response Code (Y or N)	Vendor Response Comment(s)
FR3.10	The Vendor must provide manufacturers with electronic invoices and claims level detail in a format agreed upon with the Department.	Y	
FR3.11	The Vendor must utilize pre-invoicing quality control edits to proactively reduce manufacturer disputes of invoiced rebate amounts (e.g., quarter-to-quarter percent change in rebate amount invoiced by NDC, rebate amount exceeds reimbursed amount, quantity exceeds expected amounts, etc.). The Vendor must obtain Department approval on all pre-invoicing edits and must provide an audit trail of all pre-invoicing adjustments along with justification recorded into the Vendor's rebate management system. The Vendor must provide the Department a quarterly report of each adjustment and related justification by NDC.	Y	
FR3.12	The Vendor must provide a pre-invoicing capability to convert unit types, when mismatches occur between the pharmacy claim unit types paid and the CMS unit rebate types.	Y	
FR3.13	The Vendor must track and process prior period adjustments including, but not limited to, the following:		
	a. Maintain all quarters of manufacturer drug rebate invoices and other information to accommodate prior period adjustment processing including a minimum of 12 quarters (available online)	Y	
	b. Identify and process, at NDC level, any corrections to rebate information received from CMS or from a manufacturer	Y	
	c. Provide capabilities to manually enter and report corrections at the NDC level on manufacturer drug rebate invoices.	Y	
FR3.14	The Vendor must process prior period adjustments, calculate interest-due amounts, and work to resolve outstanding rebate disputes including those originating prior to the Contract.	Y	
FR3.15	The Vendor must provide a rebate dispute resolution process that complies with CMS Best Practices for Dispute Resolution and must meet all State and Federal requirements for pursuing recoveries in a timely manner.	Y	
FR3.16	The Vendor must provide a method to extract claims and other documentation for NDCs that are in dispute.	Y	
FR3.17	The Vendor must compare invoices to the Reconciliation of State Invoice (ROSI) returned by a manufacturer to determine which NDC and rebate amounts are in dispute.	Y	
FR3.18	The Vendor will provide documentation, upon Department request, of its repeated efforts to resolve aged disputes.	Y	
FR3.19	The Vendor must correct invoice records at the quarter and NDC level to support the dispute resolution process and log the updated amounts into its rebate management system.	Y	
FR3.20	The Vendor must maintain an automated drug rebate dispute tracking system. This system must track by labeler and NDC: the manufacturer name, manufacturer code, invoiced amount, invoiced quantity, manufacturer's paid quantity for the NDC, unpaid quantity (positive or negative), rebate amount per unit, unpaid rebate amount, dispute reason, interest owed, and quarter.	Y	
FR3.21	The Vendor must automatically recalculate the utilization for each disputed NDC for all manufacturers after all adjustments have been recorded and log the updated amounts into its online rebate management system.	Y	

Req. #	Requirement	Response Code (Y or N)	Vendor Response Comment(s)
FR3.22	The Vendor must, at least annually or as directed by the Department, attend and actively participate in CMS-sponsored dispute resolution meetings on behalf of, or in addition to, the Department's staff. Costs associated with Vendor staff attending such meetings will be the Vendor's responsibility.	Y	
FR3.23	The Vendor must reconcile payments received from manufacturers with the amount invoiced by program, category code, quarter, and National Drug Code (NDC).	Y	
FR3.24	The Vendor must maintain the original and corrected invoice information at the NDC level.	Y	
FR3.25	The Vendor must identify discrepancies between the rebate amount due and total amount paid to pharmacy (e.g., rebate amount exceeds amount paid). The Vendor must determine reasons for any discrepancy (e.g., pharmacy billing errors, CMS imposed manufacturer penalty) and resolve the discrepancy. The Vendor must log such resolutions in its online rebate management system.	Y	
FR3.26	The Vendor must calculate and invoice interest on unpaid quarterly manufacturer rebate amounts in accordance with Federal notifications. The Vendor must report interest invoicing separately from rebates.	Y	
FR3.27	The Vendor's manufacturer drug rebate management system must house and maintain data by program, category codes, quarter, NDC, and claim including, but not limited to:		
	a. Listings of manufacturers participating in the Federal manufacturer drug rebate program	Y	
	b. Federal unit rebate amounts for the Department's Medicaid program	Y	
	c. Supplemental rebate amounts	Y	
	d. State-only rebate amounts	Y	
	e. Rebate invoiced claims data including physician and outpatient hospital administered drugs paid by the Department and pharmacy prescriptions paid by the Vendor's POS claims processing system	Y	
	f. Rebates received	Y	
	g. Pre-invoicing adjustments to unit rebate amounts and utilization	Y	
	h. Recalculated invoice amounts based on data submitted from manufacturers	Y	
	i. Manufacturer invoices	Y	
	j. Prior period adjustments	Y	
	k. Manufacturer disputes	Y	
	l. Dispute resolutions and utilization adjustments supporting dispute resolution	Y	
FR3.28	The Vendor's manufacturer drug rebate management system must have functionality to maintain complete records of all rebate data and transactions.	Y	
FR3.29	The Vendor's manufacturer drug rebate management system must provide online access for Department-designated staff.	Y	
FR3.30	The Vendor's manufacturer drug rebate management system must retain rebate records conforming to Federal regulations and notifications or as otherwise specified by the Department.	Y	
FR3.31	The Vendor's manufacturer drug rebate management system must have functionality to age the accounts.	Y	
FR3.32	The Vendor's manufacturer drug rebate management system must have functionality to apply adjustments for any given time period.	Y	
	The Vendor's manufacturer drug rebate management system must have functionality to allow multiple select keys and sort preferences including, but not limited to		

Req. #	Requirement	Response Code (Y or N)	Vendor Response Comment(s)
FR3.33	a. by manufacturer	Y	
	b. by year/quarter	Y	
	c. by type of rebate	Y	
	d. by program or category code	Y	
	e. claim level	Y	
FR3.34	The Vendor must provide automated audit trails to document, identify, and track chronological records and transactions throughout the Vendor's systems including, but not limited to, additions, deletions, and changes to:		
	a. Original rebate invoices	Y	
	b. Rebate interest billing	Y	
	c. Pre-invoicing adjustments	Y	
	d. Rebate write-offs	Y	
	e. Prior period adjustments	Y	
	f. Rebate accounts receivable and balances	Y	
	g. Dispute resolution	Y	
FR3.25	The Vendor must import into its manufacturer drug rebate management system all historical quarterly rebate data available from the Department's current rebate Vendors.	Y	
FR3.26	The Vendor must assume all administrative and management tasks associated with rebates for historical quarters as well as future quarters occurring during the Contract.	Y	
FR3.27	The Vendor must generate and transmit to CMS a file of all manufacturer rebate invoices quarterly as required by CMS. This will include, but not be limited to, original invoices, interest amounts, prior period adjustments, and adjustments resulting from resolved disputes.	Y	
FR3.28	The Vendor must provide quarterly drug rebate information in a form compatible for the Department's submission of the Quarterly Expense Report of the Medicaid Budget and Expenditure System (CMS-64) reporting requirements on or before 15 days following the close of a quarter's end.	Y	
FR3.29	The Vendor must deliver operational rebate reports to the Department within two business days after the reporting period or as otherwise specified by the Department. The Vendor must provide reports online for the Department-designated staff in downloadable versions of Microsoft® Excel or other Department-specified format.	Y	
FR3.30	The Vendor's online manufacturer drug rebate management system and operational rebate reporting functionality must separately report manufacturer rebate payments by:		
	a. Quarter	Y	
	b. Program	Y	
	c. Rebate type (e.g., Federal, State, Supplemental)	Y	
	d. Drugs crossed-walk from Healthcare Common Procedure System (HCPCS) codes to NDCs by the Vendor (i.e., practitioner and outpatient hospital claims for physician-administered drugs	Y	
	e. Prescription claim level	Y	
	f. f. Funding Source	Y	
	The Vendor must provide pre-invoicing quality control, operational reports to the Department prior to invoicing manufacturers quarterly. Reports will include, but are not limited to, NDCs for which:		

Req. #	Requirement	Response Code (Y or N)	Vendor Response Comment(s)
FR3.31	a. Rebate amounts exceed total reimbursement plus payment from other insurers	Y	
	b. Rebate amounts exceed quarter-over-quarter variability thresholds (e.g., +/- 15%)	Y	
	c. Pre-invoicing adjustment amounts have been made by the Vendor	Y	
	d. Zero rebate amounts are listed on the CMS file	Y	
	e. Reimbursement has been made by the Vendor but the NDC is not found on CMS rebate file	Y	
FR3.32	The Vendor must reconcile drug rebate data with the Department's fiscal records monthly, quarterly, and annually. Such efforts must include detailed reports that identify adjustments, unit amount rebate changes, write-offs, and other accounting transactions that impact the Department rebate reporting.	Y	
FR3.33	The Vendor must provide operational rebate reports, in a format and schedule agreed upon and approved by the Department, which track:		
	a. Rebate recoveries	Y	
	b. Current reporting period disputes by manufacturers with aged disputes for previous quarters	Y	
	c. Adjustments and recoveries resulting from dispute resolution activities	Y	
	d. Pre-invoicing adjustments, unit rebate amount changes, write-offs, and other accounting transactions	Y	
	e. Current and past accounts receivable by manufacturer	Y	
	f. Interest billed and collected	Y	
	g. Feasibility determinations of rebate write-offs	Y	
	h. Amount rebated compared to amount paid by quarter, manufacturer, and NDC	Y	
FR3.34	The Sovereign States Drug Consortium (SSDC) is a Medicaid supplemental drug rebate program that allows participating states to pool their prescription utilization numbers to obtain supplemental rebates from pharmaceutical manufacturers. The Vendor must administer the Supplemental Rebate program on behalf of the State, including participating in all required activities with the SSDC and its designees, and identifying and implementing opportunities with the SSDC to maximize the supplemental rebate amounts returned to the State.	Y	
FR3.35	The Vendor must support the State in its engagement with the SSDC and its PBM Vendor as the SSDC negotiates supplemental rebates with manufacturers. This support includes, but is not limited to:		
	a. Provide utilization and rebate modeling analytic capabilities	Y	
	b. Provide the necessary utilization, URA, and other data files on a timely basis as required by the SSDC	Y	
	c. Make recommendations and submit all potential rebate arrangements to the Department for approval prior to acceptance	Y	
	d. Perform modeling that incorporates rebate data and determined net cost to the Department associated with individual PDL decisions for a drug	Y	
	d. Participate along with State staff and/or represent the Department in all SSDC meetings, conference calls, and other venues during which rebate business is conducted	Y	
FR3.36	The Vendor must work with the SSDC and its PBM Vendor to support the State in administration of the supplemental rebate program. This support includes, but is not limited to		
	1) Calculate, prepare and issue manufacturer invoices	Y	
	2) Work with manufacturers to obtain fully executed supplemental rebate agreements (SRA)	Y	
	3) Work with the Department on any needed revisions to the SRA annually	Y	

Req. #	Requirement	Response Code (Y or N)	Vendor Response Comment(s)
	4) Track, reconcile, resolve all collections, disputes, adjustments	Y	
	5) Provide all required reporting and analysis	Y	
	6) Perform other administrative duties as defined by the State	Y	
FR3.37	The Vendor will maintain those data systems used to calculate the Supplemental Rebates. In the event material discrepancies are discovered, the Vendor will promptly make an appropriate adjustment, which may include a credit as to the amount of the Supplemental Rebates or a refund to Manufacturer.	Y	
FR3.38	The Vendor shall maintain electronic claims records for the most recent four quarters that will permit the Manufacturer to verify through an audit process the supplemental rebate summaries.	Y	
Financial Management			
FR3.39	The Vendor must, as requested by the Department, process post-payment claim reversals for pharmacy claims, such as TPL adjustments and other adjustments.	Y	
FR3.40	The Vendor must, as requested by the Department, process financial gross adjustments to pharmacy payments, such as corrective actions identified from post-payment audit findings and other adjustments.	Y	
FR3.41	The Vendor and any SubVendors must cooperate with financial audits by Department staff, other State departments, the United States Department of Health and Human Services, State or Federal designees, or others authorized to perform audits relating to the work and deliverables rendered by the Vendor and any SubVendors. Vendor and SubVendor audit support must include, but is not limited to:		
	a. Enable read and copy access to files, documentation, and personnel including inventory control files, beneficiary eligibility files, preferred drug list , diagnosis files, provider master files, all pricing files, adjudicated claims file, all software and operating manuals, all documentation along with rules, regulations, memos, internal reports, training manuals, and detail design documentation	Y	
	b. Enable access to computer resources including, but not limited to, all application programs and libraries, all system programs and libraries, the operating system along with job accounting and software	Y	
	c. Notify audit staff within 24 hours of any changes made to computer programs and edit logic between processing runs related to audit activities	Y	
	d. Provide the ability to retrieve and print claims	Y	
	e. Provide the personnel and resources necessary for automated or manual sampling of claims and reference file data including the retrieval of historical data.	Y	

Template G

Functional Requirements Approach

Instructions for RFP Response

RFP # 03410-127-14

catamaran

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List of Tables

Table 1. Functional Requirement Assumptions 140

1.0 Functional Requirements Approach

The Vendor must provide a narrative overview of how the proposed solution that will meet the Pharmacy Benefit Management (PBM) requirements. The following questions pertaining to Functional Requirements are a required portion of the RFP response and will be evaluated by Vermont.

Instructions:

Use these response sections to provide specific details of the proposed approach to meeting the functional requirements in each process area. Responses should, when necessary, reference requirements using the appropriate RFP Requirement Numbers from Template F - RFP Functional Requirements.

Responses in this section must be highly focused on the Pharmacy Benefits Management (PBM)-specific business processes and requirements. Vermont also expects the Vendor to propose their approach for meeting the Functional Requirements included in Template F, and should be focused on PBM-specific processes and business needs. Additionally, the Vendor should indicate any dependencies on existing systems or processes to provide the specified functionality. Vermont is not soliciting generic or marketing descriptions of Vendor capabilities.

The primary objective of this procurement is to contract the services of a Vendor that will be responsible for all facets of the day-to-day operational administration of the Vermont's Pharmacy Benefit Management program including adjudicating pharmacy claims and providing an array of clinical, programmatic, financial, analytic, and benefit management services. The Vendor must be innovative and proactive in employing business techniques that ensure enhanced quality of care under the State pharmacy benefit while controlling the growth of pharmacy benefit expenditures. The Vendor shall research and recommend to the State sound clinical and fiscal policies that will ensure meeting and maintaining the primary objective.

The services and systems to be provided include, but are not limited to the following.

Claims Processing and Operational Support

- Point-of-Sale (POS) claims processing system
- Automated Coordination of Benefits (COB)
- Provider Network Support, Call Center, and Portal
- Post Payment Claims
- E-Prescribing and E-Prior Authorization Capabilities

Pharmacy Benefit Management and Clinical Programs

- Utilization Management Programs
- Prior Authorization Program
- Drug Utilization Review
- State Maximum Allowable Cost (SMAC) Program and the Federal Upper Limit (FUL)
- Specialty Pharmacy
- Benefit Design and Consultative Support
- Management of Physician-Administered Drugs
- Support of Drug Appeals Process

- Reporting and Analytics
- Quality Assurance

Financial Management

- Management of State and CMS Drug Rebate Programs
- Support of Multistate Supplemental Rebate Consortium
- 340B Program Management
- Financial Management
- Dual Eligible Demonstration

Additional Services

- Medication Therapy Management
- Single Payer

1.1 Claims Processing and Operational Support

The Vendor must ensure claims processing policies and procedures are in compliance with all applicable state and federal laws, regulations, rules, and policies. Claims adjudication is the responsibility of the Vendor. However, provider payments are made by the State's current MMIS Contractor. Under this scenario, the Vendor transmits the adjudicated claims electronically to the MMIS Contractor, and the MMIS Contractor performs all of the tasks associated with payments to providers and reporting to the State. In adjudicating claims the Contractor would perform a number of prescribed functions, including applying DUR edits, Prior Authorizations, and COB functions. Please elaborate on how you would support compliance and operations in each of the key areas below.

1.1.1 Point-of-Sale (POS) Claims Processing System

The State of Vermont is seeking a vendor who will operate a real-time (POS) online claims processing system with current NCPDP format and guidelines with an emphasis on drug utilization review (DUR), utilization management (UM), prior authorization, messaging, processing and reimbursement for clinical services (MTM, Immunization administration, and other), and 340B eligible drugs. The Vendor's POS claims processing system must be capable of adding, changing or removing adjudication rules, edits and customized transmission messages to accommodate Department-required changes for its current and future pharmacy programs. The POS claims processing system may include point-of-sale durable medical equipment claims processing, such as diabetic supplies. In addition, the system should be capable of processing both NDC and UPC codes. The system must be capable of displaying the formulary status of a drug. The Vendor must describe their approach to providing a Point-of-Sale system.

Response:

Catamaran was one of the first companies to introduce an industry-leading, rules-based claims processing system to the marketplace, known as RxClaim. As your current vendor, the State's POS Pharmacy claims are adjudicated by our proprietary system RxClaim. Our software system was developed, is maintained and enhanced exclusively by our organization. RxClaim supports virtually every type of pharmacy benefit program and pharmacy delivery mechanism available. Its flexibility, capabilities, and capacity are unlimited. Our POS system handles all

NCPDP standards including rules and edits associate with drug utilization review (DUR), utilization management (UM), prior authorization, and messaging, processing and reimbursement for clinical services such as MTM and Immunization administration. Additional information regarding utilization management, prior authorization and MTM are located in Section 1.2 Pharmacy Benefit Management Clinical Programs.

Our claims processing system is designed for online, real-time adjudication of prescription drug claims at the point of sale. Retail, mail, and specialty claims are adjudicated through the same fully integrated online system. With a track record that features greater than 99.98% availability and claim transaction times that average less than 60 seconds, RxClaim's reputation for reliability, accuracy, and performance is unmatched in the industry. RxClaim users conveniently access our system with an Internet browser connection and view available claim data in real time.

Flexibility in Customizing Adjudication Rules, Edits and POS Messaging

Beginning in 2006, Catamaran has worked in collaboration with the state to design a benefit structure that could best handle the unique requirements of the State's many programs. For example, we must take into consideration aid category codes, funding source, benefits split between more than one program, COB claims etc. With this procurement, we can offer the State the ability to access benefit plan and formulary information and other components of the claim adjudication instantly and easily. We will continue to work with the State to add, change or remove adjudication rules, edits and customize point of sale transmission messaging to accommodate the State's needs.

With 24/7/365 operational support, our staff constantly monitors the performance and availability of the system. Using sophisticated monitoring hardware and software, connections are automatically tested every five minutes to ensure that our systems are performing as expected for our clients and the pharmacies that rely on us to process their claims.

RxClaim processes virtually all types of claims and supports all forms of benefit programs including:

- Commercial benefit programs
- Government programs (including fee-for-service Medicaid)
- Managed Medicaid
- Medicare Part D
- Long-term care
- Hospice
- Workers' compensation

In addition, Catamaran's point-of-sale claims processing system utilizes the Medi-Span Master Drug Database (MDDB) for drug and product detail allowing us to process claims with NDC and/or UPC codes and industry standard pricing (i.e., AWP and HCFA) for all products. The Medi-Span data is updated daily and full-file refreshes are scheduled monthly.

NCPDP D.0 Compliance

In 2010, we completed the development and testing of RxClaim in support of the National Council for Prescription Drug Programs (NCPDP) version D.0 of the NCPDP Telecommunication Standard. The features in D.0 maintain advanced functionality in the pharmacy benefit management process to:

- Deliver complete information on claims for compound prescriptions
- Provide more information to support consumer directed health initiatives
- Ensure better handling of claims involved in coordination of benefits
- Promote the ability to handle claims for pharmaceutical services outside of the dispensing process.

These upgrades sustain the advancement of technology and programs that lead to better healthcare outcomes and better overall healthcare cost management.

To prepare for the successful transition to NCPDP version D.0, the onsite Catamaran team worked with the State's staff and the current MMIS vendor Hewlett Packard Enterprises (HPES) to map out and implement all necessary changes to the custom claims extract file. The Catamaran team also worked with the State's network pharmacies to ensure no disruption in service to members. We offered pre-implementation testing and post implementation outreach to pharmacies that were found to have system set-up issues.

System Flexibility

RxClaim works collaboratively with our flexible suite of pharmacy management products and services to provide clients complete control over their pharmacy programs. The system is rules-based and not hard-coded; therefore, it enables our clients to be as creative as they choose in developing unique programs and benefit designs. The features highlighted below guarantee that our clients have unsurpassed system functionality.

- **Coordination of Benefits (COB)** – As the current vendor, Catamaran offers the State COB adjudication and alternate pricing and beneficiary pay calculations through the plan set-up. We have developed custom solutions with unique rule sets for both the Medicaid program and the Part D wrap programs. When applicable, the beneficiary record ID is flagged to identify the beneficiary has alternate insurance. The other coverage code field on the submitted claim determines whether it is approved or denied for that beneficiary. In order to ensure the State maximally cost avoids, we have applied additional customized edits and rules around the use of other coverage codes.
- **Customized POS Messaging** - To maintain a constant flow of communication, Catamaran currently offers custom messages dynamically created and immediately made available to State network pharmacies. These messages can be prioritized and sent during the adjudication process for either paid or rejected claims. If more than one message occurs of equal priority, messages are processed in a first-in, first-out order. Messages are stored on the permanent claim record and are available for reporting and through the interactive user interface for help desk operations.
- **Drug Pricing** - Multiple sources of pricing (e. g., Medi-Span, First DataBank, and RedBook) are updated daily (if reported) and supported using the full 11-digit NDC submission.

- **Drug Classification** - Medi-Span's drug therapeutic classification system, characterized by the Generic Product Identifier (GPI), is primarily used to organize drug products for use in formularies, drug exclusion lists, drug special processing rules, and other benefits components. With direction from the State or as required to obtain the necessary formulary design, Catamaran has the ability use NDC lists.
- **DUR Rules** - Medi-Span's Drug Therapy Monitoring System is used as the drug-drug interaction (DDI) source and reporting. We have collaborated with the State to determine which combination of codes warrant the claim to reject, pay but return a warning message, or suppress the alert. We have the ability to alter the reporting status of any given DDI, regardless of the alert status. Using a combination of fields, we can provide the State the ability to define user overrides by drug pair, thereby tailoring the rejection and messaging of DDI.
- **eCOB** – Enhanced coordination of benefits (eCOB) works by populating third party plans in the beneficiary's profile before a claim is processed by the pharmacy. Third party plan information is gathered by working in cooperation with other vendors to securely share third party plans. The eCOB process reduces the number of claims that require "Pay and Chase" follow-up by providing accurate, real-time cost avoidance during point-of-sale claims adjudication.
- **Eligibility Tracking** - Member eligibility updates are tracked separately. A unique self-documenting and auditing feature enables users to view how each update was applied and the entire eligibility history. Roll-logic (e.g., the ability to accept new eligibility information and make intelligent decisions about how this new information impacts previously received eligibility information) and comprehensive audit trails are built into the eligibility management components of the application. This functionality makes it very clear as to what benefit was in effect and used during the actual adjudication process.
- **Management of Online Claims History** - RxClaim can retain all history data for any agreed-upon term. At this time, we store a 36-month history period for the State, which is available for online viewing and access; however, the system can store virtually any amount of client data. The RxClaim archival storage is a permanent record that can be accessed for historical query and audit purposes.
- **Medication Therapy Management** – Catamaran is proposing our MTM program to the State. Recipient medication therapy is reviewed for areas of drug therapy optimization, such as addressing gaps in therapy for those with certain chronic conditions not prescribed appropriate therapy, changing therapy for older adults on potentially inappropriate medications, addressing medication adherence, and working to reduce drug spend and pill burden for those with costly and complex drug regimens.
- **National Physician Identification (NPI)** – Our system fully supports the NPI to identify the provider (pharmacy) and prescriber on the submitted drug claim. The State currently requires their network pharmacies to submit a valid NPI on all claims. RxClaim also accepts alternate provider and prescriber identification codes including DEA numbers, state license numbers, client-assigned ID numbers, and any number of other enumerations, if desired by the State or required by State or Federal law. To identify pharmacy providers, we can support NCPDP ID (NABP), state license numbers, state Medicaid provider numbers, client-assigned provider IDs, and any number of additional enumerations.

- **Operational and Audit Trail Reports** - Detailed operational reports produce summary totals for prescribers that have been added or updated in the system. These reports show which network of prescribers have been affected by such maintenance activity.
- **OTC Drug Product Management** - OTC claims are processed in the same manner as other pharmacy claims and are subject to plan edits and benefit parameters. If a product changes from prescription to OTC status, our Clinical Pharmacist Manager works with the State and provides options for coverage. As a State cost savings initiative in 2011, Catamaran advised and implemented major changes to OTC coverage that ensure overall cost and quality objectives are met.
- **Overrides** - Robust prior authorization capabilities permit overrides for any edit available (e.g., early refill, vacation supply, etc.). We have created documentation for our call centers regarding the State's approved procedures for the immediate override for certain reasons. As part of our proposed solution, requests for prior authorization will be handled by Clinical Pharmacy Services (CPS), our clinical call center vendor.
- **Payment Options** - The system allows for an almost infinite combination of pharmacy payment options and scenarios that can be adopted to meet the State's specific needs.
- **Physician Identification** - Physician file updates are accepted and loaded from the NCPDP Provider Database (HCIdea) on a monthly basis. Client-specific prescriber files are also supported; new prescribers can be added directly into the system.
- **RxAuth® –** Currently used by CPS today, this is a flexible, efficient prior authorization (PA) management solution that leverages the powerful PA capabilities housed in RxClaim to automate the PA process from end to end. RxAuth supports the entire PA lifecycle, from receipt of the request, through rules adjudication, to execution of the resulting decision.
- **SilentAuth –**Catamaran is proposing our SilentAuth solution to allow real-time prior authorization (PA) decisions based on the pharmacy and medical history data associated with each member. By aggregating medical and pharmacy claims into a data warehouse, prior authorization criteria is evaluated at the point of sale, returning an instant decision and minimizing impact to the member and prescriber.

RxBuilder

Through the use of RxBuilder, which is a component of the RxClaim Suite of products, we can facilitate the display of the formulary status of a drug. Catamaran is proposing that the use of RxBuilder be expanded for the State. Specifically, RxBuilder is a Web-based interface for formulary creation and maintenance. Its rules-based approach minimizes the work of list building and maintenance operation and captures efficiencies in sharing formulary information between State programs.

We are confident that our robust claims processing system will satisfy the requirements of the State.

1.1.2 Automated Coordination of Benefits (COB)

The Vendor must validate claims to determine whether there is one or more liable third party that must be billed prior to billing the State's programs including, but not limited to, the following:

- Denying payment for claims when a beneficiary is covered by one or more carriers until the billing provider indicates the claim has been fully adjudicated (paid or denied) by the other payer(s);
- Utilizing the Department's TPL data, the Vendor's external TPL data, and eligibility records to ensure that all payment opportunities are exhausted;
- Processing claims where multiple third parties are liable, some of which may be other state programs;
- Overriding COB editing as specified by the Department;
- Maintaining indicators to identify Medicare Part B drugs and process the claim balance remaining after subtracting the Medicare Part B payment for beneficiaries dually enrolled in Medicare and any of the Department's programs;
- Coordinating benefits automatically with all primary payers including capturing and storing the primary payer's data; and
- Obtaining maximum cost avoidance and reimbursement for beneficiaries covered by third parties.

The Vendor must describe their approach to providing coordination of benefits.

Response:

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1.1.3 Network Support, Call Center, and Portal

The Vendor must be the first point of contact for providers with questions, concerns and complaints and must implement and maintain a provider contact and problem resolution tracking system. The system must, at a minimum, document and track contacts with providers, identify issues and describe problem resolution. The Vendor must review the data submitted by providers, obtain any corroborating information, and prepare an analysis of the issues. The analyses must be reviewed with Department staff at regularly scheduled meetings. The Vendor is responsible for provider communications and must maintain current contact information for the provider networks.

The Vendor must implement a pharmacy and prescriber provider portal and provide support, updates, and maintenance customized to meet the needs of the State. The vendor must guarantee any data exchange on its website between the Vendor and the State or providers will be secure.

The Vendor must describe their approach to providing a portal that supports effective communications with providers.

Response:

To address questions, concerns and complaints from pharmacies, Catamaran will continue to provide our Technical Call Center. Catamaran offers pharmacies access to a dedicated toll-free phone number. Our Catamaran Technical call center provides the State's network pharmacies access to customer services representatives (CSRs) who are available 24 hours a day, seven days a week, and 365 days a year. CSRs assist pharmacists and other key stakeholders with inquiries relating to retail claims, pharmacy services, and systems operation. Licensed pharmacists and prior authorization pharmacy associates in the Clinical Pharmacy Services (CPS) clinical call center will continue to provide clinical and prior authorization (PA) assistance to prescribers through their own toll free phone and fax numbers, also available 24/7/365. CPS

also provides an IVR telephone system that helps route calls that should be going to other call centers (Technical Call Center) to avoid the need of providers making multiple phone calls or being transferred.

Our Technical and Clinical Call Centers have a wide array of state-of-the-art resources available to them such as real-time access to the claim processing system encompassing benefit design, rules, exclusions, eligibility and claims history; comprehensive desktop formulary reference tools with quick search functionality; and Web-based real time access to all plan design parameters specific to each client and its group, including the State's preferred drug list and clinical criteria manual. The resources available combined with our quality of staff allows for provider and prescriber inquires to be resolved in a prompt and complete manner. Consistently, over 99.8% of inquiries are resolved during the first call.

Provider Contact and Problem Resolution Tracking

Our CSRs use a proprietary call tracking system to document each call. We use call tracking to assign user-defined types of incoming calls from pharmacies and other parties associated with RxClaim for tracking purposes. The Call Tracking option is a free-text area of a screen, which allows the CSR to document the call. This option requires that the CSR indicate the type of call, allowing management to determine the number of calls taken for a specific type of issue. The system includes a variety of call reason types and descriptions and can be modified as necessary to add, change or delete call reason codes.

Importantly, this system allows us to maintain a call tracking report. This report is used specifically to identify percent of calls resolved within 24 hours to 5 business days for first call resolution. The report also includes detail on the date/time of the contact, the source of the contact (call, email, fax), contact type (beneficiary, pharmacy, prescriber), contact name and phone number, category and reason for call, detailed description of the reason for the call and resolution of the call, and date/time the contact was closed or resolved.

While this system is used primarily by the technical call center to document pharmacy calls, the call tracking system is also currently used by the clinical call center and the on-site Catamaran account team working with the State to document and communicate additional information in RxClaim that may need to be available to the various teams (including State staff) to support the State's members and facilitate communication. These entries are not included in the call tracking reports as they don't necessarily originate from a call.

The Clinical call center primarily interacts with prescribers in response to PA requests. A description of the entire process and associated reports is available in section 1.2.2.

Catamaran's Account Management Team assigned to the State will review call tracking reports, analyze the data and share summary details regarding the resolution of questions, concerns, and/or complaints during business review meetings with the State. A discussion of Clinical call center and PA activity is generally presented at quarterly or bi-annual client reviews.

Catamaran will assume responsibility for provider communications (pharmacy and prescriber). We will use the RxProvider Portal, FaxBlasts and postal mailings, as appropriate, after the communication has been approved for distribution by the State. Catamaran would like to explore with the State whether other electronic formats of communication, such as email, might be appropriate for non-PHI containing communication. Based on the accuracy and

completeness of the information provided by the State for providers, we will maintain current contact information for providers and regularly update these systems.

Prescriber/Provider Portal

Catamaran is proposing to the State our Web-based provider interface, RxProvider Portal. This web portal will serve as a single on-line location for pharmacists and prescribers to access information about the State's pharmacy benefit program (similar to the function of DVHA's website today). Catamaran will be responsible for updating and maintaining all educational and informational materials that are displayed here including, but not limited to, technical and clinical call center contact information, the pharmacy provider manual, payer sheets, pricing dispute process explanation and form, copies of pharmacy communications and notices, the State maximum allowable cost (SMAC) list in a searchable and downloadable format, Drug Utilization Review Board activities (schedules, agendas and minutes), the Clinical Criteria Manual, the Preferred Drug List, prior authorization forms, BriovaRx specialty drug list and prescriber mailings or notices.

Web content can be targeted to various roles within a pharmacy or prescriber office. Navigation elements and page titles are customizable, and images, icons, colors, fonts and page sizing are easily adjustable as desired by the State. It can be fully customized to meet the needs of the State including the State's chosen brand. Content and layout will be adjusted to ensure effective communication with providers and ease of information retrieval.

RxProvider Portal will be utilized by prescribers and pharmacists to view the details, including the status and expiration date, of PA's that exist for a member using the PA History pages. The portal allows access to a member's past medication history as recorded in RxClaim for a determined amount of time and displays NCPDP reject messages and any local messages associated with a claim. The portal allows a prescriber or pharmacist the ability to perform a real-time adjudication process against the member's benefit plan to verify the drug requires PA and identifies available alternative drugs.

Additionally, to ease the administrative burden and paperwork typically associated with traditional prior authorization programs, Catamaran has included as part of this response, a proposal to expand the use of RxAuth by offering it directly to prescribers via the RxProvider Portal Web interface. This portal provides an online, real-time interface for prescribers to submit and manage prior authorizations requests. An immediate response will be provided to the requestor via the Web application. The RxProvider Portal will also accommodate the submission of forms to the Clinical Call Center for manual PA determination in the event that the prescriber chooses not to complete a real-time PA request.

The Web portal can also be utilized in our Medication Therapy Management program to deliver intervention opportunities on a daily basis to participating pharmacies. All the necessary intervention materials including discussion points to share with the member's prescriber, a 120-day prescription profile if utilization issues exist, and all CMS-required beneficiary-tailored materials are also delivered through the Web portal. Upon completion of each intervention opportunity, network pharmacists are able to conveniently submit for reimbursement for the MTM service via fax or the Web portal.

RxProvider Portal provides secure access. It uses the industry standard for encryption—128-bit SSL certificate protection—to keep member protected health information (PHI) secure. Several methods of access are available for the State's consideration that all use this security method.

Catamaran guarantees any data exchange via RxProvider Portal between Catamaran and the State or providers will be secure.

1.1.4 Post Payment Claims

As requested by the State, the Vendor must process post-payment claim reversals for pharmacy claims, such as Third-Party Liability (TPL) adjustments and other adjustments.

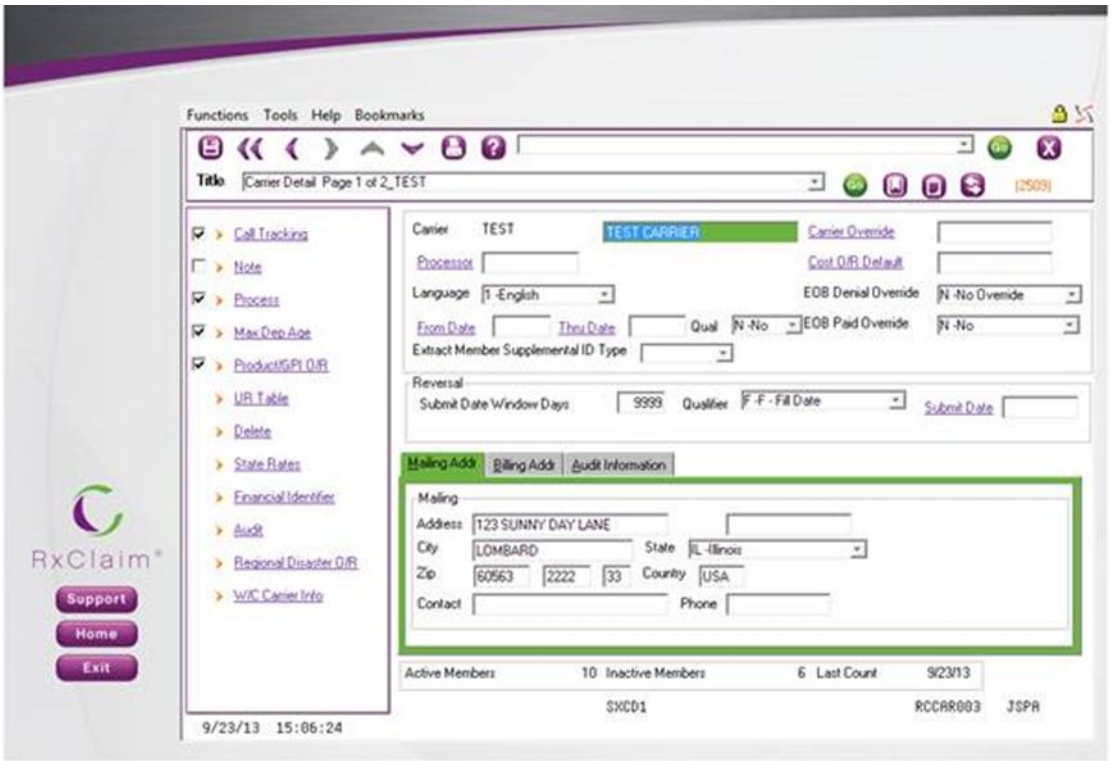
Response:

RxClaim processes claims adjustments and reversals received from the pharmacy via electronic POS submission or directly entered through the RxClaim interface by an authorized user. RxClaim also adjudicates the transaction, and makes the proper adjustments to any co-payment and/or deductible determination in Third-Party Liability cases. The TPL component within RxClaim maintains the ability to accommodate up to nine third-party payers in a single transaction. The same adjudication rules that applied to the original third party apply to each succeeding payer.

Reversals

RxClaim can accommodate the State's preferred payment policy regarding reversals. We will work with the Department to further define payment and reversal parameters and modify the system setup according to those parameters. For example, if the State prefers reversals for 90 days from the day of initial payment or fill, we can set that parameter within RxClaim. If the State later requires a change to these parameters, either Catamaran or an authorized State user with power user edit rights can easily make that change in the system.

As shown in the following RxClaim screen capture, the initial parameters for setting the allowance for timely filing of reversals can be set according to time frame, fill date, or claim paid date. Because the days and qualifiers can be changed on the fly, the State has far greater flexibility in implementing changes rapidly if needed due to a policy change, legislative mandate, or emergency.



Once the parameter is defined, all reversals are processed accordingly. In our experience, the majority of pharmacies use their POS software to submit reversals, whether needed due to keying error, a change in prescription, etc. However, if needed, authorized Department users or Catamaran employees at the Technical Call Center can submit claim or payment reversals directly into RxClaim. Additionally, the Department may wish to allow specific authorized users to perform this function to support desk or pharmacy audits. Alternatively, RxClaim can allow reversals for an infinite period but only allow new claims with a recent date range. Special unpublicized groups with relaxed timely filling requirements can be established to facilitate pharmacy reprocessing of claim identified in audit findings.

Void / Rebill

RxClaim is fully compliant with all NCPDP standard transaction sets, including a B3 (Rebill) transaction. RxClaim can process the void (reversal) and the rebill transaction within a single claim transaction. In addition, RxClaim allows for single claims adjustments and mass adjustments through the application.

RxClaim supports the capability for an authorized individual to reverse one or more claims (via selection criteria). This functionality runs in an edit-only (“trial”) or “production” mode to achieve the desired results. In addition, the system supports provider-neutral or history-only adjustments to apply financial and/or quantity adjustments to claims that will not result in an increase or decrease in payments to the provider.

1.1.5 E-Prescribing and E-Prior Authorization Capabilities

The State is interested in promoting the electronic exchange of information to support administrative simplification. Currently, pharmacy benefit eligibility verification, medication history and preferred drug list (PDL) information is made available to all Electronic Medical

Records (EMR) statewide. This is accomplished through the PBM's existing infrastructure and the network exchange services with AllScripts Healthcare Solutions, Inc. and SureScripts, LLC. The State wishes to continue its work on refinements to the PDL interface to assure accurate and meaningful displays of formulary and coverage limitations to prescribers at the time of prescribing. In addition, the State wishes to expand these capabilities by providing the means to perform electronic prior authorizations through the EMR.

The Vendor must describe their approach to work with the State to meet the goals of the program for electronic prescribing and electronic prior authorization and for providing prescribers and pharmacies information promoting both. More information can be found in the Single Formulary and Electronic Prior Authorization Recommendations (2012) document in the Provider Library.

Response:

Confidential, Proprietary, and Trade Secret Information of Catamaran.

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1.2 Pharmacy Benefit Management and Clinical Programs

Pharmacy Benefit Management services support the program in the following areas: drug benefit management services, drug utilization review, utilization management programs, and PDL management. All of these services must encompass drugs processed through both the pharmacy benefit and those physician-administered drugs processed through the medical benefit. In regards to the specific services identified below, the Vendor must describe their approach to providing these PBM services to the State.

1.2.1 Utilization Management Programs

Utilization Management programs include but are not limited to:

- Prior authorizations, quantity limits, and step therapy
- Development and dissemination of clinical criteria, procedures for its application, and proper documentation of all clinical decisions
- First reconsideration review of denials by a clinical pharmacist when requested and access to independent physician reviewers
- Proper notification of all denials and approvals to beneficiaries and prescribers within timelines established by applicable law and State policies

The Vendor must describe their approach to utilization management.

Response:

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1.2.2 Prior Authorization Program

An aggressive and effectively managed Prior Authorization (PA) program has been demonstrated to provide savings to the State's pharmacy program, while at the same time improving prescribing practices and overall quality of care. The State seeks modern state of the art prior authorization systems and capabilities. These services must encompass drugs processed through both the pharmacy benefit and those physician-administered drugs processed through the medical benefit. The PA program must be capable of utilizing medical codes such as CPT and ICD-10 codes to make PA determinations in an automated fashion through POS. In addition, the PA process must accommodate the electronic submission of forms (via provider portals) to the provider call center(s) for manual PA determinations. Both pharmacies and prescribers should have an electronic means to check on the status and expiration date of a PA through the provider portals. Additionally, the State is interested in detailed and ongoing analyses of program success focused on evaluation of drugs, criteria, return on investment, and recommendations for change. Lastly, the State is interested in implementing a PA process through the electronic medical records of provider practice management systems as soon as technology makes this feasible. The Vendor must describe their approach for conducting Prior Authorizations now and in the future.

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1.2.3 Drug Utilization Review

Drug Utilization Review (DUR) activities for the State include, but are not limited to: prospective and retrospective Drug Utilization Review including provider profiling, educational outreach, peer-to-peer education, and activities related to assuring best practice compliance assurance. The State has a focus on management of drugs of abuse and drugs used for substance abuse treatment, management of psychotherapeutic drugs in adults and children, treatment of chronic pain, ADHD, asthma and other costly and complex chronic conditions. Drug utilization review services must encompass drugs processed through both the pharmacy benefit and those physician-administered drugs processed through the medical benefit.

The Vendor must describe their proposed approach to providing Drug Utilization Review services.

Response:

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- **S = Soft Reject:** Claim is rejected but a pharmacy is allowed to override the ProDUR conflict by submitting the appropriate conflict/intervention/outcome codes. PAs can also be used to override these rejections.
- **M = Message:** Claim is payable and a conflict message is sent back to the pharmacy (e.g. warning).
- **E = Extract:** Claim is considered payable and a message is created but it is not sent back to the pharmacy. The message is viewable in Claims History and in the Claims Extract.

When deciding which clinical edits are needed, consideration is given to the order of the processing that is controlled through a priority order. This consideration places more critical edits higher in the priority sequence since current NCPDP standards allow the return of only nine ProDUR messages to a pharmacy. Messaging itself either employs the standard NCPDP text or is customized to meet the State's needs.

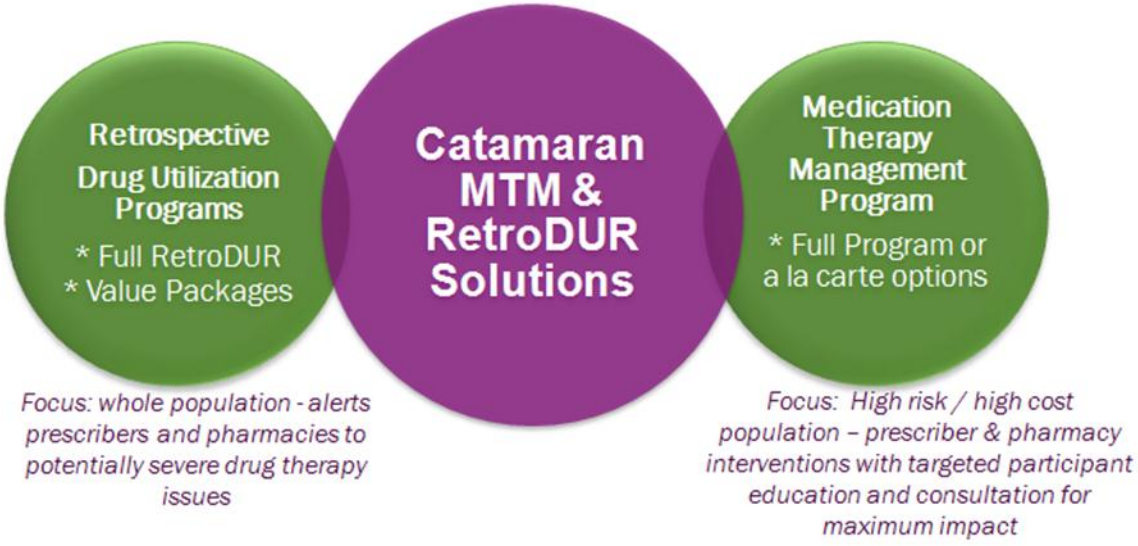
Retrospective Drug Utilization Review (RetroDUR) and Medication Therapy Monitoring (MTM)

Optimizing medication therapy can significantly improve beneficiary care and decrease overall healthcare costs. Clearly, the State recognizes this PBM services procurement as an opportunity to incorporate the next level of RetroDUR and MTM services into the PBM contract. Catamaran believes that our Retrospective DUR and Medication Therapy Management suite of programs accomplishes these goals through interventions designed to promote proper prescribing in accordance with evidence-based and national guidelines and beneficiary education about medication regimens.

In a continuum of care, these programs can help beneficiaries avoid inappropriate or potentially dangerous medications, increase medication adherence, and optimize medication therapy. By helping to reduce the risk of adverse drug events and elevate the quality of care for beneficiaries, Catamaran programs can help prevent costly disease progression and reduce total healthcare expenditures for the State and its beneficiaries.

We utilize innovative technology and customizable clinical rule sets to drive evidenced-based clinical solutions that are fully backed by guaranteed ROIs. The programs can offer varying areas of focus to target the State's priorities and can be tailored to opportunities existing in the population prior to deployment.

These programs are not suggested to replace current programming already in place through the Vermont Chronic Care Initiative, the Vermont Blueprint for Health, activities of the Substance Abuse Unit or the Program Integrity Unit. Rather, Catamaran envisions that these programs will complement and hopefully enhance what is already being accomplished.



Catamaran has purposefully designed these programs to offer varying areas of focus, forming a key strategic asset whose impact is shaped through consultation with your Clinical Pharmacist Manager to foster prevention and risk mitigation in the healthier population (RetroDUR) or target high-risk and high-cost populations (Medication Therapy Management or MTM), or both. Proposed RetroDUR programming will be discussed here while proposed MTM programming is discussed more fully in Template G Section 1.2.11.

Each program is backed by a ROI guarantee and will enable the State to target the areas of greatest concern.

Key Differentiators

The following are important characteristics of Catamaran's programming:

- **Sophisticated Rules Engine:** We utilize a sophisticated rules engine for disease identification and clinical issue identification. Currently, over 1,100 MTM and RetroDUR conflict rules can identify beneficiaries at risk for dangerous and costly drug related problems. Using the beneficiary's profile, demographics, and prescription and medical claims, the rules engine can generate conflicts or identified drug-related issues for possible intervention. The rules engine also can be used for automated outcomes 120 days after the intervention has taken place. Outcomes can be tracked across all of the interventions automatically, even when Catamaran is not directly intervening. Results are fed back into the clinical engine to update the targeting analytics.
- **Predictive Modeling and Risk Stratification:** Catamaran is cognizant of the fact that beneficiaries may have varying risks for drug therapy problems and that drug therapy problems themselves vary in severity. To address this, our RetroDUR and MTM programs all feature proprietary risk stratification utilizing our Clinical Intervention Probability (CIP) Score. This process assigns a risk score to each beneficiary based on the beneficiary's identified conflicts and beneficiary-specific factors (e.g., age, gender, presence of multiple disease states). Our clinical engine utilizes a statistical regression model to make it possible to give a computed priority to those beneficiaries with the greatest risk and those likely to require intervention by our pharmacists. The assigned

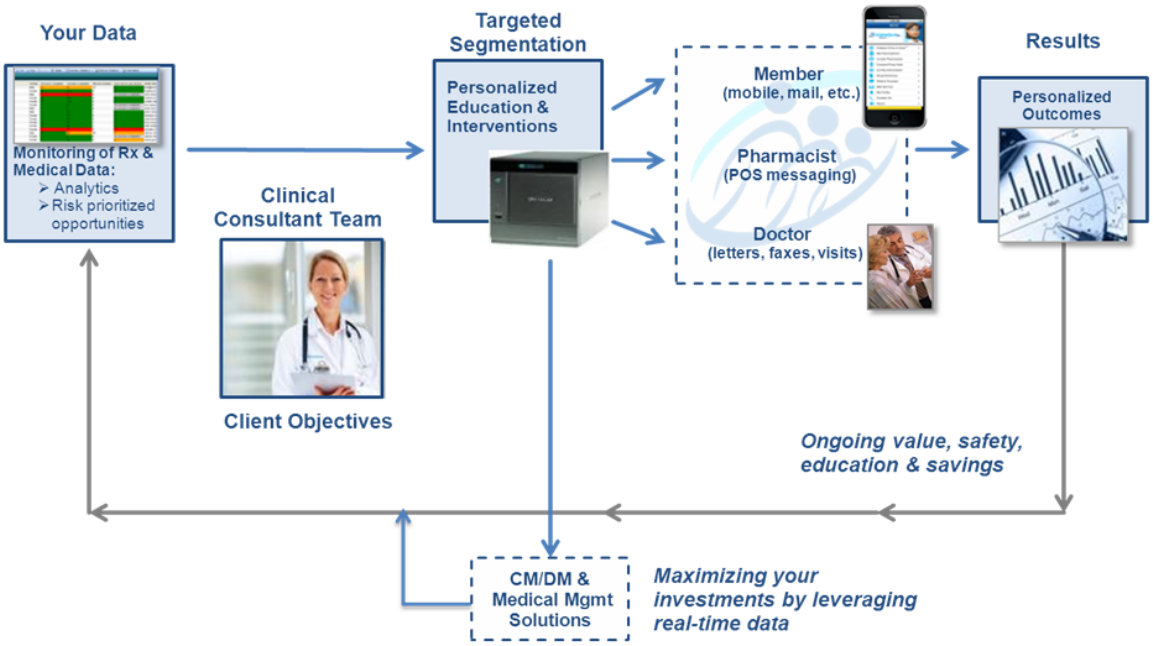
CIP score can then be measured against the pre-defined client-specific CIP score threshold to identify the beneficiary profiles which require review by a pharmacist. Further, the CIP score can assist our pharmacists with prioritizing interventions and determining the most appropriate intervention.

- **Incorporation of Medical (and other) Data for Stronger Targeting, Enhanced Clinical Opportunities, and Greater Savings Opportunities:** In addition to incorporating Physician Administered Drugs (PAD) into the pharmacy claims database, client supplied medical information can be standardized and stored in our central repository called the Medical Claims Analytical Database (MCAD). The MCAD process is an automated, systematic method of capturing, cleansing, standardizing, and storing medical claim information that can then be incorporated with pharmacy data to drive a comprehensive analytic and outcomes measurement approach. The advantages of the combined database include:
  - More robust beneficiary disease state identification capabilities not feasible through drug-inferred processes (e.g., hepatic disease, pancreatitis)
  - The ability to identify more clinical intervention opportunities (e.g., post myocardial infarction not on beta-blocker therapy)
  - Reduction of false positive based interventions to reduce prescriber complaints (e.g., prevent communication of need for osteoporosis testing if CPT code for bone density scan is present in beneficiary's medical claim record).

The graphic below depicts how our analytics are used to identify and prioritize clinical profiles for intervention at all major decision points (e.g., beneficiary, prescriber, and pharmacy). It also illustrates Catamaran's ability to partner with the State's Vermont Chronic Care Initiatives (VCCI) staff and Substance Abuse Unit staff to provide:

- Actionable data
- Reports
- Feeds
- Risk-ranked key opportunities

With this State staff can leverage the real-time nature of pharmacy data to enhance the services under their purview and create stronger integration throughout the healthcare delivery system.

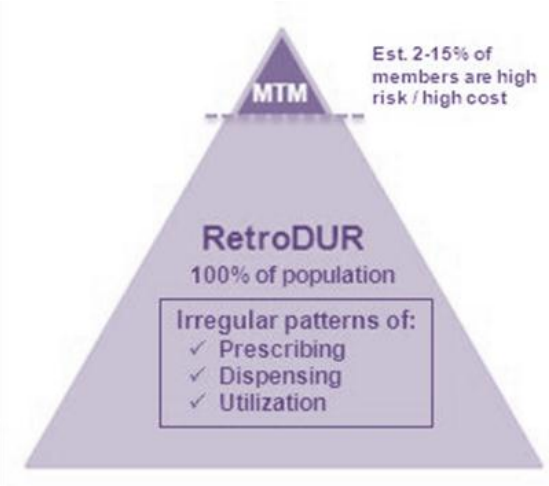


Catamaran recommends our programs as guaranteed effective solutions to provide disease support that drives measurable savings, closes gaps in care, and improves adherence to therapy.

Retroactive Drug Utilization Review (RetroDUR)

Catamaran's RetroDUR programming addresses the following elements for the State's covered lives so that typical beneficiaries do not become higher risk beneficiaries where more intensive and expensive intervention may then be needed:

- Under-utilization
- Over-utilization
- Gaps in therapy
- Inappropriate dosing
- Drug interactions
- Disease interactions
- Duplicate therapies
- High-risk medications in the elderly for the client's entire population



The highly flexible RetroDUR program that we are proposing will improve beneficiary well-being while helping save money on expensive and preventable healthcare costs. Unlike traditional drug utilization review programs (including

what Catamaran is currently providing to the State today) which may review beneficiary profiles on a monthly, quarterly or one-time basis, our proposed enhanced program reviews every prescription, every day, for potential drug-related problems. By more effectively managing drug therapies and intervening in a very timely manner, unnecessary and/or inappropriate healthcare utilization will be avoided, thereby driving healthcare costs down for the State. Additionally, by reviewing claims for all of the State's covered lives, our program is able to prevent beneficiaries from shifting from the lower-risk segment of a population to the high-risk segment.

Reports of RetroDUR interventions and associated outcomes are available for presentation and discussion with the State's Drug Utilization Review Board.

Our enhanced program will alert prescribers and pharmacies to potentially severe drug therapy issues that could result in adverse drug events, and also will alert them to beneficiaries who may experience a worsening medical condition due to the absence of critical medications that are recommended for certain disease states.

This RetroDUR Program that we are offering can review, analyze, and interpret processed claims for appropriate utilization and cost-effectiveness. The program will retrospectively review all beneficiaries' prescription claims 72 hours after they have been filled. Identified conflicts are analyzed 72 hours after the triggering prescription is filled because, on average, 40% of claims reversals occur within 72 hours of the prescription fill. This delay ensures that interventions are sound and accurate for the prescriber. All prescription and medical claims (if available) can be loaded. The program will review all claims for every beneficiary, regardless of the number of providers they see, prescriptions they fill, and disease states or conditions they may have.

Beneficiaries will be identified based on a proprietary beneficiary-risk-stratification scoring system. A program clinical pharmacist will review the profiles for beneficiaries for whom potentially severe conflicts are identified. Alerts will be communicated to the providers (prescriber and pharmacy) involved in the beneficiary's care via fax, phone, or mail.

Key program focus areas are listed below.

Drug-Drug Interactions	Targets beneficiaries who are receiving two or more drugs that, when taken together, can cause unpredictable or undesirable effects.
Drug-Disease Interactions	Targets beneficiaries who are receiving drugs that may worsen medical conditions.
Therapeutic Appropriateness	Targets beneficiaries who are not receiving certain drugs that are considered standard therapy for a medical condition, such as the use of an ACE inhibitor or ARB medication for beneficiaries with diabetes and hypertension. A majority of these interventions support Healthcare Effectiveness Data and Information Set (HEDIS) and National Committee for Quality Assurance (NCQA) guidelines.
Inappropriate Medications in the Elderly	Targets beneficiaries 65 years and older who are receiving potentially inappropriate medications based on the Beers Consensus Report and other medical literature.

High Dose or Sub-therapeutic Dose	Targets beneficiaries who are receiving drugs above or below recommended dosing guidelines.
Inappropriate Duration of Therapy	Targets beneficiaries who are receiving drugs for extended periods of time that may be inappropriate.
Overutilization	Targets beneficiaries who may be overusing habit-forming drugs, such as those used to treat pain, anxiety and attention deficit hyperactivity disorder.
Underutilization	Targets beneficiaries who may be non-adherent to their maintenance medications.
Therapeutic Duplication	Targets beneficiaries who are receiving two or more agents from the same therapeutic class of medications.

Catamaran can offer a comprehensive full RetroDUR program that includes **over 1,100 clinical rules**. We also can make available budget-friendly Value Packages with interventions only targeting key issue areas. One or more areas can be chosen. They include:

- Diabetes
- Abuse medications and narcotics
- Respiratory (e.g., asthma, COPD)
- Cardiovascular
- Adherence to medications
- HIV
- HEDIS measures

Prescriber Education and Intervention Program (PEIP)

Additionally, Catamaran would like to propose our prescriber detailing initiative, the Prescriber Education and Intervention Program. We consider this to be one of Catamaran's strongest and most differentiating programs. We all know that prescribers play a very important role in the management of pharmacy benefits as their decisions have a critical and direct impact on quality of care, as well as on pharmacy-related costs.

The PEIP is a formal physician profiling/prescriber intervention program which can work intensively on behalf of the State to promote responsible prescribing behavior among high-volume prescribers.

For the PEIP, we have strengthened the bonds between our detailing strategies and our MTM and RetroDUR programming. Our clinical engine is able to organize clinical and cost opportunity data by prescriber. With this additional data-driven identification methodology to aid our clinical consultants, we have increased the cohesive and complementary strategies between our clinical programs. Leveraging a common analytics engine and prioritized clinical opportunities increases coordinated effectiveness across all decision makers: beneficiary, prescriber, and pharmacy.

Our approach with prescriber detailing leverages our regional clinical teams and our deep knowledge of local service area dynamics. Our program is not affiliated with or funded by any pharma company. Working from a wholly independent and unbiased vantage point, we craft tailored prescriber campaigns oriented around the State's objectives that work as part of a larger plan strategy to address the prescriber arm of medication decision-making in conjunction with beneficiary and pharmacy strategies. This is complemented by specific beneficiary opportunities in the prescriber's population as well as prescriber "scorecard" information on key measures benchmarked against their peers. While we support broader objectives of improved generic prescribing and formulary compliance, our detailing is unique in that it is tailored to the State's objectives and opportunities identified in the State data and prioritized by the State with the assistance of the Catamaran Clinical Pharmacist Manager.

The PEIP focuses on educating prescribers with the goal of optimizing compliance with evidence-based guidelines, improving generic prescribing rates and maximizing formulary compliance. This unique program complements other beneficiary education and plan design initiatives aimed at addressing costs and quality of care issues. Due to the unbiased nature of the program, our experience is that prescribers tend to view our PEIP clinicians as a trusted clinical resource, providing relevant and actionable information. The program will achieve State cost savings by promoting clinically appropriate, cost-effective prescribing as defined by the State's PDL. Depending on the geographic concentration of the targeted beneficiary population, the program can be structured to primarily provide interventions via face-to-face personal visits and facsimile, or supplement or deliver only telephonic and mailed interventions.

Through this program, Catamaran clinicians will:

- Engage your top prescribers and provide them with key feedback on their prescribing patterns, including benchmarks against relevant peer groups
- Promote appropriate lower cost alternatives based on the State's PDL and trend drivers
- Review patient-specific opportunities for cost and care optimization
- Provide objective, current, and comparative drug information and clinical tools
- Distribute unbiased drug pipeline reports: including generics, new agents, specialty, and OTC
- Encourage prescribing patterns that reflect current national guidelines for clinical effectiveness and safety

Materials provided will be beneficiary-specific, actionable and chart-ready. They will include the identification of patients who have opportunities for therapeutic improvement due to gaps in care, non-adherence or safety issues, as well as suggestions for improving the cost-effectiveness of prescriptions.

Clinical interventions will focus on key disease states and opportunities including:

- Diabetes Management
- Asthma & Chronic Obstructive Pulmonary Disease (COPD)
- Osteoporosis
- Migraine Therapy

- Therapeutic Duplication
- Medication Adherence
- Overuse of Narcotics and Other Controlled Substances
- Appropriate use of Antibiotics

Building a Customized PEIP Strategy

We can work with the State to establish State-specific PEIP strategies. The following key factors are carefully evaluated and utilized to guide the process and provide the highest degree of success: identify State specific objectives, conduct regional prescribing analysis, identify what types of objective clinical materials and tools to inform prescribers about the State's PDL design are needed. Finally, an important aspect to carefully evaluate is the potential response of the intervention within the local prescriber community in light of the State's objectives.

In addition to considering the impact of local market dynamics, a review of the State's primary cost/trend drivers will be conducted. Further analysis will continue with an in-depth review of the prescribing patterns of the State's top prescribers. Catamaran's clinical staff will identify opportunities for care and-cost improvement in use of: 1) generic alternatives, 2) lower cost therapeutically equivalent brand pharmaceuticals, and/or 3) over-the-counter products. Additionally, we will develop specific prescriber (and beneficiary) education strategies drawing from our comprehensive library of material.

Ongoing Review and Outcomes of the PEIP

As a continuous part of the program, post-education and/or post-intervention prescribing patterns will be monitored to ensure continued improvement over time. Ongoing follow up interactions will be scheduled to align with behavior changes indicated by data analysis and with prescriber preferences to strengthen our prescriber relationships, always with the goal to become a valued and objective consultative clinical resource. A variety of educational materials will be provided in these interventions that can include preferred drug information, materials encouraging cost-effective and care-effective prescribing, drug pipeline information, and information to substantiate current strategies or clarify administrative procedures (e.g., formulary selection, generic advantages, step-edits, and prior-authorization requirements).

Outcomes analyses and reporting will be conducted by the clinical team based on the custom interventions employed for the State and will be provided on a quarterly basis. Metrics include intervention statistics as well as program success rates, including the percentage of successful interventions, direct prescription drug savings and literature-based medical cost avoidance savings.

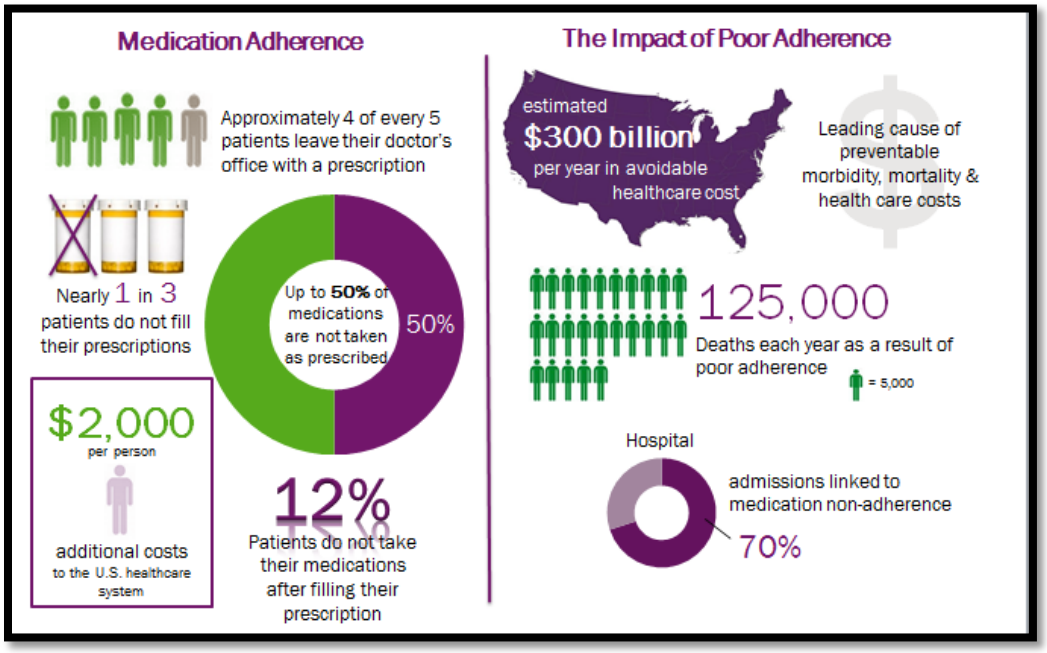
One of the distinguishing characteristics of the Catamaran program is the coordination between beneficiary and prescriber interventions—our prescriber education strategies and our RetroDUR and MTM programming work collaboratively. Our clinical engine is able to organize clinical and cost opportunity data by prescriber. With this additional data-driven identification methodology to aid our Clinical Consultants, we will be able to propel the value of our prescriber education programming to new heights and increase the cohesive and complementary strategies between our clinical programs, increasing their coordinated effectiveness across all arms of medication decision-making: beneficiary, prescriber, and pharmacy.

Promoting Medication Adherence – Catamaran's Adherence Program

Within Catamaran's RetroDUR programming, we also offer a program to focus specifically on driving improvements in adherence to medication therapy for key chronic conditions.

