Template A

Cover Letter and Executive Summary

RFP # 03410-127-14

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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	Donna Mellen	Phone	
Address		Fax	
		E-mail	

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.

_____ / _____

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

Name (typed or printed)	Timothy P. Nolan
Title	President
Company name	Magellan Medicaid Administration, Inc.
Physical address	11013 W. Broad Street, Suite 500
	Glen Allen, VA 23060
State of Incorporation	Virginia

By signature hereon, the Vendor certifies that:

1. All statements and information prepared and submitted in the response to this RFP are current, complete and accurate.

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.

MMA has attached a signed transmittal letter in **Section XII, Attachment A**.

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

Magellan Medicaid Administration, Inc. (MMA) is a wholly owned indirect subsidiary of Magellan Health Services. MMA's federal tax identification number is 54-0849793. The principal place of business for MMA is:

11013 West Broad Street
Suite 500
Glen Allen, VA 23060

Please refer to **Section XII, Attachment B,** for subcontractor letter.

Please refer to **Section XII, Attachment C,** for subcontractor letter.

Please refer to **Section XII, Attachment E,** for MMA's W-9.

The MMA employees who prepared this Proposal, including their titles, are:

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.

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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.

MMA appreciates the opportunity to submit to the State of Vermont on behalf of the Agency of Human Services (AHS) our comprehensive proposal in response to Request for Proposal (RFP) for a Pharmacy Benefits Management (PBM) Solution. MMA has served different facets of the Medicaid program over the past four decades.

We understand and support Vermont in the effort to transition to a statewide single payer solution. We believe that a single payer solution provides consistency for providers and for beneficiaries, easing the burdens associated with administration. Our experience, systems, and clinical expertise enable us to facilitate and ease this transition. Additionally, given current budget constraints and the rising costs of health care, we recognize how important it is that Vermont maximize its investment in its pharmacy program.

A Proven Systems and Services Solution

MMA's pharmacy systems and services solution meets AHS' requirements for a successful Respondent. Our solution fully supports the critical mission of the AHS: to improve the conditions and well-being of the Vermonters today and tomorrow, protecting those who cannot protect themselves. Throughout our proposal we demonstrate how our proven solution meets the following:

- √ Is a solution that is built on MITA 3.0 compliant architecture, meeting CMS Seven Standards and Conditions.
- √ Supports AHS and DVHA goals, namely to ensure the availability of clinically appropriate medication services at the most reasonable cost possible, and to provide access to high quality pharmacy benefits in Vermont's publicly-funded programs.

OVERVIEW OF VENDOR QUALIFICATIONS

MMA's core competency is as a full-service Medicaid Pharmacy Benefit Manager, providing all aspects of pharmaceutical benefit management. We provide expertise in Medicaid Program management and administration including: complete Point-of-Sale (POS) Claims Processing, Clinical Management and Consultative Support, Prior Authorization, E-prescribing and E-Prior Authorization, Utilization Management, Analytics and Reporting, Cost Containment Strategies, Post-Payment Claims Management, Preferred Drug List and Formulary Management, Management of Physician-Administered Drugs, Financial Management including rebate administration for CMS and Supplemental Rebate programs, 340B Program Management, State Maximum Allowable Cost (SMAC) Program including Federal Upper Limit (FUL), as well as Quality Assurance, Medication Therapy Management, Specialty Pharmacy, Drug Utilization Review, Automated Coordination of Benefits, and Customer Service including Portal Capabilities and Provider Network Support — all geared towards meeting the unique needs of people who receive their health benefits through Medicaid.

As a leader in the public sector market for healthcare management and information services, MMA provides integrated clinical management, superior operational administration, and leading information technology solutions, including comprehensive pharmacy benefit management services. With thirty years of pharmacy benefit management experience specifically focused on the Medicaid population, we are recognized as national experts in Medicaid pharmacy program development and cost containment strategies, providing analysis (policy, reimbursement,

clinical, informatics, and information exchange), guidance, and services to more than half the Medicaid programs in the country. MMA currently provides services to 26 of the nation's Medicaid programs. In our Medicaid pharmacy programs, we are entrusted with managing over 22 million Medicaid lives and some $17 billion in drug spend.

Medicaid-Focused Pharmaceutical Management Tools

- **Trend and formulary management** that combines clinically sound, evidence-based guidelines with market-leading Medicaid rebate expertise to deliver lowest net cost solutions — Trend, Spend, and Bend management.
- **Legislative support and analysis** from our corporate government affairs department staffed with public policy Medicaid experts who assist states in timely response to requests from the legislative and executive branches of government. We provide analytics and recommendations, not just reports, from a department focusing on a broad healthcare agenda that includes pharmacy, but is not limited to pharmacy.
- **Identification, measurement, and demonstration of value** through our Clinical Outcomes, Analytics and Research (COAR) Department, led by clinicians dedicated to and experienced in Medicaid analytics. Our expansive customer portfolio comprised of 26 Medicaid agencies uniquely enables MMA to benchmark and trend with unprecedented insight to identify opportunities for enhanced management.
- **Integrated pharmacy and medical management solutions** that combine the analytic power of medical and pharmacy data to assess the value of pharmaceuticals in the whole health management of the patient. This eliminates waste, prevents adverse events, and assists prescribers in selecting high value medications.
- **Coordination of benefits and third party liability solutions** to ensure that all appropriate cost is avoided and Medicaid is the payer of last resort at the point of sale by using the most comprehensive nationwide database available.
- **Pharmacy network management** that assists the State in understanding the economics of drug distribution and community-based counseling, providing recommendations that achieve competitive distribution costs for states and fair reimbursement for pharmacy providers. 340B drug program management provides compliant program design, network development, contracting, and management of the 340B program that ensures optimal cost savings.
- **Mental Health Pharmacy Center of Excellence** led by a pharmacist board-certified in psychiatric pharmacy. MMA is able to capitalize on this center of excellence, combining the talent of MMA and Magellan Health Services' Behavioral Health business unit to develop solutions for enhancing mental health management, as well as the physical health medications in the Medicaid mental health population.

NGA Prescription Drug Abuse Initiative

Magellan is proud to sponsor and participate in the National Governor's Association's (NGA) year-long prescription drug abuse initiative co-chaired by Alabama Governor Robert Bentley and Colorado Governor John Hickenlooper. **Prescription drug abuse is the fastest growing drug problem in the United States, and the nation's governors play a critical role in developing and implementing a coordinated and effective response.** In September 2012, NGA announced the selection of five states – Arkansas, Kentucky, New Mexico, Oregon, and Virginia – to join Alabama and Colorado in developing and implementing comprehensive and coordinated strategies that take advantage of all available tools and resources to address this growing problem. As a sponsor, Magellan is involved as part of this initiative, working with the recipients of the grants to identify and execute solutions.