Poor medication adherence is a significant source of waste in our national healthcare costs. It is estimated that every 1% improvement in adherence would result in $2 billion in national healthcare savings. Catamaran offers a comprehensive approach to adherence management to assist the State in tackling the imposing problem and significant expense of non-adherence, addressing all of the following:

- Identification of beneficiaries who are at risk for non-adherence
- New to therapy educational campaign on first fill
- Adherence barrier assessment
- Prescriber engagement
- Medication and refill reminders
- Multi-channel options to engage beneficiaries
- Quarterly outcomes reporting



Catamaran is offering two flexible program options to the State:

- **The Member Outreach option** features multi-channel engagement and focuses on three key prevalent, costly, and preventable disease states: diabetes (oral DM meds), hypertension (ACEI/ARB), and cholesterol (statins) through direct beneficiary intervention.
- **The Member and Prescriber Outreach option** builds on the Member Outreach option by offering prescriber intervention and expanded focus on the following disease states:

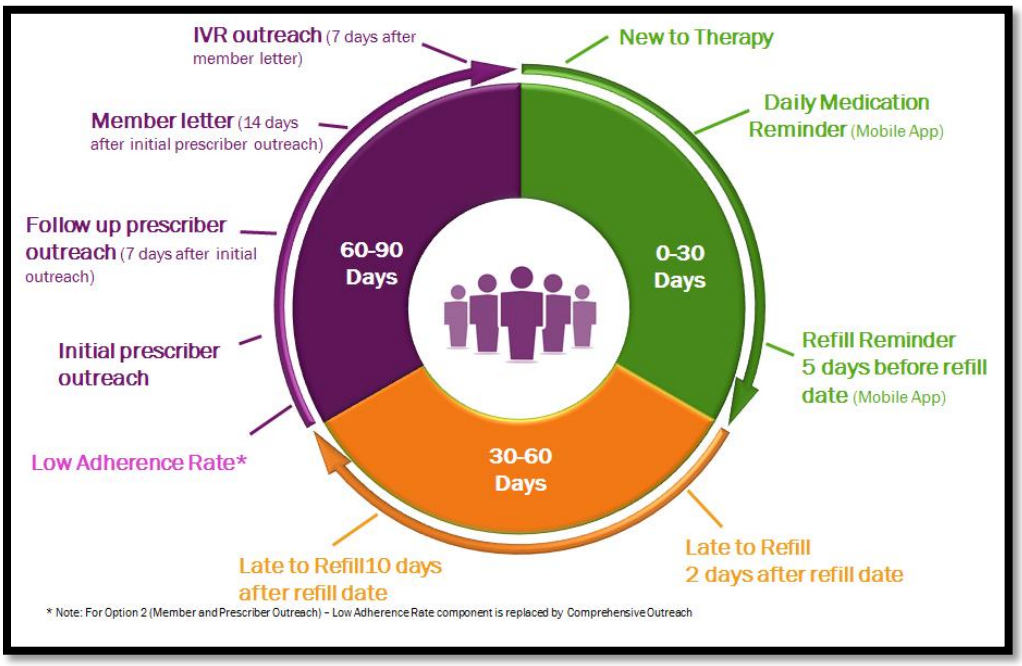
diabetes, hypertension, cholesterol, depression/mental health, respiratory, autoimmune, seizures, cardiovascular, osteoporosis, benign prostatic hyperplasia, transplant, Parkinson's disease, Alzheimer's disease, HIV/AIDs, and chemotherapy (select oral chemotherapy) medications.

The Catamaran Medication Adherence Program outreaches to the RIGHT beneficiaries (and prescribers) at the RIGHT time using the RIGHT approach. Our program success relies on identification of at risk beneficiaries and then offering multifaceted interventions:

- Members who are starting a new medication (educating beneficiaries on new therapies)
- Members who are late to refill (reminding beneficiaries to take and refill their medications)
- Members with overall low adherence rates (increasing beneficiary awareness and importance of remaining adherent and monitoring and supporting beneficiaries throughout the duration of their therapy).

The engagement approach provides a meaningful beneficiary experience:

- Interactive communications with beneficiaries to identify and address beneficiary-specific adherence barriers
- Multi-channel communications through interactive voice response (IVR), email, mail and one-on-one telephonic pharmacist consultation



Finally, recognizing the growth in the prevalence of cell service access, Catamaran has a mobile app that can provide complimentary services to the Medication Adherence program to provide further support to beneficiaries with smartphones that helps to maintain and promote positive adherence behavior. Information and instructions on mobile app downloads are provided to beneficiaries with every outreach when appropriate.

Key Differentiators

Although competitors may offer similar capabilities, we believe that Catamaran's Medication Adherence Program is more comprehensive and offers greater flexibility. Key points of differentiation include:

- Targeted focus on up to 15 disease states (depending on the program option)
- Member and prescriber outreach leveraging multiple channels of intervention
- Program options providing client choice and flexibility
- Follow-up and outreach across a 90-day period to help to keep beneficiaries compliant to their medication

Abuse Medications/Narcotics Program

Catamaran recognizes that the State has identified the healthcare crisis of opiate addiction and abuse as a very high priority issue as evidenced by Governor Peter Shumlin's most recent State of the State address and the Care Alliance for Opioid Addiction program (Hub and Spoke) that has been rolled out across the state. Catamaran has partnered with the State since 2007 to monitor utilization, manage beneficiaries and educate prescribers about the appropriate use of office based opiate treatment (OBOT).

We would like to propose as an additional component of the State's RetroDUR programming, Catamaran's comprehensive Abuse Medications/Narcotics Program. Certain medications such as pain medications, sleep aids, muscle relaxants, and behavioral medications, may be at risk for abuse, misuse or waste. Clinical management of these types of drugs can help correct:

- Unnecessary and potentially costly State drug spend
- Adverse events resulting in costly healthcare utilization
- Prescribing cascade patterns resulting from side effects experienced with these types of medications

Catamaran's program starts with proper identification of beneficiaries with patterns of potential abuse and/or misuse of certain medications, executes the right level of touch to alert providers involved with the beneficiary's care, and provides outcomes that demonstrate positive clinical and financial outcomes. The Abuse Medications/Narcotics program is a Retrospective DUR program – a Value Package of our larger RetroDUR program that is available for stand-alone purchase, with a guaranteed return on investment.

The Abuse Medications/Narcotics Program leverages all of our broader RetroDUR programming key features such as:

- Sophisticated Rules Engine
- Predictive Modeling/Risk Stratification
- Incorporation of Medical (and other) Data for Stronger Targeting, Enhanced Clinical Opportunities, and Greater Savings Opportunities
- Guaranteed performance

These unique capabilities make it possible for our proprietary, Web-based clinical application to provide a complete patient view of the patient's pharmacy and medical claims history.

Specifically, Catamaran's Abuse Medications/Narcotics program consists of the following program features:

- Daily analytics and risk identification
- Available dedicated clinical services staff trained to handle the sensitive topic of medication abuse/misuse
- Comprehensive clinical rules that target certain drug classes used to treat pain, sleep disorders, weight management, behavioral disorders and anxiety among others
- Multiple interventions to physicians and pharmacies to inform them of the issue and obtain feedback
    - Initial intervention
    - 2nd intervention to the provider(s) to be made within 5-7 business days after the initial outreach
- Quarterly activity metrics and outcomes reporting for the State
- Identification of top prescribers of potentially abused medications

The program executes the appropriate level of outreach to alert providers involved with the beneficiary's care and provides results that demonstrate positive clinical and financial outcomes.

For interventions, prescribers are sent a provider feedback form that outlines the clinical concern and intervention rationale, clinical guidelines (if applicable), and a patient 180 day prescription history. With actionable information, the physician can then make fully-informed decisions that are in the best interest of the beneficiary.

Documented Outcomes

Case Example: Catamaran client with approximately 37,000 members

- One year program activity
- Successful changes in therapy were made for 33.7% of all interventions made through the program
- First year ROI achieved = 9.1:1

1.2.4 State Maximum Allowable Cost (SMAC) Program and the Federal Upper Limit (FUL)

The Affordable Care Act modified the previous statutory provisions that required the Secretary to establish a Federal Upper Limit (FUL) for multiple source drugs. Effective October 1, 2010, the Social Security Act was revised to require that the Secretary calculate a FUL as no less than 175 percent of the weighted average (determined on the basis of utilization) of the most recently reported monthly average manufacturer prices (AMP) for pharmaceutically and therapeutically equivalent multiple source drug products that are available for purchase by retail community pharmacies on a nationwide basis. The Final Rule and revised FUL prices will most likely not be available until January, 2014.

The State Maximum Allowable Cost (SMAC) resembles the federal upper limit (FUL) methodology in that it establishes maximum reimbursement amounts for equivalent groups of multiple source drugs. While basing reimbursement payments off the FUL can save states money, they can potentially achieve additional savings by implementing a SMAC program. For example, States can include more drugs in these programs than are covered under the FUL program and reimbursement rates for drugs under a SMAC can potentially be lower than the established FUL rates.

Currently, the pharmacy reimbursement for drugs is the lower of the following calculations:

- Average Wholesale Price (AWP) less 14.2% plus a dispensing fee,
- The Federal Upper Limit (FUL) plus a dispensing fee,
- The State Maximum Allowable Cost plus a dispensing fee
- The pharmacy's usual and customary charges

The Vendor must describe their approach to implementing the new FUL rates to be published in 2014, the Vendor's approach to setting MAC rates on drugs, and the Vendor's approach to the administration and maintenance of the State's Maximum Allowable Cost program. The Vendor's MAC must be available and transparent to the State.

Response:

Implementing New FUL Rates

Catamaran will be able to accommodate the implementation of new FUL prices. We are anticipating a July 2014 release of the final FUL files. Catamaran is currently preparing an analysis for the State to compare the impact of the two FUL methodologies; monthly AMP-based FUL prices and the three-month rolling average FULs. The State will be able to use the FUL method they choose to develop a pharmacy reimbursement methodology that will allow their pharmacy payments to remain within the FUL in the aggregate. CMS is in the process of determining whether State Plan Amendments (SPAs) will be required. These FUL prices will be fed to us periodically from an outside source. To incorporate new FUL prices in the State's pricing structure, Catamaran's Benefit Administration Team simply sets up FUL as part of the lower-of pricing logic, as is already in place today. Any CMS updates to FUL will automatically feed into the product pricing logic.

Catamaran also recognizes that the State may wish to incorporate the National Average Drug Acquisition Cost (NADAC) as part of their reimbursement methodology. This would require the State to submit and get approval of a SPA. We assume that NADAC pricing will be available either directly from CMS or from a third-party vendor such as Medi-Span, and as such, will be loaded into RxClaim as other pricing types currently are today. Included will be brand and generic NDCs of both prescription and OTC products. CMS has determined that there will not be a NADAC price supplied for every product so some version of "lower of" methodology will need to continue to remain in place if the State moves to incorporate NADAC pricing.

As the current vendor, Catamaran will work with the State to understand and analyze the anticipated May 2014 release of the final outpatient prescription drug rule, including the need for evaluation of dispensing fees.

State Maximum Allowable Cost Program

Catamaran has significant experience managing maximum allowable cost (MAC) programs for several state Medicaid agencies. These SMAC programs have demonstrated the ability to contribute to pharmacy program savings by ensuring the SMAC price encourages pharmacies to dispense generic rather than brand name products, and most importantly, by directly limiting the upper reimbursement allowed for the generic products listed. It is important to utilize a SMAC list that is sufficient in both its breadth (the number of drug entities represented on the SMAC list) and depth (the number of different strengths, dosage forms and package sizes).

The Catamaran MAC unit pricing methodologies vary based on the marketplace characteristics of a particular drug. In general, we consider the number of product lines available and the range of acquisition prices for those products. Through a series of algorithms we arrive at a MAC price for a drug product. Once loaded into RxClaim, the pricing algorithms for various products consider the MAC price for the drug in effect on the date of service that the claim adjudicates for payment.

Today, the State utilizes Catamaran's standard MAC list. Our MAC team, in consultation with the Clinical Pharmacist Manager, is available to assist in the construction of a customized Vermont MAC List. Beginning with a full analysis of Vermont generic drug utilization over the past twelve months, the team will complete a gap analysis and take into consideration the State's Preferred Drug List (PDL) and the impact of the Medicaid Drug Rebate Program on net cost to the State. Our team will then provide recommendations for additions to the base Catamaran MAC list to best serve the State. Catamaran is proposing the State utilize a custom SMAC list and is prepared to support this objective.

The process for implementation of a new SMAC list begins with State approval of the drugs/devices to be included in the final customized list. The SMAC list is loaded into RxClaim and provided in electronic format for upload to Vermont's website or other Web portal. Information regarding the SMAC list, rules for adjudication, update information and the dispute process is included in our provider education materials and via the Web portal. The SMAC list posted to the Web portal will be in a searchable and downloadable format.

What qualifies a drug for SMAC consideration?

A drug is considered for inclusion in the SMAC list when a combination of the following conditions is met:

- The drug must be a multi-source product (available from more than one source) per the Medi-Span multi-source drug indicator (an industry standard metric that indicates that a drug is available from more than one source/manufacturer) and the drug has a generic equivalent. Drugs that are widely available in the market as only generic formulations from multiple manufacturers without shortages are eligible for inclusion.
- SMAC pricing will continue to be proposed for OTC products.
- Catamaran also considers the availability and the number of A-rated generic equivalent products using the Medi-Span Orange Book Code. This criterion is designed to discourage inappropriate generic substitution for brand products with low therapeutic indices.
- Additionally, Catamaran determines the spread between the unit prices for the brand and the generic products – a significant difference must be present for the product to

qualify for inclusion on the SMAC list. Price spread is considered to ensure that the SMAC is meaningful.

- Finally, the utilization of generic products in the Vermont population is considered – if a highly utilized generic drug is not present on the SMAC list per the previously defined and systematically discovered criteria, the MAC team will manually review the characteristics of that drug and make a decision regarding it's eligibility for inclusion on the list.

Catamaran employs sufficient methodology to ensure that the reimbursement pharmacies receive will allow them to procure the products and achieve a reasonable return within the SMAC pricing schema. This approach gives Catamaran credibility and the ability to defend disputes.

Catamaran provides customization of generic and brand designations through RxClaim's product level override functionality. This functionality enables the State to override the designation of a drug as brand or generic and allows application of SMAC pricing and other applicable pricing rules when needed.

Frequency of Updates

In order to operate at maximum efficacy, SMAC lists will be updated on a weekly basis. This ensures the most correct pricing at any given moment and secures provider cooperation and satisfaction. Pricing data received from Medi-Span is updated daily, while additional acquisition pricing is updated quarterly at a minimum. Once per quarter, SMAC pricing files are completely refreshed utilizing the pricing methodology algorithms described below. The State is notified at least ten business days prior to placing a SMAC rate on a product, when a SMAC has never been previously placed on that product. A new Vermont Medicaid SMAC file is created from this update routine. The new file is loaded to the RxClaim Vermont Medicaid SMAC file as a "change" file – meaning that records are not deleted and replaced. Changes to prices are accommodated using an end date for the prior record and a new pricing segment/begin date for the new price record.

Catamaran realizes that generic market conditions are dynamic (e.g., drug shortages causing inflation of acquisition prices for drugs) and has a number of processes to capture price change information and the capability to update SMAC pricing within one business day. Unfortunately, we have recently seen generic manufacturers leave the marketplace for certain generic drugs or shortages of either raw material or finished generic drug product develop. This drives up pharmacy acquisition cost and requires that the SMAC price be increased to continue to fairly reimburse pharmacies.

Catamaran appreciates the potential cost savings available from new generic launches. Our MAC team carefully monitors the generic approval and 180-day exclusive expirations pipelines to identify new opportunities. Once we have identified opportunities, we gather pricing and availability information and we will prepare comparisons to brand net cost after rebates to ensure that we provide best value reimbursement at the earliest occasion.

Additionally, Catamaran regularly reviews market place pricing dynamics for generic products. When opportunities for price reductions are identified, the MAC team will make recommendations for pricing updates.

Ongoing Quality Assurance of SMAC Prices

Catamaran understands the necessity of ongoing QA initiatives, especially as they pertain to issues that affect payment to providers. We know that accurate payment to pharmacies is of upmost importance. Internal procedures and quality assurance processes followed at Catamaran prior to implementation and utilization of a SMAC list ensure that files are loaded accurately into RxClaim. This includes regular updates, manual file review by clinical and analytics personnel and promotion to production.

From time to time, it will be possible that the provider community will be in disagreement with posted SMAC pricing. In the event a claim is paid at a price below which the pharmacy can purchase the item, the pharmacy will use the Catamaran SMAC Appeals Process, as is in place today. The pharmacy completes the Provider Pricing Appeal Form available through the Web portal. The Vermont based Catamaran team will ensure that the pricing issue is actually related to SMAC pricing and is not related to FUL or incorrect submission of a pharmacy usual and customary charge for example. Once it is established that it is SMAC pricing that is in dispute, the Catamaran MAC team will evaluate the claim based on the drug/strength/dosage form of the dispensed drug. A full review of the SMAC price is then conducted. The SMAC price on the appealed drug will be updated if it is determined that a price adjustment is warranted to an amount that is fair and reasonable based on the pharmacy's acquisition cost. If comparable products that are less costly are available to the pharmacy for procurement, the SMAC will not be adjusted. A final decision on the SMAC is made and the provider is contacted with an explanation of findings.

Pricing Methodology

While the formulas employed by Catamaran to set SMAC pricing are proprietary, Catamaran can provide the logic and processes employed to calculate the prices. In general, the following methodologies/logical steps are applied.

- First, the final selection of drug products is made. Acquisition prices are obtained from wholesalers, retailers, and the Medi-Span drug file. These prices flow into Catamaran and are identified with a date received and a source code. Quarterly, the most recent prices obtained for each drug are extracted and organized by generic drug name/strength/dosage form (for all NDCs available, excluding unit dose). Unit dose products are excluded as they generally are not dispensed in a retail pharmacy setting and are more expensive per unit due to their specialized packaging.
- Second, average wholesale prices and average sell prices are examined for each of the drugs in question, when dispensed for a 30-day supply at the recommended dose. Through a series of proprietary algorithms, the SMAC price for each generic drug/strength/dosage form (using GPI) is determined. The SMAC price is then applied across all package sizes available, but is structured to ensure that the profit to the pharmacist to dispense the generic product is higher than that associated with dispensing the brand product. This strategy provides pharmacists with an incentive to dispense generic products as well as to make recommendations to prescribers that they substitute brand products with generic therapy alternatives. When required, SMAC pricing is applied at the NDC level to allow for different pricing for different package sizes.

1.2.5 Specialty Pharmacy

Specialty pharmaceuticals are identified as one of the fastest growing segments of the State's pharmacy program. Industry projections indicate that this segment will continue to grow at a rapid rate. The State currently utilizes specialty pharmacy services for certain specialized drug therapies such as drugs used to treat multiple sclerosis, growth hormone deficiencies, cystic fibrosis, hepatitis C, and other complex medical conditions. Dispensing of specialty medications is limited to the specialty pharmacy for Medicaid beneficiaries when Medicaid is the primary insurer. The State expects that the selected PBM will provide a specialty pharmacy option and expand the program's specialty pharmacy services to support beneficiaries in better managing complex health conditions while managing specialty drug costs.

The Vendor must describe their approach to specialty pharmacy services such as developing, implementing, maintaining and enhancing innovative clinical and cost reduction efforts that ensures the appropriate use of specialty products and the management of complex medical conditions.

Response:

Confidential, Proprietary, and Trade Secret Information of Catamaran.

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1.2.6 Benefit Design and Consultative Support

The Vendor must describe their approach to providing benefit design and support, in particular the ease of implementing and making ongoing programmatic changes to the benefit program. The State is interested in understanding the Vendor's:

- Ability to implement, operationalize and manage the Department's complex benefit designs with multiple funding sources and various eligibility requirements
- Flexibility in pharmacy reimbursement structures such as Average Acquisition Cost (AAC), National Drug Acquisition Cost (NADAC),Wholesale Acquisition Cost (WAC), and 340B pricing designs
- Ability to modify benefit plans in a timely and cost-effective manner for the Department
- Ability for the Department staff to make changes to the benefit design and operational features, such as POS messaging

The Vendor should describe their ongoing approach to enhancing operational, program, and clinical value. It should include the approach to identifying recommendations for program improvements, cost reduction/avoidance strategies, and operational efficiencies. Explain how these will be developed, how the Vendor will work with the State to obtain necessary approvals and buy-in, to implement changes, and measure and report on benefits realization on an ongoing basis.

Response:

Catamaran's robust and flexible on-line transaction processing RxClaim Suite, features support for an unlimited number of variations in plan designs, plan rules and claim requirements, pricing algorithms, cost-share algorithms, and a host of other pharmacy benefits plan management functions. A flexible, table-driven benefit design drives all the processing performed by the system. RxClaim gives the State virtually unlimited flexibility in designing and administering their pharmacy benefit designs and protocols. Our POS system handles all NCPDP standards

including rules and edits associate with drug utilization review (DUR), utilization management (UM), prior authorization, messaging, processing and reimbursement for clinical services such as medication therapy management (MTM) and immunization administration. A flexible, table-driven benefit design, based on the State's defined business processes, rules and data, drives all the processing performed by the system for the State today.

Benefit Design Execution

Catamaran only uses benefit rules and makes benefit changes as directed by the State. The system allows authorized users to define all the processing rules in a benefit plan that apply to eligibility, program benefit determination, benefit limitations, provider and prescriber rules/restrictions, prior authorization requirements, pricing calculations, cost sharing calculations and all other aspects of the benefit that can be defined for the claim. The system allows for the addition, change, or removal of any rule simply by going into the plan configuration tool and identifying the component of the benefit to be changed and making the change to the desired value, rule, or restriction.

Beginning in 2006, Catamaran has worked in collaboration with the state to design a benefit structure that could best handle the unique requirements of the State's many programs. For example, we must take into consideration aid category codes, funding source, benefits split between more than one program, COB claims etc.

RxClaim works collaboratively with our flexible suite of pharmacy management products and services to provide clients complete control over their pharmacy programs. The system is rules-based and not hard-coded; therefore, it enables our clients to be as creative as they choose in developing unique programs and benefit designs. The features highlighted below guarantee that our clients have unsurpassed system functionality.

- **Coordination of Benefits (COB)** – As the current vendor, Catamaran offers the State COB adjudication and alternate pricing and beneficiary pay calculations through the plan set-up. We have developed custom solutions with unique rule sets for both the Medicaid program and the Part D wrap programs. When applicable, the beneficiary record ID is flagged to identify the beneficiary has alternate insurance. The other coverage code field on the submitted claim determines whether it is approved or denied for that beneficiary. To ensure the State maximally cost avoids, we have applied additional customized edits and rules around the use of other coverage codes.
- **Customized POS Messaging** - To maintain a constant flow of communication, Catamaran currently offers custom messages dynamically created and immediately made available to State network pharmacies. These messages can be prioritized and sent during the adjudication process for either paid or rejected claims. If more than one message occurs of equal priority, messages are processed in a first-in, first-out order. Messages are stored on the permanent claim record and are available for reporting and through the interactive user interface for help desk operations.
- **Drug Pricing** - Multiple sources of pricing (e. g., Medi-Span, First DataBank, and RedBook) are updated daily (if reported) and supported using the full 11-digit NDC submission.
- **Drug Classification** - Medi-Span's drug therapeutic classification system, characterized by the Generic Product Identifier (GPI), is primarily used to organize drug products for use in formularies, drug exclusion lists, drug special processing rules, and other benefits

components. With direction from the State or as required to obtain the necessary formulary design, Catamaran has the ability use NDC lists.

- **DUR Rules** - Medi-Span's Drug Therapy Monitoring System is used as the drug-drug interaction (DDI) source and reporting. We have collaborated with the State to determine which combination of codes warrant the claim to reject, pay but return a warning message, or suppress the alert. We have the ability to alter the reporting status of any given DDI, regardless of the alert status. Using a combination of fields, we can provide the State the ability to define user overrides by drug pair, thereby tailoring the rejection and messaging of DDI.
- **eCOB** – Enhanced coordination of benefits (eCOB) works by populating third party plans in the recipient's profile before a claim is processed by the pharmacy. Third party plan information is gathered by working in cooperation with other vendors to securely share third party plans. The eCOB process reduces the number of claims that require "Pay and Chase" follow-up by providing accurate, real-time cost avoidance during point-of-sale claims adjudication.
- **Eligibility Tracking** - Member eligibility updates are tracked separately. A unique self-documenting and auditing feature enables users to view how each update was applied and the entire eligibility history. Roll-logic (e.g., the ability to accept new eligibility information and make intelligent decisions about how this new information impacts previously received eligibility information) and comprehensive audit trails are built into the eligibility management components of the application. This functionality makes it very clear as to what benefit was in effect and used during the actual adjudication process.
- **Management of Online Claims History** - RxClaim can retain all history data for any agreed-upon term. At this time, we store a 36 month history period for the State which is available for online viewing and access; however, the system can store virtually any amount of client data. The RxClaim archival storage is a permanent record that can be accessed for historical query and audit purposes.
- **Medication Therapy Management** – Catamaran is proposing our MTM program to the State. Recipient medication therapy is reviewed for areas of drug therapy optimization, such as addressing gaps in therapy for those with certain chronic conditions not prescribed appropriate therapy, changing therapy for older adults on potentially inappropriate medications, addressing medication adherence, and working to reduce drug spend and pill burden for those with costly and complex drug regimens.
- **National Physician Identification (NPI)** – Our system fully supports the NPI to identify the provider (pharmacy) and prescriber on the submitted drug claim. The State currently requires their network pharmacies to submit a valid NPI on all claims. RxClaim also accepts alternate provider and prescriber identification codes including DEA numbers, state license numbers, client-assigned ID numbers, and any number of other enumerations, if desired by the State or required by State or Federal law. To identify pharmacy providers, we can support NCPDP ID (NABP), state license numbers, state Medicaid provider numbers, client-assigned provider IDs, and any number of additional enumerations.
- **Operational and Audit Trail Reports** - Detailed operational reports produce summary totals for prescribers that have been added or updated in the system. These reports show which network of prescribers have been affected by such maintenance activity.

- **OTC Drug Product Management** - OTC claims are processed in the same manner as other pharmacy claims and are subject to plan edits and benefit parameters. If a product changes from prescription to OTC status, our Clinical Pharmacist Manager works with the State and provides options for coverage. As a State cost savings initiative in 2011, Catamaran advised and implemented major changes to OTC coverage that ensure overall cost and quality objectives are met.
- **Overrides** - Robust prior authorization capabilities permit overrides for any edit available (e.g., early refill, vacation supply, etc.). We have created documentation for our call centers regarding the State's approved procedures for the immediate override for certain reasons. As part of our proposed solution, requests for prior authorization will be handled by Clinical Pharmacy Services (CPS), our clinical call center vendor.
- **Physician Identification** - Physician file updates are accepted and loaded from the NCPDP Provider Database (HCIdea) on a monthly basis. Client-specific prescriber files are also supported.
- **RxAuth® –** Currently used by CPS today, this is a flexible, efficient prior authorization (PA) management solution that leverages the powerful PA capabilities housed in RxClaim to automate the PA process from end to end. RxAuth supports the entire PA lifecycle, from receipt of the request, through rules adjudication, to execution of the resulting decision.
- **SilentAuth –**Catamaran is proposing our SilentAuth solution to allow real-time prior authorization (PA) decisions based on the pharmacy and medical history data associated with each member. By aggregating medical and pharmacy claims into a data warehouse, prior authorization criteria is evaluated at the point of sale, returning an instant decision and minimizing impact to the member and prescriber.

Pharmacy Reimbursement Flexibility

Catamaran's point-of-sale claims processing system utilizes the Medi-Span Master Drug Database (MDDB) for drug and product detail. It allows us to process claims with NDC and/or UPC codes and industry standard pricing (i.e., AWP and HCFA) for all products. The Medi-Span data is updated daily and full-file refreshes scheduled monthly.

However, with our flexible, table-driven claims processing design, we can accommodate almost any pricing option. They include rates published by an established source like Medi-Span or First Data Bank (including but not limited to Wholesale Acquisition Cost (WAC) and Average Wholesale Price (AWP)), and Federal Upper Limit (FUL) to be provided by CMS or the Average Acquisition Cost (AAC) as reported by CMS's contractor Myers & Stauffer, LC, or the resulting National Average Drug Acquisition Cost (NADAC). The pricing can use a "lower-of" logic or could be based on a calculation against these or other prices.

In the case of 340B pricing, we will not rely on RxClaim to support pricing for the State. We will look to our subcontractor, CaptureRx to reduce drug cost on shared beneficiaries. CaptureRx is a 340B claims clearinghouse that normalizes all 340B data and facilitates retrospective adjudication in order to eliminate the risk of duplicate discounting as well as maximize appropriate savings within a gain share model.

Benefit Design Modification

All plan design parameters can be changed in real time, for immediate impact if need be; or, changes can be scheduled to become effective on a future date, to provide the State's benefit administration team greater latitude in timing and implementing proposed changes. The system offers extensive custom messaging services to assist with communications to pharmacy providers for their use and/or for beneficiaries. The system also features extensive decision tracking and audit capabilities that support rapid and effective help desk, benefit administration, and data analysis operations.

System Change Execution

RxClaim establishes a logical for authorized State user(s) access. A logical is an index created based on client criteria that limits the view of specific data. It is within this logical where access to specific lines of business and authority levels can be granted. The specifications for user access will be part of the implementation process, where the mapping for each user and authority levels will be communicated and requests outlined. However, it is Catamaran's belief that client users should not be authorized to make system changes.

Catamaran will support the State in making any requested changes that affect claims processing from benefit design, through processing rules, to POS messaging at the time of claims adjudication. We believe this is an area that must have checks and balances to assure appropriate management so as not to risk disruption to provider operations or to benefit delivery. Thus, we propose that our Account Manager will work with the State to further enhance or define procedures that would create an audit trail from the time the State requests a change, through a process between the State and the Account Team where all rules are clearly defined; through the approval of the change and rules by a designated State personnel, until a Catamaran user enters it into RxClaim.

Once the change is entered into RxClaim, we will perform comprehensive testing and Quality Assurance as we would on any proposed coding change. The testing process is designed to prevent coding errors and claim issues from occurring. In this proposal, Catamaran commits to testing in a newly created test environment. This test environment will be unique to the State's plan setup and will allow for thorough testing of any changes in benefit plan design or program features prior to any effective date.

Consultative Support

Applied Business Analytics Process

Business intelligence support is coordinated by the Clinical Pharmacist Manager who is charged with having a deep understanding of the State's pharmacy benefit, an ability to present comprehensive rationale and guide the State to well-reasoned decision-making about the benefit plans and the well-being of their members. Supporting the Clinical Pharmacist Manager are:

- The Drug Intelligence Team – a team of pharmacists and pharmacy technicians focused on gathering broad market information, as well as deep drug and clinical information, to provide our clients a strong market and clinical decision-making context. The team undertakes strategic research in response to key trend monitoring to foster clinical program design and product development, and processes custom research requests to further the State's objectives.

- Clinical Analytics – a team comprised of both Clinicians and experienced analysts with extensive PBM experience and expertise ranging from pharmacy, finance, pharmacy consulting, public health to public health epidemiology, statistics, and actuarial science, supplying the expert clinical and benefit impact modeling and financial analysis to supplement the State's decision-making context.

Armed with the information and context these key resources provide, your Clinical Pharmacist Manager provides support of various initiatives including physician, member, pharmacy, and client education and strategic decision-support. Beyond simply providing the latest industry updates, the Clinical Pharmacist Manager's role is to make the business intelligence actionable by interpreting the information for you within the further context the State's specific needs and objectives.

Applied Analytics and Business Planning Process

Although the State will have dedicated resources that will be devoted to meeting your needs and offer anytime support on data analytics and client consultation, most clients prefer a schedule of regular account performance review. Currently, this is a semi-annual review as has been preferred by the State. In our typical performance review, with assistance from the Drug Intelligence team and Clinical Analytics, our Account team provides a consultative approach in reviewing your plan's performance. We deliver expert guidance with recommendations that have been carefully analyzed, modeled and evaluated against the backdrop of unique features of your market/region and the State's specific plan objectives, so that your opportunities are clearly identified and prioritized. Specifically, your consultative sessions include:

- Key developments within the period
- An overview of the program's trend with Catamaran's recommendations to include:
  - Program description
  - Member impact assessment
  - Modeled expected results / any recommended required investments
- An update on how we are supporting members and meeting the program's objectives
  - Safety, quality, adherence initiatives and impacts
- Industry developments and what they mean to the program and its members
- Any related contractual updates and "what's new" at Catamaran
- A summary of our actions and commitments for the next period

As part of this periodic review process (at your determined interval), your Account Team will highlight the past period's results and present a claims analysis review with recommendations for any more cost-effective benefit programs to meet your needs.

We will present the trends for the year and provide qualified recommendations that may positively impact your savings for the next year. Various costs and metrics including the following are reviewed:

- Key trend drivers (i.e., utilization, cost and drug mix)
- Disease and drug class analysis

- Book-of-business comparison (BOB)
- Overall drug spend
- Average ingredient cost
- Average generic cost
- Per Member per Year (PMPY) costs
- Generic utilization

Additionally, results, savings, and outcomes of your clinical programming will be routinely reviewed, including savings from Utilization Management strategies, Medication Therapy Management outcomes and savings, Retrospective Drug Utilization Review (RDUR) outcomes and savings, Prescriber Education & Intervention Program activities and associated savings/outcomes.

To support the State in modeling future budgetary decisions, we have the capability to provide in-depth analyses for different benefit design structure scenarios. We offer modeling support through business intelligence tools deployed over our RxTrack data warehouse.

Cost Utilization Analysis

The State will have access to various levels of customized cost and utilization analysis and modeling through our robust ad hoc reporting capabilities. Identifying claims and processing them against a new plan design (versus the existing benefit) is the key to successful modeling. The data can then be pulled into our data warehousing tools. If a standard report is used once the data is loaded, a State user can perform the reporting on demand. Your Data Analyst can design reports at your request. It is this kind of analysis that is often required by the State when determining budget initiatives to recommend or the financial or clinical impact of a legislative proposal needs to be modeled.

The Data Analyst and Clinical Pharmacist Manager will work closely with our Clinical Analytics Department on cost and utilization analyses. This team is experienced with the ad hoc design of specialized and complex queries regarding utilization and expenditure trends, cost projections, and modeling. The clinical analytics staff utilizes our Web-enabled reporting system to perform therapeutic class modeling. This decision support tool is designed to focus on the relationship of the factors driving the State's business and costs.

The following information is available:

- **Utilization and Expenditure Trends**: These reports identify who is using the most resources (e.g., by eligibility coverage category, by age group, by gender, by region, etc.) and the drivers of this utilization (e.g., patient, drug cost, prescriber). Users discover which drugs are impacting drug spend (e.g., by drug, therapeutic class) and the drivers of these trends (e.g., new drugs, drug mix, pricing increases, utilization, prescribing trends, brand vs. generic use, formulary factors).
- **Trend and Cost Projections:** These reports indicate factors that are influencing expenditure and utilization trends and determine the direction the factors are heading.
- **Modeling:** These reports distinguish the expected impact (to both expenditures and utilization) associated with a proposed benefit management change.

For example, if the State decides to implement a policy that requires prior authorization of a high cost drug that has less expensive therapeutic alternatives, thorough analysis will provide more than the potential cost savings. The comprehensive study could include such data points as:

- How many members will be impacted?
- How many prescribers will be impacted?
- How many prescriptions are currently utilized?
- How many can be expected to change to the lower cost alternative?
- How many can be expected to require prior authorization resources?
- What is the overall expected change to expenditures at different levels of substitution?
- What other resources (e.g., provider and member notification) and associated costs might be required to implement such changes?

Predictive Modeling

To support the State in modeling future budgetary decisions, Catamaran has the capability to provide in-depth analyses for different copayment and benefit design structure scenarios. At a minimum, these analyses offer a summary of the impact of formulary changes and implementations and benefit design considerations which can include modifying the member co-payment or changing the dispensing fee paid to pharmacies.

We also offer additional modeling capabilities including savings estimates for implementing mandatory mail order for maintenance drugs; implementing therapeutic exchange programs; and other clinical initiatives including step therapy programs, DUR edits, and quantity level limit programs.

1.2.7 Management of Physician-Administered Drugs

The State would like to implement a more rigorous and structured approach to managing physician-administered drugs billed through the medical benefit. This could be achieved by integrating physician administered drugs into all aspects of the Vendor's utilization management programs such as applying quantity limits, step therapy, or clinical prior authorization criteria for such drugs and coordinating with the MMIS vendor to assure consistency in the application of those UM strategies across both benefits. The State is also interested in any innovative management models

The Vendor should explain its utilization management strategies for managing Physician-Administered drugs and indicate the extent to which they can currently, or could in the future, support the State in improving the overall management of these drugs.

Response:

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1.2.8 Support of Drug Appeals Process

In addition to the PA process, the State seeks support of the appeal process for drugs whose coverage has been denied. The State receives a number of appeals for drugs either denied through the PA process or for non-covered products. Each of these appeals must go through a thorough physician review process.

The Vendor must describe their approach to supporting the State's appeal process, including, but not limited to

- Notifying providers and beneficiaries of their appeals rights in accordance with the Department's policy.
- Coordinating with State personnel who oversee the grievance and appeals process
- Preparing the appropriate reports and documents to support the Vendor's actions resulting in the request for an appeal from a beneficiary or provider
- Providing the services of a registered pharmacist to address an appeal related to pharmacy benefit services
- Providing resources to address appeals related to claims disputes
- Complying with the mandates and timelines stipulated by the Department of Vermont Health Access (DVHA)

The Vendor must describe their approach for supporting the drug appeals process.

Response:

Catamaran's Clinical Call Center supports the State's grievance and appeals process by notifying beneficiaries and providers when a prior authorization request is denied and informs them of their right to and process for requesting an internal appeal and/or a fair hearing before the Human Services Board. Notifications are made to beneficiaries by mail and to providers by facsimile. The content for all such communications is developed by the Department. The appropriate letters are programed to auto-generate with each level of denial.

Catamaran's Account Team works with State personnel to coordinate the delivery of all necessary documentation from the RxAuth system associated with the initial PA decision. The RxClaim / RxAuth system has the ability to retain all PA history data, including all PA notification and the data used to populate the notification. The responses to clinical criteria algorithms that support the denial are retrievable from RxAuth. Catamaran employs a strategy where *all* data elements related to a PA request are retained and available for reporting, analysis, and documentation for the State's grievance and appeals process. This includes all processing activity data logged by technical support staff – customer service representatives, pharmacy technicians and pharmacists; and all disposition data including reason codes, level of service codes, COB/TPL codes, PA type codes, etc.. Additionally, RxAuth is able to collect and store all documentation provided by the patient and physician and this is readily retrievable. We provide the State read access to view the appropriate documentation within the RxAuth system or we can provide all documentation via secure website or email transmission. We also ensure that an escalation process is in place for urgent requests.

The clinical pharmacist will conduct clinical and literature reviews, provide clinical guidelines for the medical condition being treated, suggest alternative treatment options and provide clinical

support for the appeals process as requested by the Department. The Account Management team also supports the Department in appeals related to other claim disputes, as requested. The Catamaran RxClaim claim processing system is state of the art systems and captures all aspects of claims processing so that claim denials can be easily researched. Catamaran understands the importance of complying with timelines and will work closely with appropriate State personnel to ensure compliance with all regulations and timely responses to all appeals.

Should a provider request second reconsideration or an appeal review by the medical director, Catamaran has recently developed a new process in collaboration with the State whereby the Clinical Call Center faxes the provider a form requesting additional information to support the medical review, including but not limited to medical history, notes, and relevant literature . This facilitates a more timely review of the request as all additional supporting information is obtained up front.

Catamaran updates RxAuth with the State's decision to approve or deny the appeal and documents all notifications to the beneficiary and provider.

The Clinical Pharmacist Manager monitors the second reconsiderations, appeals and fair hearings that are requested to identify opportunities to adjust clinical criteria when warranted to reduce administrative burden to beneficiaries, providers and the State.

1.2.9 Reporting and Analytics

The Vendor must provide reporting and analytic capabilities / services as described below that will support the reporting and analysis of claims data and PBM operations. The State expects that the Vendor will provide:

- Dashboard capabilities that support various roles of PBM operations and user-defined reporting views / screens based upon different roles, security profiles, etc. of various stakeholders
- Static or "canned" reports that are generated at pre-defined intervals, or on demand by State users
- Parameterized reports that allow State users to select from a defined number of parameters that inform a report. Parameters should include, but not be limited to: date or date range, beneficiary, beneficiary eligibility characteristic, program, drug, pharmacy, etc.)
- Ad hoc querying and reporting capabilities
- Capabilities to support graphical data (e.g., GIS) with presentation parameters configurable by the end-user; drill-down for more detailed information.
- Capabilities to export reporting data as seen in the report as well as the underlying data used to build the report in a variety of data formats
- Capabilities to support advanced analysis such as predictive analysis, root cause analysis, identification of statistical outliers, etc.
- Services to define, create and run, as requested by the State, additional static, parameterized and ad hoc reports in a timely manner, as described in the above descriptions

Examples of all current reports are included in the Procurement Library. The reports must include, but are not limited to:

- Utilization Reports
- Financial Reports
- Auditing Reports
- Preferred Drug List Reports
- Claims Processing Reports
- Coordination of Benefits (COB) Reports
- Net Cost Reports

The Vendor must describe their approach to fulfilling the Reporting and Analytics requirements.

Response:

Catamaran has a comprehensive suite of reporting tools available to State that will provide you with access to timely, accurate and actionable information to make informed decisions about your pharmacy benefit program. These tools will empower the State with standard reports, dashboard reports and ad hoc/drill-down reporting and querying capabilities that will place information at the fingertips of decision makers on demand and in virtual real-time as described in greater detail in the discussion that follows. In addition, the dedicated Catamaran Data Analyst assigned to the Key Personnel for the State is available to help extract and analyze information on behalf of the State.

Overview of Catamaran Approach to Reporting and Analytics

Confidential, Proprietary, and Trade Secret Information of Catamaran.

Catamaran is committed to supporting the State with all aspects of reporting and analytics. [redacted]

As the incumbent vendor, Catamaran is currently providing all utilization, financial, auditing, preferred drug list, claims processing, and custom coordination of benefits (COB) reports included in the procurement library and proposes to continue to provide these and more under the new contract. Catamaran has and will continue to routinely review and analyze standard reports for program operations purposes; for example, to look for prescribing, dispensing, claims processing, and utilization trends; incorrect claims submissions; opportunities for system edits; options and approaches for possible formulary changes; etc. We also routinely evaluate the effectiveness of reports in meeting their intended needs.

In addition to standardized reports, Catamaran has provided ad hoc queries as requested by the State. For each request, Catamaran staff has worked with the State to fully understand and modify it as necessary to ensure the report delivered the data in a way to clearly answer the questions for which the query was requested. When determined appropriate, ad hoc queries have been added to the customized package of reports for the State. Catamaran also utilizes ad hoc reporting tools to further analyze any trends identified in standardized reports or to test the effectiveness of the reports' elements, when necessary.

Catamaran notes that net cost reports stand out in the State's examples of required reports. While some observers might simply consider these to be financial reports, Catamaran

recognizes that net cost reporting is particularly important to state Medicaid programs. This is due to the substantial amount of federally required rebates collected that reduce the gross cost spend. It is additionally important to states like Vermont with supplemental rebate programs that further reduce costs for certain drug therapies. Net cost reports can assist the State and the Drug Utilization Review Board in identifying prescribing and utilization trends and in evaluating and managing drug spend. To date, Catamaran's ability to provide this kind of report has been limited. That has been because we did not have detailed federal rebate data on an individual drug level since the Vermont Medicaid fiscal agent managed the federal rebates. Since the State is now proposing that both federal and supplemental rebate processes will be managed by the PBM vendor, detailed data will be readily available for reporting purposes. Catamaran is eager to provide net cost reporting. We will work with the State to establish a timeline for delivery of the first and future net cost reports, recognizing that there is a calendar quarter lag in rebate data.

Comprehensive Data Warehouse and Analytical Solution: RxTrack

RxTrack is Catamaran's proprietary data warehouse query and analytical product that enables Catamaran to create a customized reporting package and perform in depth data analytics. Additionally, it provides the functionality for users to view reports, run parameterized reports, and create customized reports and ad hoc queries. These tools allow the power user to create complex queries, perform data mining activities, and analyze and assess program impact and performance.

Currently, Catamaran makes RxTrack available to the State. On several occasions, training has been provided. However, users tell us that it is a tool that is difficult to use without detailed knowledge of the data elements and frequent and repeated use. As part of this proposal, Catamaran is proposing to provide access to something new, RxTrack Connect. Other Catamaran clients report that RxTrack Connect is a far more user friendly and readily accessible tool to access state-of-the-art reporting capabilities. It makes it possible to generate both pre-defined and ad hoc reports. Catamaran is also proposing to provide RxTrack Dashboard.

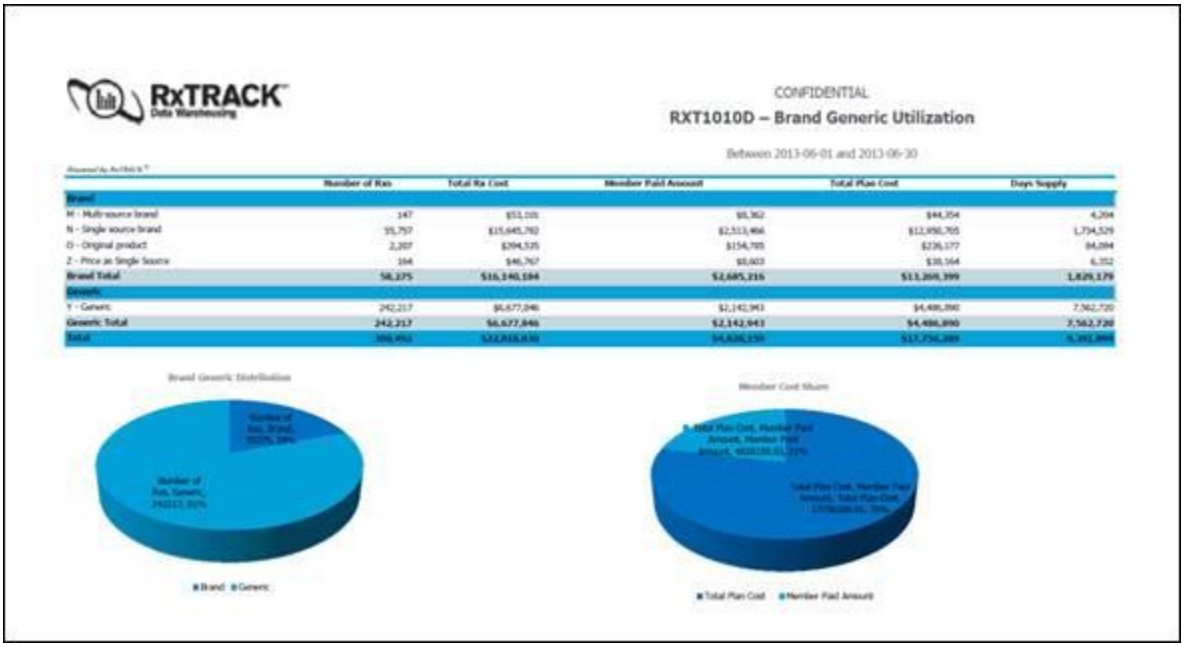
On-Demand Reporting Capabilities: RxTrack Connect Portal

Through the RxTrack Connect Portal, reports and analytics are delivered and executed using industry leading software including Cognos tools and SPSS. Cognos, founded in 1969 and serving more than 23,000 customers in 135 countries, is a world leader in business intelligence software. Its range of tools allow for reporting, analysis, dash boarding and scorecards. Cognos BI is built with a modern Web services architecture and standards such as Extensible Markup Language (XML), SOAP, and Web Service Definition Language (WSDL). The architecture provides an environment that includes extract, transform, and load (ETL) capability and automatic load balancing and is fully scalable. Reports and analyses are written once and then deployed to other users of the tool to view or manipulate. The Web-based deployment browser-based environment requires no desktop installs, plug-ins, or applets. This allows for remote access to the system; the end user can log on from anywhere. Cognos reports can be saved into multiple desired formats including: electronic mail, HTML, PDF, Microsoft Excel, CSV, and XML.

Using Cognos tools in RxTrack Connect for analysis allows for the review of large volumes of data across multiple dimensions with fast and predictable response times. Large, complex data sets can be queried with the easy-to-use, drag-and drop user interface, pivoting, and filtering.

The secure Web portal provides RxTrack Connect users with access to full-featured, management level reporting. The portal retrieves key performance indicator (KPI) information from raw and summarized data contained in the data warehouse. The reports can be scheduled and delivered in a variety of methods and formats to the end user.

Standard and Parameter Driven Reports can be accessed using RxTrack Connect. This tool enables the end user to simply click to launch parameter driven and pre-defined reports. The RxTrack Connect Portal provides State designated and approved staff with zero footprint access to predefined and custom reporting over the State's data through a secure Internet connection. The predefined or custom reporting provides the State high end graphical reporting with robust scheduling and distribution options. To illustrate what might be a Standard or Parameter Drive report. A screen shot of a RxTrack Connect Portal content on Brand Generic Utilization is shown below.



Robust ad hoc capabilities exist in RxTrack Connect as they do in Rx Track. Drill down reporting is also accessible. End users create their own queries or access a library of ad hoc queries to use as built or to manipulate to meet their needs. Users build queries against both the detail and summary files. The graphical user interface query tool can be used to build custom queries using more than 150 fields captured in the detailed extract file, the basis of Catamaran's data warehouse.

In summary, RxTrack Connect is a data access tool that empowers the end users to produce standardized and parameter driven reports and data files and to obtain transactional level detail. The users can print professional reports ranging from things as simple as mailing labels to as complex as utilization reports, or bring the data into their desktop applications. Users have the capacity to save the data captured in a spreadsheet, database or CSV file.

A Single Authoritative Reporting Resource: Catamaran RxTrack Dashboard

The Catamaran RxTrack Dashboard further simplifies access to reporting. It is a way for a user to access data found in standardized and parameter driven reporting and ad hoc queries in a

straightforward way. In that sense, the RxTrack Dashboard could be considered the command center of the reporting platform.

The Catamaran Rx Dashboard reports that we are proposing for the State will be a multi-level depiction of key metrics identified with the State. Examples might include things like program performance, generic utilization, and prescribing by specialty and non-specialty prescribers.

The Dashboard then can allow users to see what happened with a particular metric over time or in comparison to other measurements of the very same metric (benchmarks). The Dashboard can provide the user with cost and time frame comparison period options; for example, the cost of a drug or a therapeutic drug class by month, quarter, year. Other benchmark comparative choices will be defined with the State.

Drill down capability can be define and made available. For example, Individual dashboard reports allow users might want to drill-down from a Therapeutic class level to a drug level in order to provide insight into what may be trending in a particular direction.

Finally, RxTrack's comprehensive benchmarking solutions provide the opportunity for deeper insights, consultative indicators, narrative guidance and recommended actions tailored to meet the State's specific needs and reports will automatically populate with the used Benchmarking data in contrasting colors for which the reports are being generated.

The Catamaran RxTrack Dashboard options currently available in the reporting suite include the following:

- *Daily Dashboard*
- *Main Summary Dashboard*
- *GDR (Generic Dispensing Rate) Dashboard*
- *Specialty Dashboard*
- *Non-Specialty Drug Dashboard*
- *Plan Design Dashboard*
- *Member Dashboard*
- *Disease Summary Dashboard*

The following is a sample of Catamaran RxTrack Dashboard views:

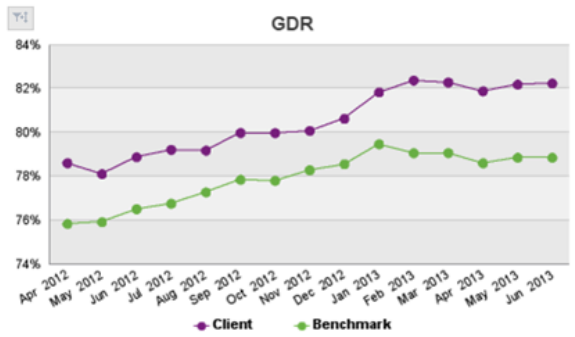
RxTrack®

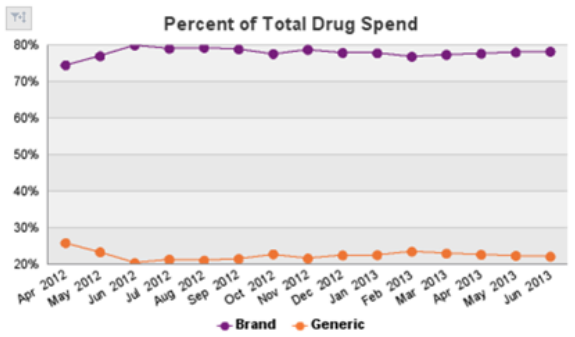
GDR Dashboard

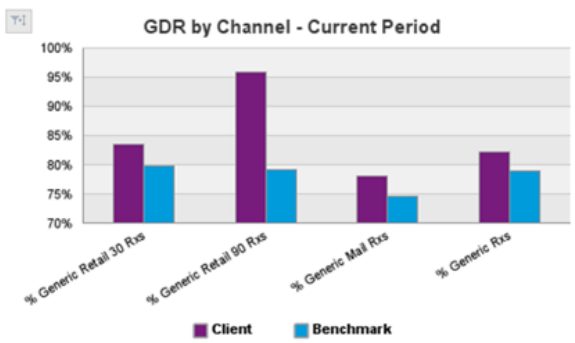
Run Date: 1/16/2014

Client : ABC Client
Carrier : ABC1234
Account : ALL
Group : ALL
Line of Business : Employer - Professional

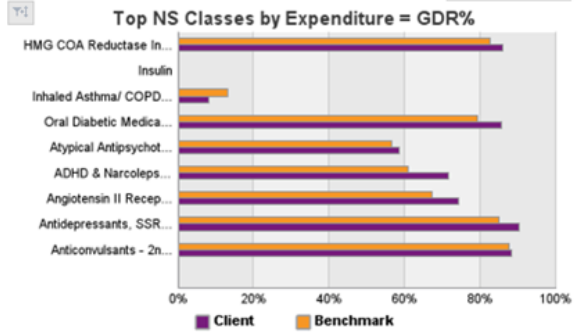
Time Frame : Current quarter vs. prior quarter
Current Period : Q2 2013
Prior Period : Q1 2013
Date Basis : Date Filled
Cost Basis : Net Plan Paid







More Metrics



Executive Summary

	Client Current Period	Client Previous Period	Client Percent Change	Benchmark Current
Rx Count	79,351	83,210	-4.6%	N/A
Generic % of Total	82.1%	82.1%	-0.1%	79.0%
Brand % of Total	17.9%	17.9%	0.3%	21.0%
Ave. Cost of Generics	$24.11	$22.54	6.9%	$23.81
Ave. Cost of Brand	$386.98	$350.76	10.3%	$313.72
Generic Cost PMPM	$16.29	$15.73	3.6%	$15.14
Brand Cost PMPM	$57.07	$53.19	7.3%	$53.14

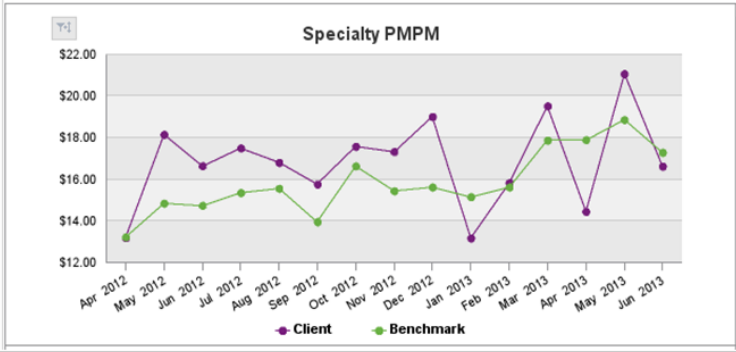
RxTrack®

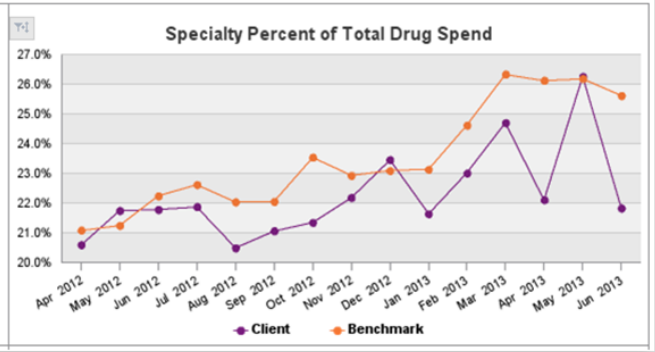
Specialty Dashboard

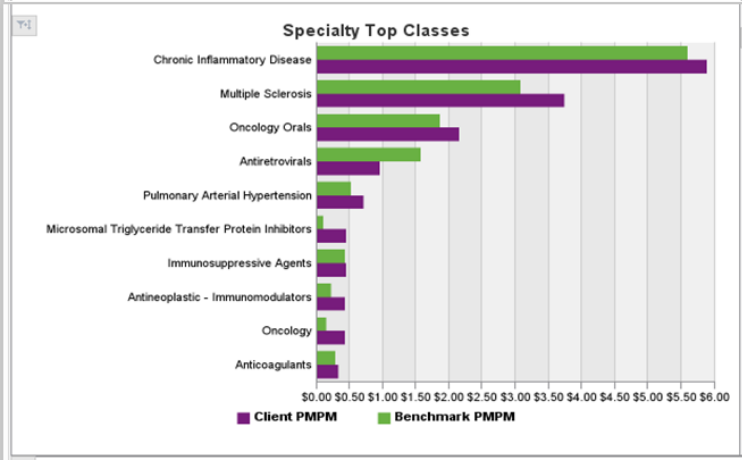
Run Date: 1/16/2014

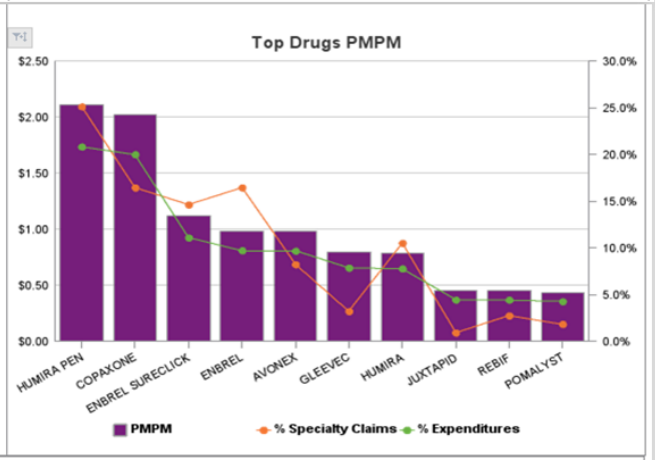
Client : ABC Client
Carrier : ABC1234
Account : ALL
Group : ALL
Line of Business : Employer - Professional

Time Frame : Current quarter vs. prior quarter
Current Period : Q2 2013
Prior Period : Q1 2013
Date Basis : Date Filled
Cost Basis : Net Plan Paid









Executive Summary

	Client Current Period	Client Previous Period	Client Percent Change	Benchmark Current
Specialty Cost	$1,656,432	$1,561,913	6.1%	N/A
Specialty % of Total Cost	23.4%	23.1%	1.3%	25.8%
Ave. Cost per Specialty Claim	$2,779	$2,774	0.2%	$2,361

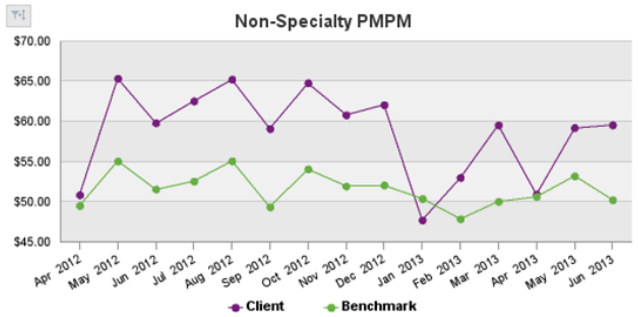
RxTrack®

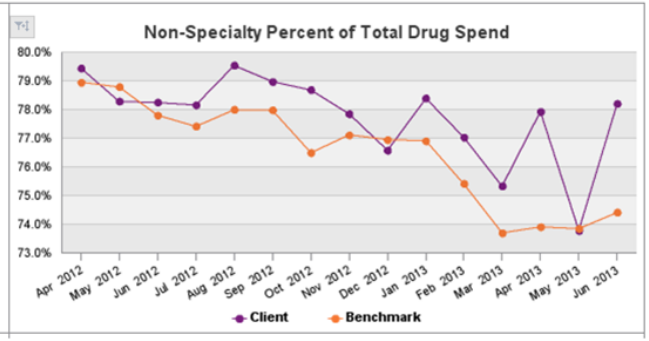
Non-Specialty Dashboard

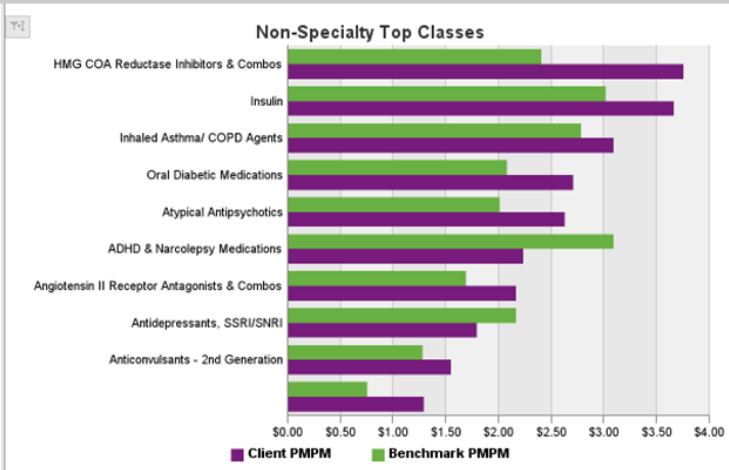
Run Date: 1/16/2014

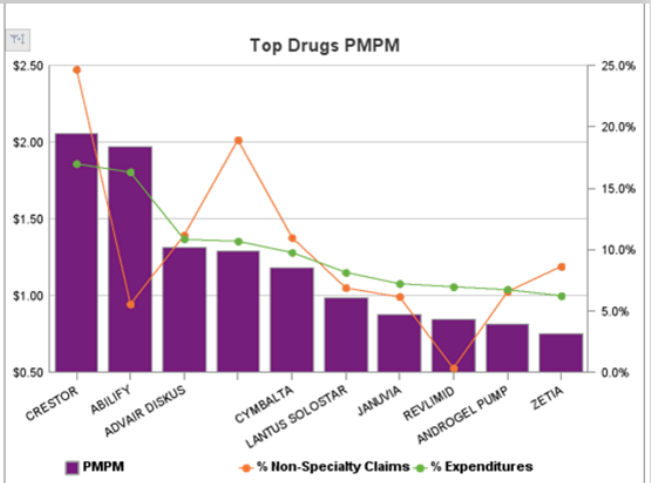
Client : ABC Client
Carrier : ABC1234
Account : ALL
Group : ALL
Line of Business : Employer - Professional

Time Frame : Current quarter vs. prior quarter
Current Period : Q2 2013
Prior Period : Q1 2013
Date Basis : Date Filled
Cost Basis : Net Plan Paid









Executive Summary

	Client Current Period	Client Previous Period	Client Percent Change	Benchmark Current
Non-Specialty Cost	$5,414,327	$5,190,508	4.3%	N/A
Non-Specialty % of Total Cost	76.6%	76.9%	-0.4%	74.2%
Ave. Cost per Non-Specialty Claim	$69	$63	9.5%	$64

Management Analysis

Over and above the defined reports and ad hoc reporting produced with RxTrack Connect and/or accessed through the RxTrack Dashboard, Catamaran has and proposes to continue to assist the State in focused management analysis.

Although Catamaran proposes to provide dedicated resources devoted to the State's needs that offer any time support and client consultation on data analytics, we find that most clients prefer a schedule of regular account performance review. Typically this is a quarterly interval but we will accommodate your preference. Currently, Catamaran has been providing this analysis bi-annually to reflect calendar year and then state fiscal year performance.

In a typical interval performance review, our Account Team provides a consultative approach in reviewing your plan's performance with assistance from our Drug Intelligence team and Clinical Analytics reporting. We deliver expert guidance with recommendations that have been carefully considered, analyzed, modeled and evaluated against the backdrop of the unique features of your market/region and your specific plan objectives, so that your opportunities are clearly identified and prioritized. Specifically, consultative sessions include:

- *Key developments within the period*
- *An overview of the program's trend with Catamaran's recommendations to include:*
  - Program description
  - Member impact assessment
  - Modeled expected results / any recommended required investments
- *An update on how we are supporting members and meeting the program's objectives*
  - Safety, quality, adherence initiatives and impacts
- *Industry developments and what they mean to the program and its members*
- *Any related contractual updates and "what's new" at Catamaran*
- *A summary of our actions and commitments for the next period*

As part of this periodic review process (at your determined interval), your Account Team will highlight the past period's results and present a claims analysis review with recommendations for any more cost-effective benefit programs to meet your needs.

We will present the trends for the year and provide qualified recommendations that may positively impact your savings for the next year. Various costs and metrics including the following are reviewed:

- *Key trend drivers (i.e., utilization, cost and drug mix)*
- *Disease and drug class analysis*
- *Book-of-business comparison (BOB)*
- *Overall drug spend*
- *Average ingredient cost*
- *Average generic cost*

- *Per Member Per Year (PMPY) costs*
- *Generic utilization*

Additionally, results, savings, and outcomes of your clinical programming will be routinely reviewed, including savings from Utilization Management strategies, Concurrent Drug Utilization Review (CDUR) activity, Medication Therapy Management outcomes and savings, Retrospective Drug Utilization Review (RDUR) outcomes and savings, Prescriber Education & Intervention Program activities and associated savings/outcomes.

Other Optional Reports Available

Catamaran recognizes that timely, complete, accurate, and accessible information is needed to support the client's benefit management goals. To address these needs, we offer a wide range of standard, optional, and ad hoc reporting capabilities to support decision-making at all levels: clinical, executive, operational, and beyond.

Our claims processing system standard management reports include more than 80 individually unique reports. Our model is to give clients the option of choosing from all the reports or only a few specific types based on particular reporting requirements. While Vermont is an existing Catamaran customer, the State has the option to reconsider reports not previously selected. For that reason we describe some reports here, including those that are most commonly used by commercial insurers and including some that are like or similar to the reports the State is currently using.

The standard Catamaran customized reporting package is designed to provide meaningful data that can be used to provide a global overview of a client's program. Several categories of standard reports include:

- **Client Services Reports:** provide information related to issues such as ID card production, provider service activities, and call center activities. The call tracking and claims processing systems generate these reports.

- **Operational Reports:** detail items such as the number of claims processed, file load balancing reporting, and downtime reports.

- **Utilization Reports:** provide a birds-eye view of drug utilization trends. Presented in a variety of ways, they enable our clients to discern areas of growth, changing client utilization patterns, and changes in prescribing patterns. These reports also allow our clients to evaluate the impact of programs aimed at utilization or expenditures. Information for the utilization reports is derived from the pharmacy claims data feed to our data warehouse and created utilizing various Business Intelligence software tools.

Report Delivery

Catamaran delivers reports in a variety of ways including:

- Online access to reports that the client / vendor can retrieve by clicking on the report name
- Static reports delivered in an electronic format (i.e. PDF, Excel report)

- Static reports delivered as a hardcopy
- Data sets in text, Excel, Access, etc.

Report Frequency

Unlike some PBMs whose data cannot be retrieved from their data warehouse for 30 to 45 days after claim submission, Catamaran updates data for claims processed through the RxClaim system into RxTrack each night. We can obtain reports for the client:

- Weekly
- Bi-weekly
- Monthly
- Quarterly
- Annually.

Available Standard Reports

As previously indicated, Catamaran's claims processing system standard management reports include more than 80 individually unique reports available to many clients. Commonly requested reports include:

Report Title	Description
Section 1 - Management Activity Reports	
Utilization Summary (Financial)	The Utilization Summary provides an overview of prescription benefit utilization by clients in the selected carrier(s), account(s), group(s), and care facility(ies).
Monthly Summary of Key Data	The Monthly Summary of Key Data provides the current month's, the quarter's (to date), and the year's (to date) values for several significant items related to the selected carrier(s), account(s), and group(s).
Executive Summary	The Executive Summary provides the current quarter's, the previous three quarters', and the year's (to date) values for several significant items related to prescription benefit utilization for the selected carrier(s), account(s), and group(s).
Section 2 - Group Utilization Reports	
Age/Sex Utilization Summary	The Age/Sex Utilization Summary provides a record of prescription data broken down by age and sex for the selected carrier(s), account(s), group(s), and care facility(ies).
Eligibility Counts	The Eligibility Counts report provides a listing of groups within each account and the corresponding counts of active clients.
Monthly Utilization Summary	The Monthly Utilization Summary provides monthly values for several significant items related to the selected carrier(s), account(s), and group(s).

Report Title	Description
Section 3 - Drug Usage Reports	
Therapeutic Class Profile Summary	The Therapeutic Class Profile Summary provides a record of drug utilization within each therapeutic class for the selected carrier(s), account(s), group(s), and care facility(ies).
Brand/Generic Utilization Summary	The Brand/Generic Utilization Summary provides a record of generic drug substitution patterns in the selected carrier(s), account(s), group(s), and care facility(ies). It shows projected available savings as well as actual savings.
Product Cost Ranking Summary	The Product Cost Ranking Summary provides a record of up to 200 drugs dispensed for the selected carrier(s), account(s), group(s), and care facility(ies) within the chosen time period, differentiated by eight-digit GPI, and ranks them by descending dollar amount for the total ingredient cost.
Drug Usage Ranking Summary	The Drug Usage Ranking Summary provides a record of each drug dispensed for the selected carrier(s), account(s), and group(s) within the chosen time period, differentiated by 14-digit GPI, and ranks them in descending order by the number of prescriptions filled.
Drug Therapeutic Class Usage Ranking Summary	The Drug Therapeutic Class Usage Ranking Summary lists therapeutic classes from which products have been prescribed for the selected carrier(s), account(s), group(s), and care facility(ies) within the specified date range. They are ranked by number of prescriptions.
Section 4 - Pharmacy Provider Reports	
Pharmacy Provider Utilization Summary (with Averages)	The Pharmacy Provider Utilization Summary provides prescription activity totals, by provider, for the selected carrier(s), account(s), group(s), chain(s), network(s), and ZIP codes.
Pharmacy Provider Performance Summary	The Pharmacy Provider Performance Summary gives a summary of all prescription activity for each provider within the selected carrier(s), account(s), group(s), chain(s), network(s), and ZIP code(s).
Section 5 - Utilization Review Report	
DUR Savings – Summary	The DUR Savings Summary Report lists eight items, each of which is shown with at least one and as many as seven values. The eight items are: • The total DUR occurrences • Total DUR overrides • Additional projected cost • Actual DUR savings

Report Title	Description
	• Additional projected savings • Total DUR savings • Total eligible clients • Total utilizing clients • The seven possible values are: • Total number • Number of utilizing clients • Sponsor cost • Average sponsor cost by occurrence • Client cost • Average client cost by occurrence • Number of future fills.

In addition reporting package customized for the State, the State has access to ad-hoc reporting capability utilizing the data warehouse and available query and reporting tools. Our reporting solution enables the Department to generate powerful reports easily and conveniently, making it an effective and efficient ad hoc reporting tool.

Report Title	Description
MAC Savings Report	The MAC Savings Report lists values for several different price types and compares them to the Maximum Allowable Cost for the indicated drug. The report sorts alphabetically by drug label name.
Call Tracking Summary/Detail	The Call Tracking Summary/Detail report provides a listing of call tracking entries made in RxClaim, in summary form, detail, or both. The report includes four different outputs that may be chosen by the user in any combination, including a detail, summary by origin of call entry, summary by call type and summary by user ID.

Report Title	Description
Call Tracking User Summary/ Detail	The Call Tracking Summary/Detail report provides a listing of calls documented about a claim, client, carrier, account or group made in RxClaim system per User ID. There are three types of call tracking entries: • Problem/Resolution • Informational • HIPAA The report criteria can be sorted by Carrier ID, Call Type or User ID.
User Tracking Summary	The User Tracking Summary provides the ability to track the number of manual adds/changes users are inputting during a specified time frame.
Top 3 Reject Codes Detail Report	The Top 3 Reject Codes Detail Report lists the reasons for claim rejections in detail. The report identifies the reject reason codes and the percentage of rejects for the range of claims selected.
Specialty Claims Summary	Specialty benefits allow for prescription coverage to be altered from the standard plan benefits. The Specialty Claims Summary report lists information for claims processed using specialty schedules.
Client Listing Detail	The Client Listing Detail Report lists all clients within the selected carrier, account, or group who are eligible as of the selected date.
Client Utilization Summary – Rank by Benefit Value	The Client Utilization Summary – Rank by Benefit Value Report provides a summary of claims statistics for up to two hundred (200) of the most active clients in the selected carrier, account, and group ranges.
Client Utilization Detail with Submitted Amounts	The Client Utilization Detail with Submitted Amounts report provides information about prescription claims activity within a chosen time period for a specific client ID or for each client of a selected carrier, account, or group.
Age/Sex Utilization Summary	The Age/Sex Utilization Summary report provides a record of benefit utilization with demographic information.

Report Title	Description
Client Utilization – Prior Authorization Detail	The Client Utilization - Prior Authorization Detail report identifies trends that might indicate a need to consider changes to the plan by providing a listing of groups within each account and may include the following sequences: carrier, account, group, drug label name, prior authorization reason code, client ID, and date filled.
Client Eligibility Detail	The Client Eligibility Detail Report provides a listing of groups within each account and the corresponding counts of active clients.
Monthly Utilization Summary	The Monthly Utilization Summary report provides a high-level summary of client census data, paid claims data, and utilization data by month.
Client Coordination of Benefits Detail – Primary Payer	The Client Coordination of Benefits Detail – Primary Payer report lists the claims that were processed for client who have secondary insurance coverage on the system.
Prior Authorization Detail	Prior Authorization Detail reflects all prior authorizations in the RxClaim environment, even if they are not associated with a specific claim.
Therapeutic Class Summary	The Therapeutic Class Summary provides a record of the selected account and/or the group's usage of drugs in the therapeutic class chosen. This report shows the overall drug spend and utilization by therapeutic class. Spikes in utilization or expenditures can first be observed here.
GPI Therapeutic Class Profile Summary	The GPI Therapeutic Class Profile Summary provides a record of the selected account and/or the group's usage of drugs in the therapeutic class chosen
Therapeutic Class Detail	The Therapeutic Class Detail report provides a record of claims for prescription drugs within the selected therapeutic class by account, group, or care facility. This report shows the overall drug spend and utilization by drug for each therapeutic class. Classes that have exhibited spiked can be further drilled down to the individual drug.
Brand/Generic Summary	The Brand/Generic Summary provides a record of generic drug substitution patterns in the selected carrier, account, group, or care facility. It shows projected available savings as well as actual savings.

Report Title	Description
Drug Usage Summary	The Drug Usage Summary provides statistics for each drug that falls within the selected NDC range and was dispensed to clients of the selected account and/or group during the specified time period. This report can be manufacturer-, product-, or package-size-specific.
Drug Usage Detail	The Drug Usage Detail Report provides a record of usage patterns for a specific drug among clients of the selected carrier, account, or group.
Drug Cost Ranking Summary	The Drug Cost Ranking Summary provides a record of up to two hundred (200) drugs dispensed within the selected time period. The report lists each drug's fourteen (14) digit GPI and ranks the drugs in descending order by dollar value of the total ingredient cost. This identifies single drugs that are costly to the program.
Product/GPI Cost Ranking Summary	The Product/GPI Cost Ranking Summary provides a record of up to two thousand (2000) products dispensed within the selected time period, based on ingredient cost, plan cost, or patient pay.
Drug Usage Ranking Summary	The Drug Usage Ranking Summary provides a record of drugs dispensed within the selected time period, differentiated by fourteen (14) digit GPI, and ranks them by the number of prescriptions filled.
Product/GPI Usage Ranking Summary	The Product/GPI Usage Ranking Summary provides a record of drugs dispensed within the selected time period, differentiated by eight (8) digit GPI, and ranks them by number of prescriptions dispensed.
Drug Cost Ranking by Specialty	The Drug Cost Ranking by Specialty Report lists drugs ordered within each selected prescriber specialty by total ingredient cost.
Drug Usage Ranking by Specialty	The Drug Cost Ranking by Specialty report lists drugs ordered within each selected prescriber specialty by number of prescriptions.
Ranking by Therapeutic Class Cost	The Ranking by Therapeutic Class Cost report provides statistics ranked by total amount paid for each therapeutic class.
Therapeutic Class Ranking Summary	The Therapeutic Class Ranking Summary report ranks, by number of prescriptions, therapeutic classes from which products have been prescribed during the selected date range.

Report Title	Description
FINANCIAL Pharmacy Provider Claims Detail	The Pharmacy Provider Claims Detail report provides a look at all prescription activity for each selected provider.
Pharmacy File Extract	The Pharmacy File Extract allows clients to generate a list of pharmacies available in a pharmacy network. This report is useful in identifying a list of pharmacies available in a pharmacy network.
Prescriber Utilization Summary by Specialty	The Prescriber Analysis Summary shows statistics for each prescriber associated with a claim or claims in the selected carrier, account, or group.
Prescriber Utilization Summary Ranked by Cost	The Prescriber Utilization Summary Ranked by Cost report ranks prescribers in a selected carrier, account, or group in descending order by total ingredient cost. The report also shows average costs, prescription totals, and drug type percentages.
Prescriber Utilization Summary Ranked by Volume	The Prescriber Utilization Summary Ranked by Volume ranks prescribers by number of prescriptions, in descending order.
Prescriber Detail Sorted by NCPDP#, RX#	The Prescriber Detail Sorted by NCPDP Provider ID, RX Number is based upon.
Prescriber Practice Summary	The Prescriber Practice Summary provides a summary of physician prescribing habits over a specified period of time. Non-formulary NDC and GPI lists can be specified.
Rx Detail by Client, Dup Drug Different Prescriber	The Rx Detail by Client, Duplicate Drug Different Prescribers report lists all clients who have had therapeutically equivalent drugs (same GPI) prescribed by multiple physicians.
Rx Detail by Client, Dup Drug Different Provider	The Rx Detail by Client Duplicate Drug Different Providers produces records of benefit utilization by clients with claims for the same drug from different pharmacies.
Rx Detail by Client, Dup Drug within X Days	The Rx Detail by Client Duplicate Drug Within X Days provides records of benefit utilization by clients with claims for equivalent drugs within a user-specified number of days.
Rx Detail by Client, Therapeutic Duplication	The Rx Detail by Client/Therapeutic Class Duplicate provides records of benefit utilization by clients with claims for drugs from the same therapeutic class.

Report Title	Description
Rx Detail by Client, More Than X Prescribers	The Prescription Detail by Client ≥ X Prescribers provides records of benefit utilization by clients with claims for prescriptions written by a user-specified number of prescribers.
Plan Contingent Therapy Edit – Summary	The Plan Contingent Therapy Edit – Summary reports on all claims, paid and rejected, which edited against the Contingent Therapy edits.
GPI List Adds/Changes	The GPI List Adds/Changes report allows clients to view a listing of any additions or changes made to a specific GPI list during a specific period of time. The GPI will appear on the report if the add/change date for the GPI on the GPI list is within the date range selected on the parameter screen.
NDC List Adds/Changes	The NDC List Adds/Changes report allows clients to view a listing of any additions or changes made to a specific NDC list during a specific period of time. The NDC will appear on the report if the add/change date for the NDC on the NDC list is within the date range selected on the parameter screen.
DUR Table Detail	The DUR Table Detail Report allows a user to print the parameters of a DUR Table, independent of a specific plan. Clients who can only view or edit selected DUR Tables will be restricted to selecting only those tables that apply to their book of business.
DUR Override List Details Report	The DUR Override List Details Report allows you to view the contents of a DUR Override List. The DUR Override List contains GPIs that are to be used preferentially over any other therapeutic duplication as defined by the client.
Client Claim History Report	The Client Claim History Report allows clients to identify all claims processed for a specific client. The report can be run over a C/A/G, C/A/*All or C/*All/*All.
DUR Conflict Extract	The DUR Conflict Extract provides an annual data file that summarizes DUR (Drug Utilization Review) conflicts within a state Medicaid program. The file can be imported into Excel where it can be viewed and manipulated as necessary.
Annual Performance Report	Summary information about calls presented, handled, abandoned, average speed of answer, service level and handle time on a monthly, quarterly, and annual basis.

Report Title	Description
Summary Interval Reports	Summary information about calls presented, calls handled, and calls abandoned for each interval. Different reports are available and provided for each skill/call queue, for example beneficiary, pharmacy, physician.
DUR Savings – Summary	Lists total DUR occurrences, total DUR overrides, additional projected cost, actual DUR savings, additional projected savings, total DUR savings, total eligible clients, and total utilizing clients. Each item is shown with at least one and as many as seven values, which include the total number, the number of utilizing clients, the sponsor cost, the average sponsor cost by occurrence, the client cost, the average client cost by occurrence, and the number of future fills.
Prior Authorization Summary (by Therapeutic Class)	Counts of PA activity by therapeutic class by status
Top Prescribers	Summary of the Top Prescribers sorted in a variety of ways by amount paid, by claim volume, by Rx count, etc.
Top Utilizing Recipients by Aid Category	Summary of the Top Recipients by top ranking aid categories sorted by Rx count and amount paid
Top 100 Pharmacies	Summary of the Top Pharmacies sorted in descending order by amount paid and by claims volume
Top Therapeutic Classes by Amount Paid	Top therapeutic classes in descending order by amount paid. Report allows drilling down from therapeutic class to the generic name level.
Top Therapeutic Classes by Claim Volume	Top therapeutic classes in descending order by claim volume. Report allows drilling down from therapeutic class to the generic name level.
Top Prescribers by Average Cost/Rx	Summary of the Top Prescribers sorted by the average amount paid per paid claim and amount paid per utilizing recipient
Brand / Generic Dispensing Report	Summary of Generic Dispensing Rates including % of drugs dispensed as generic.
Denied Claims Detail	Summary of claim counts for NCPDP Reject codes.

Report Title	Description
Brand/Generic Report	Summary of Brand v. Generic Dispensing Rates - Trended over time.
Brand Generic Utilization Summary	This report breaks down utilization by Brand/Generic classifications and indicates key measures such as Net Paid Claims, Total RxPrice, Client Pay, Sponsor Pay, and Days' Supply. The report also calculates the savings associated with using generics, estimated additional potential savings if all brands dispensed were dispensed as generics (if available) and the generic potential usage (use of a generic where a generic could potentially be used). Graphs are included that show the Brand/Generic distribution as well as the proportion of Client Due Amount and Client / Patient Paid Amount.
Cost Type Utilization Summary	This report shows the cost type utilization summary based on the date range and Carrier/Account/Group combination provided by user. It indicates key measures such as Net Paid Claims, Total RxPrice, Client Pay, Sponsor Pay and Days' Supply.
Product Top N Report by Client Ingredient Cost	This report lists the Top N (consumer defined) products ranked by the total Client Ingredient Cost for the date range and Carrier/Account/Group combination provided by the user. The report indicates additional key measures such as Net Paid Claims, % of Total Ingredient Cost, Total Client Due Amount, Total Metric Decimal Quantity, Total Days' Supply and Average Pharmacy Due. The report also indicates totals for these key measures for the Top N as well as the totals for all products.
Product Top N Report by Net Rxs	This report lists the Top N (consumer defined) products ranked by Net Paid Claims for the date range and Carrier/Account/Group combination provided by the user. The report indicates additional key measures such as % of Total Net Paid Claims, Total Client Due Amount, Total Metric Decimal Quantity, Total Days' Supply and Average Due Pharmacy. The report also indicates totals for these key measures for the Top N as well as the totals for all products.
Utilization Review by Age Band	This report breaks down utilization by Age Band and indicates key measures such as Average RxTrack Eligible Clients, Average RxTrack Utilizing Clients, Total Net Rxs, Total Rx Price, Average Per Net Rx , Average Net Rxs Per Client Per Year. This report also displays graphs for Average Eligible Client distribution by Age Band and Average Rxs Per Client Per Year distribution by Age Band

Report Title	Description
Utilization Review by Gender	This report breaks down utilization by Gender and indicates key measures such as Average RxTrack Eligible Clients, Average RxTrack Utilizing Clients, Total Net Rxs, Total Rx Price, Average Per Net Rx, Average Net Rxs Per Client Per Year. This report also contains graphs for Average Eligible Client distribution by gender and Average Rxs Per Client Per Year by gender.
Savings Report by Major Drug Group	This report shows the savings by Major Drug Group and indicates key measures such as Net Paid Claims, Total Submitted Ingredient Cost, Total Submitted U & C, Total AWP Unit Cost, Total Client (Approved) Ingredient Cost Paid, Savings Off AWP and Savings Off U & C.
Therapeutic Class Summary Including Product Names	This report shows the Therapeutic Class Summary including the Product Names and indicates key measures such as Net Paid Claims, % of Total Net Paid Claims, Total Client Due Amount, Total Metric Decimal Quantity, Total Days' Supply and Average Due Pharmacy. Subtotals are provided for each Therapeutic Class.
Top Therapeutic Class Summary by Net Rxs	This report lists the Top N (consumer defined) Therapeutic class ranked by Net Paid Claims for the date range and Carrier/Account/Group combination provided by the user. It indicates additional key measures such as % of Total Net Paid Claims, Total Client Due Amount, Total Metric Decimal Quantity, Total Days' Supply and Average Due Pharmacy. It also indicates totals for these key measures for the Top N as well as the totals for all products.
Pharmacy Top N Report by Ingredient Cost	Client Ingredient Cost for the date range and Carrier/Account/Group combination provided by the user. It indicates additional key measures such as Net Paid Claims, % of Total Ingredient Cost, Total Client Due Amount, Total Metric Decimal Quantity, Total Days' Supply and Average Due Pharmacy. Also, it indicates totals for these key measures for the Top N as well as the totals for all products.
Pharmacy Top N Report by Net Rxs	This report lists the Top N (consumer defined) pharmacies ranked by Net Paid Claims for the date range and Carrier/Account/Group combination provided by the user. The report indicates additional key measures such as % of Total Net Paid Claims, Total Client Ingredient Cost, Total Client Due Amount, Total Metric Decimal Quantity, Total Days' Supply and Average Due Pharmacy. The report also indicates totals for these key measures for the Top N as well as the totals for all products.

Report Title	Description
Prescriber Top N Report by Ingredient Cost	This report lists the Top N (consumer defined) prescribers ranked by the total Client Ingredient Cost for the date range and Carrier/Account/Group combination provided by the user. The report indicates additional key measures such as Net Paid Claims, % of Total Ingredient Cost, Total Client Due Amount, Total Metric Decimal Quantity, Total Days' Supply and Average Due Pharmacy. The report also indicates totals for these key measures for the Top N as well as the totals for all products.
Prescriber Top N Report by Net Rxs	This report lists the Top N (consumer defined) prescribers ranked by Net Paid Claims for the date range and Carrier/Account/Group combination provided by the user. The report provides Prescriber Submitted Id, Prescriber Last Name and indicates additional key measures such as % of Total Net Paid Claims, Total Ingredient Cost, Total Client Due Amount, Total Metric Decimal Quantity, Total Days' Supply and Average Due Pharmacy. The report also indicates totals for these key measures for the Top N as well as the totals for all products.
Drug Group Average Cost Per Day	This report lists major Average Cost Per Day by Drug Group and indicates key measures such as Total Days' Supply, Total Rx Price and Average Rx Price per Day.

1.2.10 Quality Assurance

The Vendor must develop and implement quality management and assurance, using best practices consistent with industry standards, principles, and processes including, but not limited to:

- Implement Quality Improvement Processes for recurring processes
- Continuous performance measurement and improvement through the use of technical reviews, internal audits, and Vendor provider satisfaction surveys, or other assessment tools; (for example)
- Ongoing Vendor staff training

The Vendor must describe their approach to providing a quality assurance program.

Response:

As your current vendor, we understand the need and are committed to a high level of quality management and assurance. Catamaran follows industry best practices as outlined below. Quality is a top priority for Catamaran and we have exciting quality initiatives planned in 2014. For example, The Catamaran Difference in Quality initiative has comprehensive plans to include

a company-wide process excellence training delivered to a target of 400 internal staff. The initiative will focus on process improvement tools and techniques and a process improvement portfolio to include 50+ projects to further raise the bar on meeting our customer satisfaction and operational performance targets.

The Catamaran Difference in Quality initiative fully supports the commitments we make to our clients. This initiative includes a "First Time Right" approach that delivers high quality outcomes and performance with cost efficiency. In addition, we provide support and quality assurance initiatives for all of our clients.

URAC Accreditation

Catamaran has received PBM and Specialty URAC accreditations. As such, we follow the high standards and guidelines offered by URAC with respect to quality improvement. We have instituted a Quality Assurance Executive Committee (QAEC), which regularly meets to review performance and provide guidance on quality management priorities and projects. The committee consists of the company's chairman and chief executive officer as well as executive and senior vice presidents and vice presidents. The QAEC reviews input from providers, provides guidance to our management and staff on quality priorities and projects, and assesses our performance toward meeting objectives for customer satisfaction, URAC compliance, and continuous improvement activities.

Federal Compliance

Catamaran is SOX (Sarbanes Oxley) 404 compliant; therefore, an independent auditing firm attests that our internal control processes and systems are effective and satisfactory. We also have received a SSAE 16/SOC 1, Type II report related to our pharmacy claims processing services audited by an independent CPA firm. In addition, our internal audit team is responsible for testing the design and operating effectiveness of key internal controls for compliance with Sarbanes-Oxley 404. This process occurs throughout the year and includes planning, risk assessment, testing, reporting results, and issue resolution. The internal audit team also is responsible for coordinating and facilitating the claim system SOC 1 report audit conducted by an independent accounting firm.

Quality Management Program

Our Quality Management Program ensures ongoing performance and monitoring of operational improvement activities by systematically gathering and reviewing performance data and metrics. When quality improvement projects (QIP) are identified, we follow a specific workflow:

- Identify the business issues through review of business metrics, customer inquiries, or other performance metrics
- Assign the QIP to a project owner for action
- Assemble a team of subject matter experts with appropriate cross-functional representation to analyze the issue and identify action items
- Analyze business performance information and corrective action to develop an implementation plan
- Implement corrective action steps
- Monitor business performance for improvement.

If business performance improves to desired levels, the QIP is completed; otherwise, the team continues their analysis and identifies additional corrective action steps.

The intent of each QIP is to:

- Continually improve our processes and the way we do business
- Share best practices from QIPs across functions and business units
- Communicate to our staff that quality at Catamaran is a culture, not just a program.

Tracking and Measuring QIPs

Catamaran ensures ongoing monitoring of operational activities by systematically gathering performance metrics for trending and analysis. We evaluate operational performance and identify and implement quality improvement initiatives based on these findings. The goal of our Quality Management Program is to maintain compliance with applicable regulatory quality standards and internal procedures, as well as to maintain and continually improve operational excellence as defined by accuracy, service levels, and customer satisfaction.

We apply appropriate controls to all data and documents to ensure that only approved and correct documents are available to ensure for the integrity and security of data, particularly records that contain Protected Health Information (PHI). We maintain records to demonstrate conformance to the Quality Management Program, contractual agreements, and industry standards (including URAC requirements) to allow us to meet the demands of our customers and users.

We also integrate a regulatory compliance program, which tracks applicable laws and regulations in the jurisdictions we serve in our Quality Management Program. We utilize this information to promote Catamaran's compliance with applicable laws and regulations.

Our staff performs specific operational quality assurance monitoring, performance measurement, and improvement initiatives within each operating function. Each business unit and functional area initiates projects to improve processes, increase efficiencies, and enhance client satisfaction. Process improvement teams lead quality improvement projects by utilizing a specific process workflow. Each quarter, the Quality Assurance Department monitors and reports on the status and outcome of these projects.

Client Satisfaction Surveys

Catamaran's Quality Management Program requires the survey of clients at least annually to assess the performance of our Account Management Team and the services provided. Satisfaction is evaluated using Catamaran's standard client satisfaction survey and methodology, which was designed in collaboration with ZS Associates, an industry leading market research and measurement firm. Our survey is administered using Qualtrics, the leading global supplier of enterprise data collection and analysis which is used by leading brands such as The Wall Street Journal, Duke University, FedEx, Deloitte, Capital One, and more.

Satisfaction is defined as an average rating of five (5) or greater on a seven (7) point scale. Any data collected is reported, in aggregate, on an annual basis.

Provider Satisfaction Surveys

Catamaran believes that stakeholder surveys are a vital tool that assists in gauging the effectiveness of a PBM vendor's services. Surveys help to clarify areas for improvement, help to justify change initiatives, and facilitate a better understanding of appropriate goals throughout the life of the contract. Well-written, properly conducted surveys that mitigate bias, engage a significant sample size, and ask relevant questions are very effective in quantifying stakeholders' perception of the PBM services, Catamaran, and vicariously, the State. Recognizing their effectiveness, Catamaran will conduct stakeholder surveys on behalf of the State, analyze results, and report the results to the State.

Catamaran's survey management solution encompasses the use of a variety of survey types, including web, paper, email, and telephone. For example, we can conduct surveys on a variety of useful topics including stakeholder experience with Catamaran's web site, service desk satisfaction, clinical call center satisfaction or stakeholder satisfaction on specific matters. We will collaborate with the State to create a survey that will best suit your needs and capture the most effective feedback from the State's stakeholders.

Catamaran uses established survey management tools to write, administer the surveys, and evaluate results. We use proven research techniques to ensure the validity of the data collected. We will establish a process with the State for survey results to be stored and disseminated according to mutually agreed upon terms.

Data Audit Trails

One advantage that Catamaran maintains over most every other vendor in the pharmacy benefit administration market is the breadth of the data that we retain in our data warehouse and the manner in which it is stored and accessed. The typical approach for most vendors is the warehousing of selected data elements from claims history, eligibility and reference files. Catamaran makes all data elements available for auditing and reporting. This includes not only the typical array of data elements extracted from history, eligibility, provider and reference tables, but operational data as well. We retain all data related to a provider override transaction, and all processing activity data logged by technical support staff (call center representatives), pharmacy technicians and clinical pharmacists. All disposition data including reason codes, level of service codes, COB/TPL codes, PA type codes, etc., are warehoused and available for auditing, reporting, and analysis.

We use operational activity data for reporting, analysis and documentation purposes, as well as for auditing individual and departmental performance. This data integrate with the call management system data to identify operational problem areas, balance workload demands, optimize response times and comply with performance standards.

Catamaran's RxClaim Suite tracks all updates to all tables within the system by user ID and date/time of change. It tracks updates separately and a unique self-documenting/auditing feature enables users to view how each update was applied and the entire history. The system management components of the application include roll-logic (the ability to accept new information and make intelligent decisions about how this new information impacts previously received information) and comprehensive audit trails.

Multi-layer physical and logical measures protect all information processed and stored on Catamaran systems and transferred to and from customers and business partners. Logical access controls are standard on all Catamaran computer systems and networks. All Catamaran

computer systems are designed and maintained with the appropriate degree of security necessary to protect data, computer functions, operations and resources and with the ability to audit user and automated system activity.

Dependent on the specific needs of the end user as determined by the State, we currently provide State staff with various levels of system access. The State identifies the appropriate level of access for each user and indicates when access should be terminated. To assure that only State staff with active employment can access our system, Catamaran provides the State a monthly report showing State staff with current access to our system for their review.

Claims Processing Sampling and Reconciliation

As your current vendor, Catamaran performs comprehensive testing and Quality Assurance on any proposed coding change. The testing process is designed to prevent coding errors and claim issues from occurring. In response to this RFP, many new initiatives are being offered to the State. Catamaran will commit to the State that any testing for these will be performed in a newly created test environment. This test environment will be unique to the State's plan setup and will allow for thorough testing of benefit plan design and program features prior to any effective date.

If a coding error or claim issue is discovered after an implementation, we manage error resolution with the highest level of urgency. We strive to resolve errors on the same day they are identified in order to rectify the situation and minimize any possible disruption to operations. Upon the discovery of any processing error, a member of the onsite Catamaran Account Team logs the issue in Pulse, Catamaran's internal issue tracking tool. . Based on the specific issue or error noted, the task is then assigned to the appropriate department for review. . .All activity around the issue is thoroughly documented in Pulse. We have found this method is a highly effective manner to troubleshoot and document an issue from start to finish.

Catamaran's test claims are logically separated from production claims and are suppressed from extracts and financial functions. In response to this RFP, we will commit to the State that a random selection of 500 sample claims will be reviewed monthly for processing accuracy. It will be the Account Manager's responsibility to notify the Department by phone or email of any identified processing issue that could impact program operations. In addition, the detail and summary for the sample claims review will be documented on a scorecard and provided to the Department for review. If issues are identified, the Catamaran Account Manager will document them on the Action Log for discussion during weekly team meetings at which time any plan of action can be established.

Operational Quality Assurance Monitoring

Quality assessment is a standard operating component at all levels of the Catamaran organization, down to specific tasks and processes. Our staff performs specific operational quality assurance monitoring, performance measurement, and improvement initiatives within each operating function. Each business unit and functional area initiates projects to improve processes, increase efficiencies, and enhance client satisfaction. Process improvement teams lead quality improvement projects by utilizing a specific process workflow.

A good example of our quality review process related to tasks is the quality auditing program within our call center operations. We strive to provide the best service possible to the State's providers. The on-site Catamaran Account Team works closely with our Technical Call Center to update or enhance the custom call center protocols that have been developed to meet the

specific rules regarding the State's many programs. Our quality assurance (QA) auditors perform random call monitoring and the supervisor completes an evaluation form while monitoring the service representative.

During the monitoring session, the QA auditor simultaneously monitors the telephone conversation and views the service representative's computer desktop. Monitoring the audio of a call, in addition to the onscreen activity, enables the auditor to verify whether the representative is providing accurate information and is entering accurate and relevant information into the call-tracking component. Evaluating the audio portion of a call also allows the QA auditor to observe and evaluate overall customer service skills, including tone of voice, politeness, patience, and professionalism.

The objective of using call monitoring is to ensure that our service representatives provide timely, functional, and valuable support, while being professional, considerate, supportive, and responsive to the caller's needs.

An excellent example of how we assess processes from a quality perspective is the method the drug rebate team utilizes to verify rebate calculations prior to invoicing. The Catamaran rebate team employs a three-step process to ensure that rebate calculations are correct, prior to invoice mailing. Using a random sample from the scheduled invoice run, Catamaran employs this process to ensure that rebate calculations are correct, prior to invoice mailing.

If issues are identified in any of the three steps, Catamaran rebate staff investigates further before invoices are mailed.

Catamaran Staff Training

Catamaran employs a comprehensive training program for newly hired and existing personnel. The training content is customized for each contract to encompass program specific rules, regulations, benefits and policies.

Upon hire and on an annual basis thereafter, Catamaran requires all employees to complete the following curriculum. These training modules ensure our compliance with State and Federal requirements and accrediting bodies.

Catamaran Annual Training Curriculum
Catamaran Employee Orientation *(New Employees Only)*
Compliance Courses Catamaran Compliance Training HIPAA Training False Claims Act Training CMS Fraud Waste and Abuse Training
URAC Accreditation Training

Catamaran Annual Training Curriculum

Compliance Policy Training

- Code of Business Conduct and Ethics
- Compliance Program
- Conflict of Interest Policy and Procedure
- HIPAA Associate Confidentiality Agreement
- Whistleblower Policy
- Employee Handbook

Catamaran University is a Web-based classroom where all employees access required and supplemental training. The Catamaran University catalogue incorporates hundreds of training events and eLearning courses ranging from general skills and competencies to product/technical proficiency to leadership development.

Catamaran University is a component of My Career Gateway, which is the site utilized to manage each employee's annual goals, objectives and performance plans. The courses each employee completes via Catamaran University are automatically documented in their performance plan.

While Catamaran University/ My Career Gateway is the vehicle for executing the company's Annual Training, it is also a resource for individual departments to disseminate department specific, role based, and contract based curricula. Managers use the site to assign training courses to their teams. Individual employees are also able to access the hundreds of courses available to support their independent learning objectives.

Catamaran is confident that the State will find our quality management and assurance practices are among the best in the industry. Our staff undergo both annual mandatory training and training as it relates specifically to their client, in this case, the State.

1.2.11 Medication Therapy Management

Medication Therapy Management (MTM) is a partnership of the pharmacist, the beneficiary and other health professionals that promotes the safe and effective use of medications and helps beneficiaries achieve the targeted outcomes from medication therapy.

Vermont believes that any MTM program implemented must include the analytical, consultative, educational and monitoring services provided by pharmacists to help beneficiaries get the best results from medications through enhancing understanding of medication therapy, increasing adherence to medications, controlling costs, and preventing drug complications, conflicts, and interactions.

The State is interested in developing an MTM program that will comply with all Part D requirements for such programs, will be offered to both Medicaid and Medicaid/Medicare eligible populations, and will be integrated into and coordinate with other State initiatives such as the Vermont Chronic Care Initiative. This is envisioned as a utilizing a combination of community pharmacists who currently see beneficiaries on a regular basis and supply their medication

needs, and State and/or Vendor clinical pharmacists who will coordinate with the DVHA, community pharmacists, the VCCI program, and other stakeholders to assure continuity and coordination of MTM services. Pharmacists should be reviewing medication regimens for and potential problems such as drug interactions, duplications of therapy, appropriate dosing, dosage forms, and routes of administration, medication adherence and compliance, side effects, cost optimization such as promoting generic utilization, and assuring compliance with the State's PDL

The MTM program goals are:

- Strive to reach optimum therapeutic outcomes for targeted beneficiaries through improved medication usage
- Reduce the risk of adverse events
- Be developed in cooperation with licensed and practicing pharmacists and physicians
- Be furnished by pharmacists or other qualified providers
- Distinguish between services in ambulatory and institutional settings
- Be coordinated with any care management plan established for a targeted individual under Vermont's chronic care initiative program (VCCI)

There are no detailed functional requirements for this capability. The Vendor should provide an overview of their approach to MTM and how they can support the implementation a customized MTM program for the State.

Response:

Confidential, Proprietary, and Trade Secret Information of Catamaran.

[redacted]

[redacted]

[redacted]

[redacted]

1.3 Financial Management

Financial support services are an important component of the PBM services being solicited. The State seeks Vendor services in the administration of all rebate programs, including the Federal OBRA '90 rebates, supplemental rebates and State-only rebates. It will also rely on the Vendor to support the State's participation in the Sovereign States Drug Consortium (SSDC) multi-state supplemental rebate pool.

1.3.1 Management of State and CMS Drug Rebate Programs

The Medicaid Drug Rebate Program is a partnership between CMS, State Medicaid Agencies, and participating drug manufacturers that helps to offset the Federal and State costs of most outpatient prescription drugs dispensed to Medicaid patients. Approximately 600 drug manufacturers currently participate in this program which requires a drug manufacturer to enter into a national rebate agreement with the Secretary of the Department of Health and Human Services (HHS) in exchange for State Medicaid coverage of that manufacturer's drugs. Manufacturers are required to pay a quarterly rebate on those drugs each time that they are dispensed to Medicaid patients. These rebates are shared between the States and the Federal government to offset the overall cost of prescription drugs under the Medicaid Program.

In addition, the State administers a state rebate program for state funded pharmacy programs. This program is similar to the federal program, and is based on a pro-rated share of the federal rebate calculation.

The State seeks full support of the Federal and State Rebate program. The Vendor should describe how it manages all aspects of rebate support including, but not limited to:

- Producing Drug Rebate Invoices for drug manufacturers
- Processing the CMS Rebate Utilization files
- Providing rebate reporting to the State and partners
- Reconciliation and resolving drug rebate disputes
- Supporting manufacturer inquiries such as claims level detail

The Vendor must describe their approach for supporting the Agency's Drug Rebate program and maximize the value achieved for the State.

Response:

Catamaran is widely recognized as an industry leader in providing rebate administration services to both governmental agencies as well as commercial payers. This leadership is built on three key attributes:

- Qualified and experienced rebate personnel who manage each and every step in the rebate cycle;
- A proprietary rebate management application which provides the functionality and flexibility necessary for the successful management of different types of rebate programs; and
- Efficient and effective operational processes and procedures.

This unequaled combination of attributes, as well as Catamaran's reputation for providing inventive solutions, positions the State to maximize its rebate revenue through efficient invoicing and collection, thus reducing rebate disputes.

Rebate Management Team

Confidential, Proprietary, and Trade Secret Information of Catamaran.

[redacted]

[redacted]

[redacted]

Catamaran rebate personnel are experts in Federal, Supplemental and State-only rebate programs. As a result, there will be a seamless transfer in the administration of the State's Federal OBRA '90 (Federal) and State-only rebate programs to Catamaran from the current vendor. Since Catamaran is the current administrator of the Supplemental rebate program, no transition is required which provides an additional benefit to the State. The Catamaran rebate staff is not only highly experienced in Medicaid rebate contracting and administration, but they are required to actively maintain their industry-leading expertise by constantly monitoring industry trends and legislative activity at the state and Federal level and remain compliant with CMS drug rebate provisions as well as Section 1927 of the Social Security Act.

Resumes for the Rebate Management Team members are included in Attachment F.

Catamaran Rebate Management System – RxMax

Catamaran implements a software and business process solution based on our proprietary rebate administration application, RxMax. Catamaran understands that business process requirements change (sometimes very quickly) due to changes in Federal, state and Medicaid agency policy. Catamaran is prepared to handle such changes and has in place an established team of experienced developers and business analysts to monitor, maintain, and enhance RxMax to meet the needs for all of the State's rebate programs. Since Catamaran is the designer, developer and owner of RxMax, we can be very responsive to needed changes.

RxMax provides all the functionality required by state and Federal regulations. This flexible, table-driven rebate management system is in place today and is processing more than 500 million claims annually for our clients. RxMax utilizes both CMS and NCPDP rebate standards as its foundation, allowing it to support the entire rebate process for Federal and State-only rebates to include:

- Mapping and loading all available electronic historical rebate data received from the State (a minimum of 12 quarters, per the RFP)
- Rebate drug data (drug information and URAs) file receipt, verification and load
- Unit conversion table development and maintenance
- Invoice calculation, generation and verification
- Pharmacy claims receipt, verification and load
- Interest calculation, accrual, collection, and reporting
- 340B provider identification and maintenance
- Rebate reconciliation and maintenance of accounts receivable

- Delinquent payment tracking and resolution
- Dispute tracking and resolution
- Physician-administered drug claims receipt, verification and load
- State rebate contract construction and retention
- Rebate payment collections through ROSI and PQAS
- Manufacturer contact file receipt, verification and load
- Report generation (standard and ad-hoc)
- Rebate offset data (UROAs) file receipt, verification and load
- HCPCS/CPT Code to NDC crosswalk development and maintenance
- Rebate records retention

Catamaran implements RxMax with the specific needs of the State in mind. There are numerous parameters and documents that are configurable based on the State's policies and procedures. These functions and parameters include:

- Establish rebate invoice threshold tolerance levels
- Establish manufacturer participation effective date
- Determine media types for invoices
- Format and content of invoices
- Format and content of collection letters
- Establish parameters for claim audits
- Establish parameters for invoice audits
- Format and content of invoice cover letters
- Format and content of dispute resolution letters
- Full accounting functionality

Catamaran provides applicable State staff with read-only, real-time access to RxMax as well as all necessary training. State staff securely access RxMax via the Internet from any computer with an internet connection and standard web browser (Microsoft Internet Explorer).

Catamaran Rebate Administration Processes and Procedures

Based on our experience administering Medicaid rebate programs, Catamaran has developed efficient and effective processes and procedures for the following functions:

- Claims scrub and load
- Identification and exclusion of 340B provider claims
- Payment receipt and reconciliation
- Non-responsive manufacturer collection efforts
- Rebate reporting
- Conversion of physician administered claims
- Invoicing
- Interest calculation and tracking
- Dispute identification, tracking and resolution
- CMS utilization file creation and submission

Effective rebate administration is essential in order to achieve cost savings. Accurate rebate calculation and invoicing are essential in order to reduce manufacturer disputes and expedite rebate collections and RxMax provides this capability.

Catamaran establishes the State only rebate program as a separate program in RxMax and administers the program as mandated by the State and the terms of the State's contracts with manufacturers. Catamaran understands that State only rebates are calculated in proportion to the State's share of the total cost of a claim (in contrast to the rule for Federal rebates in which the State is entitled to the full rebate amount as long as the State pays some portion of the claim). RxMax provides the breadth of functionality to calculate State-only rebate amounts utilizing quarterly URAs provided by CMS for the Federal rebates and the amounts paid by the State for the utilization. For example, if the total paid amount of a claim is $100 with a third-party paying $80 and the State paying $20, RxMax calculates the State-only rebate as twenty percent of the full amount of the Federal rebate (applicable CMS-provided URA multiplied by the number of units for the claim).

RxMax utilizes CMS and NCPDP rebate standards as its foundation, allowing it to support the entire rebate process for Federal and State-only rebates. Catamaran rebate staff set up each rebate program separately within RxMax. In regard to the State-only rebate program, Catamaran assumes that many of the basic functions (e.g., invoicing, payment receipt and reconciliation, dispute tracking and resolution, reporting) needed to administer the program are very similar, if not identical, to those of the Federal rebate program. As a result, most of the following processes and procedures are appropriate for both the State's Federal and State-only rebate programs.

Rebate Invoicing

Catamaran processes all rebate invoicing on a quarterly basis. Each of the State's rebate programs is set up as a separate program within RxMax to ensure that rebates are properly attributed to each program's utilization. In order to process rebate invoicing, Catamaran requires utilization data (both pharmacy drug claims and physician administered drug claims) and rebate data provided by CMS.

On a weekly basis, pharmacy utilization and provider data is extracted from RxClaim and loaded into RxMax. The claims received include paid claims from the subject quarter as well as reversals and adjustments to claims paid in prior quarters. RxMax follows CMS directives with regard to processing inter-quarter utilization changes. In order to avoid negative unit amounts, RxMax places the reversed claim and if applicable, the adjusted claim in the quarter associated with the original paid claim. This results in Catamaran producing invoicing which notifies the applicable manufacturer of the utilization change.

Each input file goes through an editing, validation and scrubbing process to ensure that clean data is captured and loaded into the system. This process includes the application of the State's rebate exclusion criteria. RxMax allows Catamaran to create and update the rebate exclusion lists to ensure that rebatable claims are tagged as such, and that claims that are not eligible for rebates are marked as excluded. RxMax exclusion lists are dynamic allowing Catamaran to exclude claims by numerous attributes including:

- Service provider IDs (NCPDP, NPI, and Medicaid assigned) to exclude specific providers

- Service provider type (retail, mail order)
- Service provider network
- NDC's (NDC-11, NDC-9, NDC-5) to exclude specific products
- Drug hierarchy attributes (GPI, GPI-10, GPI-6, GPI-4, GPI-2) to exclude specific classes or groups of drugs
- Claim paid amounts to exclude zero paid claims
- Plan hierarchy attributes (carrier, account, group) to exclude specific beneficiaries (e.g., Title XXI CHIP beneficiaries)
- HCPCS/CPT to NDC Crosswalk status for claims that did not have a valid HCPCS/CPT to NDC match

In addition, Catamaran requires physician administered drug claims from the State's MMIS vendor. Catamaran requests that physician administered drug claims be provided on at least a weekly basis in order to allow for claim transformation and auditing to ensure that utilization issues are identified and resolved in advance of Catamaran's receipt of the quarterly CMS drug rebate data.

All claims are extracted based on the paid dates (only claims with paid dates that fall within the subject quarter are extracted) and are subjected to the following edits to ensure correct utilization is used in rebate invoicing:

- Medicaid amount reimbursed is greater than $0.00
- Participating 340B providers are excluded
- Non-rebateable products – Federal Financial Participation (FFP) is available but products are excluded from the Federal rebate program (e.g., vaccines)

On a quarterly basis, RxMax electronically receives and processes rebate information from either the CMS Drug Data Reporting (DDR) system or the CMS Enterprise File Transfer (EFT) system. In either case, quarterly rebate data is available to be loaded into RxMax immediately upon release by CMS. The quarterly rebate data is provided by CMS in three (3) files: the rebate rate file (Rate File), the labeler contact file (Labeler Contact File) and the unit rebate offset amount file (UROA File).

The Rate File contains product information at the 11-digit NDC level and URAs for each drug deemed to be a "covered outpatient drug." CMS uses this file to update product baseline data such as DESI codes, termination dates, clotting factor and pediatric indicators etc., as well as providing URAs for the current quarter and any URA changes for prior quarters. Records for baseline data changes are marked with a correction flag of "1" while records with current quarter URAs are marked with a correction flag of "0". URA changes for prior quarters or Prior Period Adjustments (PPAs) are identified with a pair of records. CMS provides the original URA on a record with a correction flag of "2" and the replacement URA on a record with a correction flag of "3". RxMax files are updated with this information in order to create accurate quarterly rebate invoicing.

The Labeler Contact File provides a listing of contact names, addresses and phone numbers for each manufacturer that is actively participating in the Medicaid Drug Rebate Program as well as manufacturers that have terminated since the last quarterly CMS rebate data was released. RxMax files are updated with this contact information to ensure correct delivery of the quarterly invoice package.

The UROA File contains unit rebate offset amounts (UROAs) per unit type at the 11-digit NDC level. Like the Rate File, the UROA File provides UROAs for the current quarter and any UROA changes for prior quarters. Initial or current records have a record type indicator of “0”. UROA changes for prior quarters or Prior Period Adjustments (PPAs) are identified with a pair of records. CMS provides the old UROA record with a record type indicator of “8” and the replacement UROA record with a record type indicator of “9”. RxMax files are updated with this information in order to create accurate rebate offset amounts. Rebate offset amounts only apply to Federal rebates.

Drug and manufacturer information can change between the quarterly releases by CMS. These changes, as well as policy directives, are disseminated by CMS through program releases, electronic mail and the CMS DDR system. Since this information can impact drug coverage, Catamaran rebate staff in most instances immediately notify the State and if applicable, other State contractors, of the changes and/or policy directives. Catamaran provides the State with a copy of the CMS communication, Catamaran’s assessment of same and a work plan to implement the changes and/or policy directive. Should it be necessary to make changes to the drug rebate management system, RxMax has the functionality to allow for the manual entry of data. Catamaran rebate staff will include Catamaran Account Management in these communications when necessary.

RxMax obtains additional drug information from First DataBank and Medi-Span which includes information not available from the CMS Rate File (e.g., pricing points such as AWP, FUL, WAC, etc.), as well as information available from the CMS Rate File (e.g., DESI codes). Because CMS has been adamant about Medicaid programs utilizing its data, where information is provided by CMS and third parties (e.g., DESI codes), RxMax utilizes the information provided by CMS in rebate administration. This policy ensures that Federal Financial Participation (FFP) is not jeopardized when the data provided by third parties (e.g., First DataBank and Medi-Span) differs from that provided by CMS.

Catamaran understands that only units from “covered outpatient drug” claims should be invoiced for rebates. In order to ensure this occurs, Catamaran employs a two-pronged strategy. During claims processing, RxClaim utilizes CMS data to determine what drugs are rebate eligible. In addition, RxClaim utilizes the Therapeutic Equivalence Indicator from First DataBank, which identifies non-drug products. As a final check, Catamaran rebate staff use the same information in performing claim audits.

Per CMS requirements, RxMax calculates rebates at the 11-digit NDC level. Once the following tasks are completed, the rebate calculation process is initiated in RxMax:

- Load utilization data (pharmacy and physician administered drug claims);
- Load the quarterly CMS Rate and Labeler Contact files;
- Perform any final claim audits;
- Update crosswalk records;

- Update unit conversions;
- Update supplemental and diabetic supply rates and products;
- Update 340B providers; and
- Update T-Bill rates.

Once the rebates are calculated, invoice audits are performed. The invoice audits identify any unusual invoice amounts that may trigger a dispute. The parameters for the audits are established during implementation based on input from the State. These audits compare the current quarter invoices to past quarters. Suspect invoices are reviewed by Catamaran rebate staff to determine if adjustments are warranted. If adjustments are made, invoices are then recalculated.

Since CMS has charged manufacturers with calculating and remitting interest due, Catamaran does not send interest invoices with the current quarter invoices. However, in compliance with CMS guidelines, Catamaran does send utilization changes for prior quarters to manufacturer with the current quarter invoice. Although not required by CMS, Catamaran also sends invoices related to URA changes. There is a separate invoice page for each prior quarter reported.

RxMax provides the functionality to suppress the production of invoices that fall below a tolerance threshold amount (e.g., $10.00), which is established at the State's direction during implementation and can be adjusted based on the needs of the State. Invoices that fall below the tolerance threshold are written-off or retained, as determined by the State. Rebate amounts retained are carried forward until the cumulative total of rebates for several quarters exceeds the tolerance threshold. At that point, rebate invoices are sent to the applicable manufacturers.

CMS has suggested that Medicaid programs applying the tolerance should report the quarter, NDCs and number of units to the affected manufacturers. Catamaran has the capability to provide manufacturers with this information if requested by the State.

Medicaid programs are required to submit drug rebate invoices to manufacturers no later than 60 days after quarter end. The generation and sending of rebate invoices is predicated on the receipt of utilization data as well as the quarterly CMS rebate data. Upon receipt of the CMS rebate data, Catamaran generates and mails rebate invoices to manufacturers as soon as possible and in all instances within 30 days of the receipt of the CMS rebate data. Prior quarter utilization changes are generated and mailed within the same time frame. Rebate invoices are generated for manufacturers that are actively participating in the Medicaid Drug Rebate Program and manufacturers who have terminated their participation but are still responsible for rebates per CMS requirements.

Catamaran has the capability to produce drug rebate invoices and cover letters on paper and on an electronic medium. In addition, manufacturers can download their invoices directly through the web portal or can have them mailed either in paper format or burned to a CD. The paper invoices replicate the Form CMS-R-144 while the electronic invoices are in the file layout employed to send the quarterly utilization data to CMS. Electronic invoices can also be produced in the NCPDP file layout. Invoice cover letters are included with each invoice mailed. Generally, the cover letters provide payment instructions to manufacturers and other content pertinent to the particular rebate program.

Catamaran disseminates paper invoices and cover letters to every participating manufacturer and electronic invoices to requesting manufacturers. Paper invoices are mailed to manufacturers as interest calculations are based on the postmark date of the invoice. For requesting manufacturers, Catamaran delivers electronic invoices through secure electronic mail or by a secure FTP connection. Pursuant to direction by CMS (CMS Medicaid Drug Rebate Program Release No.154 For State Medicaid Directors), Catamaran also tracks the dates electronic mail is sent as such dates are deemed by CMS to be the "postmark" date for invoices sent via electronic mail.

RxMax includes the ability to push invoices out to a manufacturer through the manufacturer portal. After the Catamaran rebate staff completes the invoice run, certain invoices are available on the manufacturer portal for those manufacturers with authorized use. If a manufacturer has one or more users registered within the system, an e-mail notification will be sent to the identified users for the manufacturer notifying them that their invoices are available for download. The notification e-mail contains the URL to access the system and a summary of the invoice information, including the list of NDCs and the associated invoice amount. The detail contained within the e-mail complies with CMS guidance that allows us to consider the invoice mailed to the manufacturer and to set the postmark date accordingly.

An authorized manufacturer user can log into the system at any time to download their invoices. Invoices that have not previously been downloaded are listed on the current download screen. The user can also access an invoice history screen to review any invoices that have previously been downloaded. When an invoice is downloaded for the first time, the system updates its internal download status to mark the invoice as downloaded. This will remove the invoice from the current invoice list. The invoice will still be available within the invoice history. The system tracks each time a user downloads an invoice. This information is tracked internally and made available to authorized users through the user interface.

Once the invoices are printed, the Catamaran rebate staff employs quality assurance procedures. An Invoice Register is produced and the invoice amounts and corresponding manufacturers (at the labeler code level) are compared against the respective invoices. In addition the Catamaran rebate staff verifies manufacturer invoice contact information and URAs to rebate data supplied by CMS as well as the accuracy of the rebate calculation (total units reimbursed multiplied by URAs). Once the quality assurance process is complete, the invoices are put into envelopes and mailed in bulk utilizing the United States Postal Service. The postmark date is recorded in RxMax in order to facilitate interest calculations.

A summary rebate invoice report is provided for State review at least three business days prior to invoice distribution.

Payment Reconciliation

Rebate payments are entered into RxMax at the rebate program/11-digit NDC/year-quarter level by Catamaran rebate staff. The allocation of payments for the most current quarter is based on the ROSIs received and allocations to any prior quarters are based on the PQAS received. The payment data entry screens in RxMax are arranged to replicate the layout of the ROSI and PQAS rebate reconciliation forms. Certain fields are pre-populated by the system based on the invoice (unit totals, URAs and rebate amounts) with Catamaran rebate staff manually entering the information provided by manufacturers. This provides Catamaran rebate staff with the ability to view and compare to determine which 11-digit NDC items are different than the invoice and/or in dispute. RxMax also provides the capability to take an aggregate payment (e.g., one

manufacturer check), separate and apply the proceeds to multiple invoices, rebate programs and year and quarter combinations.

RxMax automatically calculates outstanding balances whenever any accounts receivable transactions (whether debit or credit) are posted to a manufacturer's account. In addition, interest is posted to the accounts receivable file upon the receipt and entry of a payment or credit by a manufacturer from a ROSI or PQAS. Accounts receivable transactions are posted in real-time, enabling the Catamaran rebate staff to immediately review outstanding balances.

All payments, full and partial, are entered into RxMax. In the case of a partial payment, Catamaran rebate staff contacts the manufacturer directly to determine why full payment was not made and ascertain whether there is a dispute. If a dispute is determined, Catamaran rebate staff enters the disputed units, the dispute code(s), and initiates the dispute resolution process.

If a partial payment is due to a change in URA, we expect to receive a corrected URA with the next quarterly CMS rebate data, at which time RxMax automatically reconciles the difference. If both situations apply to an underpayment, then both processes are implemented. If a manufacturer simply does not pay the correct amount or does not pay at all, the collections process is implemented. RxMax has the functionality to differentiate between a dispute and non-payment.

When a partial payment is made, and a legitimate dispute or URA change is documented, the original postmark date still applies to the payment and as long as it was mailed within 38 days, interest does not accrue. However, if the dispute process results in a balance due by the manufacturer, interest is calculated based on the postmark date of the original payment.

Rather than issue refund payments, manufacturer overpayments can be applied toward any invoice where payment has not been received in full, including the next quarter's invoice. RxMax automatically calculates and tracks manufacturer overpayments allowing Catamaran rebate staff to apply the overpayments to any open invoices. Upon contract award, Catamaran works with the State to establish a procedure to refund manufacturer overpayments in situations where manufacturers terminate from the Medicaid Drug Rebate Program and will not be receiving future invoices.

Interest

RxMax calculates interest owed for the Federal rebates at the 11-digit NDC level pursuant to CMS guidelines. The Medicaid Drug Rebate program provides for the application of interest to disputed or unpaid amounts and late rebate payments. The National Rebate Agreement (Drug Rebate Manufacturer Agreement) requires that interest be paid or credited when due by either the manufacturer or the state. Interest begins to accrue on the 38th calendar day from the date the rebate invoice was postmarked and continues to accrue and is calculated up to the postmark date of the manufacturer's mailed payment. Unpaid interest becomes principal and interest accrues on the new principal amount as of the date the manufacturer paid the original invoice amount (as evidenced by the postmark date of the manufacturer's mailed payment).

In calculating interest due, the interest rate utilized is based on the yield of the weekly 13-week investment rates from the Treasury bill (T-Bill) auctions during the period for which interest has accrued. Information regarding T-Bill rates is obtained from the U.S. Department of Treasury, Bureau of the Fiscal Service Web site (**http://www.treasurydirect.gov/instit/annceresult/annceresult.htm**).

Catamaran rebate staff enters the T- Bill rates into RxMax on a weekly basis.

RxMax provides the functionality to calculate interest for State-only rebates in the same manner as the Federal rebates or allow for parameter changes (e.g., interest accrual begin date, constant interest percentage) to accommodate interest calculation methodology specific to the State-only rebate program.

Catamaran rebate staff may enter interest paid at the 11-digit NDC / quarter level or at the labeler code / quarter level as is more commonly seen due to the layout of the ROSI and PQAS forms (one single line at the bottom of the form to list the amount of the interest payment). If interest is remitted at the labeler code / quarter level, RxMax automatically allocates interest to all NDCs for that quarter or provides the capability for the Catamaran rebate staff to determine how the allocation is made.

Non-Responsive Manufacturers

Catamaran handles non-responsive manufacturers by utilizing a delinquent account procedure. Per CMS guidelines, manufacturers are given 38 days from the invoice postmark date to remit payment for the invoice, dispute the invoice or remit partial payment and dispute the remainder. Manufacturers who fail to take any of the foregoing actions are deemed non-responsive. RxMax has the capability to track non-responsive manufacturers and Dunning Notices (collection letters) are generated pursuant thereto. In addition to mailed notices, where electronic mail addresses are available Catamaran rebate staff sends electronic mail to manufacturer contacts requesting immediate payment.

On the 45th day after the postmark date of the subject invoice, Catamaran generates and mails the initial Dunning Notices to non-responding manufacturers. For manufacturers who fail to respond to the initial Dunning Notices, subsequent Dunning Notices are sent at 75 days after the postmark date of the subject invoice and if necessary, 105 days after the postmark date of the subject invoice. After each mailing, Catamaran sends the State copies of each Dunning Notice sent via electronic mail. Catamaran works with the State during requirements analysis to finalize the exact content and frequency of the Dunning Notices.

It has been Catamaran's experience that most manufacturers are responsive to our collection efforts and remit payment. Of course, there are situations where this is not the case such as when a manufacturer files for bankruptcy. In the event a manufacturer does not respond to the final Dunning Notice or files bankruptcy, Catamaran consults with the State and determines further action to be taken. Once a plan of action is developed, Catamaran is responsible for its execution.

Dispute Resolution

Catamaran employs a variety of measures to proactively prevent rebate disputes and expedite cash flow for the State. These measures were developed based on our experience and thorough understanding of the reasons rebate invoices are disputed by manufacturers. These reasons include:

- Unit of measure discrepancies,
- Invalid unit amounts,
- Invalid and terminated NDCs,

- Inclusion of 340B provider claims,
- Aberrant quantities, and
- Zero-pay drug claims

Key to dispute resolution support is the broad functionality delivered by RxMax in virtually every aspect of the dispute resolution process. Catamaran utilizes RxMax to maintain and provide the data necessary to resolve rebate disputes with drug manufacturers. RxMax provides the functionality to house both historic and current data at the 11-digit NDC level for all manufacturers that participate in each of the State's rebate programs. RxMax contains data that covers all aspects of the rebate programs including:

- Claims data (quarterly utilization),
- Quarterly unit rebate amounts (URAs),
- Quarterly unit rebate offset amounts (UROAs),
- Quarterly rebate invoiced amounts,
- Quarterly rebate offset amounts,
- Utilization and URA changes (including reasons for the changes),
- UROA changes,
- Outstanding balances (for both units and dollars),
- Rebate collections,
- Postmark dates for invoices,
- Rebate payments received, and
- Disputed units (including CMS dispute codes)

This enables Catamaran rebate staff to comply with the dispute resolution processes and procedures established by CMS as well as any State mandated requirements. Catamaran rebate staff identifies disputes from the ROSI and PQAS and flag them in RxMax at the 11-digit NDC/year-quarter level utilizing the dispute codes defined by CMS.

RxMax has the capability to generate claims level detail to support the aggregated invoice information for use during rebate dispute resolution. The claims level detail while containing the minimum necessary information does not provide any patient identifying information and is HIPAA compliant. Claims level data may be generated for an entire invoice, a subset of NDCs within an invoice or a specific NDC from an invoice. Additionally, the HIPAA compliant claims level detail can be generated along with the invoice or after the fact pursuant to a request by a manufacturer.

Regardless of when the claims level detail is generated or if it is for a full invoice or just a portion, it is always provided in electronic format, with HIPAA compliant content and delivery. The claims level detail is provided to manufacturers via various delivery methods including secure email, mailed password protected disks and through the manufacturer web portal.

Catamaran's rebate staff utilizes the dispute resolution process and timelines established by CMS as a guide in developing procedures and action plans. Ultimately, Catamaran defers to the

State's direction in finalizing the approach to follow. Generally, Catamaran rebate staff contact manufacturers and pharmacy providers to schedule calls and meetings to resolve disputes. Once agreement is reached on a given dispute, dispute resolution confirmation letters are sent to confirm the terms of resolution. Any failure by a manufacturer to remit payment subject to a resolution agreement results in the matter being shifted to a delinquent account procedure.

All dispute write-offs follow CMS guidelines and the State's decisions as to final disposition.

CMS Reporting

Once invoicing is complete (and within 60 days of quarter end), the quarterly utilization file is created by RxMax and submitted to CMS via the EFT system. At the NDC and quarter level, the file provides the unit rebate amount, units reimbursed, rebate amount claimed, number of prescriptions, Medicaid amount reimbursed, non-Medicaid amount reimbursed and total amount reimbursed. Utilization information is provided for both the current quarter as well as any changes to utilization, number of prescriptions, Medicaid amount reimbursed, non-Medicaid amount reimbursed or total reimbursement amounts for past quarters. In addition, CMS added a new field (Record ID) to the file layout, which identifies whether the record is for FFS or Medicaid Managed Care organization (MCO) utilization.

On a quarterly basis, the State is required to submit the CMS-64 expense report to CMS. This report is a statement of the expenditures for which the State is entitled to Federal Financial Participation (FFP). Since rebates are considered a reduction in the amount expended by the State for the purpose of FFP, they are shared with CMS in the same percentage as the FFP utilized to pay for the utilization for which rebates were paid. As a result, rebates must be reported on the CMS-64 report as well.

CMS developed the CMS-64.9R report to document the financial impact of drug rebates for the subject calendar quarter. This document serves as an accounts receivable report and shows the following activities that occurred within the subject calendar quarter:

- Balance as of the beginning of the quarter;
- Adjustments to previously reported rebates from manufacturers (URA and utilization changes);
- Rebates invoiced during the quarter;
- Rebates received during the quarter (this information is entered on Line 7.A. of the CMS-64.9 report); and
- Balance as of the end of the quarter.

Each of the past four (4) rebate quarters are reported separately and the remaining rebate quarters are aggregated together.

Catamaran provides the State with the CMS-64.9R report on a quarterly basis as part of the standard rebate reporting. In addition, Catamaran can provide additional rebate reporting for certain categories that may qualify for enhanced FFP (and for which rebates are shared with CMS at the enhanced percentage). Examples of these categories may include:

- Indian Health Service (IHS) Facility Services;
- Family Planning Services (FPS);

- Breast and Cervical Cancer Prevention and Treatment Services (BCCPTS) and
- ACA Medicaid expansion populations.

The second page of the CMS-64.9R report provides a narrative section. CMS has directed states to use this section to report on manufacturers with the largest outstanding rebate balances (see CMS Medicaid Drug Rebate Program Release Number 40 to all State Medicaid Directors). Per the requirements of Section 2500 of the State Medicaid Manual, Catamaran reports on at least seventy-five (75%) of the outstanding rebate amount reported in Column (e), Line 6 of page one (1) of the CMS-64.9R report and provide the following:

- The name of the manufacturer involved (and labeler code);
- The amount of rebates outstanding (principal only);
- The applicable quarters involved;
- Brief description of the dispute; and
- The reason for the delay in resolving the dispute with the manufacturer.

Rebate Reporting

Catamaran is committed to working cooperatively with the State and all partner organizations to fulfill reporting requirements. Reliable, accurate data is available through the RxTrack data warehouse in order to perform a variety of functions – from basic report development to in-depth data mining – on various data types. RxTrack provides the ability to generate reports easily and conveniently, making it an effective and efficient ad hoc reporting tool. Catamaran provides the State with a complete rebate reporting package. Rebate reporting is generally at the 11-digit NDC level and tracks:

- Rebates invoiced;
- Rebate payments received (including comparison of invoiced amount to paid amount);
- Rebate disputes;
- Interest billed and collected;
- Changes to quarterly utilization based on dispute resolution adjustments; and
- Current and past accounts receivable by manufacturer.

The following table offers a list of all standard reports and a detailed description of each.