- **Medicaid-focused pharmacy technology** that meets the unique needs of Medicaid by enabling rapid response to program changes with flexible clinical management tools and on-line claims administration that implement changes through user configuration.
- **Customer Forums** to discuss hot topics, share expertise, and network with state Medicaid pharmacy leaders on a quarterly basis.

Our focus on serving Medicaid customers has led to a deep understanding of the population these programs serve, the State and Federal rules under which they operate, and the benefit designs, clinical policies, and programs allowable within the constraints of regulations that have proven effective in providing and preserving access to clinically appropriate care in a cost-effective manner.

Commitment to and Alignment with Medicaid Information Technology Architecture (MITA)

With more than four decades of Medicaid-specific experience, and currently providing services in 25 states and the District of Columbia, MMA is proud of our recognition as a Medicaid Pharmacy Benefits Manager. We consistently demonstrate our expertise in the Medicaid arena by identifying, creating, and delivering value for Medicaid agencies, providers, and patients. As detailed in our proposal, our overall approach to providing AHS with a best-in-breed pharmacy management system and services is very much aligned with MITA goals.

CONTEMPORARY APPROACH TO THE STATE'S SOLUTION

As we face long-term economic challenges and increasing demand for healthcare services, innovative market-driven firms need to work together to develop private sector solutions that transform the healthcare delivery model, or risk finding ourselves without a role. We are prepared to work with Vermont to bring much more than pharmacy benefits management capabilities to a partnership with the State. We will bring the full array of our corporate experience, relationships, and resources to help Vermont successfully enter and transform the expanding public sector health market to ensure continuing a much-needed and highly successful program. We can help the State meet its goals of ensuring access to and the availability of safe, efficacious, and clinically appropriate drug therapy at the lowest possible cost and of implementing business practices that reduce the administrative burden on DVHA, providers, and beneficiaries. We will support DVHA's health reform initiatives —including the Governor's single payer/formulary vision and payment reform models.

We propose to implement our premier claims adjudication engine, FirstRx™. This highly configurable, rules-based, parameter-based, and table-driven system offers unparalleled flexibility and an array of system edits to support DVHA with all pharmacy program rules. Additionally, we propose to implement our state-of-the-art eRebate™ management tool for the purposes of administering and invoicing for Vermont Federal, State, and supplemental rebate programs. eRebate is also fully capable of processing data for pharmaceuticals and durable medical equipment (DME). Our systems are fully HIPAA-compliant, and our proposed solution

Valuable Support for our Medicaid Customers

"Having been involved with two other PBM vendors, I have found Magellan to be a superior vendor. I have found their staff expertise to be exceptional. They have a wide variety of experts on their Implementation team including several pharmacists with varied expertise outside of the PBM world...Everyone is very personable and easy to work with.

I think my highest level of satisfaction with Magellan is their willingness for customization and adaptation to our program needs."

Tami Eide, PharmD, BCPS
Medicaid Pharmacy Program Manager
Idaho Department of Health and Welfare

meets all Federal pharmacy point-of-sale certification requirements. MMA is committed to the continued enhancement of our capabilities through routine releases and enhancements to the products. Our investments in technology align well with MITA and the Vermont vision through the use of industry-leading platforms, such as Oracle Fusion, that focus on integration capabilities and SOA.

Our cutting-edge PBM system solutions are tailored and proven in multiple state Medicaid programs and fully integrated for optimal efficiency. These systems processed 190 million claims last year and include the FirstRx™ POS system, FirstTrax™ call management and call tracking and prior authorization solution, eRebate for web-based CMS and supplemental rebate administration, and Cognos BI for pharmacy information analysis and web-based reporting. We also provide our innovative WebPA and IVR solutions to decrease providers' administrative burden and to support fully automated workflow of the PA process, regardless of method of submission. Our platform has been customized to address the dynamic demands of the Medicaid population, with 4,500 claim checks and edits embedded to manage care within the confines of Medicaid rules. These systems are also highly configurable, enabling us to make rapid adjustments in response to changing demands of program strategy and tactics — including formulary design, therapy limits, lock-ins, and other policy changes. The knowledge of our staff, combined with the flexibility of our platform, enables us to deliver a pharmacy benefit management program tailored to Medicaid — and that will readily adapt to the Global Commitment to Health Demonstration for Medicaid. This will allow Vermont to improve coverage, affordability, and access to health care via changes to the demonstration under the Affordable Care Act.

MMA proposes MedImpact as our MTM provider, with MMA providing oversight of Medicare D services. In addition, we propose to use NorthStar HealthCare Consulting, LLC as our Pharmacy Audit partner.

TIME FRAME TO DELIVER THE SERVICES

We have implemented many Medicaid pharmacy systems solutions, some in as little time as 47 days from contract signing to live operations. Our on-time implementation record is flawless; we have never been late on a Medicaid pharmacy implementation. Our CMS-certified system meets all HIPAA and NCPDP transaction sets and has been developed around and consistent with the MITA framework. We propose a 9-month implementation, beginning on the date of contract finalization and ending on December 31, 2014.

PROPOSED TEAM

Our proposed Vermont leadership team, led by ., Account Director, has full authority over the MMA Vermont dedicated team, as well as the complete support of MMA's executive management team. In addition, our proposed Clinical Pharmacist Manager, , Pharm.D., has over years of experience in Medicaid pharmacy benefit management. the dedicated Account Manager, has years of experience in supporting Medicaid customers and will be instrumental in obtaining MECT certification for DVHA.

MMA will provide AHS with an experienced and seasoned Implementation Team that has an extensive, proven record of success in the effective and timely delivery of pharmacy systems and services. Our team is skilled in communication with the wide variety of pharmacy stakeholders needed for a highly successful POS program. Our team will be backed by our considerable corporate resources, including Senior Management, IT, Clinical, and Operations specialists to assure the State of a successful and on-time implementation

We are fully committed to deliver all services sought under this RFP in a resulting contract. Our proposed staffing for the key positions has the necessary qualifications, experience, and skills to

create an exemplary team to partner with AHS pharmacy professionals. All MMA staff undergo rigorous training programs to ensure that both the newly hired and existing staff are fully trained and knowledgeable in their job requirements, including the use of tools, reference documentation, customer service skills, and in the specific job-related performance requirements of the Vermont pharmacy program, including continuing education requirements necessary for certification and licensure as appropriate. While we believe our proposed staffing is stellar, we are amenable to offering employment to any of the incumbent vendor's existing key staff for this account, with Vermont's recommendation and approval. We understand changing vendors is no small undertaking, but it our intent to make any transition as smooth as possible. We are committed to retaining any qualified staff AHS recommends.