Standard Rebate Reporting Package		
1.	**Medicaid Drug Rebate Schedule (64.9R)**	Reports the rebate invoicing, collections and adjustments (utilization and URA changes) that were processed during a calendar quarter that affected each rebate quarter. The report contains specific data for the four (4) most recent rebate quarters and aggregated data for all other rebate quarters back to 1Q1991. In addition, the second page of the report is sorted by manufacturer and lists labeler code, outstanding principal amount, applicable quarters involved, and brief description of the dispute and reason for the delay in resolving the dispute. This report is provided quarterly.
2.	**Drug Rebate - PHS Exempt Claims Report**	PHS Exempt Claims Report provides claim level details for all claims that were marked with a rebate eligibility status of "Excluded", due to the PHS (Public Health Service) or 340B Exempt rebate eligibility criteria, determined during the claim payment load. This report is generated as needed.
3.	**Medicaid Drug Rebate Invoice**	Reports current quarter utilization to manufacturers. The report is produced at the labeler code level and includes Record ID, NDC, drug name, unit rebate amount, total units reimbursed, total rebate amount claimed, prescription count, Medicaid amount reimbursed, Non-Medicaid amount reimbursed and total amount reimbursed. This report is provided quarterly.
4.	**Medicaid Drug Rebate Utilization Change Invoice**	Reports changes in the total units reimbursed to manufacturers for prior quarters. The report is produced at the labeler code level and includes Record ID, NDC, drug name, unit rebate amount, total units reimbursed, total rebate amount claimed, prescription count, Medicaid amount reimbursed, Non-Medicaid amount reimbursed and total amount reimbursed. A separate invoice is utilized for each quarter being reported. This report is provided quarterly.
5.	**Claims Detail Report – Utilization File**	Provides detail information at the claim level. This report is created per NCPDP utilization standards and can be given to manufacturers to facilitate dispute resolution. The report is generated as needed.

Standard Rebate Reporting Package		
6.	**Drug Rebate – Final Manufacturer's Invoice Report**	Reports the current quarter invoice amount for each manufacturer. The report is sorted by labeler code and includes identification of the current quarter, manufacturer name, invoice number, total units reimbursed, total rebate amount claimed, number of scripts, total reimbursement amount, correction flag, quarter covered and contract run ID. This report is generated as needed.
7.	**Invoice Totals by Labeler**	Shows the number of prescription claims for drug rebate products dispensed to clients on a participating manufacturer basis. This report is provided quarterly.
8.	**Product Dispute Summary**	Product Dispute Summary provides an overview by manufacturer and quarter of the NDCs that have been disputed. The report includes NDC, product name, dispute code(s), URA, units invoiced, rebate amount invoiced, units disputed and rebate amount disputed. This report is generated as needed.
9.	**Labeler A/R Transactions & Payments Summary**	Reports on the status of one or multiple manufacturers. The report can include one or multiple quarters and for each manufacturer and quarter combination includes rebate billing debit, rebate adjustment debit, rebate payment debit, rebate adjustment credit and rebate balance. This report is provided quarterly.
10.	**Accounts Receivable Reports: Payment Detail-Posted and Billing & Adjustments-A/R Transactions**	Payment Detail-Posted reports on manufacturer payments that are posted during the requested date range. The report includes the payment number, reference number, deposit date, payment amount, issuing labeler code, issuing organization, payment postdate and the user ID for the Catamaran rebate staff beneficiary posting the payment. Billing & Adjustments-A/R Transactions reports on all types of accounts receivable transactions that are posted during the requested date range. The report is sorted by quarter and manufacturer and includes NDC, drug name, drug rebate category code, drug rebate category code description, DESI code, units per package, A/R post timestamp, postmark effective date, debit/credit designation, transaction amount type, and A/R transaction amount. These reports are generated as needed.

Standard Rebate Reporting Package		
11.	**Unbreakable Package NDCs**	Reports on products that are distributed in unbreakable packages. The report is sorted by NDC and includes each product's name, unit conversion factor, CMS unit type, package size, CMS unit per package size, effective date and if applicable, termination date. This report is generated as needed.
12.	**Non-Rebateable NDCs**	Reports on products that are deemed non-rebateable and not eligible for Federal Financial Participation (FFP). The report is sorted by NDC and includes each product's name, manufacturer, and claim count. This report is generated as needed.
13.	**ROSI/PQAS URA Discrepancies**	Reports on NDCs where the URAs submitted by manufacturers does not match the URAs subsequently received by CMS. The report is sorted by rebate quarter and includes each product's NDC, name, the URA submitted by the manufacturer and the URA submitted by CMS. Once the URAs submitted by the manufacturer and CMS are the same, the record no longer appears on this report. This report is generated as needed.
14.	**Invoice Comparison Report**	Compares the current quarter rebate amount and claim count to the immediate prior quarter rebate amount and claim count and reports the percentage change for both. The report is sorted by labeler code and includes manufacturer name, current quarter being reported, current quarter rebate amount, current quarter claim count, immediate prior quarter being reported, immediate prior quarter rebate amount, immediate prior quarter claim count and the percentage change for rebate amount and claim count. This report is generated as needed.
15.	**Unit Type Discrepancy Report**	Reports on products that have different unit types in the claims processing system and RxMax. The report is sorted by NDC and includes each product's name, CMS unit type, CMS UPPS, billing unit type, billing unit per package, unit conversion factor and rebate quarter. This report is generated as needed.

Standard Rebate Reporting Package		
16.	**CMS Ineligible DESI Code Report**	Reports on products that are reported by CMS as having a DESI Code of “5” or “6” and thus not eligible for rebates or FFP. The report is sorted by NDC and includes each product’s name, manufacturer, DESI code, effective date and if applicable, termination date. This report is generated as needed.
17.	**CMS New/Terminated Product Report**	This report has two sections: 1 Reports products that are new (present in the requested quarter but not in the requested quarter less one quarter). 2 Reports products that are terminated in the requested quarter where the CMS Termination Date is not less than the first day of the Rebate Year/Quarter being processed. This report is generated as needed.
18.	**Claim with No CMS NDC Data Report**	Shows claims with no manufacturer for the paid date (within the quarter being requested) and gives claim level detail for the claim. The report is sorted by ICN/TCN, ingredient number, claim type and includes the ICN/TCN, ingredient number, claim type, HCPCS/CPT code (if medical claim), NDC, Rx number (if available), drug name, paid date, quantity dispensed, days’ supply, and total paid amount with one output line per claim that meets the defined criteria. This report is generated as needed.
19.	**Rebate Amount Exceeds Reimbursed Amount**	Reports at the claims level where the rebate amount claimed exceeds the amount reimbursed by Medicaid. The report is at the claim level and is sorted by NDC. The report includes the following fields: NDC, claim ID, drug name, manufacturer, CMS Unit type, billing unit type, URA, unit conversion factor, units dispensed, units invoiced, rebate amount claimed, Medicaid amount reimbursed, Non-Medicaid amount reimbursed and total amount reimbursed as well as numerous other fields. This report is generated as needed.
20.	**Zero CMS URA Report**	Reports on NDCs that have a zero unit rebate amount (URA). The report is sorted by rebate quarter and includes each product’s NDC, name, and manufacturer. Once the product’s URA is received from CMS for the subject rebate quarter, the record no longer appears on this report. This report is generated as needed.

Standard Rebate Reporting Package		
21.	**UROA Report – Summary**	Reports at the rebate quarter level, the total rebate offset amounts based on units paid, UROAs and adjustments (to utilization and UROAs) that were processed during a calendar quarter that affected each rebate quarter. The report includes reporting quarter, contract type, rebate quarter and current ROA. The report contains specific data for all rebate quarters from 1Q2010 forward. This report is provided quarterly.
22.	**UROA Report - Detail**	Reports at the rebate quarter/NDC level, the total rebate offset amounts based on units paid, UROAs and adjustments (to utilization and UROAs) that were processed during a calendar quarter that affected each rebate quarter. The report includes reporting quarter, contract type, rebate quarter, NDC, current ROA, current units paid to date and current UROA. The report contains specific data for all rebate quarters from 1Q2010 forward. This report is provided quarterly.

1.3.2 Support of Multistate Supplemental Rebate Consortium

It is the intent of the State to receive supplemental rebates, in addition to the CMS Rebates received under the Medicaid Drug Rebate Agreement, pursuant to Section 1927 of the Social Security Act (42 U.S.C. § 1396r-8), for the manufacturer's supplemental covered product(s) quarterly utilization in the State's Medicaid programs in which there is Medicaid federal financial participation.

The State participates in the Sovereign States Drug Consortium (SSDC) a multi-state purchasing pool. The SSDC uses a multi-state administered collaboration to create a pharmaceutical purchasing pool. The pool focuses on negotiating and acquiring rebates supplemental to federal Medicaid rebates from drug manufacturers. At the same time, the SSDC preserves each State's ability to manage its pharmacy benefit by customizing its own Preferred Drug List and Prior Approval programs. The SSDC has procured a vendor who provides the following drug rebate procurement related services:

- Compile drug utilization data as part of the annual bid procurement.
- Rebate bid solicitation from drug manufacturers for annual review
- Bid compilation and presentation to the SSDC members.
- Rebate bid negotiation annually and as needed: Negotiation that may occur at the request of a Member State or States after bid review.
- Bid selection notification to manufacturers
- General administrative functions in support of the rebate solicitation

In general, States belonging to the SSDC leverage their collective lives and utilize Preferred Drug Lists for select high use, high cost drug classes. State members promote clinically

appropriate alternatives that are the most cost-effective in the individual classes, and prefer products that have a low net cost to the State (e.g. generics and low net cost brands)

As part of the contract, the Vendor must support the State in managing the Supplemental Rebate program. The scope of Vendor responsibilities includes, but is not limited to:

- Working with the SSDC vendor in conjunction with the State as necessary to administer the program
- Bid review and selection, determining the value proposition and advising the State on rebate acceptance
- Contract finalization with manufacturers
- Rebate invoicing, collections, dispute resolution, and reporting
- Clinical management
  - development of clinical criteria in support of its PDL
  - managing changes to the PDL as a result of negotiations
- Representing the State at all meetings where rebate business is conducted

The Vendor must describe their approach to managing the State Supplemental Rebate program and maximizing the benefit to the State from participation in the SSDC.

Response:

Catamaran has served as the State's PBM since 2006, the year in which the SSDC was authorized by CMS. In fact, we have been the State's sole vendor supporting the management of the Preferred Drug List (PDL) and the Supplemental rebate program. As a result, Catamaran has extensive experience working with the SSDC vendor. Due to this history, Catamaran is uniquely positioned to understand and effectively manage the State's Supplemental rebate program.

Since the first Supplemental rebate pool was approved by CMS in 2004, the SSDC is the only pool which is state-administered. In contrast, the other CMS approved Supplemental rebate pools have been dependent on business relationships with the PBMs who managed those pools. The state-administered pool model provides the State with the opportunity to take advantage of SSDC negotiated rebates while retaining a "best in breed" PBM solution.

Representing the State at All Rebate Business Meetings / Working with the SSDC Vendor

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Catamaran has and will continue to attend all rebate business meetings with the State or as the State's representative at the State's direction. This includes telephone conferences as well as the annual multi-day on-site meetings conducted by the SSDC vendor for the SSDC member states. Catamaran also receives direct communications from the SSDC vendor to alert us to new Supplemental rebate opportunities that need to be modeled and discussed with the State.

We consider all rebate procurement approaches as part of our overall charge of managing the State's benefit and, particularly, the State's PDL.

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Supplemental Rebate Bid Review, Analysis, and Selection

Catamaran believes that a Supplemental rebate program and a PDL must work together to achieve the best result possible. The review and analysis of any Supplemental rebate offer must consider the consequences of accepting that offer. It is not merely an estimation of the value of the Supplemental rebate collection based on historic utilization. The analysis must always consider any potential impact of the drug spend for the class as a whole. In the worst case scenario, a branded drug with a high Supplemental rebate promoted through a PDL may result in increased utilization of that drug at the expense of less expensive generic and branded alternatives such that the resulting net spend of the drug class will increase rather than decrease. In some cases, this increased utilization may continue for many years all while the product is under patent protection.

Catamaran believes that there are three important components that we can offer the State as it relates to support in managing the Supplemental rebate program.

- **Full Transparency:** Catamaran proposes to continue to manage the State's Supplemental rebate program based only on the administrative fee we receive through the contract with the State. Catamaran does not share in any rebate dollars and we are not beholden to any manufacturer based on a relationship on a larger book of business in the commercial or Medicaid space.

- **Analytical and Decision Support:** Catamaran will continue to provide experienced consultative and management support to help analyze, interpret, strategize and communicate the program's cost savings effectiveness. This includes cost modeling that determines the net cost savings from various PDL, Supplemental rebate contracting, or utilization management initiatives to assist the State in determining the best approach. In modeling net cost savings based on Supplemental rebate contracting, Catamaran provides reporting that shows detailed net unit costs at various levels on all drugs in a therapeutic class.

- **Program Coordination and Collaboration:** Catamaran will continue to assist the State in integrating its PDL and Supplemental rebates with other pharmacy benefit management strategies (e.g., coordinating PDL/Supplemental rebate decisions with point-of-sale step therapy or prior approval protocols, dispensing limits, drug utilization review programs, education efforts and pharmaceutical care interventions). We believe that coordinating efforts to lower unit cost and affect prescribing behavior, medication use and treatment outcomes will always yield the best results.

Catamaran provides consultative support in advising the State as to Supplemental rebate contracts that may be financially advantageous and clinically appropriate based upon the following factors:

- State specific drug prescribing and recipient utilization patterns;
- The comparative clinical efficacy of the offered products in a class;
- The comparative net costs of competing offered products after Federal rebates, the offered Supplemental rebates, and generic drug cost determinants;
- Clinical coverage criteria requirements;
- Brand and generic availability considerations;
- Upcoming patent expirations in the therapeutic drug class which may result in near term lower cost generic drug availability and support declining a Supplemental rebate on a branded product;
- The likelihood of achieving market share shift; and
- Potential prescriber and beneficiary impact from a PDL change.

The key administrative tool in this support is predictive modeling. Once Supplemental rebate offers are received from the SSDC vendor, our modeling utilizes “what if” scenarios based on product selection and estimated market share movements to predict changes to pharmacy reimbursement, estimate Federal rebates and unit rebate offset amounts, provide an estimation of resulting Supplemental rebates and, where applicable, provide changes to program administrative costs (e.g., changes in claim volume or prior authorization requests). The information gained from such modeling provides the State with a net-net cost that can be applied at various levels depending on the drugs being modeled. These levels include per claim, per unit, per day, per drug strength (for drugs which are dosed the same but are packaged differently) and per dose (for drugs which are dosed the same but have different unit types).

Clinical Management

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Therapeutic Class Reviews / Utilization

Fundamental to Catamaran's strategy to maximize Supplemental rebate impact is its analysis of the State's utilization data to identify the therapeutic classes that can be affected the most by clinical review and management. We analyze the State's pharmacy claims (and applicable physician-billed claims) to determine the total paid amount, total number of prescriptions and the market share for each agent in each therapeutic class. This analysis not only identifies the therapeutic classes with the highest drug spend (and potential Supplemental Rebate opportunities) but also serves as a means to identify classes not under clinical management or classes with ineffective clinical management (e.g., consistently high rate of PA approvals). At the same time, PDL recommendations are never made solely to maximize rebate collections at the expense at overall net spend to the program and Catamaran routinely incorporates generic drugs into the PDL where appropriate in order to maximize cost benefits to the State.

Traditionally, recognized groupings of drugs such as GPI or AHFS were utilized in establishing therapeutic classes when designing or managing a PDL; the theory being that in order to enhance Supplemental rebate opportunities, therapeutic interchange between agents is essential. As such, drugs that have the same indications and the same or similar mechanisms of action have been grouped together.

While Catamaran subscribes to this basic theory, certain factors require us to employ a strategic approach when stratifying therapeutic classes. These factors include both the inclusion of new drug entities as well as generic products within traditional therapeutic class groupings. Additional factors include new indications, off-label uses and new clinical data. Catamaran looks for opportunities to break out therapeutic drug classes into sub-classes to provide stratification that creates better Supplemental rebate opportunities by providing higher level tier (greater rebate) options in individual sub-classes. Catamaran's goal is to rationally stratify therapeutic classes from a clinical standpoint while maximizing the Department's return on investment through enhanced Supplemental rebates.

Preferred / Non-Preferred Status Recommendations

Preferred / non-preferred status recommendations are included in monographs provided to the State's DUR Board by Catamaran. Based upon the clinical data Catamaran compiles and the Supplemental rebates recommended for acceptance by the Clinical Pharmacist Manager and the Catamaran Rebate Team, we apply a combination of detailed clinical scrutiny, predictive modeling, and cost analysis to develop our preferred / non-preferred status recommendations. Additionally, the Catamaran Clinical Team recommends clinical criteria to be adopted for those drugs with non-preferred status.

Subsequent to this clinical evaluation process, the Catamaran Rebate Team applies its innovative economic modeling tools to further enhance and round-out PDL decision-making processes based on the economic impact of inclusion or exclusion of particular drug classes. Included in this analysis is a discussion with the State of the prescriber and beneficiary disruption that might be realized by a particular PDL status recommendation and the likelihood that significant market share could actually be moved to achieve significant Supplemental rebate savings.

Supplemental Rebate Contract Administration

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Under the direction of [redacted] Catamaran has been and will continue to be responsible for all aspects of Supplemental rebate contract administration including:

- Compiling Supplemental rebate contracts based on accepted manufacturer bids and specific terms and conditions;
- Submitting Supplemental rebate contracts to manufacturers for execution;
- Submitting Supplemental rebate contracts to the State for execution;
- Tracking and follow-up to ensure that participating manufacturers receive original fully executed contracts; and
- When appropriate, assisting the State in revising its Supplemental rebate contract template for CMS approval.

Supplemental Rebate Administration

Catamaran will utilize our proprietary rebate administration application, RxMax, to manage the Supplemental rebate program. As with the Federal and State-only rebates, RxMax supports the entire rebate management process and is configurable based on the State's policies and procedures as fully described above in Catamaran's response to Section 1.3.1 (Management of State and CMS Drug Rebate Programs).

A Supplemental rebate program mirrors that of the Federal rebate program since most of the administrative functions and CMS rules apply to both programs. As a result, the following processes and procedures utilized for the Federal rebate program, as fully described above in Catamaran's response to Section 1.3.1 (Management of State and CMS Drug Rebate Programs), are also employed for the State's Supplemental rebate program:

- Claims validation, scrubbing and loading;
- Identification and exclusion of 340B provider claims;
- Rebate calculation;
- Invoice auditing;
- Rebate invoice creation and distribution;
- Payment receipt and reconciliation;
- Interest calculation and tracking;
- Non-responsive manufacturer collection efforts;
- Dispute tracking and resolution;
- CMS-64.9R reporting; and
- Rebate reporting.

Catamaran establishes the Supplemental rebate program as a separate program in RxMax and administers the program as mandated by CMS, the State and the terms of the State's contracts with rebates negotiated via the SSDC vendor. Although most administrative functions and CMS rules that apply to Federal rebates also apply to Supplemental rebates, Catamaran understands that there are some differences in administering the State's Supplemental rebate program.

One important difference is how unit rebate amounts (URAs) are obtained. Since CMS offers states the latitude to negotiate and contract directly with manufacturers, URAs are calculated based on the terms of the individual Supplemental rebate agreements. As a result, quarterly URAs must be calculated rather than being supplied by CMS. Having first been developed to administer commercial rebate programs, RxMax provides the unique capability to handle the myriad of URA calculation methodologies devised by manufacturers and the states. Some examples of the URA calculation methodologies that RxMax can perform include:

- Flat rebates based on a fixed percentage of a pricing point such as Wholesale Acquisition Cost (WAC), Average Wholesale Price (AWP) or Average Manufacturer Cost (AMP);
- Price protection rebates such as Guaranteed Net Unit Price (GNUP) or Quarterly Rebate Percentage; and
- Tiered rebates that are calculated based on a market basket of products and the relative market shares of those products.

As the States' current Supplemental rebate vendor, Catamaran has utilized several of the methodologies listed above in calculating Supplemental rebates. This has resulted in the creation of Supplemental rebate invoices which are accurate.

1.3.3 340B Program Management

Vermont has participated in the federal 340B program since 2005, and has made substantial progress in expansion of the program. In 2010, the State encouraged enrollment of 340B covered entities made newly eligible by the Affordable Care Act and as a result of the Challenges for Change legislation passed in Vermont that year. Twelve of Vermont's fourteen hospitals are eligible for participation in the 340B program in addition to other covered entities in the state such as federally-qualified health plans. The State expanded its 340B program to encourage enrollment of both existing and newly eligible entities within Vermont and to encourage covered entities to "carve-in" Medicaid (e.g. to include Medicaid eligible in their 340B programs). There is no state requirement for covered entities to carve-in Medicaid, but if they do, the 340b acquisition cost of the drugs must be passed on to Medicaid. The 340B acquisition cost is defined as the price at which the covered entity has paid the wholesaler or manufacturer for the drug, including any and all discounts that may have resulted in the sub-ceiling prices.

The State established a shared savings program with participating covered entities that provides for the pass through of acquisition cost to the State. Entities who carve-in Medicaid receive a 340B dispensing fee, and based on a retrospective true-up process, share in the overall savings attributable to the program. The Vendor must comply with all federal 340B rules and regulations, and must implement a process by which 340B claims are excluded from rebate invoices processed for manufacturers. In addition, the State seeks support of the 340B program including tracking, invoicing, and financial reconciliation of the shared savings model, in addition to covered entity provider relations and support.

The Vendor must describe their approach to supporting the State in operating the program including, but not limited to administrative support, financial analysis, interacting with covered entities, invoicing, cost analysis, and other tasks as directed by the State.

Response:

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1.3.4 Financial Management

As requested by the State, the Vendor must process financial gross adjustments to pharmacy payments, such as corrective actions identified from post-payment audit findings and other adjustments. The Vendor must describe their approach to managing financial adjustments and reversals.

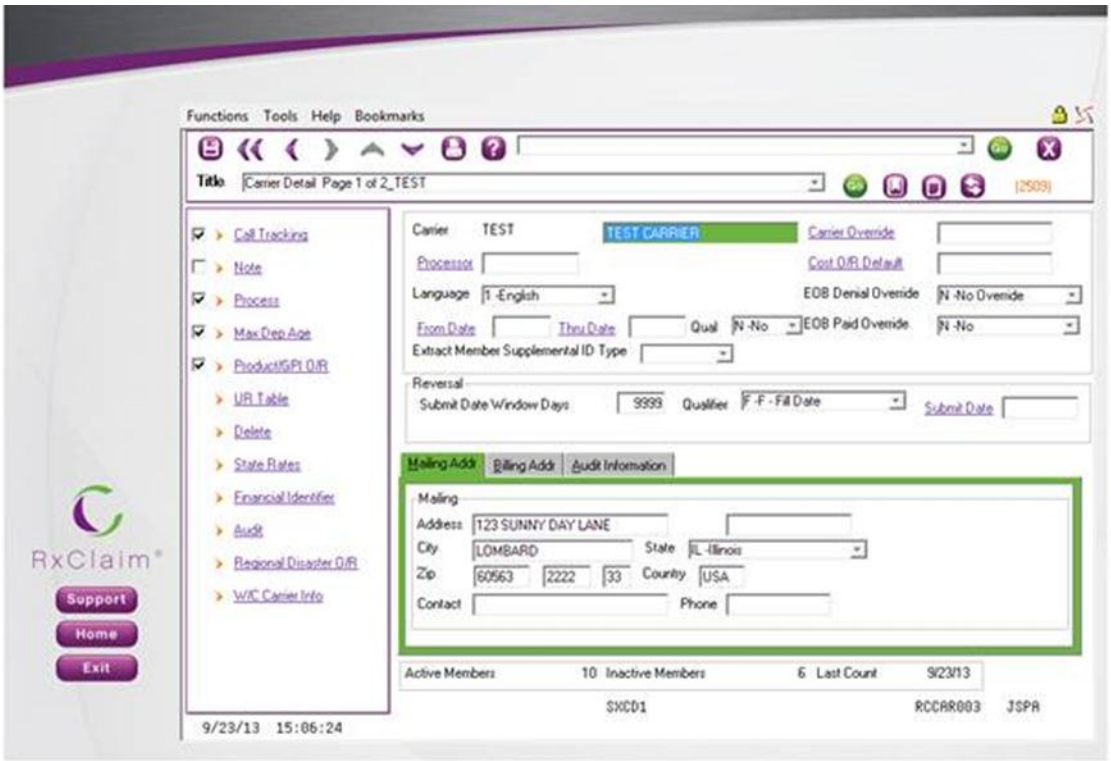
Response:

RxClaim processes claims adjustments and reversals received from the pharmacy via electronic POS submission or directly entered through the RxClaim interface by an authorized user.

Reversals

RxClaim can accommodate the State's preferred payment policy regarding reversals. We will work with the Department to further define payment and reversal parameters and modify the system setup according to those parameters. For example, if the State prefers reversals for 90 days from the day of initial payment or fill, we can set that parameter within RxClaim. If the State later requires a change to these parameters, either Catamaran or an authorized State user with power user edit rights can easily make that change in the system.

As shown in the following RxClaim screen capture, the initial parameters for setting the allowance for timely filing of reversals can be set according to time frame, fill date, or claim paid date. Because the days and qualifiers can be changed on the fly, the State has far greater flexibility in implementing changes rapidly if needed due to a policy change, legislative mandate, or emergency.



Once the parameter is defined, all reversals are processed accordingly. In our experience, the majority of pharmacies use their POS software to submit reversals, whether needed due to keying error, a change in prescription, etc. However, if needed, authorized Department users or Catamaran employees at the Service Desk can submit claim or payment reversals directly into RxClaim. Additionally, the Department may wish to allow specific authorized users to perform this function to support desk or pharmacy audits. Alternatively, RxClaim can allow reversals for an infinite period but only allow new claims with a recent date range. Special unpublicized groups with relaxed timely filling requirements can be established to facilitate pharmacy reprocessing of claim identified in audit findings.

Void/ Rebill

RxClaim is fully compliant with all NCPDP standard transaction sets, including a B3 (Rebill) transaction. RxClaim can process the void (reversal) and the rebill transaction within a single claim transaction. In addition, RxClaim allows for single claims adjustments and mass adjustments through the application.

RxClaim supports the capability for an authorized individual to reverse one or more claims (via selection criteria). This functionality runs in an edit-only ("trial") or "production" mode to achieve the desired results. In addition, the system supports provider-neutral or history-only adjustments to apply financial and/or quantity adjustments to claims that will not result in an increase or decrease in payments to the provider.

1.3.5 ~~Dual Eligible Demonstration -~~ Requirement Deleted by the State

~~In May of 2012, Vermont submitted a proposal to the Centers for Medicare and Medicaid Services (CMS) to participate in a State demonstration to integrate care for approximately 22,000 beneficiaries who are dually eligible for both Medicare and Medicaid. The goal of Vermont's *Dual Eligible (DE) Demonstration* is to fully integrate the delivery and financing of Medicare and Medicaid services for Vermont's dually eligible population. According to CMS, the 9 million dual eligible beneficiaries nationally account for a disproportionate amount of spending between the two programs, approximately $300 billion a year. For example, dual eligible beneficiaries account for 16 percent of Medicare enrollees but 27 percent of Medicare spending; in the Medicaid program, individuals who are dually enrolled make up 15 percent of the program but account for 39 percent of costs.~~

~~Vermont was one of 15 states selected by CMS to develop approaches to improve the coordination of care for dual eligible individuals. Each state was awarded up to $1 million to develop a model for structuring and implementing its planned approach. Vermont's DE Demonstration model focuses on providing person-directed interventions to improve care coordination and service delivery, with performance measures and outcomes linked to payment reforms. Vermont's model will:~~

- ~~Offer high quality, seamless and cost-effective care;~~
- ~~Coordinate primary, acute, mental health, substance abuse treatment, pharmacy services, and long-term supports and services; and~~
- ~~Meet the unique needs of all individuals who are dually eligible for Medicare and Medicaid.~~

~~*Development of an Integrated Medicare-Medicaid Service Delivery Model*~~

~~Through the DE Demonstration, Vermont and CMS will develop a fully integrated model for financing and delivering the full array of health care services for this population. As part of this initiative, Vermont intends to integrate benefits covered under Medicaid and Medicare (Parts A, B and D), providing beneficiaries with a truly comprehensive and seamless set of services. This approach offers Vermont the opportunity to work with CMS to eliminate some of the regulatory conflicts and cost-shifting incentives that currently exist between Medicare and Medicaid, including those related to prescription drug coverage.~~

~~Under the current delivery model, dual eligible beneficiaries receive different covered benefits under Medicare and Medicaid, with each program managed differently and using different funding sources. In contrast, the DE Demonstration allows Vermont to develop initiatives to offer high-quality, seamless and cost-effective care through a coordinated, person-centered delivery~~

~~model designed to address the unique needs of the dually eligible population. Since participation is voluntary, beneficiaries may elect to participate in the Demonstration or continue to receive benefits through current programs.~~

~~Vermont has proposed to build upon its unique public Medicaid managed care model to provide integrated care for the dual eligible population. Participating beneficiaries will access all of their Medicaid and Medicare covered services (including prescription drug coverage) under the authority of a single entity, the State. As with the existing Medicaid managed care model, integrated funding provides Vermont with greater flexibility in designing programs and services that meet the particular needs of the dual eligible population.~~

~~The Pharmacy Benefit Manager (PBM) chosen by the State of Vermont must support the DE Demonstration and therefore, in addition to adjudicating Medicaid claims, it must be able to design, deliver, implement, and administer a Medicare Part D benefit. In doing so, the PBM must meet all CMS requirements related to the administration of the Part D benefit. Further, the PBM generally must support Vermont's goal to move to a single payer health care system.~~

~~The vendor must respond with their experience providing Medicare Part D-related PBM services, as well as their approach to meeting the needs of the State's Duals Demonstration Project.~~

Response:

Requirement deleted.

1.4 Additional Services

Additional Services are optional and should not be included in Template L: Cost Worksheets. Attachment G contains no detailed functional requirements detailing these services.

1.4.1 Single Payer

The Vermont legislature passed Act 48 in May, 2011. The law recognizes the fiscal and economic imperative for Vermont to undertake fundamental reform of its health care system. Act 48 puts Vermont on a path to a single payer system. The State still needs to take additional steps to reach that goal. These include development of a financing plan that assures a single payer will cost less than the current system. There are a number of other initiatives that could become part of the State's single payer system, including a single state-wide formulary.

The Vendor will be required to support Vermont's health reform plans to transition to a Statewide single payer health care system by 2017.

The Vendor must describe how they are positioned to support Vermont's health reform plans to transition to a Statewide single payer health care system by 2017. Vermont's ACT 48 can be found at: www.leg.state.**vt**.us/docs/2012/**Acts**/**ACT**048.pdf

Response:

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2.0 Functional Requirements Approach Assumptions

Document the assumptions the Vendor has made while responding to the Functional Requirements Approach in Section 1 of this document in Table 1 below. These assumptions should include any assumptions that guided the responses, and will be considered in regards to specific approach responses, and the overall proposal the Vendor provides.

The Vendor may add any additional rows to the table as necessary.

Table 1. Functional Requirement Assumptions

Item #	Reference (Section, Page, Paragraph)	Description	Rationale
1.	NA	NA	NA
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

State of Vermont - Pharmacy Benefits Management
Template H - RFP Non-Functional Requirements Response

RFP Vendor Instructions

This workbook contains Non-Functional Requirements for the solution desired by the State of Vermont. The response codes below should be used by the Vendor to indicate the fit of their solution to the State of Vermont Requirements specified in this Template. This Template must be completed and submitted as an MS Excel file as part of the response to this RFP.

Responses	Definition
Response Code: Will this Technical Requirement be met by your solution?	**Indicate if the requirement will be met by entering either "Y" or "N".** **Each requirement must be responded to, and must be responded to in this cell by one of these two responses**
	Y = Comply – The State of Vermont Requirement will be met by the Vendor solution.
	N = Not Comply – The State of Vermont Requirement will not be met by Vendor's solution. Please indicate in the Vendor Response Comments colunm the reason that requirement cannot be satisfied.
Vendor Response Comments	Provide comments as necessary in regards to specific requirements using this response template. For more details regarding the approach for meeting a requirement, or combination of requirements, or overall Technical area, use Template J - Technical Requirements Approach and provide a reference to the appropriate **RFP Req. #**(s) in this Template.

Sections

ID	Section Title
A	**Architecture / Policy Requirements**
A1	General System
A2	Interoperability - Integration
A3	Regulatory and Security
A4	User Interface
A5	Business Intelligence and Reporting
I	**Implementation Requirements**
I1	Project Management
I2	Knowledge Transfer & Training
I3	Testing and Validation
I4	Data Conversion and Migration
I5	Quality Management
O	**Operation Requirements**
O1	Operations
P	**Performance Requirements**
P1	Service Level and Performance

Defined Terms

Defined Term	Acronym (if used)	Description
American Recovery and Reinvestment Act	ARRA	American Recovery and Reinvestment Act of 2009, including any subsequent laws, rules, mandates, etc. derived from it, as interpreted by the State of Vermont.
Applicability Statement 1	AS1	A specification about how to transport data securely and reliably over the Internet
Applicability Statement 2	AS2	A specification about how to transport data securely and reliably over the Internet
Application Programming Interface	API	Application Programming Interface
Application to Application	A2A	Application to Application
Audit Trails and Node Authentication	ATNA	Audit Trails and Node Authentication
Business Intelligence	BI	Business Intelligence
Business Process Change Management Plan		A plan that is included in overall Project Management Plan
Business Process Execution Language	BPEL	Business Process Execution Language
Business Process Modeling Notation	BPMN	Business Process Modeling Notation
Business to Business	B2B	Business to Business
Capacity Plan		A plan that is included in overall Project Management Plan
Communications Management Plan		A plan that is included in overall Project Management Plan
Continuity of Care Document	CCD	An HL7 XML-based markup standard intended to specify the encoding, structure and semantics of a patient summary clinical document for exchange.
Cross-Community Access	XCA	Supports the means to query and retrieve patient relevant medical data held by other communities.
Cross-Enterprise Document Sharing	XDS	Cross-Enterprise Document Sharing (XDS) facilitates the registration, distribution and access across health enterprises of patient electronic health records.
Data Dictionary		A centralized repository of information about data such as meaning, relationships to other data, origin, usage, and format.
Data Model		A form to explain the structure and relationships of data that is independent of its storage method.
Database Administration	DBA	
Database Management System	DBMS	
Demilitarized Zone	DMZ	
Design and Development Plan		A plan that is included in overall Project Management Plan
Developer's Manual		A document that contains information at the developer level independently supporting future development efforts
Eligiblity Automation Foundation	EAF	Includes Screening, Application, and Determnination

Defined Terms

Defined Term	Acronym (if used)	Description
Electronic Data Interchange	EDI	Electronic Data Interchange
Electronic Data Interchange For Administration, Commerce and Transportation	EDIFACT	Electronic Data Interchange For Administration, Commerce and Transportation
Engineering Management Plan		A plan that is included in overall Project Management Plan
Enterprise Service Bus	ESB	Enterprise Service Bus
eXtensible HyperText Markup Language	XHTML	eXtensible HyperText Markup Language
eXtensible Markup Language	XML	eXtensible Markup Language
Extensible Style sheet Language Transformations	XSLT	Extensible Style sheet Language Transformations
Extract-Transform-Load	ETL	Extract-Transform-Load
Family Educational Rights and Privacy Act	FERPA	Family Educational Rights and Privacy Act
Graphical User Interface	GUI	
Health Benefits Exchange	HBE	"The Exchange" Vermont's implementation of a Health Insurance Exchange
Health Information Technology for Economic and Clinical Health	HITECH	Health Information Technology for Economic and Clinical Health
Health Insurance Portability and Accountability Act	HIPAA	Health Information Technology for Economic and Clinical Health Act of 2009, including any subsequent laws, rules, mandates, etc. derived from it, as interpreted by the State of Vermont.
Health Services Enterprise	HSE	The overarching program that includes Systems such as the Health Insurance Exchange, the Integrated Eligibility System and shared capabilities as part of the HSE Platform
Health Services Enterprise Platform	HSEP	Service Oriented Architecture Enterprise Platform for the State's Health and Human Services Programs and Services providing common services including Gateway, Master Data Management, Enterprise Service Bus, Screening/Application/Determination Functionality and Shared Analytics among other shared capabilities
Health Level Seven	HL7	A not-for-profit, ANSI-accredited standards developing organization dedicated to providing a comprehensive framework and related standards for the exchange, integration, sharing, and retrieval of electronic health information that supports clinical practice and the management, delivery and evaluation of health services. In this document, this may also refer to the standards developed and/or managed by the organization.
Help Desk Support Plan		A plan that is included in overall Project Management Plan

Defined Terms

Defined Term	Acronym (if used)	Description
High Availability & Disaster Recovery Plan		A plan that is included in overall Project Management Plan
Hypertext Markup Language	HTML	
Hypertext Transfer Protocol	HTTP	
Implementation Plan		A plan that is included in overall Project Management Plan
Information Technology Infrastructure Library version 3	ITIL v3	
Information Technology	IT	
Integrating the Healthcare Enterprise	IHE	IHE is an initiative by healthcare professionals and industry to improve the way computer systems in healthcare share information. IHE promotes the coordinated use of established standards such as DICOM and HL7 to address specific clinical need in support of optimal patient care. Systems developed in accordance with IHE communicate with one another better, are easier to implement, and enable care providers to use information more effectively. In this document, this may also refer to the standards developed and/or managed by the organization.
Interface Management Plan		A plan that is included in overall Project Management Plan
Internet Inter-ORB Protocol	IIOP	Internet Inter-ORB Protocol
Internet Protocol Security	IPSec	Internet Protocol Security
Java 2 Platform, Enterprise Edition	J2EE	Java 2 Platform, Enterprise Edition
Java Database Connectivity	JDBC	Java Database Connectivity
Knowledge Transfer and Training Plan		A plan that is included in overall Project Management Plan
Local Area Network	LAN	
Maintenance and Operations Plan		A plan that is included in overall Project Management Plan
Maintenance and Operations	M&O	Maintenance and Operations
Master Client Index	MCI	Master Client Index
Master Provider Index	MPI	Master Provider Index
Medicaid Information Technology Architecture	MITA	Medicaid Information Technology Architecture
Message-Oriented Middleware	MOM	Message-Oriented Middleware
Network Time Protocol	NTP	Network Time Protocol
On-Site Implementation Support Plan		A plan that is included in overall Project Management Plan
Online Analytical Processing	OLAP	Online Analytical Processing
Online Transactional Processing	OLTP	Online Transactional Processing

Defined Terms

Defined Term	Acronym (if used)	Description
Open Database Connectivity	ODBC	Open Database Connectivity
Operational Recovery Plan		A plan that is included in overall Project Management Plan
Pharmacy Benefits Management	PBM	
Personally Identifiable Information	PII	Personally Identifiable Information
Pilot Plan		A plan that is included in overall Project Management Plan
Plain Old XML	POX	Plain Old XML
Problem resolution Management Plan		A plan that is included in overall Project Management Plan
Production Release Plan		A plan that is included in overall Project Management Plan
Production Support and Transition Plan		A plan that is included in overall Project Management Plan
Project Charter		An initial part of the Project Management Plan
Project Governance Plan		A plan that is included in overall Project Management Plan
Project Management Institute	PMI	Project Management Institute
Project Management Plan	PMP	The overall plan that describes the overall structure and scope of the project
Project Schedule		Project Schedule
Project Management Body of Knowledge	PMBOK	Project Management Body of Knowledge
Protected Health Information	PHI	Protected Health Information
Public Key Infrastructure	PKI	Public Key Infrastructure
Quality Management Plan		A plan that is included in overall Project Management Plan
Relational Database Management Systems	RDBMS	Relational Database Management Systems
Representational State Transfer	REST	Representational State Transfer
Requirements Management Plan		A plan that is included in overall Project Management Plan
Role-Based Access Controls	RBAC	Role-Based Access Controls
Screening, Application and Determination	SAD	Shared Functionality for Screening, Application and Determination
Secure Sockets Layer	SSL	Secure Sockets Layer
Secure/Multipurpose Internet Mail Extensions	S/MIME	Secure/Multipurpose Internet Mail Extensions
Service Level Agreement	SLA	Service Level Agreement
Shared Analytics Infrastructure	SAI	Shared Analytics Infrastructure
Service Oriented Architecture	SOA	Service Oriented Architecture
Simple Network Time Protocol	SNTP	Simple Network Time Protocol
Simple Object Access Protocol	SOAP	Simple Object Access Protocol

Defined Terms

Defined Term	Acronym (if used)	Description
Software Configuration Management Plan		A plan that is included in overall Project Management Plan
Software Development Life Phase	SDLC	Software Development Life Phase
System Acceptance Document		A document that includes a final requirements traceability matrix identifying all HSE Platform requirements allocated to current, in-production System components. A version of this document, accepted and signed by the State, will constitute acceptance of the System.
System Operation Manual		A document that describes the overall operations and management of the System at a systems administrator and user level. It will include all information about use, management, maintenance and operations that is not included in the Developer Manual or other System documentation.
Structured Query Language	SQL	Structured Query Language
Test Plan		Includes: - Unit Testing - Functional Testing - Integration Testing - Security Testing - Regression Testing - Stress/Load Testing - Performance Testing
Transition-Out Plan		A plan that is included in overall Project Management Plan
Transmission Control Protocol (TCP) / Internet Protocol (IP)	TCP/IP	Transmission Control Protocol (TCP) / Internet Protocol (IP)
Transport Layer Security	TLS	Transport Layer Security
Triple-DES	3DES	Triple-DES
Universal Description, Discovery and Integration	UDDI	Universal Description, Discovery and Integration
User Acceptance Testing	UAT	User Acceptance Testing
Vendor		The Vendor, or one of the Vendors, selected and contracted to participate in planning, implementing, maintaining, enhancing, upgrading, operating, providing support, etc. of the System
Virtual Private Network	VPN	Virtual Private Network
Web Services	WS	Web Services
Web Services Flow Language	WSFL	Web Services Flow Language
Web Services Interoperability	WS-I	Web Services Interoperability

Defined Terms

Defined Term	Acronym (if used)	Description
Wide Area Network	WAN	
Work Breakdown Structure		A document that is included in overall Project Management Plan
XML Process Definition Language	XPDL	XML Process Definition Language

State of Vermont - Medicaid Operations - Pharmacy Benefits Management
Template H - RFP Non-Functional Requirements Response
General System Requirements

RFP Req #	Requirement Description	Response Code (Y or N)	Vendor Response Comment(s)
A1.1	The System will be in compliance with the Health Insurance Portability and Accountability Act (HIPAA) privacy and beneficiary consent for release requirements, where applicable	Y	
A1.2	The System will accommodate diverse populations of users including those with visual and hearing impairments, persons with low and moderate educational levels, and the elderly (Section 508 compliant) http://www.section508.gov/ and all similar State of Vermont policies	Y	
A1.3	The System will accommodate diverse populations of users including those with disabilities and limited English proficiency as defined in section 504 of the Rehabilitation Act of 1973	Y	
A1.4	The System will be designed and developed to support a 24/7 production environment and reporting system	Y	
A1.5	The System will uniquely identify each beneficiary using both SS# and Unique ID number assigned by SoV Enrollment System	Y	
A1.6	The System will uniquely identify each provider using both NPI and a system generated Unique ID	Y	
A1.7	The System will have the capability to interact with other systems as needed to collect and report services and benefits provided to a beneficiary	Y	
A1.8	The System will provide a mechanism to limit access to view/update information, based on user role, access rights and program rules	Y	
A1.9	The System will have the capability to save and print all forms, reports, documents, screens, based on user role and program rule	Y	
A1.10	The System will automatically save information as users enter it.	Y	
A1.11	The System will validate that all mandatory data fields have been completed when a user attempts to submit information	Y	
A1.12	The System will inform the user of errors based on the validations performed	Y	
A1.13	The System will allow the user to review and update information if there are correctable errors	Y	
A1.14	The System will contain a "help" function on each screen as needed to provide users with instructions on how to perform functions, descriptions of data elements and/or other information	Y	
A1.15	The System may provide access to "rules/regulations documentation" via the System for look up and reference in the relevant context of the screen/process.	Y	
A1.16	The System will send alerts/notifications to users who (1) have subscribed to these types of notifications, (2) have consent to view the beneficiary 's data (3) have the correct access rights and (4) have a valid reason for viewing this data	Y	
A1.17	The System will send notifications based on the preferences a beneficiary or user has indicated in their profile unless a specific delivery method is specified by policy (e.g., certain notifications must be sent via US postal mail, ADA compliant communication). Where possible, electronic delivery methods (email, SMS) will be selected.	Y	
A1.18	The System will have role based access control at the data field level	Y	
A1.19	The System will have rules based access control and display information	Y	

RFP Req #	Requirement Description	Response Code (Y or N)	Vendor Response Comment(s)
A1.20	The System will have a user interface written in English (including warnings, notifications and user prompts) free of grammatical errors and typos	Y	
A1.21	The System will contain written language targeted to the average adult reading level (e.g., 6th grade level) Note: This applies to all languages	Y	
A1.22	The System may provide the capability to check an individual's language indicator to include language specific text on notices, correspondence and other materials.	Y	
A1.23	The System will maintain a record (e.g. audit trail) of all changes made to data in the System - system initiated changes or user initiated changes. This should be readily searchable by user ID, system ID or beneficiary ID. This must include but is not limited to: i. The user ID of the person who made the change or system ID if the change was system generated ii. The date and time of the change iii. The information that was changed iv. The data before and after it was changed v. The data source if the change was system generated	Y	
A1.24	The System will record the date, time, and name of users viewing beneficiary information	Y	
A1.25	The System will use industry standard taxonomy (ies) if relevant	Y	
A1.26	The System will provide web pages with general information about Pharmacy Benefit programs to the general public without requiring a login	Y	
A1.27	The System will authenticate users before allowing access to functionality requiring a login	Y	
A1.28	Provide Optical Character Recognition to convert appropriate paper documentation received through PBM System Operations into indexed, content searchable electronic format (e.g., claims and attachments, correspondence, provider information).	Y	
A1.29	The State will have the final authority to hire/fire any contract staff working in state facilities	Y	

RFP Req #	Requirement Description	Response Code (Y or N)	Vendor Response Comment(s)
A2.1	The System's interfaces will secure and protect the data and the associated infrastructure from a confidentiality, integrity and availability perspective.	Y	
A2.2	The System will be able to support Application to Application (A2A) synchronous and asynchronous messaging using web services. The messaging capabilities will be able to support a wide variety of A2A patterns including, but not limited to, the following: - Data look-up and retrieval - Data look-up with services provided by other applications - Simple bulk data transfer to/from other Systems.	Y	
A2.3	The System's interface infrastructure will continue to operate despite failure or unavailability of individual technology components such as a server platform or network connection.	Y	We maintain a primary data center and alternate processing center. We have identified all single points of failure within our operations, and our backup and/or redundant systems which will allow for continued operation of services in the event of an equipment failure. Redundant systems include: • Claims processing servers • Prescription processing servers • Terminal servers • Print servers • Web and portals servers Our Business Continuity Plan makes it possible for our services to continue to operate in the event that facility is completely disabled. We test and verify the operation of our alternate site at least once per month and actually operate production activities out of this site during the exercise—processes that are completely transparent to our clients and business partners.
A2.4	The System's interfaces must be scalable to accommodate changes in scale including changes in user population, transaction volume, throughput and geographical distribution. The System will be capable of making any changes to the interface data elements/layouts easily, and to test those changes.	Y	The member portal allows for branding and functionality changes based on population (Carrier/Account/Group). If data elements are in need of change, we work with the client to understand those requests and more forward with necessary specs and testing.

RFP Req #	Requirement Description	Response Code (Y or N)	Vendor Response Comment(s)
A2.5	The System will implement, at a minimum, interfaces (both real-time or batch) with the systems requiring integration and data sources listed in Table 5 of Section 2.3.3: (ACCESS / Integrated Eligibility, HSE Platform and the Existing and replacement MMIS) of the RFP. These interfaces will be implemented using point-to-point methods and secure file transfer for the legacy systems and Vermont's Health Services Enterprise integration middleware, Oracle SOA Suite and Service Bus for the replacement systems.	Y	The member portal can be setup with SSO from the client's site to our site. Our applications pull from RxCLAIM, RxBUILDER, RxAUTH, RxEXPRESS in real time already so as long as the applicable data is in those places, we can display within the member portal.
A2.6	The System will implement, at a minimum, interfaces (both real-time or batch) with the applications and data sources listed in section 2.1.2 of the RFP - Systems requiring integration. These interfaces will be implemented using Vermont's Health Services Enterprise integration middleware, Oracle SOA Suite and Service Bus.	Y	Catamaran has developed an extensive set of Web Services that allow for the exchange of information on a real-time basis between Catamaran and partner systems/applications at client sites. These Web services enable clients to integrate the Catamaran interface as part of their existing application architecture.
A2.7	The System will provide the capability to perform source to destination file integrity checks for exchange of data and alert appropriate parties with issues	Y	Testing takes place within all our applications prior and during and product releases and patch installs. Any outages, issues, etc are communicated to the client directly through Account Management.
A2.8	Systems components will be committed to an advanced approach to interoperability using web services and Service Oriented Architecture (SOA) aligned with State standards and vision for interoperability.	Y	Clients use our web services to return data from various applications in their own sites, applications, interfaces, in real time.
A2.9	Systems will integrate with VT HSE using a Service Oriented Architecture by using an Enterprise Service Bus, responsible to monitor and control routing of message exchange between services, resolve contention between communicating service components, control deployment and versioning of services and marshal use of redundant services.	Y	If this is referring to web services, we can certainly accommodate. Clients use our web services to return data from various applications in their own sites, applications, interfaces, in real time.
A2.10	Systems will support creation and extension of service interfaces through the use of Web Services Description Language (WSDL)	Y	
A2.11	Systems will develop/integrate services using standardized Web Services formats.	Y	
A2.12	Systems will provide the ability to publish services and related data to be used by different types and classes of service consumers.	Y	
A2.13	Systems will provide the capabilities for a Real-Time (or near real-time) Integrated Enterprise where common data elements about the customers served and services rendered are easily shared across organizational units with appropriate adherence to security and privacy restrictions.	Y	
A2.14	Systems will have the capability to implement synchronous and asynchronous program-to-program communication, moving messages between SOA service consumer modules and service provider modules at runtime. The ESB component may also move files, database rows and other data.	Y	Supports synchronous and asynchronous communication
A2.15	Message and data formats should be based on logical representations of business objects rather than native application data structures	Y	ESB and Web Services

RFP Req #	Requirement Description	Response Code (Y or N)	Vendor Response Comment(s)
A2.16	Data transformations will be to and from normalized formats. Normalized data formats facilitate composition and reduce the number of transformations that must be created and maintained. A canonical data representation that spans the enterprise can be used but is not required. A federated approach to data normalization is also possible	Y	Our web applications return data as it's displayed in RxCLAIM, RxAUTH, RxEXPRESS, RxBUILDER. Web Services allow the client to choose which response fields they want to utilize/label within their own applications.
A2.17	Point-to-point integrations are to be avoided. Application integration, both internal and external, will go through the central ESB.	Y	Web services are available
A2.18	All System services will be classified with one of the following values: Presentation, Process, Business, Data, Access, or Utility	Y	ESB and Web Services
A2.19	All services will be reviewed, classified, and cataloged prior to use. The Documentation Artifacts will be modeled per ISO/IEC/IEEE 42010Architecture Description Template as part of the Vermont Enterprise Architecture Program Requirements. Duplicate services will be rationaled and retired appropriately.	Y	Available web services are listed/documented and can be made available upon request
A2.20	All services will have key stakeholder/owners identified following the ADM Architecture Model. Role Matrix should include s/w developers, integrationists, technologists, Enterprise Architects, Business Leads, Testing teams, UAT Teams.	Y	The Catamaran ESB, Ecommerce and Ecommerce Technology groups fulfill all of those roles.
A2.21	All WSDLs developed for Vermont will conform to the WSDL Development Standards	Y	We conform to WSDL standards
A2.22	All SOA-related messages will be formally defined with XSD (preferable) or DTDs. A SOA Architecture Repository will be required.	Y	
A2.23	SOA-related services hosted should be implemented in Java.	Y	They are coded and implemented in Java
A2.24	Implemented services will rely on WS-Policy configurations for message reliability (WS-Reliable Messaging)	N	The implemented services are SOAP based, they by nature cannot support ws-reliablemessaging. However, our infrastructure support messaging pattern (JMS) for this type of requirement.
A2.25	The following metadata attributes will be tracked for all services in the services catalog: {name, lifecycle status, class, description, owner, version, revision history, release frequency, versioning policy, deprecation policy, message exchange patterns, compensating transaction support, availability requirements, volume, max message size, security attributes, sla, logging requirements}	Y	
A2.26	SOA services will be attributed with one of the following SOA Lifecycle Status values: Candidate, Justified, Defined, Designed, Implemented, Operational, or Retired. A SOA Architecture Repository will be required and opened to Vermont EA Program.	Y	
A2.27	The System will be designed, built and deployed with enterprise architecture best practices including substantial reliance on highly configurable SOA components. The System will undergo, at a minimum, 2 iterations integrated with HSEP development environment. Each iteration will be have a maximum period of 10 days. The Systems will have an alpha deployment on HSEP staging Environment and also will have, at a minimum, three weeks of UAT Testing by Business SMEs on the HSEP Staging Environment	Y	
A2.28	Systems will provide reliable, once-only delivery of messages (guarantee of reliable and non-repetitive delivery).	Y	

RFP Req #	Requirement Description	Response Code (Y or N)	Vendor Response Comment(s)
A2.29	Systems will have the capability to integrate with the VT ESB technology to perform syntactic and semantic hub-based transformation of messages, including: ' Support of taxonomy ' Support of ontology ' Reusable transformation maps ' Built-in transformation functions ' Extending the transformation function with custom-coded logic ' Support B2B project translation including Electronic Data Interchange (EDI), RosettaNet, HL7, etc.	N	We do not have tools to support standard transformation like Electronic Data Interchange (EDI), RosettaNet, HL7 etc.
A2.30	Systems will provide the functionality that provides reliability for applications, services or message flows: ' Load balancing ' High availability ' Fault tolerance ' Failover ' In-order delivery ' Transaction support ' Execution prioritization ' Message prioritization. Tests for High Availability and Failover must be completed prior to the release to UAT.	Y	In the ESB
A2.31	Systems will provide the technology that manages the metadata and provides the features needed to support the reliable operation of services. Examples include: ' Online catalog of services and associated artifacts such as WSDL files, XSDs, BPEL files ' A single point of controlled access for cataloging, promoting, publishing and searching for information about managed assets ' Metadata that enables an Enterprise Service Bus (ESB) to find, bind to and invoke the execution of a service implementation ' Support for extending existing asset types and defining and populating custom asset types	Y	In the ESB
A2.32	Systems will provide support for integrating with applications with SOA and event-driven architectures in a manner that supports the following implementation strategies: ' Web Services: Web Services Interoperability (WS-I) Organization-compliant implementation of basic Web services standards, including SOAP, WSDL and Universal Description, Discovery and Integration (UDDI), as well as higher-level Web services standards, such as WS-Security. ' Representational State Transfer (REST): Support for XML-based messages, processing and HTTP, and XHTML.	Y	
A2.33	Systems will have the ability to track a message from its origin to its destination (inside a firewall), inquire on the status of that message and address exceptions (for example, resend the message if a target times out). Usually implemented via a warehouse for archiving messages together with the associated tracking and logging data.	Y	
A2.34	The Systems will have the ability to use standards-based communication protocols, such as TCP/IP, HTTP, HTTP/S and SMTP. ' Protocol bridging: The ability to convert between the protocol native to the messaging platform and other protocols, such as Remote Method Invocation (RMI), IIOP and .NET remoting.	Y	Supports Http, Https
A2.35	The System will seamlessly work with the technology and programs that act as glue, transforming among protocols, connecting to databases and linking pre-SOA Application Programming Interfaces (APIs) to the SOA backplane.	Y	ESB and RxClaim Web Services
A2.36	The System will have the capability to work with a Service Registry that serves as an integration point for runtime tooling	Y	Catamaran has a service catalog where we maintain service artifacts.
A2.37	The System will have the capability to work with security policy manager for Web services that allows for centrally defined security policies that govern Web services operations (such as access policy, logging policy, and load balancing)	Y	

State of Vermont - Medicaid Operations - Pharmacy Benefits Management
Template H - RFP Non-Functional Requirements Response
Regulatory and Security Requirements

RFP Req #	Requirement Description	Response Code (Y or N)	Vendor Response Comment(s)
A3.1	The System will, at a minimum, provide a mechanism to comply with security requirements and safeguard requirements of the following Federal agencies / entities: - Health & Human Services (HHS) Center for Medicare & Medicaid Services (CMS) - Administration for Children & Families (ACF) - NIST 800-53 and DOD 8500.2 - Federal Information Security Management Act (FISMA) of 2002 - Health Insurance Portability and Accountability Act (HIPAA) of 1996 - Health Information Technology for Economic and Clinical Health Act (HITECH) of 2009 - Privacy Act of 1974 - e-Government Act of 2002 - Patient Protection and Affordable Care Act of 2010, Section 1561 Recommendations - Vermont Statute 9 V.S.A. § 2440. Social security number protection (http://www.leg.state.vt.us/statutes/fullsection.cfm?Title=09&Chapter=062&Section=02440) - Vermont Statute 9 V.S.A. § 2435. Notice of security breaches (http://www.leg.state.vt.us/statutes/fullsection.cfm?Title=09&Chapter=062&Section=02435)	N	Catamaran's information security program is currently aligned with the ISO framework and the COBIT framework. Catamaran reviews the information security program annually. This is to assure compliance with industry (PCI) and regulations (e.g., HIPAA, etc.) and to evaluate potential changes to the program. Catamaran is SOX (Sarbanes Oxley) 404 compliant; therefore, an independent auditing firm attests that our internal control processes and systems are effective and satisfactory. We also have received a SSAE 16/SOC 1, Type II report related to our pharmacy claims processing services audited by an independent CPA firm. In addition, our internal audit team is responsible for testing the design and operating effectiveness of key internal controls for compliance with Sarbanes-Oxley 404. This process occurs throughout the year and includes planning, risk assessment, testing, reporting results, and issue resolution. The internal audit team also is responsible for coordinating and facilitating the claim system SOC 1 report audit conducted by an independent accounting firm. Yearly compliance reports are made available for clients to review. Catamaran has received PBM and Specialty URAC accreditations. As such, we follow the high
A3.2	The System will conform with the sub-parts of Section 508 of the Americans with Disabilities Act (ADA), and any other appropriate State or Federal disability legislation.	Y	
A3.3	The System will comply with all applicable State security policies and adhere to all legal, statutory, and regulatory requirements, as determined by Vermont leadership.	Y	
A3.4	The System will implement security controls in accordance with all Federal and State security policy and regulations.	Y	
A3.5	The System will comply with accessibility requirements described in 45 CFR 85 and with State of Vermont accessibility requirements located at http://cio.vermont.gov/policy_procedures.	Y	
A3.6	The System will comply with Vermont branding standards as defined by the state.	Y	Catamaran provides branding on public facing portals and web pages as required.
A3.7	The Vendor will adhere to the principle of "Fail Safe" to ensure that a system in a failed state does not reveal any sensitive information or leave any access controls open for attacks	Y	
A3.8	The System will allow for controlled access to beneficiary records. Users will be able to view beneficiary data within the System at the State-defined levels of access based on user security privileges.	Y	

RFP Req #	Requirement Description	Response Code (Y or N)	Vendor Response Comment(s)
A3.9	The System will maintain a level of security that is commensurate with the risk and magnitude of the harm that could result from the loss, misuse, disclosure, or modification of information.	Y	
A3.10	The System will provide the ability for concurrent users to simultaneously view the same record, documentation and/or template.	Y	For record integrety purposes, while viewing simultaneoulsy is allowed, only one user would be allowed to update the record at any given time.
A3.11	The System will provide protection to maintain the integrity of data during concurrent access.	Y	For record integrety purposes, while viewing simultaneoulsy is allowed, only one user would be allowed to update the record at any given time.
A3.12	The System will be configurable to prevent corruption or loss of data already accepted into the System in the event of a System failure (e.g. integrating with a UPS, etc.).	Y	
A3.13	The System will support protection of confidentiality of all Protected Health Information (PHI) delivered over the Internet or other known open networks via encryption using triple-DES (3DES) or the Advanced Encryption Standard (AES) and an open protocol such as Transport Layer Security (TLS), Secure Sockets Layer (SSL), Internet Protocol Security (IPsec), XML encryptions, or Secure/Multipurpose Internet Mail Extensions(S/MIME) or their successors. This System will be subject to external Audit checks.	Y	
A3.14	The System, when storing PHI on any device intended to be portable/removable (e.g. smart phones, portable computers, portable storage devices), will support use of a standards based encrypted format using 3DES, AES or their successors.	Y	
A3.15	The System, prior to access to any PHI, will display a configurable warning or login banner (e.g. "The System should only be accessed by authorized users"). In the event that a System does not support pre-login capabilities, the System will display the banner immediately following authorization.	Y	
A3.16	The Vendor must have written policies and procedures addressing the use of any protected health data and information that falls under the Health Insurance Portability and Accountability Act (HIPAA) requirements. The policies and procedures must meet all applicable federal and State requirements including HIPAA requirements. These policies and procedures must include restricted access to the protected health data and information by the Vendor's employees.	Y	
A3.17	The System will have obtained Medicaid Management Information System (MMIS) certification by CMS, including compliance with all MITA 3.0 standards where applicable	Y	Catamaran's system is independently certified by CMS in one state and certified as part of the MMIS in other states. Catamaran's systems comply with MITA 3.0 standards where applicable.
A3.18	The Vendor must immediately notify the State of Vermont upon learning of any suspected or actual unauthorized use or disclosure of protected health data and information that falls under the HIPAA requirements. Vendor must work with the State of Vermont to mitigate any breach and provide assurances to the State of Vermont on corrective actions to prevent future unauthorized uses or disclosures.	Y	While it is Catamaran's policy to notify the client within 5 business days we always strive to notify the client as soon as possible.

RFP Req #	Requirement Description	Response Code (Y or N)	Vendor Response Comment(s)
A3.19	In accordance with HIPAA requirements, the Vendor is liable for any claim, loss or damage relating to unauthorized use or disclosure of protected health data received from the State of Vermont or any other source.	Y	Yes, to the extent, the unauthorized use or disclosure of PHI is caused by Catamaran.
A3.20	The Vendor must immediately notify the State of Vermont upon learning of any breach of system or data security. Subject to the approval of the State of Vermont, the Vendor must undertake such additional safeguards or changes as recommended by a subsequent independent security audit at the Vendor's expense.	Y	While it is Catamaran's policy to notify the client within 5 business days we always strive to notify the client as soon as possible.
A3.21	In the delivery and provision of information technology hardware, software, systems, and services through the Contract, the Vendor must prevent unauthorized access to the "Identity Information" of any individual. "Identity Information" includes, but is not limited to, an individual's first name or initial and last name, in combination with any of the following: a. Social Security Number; b. Driver's license number; c. System access identification number and associated passwords; d. Account information such as account number(s), credit/debit/Medicaid card number(s), and/or passwords or security codes.	Y	
A3.22	For even a single known violation of the identity theft prevention and reporting requirements, the State may terminate for default its Contract(s) and may withhold payment(s) owed to the Vendor in an amount sufficient to pay the cost of notifying individuals of unauthorized access or security breaches.	Y	Yes, to the extent, the unauthorized use or disclosure of PHI is caused by Catamaran.
Identity and Access Management			
A3.23	The System will support a form of user authentication.	Y	
A3.24	The System upon detection of inactivity of an interactive session will prevent further viewing and access to the System by that session by terminating the session, or by initiating a session lock that remains in effect until the user reestablishes access using appropriate identification and authentication procedures. The inactivity timeout will be configurable.	Y	
A3.25	The System will enforce a limit of (configurable) consecutive invalid access attempts by a user. The System will protect against further, possibly malicious, user authentication attempts using an appropriate mechanism (e.g. locks the account/node until released by an administrator, locks the account/node for a configurable time period, or delays the next login prompt according to a configurable delay algorithm).	Y	
A3.26	The System will provide the capability to prevent database administrators from seeing the data in databases they maintain.	N	
A3.27	The System will support grouping users by functional departments or other organization to simplify security maintenance.	Y	
A3.28	The System will provide the ability to maintain a directory of all personnel who currently use or access the system/IVR/SQL database.	Y	Catamaran provides a list of User IDs upon request.
A3.29	The System will provide the ability to create and maintain a directory of external providers to facilitate communication and information exchange.	Y	Catamaran maintains a list of external providers as provided to us by the MMIS, which is the provider system of record.
A3.30	The System will provide the ability to identify certain information as confidential (e.g. PII, PHI, etc.) and only make that accessible by appropriately authorized users.	Y	
A3.31	The System will restrict access to summarized information according to organizational policy, scope of practice, and jurisdictional law.	Y	

RFP Req #	Requirement Description	Response Code (Y or N)	Vendor Response Comment(s)
A3.32	The System must be able to associate permissions with a user using one or more of the following access controls: 1) user-based (access rights assigned to each user) 2) Role-Based Access Controls (RBAC; users are grouped by role and access rights assigned to these groups) 3) context-based (role-based with additional access rights assigned or restricted based on the context of the transaction such as time-of-day, workstation-location, emergency-mode, etc.)	Y	The system is a combination of panel and role based security that can be administered down to user or group of users level.
A3.33	The System will provide the ability to prevent specified user(s) or groups from accessing confidential information such as a beneficiary's SSN, medication information and other confidential data	Y	Access to information is configurable based on user ID and role.
A3.34	The System will provide the ability to limit access to certain confidential information such as a beneficiary's SSN and other confidential data to providers directly involved in service of the patient, or providers involved in review of the service.	Y	
A3.35	When access to a user's account is restricted, the System will provide a means for appropriately authorized users to "break the glass" and obtain access for emergency situations, as defined by Vermont policy.	Y	
A3.36	When access to Beneficiary's confidential data is restricted but still the "break the glass" has occurred, the System will provide the ability to notify specified users and provide an audit trail for this access.	Y	
A3.37	The System will enforce the most restrictive set of rights/privileges or accesses needed by users/groups or processes acting on behalf of users, for the performance of specified tasks.	Y	
A3.38	The System will provide the ability for authorized administrators to assign restrictions or privileges to users/groups.	Y	Configuration is performed by appropriate Catamaran staff.
A3.39	The System will support removal of a user's privileges without deleting the user from the System to ensure history of user's identity and actions.	Y	
A3.40	The System will be able to support RBAC in compliance with the HL7 Permissions Catalog.	N	In as much as HL7 is not a currently supported HIPAA standard, we do not currently support this protocol.
A3.41	The System will be capable of operating within an RBAC infrastructure conforming to ANSI INCITS 359-2004, American National Standard for Information Technology – Role Based Access Control.	Y	
A3.42	The System will provide more-advanced session management abilities such as prevention of duplicate logins, remote logout and location-specific session timeouts.	Y	While there are advanced functions, duplicate sessions are allowed as part of normal business applications. The same login ID is, however, not duplicated.
A3.43	The System will provide the ability to perform System administration functions such as reference table maintenance and adding / removing users from the system.	Y	
A3.44	The System will allow users access based on their roles irrespective of their geographical location.	Y	

RFP Req #	Requirement Description	Response Code (Y or N)	Vendor Response Comment(s)
A3.45	The System will provide the capability to integrate with existing authentication and authorization mechanisms	Y	The system is capable of integrating with single sign-on repositories and certifcates. However, this capability is dependent on the infrastructure involved in the source systems.
A3.46	The System will provide the capability to create temporary and emergency accounts and terminate those accounts automatically after a user defined period of time.	Y	The processes and procedures for automatically terminating temporary accounts will have to be mutually agreed upon.
A3.47	The System will provide the capability to override a role and restrict access to information by users or groups of users.	Y	
A3.48	The System will provide the capability to monitor events on the information system, detect attacks, and provide identification of unauthorized use of the system.	Y	
A3.49	The System will provide the capability to identify and report on inappropriate access to information in the system, based on user defined criteria.	Y	The system is capable of of preventing inapropriate access to information based on the RBAC assigned to each user. The defintion of what is appropriate for each user role is defined during the design phase. Since the system does not allow inappropriate access based on the RBAC, only attempts at accessing inappropriate information can be identified and reported. Therfore, the system logs and reports attempts at accessing inappropriate information.

State of Vermont - Medicaid Operations - Pharmacy Benefits Management
Template H - RFP Non-Functional Requirements Response
User Interface Requirements

RFP Req #	Requirement Description	Response Code (Y or N)	Vendor Response Comment(s)
A4.1	The System will provide an unlimited free-form text note within the PBM System for various functions such as provider enrollment process, prior authorizations, and case management, accessible by authorized PBM System users that includes, for example: • Provides the ability to display the narrative sorted by user and business unit. • Provides the ability to display free form narrative in chronological or reverse chronological sequence. • Provides basic word processing functionality such as sentence case, spell check, auto text, bold, underline, italics, color font, bulleted lists, tabs, indents, wrap-text, tables, printable.	Y	
A4.2	System will provide a graphical user interface for authorized PBM System users to define plans, benefits, and pricing.	Y	
A4.3	System will provide the ability for authorized users and its designees to view, search, and query by Department defined fields as well as pull reports and documentation associated with these fields.	Y	Applicable fields will be defined and mutually agreed to during requirements verfification
A4.4	System will provide the ability to view the results of filtered searches based on multiple or single criteria, the capability to search on multiple criteria at the same time, and the ability to perform secondary and tertiary searches within the primary search results.	Y	
A4.5	System will provide the ability to save and name multiple user-defined search and sort parameters so that users can repeat the same search/ sort queries at a later time.	Y	
A4.6	System will provide the ability to view the results of wild card searches (including both single character and string wildcard search) for all searchable fields, including searches with partial ID numbers.	Y	
A4.7	Accept digital signatures from providers where applicable as defined in the functional requirements	Y	
A4.8	Propose, develop, produce, publish and deliver all applicable PBM System User Guide/ Help updates.	Y	
A4.9	Propose, develop, produce, and maintain frequently asked questions (FAQs) on PBM System screens and functionality.	Y	
A4.10	The PBM System may provide the following: 1) Provide a forum for authorized PBM System users to post inquiries, and to respond to other posters and create topical “threads” on problems. 2) Allow Department staff and other designated users to access the forum and to participate and moderate the posts and threads, based upon user roles. 3)Provide a search capability to find posts and threads by date or relevance.	Y	
A4.11	Ensure that all codes and abbreviations used in the PBM System have corresponding and easy-to-view narrative descriptions.	Y	
A4.12	The System will limit the amount of information displayed, while also enabling the user to immediately expand the scope of the information visible.	Y	
A4.13	The System will speak the users' language, with words, phrases and concepts familiar to the user, rather than system-oriented terms.	Y	

RFP Req #	Requirement Description	Response Code (Y or N)	Vendor Response Comment(s)
A4.14	The users will be able to easily navigate to a variety of functions available to them without having to move sequentially through excessive menus and screens.	Y	
A4.15	The System will follow standardized conventions. Users should not have to wonder whether different words, situations, or actions mean the same thing.	Y	
A4.16	The System will eliminate error-prone conditions or check for them and present users with a confirmation option before they commit to the action.	Y	
A4.17	The System's User Interface will be simple, consistent, and use familiar terminology.	Y	
A4.18	The System's navigation will be familiar and consistent, and all user actions will be predictable and reversible.	Y	

State of Vermont - Medicaid Operations - Pharmacy Benefits Management
Template H - RFP Non-Functional Requirements Response
Business Intelligence and Reporting Requirements

RFP Req #	Requirement Description	Response Code (Y or N)	Vendor Response Comment(s)
A5.1	The Vendor will make available a state approved reporting tool, all state specified pharmacy data elements, including but not limited to elements in the drug file, the claim file, recipient information, provider information, and the prior authorization file. SoV DII EA will work with State business lead and vendor will ensure reporting components confirm to Enterprise Platform	Y	We will provide a state-approved reporting tool as mutually agreed upon by DVHA and Catamaran during the contracting phase. Any updates or modifications to the tool during the life of the contract will be mutually agreed upon by DVHA and Catamaran.
A5.2	The Vendor will maintain a training program for State staff and Vendors to ensure maximum use and understanding of the functionality of state approved reporting tool	Y	
A5.3	The Vendor will create reports based on the following, including but not limited to, a combination of pharmacy claim data elements; beneficiary characteristics; provider characteristics; prior authorization characteristics; and drug reference file elements including drug pricing, drug rebate status elements, lock-in characteristics, pharmacy claim errors, and net cost. This is a small sampling to show the types of reports expected of the System. A comprehensive list of all reports will be determined in collaboration with the State both during the contract negotiation phase as well as the System Implementation phase	Y	
A5.4	The Vendor will establish and maintain a methodology for the development and maintenance of the data analytic capabilities the PBM System provides and ensure that it is well documented.	Y	
A5.5	The Vendor will establish, maintain, implement and manage analytic capabilities to include but not be limited to data summarization, data comparison, data correlation, forecasting, trending, and statistical analysis	Y	
A5.6	The Vendor will establish and maintain a methodology for the development and maintenance of production and system reports. Vendor will work with SoV agencies to determine what reports are needed such as system performance reports and user access reports by the various departments	Y	
A5.7	The Vendor will establish and maintain a methodology for the development and maintenance of ad hoc reports	Y	
A5.8	The Vendor will establish, maintain, implement and manage a schedule for reporting that includes prioritization	Y	
A5.9	The Vendor will track and report the status of each data and reporting request	Y	
A5.10	The Vendor will produce, distribute and manage production reports in accordance with Business area, State, and Federal specifications	Y	As applicable to the programs and services that we provide as a PBM.
A5.11	Produce, distribute and manage ad hoc reports in accordance with Business area, State, and Federal specifications	Y	As applicable to the programs and services that we provide as a PBM.
A5.12	The Vendor will notify the report requester when report timeliness cannot be met. In addition, the PBM Vendor will provide a summary level report to the State, at a predetermined frequency, on quality and timeliness of all reports generated within that period.	Y	

RFP Req #	Requirement Description	Response Code (Y or N)	Vendor Response Comment(s)
A5.13	The Vendor will ensure that all existing Federal, State, and Business area measures and reports continue to meet Business area, State, and Federal standards	Y	As applicable to the programs and services that we provide as a PBM.
A5.14	Maintain report distribution lists to ensure accurate report distribution at all times	Y	
A5.15	The Vendor will maintain detailed procedures documenting how reports are prepared and detailing the procedures used to validate the accuracy of the report information	Y	
A5.16	The Vendor will store historic reports in accordance with Business area, State, and Federal retention schedules	Y	
A5.17	The Vendor will provide data and information for federal and state reporting in accordance with business area, state, and federal specifications	Y	
A5.18	The Vendor will provide data to the State in support of the PBM's function of analyzing and reporting pharmacy program status to the State	Y	
A5.19	The Vendor will provide ad hoc reporting and data analysis as agreed to through negotiation with the State. Such reporting and analysis will be in an agreed upon format and in accordance with a schedule agreed to by the Vendor and the State.	Y	
A5.20	The Vendor will provide the ability to regularly and accurately produce operational reports using PBM System data.	Y	
A5.21	The Vendor will ensure that the data in reports are current, accurate, and accessible and that the report is produced in a timely fashion to meet the report's delivery deadline.	Y	
A5.22	The Vendor will ensure that any reporting functionality supports the ability to pull and use the narrative descriptions of codes and abbreviations in addition to the codes and abbreviations themselves.	Y	
A5.23	The Vendor will develop the HIPAA attachment transaction for claims and Prior Authorization Requests in the PBM System (e.g., HL7/ 275).	Y	
A5.24	The Vendor will provide capacity to capture, store, update, report on system operational metrics from a decision support system that offers digital dashboards, online reporting and print capacity with ability to download to common media.	Y	
A5.25	The Vendor will provide routine, adhoc, and complex (consolidation, drill-down, slicing and dicing) analytical reporting	Y	
A5.26	The Vendor will provide drilldown capabilities and tabbed daily, weekly, monthly, quarterly, yearly, prior year, etc.	Y	
A5.27	The Vendor will provide an user friendly interface and ability to customize dashboards by user and because of changing needs.	Y	
A5.28	The Vendor will provide archivable reports (unalterable) with ability to retain original report template for future use.	Y	
A5.29	The Vendor will provide graphical presentation with gauges and other representations to highlight important events and alerts.	Y	

State of Vermont - Medicaid Operations - Pharmacy Benefits Management
Template H - RFP Non-Functional Requirements Response
Project Management Requirements

RFP Req #	Requirement Description	Response Code (Y or N)	Vendor Response Comment(s)
I1.1	The Vendor will employ, maintain, and execute a project management methodology that complies with the Project Management Institute (PMI) standards or equivalent.	Y	
I1.2	The Vendor will describe the project management approach and methodology to be used for all System project life cycles.	Y	
I1.3	The Vendor will develop a Project Management Plan (PMP) conforming to the Project Management Body of Knowledge (PMBOK). The PMP will incorporate the following PMBOK knowledge areas: - Project Integration Management - Project Scope Management - Project Time Management - Project Cost Management - Project Quality Management - Project Human Resource Management - Project Communications Management - Project Risk Management - Project Procurement Management	Y	
I1.4	The Vendor will develop a Project Charter.	Y	
I1.5	The Vendor will develop a Project Governance Plan. The project governance plan will take into account and leverage the existing AHS governance structure.	Y	
I1.6	In collaboration with the State, the Vendor will develop a Business Process Change Management Plan. The State envisions significant process change during the development and implementation of the System. The Vendor will provide plans for a change readiness assessment, gap analysis, and recommendations for organizational and process changes. The Change Control Board will be managed by the State.	Y	
I1.7	The Vendor will document the business process management activities and outcomes described in the Business Process Change Management Plan. Additionally, the Vendor will document Operational and System Changes in the Technical Change Management Plan.	Y	
I1.8	Where available and agreed between the Vendor and the State, the Vendor will use State templates for project management deliverables. State templates listed in EPMO templates from the link: http://dii.vermont.gov/pm/pmtemplates	Y	
I1.9	The Vendor will develop a PMI compliant Communications Management Plan. The Communications Management Plan must describe participant's roles and responsibilities, internal communications, external communications, other communications and information management including communications protocols.	Y	

RFP Req #	Requirement Description	Response Code (Y or N)	Vendor Response Comment(s)
I1.10	The Vendor will leverage DII EPMO Project Log template as applicable to establish an issues and action items process and tracking document that must ensure that unanticipated issues, action items and tasks are assigned to a specific person for action and are tracked to resolution. DII EPMO Project Log Template can be found in http://dii.vermont.gov/sites/dii/files/pdfs/EPMO-Project-Log-Template.pdf The issue and action item tracking document must include the following: - Issue description. - Issue priority - Issue status - Plan for resolution. - Individual responsible for resolution. - Targeted resolution date. - Actual resolution dates. - resolution action.	Y	
I1.11	The Vendor must electronically provide project management documents (e.g., Project Management Plan, Project Schedule, Work Breakdown Structure, etc.) using Microsoft software products and/or pdf. The software version must be no less than a version still available on the common market and that is still supported by the manufacturer. The State will work with the Vendor in approving specific versions to assure that the application is synchronized with the State's plans.	Y	
I1.12	The Vendor will advise the State and Vendor management of progress in meeting goals and schedules contained in the work plans as well as any risks and issues during weekly progress meetings attended by the Vendor and the State. These may include walkthroughs of selected deliverables as requested by State staff.	Y	
I1.13	The Vendor will develop weekly progress reports. Weekly written progress reports will be provided by the Vendor to the State one working day before each weekly meeting, and containing items to be discussed at the meeting, including: - Progress of each task/activity. - Action items and decisions from the previous meeting. - Problems encountered, proposed resolutions, and projected completion dates for problem resolution. - Planned activities for the next two reporting periods. - Status of contractually defined deliverables, milestones, and walkthroughs scheduled in the project schedule. - Updating of information on a weekly basis in the State project and portfolio management tool. - Other information as needed (per Vendor or the State). Frequency of periodic reports" can be adjusted during the course of project as agreed by the State and Vendor.	Y	

RFP Req #	Requirement Description	Response Code (Y or N)	Vendor Response Comment(s)
I1.14	The Vendor will develop monthly progress reports. The progress report will include deliverables, milestones, walkthroughs, the State approvals, and lessons learned and will be used by the Vendor and the State in measuring the Vendor 's progress and performance. The report will also contain: - Issues, problems, and corrective actions, steps, and assignments. - Risks and mitigations. - Total budget and cost variance reporting - Lessons learned - Percentage complete - Resources and time required to completion During the application development phase of the project, Business Lead, PM, and EA to sit in on weekly SCRUMs as needed. As the project nears completion, Business Lead, PM, and EA will host mtgs for daily status updates.	Y	
I1.15	If the Vendor must substitute key staff during the project, the Vendor will submit to the State, in writing, the reason for the change and provide a completed staff experience reference form and resume for the substitute personnel. The State will either approve or reject the substitution.	Y	
I1.16	The Vendor will provide contract close-out plans and manage project close-out activities in accordance with the plan.	Y	
I1.17	As part of the proposal, the Vendor will describe the staffing approach and methodology used for the project, which will include: - Estimated number of Vendor 's resources needed per each phase of the project. - The number of staff resources within the following categories: Management, Business, and Technical. - The number of staff resource onsite vs. remote per the phase of the project - A description of the methodology used for releasing and adding staff to the project and managing staff PTOs - Outsourcing staff if applicable - Types and number of resources that State needs to provide per the phase of the project and expected hours from those resources - Providing a project organization chart.	Y	
I1.18	The Vendor will describe issue escalation process to settle matters of dispute as it relates to roles, responsibilities, or unmatchable level of service (i.e. what is their escalation chain) and this will be aligned with the State's escalation plan.	Y	
I1.19	The Vendor will describe their approach to remediate and realign the project and project plan in the event that the Vendor or the State decides that any aspect necessitates immediate attention and/ or State/Vendor management intervention.	Y	
I1.20	The Vendor will provide a minimum of one full time assigned PMI Certified project manager	Y	
I1.21	The Vendor will describe their approach regarding the project documentation repository. The Vendor is recommended to align with the State's document repository. In case the Vendor cannot, they must provide justification as to why their proposed repository works well in the best interests of the State	Y	

State of Vermont - Medicaid Operations - Pharmacy Benefits Management
Template H - RFP Non-Functional Requirements Response
Knowledge Transfer and Training Requirements

RFP Req #	Requirement Description	Response Code (Y or N)	Vendor Response Comment(s)
I2.1	The Vendor will develop (in cooperation with the State) and execute a Knowledge Transfer and Training Plan that describes roles and responsibilities of the State and Vendor and the approach for bringing managers, end users, and technical personnel to an appropriate level of understanding with the System.	Y	Team Catamaran training staff will work with the State to evaluate the number of individuals who must be trained, their roles, the applications on which they will require training, and the ideal targets of training to maximize learning to develop a Training Master Plan that outlines the key goals, features, and timelines of a training solution.
I2.2	The Knowledge Transfer and Training Plan will address and describe, at a minimum: - Training goals/standards and the specific plan for training technical personnel and end users. - Size of population and types of roles that need training - Strategy for providing training early in the project to allow the training goals to be implemented throughout the project life Phase. - Tasks, deliverables and resources necessary to complete the training effort and identify tools and documentation that will be necessary to support proposed effort. - Types of training, the specific courses and course materials, the training approach for both technical personnel and end users, and how training effectiveness will be measured and addressed. - Deliverables to support initial and ongoing training including user manuals, System manuals, and on-line help and training materials for technical/non-technical personnel. - Knowledge Transfer to enable the State personnel to operate, maintain, configure and modify the System including operation of the testing tools, supporting infrastructure, and security as agreed between the State and Vendor. - Metrics for tracking progress in achieving training and knowledge transfer objectives. - Reporting progress of training and knowledge transfer activities. - Additional training for technical staff on development, reporting and maintenance including processes and tools as needed - The training must include all aspects of the use of the New System - both Technical and Operational All Training Materials are due at the time of Staging and before the 3rd iteration of any application development	Y	Catamaran will assist with the overall training needs analysis and will provide the necessary materials to support training in print and/or electronic versions as requested by the State. Tracking will be available for any training sessions facilitated on behalf of the State, and flexibility will be provided with regard to the types of training delivered, including remote, Web-based training and onsite classroom sessions if appropriate.
I2.3	The Vendor will provide end user training documentation (including user manuals, online content, reference cards, etc.). Vendor is to supply full provisioning to all primary, secondary, and third level support personnel identified by the Business Lead. Provisioning for these users to be completed on the staging platform prior to SoV UAT	Y	Training Materials will be developed and updated on an ongoing basis. All materials identified as necessary for the implementation will be made available at the earliest opportunity prior to the implementation. This includes all printed material, online courses, and other files related to Catamaran's training offerings.

RFP Req #	Requirement Description	Response Code (Y or N)	Vendor Response Comment(s)
I2.4	The Vendor will provide the State a training course outline for review and acceptance at least thirty (30) calendar days prior to the beginning of scheduled training.	Y	Training contents and outline will be provided to the state for review within the requested timeframe.
I2.5	The Vendor will submit all training packages to the State for review and acceptance at least twenty-one (21) calendar days prior to the beginning of scheduled training.	Y	Training materials will be provided to the State for review within the requested timeframe.
I2.6	The Vendor will provide (customized as required) training manuals for all classroom as well as any online training they provide. Softcopies of all training manuals will be provided by the Vendor for both modes of training (classroom or online). Additionally, Hard copies of training manuals will be provided for class room training.	Y	Hard copy Training Guides will be provided for all classroom sessions, along with electronic versions for reference and distribution.
I2.7	The Vendor will provide all training materials developed for the system to the State. Those materials will become the property of the State and may be modified and duplicated by the State.	Y	This requirement will apply only to custom developed materials.
I2.8	The Vendor will provide electronic copies of all training materials (end-user, technical, trainee and instructor) in a format that can be easily accessed, updated and printed by State staff using software for which the State owns licenses. This includes but not limited to CDs/DVDs, and online. All training materials must conform to the applications and components interfacing with the Enterprise Staging Platform prior to release into production	Y	Electronic versions of any training materials used will be provided upon request.
I2.9	The Vendor will provide updated training documentation as necessary to incorporate new processes or functionality due to system releases, upgrades, or changes throughout the contract term.	Y	Team Catamaran regularly updates training materials with new system enhancements and provides informational sessions with each system enhancement to notify system users of critical updates to system functionality.
I2.10	The Vendor will schedule all training during regular work hours as approved by the State, unless the Vendor receives advance approval from the State for specific training at other times.	Y	Team Catamaran will work with the State to identify the most optimal times and numbers of sessions required for any scheduled training sessions on Catamaran's applications, regardless of remote or classroom delivery style.
I2.11	The Vendor will provide all training within the State of Vermont at locations convenient to the attendees of the training, unless the Vendor receives advance approval from the State for specific training at other locations.	Y	If deemed necessary, onsite training will occur at a location indicated by the State. Any remote or Web-based training will be accessible by trainees from their location in State offices or as indicated by the State.
I2.12	The Vendor will schedule staff training in a manner that is least disruptive to the normal business operations.	Y	Team Catamaran will work with the State to identify the most optimal times and numbers of sessions required for any scheduled training sessions on Catamaran's applications, regardless of remote or classroom delivery style.
I2.13	The Vendor will provide instructions to the State on Vendor tools and procedures used to support the training.	Y	Team Catamaran will provide the necessary information and instructions as needed.

RFP Req #	Requirement Description	Response Code (Y or N)	Vendor Response Comment(s)
I2.14	The Vendor will ensure that Vendor staff members are not assigned to train State staff and work on critical path development tasks concurrently.	Y	All training will be done by Catamaran's Training and Documentation Team, whose sole responsibility is the training of Catamaran systems.
I2.15	The Vendor will assist the State in developing end-user training on the System business functionality.	Y	Team Catamaran will perform a task-based training needs analysis to determine the individual needs of end-users at the state. Training materials will be selected and developed to fit these needs per the results of the analysis.
I2.16	The Vendor will provide end-user classroom training sessions and on-line training as agreed with the State for all end-users.	Y	Team Catamaran's primary training solutions include both Web-based and onsite classroom sessions. The route of delivery will be determined per the training needs analysis and discussions with the State.
I2.17	The Vendor will identify the number of staff necessary for maintenance and operations of the System as well as the skill sets necessary, with the State's agreement.	Y	
I2.18	The Vendor will develop and provide training for the technical support staff including State staff and contractors.	Y	Team Catamaran will perform a task-based training needs analysis to determine the individual needs of end-users at the State. Training materials will be selected and developed to fit these needs per the results of the analysis.
I2.19	For the duration of the contract, the Vendor will continue to provide training to the technical staff if system upgrades have been installed and there is a change in System components functionality.	Y	Team Catamaran regularly updates training materials with new system enhancements and provides informational sessions with each system enhancement to notify system users of critical updates to system functionality.
I2.20	The Vendor will create a training approach and needs analysis early in each project Phase which will determine the training requirements	Y	Team Catamaran will assist with the overall training needs analysis and will provide the necessary materials to support training in print and/or electronic versions as requested by the State.

RFP Req #	Requirement Description	Response Code (Y or N)	Vendor Response Comment(s)
I3.1	The Vendor will describe the overall testing approach and methodology used for the System deployment. The Vendor will work with the State's Business Units in fine tuning the testing approach and get the State's approval before starting the testing phase	Y	
I3.2	The Vendor will incorporate the testing approach into a comprehensive Test Plan. The Test Plan will include the procedures for documenting the completion of each test phase, test scripts, test conditions, test cases, and test reports. Detailed test plans will be created for the following testing areas: - Integration Testing - Security Testing - Performance Testing - User Acceptance Testing - Operations Acceptance Testing All Integrated System Testing will be performed on the Enterprise Testing platform while the UAT will be performed on the Staging platform. No testing may be conducted on the production platform and all testing must be completed prior to deployment.	Y	
I3.3	The Test Plan must, at a minimum, include the following areas: - Test philosophy (including objectives, required levels or types of testing, and basic strategy (developing, testing and release of major subsystems/components). - Procedures and approach to ensure the testing will satisfy specific objectives and demonstrate that the requirements are met. - Procedures and approach to ensure that each phase of the testing is complete, and how formal reports/debriefings will be conducted for each phase of testing. - Approach to define tested workload types (performance testing) and test data - Overview of testing facilities, environment and specific testing tools to be used. - Overview of processes and procedures that will be used by the Vendor for releasing testing results and review of test results. - Process and procedures for tracking and reporting for results/variances/defects will be tracked and reported. - State resources required for testing during the development life cycle for each testing area. - Method for review of test cases and procedures - Configuration management of the test environment - Describe User Acceptance Testing and User Sign-Off - Plan and deliverables for each testing area described above - Vendor is responsible for providing detailed instructions in modifying any desktop configuration settings prior to the commencement of System testing.	Y	
I3.4	The Test Plan will provide a detailed description of each test required to ensure that all of the System components, interfaces, and components comply with the requirements and specifications.	Y	
I3.5	Testing and Development will have their own environments, separate from Production. Testing or development will not be performed in the production environment.	Y	
I3.6	The Vendor will repeat the test life cycle when a failure occurs at any stage of testing.	Y	

RFP Req #	Requirement Description	Response Code (Y or N)	Vendor Response Comment(s)
I3.7	The Vendor will be responsible for building test plans, executing test plans, and creating reports. The State will evaluate the Vendor test plans, and Vendor test results, and may validate the testing done by augmenting it with State testing.	Y	
I3.8	The Vendor will document the testing tools, test configurations and related documentation. The Vendor will provide all necessary performance testing scripts with input from the State's Business Units. The State will have the final say on what is an acceptable performance. Performance testing to be completed by the Vendor with input from the EA Office and the Business Lead. The Staging Platform to be used for all performance testing. Benchmark reports to be issued to Business Lead and EA Office.	Y	
I3.9	The Vendor will provide the State with the test scripts, test results and quality reports.	Y	
I3.10	The Vendor will provide staff to the State to answer questions and address any problems that may arise during testing conducted by the State.	Y	
I3.11	The Vendor will refine the test documents, procedures, and scripts throughout development and through full System acceptance to reflect the as-built design and current requirements.	Y	
I3.12	The Vendor will allow the State to run validation and testing software against externally facing Internet applications to help identify potential security issues, and must agree to repair any deficiencies found during this testing.	N	Yearly compliance reports are made available for clients to review.Catamaran's information security program is currently aligned with the ISO framework and the COBIT framework. Catamaran reviews the information security program annually. This is to assure compliance with industry (PCI) and regulations (e.g., HIPAA, etc.) and to evaluate potential changes to the program. Catamaran is SOX (Sarbanes Oxley) 404 compliant; therefore, an independent auditing firm attests that our internal control processes and systems are effective and satisfactory. We also have received a SSAE 16/SOC 1, Type II report related to our pharmacy claims processing services audited by an independent CPA firm. In addition, our internal audit team is responsible for testing the design and operating effectiveness of key internal controls for compliance with Sarbanes-Oxley 404. This process occurs throughout the year and includes planning, risk assessment, testing, reporting results, and issue resolution. The internal audit team also is responsible for coordinating and facilitating the claim system SOC 1 report audit conducted by an independent accounting firm. Catamaran has received PBM and Specialty URAC
I3.13	As System events contain date and time-sensitive elements, the testing infrastructure must provide a method of altering and synchronizing the System date throughout each test phase. This requires the ability to change the System date and time in some scenarios.	N	It is against Catamaran policy to change the system date in our environments. Most testing is based on fill date logic and can be accomplished through date bound rules and future/prior fill testing methods.
I3.14	The Vendor must develop a comprehensive Defect resolution Management Plan that describes the approach to be taken in managing all problems discovered during any testing phase and in production.	Y	

RFP Req #	Requirement Description	Response Code (Y or N)	Vendor Response Comment(s)
I3.15	The Vendor will install and test a single Defect resolution Tracking System that the Vendor and the State will use collaboratively for the tracking of System defects, security, and System issues.	Y	
I3.16	The Defect resolution Tracking System must, at a minimum, include: - All defects in the System identified during any testing phase must be recorded, prioritized, tracked, and resolved in a timely manner. Each must be assigned a “Defect Level” based on the following definitions: 1. Critical - Results in a complete System outage and/or is detrimental to the majority of the development and/or testing efforts. There is no workaround. 2. Serious - System functionality is degraded with severe adverse impact to the user and there is not an effective workaround. 3. Moderate - System functionality is degraded with a moderate adverse impact to the user but there is an effective workaround. 4. Minor - No immediate adverse impact to the user. - The Vendor will allow the State full access to the Defect resolution Tracking System. - The Defect resolution Tracking System will be designed in a manner to allow for the transfer of ownership to the State following contract completion. - The processes and management of the Defect resolution Tracking System will be addressed as part of the Quality Management Plan. - The Vendor will address defect as such: Critical and serious defects will require remediation and	Y	
I3.17	All components of the System will accommodate leap year processing and daylight savings time start/end dates.	Y	
I3.18	The Vendor will compare and contrast the design of System components to CMS architectural standard. The Vendor will apply a documented and structured Architecture Development Methodology (ADM) for the design of System components. The Vendor will provide all necessary performance testing scripts with input from the State's Business Units. The State will have the final say on what is an acceptable performance.	Y	The State and Catamaran will mutually agree to what is acceptable performance based on the requirements contained in this RFP and later confirmed and detailed in the requirements verification phase. Further, the approved test plan artifact will memorialize the agreed upon acceptance criteria for each phase of testing.

State of Vermont - Medicaid Operations - Pharmacy Benefits Management
Template H - RFP Non-Functional Requirements Response
Data Conversion and Migration Requirements

RFP Req #	Requirement Description	Response Code (Y or N)	Vendor Response Comment(s)
I4.1	The Vendor will describe the migration approach and methodology used for the PBM project as per the Migration phase approach outlined in the ADM	Y	
I4.2	The Vendor will incorporate a detailed Migration approach into a comprehensive Migration Plan which will be added to other PM plans as part of the PMO. The State anticipates considerable collaboration with the Vendor in the plan's construction, with particular attention to high complexity components of the existing the State systems as well as the proposed System.	Y	
I4.3	Disaster recovery requirements relative to the physical System components and planning for recovery from operational failures are the responsibility of the Vendor. The Vendor will develop an Operational Recovery Plan that addresses the following: - Areas of the most susceptible to failure or disaster that would result in downtime. - Recommendations for System recovery processes, or steps to take in the event of a downtime event. - Recommendations for the State on how to comprehensively and effectively mitigate the risk of a downtime event. - Recommendations for securing the System components during a period of emergency operation. - Testing Failover and DR while on Staging Platform after testing has concluded and prior to deployment on Production Platform. - DR requirements must include networking DR for Datacenter access.	Y	
I4.4	The Vendor will describe the interface management approach and methodology used for the PBM Project.	Y	

RFP Req #	Requirement Description	Response Code (Y or N)	Vendor Response Comment(s)
I4.5	The Vendor will incorporate the interface management approach into a comprehensive Interface Management Plan for all interface mechanisms used for System (e.g. batch, ESB/web services). The Interface Management Plan will be used by the State to document the plan for integrating the PBM System with all systems internal and external to the State. The Interface Management Plan will, at a minimum, document the following areas: - The approach to developing and managing internal and external System interfaces. - Technical tools that will be used for data transformation, transport and error recovery. - A description of how the Vendor's development standards will be reconciled, to reflect use of ESB and web services as wrappers to legacy systems. The Vendor should produce example scenarios for integration reflecting their infrastructure components and toolset. - Tasks, deliverables and resources necessary to complete interface development and Migration. - Description of how the System development and test systems will work with the external interfaces. - References to applicable sections in the relevant design documents that describe how the System System will be synchronized with the specific internal and external interfaces. - References to applicable sections in the detailed design that describe the mappings between internal and external System data and the System data. - Descriptions of the process for managing changes to the interfaces, both in the production and non-production environments - Interface(s) needed for maintaining data synchronization between an interim production System and the final production Migration. - System interfaces, data format, frequency of updates and expected data volume. - Process for interfacing and collaborating with interface partners, including roles, responsibilities, deliverables and timelines. - How the State development and test systems will work with the external non-production	Y	
I4.6	The Vendor will validate that each interface is working correctly. The Vendor will repair all interface-related problems caused by Vendor-developed interfaces.	Y	Catamaran validates that each interface is working correctly. We expect DVA to review and approve interfaces, even those in production now if not approved already. This will clarify what is a "change" and what is a "defect".
I4.7	The Vendor will assist the State in identifying root causes for all System interface related problems.	Y	

RFP Req #	Requirement Description	Response Code (Y or N)	Vendor Response Comment(s)
I4.8	When functionality is ready to be delivered to the State for User Acceptance Testing (UAT), it will be delivered in the form of a pre-production release (defined as ready for production in every respect but just not yet in production). Since the State will approve all releases into production, a pre-production release is equivalent to a production release and requires the rigor associated with a production release. Upon successful completion of UAT, the State will schedule a release to be moved to the production environment. Each pre-production release will include the following: - Release-specific hardware and software System components. - Release description including architecture or design updates, new functionality introduced, defects fixed, modifications to interfaces with other systems, other changes to existing code, and any software and hardware configuration changes. - Release contents including a description of the release structure and contents and instructions for assembling and/or configuring the components of the release. - Test Plan and test execution results. - Detailed hardware and software configuration information including any software and hardware dependencies and instructions at a level of detail that will enable administration staff to rebuild and configure the hardware environment without outside assistance. - Database documentation conforming to industry standards.	Y	
I4.9	Deployment will be iterative from both a business process and applied technology perspective and will be accepted by the State through application of the acceptance criteria in testing plans.	Y	
I4.10	The Vendor will deliver to the State a requirements traceability matrix for all delivered functionality, showing all testing activities tracing to delivered functionality, and all delivered functionality tracing to requirements in the requirements repository.	Y	
I4.11	The Vendor will assist the State with testing and release preparation in the pre-production environment.	Y	
I4.12	The Vendor must produce and execute an Migration Support Plan.	Y	
I4.13	The Vendor must provide support staffing information such as the proposed number, ratios, duration, and roles/responsibilities for on-going support (as identified in previously submitted Migration approach and plan).	Y	
I4.14	The Vendor must assess the pre-Migration readiness of each part of the organization and will document the status in a pre-Migration readiness assessment. The Vendor will conduct an Migration readiness review ten days prior to cutover at each part of the organization.	Y	
I4.15	Upon successful completion of the pre-production testing, the Vendor will, in coordination with the State, create a Release Plan that will consist of an updated Pre-Production Release notification to assist the State in successfully releasing and maintaining the System for production business use.	Y	
I4.16	The Vendor will describe the approach to pilot the System, including a high-level draft Pilot Plan.	Y	

RFP Req #	Requirement Description	Response Code (Y or N)	Vendor Response Comment(s)
I4.17	The Pilot plan will be executed on the Staging platform and, at a minimum, will address the following: - Pilot locations, users, durations, sequencing and timing - Pilot support model including roles and responsibilities of the Vendor and the State; number of staff on-site and off-site; and staffing hours - How the pilot will be representative of staff from each broad category of work reflected in the State and represent the diversity in size of the various offices - Strategy for testing of all production functionality of the System components including interfaces to external systems - Reporting in the dual environment - Training of users and technical staff - Help desk procedures, functionality and incident reporting - Problem management procedures - Help related documentation - Functionality and operations of interfaces - Approach for validating worker productivity and efficiency - Approach for testing and validating mobility - Readiness planning - Plan and approach for resolving data corruption issues as a result of conversion - Change management processes - Approach for communication and coordination of pilot activities and issues - Approach and procedures for evaluating user experience and feedback - Approach and process for evaluation of the pilot against defined pilot success criteria - Detail process to validate the Migration process and tools and certify the State application, technical environment, and users as ready to move to full production Migration	Y	
I4.18	The pilot(s) will test all System components including at a minimum: - Training - Help desk - Production Support - Documentation - Interfaces - All Functionality - Reporting - Security - Problem escalation - Change process	Y	
I4.19	The Vendor will produce a lessons learned document after conducting the System component pilots and provide recommendations for changes to the Migration process.	Y	
I4.20	The Vendor will ensure smooth flow of data between the various systems interfacing with the PBM System including the MMIS system and others.	Y	
I4.21	The Vendor will provide data coversion from legacy system to new system	Y	

State of Vermont - Medicaid Operations - Pharmacy Benefits Management
Template H - RFP Non-Functional Requirements Response
Quality Management Requirements

RFP Req #	Requirement Description	Response Code (Y or N)	Vendor Response Comment(s)
I5.1	The Vendor will describe the quality management approach and methodology used for the System with input from the Business Units	Y	
I5.2	The Vendor will develop a Quality Management Plan to describe the approach they will use to ensure the quality of the Service and the work it performs. The Plan will include at least the following items: • The State's management of the requirements. This includes the identification of inconsistencies between the requirements, and the project's plans and work products. • The State's requirements traceability matrix that will be used for requirements management, and will map where in the software a given requirement is implemented. • The practices and procedures that will be followed for reporting, tracking, and resolving problems or issues identified in System Testing, System Migration, and System Operations. • The business process changes resulting from the System. • The quality of work products developed and delivered by Vendor's sub-Vendors/partners, if applicable. • A metrics process that describes how measurements will be identified, collected, and analyzed to ensure that quality goals, including management and the System goals, are being met. It should also describe the types of project metrics used. • The Vendor's organizational structure, and the roles and responsibilities of Vendor staff as they relate to quality management. • Description of the processes and management of the Defect and Issue Tracking System for System of items and, if applicable, how corrective action plans will be developed to address more significant issues.	Y	
I5.3	The Vendor must, subject to review by the Department as needed, implement and document quality assurance processes and procedures to ensure integrity of services and of the processing and storage of the Vendor's data including, but not limited to, the following:	Y	
I5.4	a. Maintain separate testing environments, emulating the production environment, where users can test systems changes, edits, and pricing without affecting the production systems	Y	
I5.5	b. Allow online update and inquiry of all data repositories in the test environment(s) to simulate the production environment	Y	
I5.6	c. Generate test results to evaluate the fiscal impact of changed edits or other test conditions	Y	
I5.7	d. Validate and document internal systems by balancing input and output data execute batch jobs appropriately, and generate outputs appropriate for the executed cycle	Y	

RFP Req #	Requirement Description	Response Code (Y or N)	Vendor Response Comment(s)
I5.8	e. Comply with the requirements of the Payment Error Rate Measurement (PERM) program and other quality assurance programs as specified by CMS, the State, and the Department	Y	Any new QA programs specified by the State or Department will need to be mutually agreed upon prior to commencement.
I5.9	f. Maintain internal quality control procedures for functionality and data integrity	Y	

State of Vermont - Medicaid Operations - Pharmacy Benefits Management
Template H - RFP Non-Functional Requirements Response
Operations Requirements

RFP Req #	Requirement Description	Response Code (Y or N)	Vendor Response Comment(s)
O1.1	The PBM Vendor will have recovery plans in place for the non-production environments of the PBM System enterprise (Development, Testing, Staging, Model Office and Business to Business environments.)	Y	
O1.2	The PBM Vendor will have a Disaster Recovery Plan in place for the production PBM System environment in the event of a catastrophic disaster at either the primary or secondary sites.	Y	
O1.3	The PBM Vendor will be required to supply hot failover and fail back capability for the production PBM System. This capability will be invoked during system maintenance of the PBM System at the primary production site and during any production outage at the primary site and/or Secondary Network back up to primary Data Center should primary circuit fail but Data Center is Ok. At a minimum, this failover functionality will be tested each quarter of the year for the duration of the contract. If no system maintenance or outages have occurred during a quarter to exercise this capability, then the PBM Vendor will schedule a test failover and fail back to occur within the month following the end of such quarter.	Y	
O1.4	The PBM Vendor will be required to supply a PBM System Help Desk that is available during regular business hours (Monday – Friday, 8:00 a.m. – 7:00 p.m. Eastern Time and Saturdays from 8:00 am – 5:00 pm Eastern Time) to assist with usability questions, problem analysis and for reporting technical issues	Y	
O1.5	The PBM Vendor must have a defined escalation plan for technical problems that cannot be addressed by the PBM System Help Desk. The escalation plan must include a definition of severity levels and specific escalation procedures based upon the severity of the technical problem.	Y	
O1.6	The System will have the ability to generate administrative alerts and warnings when statistics indicate an impact or potential limits on system performance and availability. These alerts will need to be communicated through various mechanisms including SMS, Phone and Email	Y	Catamaran utilizes email alerts.
O1.7	The System will provide SLA monitoring and reporting capabilities.	Y	
O1.8	The System will provide event management and monitoring functionality according to ITIL best practices.	Y	Catamaran follows the ITIL framework for Problem, Change and Incident Management through our Service Now ITAM Technology Suite.
O1.9	The System will provide Data archiving capabilities based on State defined criteria.	Y	
O1.10	The System will provide version control capabilities to ensure the integrity of all software releases.	Y	
O1.11	The System will provide logging, reporting for accessing errors and exceptions.	Y	
O1.12	The System will monitor and provide reports on any unauthorized access.	Y	
O1.13	The System will track unusual or out of normal system operations usage or user access.	Y	Catamaran provides standard reporting on activity based upon User ID

RFP Req #	Requirement Description	Response Code (Y or N)	Vendor Response Comment(s)
O1.14	All system communications will be protected by at least 128-bit encryption.	Y	The Catamaran Data Centers employ 256bit AES encryption.
O1.15	The System will maintain the privacy and participant consent requirements of the participants.	Y	
O1.16	The System will protect the integrity of the data across all interfaces. Data will be accurate and timely.	Y	
O1.17	The System will provide role-based user and identity management.	Y	
O1.18	The System will maintain a level of security that is commensurate with the risk and magnitude of the harm that could result from the loss, misuse, disclosure, or modification of information.	Y	
O1.19	The System will implement security controls in accordance with Federal and State security policy and regulations.	Y	

State of Vermont - Medicaid Operations - Pharmacy Benefits Management
Template H - RFP Non-Functional Requirements Response
Service Level and Performance Requirements

RFP Req #	Requirement Description	Response Code (Y or N)	Vendor Response Comment(s)
System Availability and Response Times			
P1.1	The PBM System will be operational every calendar day of the year and 24 hours every day. The Vendor will meet a 99.90% PBM System availability requirement. This includes end-to-end System availability of all software, hardware and communications interfaces between the PBM System and all ancillary systems. The Contractor must measure and report its performance on this SLA monthly.	N	Except for scheduled maintenance periods, Catamaran's on-line claims adjudication system will be available at least ninety-nine and five tenths percent (99.5%) of the time.
P1.2	The Vendor's PBM System response time be no greater than 8 seconds and must average 3 seconds or less for all interactive system transactions other than the reporting-related system interactions covered by the next 4 SLRs. The response time is measured as the time from when the users presses enter until the screen refresh in response is complete.	Y	Average < 3 seconds per transaction (From when the transaction enters the RxClaim System to when it leaves the RxClaim System). Catamaran cannot be held responsible for failures of networks or switches outside of our control.
P1.3	The maximum response time for search and lookup performance is 3 seconds for 95 percent of the time. Maximum response time shall not exceed 15 seconds except for specified and agreed to exclusions.	Y	Average of <= 3 seconds for 95 percent of the time within the Catamaran controlled network. Catamaran cannot be held responsible for failures of networks outside of our control.
P1.4	The maximum response time for a Dashboard report is 5 seconds, 95% of the time.	Y	Average of <= 5 seconds for 95 percent of the time within the Catmaran controlled network. Catamaran cannot be held responsible for failures of networks outside of our control.
P1.5	The maximum response time for a Static Standard report is 5 seconds, 95% of the time.	Y	Average of <= 5 seconds for 95 percent of the time within the Catmaran controlled network. Catamaran cannot be held responsible for failures of networks outside of our control.
P1.6	The maximum response time for a parameter-based report is 20 seconds.	N	Since parameter based reports could include the entire data set, it is impossible to bound the response time without also limiting the quantity of records retruned to a parameter-based report. Further, Catamaran cannot be held responsible for failures of networks outside of our control.
P1.7	The PBM Vendor must take immediate action to ensure that the System downtime does not exceed 15 minutes per occurrence and take necessary action to meet End-to-End System Availability and Response times as agreed to in the contracted service level agreements.	N	Scheduled downtime will occur during mutually agreed upon windows. In some cases it will exceed 15 minutes due to MOD releases which occur every other month. However, our typical scheduled downtime is less than 10 minutes and on average, it will be less than 15.

RFP Req #	Requirement Description	Response Code (Y or N)	Vendor Response Comment(s)
System Availability and Response Times			
P1.8	Unscheduled System down time per occurrence- The amount of time that the PBM Service has an unscheduled downtime will not exceed 2 hours per occurrence, and no more than 2 incidents per year	Y	
System Disaster Recovery Performance Measures			
P1.9	Recovery Time Objective (RTO) will be within 4 hours. In case of a disaster that effects the PBM operations, the entire service shall be restored within 4 hours	Y	Measure quarterly, reconcile annually and based upon book of business data.
P1.10	Recovery Point Objective (RPO) will be no more than 1 hour of data loss. In case of a disaster that effects the PBM operations, 1 hour of data inputs to the system (but no more) may be lost and need to be re-entered.	Y	Measure quarterly, reconcile annually and based upon book of business data.
Call Center Performance Measures			
P1.11	First Call resolution Rate will be 95% or greater. First contact completion applies when the first person the customer reaches either answers the question, resolves the problem, or dispatches service where appropriate.	N	Ninety-five percent (95%) or greater of calls to Catamaran's help desk will be resolved within one (1) business day.
P1.12	Call Answering Time - 95% of all calls entering the hold queue will be answered within 30 seconds by an agent with 90% of those answered within 20 seconds and the remaining answered within 40 sec.	Y	
P1.13	Call abandonment Rate will be 3% or less. This is the % of calls that are disconnected/abandoned after entering the hold queue.	Y	
POS System SLRs			
P1.14	The POS system provided to the Pharmacies will operate with 24x7x365 availability no less than 99.9% of the time – except for Vendor scheduled downtime approved by the State of Vermont	N	Except for scheduled maintenance periods, Catamaran's on-line claims adjudication system will be available at least ninety-nine and five-tenths percent (99.5%) of the time. Measure quarterly.
P1.15	Average POS response time of three seconds or less on all transactions. (Response time means the time from when the claim is received by the Vendor's processor to the time the results are transmitted from the Vendor's processor and includes all procedures required to complete claim adjudication.)	Y	Average ≤ 3 seconds per transaction (From when the transaction enters the RxClaim System to when it leaves the RxClaim System).
P1.16	The Vendor must notify staff designated by the State of Vermont of performance issues impacting POS adjudication within 15 minutes of the Vendor's knowledge of the system problems. The State of Vermont will provide procedures for after-hours contact during the Design, Development, and Implementation phase of the Contract.	Y	
P1.17	99% of enrollment eligibility data and provider enrollment data is updated within _____ of receipt of the eligibility and provider information, including electronic file transfers and manual updates.	Y	Ninety-nine percent (99%) or greater of Usable Eligibility Files will be loaded and active in the on-line claims adjudication system within twenty four (24) hours of Catamaran's receipt.
P1.18	99.9% of all prescription claims will be processed accurately.	Y	Ninety-nine and nine tenths percent (99.9%) of all POS claims will be processed and paid accurately in accordance with the client-approved benefit design.

RFP Req #	Requirement Description	Response Code (Y or N)	Vendor Response Comment(s)
System Availability and Response Times			
P1.19	99.9% of all prescription claims will be processed accurately.	Y	Ninety-nine and nine tenths percent (99.9%) of all POS claims will be processed and paid accurately in accordance with the client-approved benefit design.
Other SLRs			
P1.17	The PBM Vendor will notify the State according to HIPAA requirement of any security or data breach including PHI or PII data breach and will follow and be responsible for the incident response procedures and activation.	Y	
P1.18	The PBM Vendor will be required to correct any Federal or State audit findings specific to the PBM System environment in the time frame specified in the audit report.	Y	
P1.19	The PBM Vendor will provide a detailed approach to Operational Management in line with the State's strategy. Additionally, the Vendor will provide detailed Operational information on automated and manual tools as well as details on processes that will be performed by the PBM Vendor to ensure effective system control, reliability, documentation, and recovery.	Y	
P1.20	Provide the capability to track, monitor, and report on all activities as defined within SLAs.	Y	
P1.21	Provide an automated real-time capability to track and monitor performance of all system components (End-to-End).	Y	Catmaran has substantial performance monitoring tools and capabilities for internal consumption. We can work with the State to determine what measures and outputs the State would like to see reported on.
P1.22	The PBM Vendor will meet all HIPAA standards for the protection of PHI and PII data and will be held responsible to remediate any system breach that results in identify theft. The Vendor will be responsible for all fines and damages related to any breach of PHI or PII data security.	Y	
P1.23	The PBM Vendor will meet all federal mandates and deadlines for compliancy as defined the Regulatory and Security tab. All Security efforts, to bring the PBM System under compliance, will not be considered as separately payable under the PBM System Application Support arrangement but should be factored into the overall cost for providing the system to State.	Y	
P1.24	Facilitate the continued improvement of performance and process efficiency by providing reporting that includes both current values and historical data with sampling frequencies and timeframes.	Y	
P1.25	Provide an automated performance monitoring system to measure operational performance against defined Service Level Agreements and report results using a Scorecard.	N	The level of automation available in performance reporting is dependent on the specific SLA. Some service levels such as account management responsiveness do not lend themselves to automated reporting.
P1.26	The System will have the ability to generate administrative alerts and warnings when statistics indicate an impact or potential limits on system performance and availability. This includes alerts from every System component including the Database.	Y	
P1.27	The Vendor must notify staff designated by the Department of performance issues impacting PA processing within 30 minutes of the Vendor's knowledge of system problems.	Y	
P1.28	100% of the monthly and quarterly standard management reports shall be available and delivered to the Department within 30 days after the end of each qurter.	Y	

RFP Req #	Requirement Description	Response Code (Y or N)	Vendor Response Comment(s)
System Availability and Response Times			
Account Management			
P1.29	85% of all calls are resolved within two business days of receipt	Y	Catamaran's account management team will respond wihtin two (2) hours of receipt of an e-mail or phone call from the State. Some issues can be resolved within two business days. However, if the issue is unable to be resolved within two business days, the account management team will notify the State of updates and the expected time of resolution.
P1.30	All written inquiries will be responded to within two business days	Y	
P1.31	Ongoing change requests including programming changes requested the Department, are completed within 20 business days or 30 calendar days of receipt of the request, unless other time parameters are agreed to by the Department.	N	Catamaran cannot agree to this performance without knowing the scope of the change. Further, changes will be designated to be included in a scheduled MOD release which may fall out of the required timeframe. Changes to the benefit design can be accomodated in this performance measure.
P1.32	The Vendor guarantees a satisfaction rating of at least 100 for satisfied or very satisfied. The Vendor will survey Department staff and report results back to DVHA.	N	Since client satisfaction is a purely subjective measure, it is impossible to agree to guarantee a person's subjective respone. Catamaran is committed to client satisfaction. It is a part of our culture, our Client's for Life program, and is inculded in every employee's performance review and compensation plan.

RFP Req #	Requirement Description	Response Code (Y or N)	Vendor Response Comment(s)
System Availability and Response Times			
Legal/ Contracting			
P1.33	The Vendor guarantees the timing of response to the Department comments of the contract draft within 10 business days of the receipt of the contract requested changes.	N	Catamaran strives to meet this goal. However, without knowing the timing of the receipt of the draft, staffing levels during that time, and other workload it is impossible to predict the response time. Again, we will do everything we can to meet this requirement.

Template I

Non-Functional Requirements Approach

Instructions for RFP Response

RFP # 03410-127-14

catamaran

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1.0 Introduction and Instructions

Please use these response sections to provide specific details of the proposed approach to meeting Vermont PBM requirements in each area. Responses should, when necessary, reference requirements using the appropriate RFP Requirement Numbers from Template H - RFP Non-Functional Requirements.

Also, include one or more diagrams where necessary that detail the proposed design, approach and the relationships between key components.

Responses in this document must be highly-focused on the specific requirements and must not simply provide generic or marketing descriptions of the Vendor's capabilities.

2.0 Interoperability and Integration

Instructions: Describe the system integration approach between the PBM System, State of Vermont Interfaced Systems and any other proposed third party systems or products. Describe the interoperability features and capabilities of the proposed PBM System including integration with the VT HSEP (Vermont Health Service Enterprise Platform) and VISION (State's accounting system) using a Service Oriented Architecture via an Enterprise Service Bus The approach must, at a minimum, provide details on how the proposed Solution intends to meet or exceed the Interoperability-Integration Requirements set forth in the document 'Non-Functional Requirements, Tab A1 Interoperability-Integration Requirements'.

Response:

Catamaran has considerable experience in both the design and implementation of interfaces with external systems including MMIS. Catamaran has successfully completed integration efforts with every major MMIS vendor in support of state Medicaid agencies. The processes for developing interfaces and interoperability with other systems are mature and take into consideration the complexities and nuances of functioning within the framework of a multi-vendor, multi-system environment. We use a comprehensive workflow process for file transfers, which begin with thorough documentation of file content requirements, transfer protocols, and published schedules. In addition to the major MMIS vendors, we have integrated with more than 150 other health plans.

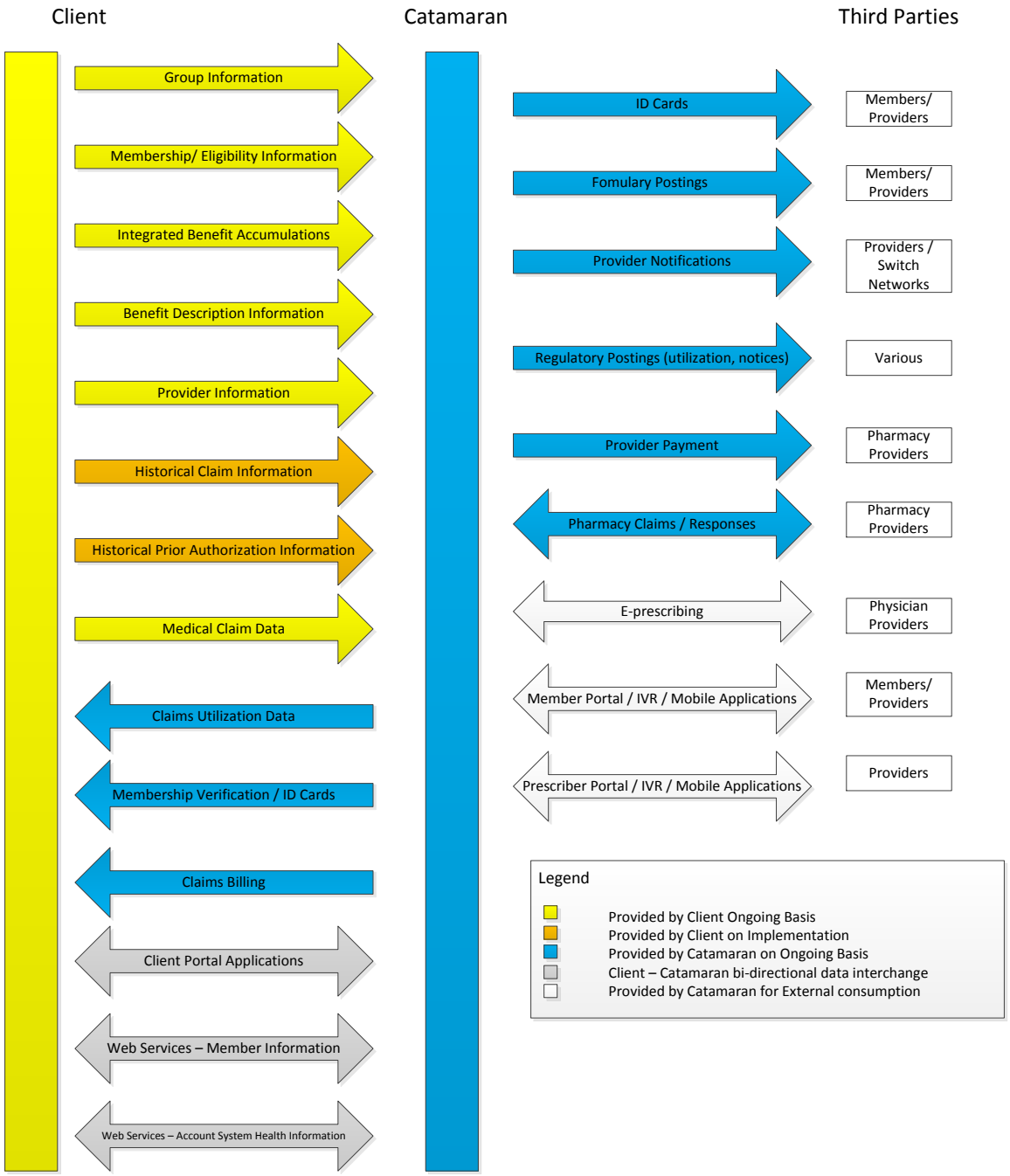
Quality assurance includes file balancing and exception reporting, along with detailed audit trails assuring that files are sent, received, loaded, and balanced in a timely, accurate manner. Experienced Catamaran staff assigned to the DMS interface effort is knowledgeable in all aspects of pharmacy and medical data, and are key to ensuring accurate transformation and mapping of data in and out of our claims processing and rebate systems. Additionally, the extensive testing procedures performed prior to moving a file load/extract process to production fully ensures that all data is mapped and exchanged accurately.

Catamaran's systems personnel are experienced in the processes required to accurately review and map customer-specific formats to our products' published interfaces. Additionally, Catamaran can accommodate customized file extracts to meet the needs of DMS and any other State vendors who require data from Catamaran. Personnel assigned to this process include systems staff, database administrators, and business and clinical analysts. Catamaran optimizes the use of tools and technologies to ensure that these processes are well documented, timely, and accurate.

As part of the continued investment in our core products, Catamaran maintains existing interfaces such as product reference files, provider data, rebate data, and data movements between RxClaim, SilentAuth, RxMax, and RxTrack. Our products maintain standard interfaces for eligibility, provider network, pricing, claims detail, list loads, and reference data. Catamaran provides the expertise and development effort required to perform the complete transformation from State formats to the Catamaran standard interfaces where required.

The diagram below is an example of the documentation we provide and represents an example inventory of interfaces. Documentation includes the inventory, standards, specifications, and configurations of the interfaces that are unique to the DMS implementation.

Catamaran / Client System Interfaces



Catamaran offers a number of mechanisms by which data can be exchanged with clients. The most common mechanisms include:

- FTP and secure FTP are commonly used for file-based data interchange. We can host a set of FTP folders where information can be deposited by the client (based upon the data, when it is to be applied, etc.) We also can reach out to FTP folders managed by the client.
- We support Network Data Mover (NDM), a commonly used protocol.
- We also can support exchange of data through other mechanisms (e.g., email) on the condition that both parties agree that such exchange is secure and verifiable.

We can support the exchange of file-based data on virtually any schedule that meets client requirements. Most commonly, the daily exchange of data is used for eligibility updates, financial balances, prior authorization data (if applicable), and other commonly exchanged information. However, for interfaces such as eligibility, we are able to support more frequent file exchanges. Some of our client file-based eligibility interfaces allow for updates as frequently as every 15 minutes.

- We support industry standard (and HIPAA-mandated) formats, such as the X-12 834 (eligibility) and 835 (payment reconciliation) formats, for information exchange. We have extensive EDI and data remapping experience and are able to handle proprietary formats when appropriate and required.
- We also have developed an extensive set of SOA-based Web Services that allow for the exchange of information on a real-time basis. These Web Services enable clients to integrate the Catamaran interface as part of their existing application architecture. Some common applications of these services include:
  - Eligibility - Web Services are available to verify eligibility and perform standard add, change, and terminate functions. These services are used to interface Catamaran systems with client enrollment systems and have also been deployed in the client-developed Web applications, such as a member portal and Catamaran's RxPortal.
  - Member Profile - Web Services are available to securely exchange information to gather member demographic and claims data. These services are also used in portal applications and in other client-developed offerings, such as custom help desk services or clinical service applications.

Our suite of Web Services grows monthly based upon client needs and other industry influences.

Based on our policies, client data transmissions, containing PHI or not, must be encrypted. We utilize a Multi-Enterprise Services Architecture (MESA) known as Sterling GIS for data exchange of all file-based transfers. All transfers take place in accordance with the MESA guarantees and established procedures for a particular client. The MESA ensures that all transfers:

- Take place between established end points
- Use established protocols
- Use established encryption methods and keys
- Are authenticated

- Are logged
- Are conducted using mechanisms that are designed to optimize the speed and success of delivery.

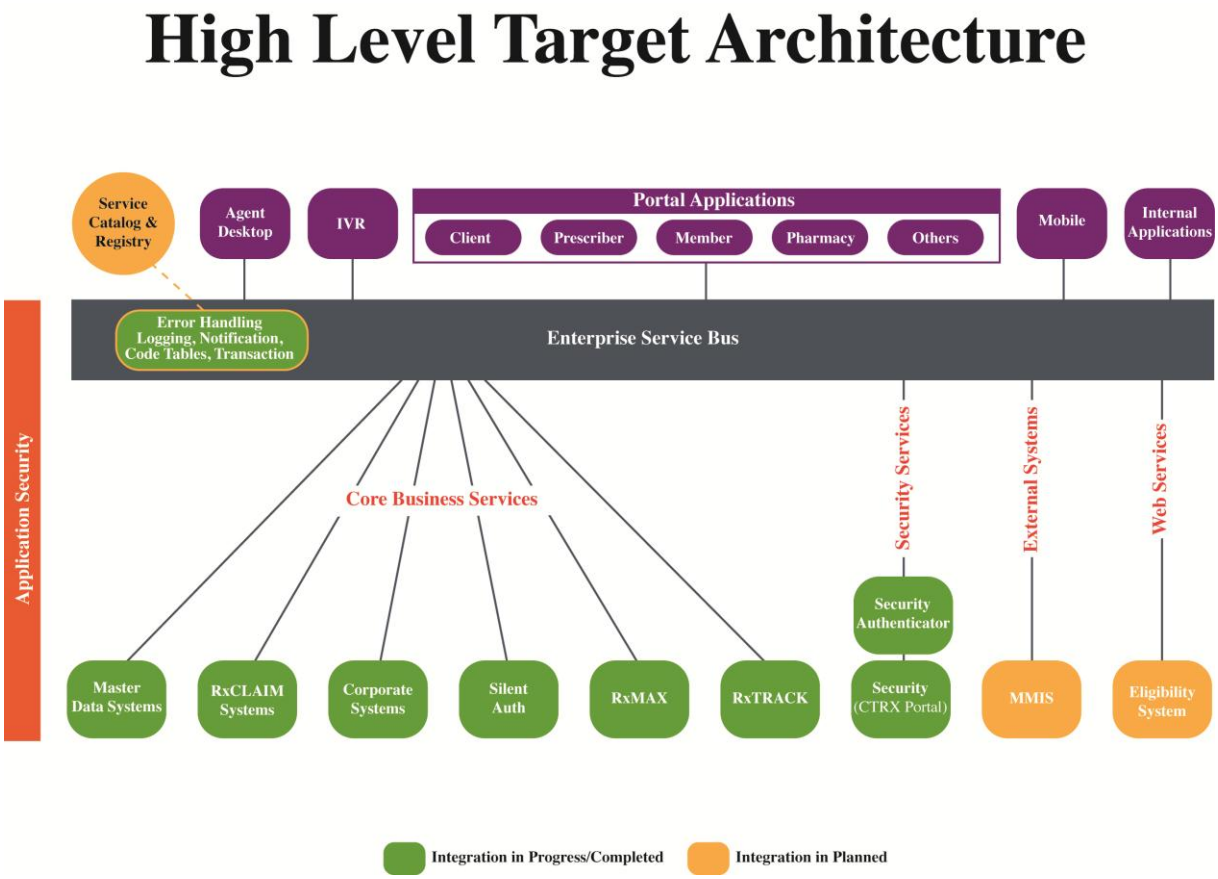
The MESA is used to conduct all scheduled and ad hoc transmissions. Used for both inbound and outbound transmissions, it is flexibly deployed and works with a large number of established protocols and other data transmission products.

SOA

RxClaim's SOA-based system architecture allows integration with new the MMIS and other systems by adjusting and aligning services, from point-to-point interfaces for tightly coupled end-points, to Web Services (WSDL), and other transformation services (ESB) in the RxClaim Integration level. This future proof design provides multiple mechanisms for integration and service substitution and insulates the data, application, and presentation layers from changes. It also has the capability for more rapid development and implementation of the new MMIS interfaces and more efficient cost management while maintaining the integrity and quality of data the service consumer requests from service provider.

Catamaran publishes Web services at the following address and invites reviewers of this proposal to browse our Web Services definitions library:
http://www.sxc.com/help/SXC_Webservices.htm

The picture below shows our High Level Target Architecture.



3.0 Regulatory and Security

Instructions: Describe how the Vendor maintains physical and logical security relative to the services it provides. This should include an overview of the policies and practices to prevent, detect, and resolve security breaches. In addition, the Provider shall demonstrate experience and ability to meet all federal and local regulatory requirements (e.g., HIPAA, SOX, data privacy). The approach must, at a minimum, provide details on how the proposed Solution intends to meet or exceed the Regulatory and Security Requirements set forth in the document 'Non-Functional Requirements, Tab A2 Regulatory and Security'.

Response:

Catamaran's information security program is aligned with the ISO framework and the COBIT framework. Catamaran reviews the information security program annually. This is to assure compliance with industry (Payment Card Industry (PCI)) and regulations (e.g., HIPAA, etc.) and to evaluate potential changes to the program.

Catamaran is SOX (Sarbanes Oxley) 404 compliant; therefore, an independent auditing firm attests that our internal control processes and systems are effective and satisfactory. We also have received a SSAE 16/SOC 1, Type II report annually, which is related to our pharmacy claims processing services audited by an independent CPA firm. In addition, our internal audit team is responsible for testing the design and operating effectiveness of key internal controls for compliance with Sarbanes-Oxley 404. This process occurs throughout the year and includes planning, risk assessment, testing, reporting results, and issue resolution. The internal audit team also is responsible for coordinating and facilitating the claim system SOC 1 report audit conducted by an independent accounting firm. Yearly compliance reports are made available for clients to review.