ADVANTAGE TO THE STATE OF VERMONT

We possess the clinical, technical, quality assurance, financial, and data processing resources, coupled with the vast Medicaid pharmacy management expertise, necessary to meet and exceed all RFP requirements. The strength of our technology solutions allows us to partner collaboratively with the State in the delivery of innovative healthcare solutions focused on positive health outcomes through fiscally responsible programs.

We recognize the importance of the Vermont Medicaid pharmacy program and the technically challenging solution the State is seeking from a PBM. The PBM will need to have significant integration experience with MMIS fiscal agents. We have successfully interfaced with other fiscal agents (e.g., Molina [formerly Unisys], HPES [formerly EDS], and ACS, [a Xerox Company], CNSI, and CSC). We have also partnered with Accenture on recent MMIS/Pharmacy combined bids. In addition, MMA's prior background as an MMIS fiscal agent gives us a thorough understanding of the interfaces required to successfully exchange data, the need to effectively coordinate programs, and the essential nature of clear and timely communication that met the needs of Vermont.

We pride ourselves upon our ability to work collaboratively in a full partnership with each of our valued customers. We recognize the fact that our customers heavily rely upon our experience and knowledge of Industry Best Practices to help them make the most appropriate policy decisions. Our customers are always treated with the utmost respect, and every request is considered a priority. Additionally, we welcome all customers and prospective customers to visit any of our corporate locations for site visits. We operate a completely transparent business model, and we encourage open feedback, as well as interaction between our customers. We urge you to solicit information on our performance from any of our existing customers, and we welcome you to visit our main corporate facility in Glen Allen, Virginia.

Our proven Medicaid pharmacy solutions and performance, combined with our extensive experience with Medicaid fiscal agents, demonstrates our solution's flexibility and responsiveness to the constant changes in the healthcare industry. This makes MMA the right choice to meet the State's Medicaid Pharmacy needs as Vermont moves forward with its healthcare initiatives.

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.

CONFIDENTIAL MATERIAL: CONTAINS HIGHLY SENSITIVE PROPRIETARY AND/OR TRADE SECRET INFORMATION; PUBLIC DISCLOSURE WILL CAUSE SIGNIFICANT COMPETITIVE INJURY AND DISRUPTION.

Table 1 Vendor Contract Information

COMPANY HEADQUARTERS INFORMATION:	
Company Name:	Magellan Health Services
Address:	55 Nod Hill Road
City, State & Zip Code:	Avon, Connecticut 06001
Company Type (Check One):	☐Private ☒Public
Company Size:	6,205 (Total Number of Employees)
Annual Revenue:	$3.2 billion

PRIMARY CONTACT INFORMATION:

REGIONAL OR LOCAL OFFICE INFORMATION:	
Company Name:	Magellan Medicaid Administration, Inc.
Address:	11013 West Broad Street, Suite 500
City, State & Zip Code:	Glen Allen, Virginia 23060

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.

CONFIDENTIAL MATERIAL: CONTAINS HIGHLY SENSITIVE PROPRIETARY AND/OR TRADE SECRET INFORMATION; PUBLIC DISCLOSURE WILL CAUSE SIGNIFICANT COMPETITIVE INJURY AND DISRUPTION.

Table 2 Subcontractor Contact Information

COMPANY INFORMATION:	

PRIMARY CONTACT INFORMATION:

Table 3 Subcontractor Contact Information

COMPANY INFORMATION:

PRIMARY CONTACT INFORMATION:

Table 4 Subcontractor Contact Information

COMPANY INFORMATION:

PRIMARY CONTACT INFORMATION:

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 5. 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 5 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, Section 2, Response 2.1**
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, Section 2, Response 2.1, 2.3** **Template C**
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, Section 1, Response 1.1** **Template G, Section 1.2, Response 1.2.11 and Section 1.3, Response 1.3.5**

#	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, Section 1, Response 1.1** **Template G, Section 1.2, Response 1.2.11 and Section 1.3, Response 1.3.5**
5	The bidder must have three project references	**YES** ☒	**NO** ☐	**Template C**
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 H, A.2, and I.4**
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 G, Section 1.1, Response 1.1.1**

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Template B

Vendor Experience

RFP # 03410-127-14

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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.

Table 1. Vendor Organization Profile

Company Name	Magellan Medicaid Administration, Inc.
Name of Parent Company	Magellan Health Services, Inc.
Industry (NAICS) (North American Industry Classification System)	518210
Type of Legal Entity	Magellan Medicaid Administration, Inc. (MMA) is a corporation.
Company ownership (i.e., private/public, joint venture)	Magellan Health Services (Magellan) is a publically traded for-profit corporation. MMA is a wholly-owned indirect subsidiary of Magellan.
Number of full time employees	MMA has 891 full-time employees. Overall, Magellan has over 6,000 full-time employees.
Last Fiscal Year Company Revenue	$3.2 billion
Last Fiscal Year Company Net Income	$151 million
% of revenue from State and Local Government clients in the United States	97.8%
% of revenue from IT Design and Implementation Services	2.2%
Number of years in business	MMA was incorporated in the Commonwealth of Virginia on December 4, 1968, as The Computer Company; we have been in business 45 years. We began healthcare claims processing in 1972 with our first Medicaid fiscal agent contract with Virginia. We have been in the healthcare business for over 41 years.
Number of years Vendor has been providing the type of services specified in the RFP	We have been providing the types of services specified in this RFP for 30 years.
Number of Employees providing the type of services specified in the RFP	We have over 800 employees across the country that provide pharmacy claims processing, operational support, clinical program management, and financial management which includes the type of services specified in this RFP.

Headquarters in the USA	MMA's corporate headquarters is located at: 11013 West Broad Street, Suite 500 Glen Allen, Virginia 23060 Our parent company is located at the following address: 55 Nod Road Avon, Connecticut 06001
Locations in the USA	We have 30 locations throughout the United States. As noted above, MMA's corporate headquarters is located in Glen Allen, Virginia. Please refer to **Section XII, Attachment D,** for a detailed listing of all office locations.
Office Servicing this Account	The office servicing DVHA is our Glen Allen, Virginia, location. In Figure 5 below we have identified the offices that will provide services to the State.

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.