Catamaran has received PBM and specialty pharmacy Utilization Review Accreditation Commission (URAC) accreditations. As such, we follow the high standards and guidelines offered by URAC with respect to quality improvement. We have instituted a Quality Assurance Executive Committee (QAEC) that regularly meets to review performance and provide guidance on quality management priorities and projects. The committee consists of the company's Chairman and Chief Executive Officer as well as executive and senior vice presidents and vice presidents. The QAEC reviews input from clients, providers and beneficiaries and provides guidance to our management and staff on quality priorities and projects, and assesses our performance toward meeting objectives for customer satisfaction, URAC compliance, and Continuous Quality Improvement activities.

Catamaran assures compliance with SOX, HIPAA, PCI regulations and operates in accordance with our Business Associate Agreements (BAA), which we require for all third party vendors with whom we conduct business.

Security

Catamaran understands the importance of safeguarding the privacy, confidentiality and security of our clients' data and patient medical information – we have spent over two decades designing, developing and implementing leading healthcare solutions, constructed with the highest available security measures found in the industry. RxClaim Suite is CMS certified and is the only pharmacy claims system to be independently certified. It currently meets all Pharmacy Program requirements in the CMS State Medicaid Manual (SMM) as well as the Certification

Toolkit, and therefore meets all applicable regulations under HIPAA, including accepting and sending all pharmacy related HIPAA transactions.

Catamaran has undertaken a number of initiatives to ensure that our software and services comply with the ongoing security provisions of HIPAA legislation. Education has been in the forefront as we have worked to ensure that all of our staff is continually trained and mindful of these provisions in their responsibilities. A few highlights from these activities should serve to illustrate the nature of our efforts.

We have reviewed the State Technology Requirements, the Information Security Policies and the System Security Plan Template provided in the procurement library. Catamaran's policies, processes and procedures, as well as our own System Security Plan are compliant with the State's requirements. During the Design and Definitions Phase of this project, Catamaran submits our System Security Plan for the State's review and approval.

Confidentiality and Data Integrity

Catamaran policies for network usage include the mandatory encryption of any PHI that is transmitted into or out of the Catamaran offices using any public network, whether the transmission is for OLTP, OLAP, or reporting purposes. We use network intrusion detection systems and architect our wide area network to provide an extremely secure and defensible facility, while still allowing for reliable and secure access for all authorized users. Confidential and sensitive information sent via electronic mail is encrypted using ZixMail®. If the data is transmitted via FTP, we use Secure FTP to secure the data. We also use VPN as a transport.

While transmitting PHI over the Internet, comprehensive security measures must be in place to ensure data confidentiality and integrity. That is why all PHI accessed through Catamaran's Web portal is protected with the industry standard Secure Socket Layer (SSL) technology. SSL is an Internet security protocol that uses cryptography to encrypt all sensitive data that is transmitted over the Internet. Integrity controls ensure that the data received on a client workstation came from Catamaran and that no third parties were able to view or change the data during transmission. Catamaran does not support unsecured data transmission of any customer data regardless of the presence or absence of PHI. Additionally, RxClaim Suite displays a login banner, warning users when they are attempting to access areas containing PHI.

All access to the production system is controlled through authorized user access. We do not allow generic or non-specific User IDs. Audit fields on each table in the database are used to track modifications. These fields include the time and date of a database change and the User ID of the party who made the change. Catamaran also keeps system journals for nine weeks so that all database changes can be tracked, by sequence, if necessary.

The RxClaim Suite also employs strict field-level filters to ensure that any data entered through manual processes is compliant with field validation rules. Database integrity is maintained through integrity rules defined within the DB2 relational database itself, ensuring that all adds, changes and deletes are compliant with defined database integrity rules.

When mobile devices are utilized to access the RxClaim suite, via the RxProvider Portal for instance, users are authorized and authenticated users through our mobile applications. Industry standard encryption (128-bit SSL certificate protection) is utilized to client PHI secure.

HIPAA Training

Every Catamaran team member and our trading partners are required to complete annual HIPAA, regulatory, and ethics training, which includes the safeguarding of Protected Health Information (PHI) and other confidential material included in our system transactions and otherwise. Additionally, we conduct ongoing online training to ensure that all employees and pharmacy system users are kept apprised of any HIPAA-related updates or enhancements and to reinforce the privacy standards, including minimum necessary use and disclosure based on HIPAA policies and procedures. This training is defined on a job-by-job basis to address targeted populations regarding security measures specific to handling Protected Health Information (PHI).

Physical Safeguards

All of our facilities are protected by electronic security systems that limit physical access to the buildings to only authorized personnel. Areas of the buildings that house critical information management equipment and those areas where electronic and/or printed material containing PHI have even further access restrictions through this same security system. We have security cameras that monitor the entrances to our facilities. Any data that is removed from our facility for backup protection purposes is moved only in locked cases and only carried by organizations with which we have chain of trust agreements. All computer disks that are no longer in use are either destroyed or are re-formatted to ensure that any PHI is removed before these devices are recycled.

Technical Security Services

Catamaran has implemented password protection and usage policies that include mandatory non-trivial password changes on a regular basis for all users that access our facility. The RxClaim Suite allows for a flexible definition of user roles and rights, thus allowing for greater control of which types of user have the ability to see secured data.

Network Security and Availability

As indicated above, Catamaran has policies in place for network usage that include the mandatory encryption of all PHI transmitted into our out of our offices using any public network and for any reason. We have also bolstered our network intrusion detection systems and re-architected our wide area network to provide a more secure and defensible facility, while still allowing for reliable and secure access for all authorized users.

We expose our systems and procedures to annual SSAE-16 audits and at the minimum, annual testing by outside parties to ensure that we comply with current standards and our systems are properly secured from known security or operational threats. This testing includes reviews of security procedures, system administration procedures, access procedures, and network penetration testing. All applicable findings from these events are shared with the State.

Application Security

RxClaim Suite uses a combination of OS/400 level and application level security to limit access to the system to only authorized users. Additionally, the system uses these same features to control the access of different user classes that have varying levels of authorization. The security system is password-based. All users are assigned their own unique user ID and password. Passwords are set to expire at a pre-set date, requiring users to change passwords with a pre-determined frequency. The security systems of OS/400 are extensive and full-

featured, and our system has been designated as level C2 security-compliant by the U.S. Department of Defense.

RxClaim Suite has been integrated with a state-of-art EDI translator from the Extol organization. We maintain a technical support and software maintenance contract with Extol to ensure the services it provides in this area comply with the latest HIPAA and industry standards.

Authorization

Catamaran allows only a limited number of identified client personnel to determine the roles that other client personnel have. Dependent upon this role, the system restricts which functions and features of the claims processing application each user has.

Customers and their authorized users have access only to their specific data through the claims processing application. Thus, the role assigned (as described above) completely defines what operations the user is authorized to perform. Non-application operations are not permitted.

Access

Access is controlled by the role assigned to the various users. If direct access to data is required for user personnel, accommodations are made for individual customers' personnel. This access is provided through the data warehouse product or via various data export routines where claims data is made available for use by the client on their own computing facilities.
We have established a team dedicated to the analysis and implementation of items mandated by HIPAA. This task includes transaction standards, code sets, and rules concerning privacy and security. Additionally, Catamaran conducts audits of its procedures and controls to ensure that it continues to operate within the HIPAA regulations for electronic transaction processing, security, and privacy.

Password Procedures

Passwords must be changed by the owner every 30 days, and we currently require that the password not be reused within a 12-month period. The password must be at least eight characters long and cannot be the same as the account name. Passwords automatically expire every 30 days. The system allows three (3) unsuccessful logon attempts before locking out the user. Our security measures are continually scrutinized to ensure all data is protected appropriately. We test our security compliance quarterly.

Improper Disclosure of PHI and other Confidential Information

All employees handling sensitive data (i.e., patient health information and claims data) are educated in data security and confidentiality. Employees recognize that failure in this duty is grounds for immediate termination. Protected Health Information (PHI) is housed in accordance with rules set by state and federal laws. All PHI is secured and shared on a need-to-know basis and only with approved staff, providers, and client-sanctioned staff. In addition, we protect the confidentiality of individual health information by:

- Training employees on the importance of maintaining member information confidentiality and how to preserve that need in their work environment
- Restricting access to information by using appropriate technology procedures, including secured Internet applications that protect confidentiality
- Establishing and maintaining programs that protect confidentiality of member healthcare information.

In the event Catamaran, or persons under its direction, discloses information, or it is reasonably believed that confidential information may have been disclosed, Catamaran employs a comprehensive response plan and the specific inclusion of the following:

- Notification to the State of the unauthorized disclosure immediately or no more than 24 hours after the unauthorized disclosure event is discovered
- Identification of affected individuals and specific information wrongfully disclosed,
- Work to take any further action related to the unauthorized disclosure, as directed by the State
- Provide the State with an incident report containing a root cause analysis and a corrective action plan within five (5) business days of the discovery, ensuring that further unauthorized disclosure(s) does not reoccur

It is the responsibility of all Catamaran employees to report a suspected security breach immediately to the employee's supervisor, another manager if the employee's supervisor is not available, or the Catamaran Chief HIPAA/Security Officer. The Chief Security Officer is responsible for making initial assessment and documentation of the suspected violation and notifying systems, account, and operations management staff of the suspected violation. This occurs within the first thirty minutes of notification. As soon as it becomes reasonably certain that a violation has occurred, the Catamaran's Chief Security Officer and the Vermont Account Manager, Nancy Miner, contacts the State to explain the circumstances surrounding the suspected violation and what immediate steps are being taken. This occurs no later than twenty-four (24) hours from the time the breach is detected. Concurrently, operations and account systems staff take any steps demanding immediate attention, as internally determined or as directed by the State, including the identification of all individuals for whom their PHI was breached or compromised. As remedial steps are taken all actions are documented.

Account staff also work with the State to prepare a Security Incident Reporting, if requested. A formal report is prepared whenever there has been an actual physical or electronic intrusion. This report is completed within five (5) business days of Catamaran Privacy Officer notification and follows standard guidelines, as detailed below:

- For intrusion of secured areas, notification may also include the FBI, U.S. Attorney's Office, State Police, local police department, and/or other law enforcement agencies
- For catastrophic disasters such as fire, bomb threats, floods, or destructive storms, notification procedures include the local fire department and/or police department
- For incidents involving electronic intrusions, other state agencies are notified as appropriate. Any data captured that resulted in detecting the intrusion is kept until the incident has been investigated and cleared
- For incidents involving deception and fraud, additional notification may include the police department depending upon the severity of the incident

The following procedures apply to all security violations:

- Documentation includes a detailed log of all pertinent information and activities. This log is maintained by the Catamaran Security Officer.
- If the breach is electronic, and if possible, snap-shot of the system is taken to aid remediation and supplement documentation.

- Catamaran makes copies of all audit trail information such as system log files, root history files, etc.
- The Catamaran Security Officer is responsible for notifying all heads of departments affected by the breach as well as the Chief Operating Officer and the Segment President of Public Sector Programs.
- All information related to the breach is to be secured and released only to those persons involved in remediation, Catamaran management, the State staff and legal representatives of the respective organizations. Any release of information beyond these individuals is the responsibility of, and at the discretion of, appropriate State staff.
- After an incident has been fully handled and all systems are restored to a normal mode of operation, a follow up analysis is to be performed. All involved parties meet and discuss the actions that were taken and the lessons learned. All existing procedures are evaluated and modified as needed.

4.0 User Interface

Instructions: Describe the design approach and the characteristics of the user interface for the proposed PBM System. The System must be designed to utilize a browser based or a Rich Internet Application that can provide feature rich applications that can be updated over the Wide Area Network and the Internet, and should deliver a consistent user experience to State employees, providers, contractors, and partners. The approach must, at a minimum, provide details on how the proposed Solution intends to meet or exceed the User Interface Requirements set forth in the document 'Non-Functional Requirements, Tab A3 User Interface'.

Response:

Catamaran is pleased to offer our RxClaim Suite of products that meet and in many areas exceed the State's technical requirements for a consistent user experience for State employees, providers, contractors, and partners. The RxClaim Suite is a flexible, easy-to-use system with modular components that manage all aspects of pharmacy benefits. At its core, it is a claims processing engine designed to perform online, real-time adjudication of prescription drug claims at the point and time of service. RxClaim Suite manages encounter data, edits and prices claims and encounters, adjudicates claims, and generates claims processing related reports.

Catamaran provides Internet-accessible URLs that allow users of the RxClaim graphical user interface (GUI) to securely connect to the RxClaim Suite (RxClaim, RxAuth, RxMax, RxBuilder, and RxTrack) from virtually anywhere. Generally, system access only requires Internet access. The user interface is initiated on the user desktop via a standard browser (e.g., Microsoft Internet Explorer, Safari, Google Chrome, Firefox, etc.) by accessing our Internet URL. This user interface is characterized as a "thin client interface," and for most workstations the interface is self-maintained. This means there is a small applet that needs to reside on the workstation, which is delivered to the workstation and updated automatically. This interface has been designed to deliver sub-second response times and an efficient user experience, even when accessing the system over relatively "slow" communication links like wireless WAN or through mobile broadband technology. The RxClaim Suite GUI provides a secure, intuitive, browser-like interface to make all features of the application available and easy to utilize.

The capabilities of the system will provide users with the functionality described in Template H Non-Functional Requirements located under Tab A4 User Interface. Specifically, the interface provides users with robust access to a range of capabilities, including the ability to query free

form text entered into the system. Authorized users will have access to filter and sort data based on single and multiple criteria as well as save user-defined search criteria. In addition, users will be able to post questions and search conversation threads based on role and responsibility. A PBM user/help manual and frequently asked questions (FAQs) also resides within the system for convenient access by users.

Our Web-based provider interface, RxProvider Portal, offers physicians and pharmacists easy access to clients' plan information from RxClaim to provide more accurate and cost-efficient prescription medications. This portal gives providers the ability to search a specific prescription number and view details of that claim, remittance advice, forms and contracts, and client eligibility information. It also allows for extension of real-time prior authorization (PA) request and response capabilities to the physician or other requestor. Through integration with Catamaran's content management/imaging solution, the system also supports capture of images of inbound requests and supporting documentation, as well as production and image capture of outbound communication related to requests. Together these tools and support services simplify the claims process for providers and the State.

Limiting Access to Authorized Users

RxClaim uses a combination of OS/400 level and application level security to limit access to the system to authorized users only. Additionally, the system uses these same features to control the access of different user classes that have varying levels of authorization. The security system is password-based. All users are assigned their own unique user ID and password. Passwords are set to expire at a pre-set date, requiring users to change passwords with a pre-determined frequency. The security systems of OS/400 are extensive and full-featured, and our system has been designated as level C2 security-compliant by the U.S. Department of Defense.

RxClaim has been integrated with a state-of-art EDI translator from the Extol organization. We maintain a technical support and software maintenance contract with Extol to ensure that the services it provides in this area comply with the latest HIPAA and industry standards.

Authorization: Catamaran allows only a limited number of identified client personnel to determine the roles that other client personnel have. Dependent upon this role, the system restricts which functions and features of the claims processing application to which each user has access.

Customers and their authorized users have access only to their specific data through the claims processing application. Thus, the role assigned (as described above) completely defines what operations the user is authorized to perform. Non-application operations are not permitted.

Access: Access is controlled by the role assigned to the various users. If direct access to data is required for user personnel, accommodations can be made for individual customers' personnel through the data warehouse product or via various data export routines where claims data is made available for use by the client on their own computing facilities.

We have established a team dedicated to the analysis and implementation of items mandated by HIPAA. This task includes transaction standards, code sets, and rules concerning privacy and security. Additionally, Catamaran conducts audits of its procedures and controls to ensure that it continues to operate within the HIPAA regulations for electronic transaction processing, security and privacy. We have expended substantial corporate resources to comply with the regulations under HIPAA and have instituted processes to ensure full compliance with state confidentiality laws.

5.0 BI and Reporting

Instructions: Describe the Vendors approach to providing BI and Reporting capabilities and features as part of the proposed PBM System. This includes the provision of a comprehensive set of standard reports through a dashboard interface, ad hoc reporting, and the capability to perform analytics. The approach must, at a minimum, provide details on how the proposed System intends to meet or exceed the BI and Reporting Requirements set forth in the document 'Non-Functional Requirements, Tab A4 BI and Reporting'

Response:

Confidential, Proprietary, and Trade Secret Information of Catamaran.

Catamaran has a comprehensive suite of reporting tools available to State that will provide you with access to timely, accurate and actionable information to make informed decisions about your pharmacy benefit program. These tools will empower the State with standard reports, dashboard reports and ad hoc/drill-down reporting and querying capabilities that will place information at the fingertips of decision makers on demand and in virtual real-time as described in greater detail in the discussion that follows. In addition, the dedicated Catamaran Data Analyst assigned to the Key Personnel for the State is available to help extract and analyze information on behalf of the State.

Overview of Catamaran Approach to Reporting and Analytics

Catamaran is committed to supporting the State with all aspects of reporting and analytics. The Catamaran professionally trained data analyst, Jacquelyn Stager, currently dedicated to the State, will continue in this role as a key member of the Catamaran team assigned to the State. Reporting packages and ad hoc reports will continue to be her responsibility. She is uniquely familiar with the specialized and customized requirements of the State.

As the incumbent vendor, Catamaran is currently providing all utilization, financial, auditing, preferred drug list, claims processing, and custom coordination of benefits (COB) reports included in the procurement library and proposes to continue to provide these and more under the new contract. Catamaran has and will continue to routinely review and analyze standard reports for program operations purposes; for example, to look for prescribing, dispensing, claims processing, and utilization trends; incorrect claims submissions; opportunities for system edits; options and approaches for possible formulary changes; etc. We also routinely evaluate the effectiveness of reports in meeting their intended needs.

In addition to standardized reports, Catamaran has provided ad hoc queries as requested by the State. For each request, Catamaran staff has worked with the State to fully understand and modify it as necessary to ensure the report delivered the data in a way to clearly answer the questions for which the query was requested. When determined appropriate, we have added ad hoc queries to the customized package of reports for the State. Catamaran also utilizes ad hoc reporting tools to further analyze any trends identified in standardized reports or to test the effectiveness of the reports' elements, when necessary.

Catamaran notes that net cost reports stand out in the State's examples of required reports. While some observers might simply consider these to be financial reports, Catamaran recognizes that net cost reporting is particularly important to state Medicaid programs. This is due to the substantial amount of federally required rebates collected that reduce the gross cost spend. It is additionally important to states like Vermont with supplemental rebate programs that further reduce costs for certain drug therapies. Net cost reports can assist the State and the

Drug Utilization Review Board in identifying prescribing and utilization trends and in evaluating and managing drug spend. To date, Catamaran's ability to provide this kind of report has been limited. That has been because we did not have detailed federal rebate data on an individual drug level since the Vermont Medicaid fiscal agent managed the federal rebates. Since the State is now proposing that both federal and supplemental rebate processes will be managed by the PBM vendor, detailed data will be readily available for reporting purposes. Catamaran is eager to provide net cost reporting. We will work with the State to establish a timeline for delivery of the first and future net cost reports, recognizing that there is a calendar quarter lag in rebate data.

Comprehensive Data Warehouse and Analytical Solution: RxTrack

RxTrack is Catamaran's proprietary data warehouse query and analytical product that enables Catamaran to create a customized reporting package and perform in depth data analytics. Additionally, it provides the functionality for users to view reports, run parameterized reports, and create customized reports and ad hoc queries. These tools allow the power user to create complex queries, perform data mining activities, and analyze and assess program impact and performance.

Currently, Catamaran makes RxTrack available to the State. On several occasions, training has been provided. However, users tell us that it is a tool that is difficult to use without detailed knowledge of the data elements and frequent and repeated use. As part of this proposal, Catamaran is proposing to provide access to something new, RxTrack Connect. Other Catamaran clients report that RxTrack Connect is a far more user friendly and readily accessible tool to access state-of-the-art reporting capabilities. It makes it possible to generate both pre-defined and ad hoc reports. Catamaran is also proposing to provide RxTrack Dashboard.

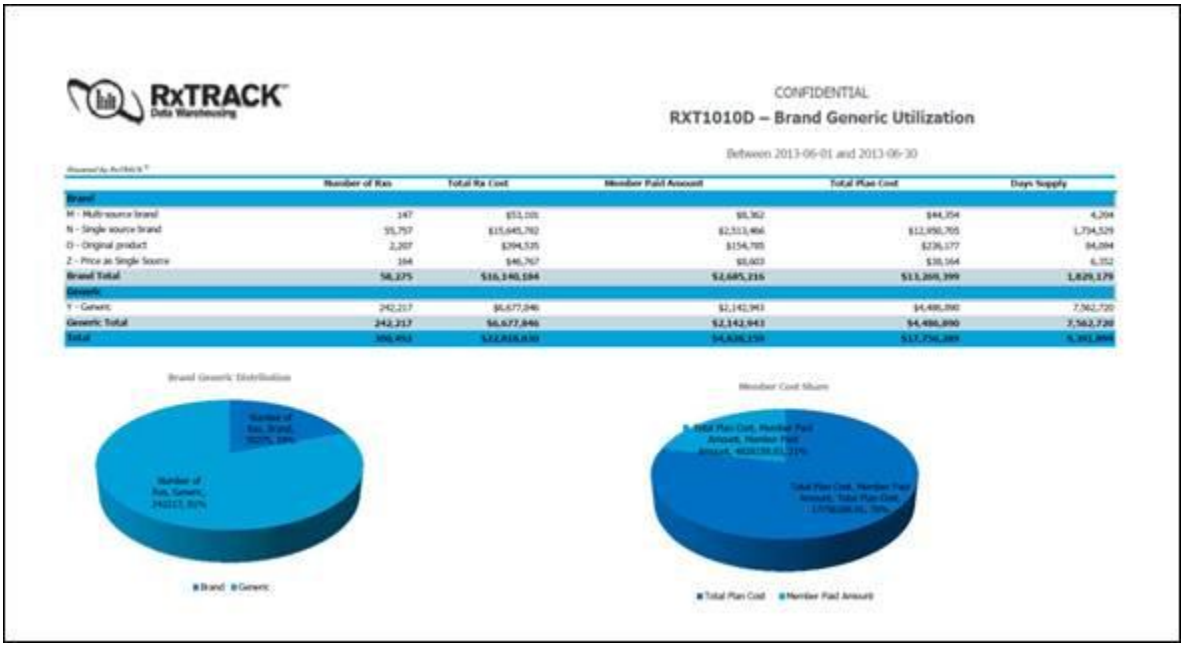
On-Demand Reporting Capabilities: RxTrack Connect Portal

Through the RxTrack Connect Portal, reports and analytics are delivered and executed using industry leading software including Cognos tools and SPSS. Cognos, founded in 1969 and serving more than 23,000 customers in 135 countries, is a world leader in business intelligence software. Its range of tools allow for reporting, analysis, dash boarding and scorecards. Cognos BI is built with a modern Web services architecture and standards such as Extensible Markup Language (XML), SOAP, and Web Service Definition Language (WSDL). The architecture provides an environment that includes extract, transform, and load (ETL) capability and automatic load balancing and is fully scalable. Reports and analyses are written once and then deployed to other users of the tool to view or manipulate. The Web-based deployment browser-based environment requires no desktop installs, plug-ins, or applets. This allows for remote access to the system; the end user can log on from anywhere. Cognos reports can be saved into multiple desired formats including: electronic mail, HTML, PDF, Microsoft Excel, CSV, and XML.

Using Cognos tools in RxTrack Connect for analysis allows for the review of large volumes of data across multiple dimensions with fast and predictable response times. Large, complex data sets can be queried with the easy-to-use, drag-and drop user interface, pivoting, and filtering.

The secure Web portal provides RxTrack Connect users with access to full-featured, management level reporting. The portal retrieves key performance indicator (KPI) information from raw and summarized data contained in the data warehouse. The reports can be scheduled and delivered in a variety of methods and formats to the end user.

Standard and Parameter Driven Reports can be accessed using RxTrack Connect. This tool enables the end user to simply click to launch parameter driven and pre-defined reports. The RxTrack Connect Portal provides State designated and approved staff with zero footprint access to predefined and custom reporting over the State's data through a secure Internet connection. The predefined or custom reporting provides the State high end graphical reporting with robust scheduling and distribution options. To illustrate what might be a Standard or Parameter Drive report. A screen shot of a RxTrack Connect Portal content on Brand Generic Utilization is shown below.



Robust ad hoc capabilities exist in RxTrack Connect as they do in Rx Track. Drill down reporting is also accessible. End users create their own queries or access a library of ad hoc queries to use as built or to manipulate to meet their needs. Users build queries against both the detail and summary files. The graphical user interface query tool can be used to build custom queries using more than 150 fields captured in the detailed extract file, the basis of Catamaran's data warehouse.

In summary, RxTrack Connect is a data access tool that empowers the end users to produce standardized and parameter driven reports and data files and to obtain transactional level detail. The users can print professional reports ranging from things as simple as mailing labels to as complex as utilization reports, or bring the data into their desktop applications. Users have the capacity to save the data captured in a spreadsheet, database or CSV file.

A Single Authoritative Reporting Resource: Catamaran RxTrack Dashboard

The Catamaran RxTrack Dashboard further simplifies access to reporting. It is a way for a user to access data found in standardized and parameter driven reporting and ad hoc queries in a straightforward way. In that sense, the RxTrack Dashboard could be considered the command center of the reporting platform.

The Catamaran Rx Dashboard reports that we are proposing for the State will be a multi-level depiction of key metrics identified with the State. Examples might include things like program performance, generic utilization, and prescribing by specialty and non-specialty prescribers.

The Dashboard then can allow users to see what happened with a particular metric over time or in comparison to other measurements of the very same metric (benchmarks). The Dashboard can provide the user with cost and time frame comparison period options; for example, the cost of a drug or a therapeutic drug class by month, quarter, year. Other benchmark comparative choices will be defined with the State.

Drill down capability can be define and made available. For example, Individual dashboard reports allow users might want to drill-down from a Therapeutic class level to a drug level in order to provide insight into what may be trending in a particular direction.

Finally, RxTrack's comprehensive benchmarking solutions provide the opportunity for deeper insights, consultative indicators, narrative guidance and recommended actions tailored to meet the State's specific needs and reports will automatically populate with the used Benchmarking data in contrasting colors for which the reports are being generated.

The Catamaran RxTrack Dashboard options currently available in the reporting suite include the following:

- *Daily Dashboard*
- *Main Summary Dashboard*
- *GDR (Generic Dispensing Rate) Dashboard*
- *Specialty Dashboard*
- *Non-Specialty Drug Dashboard*
- *Plan Design Dashboard*
- *Member Dashboard*
- *Disease Summary Dashboard*

The following is a sample of Catamaran RxTrack Dashboard views:

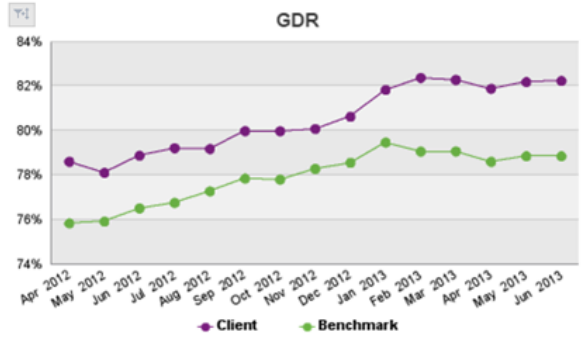
RxTrack®

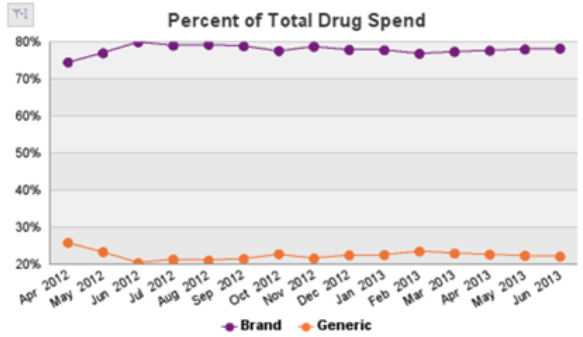
GDR Dashboard

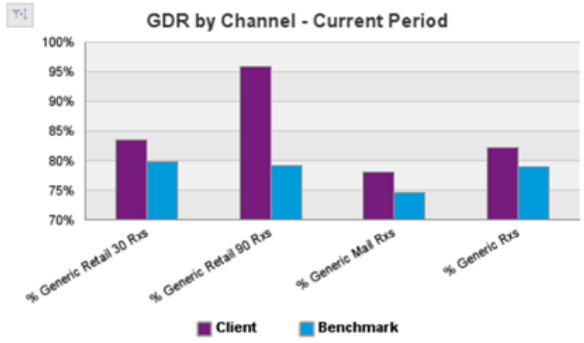
Run Date: 1/16/2014

Client : ABC Client
Carrier : ABC1234
Account : ALL
Group : ALL
Line of Business : Employer - Professional

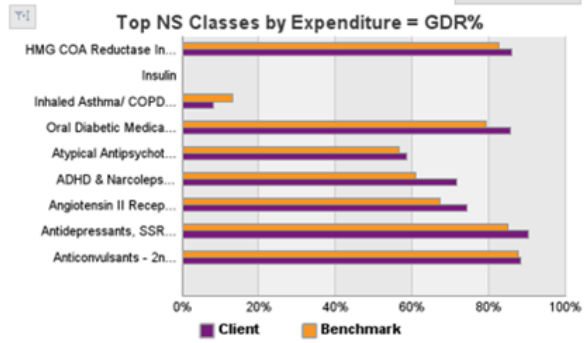
Time Frame : Current quarter vs. prior quarter
Current Period : Q2 2013
Prior Period : Q1 2013
Date Basis : Date Filled
Cost Basis : Net Plan Paid







More Metrics



Executive Summary

	Client Current Period	Client Previous Period	Client Percent Change	Benchmark Current
Rx Count	79,351	83,210	-4.6%	N/A
Generic % of Total	82.1%	82.1%	-0.1%	79.0%
Brand % of Total	17.9%	17.9%	0.3%	21.0%
Ave. Cost of Generics	$24.11	$22.54	6.9%	$23.81
Ave. Cost of Brand	$386.98	$350.76	10.3%	$313.72
Generic Cost PMPM	$16.29	$15.73	3.6%	$15.14
Brand Cost PMPM	$57.07	$53.19	7.3%	$53.14

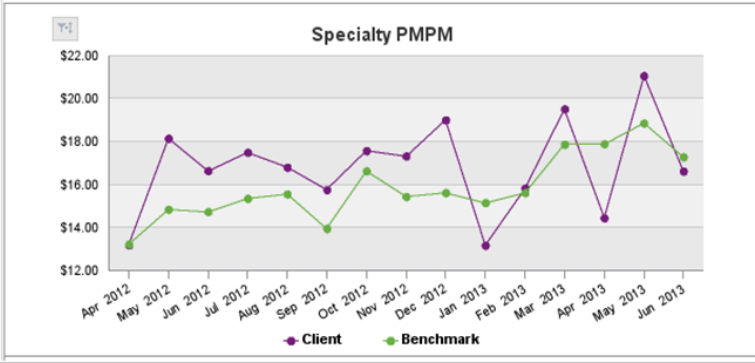
RxTrack®

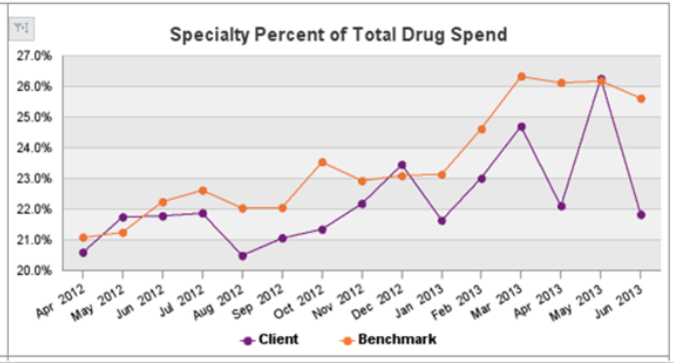
Specialty Dashboard

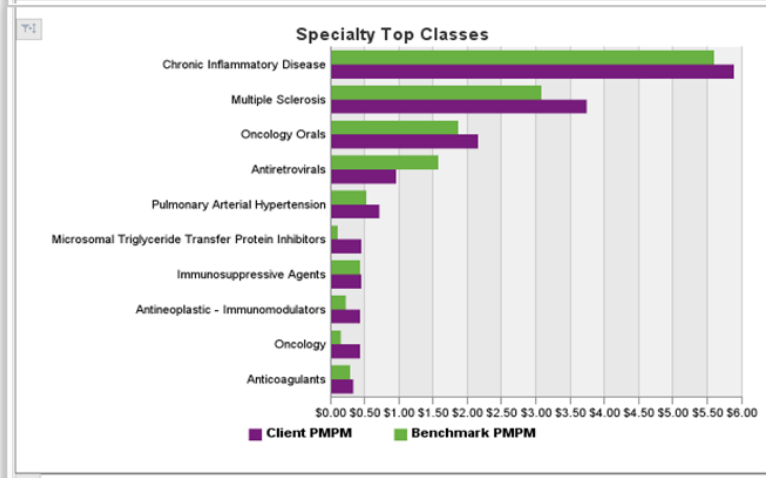
Run Date: 1/16/2014

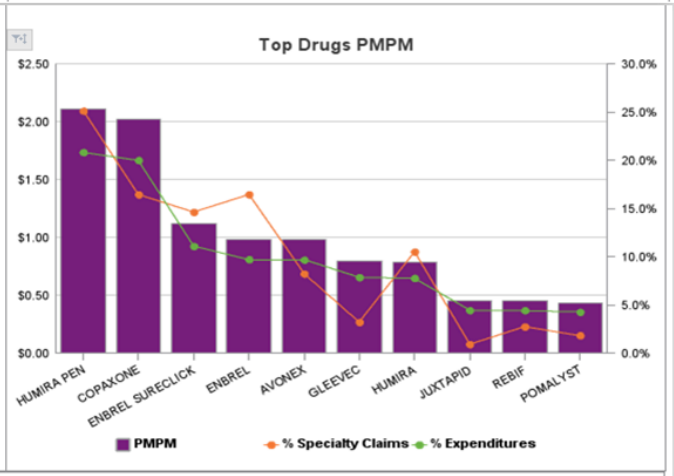
Client : ABC Client
Carrier : ABC1234
Account : ALL
Group : ALL
Line of Business : Employer - Professional

Time Frame : Current quarter vs. prior quarter
Current Period : Q2 2013
Prior Period : Q1 2013
Date Basis : Date Filled
Cost Basis : Net Plan Paid









Executive Summary

	Client Current Period	Client Previous Period	Client Percent Change	Benchmark Current
Specialty Cost	$1,656,432	$1,561,913	6.1%	N/A
Specialty % of Total Cost	23.4%	23.1%	1.3%	25.8%
Ave. Cost per Specialty Claim	$2,779	$2,774	0.2%	$2,361

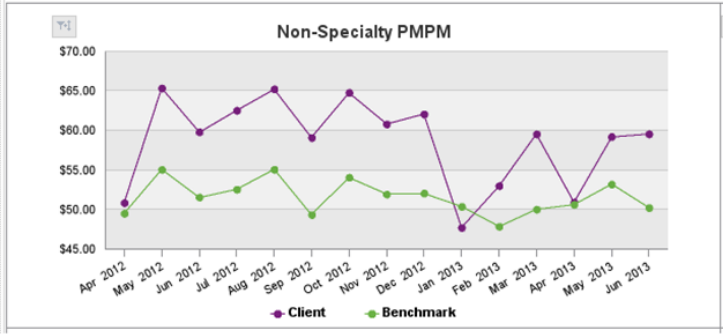
RxTrack®

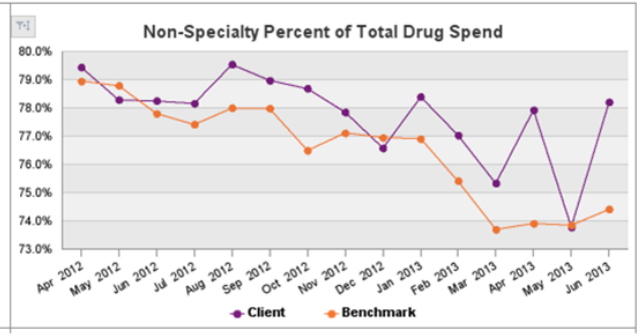
Non-Specialty Dashboard

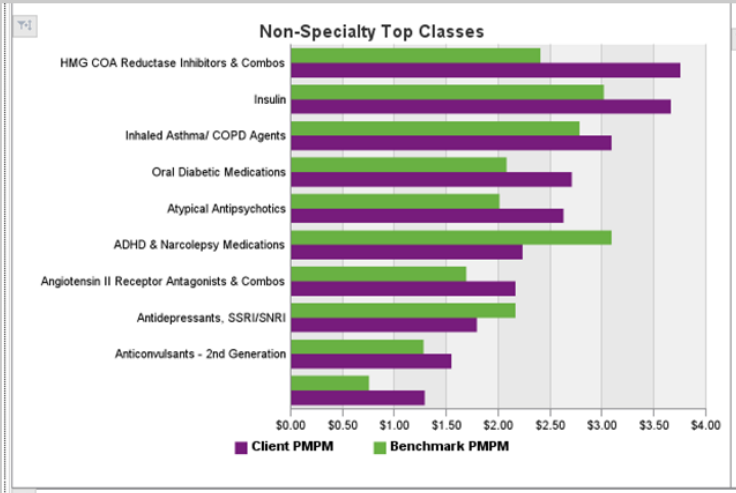
Run Date: 1/16/2014

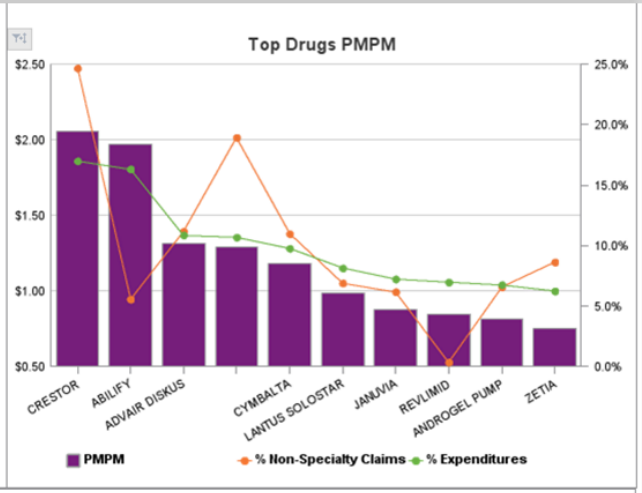
Client : ABC Client
Carrier : ABC1234
Account : ALL
Group : ALL
Line of Business : Employer - Professional

Time Frame : Current quarter vs. prior quarter
Current Period : Q2 2013
Prior Period : Q1 2013
Date Basis : Date Filled
Cost Basis : Net Plan Paid









Executive Summary

	Client Current Period	Client Previous Period	Client Percent Change	Benchmark Current
Non-Specialty Cost	$5,414,327	$5,190,508	4.3%	N/A
Non-Specialty % of Total Cost	76.6%	76.9%	-0.4%	74.2%
Ave. Cost per Non-Specialty Claim	$69	$63	9.5%	$64

Management Analysis

Over and above the defined reports and ad hoc reporting produced with RxTrack Connect and/or accessed through the RxTrack Dashboard, Catamaran has and proposes to continue to assist the State in focused management analysis.

Although Catamaran proposes to provide dedicated resources devoted to the State's needs that offer any time support and client consultation on data analytics, we find that most clients prefer a schedule of regular account performance review. Typically this is a quarterly interval but we will accommodate your preference. Currently, Catamaran has been providing this analysis bi-annually to reflect calendar year and then state fiscal year performance.

In a typical interval performance review, our Account Team provides a consultative approach in reviewing your plan's performance with assistance from our Drug Intelligence team and Clinical Analytics reporting. We deliver expert guidance with recommendations that have been carefully considered, analyzed, modeled and evaluated against the backdrop of the unique features of your market/region and your specific plan objectives, so that your opportunities are clearly identified and prioritized. Specifically, consultative sessions include:

- *Key developments within the period*
- *An overview of the program's trend with Catamaran's recommendations to include:*
  - Program description
  - Member impact assessment
  - Modeled expected results / any recommended required investments
- *An update on how we are supporting members and meeting the program's objectives*
  - Safety, quality, adherence initiatives and impacts
- *Industry developments and what they mean to the program and its members*
- *Any related contractual updates and "what's new" at Catamaran*
- *A summary of our actions and commitments for the next period*

As part of this periodic review process (at your determined interval), your Account Team will highlight the past period's results and present a claims analysis review with recommendations for any more cost-effective benefit programs to meet your needs.

We will present the trends for the year and provide qualified recommendations that may positively impact your savings for the next year. Various costs and metrics including the following are reviewed:

- *Key trend drivers (i.e., utilization, cost and drug mix)*
- *Disease and drug class analysis*
- *Book-of-business comparison (BOB)*
- *Overall drug spend*
- *Average ingredient cost*
- *Average generic cost*

- *Per Member Per Year (PMPY) costs*
- *Generic utilization*

Additionally, results, savings, and outcomes of your clinical programming will be routinely reviewed, including savings from Utilization Management strategies, Concurrent Drug Utilization Review (CDUR) activity, Medication Therapy Management outcomes and savings, Retrospective Drug Utilization Review (RDUR) outcomes and savings, Prescriber Education & Intervention Program activities and associated savings/outcomes.

Other Optional Reports Available

Catamaran recognizes that timely, complete, accurate, and accessible information is needed to support the client's benefit management goals. To address these needs, we offer a wide range of standard, optional, and ad hoc reporting capabilities to support decision-making at all levels: clinical, executive, operational, and beyond.

Our claims processing system standard management reports include more than 80 individually unique reports. Our model is to give clients the option of choosing from all the reports or only a few specific types based on particular reporting requirements. While Vermont is an existing Catamaran customer, the State has the option to reconsider reports not previously selected. For that reason, we describe some reports here, including those that are most commonly used by commercial insurers and including some that are like or similar to the reports the State is currently using.

The standard Catamaran customized reporting package is designed to provide meaningful data that can be used to provide a global overview of a client's program. Several categories of standard reports include:

- **Client Services Reports:** provide information related to issues such as ID card production, provider service activities, and call center activities. The call tracking and claims processing systems generate these reports.

- **Operational Reports:** detail items such as the number of claims processed, file load balancing reporting, and downtime reports.

- **Utilization Reports:** provide a birds-eye view of drug utilization trends. Presented in a variety of ways, they enable our clients to discern areas of growth, changing client utilization patterns, and changes in prescribing patterns. These reports also allow our clients to evaluate the impact of programs aimed at utilization or expenditures. Information for the utilization reports is derived from the pharmacy claims data feed to our data warehouse and created utilizing various Business Intelligence software tools.

Report Delivery

Catamaran delivers reports in a variety of ways including:

- Online access to reports that the client / vendor can retrieve by clicking on the report name
- Static reports delivered in an electronic format (i.e. PDF, Excel report)
- Static reports delivered as a hardcopy

- Data sets in text, Excel, Access, etc.

Report Frequency

Unlike some PBMs whose data cannot be retrieved from their data warehouse for 30 to 45 days after claim submission, Catamaran updates data for claims processed through the RxClaim system into RxTrack each night. We can obtain reports for the client:

- Weekly
- Bi-weekly
- Monthly
- Quarterly
- Annually.

Available Standard Reports

As previously indicated, Catamaran's claims processing system standard management reports include more than 80 individually unique reports available to many clients. Commonly requested reports include:

Report Title	Description
Section 1 - Management Activity Reports	
Utilization Summary (Financial)	The Utilization Summary provides an overview of prescription benefit utilization by clients in the selected carrier(s), account(s), group(s), and care facility(ies).
Monthly Summary of Key Data	The Monthly Summary of Key Data provides the current month's, the quarter's (to date), and the year's (to date) values for several significant items related to the selected carrier(s), account(s), and group(s).
Executive Summary	The Executive Summary provides the current quarter's, the previous three quarters', and the year's (to date) values for several significant items related to prescription benefit utilization for the selected carrier(s), account(s), and group(s).
Section 2 - Group Utilization Reports	
Age/Sex Utilization Summary	The Age/Sex Utilization Summary provides a record of prescription data broken down by age and sex for the selected carrier(s), account(s), group(s), and care facility(ies).
Eligibility Counts	The Eligibility Counts report provides a listing of groups within each account and the corresponding counts of active clients.
Monthly Utilization Summary	The Monthly Utilization Summary provides monthly values for several significant items related to the selected carrier(s), account(s), and group(s).
Section 3 - Drug Usage Reports	

Report Title	Description
Therapeutic Class Profile Summary	The Therapeutic Class Profile Summary provides a record of drug utilization within each therapeutic class for the selected carrier(s), account(s), group(s), and care facility(ies).
Brand/Generic Utilization Summary	The Brand/Generic Utilization Summary provides a record of generic drug substitution patterns in the selected carrier(s), account(s), group(s), and care facility(ies). It shows projected available savings as well as actual savings.
Product Cost Ranking Summary	The Product Cost Ranking Summary provides a record of up to 200 drugs dispensed for the selected carrier(s), account(s), group(s), and care facility(ies) within the chosen time period, differentiated by eight-digit GPI, and ranks them by descending dollar amount for the total ingredient cost.
Drug Usage Ranking Summary	The Drug Usage Ranking Summary provides a record of each drug dispensed for the selected carrier(s), account(s), and group(s) within the chosen time period, differentiated by 14-digit GPI, and ranks them in descending order by the number of prescriptions filled.
Drug Therapeutic Class Usage Ranking Summary	The Drug Therapeutic Class Usage Ranking Summary lists therapeutic classes from which products have been prescribed for the selected carrier(s), account(s), group(s), and care facility(ies) within the specified date range. They are ranked by number of prescriptions.
Section 4 - Pharmacy Provider Reports	
Pharmacy Provider Utilization Summary (with Averages)	The Pharmacy Provider Utilization Summary provides prescription activity totals, by provider, for the selected carrier(s), account(s), group(s), chain(s), network(s), and ZIP codes.
Pharmacy Provider Performance Summary	The Pharmacy Provider Performance Summary gives a summary of all prescription activity for each provider within the selected carrier(s), account(s), group(s), chain(s), network(s), and ZIP code(s).
Section 5 - Utilization Review Report	
DUR Savings – Summary	The DUR Savings Summary Report lists eight items, each of which is shown with at least one and as many as seven values. The eight items are: • The total DUR occurrences • Total DUR overrides • Additional projected cost • Actual DUR savings • Additional projected savings • Total DUR savings

Report Title	Description
	• Total eligible clients • Total utilizing clients • The seven possible values are: • Total number • Number of utilizing clients • Sponsor cost • Average sponsor cost by occurrence • Client cost • Average client cost by occurrence • Number of future fills.

In addition to the customized reporting package, the State has access to ad-hoc reporting capability utilizing the data warehouse and available query and reporting tools. Our reporting solution enables the State to generate powerful reports easily and conveniently, making it an effective and efficient ad hoc reporting tool.

Report Title	Description
MAC Savings Report	The MAC Savings Report lists values for several different price types and compares them to the Maximum Allowable Cost for the indicated drug. The report sorts alphabetically by drug label name.
Call Tracking Summary/Detail	The Call Tracking Summary/Detail report provides a listing of call tracking entries made in RxClaim, in summary form, detail, or both. The report includes four different outputs that may be chosen by the user in any combination, including a detail, summary by origin of call entry, summary by call type and summary by user ID.
Call Tracking User Summary/ Detail	The Call Tracking Summary/Detail report provides a listing of calls documented about a claim, client, carrier, account or group made in RxClaim system per User ID. There are three types of call tracking entries: • Problem/Resolution • Informational • HIPAA The report criteria can be sorted by Carrier ID, Call Type or User ID.

Report Title	Description
User Tracking Summary	The User Tracking Summary provides the ability to track the number of manual adds/changes users are inputting during a specified time frame.
Top 3 Reject Codes Detail Report	The Top 3 Reject Codes Detail Report lists the reasons for claim rejections in detail. The report identifies the reject reason codes and the percentage of rejects for the range of claims selected.
Specialty Claims Summary	Specialty benefits allow for prescription coverage to be altered from the standard plan benefits. The Specialty Claims Summary report lists information for claims processed using specialty schedules.
Client Listing Detail	The Client Listing Detail Report lists all clients within the selected carrier, account, or group who are eligible as of the selected date.
Client Utilization Summary – Rank by Benefit Value	The Client Utilization Summary – Rank by Benefit Value Report provides a summary of claims statistics for up to two hundred (200) of the most active clients in the selected carrier, account, and group ranges.
Client Utilization Detail with Submitted Amounts	The Client Utilization Detail with Submitted Amounts report provides information about prescription claims activity within a chosen time period for a specific client ID or for each client of a selected carrier, account, or group.
Age/Sex Utilization Summary	The Age/Sex Utilization Summary report provides a record of benefit utilization with demographic information.
Client Utilization – Prior Authorization Detail	The Client Utilization - Prior Authorization Detail report identifies trends that might indicate a need to consider changes to the plan by providing a listing of groups within each account and may include the following sequences: carrier, account, group, drug label name, prior authorization reason code, client ID, and date filled.
Client Eligibility Detail	The Client Eligibility Detail Report provides a listing of groups within each account and the corresponding counts of active clients.
Monthly Utilization Summary	The Monthly Utilization Summary report provides a high-level summary of client census data, paid claims data, and utilization data by month.

Report Title	Description
Client Coordination of Benefits Detail – Primary Payer	The Client Coordination of Benefits Detail – Primary Payer report lists the claims that were processed for client who have secondary insurance coverage on the system.
Prior Authorization Detail	Prior Authorization Detail reflects all prior authorizations in the RxClaim environment, even if they are not associated with a specific claim.
Therapeutic Class Summary	The Therapeutic Class Summary provides a record of the selected account and/or the group's usage of drugs in the therapeutic class chosen. This report shows the overall drug spend and utilization by therapeutic class. Spikes in utilization or expenditures can first be observed here.
GPI Therapeutic Class Profile Summary	The GPI Therapeutic Class Profile Summary provides a record of the selected account and/or the group's usage of drugs in the therapeutic class chosen
Therapeutic Class Detail	The Therapeutic Class Detail report provides a record of claims for prescription drugs within the selected therapeutic class by account, group, or care facility. This report shows the overall drug spend and utilization by drug for each therapeutic class. Classes that have exhibited spiked can be further drilled down to the individual drug.
Brand/Generic Summary	The Brand/Generic Summary provides a record of generic drug substitution patterns in the selected carrier, account, group, or care facility. It shows projected available savings as well as actual savings.
Drug Usage Summary	The Drug Usage Summary provides statistics for each drug that falls within the selected NDC range and was dispensed to clients of the selected account and/or group during the specified time period. This report can be manufacturer-, product-, or package-size-specific.
Drug Usage Detail	The Drug Usage Detail Report provides a record of usage patterns for a specific drug among clients of the selected carrier, account, or group.
Drug Cost Ranking Summary	The Drug Cost Ranking Summary provides a record of up to two hundred (200) drugs dispensed within the selected time period. The report lists each drug's fourteen (14) digit GPI and ranks the drugs in descending order by dollar value of the total ingredient cost. This identifies single drugs that are costly to the program.

Report Title	Description
Product/GPI Cost Ranking Summary	The Product/GPI Cost Ranking Summary provides a record of up to two thousand (2000) products dispensed within the selected time period, based on ingredient cost, plan cost, or patient pay.
Drug Usage Ranking Summary	The Drug Usage Ranking Summary provides a record of drugs dispensed within the selected time period, differentiated by fourteen (14) digit GPI, and ranks them by the number of prescriptions filled.
Product/GPI Usage Ranking Summary	The Product/GPI Usage Ranking Summary provides a record of drugs dispensed within the selected time period, differentiated by eight (8) digit GPI, and ranks them by number of prescriptions dispensed.
Drug Cost Ranking by Specialty	The Drug Cost Ranking by Specialty Report lists drugs ordered within each selected prescriber specialty by total ingredient cost.
Drug Usage Ranking by Specialty	The Drug Cost Ranking by Specialty report lists drugs ordered within each selected prescriber specialty by number of prescriptions.
Ranking by Therapeutic Class Cost	The Ranking by Therapeutic Class Cost report provides statistics ranked by total amount paid for each therapeutic class.
Therapeutic Class Ranking Summary	The Therapeutic Class Ranking Summary report ranks, by number of prescriptions, therapeutic classes from which products have been prescribed during the selected date range.
FINANCIAL Pharmacy Provider Claims Detail	The Pharmacy Provider Claims Detail report provides a look at all prescription activity for each selected provider.
Pharmacy File Extract	The Pharmacy File Extract allows clients to generate a list of pharmacies available in a pharmacy network. This report is useful in identifying a list of pharmacies available in a pharmacy network.
Prescriber Utilization Summary by Specialty	The Prescriber Analysis Summary shows statistics for each prescriber associated with a claim or claims in the selected carrier, account, or group.
Prescriber Utilization Summary Ranked by Cost	The Prescriber Utilization Summary Ranked by Cost report ranks prescribers in a selected carrier, account, or group in descending order by total ingredient cost. The report also shows average costs, prescription totals, and drug type percentages.

Report Title	Description
Prescriber Utilization Summary Ranked by Volume	The Prescriber Utilization Summary Ranked by Volume ranks prescribers by number of prescriptions, in descending order.
Prescriber Detail Sorted by NCPDP#, RX#	The Prescriber Detail Sorted by NCPDP Provider ID, RX Number is based upon.
Prescriber Practice Summary	The Prescriber Practice Summary provides a summary of physician prescribing habits over a specified period of time. Non-formulary NDC and GPI lists can be specified.
Rx Detail by Client, Dup Drug Different Prescriber	The Rx Detail by Client, Duplicate Drug Different Prescribers report lists all clients who have had therapeutically equivalent drugs (same GPI) prescribed by multiple physicians.
Rx Detail by Client, Dup Drug Different Provider	The Rx Detail by Client Duplicate Drug Different Providers produces records of benefit utilization by clients with claims for the same drug from different pharmacies.
Rx Detail by Client, Dup Drug within X Days	The Rx Detail by Client Duplicate Drug Within X Days provides records of benefit utilization by clients with claims for equivalent drugs within a user-specified number of days.
Rx Detail by Client, Therapeutic Duplication	The Rx Detail by Client/Therapeutic Class Duplicate provides records of benefit utilization by clients with claims for drugs from the same therapeutic class.
Rx Detail by Client, More Than X Prescribers	The Prescription Detail by Client ≥ X Prescribers provides records of benefit utilization by clients with claims for prescriptions written by a user-specified number of prescribers.
Plan Contingent Therapy Edit – Summary	The Plan Contingent Therapy Edit – Summary reports on all claims, paid and rejected, which edited against the Contingent Therapy edits.
GPI List Adds/Changes	The GPI List Adds/Changes report allows clients to view a listing of any additions or changes made to a specific GPI list during a specific period of time. The GPI will appear on the report if the add/change date for the GPI on the GPI list is within the date range selected on the parameter screen.
NDC List Adds/Changes	The NDC List Adds/Changes report allows clients to view a listing of any additions or changes made to a specific NDC list during a specific period of time. The NDC will appear on the report if the add/change date for the NDC on the NDC list is within the date

Report Title	Description
	range selected on the parameter screen.
DUR Table Detail	The DUR Table Detail Report allows a user to print the parameters of a DUR Table, independent of a specific plan. Clients who can only view or edit selected DUR Tables will be restricted to selecting only those tables that apply to their book of business.
DUR Override List Details Report	The DUR Override List Details Report allows you to view the contents of a DUR Override List. The DUR Override List contains GPIs that are to be used preferentially over any other therapeutic duplication as defined by the client.
Client Claim History Report	The Client Claim History Report allows clients to identify all claims processed for a specific client. The report can be run over a C/A/G, C/A/*All or C/*All/*All.
DUR Conflict Extract	The DUR Conflict Extract provides an annual data file that summarizes DUR (Drug Utilization Review) conflicts within a state Medicaid program. The file can be imported into Excel where it can be viewed and manipulated as necessary.
Annual Performance Report	Summary information about calls presented, handled, abandoned, average speed of answer, service level and handle time on a monthly, quarterly, and annual basis.
Summary Interval Reports	Summary information about calls presented, calls handled, and calls abandoned for each interval. Different reports are available and provided for each skill/call queue, for example member, pharmacy, physician.
DUR Savings – Summary	Lists total DUR occurrences, total DUR overrides, additional projected cost, actual DUR savings, additional projected savings, total DUR savings, total eligible clients, and total utilizing clients. Each item is shown with at least one and as many as seven values, which include the total number, the number of utilizing clients, the sponsor cost, the average sponsor cost by occurrence, the client cost, the average client cost by occurrence, and the number of future fills.
Prior Authorization Summary (by Therapeutic Class)	Counts of PA activity by therapeutic class by status
Top Prescribers	Summary of the Top Prescribers sorted in a variety of ways by

Report Title	Description
	amount paid, by claim volume, by Rx count, etc.
Top Utilizing Recipients by Aid Category	Summary of the Top Recipients by top ranking aid categories sorted by Rx count and amount paid
Top 100 Pharmacies	Summary of the Top Pharmacies sorted in descending order by amount paid and by claims volume
Top Therapeutic Classes by Amount Paid	Top therapeutic classes in descending order by amount paid. Report allows drilling down from therapeutic class to the generic name level.
Top Therapeutic Classes by Claim Volume	Top therapeutic classes in descending order by claim volume. Report allows drilling down from therapeutic class to the generic name level.
Top Prescribers by Average Cost/Rx	Summary of the Top Prescribers sorted by the average amount paid per paid claim and amount paid per utilizing recipient
Brand / Generic Dispensing Report	Summary of Generic Dispensing Rates including % of drugs dispensed as generic.
Denied Claims Detail	Summary of claim counts for NCPDP Reject codes.
Brand/Generic Report	Summary of Brand v. Generic Dispensing Rates - Trended over time.
Brand Generic Utilization Summary	This report breaks down utilization by Brand/Generic classifications and indicates key measures such as Net Paid Claims, Total RxPrice, Client Pay, Sponsor Pay, and Days' Supply. The report also calculates the savings associated with using generics, estimated additional potential savings if all brands dispensed were dispensed as generics (if available) and the generic potential usage (use of a generic where a generic could potentially be used). Graphs are included that show the Brand/Generic distribution as well as the proportion of Client Due Amount and Client / Patient Paid Amount.
Cost Type Utilization Summary	This report shows the cost type utilization summary based on the date range and Carrier/Account/Group combination provided by user. It indicates key measures such as Net Paid Claims, Total RxPrice, Client Pay, Sponsor Pay and Days' Supply.

Report Title	Description
Product Top N Report by Clt Ingredient Cost	This report lists the Top N (consumer defined) products ranked by the total Client Ingredient Cost for the date range and Carrier/Account/Group combination provided by the user. The report indicates additional key measures such as Net Paid Claims, % of Total Ingredient Cost, Total Client Due Amount, Total Metric Decimal Quantity, Total Days' Supply and Average Pharmacy Due. The report also indicates totals for these key measures for the Top N as well as the totals for all products.
Product Top N Report by Net Rxs	This report lists the Top N (consumer defined) products ranked by Net Paid Claims for the date range and Carrier/Account/Group combination provided by the user. The report indicates additional key measures such as % of Total Net Paid Claims, Total Client Due Amount, Total Metric Decimal Quantity, Total Days' Supply and Average Due Pharmacy. The report also indicates totals for these key measures for the Top N as well as the totals for all products.
Utilization Review by Age Band	This report breaks down utilization by Age Band and indicates key measures such as Average RxTrack Eligible Clients, Average RxTrack Utilizing Clients, Total Net Rxs, Total Rx Price, Average Per Net Rx, Average Net Rxs Per Client Per Year. This report also displays graphs for Average Eligible Client distribution by Age Band and Average Rxs Per Client Per Year distribution by Age Band
Utilization Review by Gender	This report breaks down utilization by Gender and indicates key measures such as Average RxTrack Eligible Clients, Average RxTrack Utilizing Clients, Total Net Rxs, Total Rx Price, Average Per Net Rx, Average Net Rxs Per Client Per Year. This report also contains graphs for Average Eligible Client distribution by gender and Average Rxs Per Client Per Year by gender.
Savings Report by Major Drug Group	This report shows the savings by Major Drug Group and indicates key measures such as Net Paid Claims, Total Submitted Ingredient Cost, Total Submitted U & C, Total AWP Unit Cost, Total Client (Approved) Ingredient Cost Paid, Savings Off AWP and Savings Off U & C.
Therapeutic Class Summary Including Product Names	This report shows the Therapeutic Class Summary including the Product Names and indicates key measures such as Net Paid Claims, % of Total Net Paid Claims, Total Client Due Amount, Total Metric Decimal Quantity, Total Days' Supply and Average Due Pharmacy. Subtotals are provided for each Therapeutic Class.

Report Title	Description
Top Therapeutic Class Summary by Net Rxs	This report lists the Top N (consumer defined) Therapeutic class ranked by Net Paid Claims for the date range and Carrier/Account/Group combination provided by the user. It indicates additional key measures such as % of Total Net Paid Claims, Total Client Due Amount, Total Metric Decimal Quantity, Total Days' Supply and Average Due Pharmacy. It also indicates totals for these key measures for the Top N as well as the totals for all products.
Pharmacy Top N Report by Ingredient Cost	Client Ingredient Cost for the date range and Carrier/Account/Group combination provided by the user. It indicates additional key measures such as Net Paid Claims, % of Total Ingredient Cost, Total Client Due Amount, Total Metric Decimal Quantity, Total Days' Supply and Average Due Pharmacy. Also, it indicates totals for these key measures for the Top N as well as the totals for all products.
Pharmacy Top N Report by Net Rxs	This report lists the Top N (consumer defined) pharmacies ranked by Net Paid Claims for the date range and Carrier/Account/Group combination provided by the user. The report indicates additional key measures such as % of Total Net Paid Claims, Total Client Ingredient Cost, Total Client Due Amount, Total Metric Decimal Quantity, Total Days' Supply and Average Due Pharmacy. The report also indicates totals for these key measures for the Top N as well as the totals for all products.
Prescriber Top N Report by Ingredient Cost	This report lists the Top N (consumer defined) prescribers ranked by the total Client Ingredient Cost for the date range and Carrier/Account/Group combination provided by the user. The report indicates additional key measures such as Net Paid Claims, % of Total Ingredient Cost, Total Client Due Amount, Total Metric Decimal Quantity, Total Days' Supply and Average Due Pharmacy. The report also indicates totals for these key measures for the Top N as well as the totals for all products.
Prescriber Top N Report by Net Rxs	This report lists the Top N (consumer defined) prescribers ranked by Net Paid Claims for the date range and Carrier/Account/Group combination provided by the user. The report provides Prescriber Submitted Id, Prescriber Last Name and indicates additional key measures such as % of Total Net Paid Claims, Total Ingredient Cost, Total Client Due Amount, Total Metric Decimal Quantity, Total Days' Supply and Average Due Pharmacy. The report also indicates totals for these key measures for the Top N as well as the totals for all products.

Report Title	Description
Drug Group Average Cost Per Day	This report lists major Average Cost Per Day by Drug Group and indicates key measures such as Total Days' Supply, Total Rx Price and Average Rx Price per Day.

6.0 Project Management

The Vendor must provide a narrative overview of how the proposed solution will meet the Vermont PBM Project Management requirements. The approach must, at a minimum, provide details on how the Vendor intends to meet or exceed the Project Management Requirements set forth in the document "Non-Functional Requirements," Tab I1 Project Management.

The following information pertaining to Vendor's Project Management Methodology must be provided.

6.1 Program and Project Management

Instructions: Describe the Vendor's methodology, tools, and techniques used to support projects from inception through finished deliverables including deployment of the new System, project management, checkpoints and periodic status reporting. Describe policies and procedures employed to ensure the timely completion of tasks in a quality fashion.

Response:

6.0 Project Management

The Vendor must provide a narrative overview of how the proposed solution will meet the Vermont PBM Project Management requirements. The approach must, at a minimum, provide details on how the Vendor intends to meet or exceed the Project Management Requirements set forth in the document "Non-Functional Requirements," Tab I1 Project Management.

The following information pertaining to Vendor's Project Management Methodology must be provided.

6.1 Program and Project Management

Instructions: Describe the Vendor's methodology, tools, and techniques used to support projects from inception through finished deliverables including deployment of the new System, project management, checkpoints and periodic status reporting. Describe policies and procedures employed to ensure the timely completion of tasks in a quality fashion.

Response:

Catamaran's proposed Account Director, Craig Boon, PMP is responsible for management and monitoring of all approved tasks identified in the project plan. Project tasks are assigned to resources and the expected start and finish dates are communicated prior to the project start. All project resources are required to submit regular status reports that provide details on their respective current and upcoming tasks. The resource is required to indicate the status of the task and the likelihood the task will be completed within the times scheduled. The resource is also required to document any current or potential issues and risks that may affect completion of the task.

Project Governance is another key aspect of the Project Management approach that is utilized for this engagement. The Governance structure established is one that ensures constant and consistent communication between Catamaran and the State. The Governance and Oversight model facilitates open communication that focuses on quality solution delivery.

Successful project planning establishes the foundation for successful project performance. The methodologies, processes, tools, and information that form the core of our project delivery approach, have been refined over the course of multiple successful implementations and adhere to the PMBOK methodology of project management. The Catamaran Difference is the combination of proven project management processes and the flexibility of the RxClaim Suite. The knowledge gained from processing one in four pharmacy claims in the United States provides insight into not only best practices, but unmatched experience in determining the best solution for most any scenario imaginable. Our team understands RxClaim Suite and as such, project planning is a repeatable process that provides value to the State by eliminating cost and schedule overruns. This approach has allowed Catamaran to enjoy a perfect record of on-time implementations.