MMA proposes the use and to provide support for the State of Vermont's PBM contract. We use an extensive proposal procurement process to select subcontractors to help support our customers. Once a subcontractor is selected, we immediately begin negotiating a contract that outlines the level of service to be provided. In addition, MMA maintains overall responsibility and accountability for each subcontractor, creating a seamless interaction for the State. Before engaging a subcontractor, we sign a Business Associate Agreement (BAA) and create detailed metrics with penalties to ensure that service levels are maintained. For each customer where we engage the use of a subcontractor, an amendment is drafted that details the services to be provided and the service level agreements that must be met to ensure contract compliance.

Below we have provided details on the services that will be provided by and .

Consulting Subcontractor Overview

monitors and tracks fraud and abuse at the pharmacy, prescriber, and beneficiary levels. , in addition to MMA, has proprietary algorithms and reports that highlight outliers and utilization patterns that trend outside the norm of comparative prescribers. and MMA then utilize statistical analysis to identify patterns of fraud and outliers to facilitate potential claims and pharmacies to be audited. is currently the pharmacy auditor for both the Georgia Medicaid fee-for-service program and the TennCare program. will leverage this experience gained through these programs to provide Vermont with an effective and proven audit approach.

Audit programs consist of modules for desk audits and on-site field audits described below.

> **Desk Audits**: A desk audit provides a detailed claims analysis using statistical tools and proprietary audit reports. Claims are reviewed utilizing proprietary algorithms that are designed to find claims that may be fraudulently, erroneously, or suspiciously filed. NHC examines compound claims, controlled substance dispensing, and comparative metrics to identify trends occurring outside the norms of the rest of the network. This information

will also be used when selecting pharmacies for on-site audits. Findings are then forwarded directly to the pharmacy, and recoveries are made.

On-Site Audits: Utilizing a statistical analysis tool, pharmacies are scored and ranked based on a variety of comparative metrics and benchmarks. Throughout the year, identifies and visits pharmacies to conduct in-depth audits. At these audits, looks for:

- Phantom prescriptions
- Billing for brand drugs when generics are dispensed
- Billing for prescriptions that were not picked up
- Prescription forgery
- Double billing on secondary claims or not following COB requirements.

Once identified, pharmacies receive an initial notification letter of the pending audit and are given a date of inspection and time range of audit. Approximately 10 days before the audit, pharmacies are provided with a masked list of prescriptions so that they may retrieve the filed books of prescriptions and prepare for the audit. Approximately two weeks after the audit, pharmacies will receive an initial findings letter containing a report of audit findings and guidelines for additional documentation submission or appealing the finding. For all audit modules, if proper documentation is not provided within 30 days of receiving notice/report, then findings are considered final and undisputed. If a provider submits further information for review, a final findings letter is generated with a report of audit findings and guidelines for appeal. If providers do not dispute the final findings, then the recovery process is initiated.

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Table 2. Subcontractor Organization Profile

Systems Subcontractor Overview

, in collaboration with , will provide Vermont with a full service MTM program that offers two options:

1. Telepharmacy outreach
2. Vermont community pharmacy outreach.

Telepharmacy Outreach

The telepharmacy outreach includes MTM eligibility verification, member enrollment, comprehensive medication reviews (CMRs), and targeted medication reviews (TMRs), targeted prescriber and beneficiary outreach, and CMS reporting. In addition, the telepharmacy outreach includes network of community pharmacists that will assist with the resolution of potential concerns that trigger an alert. Every time a beneficiary fills a prescription and every time they are supposed to fill a prescription for a chronic medication, the beneficiary's medication profile is reviewed for potential medication related problems. This process is designed to identify safety concerns, adherence to national consensus treatment guidelines, adherence to prescribed medication regimens, and cost savings opportunities. Alerts are triaged based on severity levels of 1 to 10. Higher complexity alerts are completed by pharmacists while lower complexity alerts may be completed by a licensed pharmacy intern under the supervision of a pharmacist. Alert levels can also be used to dictate whether the alert should include a phone call to the beneficiary or if the alert is better handled by direct to provider communication.

Community Pharmacy Outreach

Using process, specific alerts will be routed to the patient's community pharmacy for completion. The alerts will be routed via fax. The fax form will serve as both the documentation and billing tool. Pharmacists will be reimbursed for their services and the documentation will be loaded into the software to ensure complete integration of reporting.

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Table 3. Subcontractor Organization Profile

2.0 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.

MMA is one of the largest stand-alone Medicaid pharmacy benefit managers in the nation, offering a full line of pharmacy services. We provide Medicaid pharmacy services in 25 states and the District of Columbia. We currently manage 22 million lives, process approximately 150 million prescriptions per year, and manage over $17 billion in annual drug spend.

Our expertise includes Medicaid program management, customer service, informatics, information systems, claims management, enrollment, formulary management, and clinical management — all geared towards meeting the unique needs of people who receive their health benefits through Medicaid. As part of our full-service offering, we provide URAC-accredited specialty pharmacy management services, including the management of physician-administered drugs, through ICORE, our affiliate company within the Magellan organization. MMA has three decades of pharmacy benefit management experience specifically focused on the Medicaid population including four and a half years of experience providing PBM services to Vermont. Our fee-for-service model is 100% transparent and in compliance with all federal and state regulations.

MMA is a Pharmacy Benefit Manager

MMA's service offerings span the full spectrum of pharmacy benefit management services, including direct experience in implementing, developing, and supporting pharmacy claims adjudication systems, preferred drug lists (PDLs)/formularies, P&T Committee and DUR Board operations, rebate management, network development, auditing, physician and pharmacy profiling and education programs, supplemental rebate negotiations, and a variety of utilization management programs. In providing these services, MMA is committed to reducing overall healthcare costs, while enhancing the quality of care and beneficiary satisfaction.

MMA has adopted a strategy to be compliant with MITA which includes adoption and implementation of SOA. We consistently review the MITA principles to forward our advancement of integrated business and information technology within our systems and between us and our partners and vendors. We look to build common frameworks for our systems to communicate, and migrate data between business partners, utilizing these efficiencies to offer modern and agile business and technical solutions.

We are recognized as national experts in Medicaid pharmacy program development, providing analysis (e.g., policy, reimbursement, clinical, informatics, information exchange, etc.), guidance, HIT support including e-prescribing, and services to over half the Medicaid programs in the country. It is this experience we will leverage to provide innovative and cost-effective prescription benefit practices for the Vermont pharmacy program and its stakeholders.

MMA has served different facets of the Medicaid program over the past four decades. As a national Medicaid Pharmacy Benefit Management company, we actively manage the prescription benefits for 22 million of our customers' beneficiaries across the country. Our core competency is as a full-service Medicaid Pharmacy Benefit Manager, providing all aspects of pharmaceutical benefit management.

Figure 1 below illustrates MMA's depth of experience.

Figure 1. MMA's Healthcare Experience

MMA Healthcare Services	Experience
State MAC List Development and Maintenance (Rate Setting)	12 years
Pharmacy Claims Processing	30 years
POS/ProDUR	23 years
RetroDUR	26 years
CMS Drug Rebate Administration	15 years
Supplemental Rebate Negotiation and Management for PDL	12 years
PDL Design, Development, Implementation, and Operations/Maintenance	12 years
Diabetic Supply Programs	5 years
P&T Committee/DUR Board Support	20 years
Pharmacy Prior Authorization Program Management	21 years
Call Center Services	25 years
Health Care Management Services	24 years
Fiscal Agent Services	42 years
Proprietary Pharmacy Network Management and Administration	28 years
Drug-Related Medical Supply Rebate Management	4 years
Formulary Management and Support	28 years
Pharmacy Auditing	9 years
Pharmacy Financials	42 years
Developing Medicaid Pharmacy Benefit Cost Containment Strategies	28 years
Website Services	11 years
Specialty Pharmacy Management	13 years
Reporting Services	42 years

While MMA has been in the healthcare space for 42 years, we have provided PBM services for state Medicaid populations for 30 years. Our experience in serving over half of the nation's programs has given us the ability to offer Vermont a wide variety of services that include:

- Point-of-sale (POS) design, development, implementation and operations
- Enrollment and eligibility verification
- POS prospective drug utilization review (ProDUR) edits and drug monitoring
- Formulary management
- Prior authorization
- Retrospective drug utilization review (RetroDUR)
- Billing and reimbursement services
- CMS drug rebate administration
- Detailed analysis and reporting
- Clinical consultation
- Disease management
- Third party liability services
- Help desk support for pharmacies and providers
- Pharmacy auditing services through NorthStar
- MTM services through
- Prescription drug list (PDL) development
- Supplemental drug rebate administration
- Development of custom maximum allowable cost (MAC) lists.
- E-Prescribing.

To demonstrate to DVHA our experience in servicing projects similar in scope and complexity to this project, we have highlighted our service offering .

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Our service offerings to the State include:

- Eligibility verification
- MMIS data integration
- Clinical consultation and management
- POS edit management
- ProDUR and RetroDUR services
- Prior authorization support
- Network and operations management
- Dedicated beneficiary and provider help lines
- PDL management.

PBM Implementation Success

MMA has extensive experience and an outstanding track record for successful Medicaid PBM implementations. Our proven approach to project management, provider education, and pharmacy program implementation has been fine tuned over the years and further strengthened by our enhanced tools, technology, and experienced professionals in the Medicaid PBM space.

We have successfully worked with every major MMIS vendor including HP (Vermont's current MMIS vendor); additionally, our prior background as an MMIS fiscal agent gives us a greater understanding of the interfaces required to successfully exchange data, the need to effectively coordinate programs, and the essential nature of communicating clearly and timely.

MMA is an ideal partner for DVHA to thrive in the changing Medicaid environment. We offer DVHA the advantage of a seasoned team with decades of *pharmacy and Medicaid experience, as well as previous hands-on Vermont program experience,* which is fully equipped with new and innovative tools to provide appropriate pharmacy interventions, thereby improving clinical outcomes while managing costs. We will work collaboratively with DVHA to develop a customized program that is truly transparent and highly adaptable to the changing pharmacy landscape.

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.

As an organization known for our industry-leading approach to Medicaid fee-for-service and managed care pharmacy benefit management, we offer DVHA over 40 years of Medicaid-specific experience and 30 years of PBM experience. We currently provide services to 25 states and the District of Columbia and manage over 22 million lives and $17 billion in drug spend. With our experience in managing the Medicaid population, we have gained an understanding of the population these programs serve, the state and federal rules under which they operate, and operating within the regulations that preserve clinically appropriate care.

Pharmacy benefit management in the Medicaid industry provides for a dynamic environment that is impacted by pharmaceutical manufacturer trends, drug distribution trends, patient demographics, quality of life, and economic trends. We believe that future trends in the PBM industry include:

- Increased focus on Medicaid Information Technology Architecture (MITA) and the CMS MECT
- Increase in specialty pharmacy dispensing
- Existence of fragmented drug management and delivery systems
- Increase in the number of eligible members for Medicaid and Medicare due to baby boomers
- Increase in innovative payment methodologies by CMS in order to provide the government value.

Below we have provided more details on each of these trends and how our solution will translate into benefits for Vermont.

Trend #1

One of the key trends is the evolution toward the Medicaid Information Technology Architecture (MITA) roadmap and toolkit, which enables states to transform their more dated Medicaid Management Information Systems (MMISs) into enterprise-wide beneficiary-centric systems. This evolution is instrumental to enabling AHS and DVHA goals, which ultimately align information technology opportunities with the upcoming business needs, such as migration to a single payer solution.

Solution

Our pharmacy benefit management solution complies with CMS Seven Standards and Conditions and CMS' MITA 3.0. Our solution will be closely integrated with DVHA's MMIS, which is an integral part of Vermont's HSE. Additionally, we fully supports AHS and DVHA goals to protect the availability of clinically appropriate medication services at the most reasonable cost possible, and to provide access to high quality pharmacy benefits in Vermont's publicly-funded programs.

Trend #2

Another key trend is the dramatic increase in Specialty drug expenditure. Specialty costs are trending rapidly and are expected to be 50 percent of total drug cost by 2018.

Solution

We have a proven and transferable specialty management program that integrates medical and pharmacy benefits. Our comprehensive specialty management suite of services provides beneficiaries with access, outcomes, and improvement in quality of life. In addition, through our specialty management program, ICORE, DVHA beneficiaries receive a unique Site of Service management program. By evaluating the appropriate site of service for beneficiaries, we are able to improve his or her experience with care and reduce costs.