Catamaran considers the Project Planning Phase the most important phase in this Project Management Methodology. The Planning Phase provides the Project Management Team a formal time within the project lifecycle to evaluate and plan for all project related activities. It is during the early stage of this phase when a Kick-Off Meeting with key stakeholders and the State project team members occur. The objective of the Kick-Off Meeting is to:

- Introduce new project team members and stakeholders.
- Review the project mission and guiding principles.
- Determine the format and protocol for ongoing project status meetings.
- Review the project Deliverable schedule and review process.
- Identify project risks and mitigation process.
- Communicate the issue identification and risk process

Concurrently, Catamaran updates and modifies the project plan to account for knowledge and information gained from the State and other key stakeholders. The purpose of the Project Plan is to detail Catamaran's involvement on the project and to ensure that all deliverables and service levels documented in the RFP response are thoroughly planned for by completing the following:

- Consolidate the planning for the project into a single document or set of documents
- Provide a single plan that is used to manage the project
- Provide a means for updating the plan as the project progresses
- Establish a SharePoint portal to allow access, and when appropriate, update access to project documents by key stakeholders

During Catamaran's participation in the Project Planning Phase, the following are identified, evaluated and planned:

- Integrated Project Team Structure is established
- WBS Dictionary is established

- Project Management Plan is established
- Project Governance Plan is established
- Network Diagram(s) is established
- Critical Path is established
- Risk Management Plan is created
- Project Budget is established
- Communication Requirements are further defined from Project Chartering process
- Risk Identification, Qualification, Quantification, and Response Planning are completed
- Detailed Work Breakdown Structure (WBS) is established
- Organization Breakdown Structure (OBS) is established
- Project Charter is reviewed
- Cost and Time submitted in the proposal is verified
- Review and begin planning approach to ensure the project meets Service Levels
- Project Schedule (Timeline) is developed
- Quality Standards are further defined from Project Chartering process
- Establish Resource Requirements

During the Project Planning Phase, the project team members (Catamaran & the State) come together to form an integrated team. While each team has clearly defined and separate roles through the orientation activities, we ensure that all parties are working together with an understanding of each entity's roles and responsibilities.

As RxClaim Suite is an established system in operation in Vermont today, much of our "development" is related to system configuration. For that reason, in this part of the Project Start-up, we focus on any gaps in the legacy system data and high-level architectural design and enhancements required. Since Catamaran operates the existing system our focus will also be on new system interfaces and the move to the new Catamaran environment. In every implementation project, the two highest risk items are almost always data conversion and interfaces. Much of the risk associated with these items is diminished through our knowledge of our own system and Vermont's data, but also through knowledge of the State's existing architecture and interface specifications.

Catamaran's Project Management approach is to work collaboratively and transparently with the State in all aspects of creating, submitting, reviewing, modifying and obtaining approval for all Project Management based deliverables including:

- Project Charter
- Project Governance Plan
- Business Process Change Management Plan
- Technical Change Management Plan
- Project Management Plan
    - Communications Management Plan
    - Risk Management Plan
    - Configuration Management Plan
    - Issue Management Plan
    - Quality Management Plan
    - Resource Management Plan
    - Reporting Templates

- Project Schedule / Work Breakdown Structure

Where possible, Catamaran will use existing State templates for these plans and are developed in coordination with the State.

The governance structure we employ is a key aspect of our Project Management approach in that it ensures constant and consistent communication between Catamaran and the State and facilitates open communication that focuses on quality solution delivery. Catamaran's organization and processes align to fully integrate with the State to establish an environment of collaboration and success.

Catamaran considers the Project Planning Phase the most important phase in the project. It is the phase when Catamaran and the State work together to evaluate and plan for all project related activities. It is during the early stage of this phase that all stakeholders are introduced. We come together to fully understand the project mission and guiding principles, determine the format and protocol for communication, develop an understanding and agreement on the project deliverable schedule, and identify project risks, issues and develop an understanding of the mitigation process. This groundwork sets the stage for seamless continuity between the implementation phase and the operations phase.

The open communication established early in the relationship ensures that "if Catamaran sees it, the State sees it". Catamaran provides reporting that covers all aspects of the project including schedules, adherence to the project budget established in the Planning Phase, risk management, task/activity completion and staging of short and long-term events. Project status reporting is the responsibility of all project staff. The Catamaran project team follows a formal approach in the collection and organization of information to be reported, monitored and presented to Catamaran management and the State. Schedules and standards for status reporting format and content are defined at the start of the project and documented in the Communication Management Plan and project staff are required to strictly comply with the standards and schedules.

The Project Management Plan defines Catamaran's Project Methodology and Approach. It also identifies the project management activities performed by Catamaran in support of the Project in addition to touch points between Catamaran and the State.

Project Management Plan

This Project Management Plan provides a definition of the Project, including the project's goals and objectives, as well as a guide to the work of the project in terms of what, why, when, and by whom (Catamaran and State). Additionally, the Project Management Plan serves to provide a description of how the project is managed among the State, Catamaran, and other stakeholders and personnel associated with or affected by the Project. This Project Management Plan describes the project management deliverables, overall approach, and Catamaran's methodologies for synchronizing our project management processes with the knowledge areas and process groups consistent with the Project Management Institute's (PMI) Project Management Body of Knowledge (PMBOK).

The Project Management Plan is a living document and is updated throughout the life of the project. The initial version focuses primarily on the Implementations Phase. As the project progresses, additional updates are added to the plan. Project re-baselines (if any) and schedule changes or updates are significant events that warrant a review of the Project Management Plan to identify possible changes. Minor updates and maintenance to the plan are performed on

a regular basis. Any major milestone affecting updates or re-baselines is coordinated in collaborative sessions with the State, and is submitted for review and approval (Updated Project Management Plan) according to the State's deliverable approval process within the timeframes documented in the Project Schedule.

Work Breakdown Structure and Schedule

The Work Breakdown Structure (WBS) shows each project task and the major groups of activities that exist within it. The project work effort planned for the Project finds its basis in the WBS. Some of the major groups are broken down into smaller groups providing further clarity on the organization of the work they include. The WBS not only identifies the work packets required to complete the project; but also how the work packets relate to each other and the critical path, the effort planned for each work packet, the planned start and end dates, the dependencies, predecessors, precursors, and other relationships, as well as the status and percent complete of the packets.

The goal of the WBS is to show, at a high-level, the work that exists on the Project and how it is organized for management purposes. The Project WBS is created and contained in its MS Project application. It is reviewed and reported on weekly and provided as a file to the State.

The State of Vermont project objectives are grouped under the five main project phases that are defined by the PMBOK.

- Initiating
- Planning
- Executing
- Monitoring and Controlling
- Closing

These phases form the basis for the project WBS and are part of the overall foundation of the PBM project.

Task	Deliverable
Task 1 — Project Initiation and Planning	Deliverable 1 — Project Kick-off Presentation
	Deliverable 2 — Project Management Plan
	Deliverable 3 — Project Work Plan and Schedule
	Deliverable 4 — Monthly Project Status Reports
Task 2 — Requirements Validation	Deliverable 5 — Requirements methodology and Template
	Deliverable 6 — Cross-Walk of RFP Functional against Legacy System Functionality
	Deliverable 7 — Detailed Functional and Non-Functional Requirements Traceability Matrices
Task 3 — System Design	Deliverable 8 — Configuration Design Document
	Deliverable 9 — Data Integration and Interface Design Document
Task 4 — Configuration and Development	Deliverable 10 — Client Review of Configuration
	Deliverable 11 — Unit Testing Scripts and Results
Task 5 — Testing	Deliverable 12 — Documented System Test Results

Task	Deliverable
	Deliverable 13 — User Acceptance
Task 6 — Training	Deliverable 14 — Training Plan
	Deliverable 15 — Training Materials
	Deliverable 16 — Documented Evidence of Successful End-User Training
Task 7 — Deployment	Deliverable 17 — Deployment Plan
	Deliverable 18 — CMS Certification
	Deliverable 19 — System Documentation
	Deliverable 20 — Performance SLAs
	Deliverable 21 — Rollout

The WBS is included as a subsection of the Project Management Plan.

Communication Management Plan

To ensure the success of the project, Catamaran understands communication is necessary throughout all phases of the project. To facilitate success, the Communications Management Plan requires that Catamaran report on project status, performance, change, and that we pay close attention to controlling the information to ensure that is working for all parties as intended.

Communication Management Processes are important in managing stakeholder and sponsor expectations, letting them know what information they will receive and when and how they will receive it. Catamaran invests time in defining and establishing these lines of communication up front. A significant part of analyzing the Project's communications requirements is determining the communication channels, or paths of communication that exist within it. Because the Account Director and support staff need to manage and be in control of project communications, it is important to understand that adding even a single additional person to the project can have a significant impact on the number of paths, or communication channels, that exist between people.

The number of communication channels is of specific concern when analyzing the project's communications requirements. If there are a large number of channels of communication on the Project, Catamaran works to define which are official. In the case where specific face-to-face communication (i.e., meeting) is not required, then electronic communication (i.e., conference call, e-mail) is desirable. Volumes of communication should be held to as low as is reasonably achievable. Ideally, the SharePoint Project Library provides a significant advantage in project communication, reducing, and in some cases eliminating, the need to communicate or transfer large documents and deliverables either in person or electronically.

Communications Management processes require accurate reporting of project status performance, and change; it involves knowing our stakeholders, as well as project team members, and what they need to know. Communications Management processes identify, summarize, and integrate communications planning, distribution of project information, reporting project performance and managing stakeholders' expectations and impact on the overall project in Catamaran's PM methodology.

Without an effective, daily-executed Communications Management Plan in place, the project is at high risk; Catamaran's Communications Management Plan consists of distribution schedules that include:

- Who communicates what under what conditions and at what frequency
- How it is communicated and who is included in the communications

Reporting and presenting are key aspects of the communications management process; equally, or perhaps even more, important is the leadership and management of all project stakeholders' expectations and interpretations as they relate to upcoming or recently distributed communications.

The Communications Management Plan is included as a subsection of the Project Management Plan.

Reporting Templates

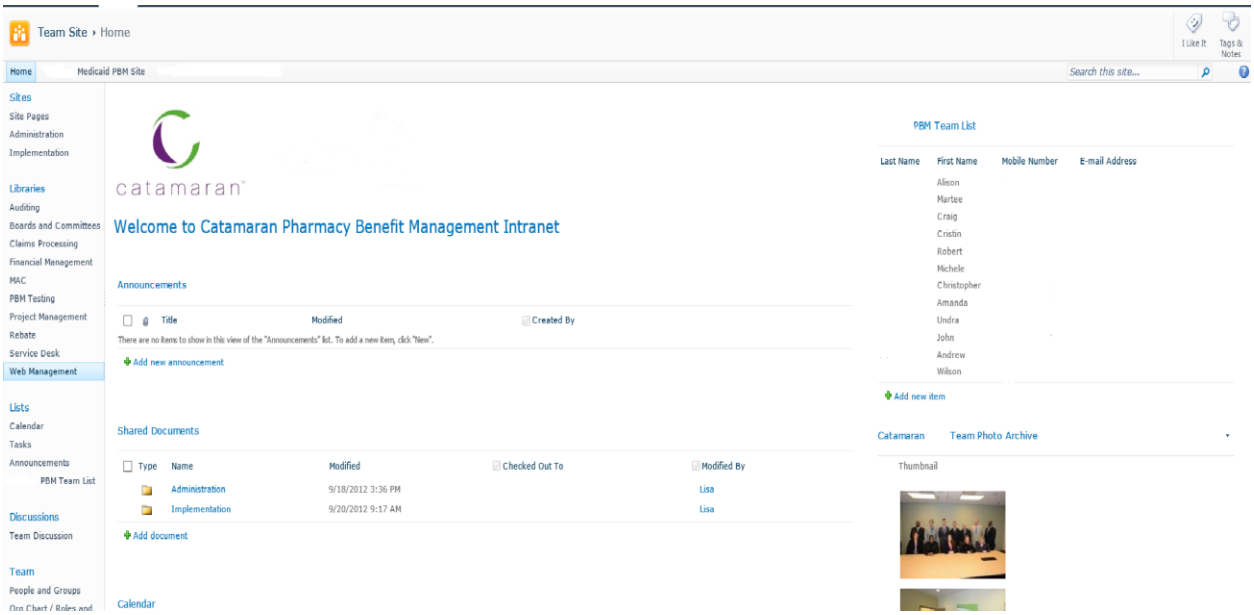
Communications Management Processes require accurate reporting and project status of performance and change; it involves knowing our stakeholders and what they need to know. Part of developing this relationship and having clear expectations is the development, review and approval of reporting templates. Based on previous successful implementations, Catamaran maintains a library of reporting templates that can be customized to meet State expectations and requirements. In addition, Catamaran is open to utilizing templates recommended/provided by the State. Once the template(s) is approved, Catamaran utilizes the approve template for ongoing reporting.

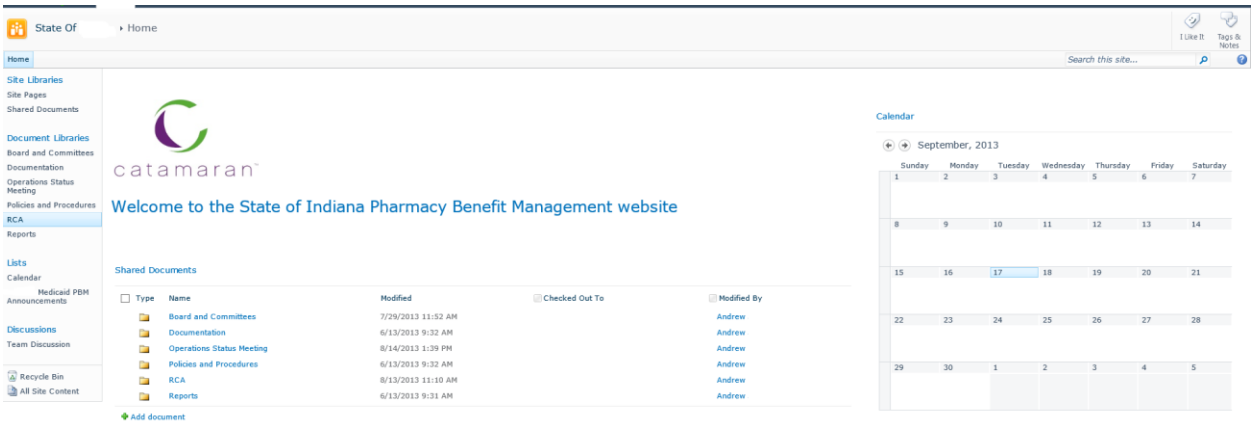
The Reporting Template is included as an attachment to the Communications Management Plan, which is a subsection of the Project Management Plan.

Electronic Document Repository

Catamaran maintains a SharePoint site not only to support implementation, but also to be used throughout operations as the electronic document repository. SharePoint will be managed by Catamaran and will contain communications, deliverables, Issues and Risk logs, and any other project and/or operations documentation. The flexibility of the solution allow Catamaran to partition off parts of SharePoint so that the incumbent vendor may access and post items relevant to their responsibilities and requirements while not gaining access to other areas of SharePoint. All users will be provided secure access via user name and password.

Following are screenshots from the SharePoint tool.





Resource Management Plan

Catamaran understands the role and inevitable responsibilities of all those involved in making the Project a success: senior management, sponsors and stakeholders, and the entire project team. Catamaran synthesizes PMI's philosophy of leadership and power, which is based on the realization that the project manager is rarely given full autonomy and afforded complete and unquestioned authority on the project. Instead, the project manager motivates and persuades personnel to act and perform in the best interest of the project, the customer, and the company. Catamaran builds teams and leads members to give their best effort to the project.

For this Project there are two (2) subcomponents of the standard Catamaran Staffing Management Plan: Internal Catamaran Staffing and Required Key Personnel Staffing specific to the Vermont Project.

Staffing/HR Management Processes identify, summarize, and integrate Human Resource Planning, Acquiring the Project Team, Developing the Project Team, and Managing the Project Team in Catamaran's PM methodology. These processes address formulation of the primary outputs: project roles and responsibilities, project organization, staffing management planning,

staff assignments, and team and employee performance assessments, as well as managing change control related to staff/HR issues including change requests, recommended corrective actions, and recommended preventive actions.

Catamaran's Staffing/HR Management Processes consist of numerous activities including training and education, employee satisfaction, and planning for personnel improvement. Catamaran places the right people on the right tasks at the right time through a thorough roles and responsibilities review associated with each of the major and detailed tasks, as well as recruiting through a network of recruiters and internal HR managers. As part of the Project, Catamaran has integrated the required Key Personnel into the project at various phases to facilitate knowledge acquisition, knowledge transfer, and team building.

Catamaran greatly values our highly qualified and dedicated people. Employee turnover is one of the highest cost events that could occur on the Project as turnover costs time. Turnover also adds risks to the project and burdens other team members.

We are thoroughly aware of this, so Catamaran takes aggressive measures to ensure our employees not only know but also have a strong belief in and trust that Catamaran recognizes their value to both the company and to our client.

The Resource Management Plan is included as a subsection of the Project Management Plan.

Risk Management Plan

Risk Management Processes define how we must anticipate and identify areas of risk, how to quantify and qualify them, and how to plan for them. The more diligently we manage risks on the project, the fewer issues we have. Risk Management Processes identify, summarize, and integrate risk management planning, risk identification, qualitative and quantitative risk analysis, risk response planning and monitoring, and controlling risk in Catamaran's PM methodology.

Catamaran's Risk Management Processes begin with risk planning, identification, analysis and mitigation and contingency planning activities. They continue with those risk management activities throughout the full life cycle of the project, as well as thorough monitoring, reporting and control, so that all stakeholders are aware of Project risks and when to implement specific mitigation and/or contingency plans.

Catamaran's Risk Management Plan is a roadmap to risk management processes. It defines what level of risk is considered tolerable for the Project, how risk is managed, who is responsible for risk activities, the amounts of time that are allotted to risk activities, and how risk findings are communicated. When risks are properly managed, there are fewer issues, which result in fewer scope changes.

The Risk Management Process establishes the procedures for identifying, assessing, controlling, and monitoring risks throughout the project life cycle. The Risk Management Process is executed separately and independently of any external Quality Assurance Risk Management functions, although the processes are related and may deal with some of the same risks. The Risk Management Process incorporates a grass-roots approach to identifying risks (i.e., all project staff members and participants at all levels are empowered to identify and report risks that, in their judgment, may have negative consequences or an impact on the project).

Functional teams make risk a standard part of their status reporting. Project-level risks are documented by the DDI Manager and escalated to the State Program Management Office as needed. The project assesses risk with the State during weekly status reporting meetings. Risks are defined by a unique identifier, a risk statement indicating the risk, the result of a risk being realized, and the consequences of the risk result. Risk mitigations are defined, triggers to contingency actions are identified as needed, and additional analysis is tasked when appropriate.

The level of risk on a project is tracked, monitored and reported throughout the project lifecycle. All project change requests are analyzed for their possible impact to the project risks. Stakeholders are notified of important changes to risk status as a component to the Weekly Project Status Report.

The Risk Management Plan is included as a subsection of the Project Management Plan.

Configuration Management Plan

Configuration Management is Catamaran's process that outlines the process, people, roles and responsibilities, and technology required to manage requested changes from the State's RFP, Catamaran's Proposal, and subsequent deliverables once the project commences.

The Configuration Control process applies to any item selected for configuration control, or groups of configuration items that may be part of a baseline (e.g., requirements, design, and delivery). Changes may impact a specific project area or occur at the overall project level. All of these changes must be managed and controlled properly.

This Configuration Control Process is followed throughout the project life-cycle through design, development (configuration, and implementation of the Project. Once a baseline has been established, all changes to that baseline are submitted following the State-defined project Configuration Control Process via the Change Request.

Due to the changes associated with implementing a new system, Catamaran understands the impact to business change management and managing the people side of change. Understanding the potential impacts of a project from the user's perspective and working with the State to devise strategies to manage users' expectations, resistance and buy-in is a key to success.The Change Management Plan is included as a subsection of the Project Management Plan.

Quality Assurance Control/Quality Management Plan

PMI's philosophy of Quality Management is a proactive approach. Early theories on quality relied heavily on inspection; current thinking is focused on prevention. Catamaran adheres to these core tenets of quality as well. Quality Management is a proactive endeavor, favoring prevention over inspection. This does not indicate that Catamaran does not maintain a vigilant approach to quality control, inspection and testing of its software. Catamaran's self-imposed expectation is that we deploy software and solutions in as error-free condition as possible which attests to this philosophy. Quality Management is core to Catamaran's project management methodology, and extends beyond the efforts to simply inspect work already completed. Quality is built into all efforts associated with planning, executing, monitoring and controlling the project.

Catamaran's Quality Management Processes consist of multiple components that include Quality Planning, Project Monitoring and Control, Systems Quality Assurance, Contracts

Management Quality Assurance, Subcontracts Management Quality Assurance, and adherence to IEEE Standards.

Quality Management Processes directly affect "the degree to which a set of inherent characteristics fulfill the project requirements" through three (3) foundational quality processes: planning, assurance and control. Quality Management Processes identify, summarize, and integrate Quality Planning, Quality Assurance, and Quality Control in Catamaran's PM methodology. Quality Planning defines the Quality Assurance (QA) and Quality Control (QC) activities that are performed to provide objective and independent visibility into the quality of processes being used and products being built on the Project.

Quality Assurance activities focus on the processes being used to manage and deliver the solution to evaluate overall project performance on a regular basis. Quality assurance is a method to ensure the Project satisfies the quality standards and defines and record quality reviews, test performance, and customer acceptance.

Quality Control activities are performed continually to verify that project management and project deliverables are of high quality and meet quality standards. In addition to adhering to systems development quality standards, Catamaran aggressively monitors and controls our processes for contract compliance and overall contract quality assurance, both from the account level and at the corporate level. Catamaran performs account audits leveraging QA staff that is external to the project, to ensure Catamaran's high standards are being adhered to, in turn, promoting independent examination, and reporting.

The Quality Management Plan is included as a subsection of the Project Management Plan.

6.2 Project Work Plan

Instructions: Provide a narrative describing the Vendor's proposed processes and methodologies for providing all components as described in RFP Section 2.0 Overview and Scope of Work. Include any assumptions and the Vendor's approach to meeting the proposed project Schedule using Microsoft Project®. Provide a proposed Work Plan, Work Breakdown Structure (WBS) as part of the Vendor's proposal. This Work Plan and WBS should show all task details with responsibilities, timelines, durations, milestone dates, deliverables, and Vendor personnel hours by deliverables for each phase, State personnel hours by phase deliverable, and all critical dependencies for the project's milestones and deliverables. The Work Plan must be an attachment to the Vendor's Technical Proposal and tabbed as such in the submission as well as an electronic version of the Microsoft Project® version in the Vendor's electronic submission of the Technical Proposal.

Response:

Confidential, Proprietary, and Trade Secret Information of Catamaran

Through our 30 years of implementing pharmacy systems, Catamaran has developed and refined a sound Project Management Methodology, resulting in over 100 successful pharmacy services implementations. Refined by modern project management practices and automated project management software, the management and execution of a solid work plan remains a crucial component to a successful implementation. The Catamaran work plan for the Vermont program utilizes the RFP as the source for scope and duration constraints. In addition, key knowledge from past successful implementations helps to further define the work plan's activities, activity relationships, resources and work estimates. The proposed work plan is

intended to be a "working" plan, not one put together only for the purpose of the proposal. Catamaran intends to utilize this plan once a contract is awarded as the project work plan.
In Template J, we provide a detailed project schedule in Microsoft Project. It identifies the tasks, durations, dependencies and resources, which are required to implement our enhanced systems and services and transition to ingoing operations. The project schedule is intended to represent implementation work only which extends from the award announcement to formal project closeout. Catamaran looks forward to formally kicking off the project with the State when the joint team can have an opportunity to further refine the project schedule by updating expected work hours, durations, resources, and dependencies.

6.3 Change Management Plan

Instructions: Describe the Vendor's methodology, tools, and techniques for communicating and accomplishing organizational change management. Discuss how the Vendor can assist the State in implementing the organizational change and communicating the change to the impacted business units and associates. Describe specific techniques the Vendor uses to educate executives, build executive alignment, and cascade the change throughout the organization.
Please address the following areas (at a minimum):

- Your Change Management Methodology
- Determination of the impact of this change
- Methods of responding to the change, process harmonization and potential resistance
- Communication and planning
- Method for ensuring a successful change management program
- Lessons Learned regarding change management challenges as they will impact this project

Response:

Change Management Methodology

Catamaran's change management methodology is based upon both an individual and an organizational perspective. Our experience tells us that the success of any project ultimately lies with each individual learning to manage work, processes, time, and utilize systems, etc. in a different way. Effective change management requires an understanding for and appreciation of how each individual makes a change successfully. While change happens one person at a time, there are processes and tools that we use to facilitate change.

Determining the Impact of Change

Catamaran first works with the State to conduct a gap analysis to determine how much change will actually result from the proposed program enhancements whether they relate to policy, processes, or systems. The results of this exercise are a profile of the characteristics of the necessary changes, an understanding of how each participating organization and individual stakeholders will be impacted by the change, the identification of leadership level change managers who will champion the change, and the development of an overall Change Management Plan.

Methods of Responding to Change

The Change Management Plan is initially developed during project implementation and is comprised of a number of components that drive and manage the change whether it is policy, program, or system related. The plan provides a framework for ensuring smooth operations from the implementation phase throughout the life of the contract. The objective of the Change Management Plan is to formally document the change management and control processes for the comprehensive PBM program. The document addresses activities related to the following areas:

- Operational Change Management (people focused)
- Hardware Change Management
- COTS Software Change Management:
- Custom Application Software Change Management
- Documentation Change Management
- Environments
- Training (people focused)

Communication and Training

Communication and training are the key tools we utilize to drive organizational change. Working collaboratively with the State, Catamaran develops communication and training plans that are specific to each necessary change. These plans are a component of the overall Project Management Plan and a complement to the Change Management Plan. The Communication Plan is designed to:

- Create an awareness of the need for change
- Ensure stakeholder understanding of the reasons for the change
- Introduce the individual or team who will spearhead implementation of the change activity
- Convey the timeframe for the change
- Communicate the avenues available for training, resources and tools

Ensuring a Successful Change Management Program

Catamaran works with the State to create specific action plans for ensuring that the change is completed and sustained. Project teams develop measures and mechanisms to assess whether stakeholders are actually following the new procedures and processes and conducting operations the “new” way.

Lessons Learned

Catamaran currently provides pharmacy benefit management services for six fee for service Medicaid clients. We have worked with our agency partners to manage significant changes over many organizations during complex implementations and through ongoing operations. Through these experiences, we know that early, straightforward communication is key to ensuring a successful change management program. Each individual contributor must clearly understand why change is necessary, how the change will be implemented, how it will impact their work, and how the organization will prepare them for the change.

Please refer to Section 7.1 Change Management for more detailed information on our approach to managing system change requests.

6.4 Relationship Management

Instructions: Describe how the Vendor organization will represent itself to the State from an overall viewpoint. Discuss treatment of account management, status reporting ((hard copy and electronic), performance review meetings), contract management, audits, quality assurance, planning, setting priorities and handling service requests.

Response:

In the fast-paced environment of servicing a diverse client and beneficiary base, Catamaran utilizes a holistic and personalized approach to our operations to ensure prompt and reliable service. We work closely with clients, prescribers, and pharmacies to ensure every program is a success. As Vermont's incumbent pharmacy benefit management vendor, we are sincere in our ongoing commitment to the State. Catamaran's Account Management Team will continue to work closely with the State's personnel to ensure that all expectations for knowledgeable, efficient account management and clinical support are met.

Account Management

Catamaran's approach to Account Management includes local account oversight, with senior management involvement. Our team assigned to Vermont is intimately familiar with the State's plans, its goals, and the challenges the program faces. Nancy Miner, Account Manager and Diane Neal, Clinical Services Manager are dedicated to this project and have been for the last seven years; while Michelle Sirois, Client Services Manager has been dedicated to the project for the last three years. Their institutional knowledge allows Catamaran to continue providing a proactive, extremely personalized account management approach for the State.

We have proposed a highly experience account management professional, Craig Boon, as the dedicated Account Director. Mr. Boon is a PMI certified project manager with over 13 years of experience in account and project management and has been dedicated to some of Catamaran's most complex program implementations including Indiana, Nevada and Virginia.

Mr. Boon and the Account Management Team are supported by Catamaran's Senior Director of Account Management, Susan McCreight. Ms. McCreight has a twenty-year history in account management and most recently oversaw Catamaran's contract with Georgia Medicaid. The Vermont contract is also designated as a Key Account with our Public Sector Segment President's oversight accountability. The high-level attention of the Senior Director and the Segment President ensures that upcoming tasks are on schedule, that we appropriately identify risks in advance of task initiation, and that project tasks are not relegated to an unacceptable priority.

Considerable thought has been devoted to developing an organizational structure to ensure clear accountability to the State's management and project staff, in addition to responsive and accurate communication amongst the State, Catamaran, and other stakeholders. From a management and escalation perspective, we believe our experience-tested project organizational structure provides the highest level of responsiveness in terms of issue resolution and overall project management. Catamaran's Account Management Team will be hands on during the implementation of the new aspects of this contract, ensuring consistency in

processes, people and delivery. The team will work with the State and its personnel to address all technical and business related needs of the program.

Please refer to Template D, which includes our staffing approach and methodology the Account Management Team will utilize for this project.

Status Reporting

Catamaran's business is built upon open communication established early in all of our client relationships. This ensures that "if Catamaran sees it, the State sees it". Catamaran's Account Management Team provides status reporting that covers all aspects of the project including but not limited to task/activity completion; problems, resolutions, and schedules; risk management; and staging of short and long-term events relative to the project schedule. Status reporting is the responsibility of all project staff. The Account Team follows a formal approach in the collection and organization of information to be reported, monitored, and presented to Catamaran management and the State. Weekly and monthly schedules and standards for status reporting format and content are defined by the State at the start of the project, as specified in Template H of this RFP. All submission schedules are documented in the Communication Management Plan and project personnel are required to strictly comply with the standards and schedules.

Performance Review Meetings

Catamaran understands that project status and performance meetings are critical to communicating activity status, resource management, critical issues, problem resolution, risk planning and upcoming task/activity scheduling. Our Account Management Team will continue to coordinate and participate in all status meetings as required by the State.

Audits

Vermont's dedicated Account Manager, Nancy Miner, is the primary interface to assist State staff in responding to federal and State audit requests. Ms. Miner has support from the organization to assist her in providing all documentation requested by an auditing body, to the extent allowed by law.

Quality Assurance

Catamaran's Account Management Team knows that every aspect of the Vermont project requires a high quality deliverable as the end objective. This is because each business unit and functional area within the Catamaran organization is accountable for initiating projects to improve processes, increase efficiencies and enhance client satisfaction. These projects are led by process improvement teams utilizing a quality improvement process workflow. The status and outcome of these projects is monitored by the Corporate QA State on a quarterly basis.

The intent of each Quality Improvement Project (QIP) is to:

- Continually improve
- Share best practices from QIPs across functions, business units, and client engagements
- Communicate to the organization that quality at Catamaran is a culture, not just a program

All of the Vermont Account Management Team's quality initiatives follow these steps:

1. Team identifies the business, operational or clinical issue (e.g. through business metrics, State concerns or other program performance metrics)
2. Leadership assigns the QIP to a project owner for action
3. Project owner assembles a team of subject matter experts with appropriate cross-functional representation as needed to analyze the issue and identify action items
4. Program performance information is analyzed, corrective action steps identified and an implementation plan developed
5. The corrective action steps are implemented and program performance is monitored for improvement

If business performance improves to desired levels, the QIP is complete. Otherwise, the team continues their analysis and identifies additional corrective action steps. Please refer to Template G for a full discussion of our quality management program.

Planning and Setting Priorities

Successful project planning with well-defined priorities establishes the foundation for successful project performance. From the very beginning of a new contractual relationship, Catamaran knows that it is imperative for all project team members from Catamaran and the client to form an integrated team. Our Vermont Account Management Team has forged a productive relationship with the State's personnel over the last seven years and will build upon that existing connection to develop and clearly define a project plan. Each entity will continue to have clearly defined roles through the implementation of the new contract and ongoing operations activities.

The Catamaran team continues to work with the State to prioritize plan needs and define program objectives. The team will use the project work plan and milestone list to measure project progress and achievement. Catamaran makes no significant decisions that would impact the program without consultation with and approval by the State.

Handling Service Requests

The Vermont Account Team adheres to our best practice of returning phone calls and emails within two hours of receipt. Even if an inquiry from the State cannot be fully satisfied within that timeframe, a team member will still make contact to report on the progress. Our experience has shown that this practice allows us to address the needs of our clients while providing actual solutions to any concern expressed. In addition, we have found that the vast majority of client inquiries are resolved during the initial call or at least within several hours, depending on the complexity of the inquiry.

Our Account Management staff is skilled at working with personnel from other departments to resolve issues that may require additional research and input. We use a secure customer relationship management tool to manage all State service requests from initiation to completion. Catamaran associates involved in these projects are able to enter detailed notes and import other related information into the relationship management tool. The information is then available to authorized employees who may quickly access the entire history of the project. Once a request is completed or an issue is resolved, the Account Management Team contacts the State to notify them of the solution and ensure that Catamaran has met all of their needs.

6.5 Issue Management

Instructions: Describe the Vendor's process for problem management including: problem logging, problem resolution, tracking of unresolved problems, problem escalation procedures, and problem closeout and reporting practices. The Vendor should describe the integration of problem management across any sub-contractors, if applicable, such as the use of an automated system.

Response:

Catamaran's strategies for addressing issues, which we define as risks to the program that have been realized, acknowledges the need for a disciplined, formalized approach to efficiently and satisfactorily resolving any issues arise. Catamaran ensures the smooth and efficient delivery of our team's services and those of our subcontractor, and delivers exceptional customer service by basing our product and service offerings on three (3) critical elements:

- Superbly trained account, technical, service and clinical personnel
- Repeatable, standardized methodologies and processes
- Highly automated and customized solutions

Our reporting relationships identify responsibilities, facilitate ongoing effective communication with the State, and promote efficient decision-making in responding to the State's needs. Our reporting relationships also emphasize extensive experience at each managerial level, facilitating rapid, knowledgeable responses to the requirements and challenges of the PBM System. We take great pride in our ability to focus resources on the unique requirements of each project organization while maintaining consistent standards of excellence. From an organizational standpoint, Catamaran offers the flexibility and strength necessary to meet the State's priorities and respond quickly to its needs.

When an issue is identified that requires remedial action, it is communicated to the Account Manager, Nancy Miner, and the Manager(s) of the functional unit(s) affected by or otherwise responsible, in part or full, for the resolution of the issue. The issue is classified by severity to prioritize resources, define the level of escalation, and determine the speed with which the problem must be resolved. The issue owner is responsible for updating and documenting status in Catamaran's tracking system. All personnel participating in resolution activities and providing monitoring and oversight are copied on the resolution status and are charged with ongoing update and review of the ticket. Catamaran's tracking system maintains object attachment to issue documentation, which provides a comprehensive, living account of the issue and its status.

When an issue has been resolved, the owner is responsible for communicating the resolution status to the Account Manager, functional unit Manager(s) and monitoring Account Director and Executive (if escalated to that level). All notified Catamaran personnel must agree that an issue is sufficiently resolved. Objections are addressed until the parties agree on closed status. The State is notified of the status and any concerns are addressed until a final closed status is determined.

6.6 Risk Management

Instructions: Describe the Vendor's risk management practices. Describe the expected risk areas and mitigation plans. The response shall describe the Vendor's internal risk management

plan. This should include reference to the use of any specific methodologies, as well as any specific tools being used.

Response:

A Risk Management Plan is developed in the Initiation and Planning Phase of the project. The Risk Management Processes define how we must anticipate and identify areas of risk, how to quantify and qualify them, and how to plan for them. Catamaran's Risk Management Processes begin with risk planning, identification, analysis and mitigation and contingency planning activities. They continue with those risk management activities throughout the life of the project. The processes also include thorough monitoring, reporting, and control so all stakeholders are aware of the project's risks and when to implement specific mitigation or contingency plans.

Risk Management Processes define how we must anticipate and identify areas of risk, how to quantify and qualify them, and how to plan for them. The more diligently we manage risks on the project, the fewer issues we have. Risk Management Processes identify, summarize, and integrate risk management planning, risk identification, qualitative and quantitative risk analysis, risk response planning and monitoring, and controlling risk in Catamaran's PM methodology.

Catamaran's Risk Management Processes begin with risk planning, identification, analysis and mitigation and contingency planning activities. They continue with those risk management activities throughout the full life cycle of the project, as well as thorough monitoring, reporting and control, so that all stakeholders are aware of State of Colorado PBMS Project risks and when to implement specific mitigation and/or contingency plans.

Catamaran's Risk Management Plan is a roadmap to risk management processes. It defines what level of risk is considered tolerable for the State of Colorado PBMS Project, how risk is managed, who is responsible for risk activities, the amounts of time that are allotted to risk activities, and how risk findings are communicated. When risks are properly managed, there are fewer issues, which result in fewer scope changes.

The Risk Management Process establishes the procedures for identifying, assessing, controlling, and monitoring risks throughout the project life cycle. The Risk Management Process is executed separately and independently of any external Quality Assurance Risk Management functions, although the processes are related and may deal with some of the same risks. The Risk Management Process incorporates a grass-roots approach to identifying risks (i.e., all project staff members and participants at all levels are empowered to identify and report risks that, in their judgment, may have negative consequences or an impact on the project).

Functional teams make risk a standard part of their status reporting. Project-level risks are documented by the Account Director and escalated to the State Program Management Office as needed. The project assesses risk with the State during weekly status reporting meetings. Risks are defined by a unique identifier, a risk statement indicating the risk, the result of a risk being realized, and the consequences of the risk result. Risk mitigations are defined, triggers to contingency actions are identified as needed, and additional analysis is tasked when appropriate.

The level of risk on a project is tracked, monitored and reported throughout the project lifecycle. All project change requests are analyzed for their possible impact to the project risks. Stakeholders are notified of important changes to risk status as a component to the Weekly Project Status Report.

The Risk Management Plan is included as a subsection of the Project Management Plan and has the following purposes:

- To list the risks that have been defined as high;
- To identify the symptoms that indicate that a risk is about to materialize;
- To develop procedures to mitigate these risks;
- To define procedures within the project to identify new risks and to re-evaluate existing risks.

The following sections document the approach Team SXC will take in identifying, managing and mitigating risks for the entire project.

Risk Identification: The first step in creating a Risk Management Plan will be to identify the likely risks which may affect the project. Each of the risks identified is described in detail and documented within the Risk Register. A risk is defined as "any event which is likely to adversely affect the ability of the project to achieve the defined objectives".

Risk Quantification: Risk Quantification involves quantifying the likelihood of each risk's eventuating and its impact on the project. Each risk is prioritized according to the likelihood and impact rating and the low, medium and high priority risks are clearly marked for attention.

Priority: The priority of each risk is derived based on the likelihood of the risk eventuating and its impact on the project. Once these scores have been allocated, the priority score is calculated as follows:

- Priority equals the average Likelihood and Impact score
- This is calculated as Priority = (Likelihood + Impact)

The Rating is based on the calculated Priority score, using the following system to determine the Rating:

Priority Score	Priority Rating	Color Code
0 – 20	Very low	Blue
21 – 40	Low	Green
41 – 60	Medium	Yellow
61 – 80	High	Orange
81 – 100	Very High	Red

Risk Register: The Risk Register includes a set of actions to be taken to avoid, transfer or mitigate each risk, based on the priority of the risk assigned. Each risk identified and documented will have a preventative action to be taken to reduce the likelihood of the risk occurring and contingent action to be taken to reduce the impact should the risk eventuate. In either situation the risk is assigned an action resource and date within which the action must be completed.

Risk Management Process: A Risk Management Process is a method by which risks to the project are formally identified, quantified and managed during the execution of the project. The process entails completing a number of actions to reduce the likelihood of occurrence and the severity of impact on each risk.

Risk Management will be undertaken on this project through the implementation of five key processes:

- Identification of project risks
- Logging and prioritizing of project risks
- Identification of risk mitigating actions
- Assignment and monitoring of risk mitigating actions
- Closure of project risks

Raise Risk	Identify the risk and complete a Risk Form and submit to the Catamaran Account Director and Account Manager
Register Risk	The Catamaran Account Director reviews the risk to determine if it impacts a deliverable, quality target, delivery target or financial target and updates the risk register accordingly
Assign Risk Actions	The Catamaran Account Director and Account Manager, along with the appropriate State personnel, review the risk based on impact and likelihood to determine whether to close the risk or establish a risk mitigation plan
Implement Risk Actions	The risk actions are implemented and may include scheduling various actions, implementation of mitigation plans, evaluating the success of the action and communicating the success of the implemented action

6.7 Relationships with Third Parties

Instructions: Describe any financial relationship between Vendor and any third party hardware, software, or other Vendors that may be used to provide services or products in connection with any phase of the PBM project, whether such third party will be used by the Vendor as a Subcontractor or contracted directly by Vermont. The Vendor shall also disclose any known or perceived conflicts of interest the Vendor or its leadership many have that would impact any phase of the project.

Response:

Catamaran has no financial relationships with third party hardware or software vendors. A subcontractor relationship does exist with the University of Massachusetts Medical School, Clinical Pharmacy Services program wherein they provide clinical call center services in support of this contract. A subcontractor relationship also exists with CaptureRx, our proposed 340B clearinghouse for this program. No known or perceived conflicts of interest exist that would impact this project.

7.0 Knowledge Transfer and Training

The Vendor must provide a narrative overview of how the proposed solution will meet the Vermont PBM Knowledge Transfer and Training requirements. The approach must, at a minimum, provide details on how the Vendor intends to meet or exceed the Knowledge Transfer

and Training Requirements set forth in Template H – Non-Functional Requirements, Tab I2 Knowledge Transfer and Training'.

Please include in the response what the Vendor believes will be an effective process for each component and flow between each of the following areas:

7.1 Change Management

Instructions: Describe what the Vendor believes to be an effective Change Management strategy and approach including providing details for a change readiness assessment, gap analysis, and recommendations for organizational and process changes.

Response:

An effective Change Management strategy and approach involves developing a comprehensive Change Management Plan with formal documentation based on the achievement of critical milestones in the project. In addition, the development of a complementary communications plan will ensure that all critical stakeholders have visibility and clearly understand the underlying plan for change. Prior to developing the Change Management Plan, we will collaboratively with the State to conduct a gap analysis, which will drive overall recommendation for process improvement and organizational change.

The Change Management Plan, developed during project implementation, provides a framework for ensuring smooth operations from the implementation phase throughout the life of the contract. The objective of the Change Management Plan is to formally document the change control processes for the comprehensive PBM program. The document addresses change control activities related to the following areas:

- Operational Change Management Overview
- Hardware Change Management
- COTS Software Change Management:
- Custom Application Software Change Management
- Documentation Change Management
- Environments
- Training.

The Change Management Process is undertaken to assure that each change introduced to the project is appropriately defined, evaluated and approved prior to implementation. Change Management will be introduced to this project through the implementation of five key processes:

1. The submission and receipt of change requests
2. The review and logging of change requests
3. The determination of the feasibility of change requests
4. The approval of change requests
5. The implementation and closure of change requests

Catamaran approaches each new project with an underlying goal of establishing a "Clients for Life" relationship. This approach enables us to view the overall process as one of establishing, maintaining and growing the overall process. One of the first project steps is establishing relationships between the Catamaran team, the State, and its vendors. This is a critical point in the long-term goal of meeting all of the contractor's responsibilities associated with any changes to the existing program; moving from the Initiation and Planning Phase to the Operations Phase in a manner that is not only smooth, but also transparent to all stakeholders.

Catamaran's Account Manager is the client's single point of contact for handling issues, from receipt to final resolution, thereby ensuring a clean and smooth method for tracking and resolving issues, during the change management process as well as throughout the life of the contract. All issues are communicated directly to the Catamaran Account Manager, and she logs them. The Catamaran Account Manager assigns the issue to the appropriate subject matter expert, monitors the progress made in addressing the issue, and upon resolution, closes the issue within the issues log. Before most issues are resolved, they are logged, tracked, maintained, and available to team members.

Escalation Procedures. Catamaran ensures the smooth and efficient delivery of our team's services and delivers exceptional customer service by basing our product and service offerings on three (3) critical elements:

- Superbly trained account, technical, service and clinical personnel
- Repeatable, standardized methodologies and processes
- Highly automated and customized solutions.

Our reporting relationships identify responsibilities, facilitate ongoing effective communication with the State, and promote efficient decision-making in responding to your needs. Our reporting relationships also emphasize extensive experience at each managerial level, facilitating rapid, knowledgeable responses to the requirements and challenges of the PBM System. We take great pride in our ability to focus resources on the unique requirements of each project organization while maintaining consistent standards of excellence. From an organizational standpoint, Catamaran's team offers the flexibility and strength necessary to meet our client's priorities and to respond quickly to our client's needs.

When an issue is identified that requires remedial action, it is communicated to the Catamaran Account Manager, and the Manager(s) of the functional unit(s) affected by or otherwise responsible, in part or full, for the resolution of the issue. The issue is then classified by severity to prioritize resources, define the height of escalation (escalation hierarchy), and determine the speed at which the problem must be resolved. The Issue Owner is responsible for updating and documenting status in Catamaran's tracking system. All personnel participating in resolution activities and providing monitoring and oversight are copied on resolution status and are charged with ongoing update review of the ticket. Catamaran's tracking system maintains object attachment to issue documentation which provides a comprehensive, living account of the issue and its status.

When an issue has been resolved, the Issue Owner is responsible for communicating the resolution status to the Catamaran Account Manager, functional unit manager(s) and monitoring executive (if escalated to that level). All notified Catamaran personnel respond with assent or disagreement that the issue should be closed. Objections are addressed until the parties agree on closed status; at this point client is notified of the closed status of the issue. If client staff

objects to the closing of the issue, Catamaran staff addresses the objections and resubmits the recommendation for closure until the client agrees to closed status for the issue.

Approach to Performing Updates to the Software. Catamaran maintains a single code base across our customers. This construct allows us make software improvements and roll these out to everyone. We provide periodic (every two months) system updates to keep the software compliant with regulations. An example of this would be the recent changes in implemented for D.0. Catamaran was the first vendor in the industry to be D.0 compliant.

Changes in software to keep current with reimbursement methodologies are part of our Research & Development (R&D) effort, and these updates are made available to our customer base. Almost all of these policy changes can be made through configuration and plan changes in the software and do not require development support. However, an example of a recent modification was to update the software to remain complaint with certain mandates under Health Care Reform. Our R&D team continually ensures that the system does not become obsolete or de-supported. In order to remain competitive in the market, Catamaran continually updates its software to remain technologically competitive. For instance, Catamaran was one of the first vendors to institute Web services in its technology.

7.2 Knowledge Transfer

Instructions: Describe what the Vendor believes to be an effective Knowledge Transfer strategy and approach including describing the approach for bringing managers, end users, and technical personnel to an appropriate level of understanding of the State's solution.

Response:

Catamaran develops custom training programs for every contract, including the State of Vermont. In order to ensure that the appropriate knowledge and skill sets are developed in a targeted and timely manner, Catamaran will work with the State to identify not only the roles that require technical training, but the individual skills and tasks that must be performed by the various roles in the State on a day-to-day basis. By establishing this framework, Catamaran will create a targeted training program to ensure maximum knowledge transfer of the information and skills that are needed to those individuals who need them. The program will include training curricula and materials for every component of our RxClaim Suite, each internal and State role supporting the contract, and the provider community.

Catamaran utilizes a blended learning solution that combines instructor-led, Web-based, and print content to ensure maximum knowledge transfer and retention. Training will be provided to all entities specified by the State both initially and on an ongoing basis throughout the contract term. In addition, we will facilitate onsite system training and knowledge transfer for State as deemed necessary by the State. The training team will utilize post training testing and participant surveys to assess the quality of the training program. This information will be used to improve the training format and content as necessary and to provide feedback for the trainers.

A Knowledge Transfer and Training Plan will be developed and will include:

- Training goals to address both pre-implementation and project life training needs
- The specific plan for the State's technical and end user training
- Individual Role training

- Tasks, deliverables and resources necessary for a successfully executed and completed training plan
- Tools and documentation to support training effort
- Training Types, the courses and course materials, the training approach for both technical and end-users
- Post-Training Testing and Participant Survey plan

7.3 Training Strategy and Approach

Instructions: Describe what the Vendor believes to be an effective Training strategy and approach and what user and technical training the Vendor would recommend to the State. Include the training of State personnel who will work on the project, as well as users, executives and support staff. Describe how State and partner users will be trained. Describe how State IT staff will be provided technical training to ensure required technical capabilities to support the maintenance and operations needs of interfaces with the new System. Include the method of training for each of these classifications of individuals, an approximation of the number to be trained, estimated duration of each component of the training program, and the method to be used to ensure that the training was successful.

Response:

Given the importance that training plays in achieving a smooth transition, Catamaran places an emphasis on not only deploying an effective approach, but also assigning quality staff with the appropriate skill sets and qualifications. Tantamount to quality of the staff is an approach in which we recognize the importance of establishing the appropriate working relationships between Catamaran and State personnel and ensuring that communication is organized and efficient. Catamaran will develop a Training Plan focused on identifying the specific training-related needs of the State in order to prepare both the State and Catamaran staff for the project implementation and operations.

Catamaran's dedicated training department will provide a comprehensive array of training services tailored to meet the State's requirements. Catamaran Trainers and the State will hand select the curriculum from the extensive catalog of Catamaran training materials, which are kept up to date with every new product release. This customized curriculum for State users will be executed during the project's User Acceptance Testing phase, allowing for a smooth transition from User Acceptance Testing to the Operational Readiness Assessment phases.

Acceptance of the new work environment depends upon the success of training. The higher the user's confidence in using the new system, the faster the individual learns new skills. The first goal in Catamaran's initial training is a careful analysis of State staff training needs. We want to have a thorough understanding of where we are starting as we launch the program. The training needs analysis is the start of the training plan, pointing out the gaps between current knowledge and needed information. In the course of developing the Training Plan, we conduct a detailed training needs assessment.

A Training Plan will be developed and will include:

- Training goals to address both pre-implementation and project life training needs
- The specific plan for the State's technical and end user training
- Individual Role training

- Tasks, deliverables and resources necessary for a successfully executed and completed training plan
- Tools and documentation to support training effort
- Training Types, the courses and course materials, the training approach for both technical and end-users
- Post-Training Testing and Participant Survey plan

Each discipline includes training categories that require participants to document the purpose, delivery method(s), and outcome(s) of each category. Catamaran assesses the training needs of each of the following categories:

- Core System Training
- Project-Specific Process Training
- User Training – Overviews
- User Training – Administration Level
- State Team Acceptance Test Preparation

The method of delivery and the content and duration of each scheduled training session will coincide with the specific needs of each of the roles and categories listed above. System overview training is typically provided as a core component of any end-user training program on the RxClaim suite of applications. Depending on the depth of information required, these sessions may be scheduled via webinar or, as is the case with more intensive training requirements, as part of an onsite training program at a location and time mutually agreed upon by Catamaran and the State. System overview training, recommended for all roles connected to the RxClaim suite of applications, is typically one to two hours in duration, with longer timeframes, from two to four hours up to one business day, required for more in-depth training on topics and tasks connected to specific job functions. A custom curriculum and schedule will be determined by Catamaran in conjunction with the training needs assessment discussion with the State, and may involve multiple sessions of varying timeframes to ensure the appropriate information and skills are conveyed in a timely manner to the various roles of the State.

Catamaran's training team understands the need for flexibility with regard to the scheduling of training sessions, and any sessions scheduled with the State will correspond with the needs and availability of resources. Multiple webinar or classroom sessions will be offered if needed to ensure adequate floor coverage and continuity of work.

Catamaran will be responsible for the operation of the PBM solution and the curriculum for the State is designed to meet the particular needs of State staff. The curriculum is typically divided into a general RxClaim GUI system overview and more specific training on RxClaim and RxMax. RxClaim training will be the most critical and complex aspect of the training process for State users. Catamaran Training Resources are responsible for developing all materials necessary for training. The Catamaran operations staff will work with the State to identify specific and/or focused training needs of the State staff.

Catamaran creates the documents and materials outlined in the following table.

Document Name	Description
User Manual	Comprehensive user manual which is a base reference resource for systems functionality
User Syllabus & Curriculum	Outline of training content, learning objectives and agenda
User Training Guide	Text, presentation handouts, and screen shots with material for didactic and practical training
User Summary Exam	Survey quiz to assess level of information uptake by attendees

8.0 Testing and Validation

Instructions: Describe what the Vendor believes to be an effective Testing strategy and approach to ensure that the system is functioning and processing the data correctly. This plan should at a minimum address the end-to-end application testing, stress tests, performance tests, UAT and FAT tests to assure that the solution will meet performance requirements under expected user loads, backup and recovery testing and installation testing. The approach must, at a minimum, provide details on how the Vendor intends to meet or exceed the Testing and Validation Requirements set forth in Template H – Non-Functional Requirements, Tab I3 Testing and Validation'.

Response:

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The purpose of testing is to provide assurance that Catamaran's systems are operational and function in accordance with State requirements. A successful test program is built on a solid foundation of tried and true testing principles and processes. The two main building blocks used in the foundation of the Vermont test program are test plans and test cases. These key components maximize re-use of previously built building blocks for each successive testing phase.

We define the test plan as systematic approach to testing a software system. Catamaran's test plan has three primary components.

Unit Testing – The activities surrounding the testing of individual units of source code to determine if they are fit for use.

System Testing – A plan for all systems to describe the test approach and process for individual system testing and the test approach and process for testing the entire program functionality to ensure all systems work correctly as a whole. Catamaran focuses on the testing of all system functions for their completeness and accuracy, ensuring proper process flow and data manipulation.

User Acceptance Testing (UAT) – A plan to describe the business function and end-to-end testing across all systems. This component of the test plan is developed by Catamaran in collaboration with the State. UAT is designed to ensure that all Vermont PBM functions are tested by users, including but not limited to, proper functioning of edits, audits, and

business rules; the accuracy of claim records and file maintenance; and the format and content of all system outputs, including outputs from reporting functions.

In addition to these elements of the test plan, Catamaran develops and maintains a Requirements Traceability Matrix (RTM). This matrix shows linkages between the requirements, use cases, and test cases. When completed, the RTM becomes the basis for verifying the requirements from the RFP and business processes, to the general design, and to the associated test cases.

Once the products and/or enhancements are installed, new interface development has been completed, and system configuration has occurred, the Catamaran project team initiates System Testing. It is here that Catamaran verifies system functionality and confirms data, query, and report capabilities. In this section, Catamaran describes our approach to this phase, the resources applied, the testing tools, and the expected periods for the phase. Catamaran also provides examples of typical test scenarios and the process for test error correction.

In System Testing, Catamaran performs integration testing and validation of the interfaces between RxClaim Suite and the current MMIS. Although the portfolio of interfaces used by RxClaim Suite spans more than just the PBM to MMIS transactions, only newly constructed interfaces built as a part of this project and integration are tested as part of the overall System Testing effort. It is presumed that existing COTS interfaces (i.e. MediSpan, CMS) have been tested before becoming part of the production product. Data transmitted over the interfaces for System Testing is included as part of the System Test results. Testing is performed collaboratively by Catamaran and the State to verify that the data was successfully processed by both systems (end-to-end).

Having established that interfaces are functioning properly, a number of test cases are developed to test end-to-end scenarios, which would exercise one or more interfaces, data sets, and transaction verifications from eligibility, to claims processing and payment.

The approach to integration testing minimally requires validated converted data to populate RxClaim Suite with legacy data. Additionally, the Test strategy leverages test case scenarios from earlier testing phases. Converted claims are ineligible for use on end-to-end tests, as they have been processed previously on the legacy system and would fail to generate payment. This scenario is executed at least once as a negative test case to ensure that legacy claims fail to create payment a second time.

System Modification Testing

Catamaran also conducts comprehensive testing on each release of a system modification. A comprehensive quality assurance process is utilized to test and accept new code as functional. We will schedule releases for the Vermont environments such that additional State testing can be performed, if required, in the Vermont test system. Once a release becomes available, it will be scheduled for installation in the Vermont test environment.

Reporting

Catamaran produces summary reports of testing progress and errors discovered during the system test level. The test reports are distributed according to the Test Plan. The test results that are collected through system test execution contain both the test cases and the corresponding evidence that was collected during execution. Should any invalid results or errors be identified, the team lead follows Catamaran's corrective action process to document and

tracks this through to resolution. Test cases are included and documented as part of the RTM to provide documentation that requirements are not only documented, but tested and validated.

Once testing is completed and all tests are passed without errors, Catamaran packages the Test Results Deliverable for final approval. As part of this package, Catamaran provides test output reports. Often, these reports are in the form of claims adjudication detail and file load reports.

Defects

As defects may be discovered during the System Test Phase, Catamaran implements a standardized corrective action tracking and resolution process. Defects may be identified by the Catamaran test team as tests are executed. Defects may be identified when:

- Actual results do not correspond to expected results described in the test cases
- Processing events do not correspond with what is described in the Design Documents
- Other errors are found such as field mapping and validation, incorrect error conditions, and usability issues
- Insufficient evidence is gathered during test review
- Test cases are not fully executed

Upon discovery of a defect during test, the defect is described and documented in the Testing Defect Log. The log is a status report that is delivered at the end of each test cycle during the testing process, as agreed upon by Catamaran and the State. The report also contains results of the QA effort and identifies defects. The process for documenting, tracking, resolving and retesting identified corrective actions are included in the System Test Strategy document. Reports are generated to show the status of each defect and its associated resolution.

User Acceptance Testing

The User Acceptance Testing (UAT) phase is designed to achieve two high level outcomes, Training State staff and demonstrating that RxClaim Suite enhancements meet State specifications by performing all processes correctly and passing acceptance criteria identified during the Requirements Analysis phase. UAT is driven by the Training and Test Plans, developed by the State and Catamaran and executed within the UAT environment.

UAT is designed to ensure that all pharmacy application functions are tested by trained users including: proper functioning of edits, audits and business rules, the accuracy of claim records, payment and file maintenance, and the format and content of all system outputs. UAT also offers the opportunity to test User Manuals, forms, procedures, and business processes. During this phase, all subsystems and modules are tested. UAT is conducted in a controlled and stable environment. These tests may utilize all of, or select parts of, the preliminary converted files.

During the UAT phase, Catamaran also demonstrates the performance of the enhanced RxClaim Suite to the State, as a precursor to operational readiness. Together with State staff, the Catamaran Technical Lead and Systems Architect outline the specific tests required and performance metrics for each test area, essentially forming the acceptance criteria. As part of the development of the overall testing strategy, Catamaran and the State fully document UAT responsibilities. Generally, UAT cases are developed by the user (i.e. the State) although Catamaran does maintain a library of test cases, which may be used.

Parallel Testing

Parallel Testing compares the execution of business processing on an existing operational or controlled test version of the legacy Catamaran solution against the enhanced version of the solution, in order to demonstrate functional and business processing equivalence between the current and future solution versions. Parallel testing uses the Trial Claim feature of RxClaim to re-process loaded production history claims in test mode. The results are then compared to the actual results of the historical claim sample set. To obtain the best result, complete claims history, plan configuration, provider network, PA conversion, and eligibility information are loaded in the system up to the point in time selected for the sample size. Any differences in outputs or results between the current and future solution must be explicable in terms of differences in inputs or processing instructions between the two (2) solution versions.

- With parallel testing, Catamaran is able to assess the following factors:
- Claims that paid in the Legacy Catamaran VT processing environment and not in the new dedicated Catamaran VT environment
- Claims that paid in the new dedicated Catamaran VT environment but rejected in the Legacy Catamaran VT processing environment
- Claims that rejected for different reasons between the new Catamaran VT environment and the Legacy Catamaran VT processing environment
- Claims that paid differently in two environments (legacy Catamaran VT system and enhanced Catamaran VT system)

The objective of Parallel Testing is to verify that the enhanced solution produces consistent results when compared to the legacy system and that any variance in results can be explained.

9.0 Data Conversion and Migration

The Vendor must provide a narrative overview of how the proposed solution will meet the Vermont PBM Data Conversion and Migration requirements. The approach must, at a minimum, provide details on how the Vendor intends to meet or exceed the Data Conversion and Migration Requirements set forth in Template H – Non-Functional Requirements, Tab I4 Data Conversion and Migration' and describe the approach in the following sections:

9.1 Data Conversion Strategy, Approach and Timeline

Instructions: Describe what the Vendor believes to be an effective Data conversion strategy and approach for supporting migration of data from the current System(s) to the proposed solution. Describe how the Vendor will ensure data integrity and consistency through all phases of the project.

Response:

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The proposed Catamaran data conversion approach is mature, experience-tested and includes standardized procedures and operational systems that have been modified to accommodate the client's processes and extant systems. This approach is modified to account for the unique situation where Catamaran is the incumbent. Catamaran proposes a dedicated Vermont RxClaim environment to meet the requirements of this solicitation The environment is essentially DHVA's own instance of RxClaim containing the same code base and physical

database structure as the current system. Core system data such as claims, Prior Authorizations, MAC pricing are moved from the current environment to the dedicated environment without the traditional intensified development effort required to accurately transform, load and scrub the data. With mirrored source and target data structures, the overall data conversion risk is considerably minimized for the State.

A need still exists, however, for conversion of data sets not currently owned by Catamaran. After evaluating the RFP and the current environment, Catamaran believes that data conversion activities will need to take place for the following business areas:

- Federal rebates
- Medical claims (Physician Administered Drugs Management)
- 340B payment reconciliation

The proposed approach to data conversion of new data sets consists of the following subtasks and activities:

Planning

We develop and deliver a detailed Data Conversion Plan (DCP) in collaboration with client, which includes the following:

- Conversion processes, including associated stages, tasks, activities, ownership, and deliverables with interdependencies with other development methodology processes for the rest of the system.
- Conversion procedures describing how each task and activity to be performed.
- The use of conversion tools. Catamaran leverages our experience and tools based upon similar conversion efforts in other states
- A description of how the master list of legacy data files is created and maintained. This master list identifies data in the legacy source environment, which contains important information such as:
- Source of the data (legacy feed, legacy program data, non-legacy external data source, future data entry, manual data conversion)
- Flow of the data
- Format (i.e., flat positional data, structured extract, unstructured extract) and storage
- Manual data plans with a strategy and detailed process on how the manual data is converted
- Data Conversion execution plan describing how the tasks and activities are carried out
- Proposed Data Conversion Production Timeline including day-by-day cutover activities.

The Data Plan is developed early in the project lifecycle and is completed at the beginning of the Requirements Validation Task.

Data conversion specifications and mapping must begin with a thorough analysis of the data conversion requirements. This analysis is conducted in parallel and integrated with the client business process area requirements validation sessions.

The data conversion analysis is performed in collaboration with the client technical team and begins with data identification. Data identification includes the development of a list of input and output files, development and collaborative review of the legacy feed list, and a review of the legacy data dictionary and layouts. Once data identification is completed for each business process area, Catamaran's data conversion team develops the analysis including:

- Identify all data requirements and source data
- Unique key field identification
- Identify key relationships in and out of the feed
- Establish loading order.

After the analysis has been completed, our data conversion team conducts a high level gap analysis on the data model, which includes a gap analysis of key entities and relationships with other entities. The resulting analysis is shared with client in order for client to assist in developing the data cleansing rules.

Once the data conversion analysis is complete for each of the business process areas, the Catamaran data conversion team works collaboratively with the client to develop the conversion specifications and mapping documentation which includes:

- Conducting legacy data definition
- Developing target table sequential hierarchy
- Performing target mapping
- Conducting a structured walkthroughs with client
- Finalize the draft conversion specifications and mapping document and submit to client.

Catamaran documents the final data conversion decisions, field inclusion and exclusion information, and data mapping decisions in the DCP.

Development

At each step in the data Extraction, Transformation and Load (ETL) process, Catamaran conducts quality checks to ensure the accuracy of converted data against source data and the transformation rules. In addition to statistically significant sample size audits to check for outcomes violations on various data elements, Catamaran verifies count balances at the file and table levels and performs unit and system testing for conversion and load programs. All significant process documentation and deliverables are submitted to client for review and approval according to the schedule given in the project work plan and the DCP.

The Catamaran DCP relies upon the following key assumptions:

- That the DCP be followed faithfully and that deviations be kept to a minimum – but with the acknowledgement that situations might arise, where business needs dictate, that workarounds to standard practice might be necessary
- That client and/or other vendor(s) provides knowledgeable staff who understand the legacy data, its definition, business use and sources
- That a patent, working relationship between Catamaran staff, vendor staff, and client task charged with data conversion activities is established

- That communications and the relationship with the existing contractor receive client oversight to ensure tasks and activities are occurring according to schedule and plan
- That knowledge transfer of data definitions and business use is accurate and comprehensive
- That client provides necessary extracts and data documentation as early as practicable so that Catamaran can evaluate the quality of the data and begin data conversion tasks
- Client-assigned staff is available to respond to questions and issues and respond in a reasonable timeframe.

DCP Execution

Execution of the DCP commences with the Plan's approval. Catamaran focuses on the appropriate source and business rules for converting the data, the tracking of the input and output record counts and ensure the inclusion of client staff to review the process.

Conversion

The conversion process consists of the physical transformation of data from source files to populate flat staging files that are in turn used to load systems tables. The process for the transformation varies by file type.

Data Loading

Upon completion of the conversion/transformation phase, data is ready to be moved to the system database. Loading the converted data from the flat files into the system database consists of a running the files through a set of utilities and standard batch programs to load the data into test and production tables.

In the case of claims detail data, the standard interface is the current NCPDP batch standard. The loading process actually re-adjudicates the claim while default conversion parameters are set in the system to make sure the claim is either paid or rejected as it was in history. Additional post processes ensure that the calculated data from the legacy claim record are subsequently applied. Calculated pricing, reject detail, date fields, and other legacy data are updated on the loaded claims during this post process ensuring that each claim is exactly like it appears in the legacy system.

Data is validated before it is loaded and verified by the conversion team and client after it is loaded. Once the appropriate sources have been loaded, it is important to create processes that count the records and fields in the input file as well as those that are loaded to the target system. These record and field counts can then be balanced to ensure that no data was excluded during the loading process. Once the data is loaded, Catamaran personnel perform further data integrity checks. These checks ensure that the newly loaded data is correctly displayed for the user (e.g., that each data record is displayed in the proper fields on the screen and that the data values are within the correct validation range).