Trend #3

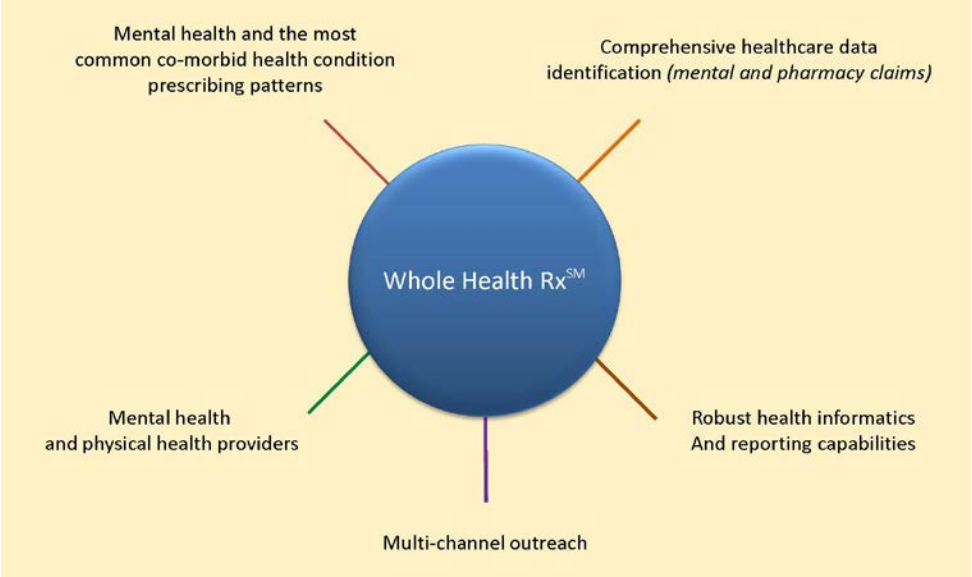
Fragmented drug management and delivery systems continue to exist across medical and pharmacy benefits, particularly in vulnerable populations with mental health conditions.

Solution

To help reduce fragmentation in care for medical and pharmacy benefits, we utilize Whole Health Rx^{SM}. Whole Health Rx leverages medical diagnosis, pharmacy claims, and lab data to identify beneficiaries taking mental health medications who also have common co-morbid

physical health conditions that affect cardiovascular, endocrine, and respiratory systems in addition to targeting patients with potential substance abuse issues. Figure 2 below illustrates Whole Health Rx's approach as the only all-inclusive product in the market that addresses **both** physical and mental health.

Figure 2. Whole Health Rx



Whole Health Rx uses advanced proprietary clinical algorithms that screen claims with the purpose of identifying prescribing patterns that are inconsistent with evidence-based, best practice guidelines. The program then reaches out to medical practitioners and engages them in a personalized consultation that can include telephonic, on-line, and face-to-face consultations, as well as ongoing education.

Trend #4

There will be an increase in the number of beneficiaries covered for Medicare and Medicaid. This is based on the age-in of the baby boomers, about 3 percent per year, for Medicare, and the changes in laws due to healthcare reform for Medicaid (about 16 million individuals). This may increase Vermont's program size, but also increase costs disproportionately due to the multiple disease states of these populations.

Solution

Lengthening life spans mean that people access Medicare Part D benefits longer than in the past contributing to the total number of people in the program. MMA works diligently to maximize the value of the pharmacy benefit for its customers. To help manage these trends, we actively focus on solutions that support your growth, and improve each beneficiary's pharmacy experience. Some of the ways in which we accomplish this is through:

- Competitive overall cost management by reducing pharmacy trend over the course of the contract.
- Comprehensive, statewide pharmacy provider network management that provides broad access and high service levels for the State's beneficiaries.
- Plan options and design through a single platform for claims adjudication offers DVHA benefit design flexibility with fail-safe security.

- Clinical pharmacy management programs through a collaborative approach with DVHA to help it realize significant savings and improved beneficiary outcomes through evidence-based clinical management.
- Quality management through industry best practices that provides quality management and assurance in each aspect of program design, implementation, and management. A personal health report card gives DVHA a tangible way to demonstrate the value of its pharmacy benefit management to beneficiaries. Beneficiaries can see exactly what medications have been prescribed and how adherent they are to those therapies.
- Disease and other care management programs with integrated solutions that include a Medication Therapy Management (MTM) program.
- Health improvement, education, and wellness programs that offer collaborative clinical support to give recommendations to DVHA on how we support Vermont in helping members improve their health status.
- Furthermore, we are committed to the delivery of products and services that address the current healthcare revolution. MMA has invested in strategic relationships, technology and process innovations to address the rapid changes in areas such as the following:
    - Healthcare payment systems
    - Network development
    - Benefit structures
    - Consumer and provider empowerment
    - Systems and data connectivity/integration and interoperability requirements.

We continue to provide consultative service and expertise through our customer teams comprised of account managers, customer service specialists, clinical pharmacist executives, business analysts, and benefit specialists. As a result of our focus and understanding of managed care organizations, we will meet and exceed the needs of DVHA. Our strategic direction is based on experience and requisite expertise serving Medicaid and Medicare plans.

Trend #5

CMS will continue to look for innovative payment methodologies in order to provide the government value. This will include demonstrations and more strict “pay for performance” rules. This is evidenced now by the advent of Accountable Care Organizations (ACOs), Medical Homes, and the Dual Demonstration Projects.

Solution

We provide DVHA with flexibility to customize benefits in order to meet needs quickly. We are able to adapt to innovative programs and deliver reporting in order to assist plans with the specialized government reporting needed to fulfill their requirements. Whether it is innovative benefit designs, development of new products and services, or customized PDLs, we will work with DVHA to provide the best value. As DVHA moves to a single-payer solution through 2017, we will collaborate with DVHA to develop solutions that help to meet program goals.

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.

MMA is one of the largest stand-alone pharmacy benefits managers in the nation, offering a full line of pharmacy services and providing transitional assistance services for the Medicare Prescription Drug Discount Card Program. MMA has served different facets of the Medicaid program over the past four decades. Our core competency is as a full-service Medicaid Pharmacy Benefit Manager, providing all aspects of pharmaceutical benefit management. We provide expertise in Medicaid program management and administration, clinical management, informatics, cost containment strategies, information systems, claims management, enrollment, PDL management, and customer service — all geared towards meeting the unique needs of people who receive their health benefits through Medicaid.

We have a successful track record for on-time delivery of Medicaid pharmacy operations. We have high levels of customer satisfaction based on scores from our annual Customer Satisfaction Survey. In 2013, 100% of our customers would recommend us as a Medicaid solution.

We are recognized for delivering positive, measurable results in pharmacy benefit management. Through the development and management of innovative clinical and technical solutions (e.g., multi-state rebate pools, Pharmaceutical Care Coordination Program, AutoPA, academic detailing), we help states manage their pharmaceutical spending while preserving clinical outcomes. Our staff is knowledgeable and broadly experienced in healthcare policy development, healthcare program management, Information Technology, pharmacy and other healthcare claims processing, clinical data analysis, and the unique challenges presented by the pharmaceutical industry.