Validation, Testing and, Approval

Testing the converted data is an important activity of data conversion. At each step in the data transformation and load process, Catamaran conducts quality checks to ensure the accuracy of converted data against source data and the transformation rules. In addition to statistically significant sample size audits to check for outcomes violations on various data elements,

Catamaran verifies count balances at the file and table level and performs unit and system testing for conversion and load programs. All subtasks and deliverables related to conversion testing are identified in the work plan and are addressed in the DCP. The DCP addresses:

- Development and execution of unit and system testing for all conversion and load programs
- Quality check procedures
- Post conversion data testing and auditing
- Objective pass/fail criteria
- Conversion Test Results Document.

The converted data, a result of the conversion process, based on mapping specifications, is tested for the following:

- Is the entire set of mapping rules defined in the mapping specifications document incorporated?
- Does the converted data follow the data structure model of the target systems?
- Are all the fields mapped from the current system converted according to the approved mapping rules?
- Are all target system constraints met or is there is any risk of data load rejections?
- Do record counts balance in both the source and target systems?

Catamaran works with the State to develop objective criteria that are used to determine if the conversion is successful.

- These criteria are used to evaluate the consistency and integrity of the data after it is converted into the production system, while enabling client to make an approval decision relating to the conversion.
- This is followed by testing a statistically valid sample of converted data elements.
- The procedures include the documentation of results and the development of an issues log for any discrepancies revealed by the audit.
- Catamaran presents audit findings to the State, proposes resolutions, and ranks the criticality of any finding from the audit.

Upon completion of testing, Catamaran submits a conversion test report that includes the result of the complete final data conversion process. Items included in the conversion test report include:

- Test results including issues encountered and the impact upon other table or file conversions
- Methods used to resolve issues or an action plan for resolving outstanding issues
- Pre-conversion and post-conversion versions of each table or file converted, including default values
- Pre-conversion and post-conversion versions of all interface partner files

- Auto-generated reports as required by client to validate converted data at detail and summary record levels
- A summary and metrics for the status of the conversions.

9.2 Data Transition Strategy, Approach and Timeline

Instructions: Describe what the Vendor believes to be an effective Data transition strategy and approach during the roll-over of data from the current System(s) to the proposed solution.

Response:

The proposed Catamaran data conversion approach is mature, experience-tested and includes standardized procedures and operational systems that have been modified to accommodate the client's processes and extant systems. This approach is modified to account for the unique situation where Catamaran is the incumbent. Catamaran proposes a dedicated Vermont RxClaim environment to meet the requirements of this solicitation. The environment is essentially the State's own instance of RxClaim containing the same code base and physical database structure as the current system. Core system data such as claims, Prior Authorizations, MAC pricing are moved from the current environment to the dedicated environment without the traditional intensified development effort required to accurately transform, load and scrub the data. With mirrored source and target data structures, the overall data conversion risk is considerably minimized for the State.

A need still exists, however, for conversion of data sets not currently owned by Catamaran. After evaluating the RFP and the current environment, Catamaran believes that data conversion activities will need to take place for the following business areas:

- Federal rebates
- Medical claims (Physician Administered Drugs Management)
- 340B payment reconciliation

The proposed approach to data conversion of new data sets consists of the following subtasks and activities:

Planning

We develop and deliver a detailed Data Conversion Plan (DCP) in collaboration with client, which includes the following:

- Conversion processes, including associated stages, tasks, activities, ownership, and deliverables with interdependencies with other development methodology processes for the rest of the system.
- Conversion procedures describing how each task and activity to be performed.
- The use of conversion tools. Catamaran leverages our experience and tools based upon similar conversion efforts in other states
- A description of how the master list of legacy data files is created and maintained. This master list identifies data in the legacy source environment, which contains important information such as:

Source of the data (legacy feed, legacy program data, non-legacy external data source, future data entry, manual data conversion)

Flow of the data

Format (i.e., flat positional data, structured extract, unstructured extract) and storage

- Manual data plans with a strategy and detailed process on how the manual data is converted
- Data Conversion execution plan describing how the tasks and activities are carried out
- Proposed Data Conversion Production Timeline including day-by-day cutover activities.

The Data Plan is developed early in the project lifecycle and is completed at the beginning of the Requirements Validation Task.

Data conversion specifications and mapping must begin with a thorough analysis of the data conversion requirements. This analysis is conducted in parallel and integrated with the client business process area requirements validation sessions.

The data conversion analysis is performed in collaboration with the client technical team and begins with data identification. Data identification includes the development of a list of input and output files, development and collaborative review of the legacy feed list, and a review of the legacy data dictionary and layouts. Once data identification is completed for each business process area, Catamaran's data conversion team develops the analysis including:

- Identify all data requirements and source data
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After the analysis has been completed, our data conversion team conducts a high level gap analysis on the data model, which includes a gap analysis of key entities and relationships with other entities. The resulting analysis is shared with client in order for client to assist in developing the data cleansing rules.

Once the data conversion analysis is complete for each of the business process areas, the Catamaran data conversion team works collaboratively with the client to develop the conversion specifications and mapping documentation, which includes:

- Conducting legacy data definition
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- Performing target mapping
- Conducting a structured walkthroughs with client
- Finalize the draft conversion specifications and mapping document and submit to client.

Catamaran documents the final data conversion decisions, field inclusion and exclusion information, and data mapping decisions in the DCP.

Development

At each step in the data Extraction, Transformation and Load (ETL) process, Catamaran conducts quality checks to ensure the accuracy of converted data against source data and the transformation rules. In addition to statistically significant sample size audits to check for outcomes violations on various data elements, Catamaran verifies count balances at the file and table levels and performs unit and system testing for conversion and load programs. All significant process documentation and deliverables are submitted to client for review and approval according to the schedule given in the project work plan and the DCP.

The Catamaran DCP relies upon the following key assumptions:

- That the DCP be followed faithfully and that deviations be kept to a minimum – but with the acknowledgement that situations might arise, where business needs dictate, that workarounds to standard practice might be necessary
- That client and/or other vendor(s) provides knowledgeable staff who understand the legacy data, its definition, business use and sources
- That a patent, working relationship between Catamaran staff, vendor staff, and client task charged with data conversion activities is established
- That communications and the relationship with the existing contractor receive client oversight to ensure tasks and activities are occurring according to schedule and plan
- That knowledge transfer of data definitions and business use is accurate and comprehensive
- That client provides necessary extracts and data documentation as early as practicable so that Catamaran can evaluate the quality of the data and begin data conversion tasks
- Client-assigned staff is available to respond to questions and issues and respond in a reasonable timeframe.

DCP Execution

Execution of the DCP commences with the Plan's approval. Catamaran focuses on the appropriate source and business rules for converting the data, the tracking of the input and output record counts and ensure the inclusion of client staff to review the process.

Conversion

The conversion process consists of the physical transformation of data from source files to populate flat staging files that are in turn used to load systems tables. The process for the transformation varies by file type.

Data Loading

Upon completion of the conversion/transformation phase, data is ready to be moved to the system database. Loading the converted data from the flat files into the system database consists of a running the files through a set of utilities and standard batch programs to load the data into test and production tables.

In the case of claims detail data, the standard interface is the current NCPDP batch standard. The loading process actually re-adjudicates the claim while default conversion parameters are set in the system to make sure the claim is either paid or rejected as it was in history. Additional post processes ensure that the calculated data from the legacy claim record are subsequently

applied. Calculated pricing, reject detail, date fields, and other legacy data are updated on the loaded claims during this post process ensuring that each claim is exactly as it appears in the legacy system.

Data is validated before it is loaded and verified by the conversion team and client after it is loaded. Once the appropriate sources have been loaded, it is important to create processes that count the records and fields in the input file as well as those that are loaded to the target system. These record and field counts can then be balanced to ensure that no data was excluded during the loading process. Once the data is loaded, Catamaran personnel perform further data integrity checks. These checks ensure that the newly loaded data is correctly displayed for the user (e.g., that each data record is displayed in the proper fields on the screen and that the data values are within the correct validation range).

Validation, Testing and, Approval

Testing the converted data is an important activity of data conversion. At each step in the data transformation and load process, Catamaran conducts quality checks to ensure the accuracy of converted data against source data and the transformation rules. In addition to statistically significant sample size audits to check for outcomes violations on various data elements, Catamaran verifies count balances at the file and table level and performs unit and system testing for conversion and load programs. All subtasks and deliverables related to conversion testing are identified in the work plan and are addressed in the DCP. The DCP addresses:

- Development and execution of unit and system testing for all conversion and load programs
- Quality check procedures
- Post conversion data testing and auditing
- Objective pass/fail criteria
- Conversion Test Results Document.

The converted data, a result of the conversion process, based on mapping specifications, is tested for the following:

- Is the entire set of mapping rules defined in the mapping specifications document incorporated?
- Does the converted data follow the data structure model of the target systems?
- Are all the fields mapped from the current system converted according to the approved mapping rules?
- Are all target system constraints met or is there is any risk of data load rejections?
- Do record counts balance in both the source and target systems?

Catamaran works with the State to develop objective criteria that are used to determine if the conversion is successful.

- These criteria are used to evaluate the consistency and integrity of the data after it is converted into the production system, while enabling client to make an approval decision relating to the conversion.
- This is followed by testing a statistically valid sample of converted data elements.

- The procedures include the documentation of results and the development of an issues log for any discrepancies revealed by the audit.
- Catamaran presents audit findings to the State, proposes resolutions, and ranks the criticality of any finding from the audit.

Upon completion of testing, Catamaran submits a conversion test report that includes the result of the complete final data conversion process. Items included in the conversion test report include:

- Test results including issues encountered and the impact upon other table or file conversions
- Methods used to resolve issues or an action plan for resolving outstanding issues
- Pre-conversion and post-conversion versions of each table or file converted, including default values
- Pre-conversion and post-conversion versions of all interface partner files
- Auto-generated reports as required by client to validate converted data at detail and summary record levels
- A summary and metrics for the status of the conversions.

9.3 Implementation/Rollout Planning

Instructions: Describe the Vendor's methodology, tools, and techniques for implementation/rollout planning. What specific staging, readiness and deployment techniques will the Vendor use to determine the proper phasing and sequencing of deployment processes and functions required for successful implementation?

Response:

The Implementation and Rollout phase ensures that all operational tasks for each functional area have been tested and reviewed by the State and Catamaran, including proper functioning of edits, audits, and business rules, the accuracy of claim processing, and the format and content of all system inputs and outputs, including outputs from reporting functions. The Readiness Review conducted with the State also offers the opportunity to perform a final validation of User Manuals, forms, procedures and business processes. Specific test cases within the acceptance test plan are linked back to requirements through the Requirements Traceability Matrix (RTM) to document complete requirements coverage throughout the plan.

The time-periods immediately preceding and following claims processing cutover represent some of the most critical and intense project periods for both the State and Catamaran project team members. Even though Catamaran is the incumbent vendor, there are elements of data that are new and it is imperative that all parties are actively engaged and that an open line of communication is maintained to ensure a smooth cut-over. The timing of final file transfers as well as messaging back to providers requires coordination among all parties. Prior to cut-over and driven from the cut-over plan, Catamaran frequently reviews the project status with the State (daily if needed), to ensure that the transition goes smoothly. Coordination with the State, operations tasks, conversion tasks, final provider communication, switch readiness confirmation, and final configuration tasks are just a subset of what is covered in the Cutover Plan.

Catamaran understands the critical objective of confirming system and operational readiness prior to go-live. Special attention is given to ensure all project stakeholders understand how implementation success criteria are established, how implementation activities are reviewed and reported, and what timetables are outlined for this phase.

In addition, Catamaran provides coordination with the State before, during, and after this project phase to make sure that go-live activities are executed as planned. Plans for meeting times to cover operational transition activities, down to the hour and minute, are reviewed and documented during this phase. The Implementation Checklist developed by Catamaran is the primary reference document used during this period to track the detailed hour-by-hour tasks required for cutover. Processing cut-over time, file delivery time, operations cut-over, and paper claims transition cutoff are but just a few of the areas managed by the Catamaran Project team from the implementation checklist.

The State is supported by all parts of our organization including software development, network services, operations, member and provider services, quality assurance, business analysis, and clinical services. Our organizational structure is designed to meet specific objectives, providing for efficient service delivery whether during development, implementation, or ongoing operations. Our team is structured to address the depth, breadth, and complexity of this project, from its inception through operations.

Catamaran understands the importance of seamless continuity between the implementation phase and the operations phase within the contract period. The hard work, attention to detail, and momentum built during the implementation period by both the State and Catamaran are carried forward during the operations phase of the contract, thus avoiding gaps in service quality.

After cut-over and during the post implementation support, the implementation team prepares to complete the closeout portion of the project. During this project phase, the following summary level tasks are completed:

- Distribute lessons learned survey
- Compile results and perform lessons learned review meeting
- Archive project artifacts and catalog them in a secure network location
- Review project deliverables and milestones for completeness
- Obtain State signoff that the project or tasks has been completed

10.0 Quality Management

Instructions: Describe the Vendor's quality assurance practices as well as how the Vendor incorporates each customer's unique requirements. The response shall describe the Vendor's internal quality management program referencing the use of any specific methodologies. The approach must, at a minimum, provide details on how the Vendor intends to meet or exceed the Quality Management Requirements set forth in Template H – Non-Functional Requirements, Tab I5 Quality Management Requirements'.

Response:

As we indicated in Template G, quality is a top priority for Catamaran. Our organization has received PBM and Specialty URAC accreditations. As such, we follow the high standards and guidelines offered by URAC with respect to quality improvement. We have instituted a Quality

Assurance Executive Committee (QAEC), which regularly meets to review performance and provide guidance on quality management priorities and projects. The committee consists of the company's chairman and chief executive officer as well as executive and senior vice presidents and vice presidents. The QAEC reviews input from clients, providers, beneficiaries and other stakeholders; provides guidance to our management and staff on quality priorities and projects; and assesses our performance toward meeting objectives for customer satisfaction, URAC compliance, and continuous improvement activities.

In this section, we address the specific quality management requirements specified in Template H. Please refer to Template G for a complete overview of our quality management program.

Develop a Quality Management Plan

Quality Management is core to Catamaran's project management methodology, and extends beyond the efforts to simply inspect work already completed. Quality is built into all efforts associated with planning, executing, monitoring and controlling the project. Upon contract award, Catamaran works collaboratively with the State to redesign the program's Quality Management Plan to incorporate all new components of the project scope, requirements and service level agreements. The plan will consist of at least the following:

- Process for the State and Catamaran to ensure consistency between the State's requirements, the project plan and the project outcomes and deliverables
- A Requirements Traceability Matrix (RTM) that shows linkages between the requirements, use cases, and test cases that when completed, becomes the basis for verifying the requirements from the RFP and business processes, to the general design, and to the associated test cases
- A refined defect tracking and issue resolution process that documents resulting program or system changes
- Defined metrics for assessing all aspects of the projects success and includes process and deliverable oversight of all subcontractors
- Defined Catamaran organizational structure with clearly defined accountability for program quality

State Review of Quality Processes and Procedures

As indicate above, Catamaran works collaboratively with the State the design and implementation of the program's Quality Management Plan. This includes State review and approval of all processes and procedures relative to the integrity of all project related data managed by Catamaran.

Test Environments

Catamaran intends to establish separate production and test environments for Vermont. These environments hold the benefit plan designs and all other components used to control claim adjudications, payment, reporting and all other related processing. The test environment references the production environment and provides the ability to conduct various forms of process validation and data manipulation without modifying or compromising the production environment. In the test environment, configuration and other data are periodically refreshed so that the best possible simulations and scenarios can be performed on changes mirroring what outcomes would occur in an actual production environment. The test environment supports much of the same type of activity for post-implementation and ongoing activities.

Test Results

Catamaran employs an all-inclusive test plan that leverages its most comprehensive testing technologies, methodologies and resources. During the implementation process, each system is tested rigorously and must pass our quality assurance testing and undergo a formal user signoff before the code is migrated to the production system. The State is an integral part of all testing processes. Test tracking is critical to show testing progress and to identify areas where issues may be impacting the schedule. Catamaran supports the documentation of all test results as an output of the acceptance testing process. The complete acceptance test results are compiled within one single deliverable document for the State's review and approval. Catamaran also archives all test results to be used for future testing and implementation of program initiatives.

Validate and Document Internal Systems

Catamaran staff works with the State and its other contractors to ensure accurate mapping of data in and out of our claims processing system. We work with all contractors to develop a comprehensive workflow process for file transfers, beginning with thorough documentation of file content requirements, transfer protocols, and data load schedules. We also coordinate quality assurance activities including file balancing and exception reporting. At each step in the data transformation and load process, Catamaran conducts quality checks to ensure the accuracy of converted data against source data and the transformation rules. In addition to statistically significant sample size audits to check for outcomes violations on various data elements, Catamaran verifies count balances at the file and table level and performs unit and system testing for conversion and load programs.

Compliance with CMS, State, and Department Quality Programs

Catamaran ensures the organization is and remains compliant with all CMS, State, and Department quality assurance programs. Our organization is SOX (Sarbanes Oxley) 404 compliant; therefore, an independent auditing firm attests that our internal quality control processes and systems are effective and satisfactory. We also have received a SSAE 16/SOC 1, Type II report related to our pharmacy claims processing services audited by an independent CPA firm. In addition, our internal audit team is responsible for the continuous testing the design and operating effectiveness of key internal controls for compliance. This process occurs throughout the year and includes planning, risk assessment, testing, reporting results, and issue resolution.

Internal Quality Control Procedures

Catamaran has policies and procedures in place to ensure the functionality and integrity of the data we maintain. These policies and procedures cover every aspect of data integrity and range from network usage, including the mandatory encryption of any PHI that is transmitted into or out of the Catamaran offices using any public network; to our network intrusion detection systems; to the encryption of electronic mail; to the controlled access to the production system. We do not allow generic or non-specific User IDs. Audit fields on each table in the database are used to track modifications. These fields include the time and date of a database change and the User ID of the party who made the change. Catamaran also keeps system journals for nine weeks so that all database changes can be tracked, by sequence, if necessary. The RxClaim Suite also employs strict field-level filters to ensure that any data entered through manual processes is compliant with field validation rules. Database integrity is maintained through integrity rules defined within the database itself, ensuring that all adds, changes and deletes are compliant with defined database integrity rules.

11.0 System Administration and Disaster Recovery

Instructions: The Vendor must provide a narrative overview of how the proposed solution will meet the System Administration and Disaster Recovery requirements. The approach must, at a minimum, provide details on how the Vendor intends to meet or exceed the System Administration and Disaster Recovery Requirements set forth in Template H – Non-Functional Requirements, Tab O1 System Administration and Disaster Recovery'.

Response:

Catamaran is resolutely committed to maintaining its PBM operations and data center services in the most reliable, secure, and consistent manner possible. In keeping with this pledge, our Business Continuity Plan (BCP) furnishes the mechanism to ensure that our services remain available in the event of a hardware, network, or site failure. This plan provides for business continuity and the survival of our normal service offerings, even in the case of a catastrophic loss of one of our processing centers, call centers, or other corporate facilities due to a natural disaster, malfunction, or other serious condition.

Any outage to call center operations or computer processing operations that could potentially exceed predetermined critical points is considered a business continuity-causing event. The outage may be caused by the loss of a single machine, the computer room floor, or even the entire building containing the computer room floor or call center. The events planned for include a power outage to a corporate facility; a fire in one of our computer rooms; water, or smoke damage to the computer room; acts of nature; or sabotage that may affect a corporate facility. The Executive Management Team makes a detailed assessment of the situation prior to determining the level of recovery to be implemented.

We organize and deploy our computing resources and personnel as stated in our BCP, which addresses the following:

- Facility Monitoring and Maintenance
- Facility Environment and Protection
- System/Network Redundancy
- Multiple Processing and Operational Sites
- Service Level Agreements (SLAs) with Key Vendors/Suppliers
- Definition/Qualifications of Potential Service Interruptions

Personnel in our Data Center Operations (DCO), Network Administration, Facility Management, and Executive Teams are familiar with the BCP and manage the organization in accordance with this plan. We maintain two data processing centers— a shared, hardened Tier-3 Data Center facility in Elk Grove Village, Illinois and a second facility located in Denver, Colorado. On any given day, the processing center in Elk Grove Village or the processing center in Denver can be designated as the primary center, with the other center serving as the secondary (or backup) center. In a similar fashion, we maintain several provider/client call centers including those in Lisle, Illinois and Phoenix, Arizona.

Facility Monitoring and Maintenance

24x7 Onsite Coverage

Our Data Center is staffed 24 hours a day, seven (7) days a week, and 365 days a year. The DCO staff on duty regularly monitors all systems for malfunctions and monitors the premises for security and safety. The DCO staff can escalate an issue at any time to the DCO Management Team, Network Administration Team, or Facility Management Team.

Climate Controlled Data Center (DCO)

The DCO climate maintains a precise environment controlled for temperature and humidity conditions and is monitored for water, gas, and fire hazards according to standard DCO climate and hazard-condition control specifications.

To preserve hardware components in the highest possible working condition, the Data Center is immaculately maintained. Catamaran standards further enhance reliability and aid in realizing the very best hardware performance. Routine cleaning of floors (both the raised flooring and the sub-flooring) is performed regularly and even unseen, hard-to-reach areas are consistently cleaned and inspected.

Facility Environment and Protection

Backup Power and Power Protection

An uninterrupted power supply (UPS) protects our systems, climate control units, and lighting against power irregularities and “unclean” power for both our data and call centers. Additionally, in the event that our electric power service is interrupted, the UPS system automatically and smoothly transitions the power supply to diesel-fired generators located on the premises. These generators satisfy the minimum power requirements of the Data Center and/or call center for at least 48 hours. We have priority agreements established with diesel fuel suppliers to ensure we have access to additional fuel in the event of any extended power outage at our facilities. Note: Our tier-3 data center in Elk Grove Village has enough diesel fuel underground to run for at least 60 hours and is designated by the US government as an essential public resource meaning that it has priority access to fuel, even in the case of a regional disaster. When electric power service is returned, the power is automatically switched from the generator back to the service provided by our electric utility. Testing of the back-up power systems is conducted weekly.

Climate Control

Our heating and cooling units are deployed so that we have redundant systems responsible for climate control. In the event of a failure of a primary system, the back-up system provides heat or cooling sufficient to keep the center within operational tolerances.

Fire Prevention

A FM200 Fire Protection System monitors and protects the computer and communication rooms. This system monitors for smoke, fire, and excessive heat. Detectors are strategically located throughout the facility and under raised flooring. This two-stage system will detect a fire and alert personnel in time to investigate and address the situation. Should multiple detectors sense a fire condition, the system begins an automatic countdown to a localized deployment of the fire suppression agent (FM200 gas). By design, the system can rapidly extinguish a fire in the immediate area with little or no damage to the equipment while simultaneously limiting risk to area personnel.

System/Network Redundancy

Redundant Systems

We have identified all single points of failure within our operations and have provided for back-up and/or redundant systems to allow for continuous operation of our services in the event of a hardware or equipment failure. The redundant systems include:

- Claims processing servers
- Terminal servers
- Print servers
- Web and Portal servers

Databases for claims processing and prescription processing are synchronized by data replication software that operates over our wide area network. This synchronization keeps the secondary systems' data current with the primary systems' data within seconds of any transaction.

Multiple Suppliers to Catamaran Processing Centers

We have arranged for multiple suppliers of critical voice and network/data services to our Data Centers. This arrangement lessens the impact to our clients and business partners should one of our suppliers be affected by an outage or other service issue. Suppliers include Internet service providers, data service providers, and voice (dual providers for both local and long distance).

We have arranged for multiple entry paths into our facilities, enabling our centers to survive interruption or damage, even to a major communication easement into a Data Center or Call Center location.

Multiple Processing Sites

As stated, we maintain two processing sites, one located in Elk Grove Village, Illinois and the other in Denver, Colorado. These facilities house redundant computer systems for our claims processing, and web-based services. Our BCP allows our services to continue to operate out of either facility, even if the other facility is completely disabled. The BCP allows for transition to the secondary facility in less than one hour during an unscheduled outage experienced at the current, primary facility. This same switch can be performed in minutes, if the switch is performed in a scheduled manner. We test and verify the operation of the alternate site at least six times per year and actually operate production activity out of that site for a minimum of 24 hours during the exercise. The failover operations are transparent to our clients and business partners and do not require any reconfiguring of their networks for either scheduled or unscheduled switches.

The same high-level plan exists for our Call Centers. The Call Center facilities in Lisle, Illinois and Phoenix, Arizona are staffed and trained to handle all types of calls – provider, client, clinical request (prior authorization), mail order support and other related call activities. The phone systems in the facilities are designed to communicate with each other and can distribute calls between facilities if call volumes are disparate. In addition, if a Call Center is impacted by a site problem, such as a communication outage, weather-related staffing issues or other event, the other Call Center will be directed to handle all call volume. Our arrangements with our voice

carriers also allow us to direct all voice traffic from one Call Center to the other, should the need arise.

Escalation Plans

Any organization can be affected by small but serious business interruptions to major disasters. To address such situations, Catamaran has established four Escalation Plans that provide classification and management the various events requiring business continuity efforts. As conditions or statuses change, the problem may be escalated to a higher-level plan, with possibly different staffing and solution methods.

Escalation Plan 1: Component Failure

Severity: MINOR

Recovery Location: At Catamaran Primary Facility

Declared if a component (computer system, workstation, printer, communication line, etc.) has failed, and the service interruptions are minor (less than 10% of the business conducted by Catamaran), or are being handled by redundant or back-up components. This Escalation Plan focuses on repairing the failing component so that if any service levels have diminished, that impact is minimized. If more expensive components (e.g., back-up phone lines) are employed, these additional costs will be kept to a minimum. Additionally, Catamaran seeks to minimize the potential for multiple failures, which may lead to a higher level Escalation Plan.

Escalation Plan 2: Minor Outage

Severity: INTERMEDIATE

Recovery Location: At Catamaran Primary Facility

Declared if the interruption is estimated to be less than two hours, or if the service outage affects less than 50% of the business conducted by Catamaran (percentages to be determined by Catamaran management). Some modification to the scheduled workload will be necessary. Little or no mobilization of the Business Continuity Team is needed.

Escalation Plan 3: Serious Outage

Severity: SEVERE

Recovery Location: At Catamaran Alternate Facility

Declared if the interruption is estimated to be more than two hours. Processing is moved from the primary to the alternate site, although it is expected that the primary site will be operational again within 48 hours. Other operations, such as remote system access, instruction of alternate site personnel, and coordination/monitoring of alternate site activities, can still be conducted from the primary site. Modifications are made to the scheduled workload to permit the highest priority application systems to run as quickly as possible. Partial or full mobilization of the Business Continuity Team may be necessary. Depending on the extent of damage, some restoration of system programming and production application data will be performed. Most applications will run at normal levels at the alternate site. Additional work and/or altered schedules may be necessary during and following the restoration and recovery process.

Escalation Plan 4: Disaster

Severity: CRITICAL

Recovery Location: At Catamaran Alternate and Various Facilities

Declared if the interruption is estimated to be more than two hours, and the operation of the primary site is not expected to be restored within 48 hours. Immediate and essential application systems are recovered at the hot site. Full mobilization of the Business Continuity Team is declared. Catamaran's management declares that PBM processing and other business services/supporting functions will operate in recovery mode.

Phone System Continuity

We employ a phone system that includes redundant hardware for all aspects of the system, including the primary and redundant data centers. This system is complemented by the use of multiple voice carriers who provide both inbound and outbound service. In addition, all equipment is under a 24x7x4-hour hardware replacement contract and supported 24x7x365 by both on-site and on-call staff.

We have arranged for multiple suppliers of critical voice and data services to lessen the impact experienced by our clients and business partners in the event that one of our suppliers is affected by an outage or other service issue. Suppliers may include:

- Internet service providers
- Frame relay service providers
- Voice - Multiple providers for both local and long distance

System Testing

Because we consider the testing of our Business Continuity Plan a critical function, we perform testing on a regular basis. At least bi-monthly, we perform some degree of testing around this plan. In a typical two month period, we actually switch production processing from our primary site to our backup site for 48 hours (usually during a weekend) to ensure that our procedures for switching (and switching back) remain operational and the processing at the backup site is fully functional. The monthly test also demonstrates connectivity with the national pharmacy switch networks (RelayHealth, Emdeon, etc.), our clients' networks, and our Web presence (for our internet-based products such as RxClaim Web Services). This testing also gives us the opportunity to test other processes that surround claim adjudication—including eligibility processing, daily report cycles, and interfaces to Catamaran products such as RxTrack and custom client interfaces.

12.0 Performance

Instructions: Describe the Vendor's approach for the proposed solution to meet performance standards. The approach must, at a minimum, provide details on how the proposed Solution intends to meet or exceed the Performance Requirements set forth in the Template H – Non-Functional Requirements, Tab O2 SLRs and Performance.

Response:

Confidential, Proprietary, and Trade Secret Information of Catamaran.

As we have noted throughout this proposal, Catamaran currently service six State Medicaid clients providing a Fee-for-Service (FFS) benefit and 17 Managed Medicaid contracts. Service level requirements are a component of all of these 23 programs and most of those the State has set forth in this RFP are currently being measured and met today. Catamaran produces internal

Service Level Requirements Reports for each of our clients that are driven primarily from system output across our various platforms (call tracking, claim processing, reporting, etc.) to determine whether we are meeting our service level agreements. Throughout the year, reviews of the program business plan produces information that determines the upgrade path dates and the amount of capacity required for the system as well as operational components such as staff workload to further ensure our ability to meet our Service Level Agreements. When any issues arise that may have a negative impact on our ability to maintain Service Levels, our workforce management team at the corporate level, is proactive in balancing work volume and identifying headcount requirements. Those requirements are addressed through training of existing staff to new skills or by adding additional headcount.

In the sections that following, we have outlined our approach to ensuring that our business processes and systems meet and exceed the performance measures required by the State.

13.0 Service Level Requirements – Business Process Performance Measures

Instructions: Describe the approach to ensuring the Vendor processes and solution are able to meet the following Service Level Requirements. Include in this response the Vendor approach to measuring and reporting on these requirements, the process for remediating any non-compliant components. The Vendor may suggest alternate or additional SLR's that they deem appropriate.

Business Process Performance Measures		
SLR Name	**Service Level Requirement**	**Frequency of Measurement**
1. File Updates	Performs required file updates – eligibility, provider, drug coverage – as required based on the frequency established by the State, with 99% accuracy.	Monthly
2. Point-of-Sale Network System Downtime	Unscheduled system downtime will be no greater than 2 hours per incident; not to exceed 2 times per contract year	Monthly
3. Prior Authorizations	All requests for Prior Authorization shall be acted upon within 72 hours	Monthly
5. Retail Point-of-Sale Claims Adjudication Accuracy	Financial accuracy rate of at least 99% for all pharmacy claims processed at point-of-sale.	Monthly
6. Payment Accuracy	The MMIS and PBM Vendor to quickly identify, correct and report to DVHA any erroneous payments from the MMIS, and ensure that no overpayments or underpayments are made from State or Federal funds	Monthly

7. First Call Resolution	First call resolution rate will be 95% or greater. First contact completion applies when the first person the customer reaches either answers the question, resolves the problem, or dispatches service where appropriate.	Monthly
8. Call Answering Time	95% of all calls received will be answered within 30 seconds	Monthly
9. Call Abandonment Rate	Not more than 3% of all calls will be abandoned	Monthly
10. Federal Compliance	Compliant with key Federal legislation (e.g. HIPAA, ADA, OSHA, etc.) in all activities	Monthly
11. State Compliance	Compliant with Vermont Law in all activities	Monthly
12. Privacy and Security	Compliant with all HIPAA requirements for privacy and security in all activities, breaches will be reported within 2 hours of becoming known by the Vendor	Immediately
13. Data Breach	Breaches in data access will be reported within 30 minutes of becoming known by the Vendor	Immediately
16. Breach Notifications	Breaches in data access regulations shall be made known to the State	Monthly

Response:

Confidential, Proprietary, and Trade Secret Information of Catamaran.

To facilitate management controls and monitoring throughout the claims processing process, Catamaran's Data Center Operations (DCO) unit is staffed 24x7x365. This team is responsible for monitoring the performance of our data center, including production server processing, external network interfaces, telecommunications services, wide area networks (WAN) operations and local area networks (LAN) operations. Operation personnel are responsible for reporting on hourly, daily, weekly, monthly and annual transaction volumes. This staff also monitors transaction times, interactive users, response times, batch processing cycle windows, and related key performance metrics.

Catamaran has a pool of network administrators, database administrators, programmers/analysts and systems analysts who are responsible for operations support, functional activity monitoring, performance monitoring and maintenance.

Adjudication Accuracy Monitoring

Client Services, Systems, and Technical Teams routinely monitor RxClaim and its systems components to ensure performance and processing accuracy. With respect to adjudication monitoring, Client Services staff are charged with two primary responsibilities. First, this unit reviews network switch reports daily to monitor claims processing times and ensure that adjudication services level agreement standards are being met. Additionally, they are also responsible for monitoring adjudication accuracy**.**

Systems Monitoring

Routine systems performance monitoring is the responsibility of the DCO unit. This department operates the systems monitoring tools and conducts regularly scheduled checks on server processing integrity, network throughput, tier communication latency, interface processing, operating system stability, security systems operability, secondary systems synchronization, database index performance, database partition competence, tablespace usage and database response and performance. This team is also responsible for monitoring system utilization (processor/memory/disk space) and network utilization. The team uses alert tools to look for outlying performance measures and utilizes statistical sampling tools to provide daily pictures on the "health" of the system and the performance of key applications. Another DCO role is to provide Task Monitoring support, monitoring not only hardware and application level performance but also verifying expected endpoint results for matters such as data extracts and loads and file transfers and purges.

We provide the State a client-specific System Report Card that shows, on a monthly basis, its transaction volumes, interactive usage, transaction times (average, mean, etc.), interactive user response times, and the number of client-specific jobs that are processed by type (reports, queries, updates, maintenance tasks).

This report card can also detail the number and type of call services, along with standard call center statistics (average time to answer, average time on hold, numbers of calls abandoned, etc.) This report card can help assure a client that its business is being well-served by help desk resources and that any service level standards are being met.

Prior Authorization Call Center

Requests for Review against the Department's Approved Clinical Protocols

Upon receipt of a phone or fax prior authorization request from the prescriber, a Clinical Call Center Pharmacy Associate currently will review the pharmacy claims history and previous prior authorization history for the beneficiary and enter the appropriate information (as provided) into the RxAuth protocol algorithm for determination decisions. The goal is to render a decision within 24 hours of receipt of the request. However, if the request does not contain sufficient information to make a decision, the request may be placed in pending status for 72 hours, allowing the prescriber time to provide the additional clinical information. If, after 72 hours, the prescriber's office does not provide the missing information, the request is denied for lack of information. A Department of Vermont Health Access authorized denial notification is faxed to the prescriber and mailed to the beneficiary. If the drug was going to be billed through the medical benefit, a fax notification is currently also being sent to the State's Clinical Unit.

Today, the prior authorization (PA) program is deployed through Catamaran's proprietary solution, RxAuth, which was designed to automate and simplify the PA process. Clinical Pharmacy Services (CPS), our clinical call center provider, will continue to leverage RxAuth to facilitate PA requests in an efficient and automated manner for requests received via phone and fax.

Catamaran recognizes the State's continued need to control escalating drug costs while at the same time desiring to ease the administrative burden of the paperwork and documentation requirements and reporting challenges typically associated with prior authorization programs. As a result, we propose to expand the use of RxAuth by offering it directly to prescribers as outlined below.

The RxAuth tool is a flexible, efficient PA management solution that leverages the powerful PA capabilities housed in RxClaim to automate the PA process from end to end. RxAuth supports the entire PA lifecycle, from receipt of the request, through rules adjudication, to execution of the resulting decision. A companion suite of Web services allows for extension of real-time PA request and response capabilities to the physician or other requestor. Importantly, through integration with Catamaran's content management/imaging solution, the system also supports capture of images of inbound requests and supporting documentation, as well as production and image capture of outbound communication related to requests.

Automation ensures consistent and timely application of criteria so that decisions can be reached efficiently and fairly. Real-time Web request/response capabilities support a paperless program that offers efficiencies to the provider and the State. We believe that expanding the automated use of RxAuth will benefit all associated stakeholders, including the patient who is awaiting the authorization decision. Those benefits include:

- Enabling real-time access to medication criteria for prescribers
- Improving workflow and efficiency
- Avoiding delays in treatment
- Improving beneficiary and provider satisfaction with the PA process
- Reducing healthcare costs.

Catamaran understands the various challenges that confront pharmacies, prescribers, and beneficiaries as well as the State, with ensuring appropriate prescribing while maintaining a PA program that is clinically sound but absent of undue burdens for all parties. With this in mind, Catamaran is proposing our SilentAuth application to improve real-time prior authorization decision making based on the pharmacy and medical history data associated with the beneficiary. Based on the incorporation of medical data (ICD-9/10 and CPT codes) from the State's adjudicated medical claims in RxAuth databases, SilentAuth will allow real-time objective decisions to be made based on documented submitted claims history. This will eliminate the burden of prescribers providing diagnosis information and claims history in a prior authorization request that is already available in the State's claims processing systems in a retrievable format.

Further detail around Catamaran's Prior Authorization solution can be found in section 1.2.2.

Technical Call Center

Catamaran employs virtual call centers located in Phoenix, Arizona; Orlando, Florida; Las Vegas Nevada; and Lisle, Illinois. Each site receives calls in an integrated seamless manner, transparent to the caller. We are able to provide responsive service times during peak demand by routing calls to call center representatives in any location because the sites operate under a shared infrastructure environment. In effect, the sites operate as a single call center, resulting in unequaled service. This ensures that Catamaran's technology and personnel are able to meet the Department's call center performance metrics of at least ninety-five percent (95%) of all calls being answered or queued within thirty (30) seconds, and no more than five percent (5%) of answered calls remaining on hold for more than one (1) minute.

Call Center System

Our call center system runs on an Avaya switch. This state-of-the-art, integrated call center solution—providing primary functions 24 hours a day / 7 days a week that include Interactive

Voice Response (IVR) and automated call distribution (ACD)—has enabled us to further enhance our customer service capabilities by more effectively responding to inquiries. By managing incoming calls through our ACD system, we have the ability to automatically direct calls to the appropriate representative, based on skills and availability, while continuing to maintain relatively short wait times for our callers. Our call centers have been using the Avaya system for approximately five years.

Operational Quality Assurance Monitoring

Quality assessment is a standard operating component at all levels of our organization, down to specific tasks and processes. Our staff performs specific operational quality assurance monitoring, performance measurement, and improvement initiatives within each operating function. Each business unit and functional area initiates projects to improve processes, increase efficiencies, and enhance client satisfaction. Process improvement teams lead quality improvement projects by utilizing a specific process workflow.

A good example of our quality review process related to tasks is the quality auditing program within our call center operations. Our quality assurance (QA) auditors perform random call monitoring and the supervisor completes an evaluation form while monitoring the service representative. The following list provides examples of criteria and data used to evaluate performance:

- Date and time of evaluation
- Proper greeting (MSR's name given)
- Clear speaking voice and enunciation
- Telephone courtesy
- Ability to distribute information received
- Ability to correctly answer caller's questions
- Information regarding the specific program's requirements
- Appropriate closing
- Length of call (classified as short, appropriate, or long)

During the monitoring session, the QA auditor simultaneously monitors the telephone conversation and views the service representative's computer desktop. Monitoring the audio of a call, in addition to the onscreen activity, enables the auditor to verify whether the representative is providing accurate information and is entering accurate and relevant information into the call-tracking component. Evaluating the audio portion of a call also allows the QA auditor to observe and evaluate overall customer service skills, including tone of voice, politeness, patience, and professionalism.

The objective of using call monitoring is to ensure that our service representatives provide timely, functional, and valuable client and beneficiary support, while being professional, considerate, supportive, and responsive to the caller's needs.

Federal and State Compliancy

Catamaran's information security program is aligned with the ISO framework and the COBIT framework. Catamaran reviews the information security program annually. This is to assure

compliance with industry (Payment Card Industry (PCI)) and regulations (e.g., HIPAA, etc.) and to evaluate potential changes to the program.

Catamaran is SOX (Sarbanes Oxley) 404 compliant; therefore, an independent auditing firm attests that our internal control processes and systems are effective and satisfactory. We also have received a SSAE 16/SOC 1, Type II report annually, which is related to our pharmacy claims processing services audited by an independent CPA firm. In addition, our internal audit team is responsible for testing the design and operating effectiveness of key internal controls for compliance with Sarbanes-Oxley 404. This process occurs throughout the year and includes planning, risk assessment, testing, reporting results, and issue resolution. The internal audit team also is responsible for coordinating and facilitating the claim system SOC 1 report audit conducted by an independent accounting firm. Yearly compliance reports are made available for clients to review.

Catamaran has received PBM and specialty pharmacy Utilization Review Accreditation Commission (URAC) accreditations. As such, we follow the high standards and guidelines offered by URAC with respect to quality improvement. We have instituted a Quality Assurance Executive Committee (QAEC) that regularly meets to review performance and provide guidance on quality management priorities and projects. The committee consists of the company's Chairman and Chief Executive Officer as well as executive and senior vice presidents and vice presidents. The QAEC reviews input from clients, providers and beneficiaries and provides guidance to our management and staff on quality priorities and projects, and assesses our performance toward meeting objectives for customer satisfaction, URAC compliance, and Continuous Quality Improvement activities.

Catamaran assures compliance with SOX, HIPAA, PCI regulations and operates in accordance with our Business Associate Agreements (BAA), which we require for all third party vendors with whom we conduct business.

Security

Catamaran understands the importance of safeguarding the privacy, confidentiality and security of our clients' data and patient medical information – we have spent over two decades designing, developing and implementing leading healthcare solutions, constructed with the highest available security measures found in the industry. RxClaim Suite is CMS certified and is the only pharmacy claims system to be independently certified. It currently meets all Pharmacy Program requirements in the CMS State Medicaid Manual (SMM) as well as the Certification Toolkit, and therefore meets all applicable regulations under HIPAA, including accepting and sending all pharmacy related HIPAA transactions.

Catamaran has undertaken a number of initiatives to ensure that our software and services comply with the ongoing security provisions of HIPAA legislation. Education has been in the forefront as we have worked to ensure that all of our staff is continually trained and mindful of these provisions in their responsibilities. A few highlights from these activities should serve to illustrate the nature of our efforts. Catamaran's policies, processes and procedures, as well as our own System Security Plan are compliant with the State's requirements. During the Design and Definitions Phase of this project, Catamaran submits our System Security Plan for the State's review and approval.

Confidentiality and Data Integrity

Catamaran policies for network usage include the mandatory encryption of any PHI that is transmitted into or out of the Catamaran offices using any public network, whether the

transmission is for OLTP, OLAP, or reporting purposes. We use network intrusion detection systems and architect our wide area network to provide an extremely secure and defensible facility, while still allowing for reliable and secure access for all authorized users. Confidential and sensitive information sent via electronic mail is encrypted using ZixMail®. If the data is transmitted via FTP, we use Secure FTP to secure the data. We also use VPN as a transport. While transmitting PHI over the Internet, comprehensive security measures must be in place to ensure data confidentiality and integrity. That is why all PHI accessed through Catamaran's Web portal is protected with the industry standard Secure Socket Layer (SSL) technology. SSL is an Internet security protocol that uses cryptography to encrypt all sensitive data that is transmitted over the Internet. Integrity controls ensure that the data received on a client workstation came from Catamaran and that no third parties were able to view or change the data during transmission. Catamaran does not support unsecured data transmission of any customer data regardless of the presence or absence of PHI. Additionally, RxClaim Suite displays a login banner, warning users when they are attempting to access areas containing PHI.

All access to the production system is controlled through authorized user access. We do not allow generic or non-specific User IDs. Audit fields on each table in the database are used to track modifications. These fields include the time and date of a database change and the User ID of the party who made the change. Catamaran also keeps system journals for nine weeks so that all database changes can be tracked, by sequence, if necessary.

The RxClaim Suite also employs strict field-level filters to ensure that any data entered through manual processes is compliant with field validation rules. Database integrity is maintained through integrity rules defined within the DB2 relational database itself, ensuring that all adds, changes and deletes are compliant with defined database integrity rules.

When mobile devices are utilized to access the RxClaim suite, via the RxProvider Portal for instance, users are authorized and authenticated users through our mobile applications. Industry standard encryption (128-bit SSL certificate protection) is utilized to client PHI secure.

HIPAA Training

Every Catamaran team member and our trading partners are required to complete annual HIPAA, regulatory, and ethics training, which includes the safeguarding of Protected Health Information (PHI) and other confidential material included in our system transactions and otherwise. Additionally, we conduct ongoing online training to ensure that all employees and pharmacy system users are kept apprised of any HIPAA-related updates or enhancements and to reinforce the privacy standards, including minimum necessary use and disclosure based on HIPAA policies and procedures. This training is defined on a job-by-job basis to address targeted populations regarding security measures specific to handling Protected Health Information (PHI).

Physical Safeguards

All of our facilities are protected by electronic security systems that limit physical access to the buildings to only authorized personnel. Areas of the buildings that house critical information management equipment and those areas where electronic and/or printed material containing PHI have even further access restrictions through this same security system. We have security cameras that monitor the entrances to our facilities. Any data that is removed from our facility for backup protection purposes is moved only in locked cases and only carried by organizations with which we have chain of trust agreements. All computer disks that are no longer in use are

either destroyed or are re-formatted to ensure that any PHI is removed before these devices are recycled.

Technical Security Services

Catamaran has implemented password protection and usage policies that include mandatory non-trivial password changes on a regular basis for all users that access our facility. The RxClaim Suite allows for a flexible definition of user roles and rights, thus allowing for greater control of which types of user have the ability to see secured data.

Network Security and Availability

As indicated above, Catamaran has policies in place for network usage that include the mandatory encryption of all PHI transmitted into our out of our offices using any public network and for any reason. We have also bolstered our network intrusion detection systems and re-architected our wide area network to provide a more secure and defensible facility, while still allowing for reliable and secure access for all authorized users.

We expose our systems and procedures to annual SSAE-16 audits and at the minimum, annual testing by outside parties to ensure that we comply with current standards and our systems are properly secured from known security or operational threats. This testing includes reviews of security procedures, system administration procedures, access procedures, and network penetration testing. All applicable findings from these events are shared with the State.

Application Security

RxClaim Suite uses a combination of OS/400 level and application level security to limit access to the system to only authorized users. Additionally, the system uses these same features to control the access of different user classes that have varying levels of authorization. The security system is password-based. All users are assigned their own unique user ID and password. Passwords are set to expire at a pre-set date, requiring users to change passwords with a pre-determined frequency. The security systems of OS/400 are extensive and full-featured, and our system has been designated as level C2 security-compliant by the U.S. Department of Defense.

RxClaim Suite has been integrated with a state-of-art EDI translator from the Extol organization. We maintain a technical support and software maintenance contract with Extol to ensure the services it provides in this area comply with the latest HIPAA and industry standards.

Authorization

Catamaran allows only a limited number of identified client personnel to determine the roles that other client personnel have. Dependent upon this role, the system restricts which functions and features of the claims processing application each user has.

Customers and their authorized users have access only to their specific data through the claims processing application. Thus, the role assigned (as described above) completely defines what operations the user is authorized to perform. Non-application operations are not permitted.

Access

Access is controlled by the role assigned to the various users. If direct access to data is required for user personnel, accommodations are made for individual customers' personnel.

This access is provided through the data warehouse product or via various data export routines where claims data is made available for use by the client on their own computing facilities.
We have established a team dedicated to the analysis and implementation of items mandated by HIPAA. This task includes transaction standards, code sets, and rules concerning privacy and security. Additionally, Catamaran conducts audits of its procedures and controls to ensure that it continues to operate within the HIPAA regulations for electronic transaction processing, security, and privacy.

Password Procedures

Passwords must be changed by the owner every 30 days, and we currently require that the password not be reused within a 12-month period. The password must be at least eight characters long and cannot be the same as the account name. Passwords automatically expire every 30 days. The system allows three (3) unsuccessful logon attempts before locking out the user. Our security measures are continually scrutinized to ensure all data is protected appropriately. We test our security compliance quarterly.

Improper Disclosure of PHI and other Confidential Information

All employees handling sensitive data (i.e., patient health information and claims data) are educated in data security and confidentiality. Employees recognize that failure in this duty is grounds for immediate termination. Protected Health Information (PHI) is housed in accordance with rules set by state and federal laws. All PHI is secured and shared on a need-to-know basis and only with approved staff, providers, and client-sanctioned staff. In addition, we protect the confidentiality of individual health information by:

- Training employees on the importance of maintaining member information confidentiality and how to preserve that need in their work environment
- Restricting access to information by using appropriate technology procedures, including secured Internet applications that protect confidentiality
- Establishing and maintaining programs that protect confidentiality of member healthcare information.

In the event Catamaran, or persons under its direction, discloses information, or it is reasonably believed that confidential information may have been disclosed, Catamaran employs a comprehensive response plan and the specific inclusion of the following:

- Notification to the State of the unauthorized disclosure immediately or no more than 24 hours after the unauthorized disclosure event is discovered
- Identification of affected individuals and specific information wrongfully disclosed,
- Work to take any further action related to the unauthorized disclosure, as directed by the State
- Provide the State with an incident report containing a root cause analysis and a corrective action plan within five (5) business days of the discovery, ensuring that further unauthorized disclosure(s) does not reoccur

It is the responsibility of all Catamaran employees to report a suspected security breach immediately to the employee's supervisor, another manager if the employee's supervisor is not available, or the Catamaran Chief HIPAA/Security Officer. The Chief Security Officer is responsible for making initial assessment and documentation of the suspected violation and

notifying systems, account, and operations management staff of the suspected violation. This occurs within the first thirty minutes of notification. As soon as it becomes reasonably certain that a violation has occurred, the Catamaran's Chief Security Officer and the Vermont Account Manager, Nancy Miner, contacts the State to explain the circumstances surrounding the suspected violation and what immediate steps are being taken. This occurs no later than twenty-four (24) hours from the time the breach is detected.

Concurrently, operations and account systems staff take any steps demanding immediate attention, as internally determined or as directed by the State, including the identification of all individuals for whom their PHI was breached or compromised. As remedial steps are taken all actions are documented.

Account staff also work with the State to prepare a Security Incident Reporting, if requested. A formal report is prepared whenever there has been an actual physical or electronic intrusion. This report is completed within five (5) business days of Catamaran Privacy Officer notification and follows standard guidelines, as detailed below:

- For intrusion of secured areas, notification may also include the FBI, U.S. Attorney's Office, State Police, local police department, and/or other law enforcement agencies
- For catastrophic disasters such as fire, bomb threats, floods, or destructive storms, notification procedures include the local fire department and/or police department
- For incidents involving electronic intrusions, other state agencies are notified as appropriate. Any data captured that resulted in detecting the intrusion is kept until the incident has been investigated and cleared
- For incidents involving deception and fraud, additional notification may include the police department depending upon the severity of the incident

The following procedures apply to all security violations:

- Documentation includes a detailed log of all pertinent information and activities. This log is maintained by the Catamaran Security Officer.
- If the breach is electronic, and if possible, snap-shot of the system is taken to aid remediation and supplement documentation.
- Catamaran makes copies of all audit trail information such as system log files, root history files, etc.
- The Catamaran Security Officer is responsible for notifying all heads of departments affected by the breach as well as the Chief Operating Officer and the Segment President of Public Sector Programs.
- All information related to the breach is to be secured and released only to those persons involved in remediation, Catamaran management, the State staff and legal representatives of the respective organizations. Any release of information beyond these individuals is the responsibility of, and at the discretion of, appropriate State staff.
- After an incident has been fully handled and all systems are restored to a normal mode of operation, a follow up analysis is to be performed. All involved parties meet and discuss the actions that were taken and the lessons learned. All existing procedures are evaluated and modified as needed.

Quality Management Program

Our Quality Management Program ensures ongoing performance and monitoring of operational improvement activities by systematically gathering and reviewing performance data and metrics. When quality improvement projects (QIP) are identified, we follow a specific workflow:

- Identify the business issues through review of business metrics, customer inquiries, or other performance metrics
- Assign the QIP to a project owner for action
- Assemble a team of subject matter experts with appropriate cross-functional representation to analyze the issue and identify action items
- Analyze business performance information and corrective action to develop an implementation plan
- Implement corrective action steps
- Monitor business performance for improvement.

If business performance improves to desired levels, the QIP is completed; otherwise, the team continues their analysis and identifies additional corrective action steps.

The intent of each QIP is to:

- Continually improve our processes and the way we do business
- Share best practices from QIPs across functions and business units
- Communicate to our staff that quality at Catamaran is a culture, not just a program.

Tracking and Measuring QIPs

Catamaran ensures ongoing monitoring of operational activities by systematically gathering performance metrics for trending and analysis. We evaluate operational performance and identify and implement quality improvement initiatives based on these findings. The goal of our Quality Management Program is to maintain compliance with applicable regulatory quality standards and internal procedures, as well as to maintain and continually improve operational excellence as defined by accuracy, service levels, and customer satisfaction.

We apply appropriate controls to all data and documents to ensure that only approved and correct documents are available to ensure for the integrity and security of data, particularly records that contain Protected Health Information (PHI). We maintain records to demonstrate the conformance to the Quality Management Program, contractual agreements, and industry standards (including URAC requirements) to allow us to meet the demands of our customers and users.

We also integrate a regulatory compliance program, which tracks applicable laws and regulations in the jurisdictions we serve into our Quality Management Program. We utilize this information to promote Catamaran's compliance with applicable laws and regulations.

Our staff performs specific operational quality assurance monitoring, performance measurement, and improvement initiatives within each operating function. Each business unit and functional area initiates projects to improve processes, increase efficiencies, and enhance client satisfaction. Process improvement teams lead quality improvement projects by utilizing a

specific process workflow. Each quarter, the Quality Assurance Department monitors and reports on the status and outcome of these projects.

Client Satisfaction Surveys

Catamaran's Quality Management Program requires the survey of clients at least annually to assess the performance of our Account Management Team and the services provided. Satisfaction is evaluated using Catamaran's standard client satisfaction survey and methodology, which was designed in collaboration with ZS Associates, an industry leading market research and measurement firm. Our survey is administered using Qualtrics, the leading global supplier of enterprise data collection and analysis which is used by leading brands such as The Wall Street Journal, Duke University, FedEx, Deloitte, Capital One, and more.

Satisfaction is defined as an average rating of five (5) or greater on a seven (7) point scale. Any data collected is reported, in aggregate, on an annual basis.

Data Audit Trails

One advantage that Catamaran maintains over most every other vendor in the pharmacy benefit administration market is the breadth of the data that we retain in our data warehouse and the manner in which it is stored and accessed. The typical approach for most vendors is the warehousing of selected data elements from claims history, eligibility and reference files. Catamaran makes all data elements available for auditing and reporting. This includes not only the typical array of data elements extracted from history, eligibility, provider and reference tables, but operational data as well. We retain all data related to a provider override transaction, and all processing activity data logged by technical support staff (member service representatives), pharmacy technicians and clinical pharmacists. All disposition data including reason codes, level of service codes, COB/TPL codes, PA type codes, etc., are warehoused and available for auditing, reporting, and analysis.

We use operational activity data for reporting, analysis and documentation purposes, as well as for auditing individual and departmental performance. This data integrate with the call management system data to identify operational problem areas, balance workload demands, optimize response times and comply with performance standards.

Catamaran's RxClaim Suite tracks all updates to all tables within the system by user ID and date/time of change. It tracks updates separately and a unique self-documenting/auditing feature enables users to view how each update was applied and the entire history. The system management components of the application include roll-logic (the ability to accept new information and make intelligent decisions about how this new information impacts previously received information) and comprehensive audit trails.

Multi-layer physical and logical measures protect all information processed and stored on Catamaran systems and transferred to and from customer's and business partners. Logical access controls are standard on all Catamaran computer systems and networks. All Catamaran computer systems are designed and maintained with the appropriate degree of security necessary to protect data, computer functions, operations and resources and with the ability to audit user and automated system activity.

Claims Processing Sampling and Reconciliation

As part of the implementation process, we perform comprehensive testing of all benefit plans and program features prior to the effective date. The testing process is designed to prevent coding errors and claim issues from occurring. However, if a coding error or claim issue is discovered after the implementation, we manage error resolution with the highest level of urgency. On average, we are able to resolve errors on the same day they are identified. We perform system changes immediately to rectify the situation and minimize any possible disruption.

Upon the discovery of any processing error, the Vermont Account Team logs the issue and assigns it to our Product Support Department. Based on the specific issue or error noted, the task is assigned to appropriate department for review. In most cases, a configuration update corrects most processing errors. In these cases, the task is assigned to our Benefits Administration Department for testing against the offending transactions. It is possible for immediate testing in production using a test client assigned to a non-production carrier/account/group structure. This method is the fastest way to troubleshoot an issue.

Test claims are logically separated from production claims and are suppressed from extracts and financial functions. Additionally, a random selection of 500 sample claims is reviewed monthly for processing accuracy. The Account Manager notifies the State by phone or email of any identified processing issue that could impact program operations. In addition, the detail and summary for the sample claims review is documented on a scorecard sent to the State for review and discussion during weekly team meetings.

14.0 Service Level Requirements – System Performance Measures

Instructions: Describe the approach to ensuring the Vendor processes and solution is able to meet the following Service Level Requirements. Include in this response the Vendor approach to measuring and reporting on these requirements, the process for remediating any non-compliant components. The Vendor may suggest alternate or additional SLR's that they deem appropriate.

System Performance Measures		
SLR Name	**Service Level Requirement**	**Frequency of Measurement**
1. On-line Availability	All Solution components as delivered shall be available 99.9% of the time.	Monthly
2. On-line PBMS Application Response Times	The Vendor's PBM System response time will be no greater than 8 seconds and must average 3 seconds or less for all interactive system transactions, including claims processing, other than the reporting-related system interactions covered by the next 4 SLRs. The response time is measured as the time from when the users presses enter until the screen refresh in response is complete.	Monthly
3. On-line Search and	The maximum response time for search and lookup performance is 3 seconds for 95 percent of the time.	Monthly

Lookup queries Response Times	Maximum response time shall not exceed 15 seconds except for agreed to exclusions.	
4. Dashboard Report Response Times	The maximum response time for a Dashboard report is 5 seconds from all user locations with a high-speed network connection (greater than 768KB), 95% of the time.	Monthly
5. Static Standard Report Response Times	The maximum response time for a Static Standard report is 5 seconds from all user locations with a high-speed network connection (greater than 768KB), 95% of the time.	Monthly
6. Parameter-based Report Response Times	The maximum response time for a parameter-based report is 20 seconds.	Monthly

Response:

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Systems Monitoring

Our claims processing system is designed for online, real-time adjudication of prescription drug claims at the point of sale. Retail, mail, and specialty claims are adjudicated through the same fully integrated online system. With a track record that features greater than 99.98% availability and claim transaction times that average less than 60 seconds, RxClaim's reputation for reliability, accuracy, and performance is unmatched in the industry. RxClaim users conveniently access our system with an Internet browser connection and view available claim data in real time.

To facilitate management controls and monitoring throughout the claims processing process, Catamaran's Data Center Operations (DCO) unit is staffed 24x7x365. This team is responsible for monitoring the performance of our data center, including production server processing, external network interfaces, telecommunications services, wide area networks (WAN) operations and local area networks (LAN) operations. Operation personnel are responsible for reporting on hourly, daily, weekly, monthly and annual transaction volumes. This staff also monitors transaction times, interactive users, response times, batch processing cycle windows, and related key performance metrics.

Catamaran has a pool of network administrators, database administrators, programmers/analysts and systems analysts who are responsible for operations support, functional activity monitoring, performance monitoring and maintenance.

Routine systems performance monitoring is the responsibility of the DCO unit. This department operates the systems monitoring tools and conducts regularly scheduled checks on server processing integrity, network throughput, tier communication latency, interface processing,

operating system stability, security systems operability, secondary systems synchronization, database index performance, database partition competence, tablespace usage and database response and performance. This team is also responsible for monitoring system utilization (processor/memory/disk space) and network utilization. The team uses alert tools to look for outlying performance measures and utilizes statistical sampling tools to provide daily pictures on the "health" of the system and the performance of key applications. Another DCO role is to provide Task Monitoring support, monitoring not only hardware and application level performance but also verifying expected endpoint results for matters such as data extracts and loads and file transfers and purges.

We provide the State a client-specific System Report Card that shows, on a monthly basis, its transaction volumes, interactive usage, transaction times (average, mean, etc.), interactive user response times, and the number of client-specific jobs that are processed by type (reports, queries, updates, maintenance tasks).

This report card can also detail the number and type of call services, along with standard call center statistics (average time to answer, average time on hold, numbers of calls abandoned, etc.) This report card can help assure a client that its business is being well-served by help desk resources and that any service level standards are being met.

Response Time

Catamaran provides Internet-accessible URLs that allow users of the RxClaim graphical user interface (GUI) to securely connect to the RxClaim Suite (RxClaim, RxAuth, RxMax, RxBuilder, and RxTrack) from virtually anywhere. Generally, system access only requires Internet access. The user interface is initiated on the user desktop via a standard browser (e.g., Microsoft Internet Explorer, Safari, Google Chrome, Firefox, etc.) by accessing our Internet URL. This user interface is characterized as a "thin client interface," and for most workstations the interface is self-maintained. This means there is a small applet that needs to reside on the workstation, which is delivered to the workstation and updated automatically. This interface has been designed to deliver sub-second response times and an efficient user experience, even when accessing the system over relatively "slow" communication links like wireless WAN or through mobile broadband technology. The RxClaim Suite GUI provides a secure, intuitive, browser-like interface to make all features of the application available and easy to utilize.

On-Demand Reporting Capabilities: RxTrack Connect Portal

As part of this proposal, Catamaran is proposing to provide access to something new, RxTrack Connect. Other Catamaran clients report that RxTrack Connect is a far more user friendly and readily accessible tool to access state-of-the-art reporting capabilities. It makes it possible to generate both pre-defined and ad hoc reports. Catamaran is also proposing to provide RxTrack Dashboard.

Through the RxTrack Connect Portal, reports and analytics are delivered and executed using industry leading software including Cognos tools and SPSS. Cognos, founded in 1969 and serving more than 23,000 customers in 135 countries, is a world leader in business intelligence software. Its range of tools allow for reporting, analysis, dash boarding and scorecards. Cognos BI is built with a modern Web services architecture and standards such as Extensible Markup Language (XML), SOAP, and Web Service Definition Language (WSDL). The architecture provides an environment that includes extract, transform, and load (ETL) capability and automatic load balancing and is fully scalable. Reports and analyses are written once and then deployed to other users of the tool to view or manipulate. The Web-based deployment browser-

based environment requires no desktop installs, plug-ins, or applets. This allows for remote access to the system; the end user can log on from anywhere. Cognos reports can be saved into multiple desired formats including: electronic mail, HTML, PDF, Microsoft Excel, CSV, and XML.

Using Cognos tools in RxTrack Connect for analysis allows for the review of large volumes of data across multiple dimensions with fast and predictable response times. Large, complex data sets can be queried with the easy-to-use, drag-and drop user interface, pivoting, and filtering.

15.0 Non-Functional Requirements Assumptions

Document the assumptions related to the Non-Functional Requirements in Table 1. The Vendor may add rows as appropriate.

Table 1 Non-Functional Requirements Assumptions

Item #	Reference (Section, Page, Paragraph)	Description	Rationale
1.	NA	NA	NA
2.			
3.			

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Confidential, Proprietary, and Trade Secret Information of Catamaran.

ID	WBS	Task Name	Duration	Start	Finish	Predecessors	Resource Names	S
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Confidential, Proprietary, and Trade Secret Information of Catamaran.

ID	WBS	Task Name	Duration	Start	Finish	Predecessors	Resource Names
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Confidential, Proprietary, and Trade Secret Information of Catamaran.

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Confidential, Proprietary, and Trade Secret Information of Catamaran.

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Confidential, Proprietary, and Trade Secret Information of Catamaran.

ID	WBS	Task Name	Duration	Start	Finish	Predecessors	Resource Names	S
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Confidential, Proprietary, and Trade Secret Information of Catamaran.

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Confidential, Proprietary, and Trade Secret Information of Catamaran.

Template K

RFP Response Checklist

RFP # 03410-127-14

catamaran

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1.0 Vendor Response Checklist

The Vendor must complete the following table in order to verify that all the RFP response requirements as part of Templates A-L have been completed as instructed.

Table 1 Vendor Response Checklist

Template	Proposal Response Item	Completed and Provided as Instructed??		Reference to Proposal Response Section
A	Cover Letter and Executive Summary	YES ☒	NO ☐	Tab A, Temp. A
B	Vendor Experience	YES ☒	NO ☐	Tab B, Temp. B
C	Vendor References	YES ☒	NO ☐	Tab C, Temp. C
D	Organization and Staffing	YES ☒	NO ☐	Tab D, Temp. D
E	Staff Experience	YES ☒	NO ☐	Tab E, Temp. E
F	Functional Requirements	YES ☒	NO ☐	Tab F, Temp F
G	Functional Requirements Approach	YES ☒	NO ☐	Tab G, Temp G
H	Non-Functional Requirements	YES ☒	NO ☐	Tab H, Temp. H
I	Non-Functional Requirements Approach	YES ☒	NO ☐	Tab I, Temp I
J	Work Plan	YES ☒	NO ☐	Tab J, Temp J
K	Response Checklist	YES ☒	NO ☐	Tab K, Temp K
L	Cost Workbook	YES ☒	NO ☐	Package 2

2.0 Vendor Attachments

The Vendor must complete the following table identifying all the other documents (outside of the Templates A-L) that are being attached as part of the RFP response. The Vendor may add more rows as necessary.

Table 2 Vendor Attachment Checklist

Item #	Attachment Name	Attachment Provided?		Reference to Proposal Response Section
1	Attachment A: W-9	YES ☒	NO ☐	Tab A Template A
2	Attachment B: Subcontractor Letters	YES ☒	NO ☐	Tab B Template B
3	Attachment C: Dun & Bradstreet Report	YES ☒	NO ☐	Tab B Template B
4	Attachment D: 10K and Annual Report	YES ☒	NO ☐	Tab B Template B
5	Attachment E: Certificate of Insurance	YES ☒	NO ☐	Tab B Template B
6	Attachment F: Rebate Team Resumes	YES ☒	NO ☐	Tab G Template G
7	Attachment G: 340B Implementation Schema	YES ☒	NO ☐	Tab G Template G
8	Attachment H: Weekly Status Report	YES ☒	NO ☐	Tab J Template J