We provide our customers with the following pharmacy benefits management services:

- **Point-of-sale claims processing:**
    - Real-time eligibility verification and claims processing at the point of sale
    - Flexible POS system with over 97% of change requests configurable
    - Table-driven, rules-based
    - Over 4,500 edits/audits supporting robust clinical and fiscal editing and auditing at the point of sale
    - Web claims submission
    - AutoPA and WebPA
    - e-Prescribing (support and prescription routing).
- Preferred Drug List (PDL)/Formulary and Rebate Management:
- Medicaid MCO rebates

- Two options for PDL Pool opportunities
  - Our National Medicaid Pooling Initiative (NMPI), the first CMS-approved and largest multi-state rebate program in the nation
  - TOP$SM, The Optimal PDL $olutionSM
  - PDL/Formulary development and management
  - Supplemental rebate management, negotiations, and dispute resolution
  - CMS rebate administration
  - DME, diabetic supply programs, and rebate management.
- Clinical management services:
  - Evidence-based clinical prior authorization programs
  - P&T Committee and DUR Board support
  - Physician and pharmacy profiling
  - Disease management and adherence programs
  - Consultation in support of policy development
  - Pharmaceutical Care Coordination (PCC)
  - Therapeutic substitution or interventions
  - Generic first
  - Medication therapy management services through .
  - Whole Health RxSM — a clinical quality management program addressing drug management and delivery systems across behavioral, medical, and pharmacy benefits.
- Cost containment strategies and implementation:
  - SMAC List
  - Prior Authorization:
    - Step Edits
    - Protocol, policy, and clinical criteria
  - Clinical Edits:
    - Dispensing limits:
      - Quantity limits
      - Unit of use edits
      - Duration or days supply limitations
  - ProDUR
  - Dose optimization
  - Third Party Liability (TPL) and full Coordination of Benefits (COB) processing capability at the point of sale
  - 340B management
  - Prescription Limits.
- Benefit design and management:
  - Step Therapy
  - Quantity and duration limits
  - Tiered and adherence-based co-payments
  - Consultative assistance with cost share management
  - Consultative assistance with reimbursement management
  - Financial forecasting
  - Enhanced Benefit Administration (EBA).

- Drug Utilization Review:
    - Clinical drug utilization review including prospective, concurrent, and retrospective drug utilization review (RetroDUR), supported by nearly 100 clinical pharmacists throughout the country
    - Profiling/intervention clinical services based on DUR data and pre-defined criteria
    - DUR Board support.
- Provider and Beneficiary Outreach and Education:
    - Physician and pharmacy education
    - Academic detailing
    - Pharmacy audits
    - Beneficiary enrollment.
- Preferred Drug List Development and Management:
    - Contracting
    - Therapeutic class reviews
    - Financial modeling.
- Provider Payment:
    - Check write and EDI 835 remittance advice for providers
    - EFT
    - WebPA
    - GAAP-compliant financial system
    - Provider network management.
- Call Centers available 24 hours a day, 7 days per week, 365 days per year:
    - Pharmacy Support (Technical) Call Center
    - Clinical Support Call Center
    - Beneficiary Call Center
    - Web Support Call Center
    - Voice-activated IVR for inquiry and eligibility verification
    - Ombudsman services.
- Program Management and Reporting:
    - Fraud and abuse detection
    - Data management, reporting
    - Healthcare analytics
    - Trending of pharmaceutical and medical claims data
    - Client report card, including comparative metrics from other customers.
- Pharmacy Network Management:
    - Fraud and abuse detection
    - Audits
    - Proprietary network — national and regional.
    - Mail Order

- Specialty Pharmacy Management
    - Distribution
    - Preferred drug list management
    - RetroDUR
    - Integrated Prior Authorization Programs
    - Variable Fee Schedules
    - Medical Pharmacy Solutions.

MMA considers innovation one of our core competencies. We have a history of delivering innovative clinical, technological, and programmatic solutions to our customers. We created one of the first OBRA '90-based RetroDUR programs in the country and developed the first and second CMS-approved Medicaid supplemental rebate pools — an innovative concept that others use as "the prototype." We were the first to develop a rebate program for diabetic supplies. We have removed barriers to the advancement of Fee-for-Service Medicaid pharmacy program management and embraced technology with the aim of furthering the efficiency of health care and increasing the quality of care. We have experience and proven solutions with the two major cost drivers of any pharmacy benefit program — specialty pharmacy and mental health.

MMA uses our focused expertise in government programs to create solutions that help states manage their Medicaid programs. With this specialized market in mind, we analyze the landscape and follow emerging trends and regulations that will impact the way programs are administered. We have been responsive to evolving regulations and industry trends and changes and have created solutions to assist states in taking advantage of new management tools and opportunities such as web-based applications.

Below in Figure 3 we provide an overview of the Medicaid pharmacy operations customers we currently serve, as well as our recently completed contracts.

Figure 3. Medicaid Pharmacy Clients and Services

CONFIDENTIAL MATERIAL: CONTAINS HIGHLY SENSITIVE PROPRIETARY AND/OR TRADE SECRET INFORMATION; PUBLIC DISCLOSURE WILL CAUSE SIGNIFICANT COMPETITIVE INJURY AND DISRUPTION.

Project	POS Design, Development, Implementation, and Operations	Enrollment and/or Eligibility Verification	POS Pro-DUR Edits & Drug Monitoring	Formulary Management	Prior Authorization	RDUR	Billing and Reimbursement	CMS Drug Rebates	Analysis & Reporting	Clinical Consulting	Disease Management	Cardholder/ Provider Services	TPL	Help Desk	Pharmacy Audits	PDL Develop./ Imple. & Supple. Rebate	MAC List
Magellan Medicaid Administration Current Contracts																	
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Project	POS Design, Development, Implementation, and Operations	Enrollment and/or Eligibility Verification	POS Pro-DUR Edits & Drug Monitoring	Formulary Management	Prior Authorization	RDUR	Billing and Reimbursement	CMS Drug Rebates	Analysis & Reporting	Clinical Consulting	Disease Management	Cardholder/ Provider Services	TPL	Help Desk	Pharmacy Audits	PDL Develop./ Imple. & Supple. Rebate	MAC List
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Project	POS Design, Development, Implementation, and Operations	Enrollment and/or Eligibility Verification	POS Pro-DUR Edits & Drug Monitoring	Formulary Management	Prior Authorization	RDUR	Billing and Reimbursement	CMS Drug Rebates	Analysis & Reporting	Clinical Consulting	Disease Management	Cardholder/ Provider Services	TPL	Help Desk	Pharmacy Audits	PDL Develop./ Imple. & Supple. Rebate	MAC List
	●	●	●		●	●	●	●	●	●		●	●	●			
				●					●	●						●	

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.

As a leader in the public sector market for healthcare management and information services, MMA provides integrated clinical management, superior operational administration, and leading information technology solutions including comprehensive pharmacy benefit management services that include Preferred Drug Lists and supplemental rebate negotiation services. With 30 years of pharmacy benefit management experience specifically focused on the Medicaid population, we are recognized as national experts in Medicaid pharmacy program development and cost containment strategies providing analysis (policy, reimbursement, clinical, informatics, and information exchange), guidance, and services to more than half the Medicaid programs in the country.

Figure 3 above in Section 2.3 shows the customers that we serve in the public sector market, the services we provide, and the duration of our relationships.

Experience Working with DVHA

From July 2001 through December 2005 we provided PBM services for DVHA. This included:

- Pharmacy POS system design and implementation
- ProDUR edits and drug monitoring
- Prior authorization services
- RetroDUR monitoring
- Provider billing and reimbursement
- Detailed analysis and reporting
- Clinical consultation
- Provider and Beneficiary Call center support
- PDL development
- Supplemental rebate management
- MAC list development.

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.

Below we have provided details on locations where work on Vermont's contract will be performed. All work for MMA and our subcontractors will be performed from the United States.

Key Project Personnel Location

Key MMA project personnel assigned to the DVHA contract will be located in Williston, Vermont, and available to the State from 8:00 a.m. – 4:30 p.m. Eastern Time, Monday through Friday. Key staff will follow the State's holiday schedule. Figure 4 below identifies the location where key project personnel will be physically located.

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Figure 4. Key Project Personnel Locations

Name	Role	Location
Key Project Personnel		
Support Project Personnel		

During implementation, support project personnel will be available to travel to Williston, Vermont, as needed.

We will provide a local site in Williston within five miles of DVHA to accommodate all in-person meetings and support during the contract period.

Our corporate real estate team follows a standard process for site selection. We use demographics and geo-access tools to determine the general location. We also provide project management for construction, if necessary. Property is sourced through an external network of real estate professionals with broker-tenant representative relationships that cover the U.S.

Call Center Locations

We own and operate two call centers located in St. Louis, Missouri, and Glen Allen, Virginia that operate 24 hours a day, 7 days a week. To support DVHA, we propose our Glen Allen, Virginia location as the primary call center. DVHA will be supported by a designated team in Glen Allen, Virginia, and a dedicated toll-free telephone number. Additional support is provided through St. Louis, Missouri, as needed during peak call volumes.

Our call centers operate in a virtual environment. This allows incoming calls to be routed to the first available agent during telecommunication disruptions or office closures. Secure VPN access is provided to critical staff enabling them to work from home should office facilities be unavailable or unusable.

Key Services Location

In Figure 5 below we have identified the locations where services identified in Section 2.2 will be provided.

Figure 5. Service Locations for DVHA Contract

Location	Services
Williston, Vermont	• Account management services • Benefit design and clinical consultative support • DUR Board Support • Support of the State's Academic Detailing program
Orlando, Florida	• Specialty pharmacy services • Management of physician-administered drugs
Astoria, New York	
Glen Allen, Virginia	• POS claims processing • Automated COB • Post-payment claims management • Specialty pharmacy services • Provider network support • Web portal support for beneficiaries and providers • Primary call center support • E-prescribing and e-prior authorization • Utilization management programs

Location	Services
	• Prior authorization program • DUR • SMAC program and FUL • Reporting and analytics • Quality assurance • Management of CMS, State, and Supplemental Drug Rebate programs • Support for SSDC multi-state supplemental rebate consortium • 340B management
St. Louis, Missouri	• Secondary customer call center support • Data Center
Atlanta, Georgia	• Management of desktop and on-site pharmacy auditing
San Diego, California Tucson, Arizona	• Medication Therapy Management

Scope of Work Deliverables

below in Figure 6 we have identified the percentage of work that is to be performed in Vermont for each task identified in Section 2.7.

Figure 6. Percentage of Work to be Completed in Vermont

Task	Deliverable	% of Work to be Performed in Vermont
Task 1 — Project Initiation and Planning	Deliverable 1 — Project Kick-off Presentation	100%
	Deliverable 2 — Project Management Plan	20%
	Deliverable 3 — Project Work Plan and Schedule	20%
	Deliverable 4 — Monthly Project Status Reports	20%
Task 2 — Requirements Validation	Deliverable 5 — Requirements Methodology and Template	30%
	Deliverable 6 — Cross-Walk of RFP Functional against Legacy System Functionality	30%
	Deliverable 7 — Detailed Functional and Non-Functional Requirements Traceability	30%

Task	Deliverable	% of Work to be Performed in Vermont
	Matrices	
Task 3 — System Design	Deliverable 8 — Configuration Design Document	10%
	Deliverable 9 — Data Integration and Interface Design Document	10%
Task 4 — Configuration and Development	Deliverable 10 — Client Review of Configuration	100%
	Deliverable 11 — Unit Testing Scripts and Results	20%
Task 5 — Testing	Deliverable 12 — Documented System Test Results	10%
	Deliverable 13 — User Acceptance	100%
Task 6 — Training	Deliverable 14 — Training Plan	10%
	Deliverable 15 — Training Materials	10%
	Deliverable 16 — Documented Evidence of Successful End-User Training	20%
Task 7 — Deployment	Deliverable 17 — Deployment Plan	10%
	Deliverable 18 — CMS Certification	10%
	Deliverable 19 — System Documentation	10%
	Deliverable 20 — Performance SLAs	10%
	Deliverable 21 — Rollout	20%

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.

At this time neither MMA, nor any of our subcontractors, have an existing business relationship with 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.

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Table 4.Projects completed in the last five years

Ref #	Project Name	Customer Name	Customer Contact	Project Duration	Business Dispute?
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					

Subcontractor Operations Contract Completed in Last Five Years

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This is not applicable to our subcontractor, . All current contracts are in progress.

Table 5. Subcontractor Operations

Ref #	Project Name	Customer Name	Customer Contact	Project Duration	Business Dispute?
1.					YES ☐ NO ☐
2.					YES ☐ NO ☐
3.					YES ☐ NO ☐
4.					YES ☐ NO ☐
5.					YES ☐ NO ☐

Below we have provided completed contracts for

Table 6. Subcontractor Operations

Ref #	Project Name	Customer Name	Customer Contact	Project Duration	Business Dispute?
1.					NO ☒
2.					NO ☒
					YES ☐ NO ☐
					YES ☐ NO ☐
					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.

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Figure 7. Pending and Closed Litigation

Case	Date Action Filed	Summary	Status

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.

As a wholly-owned indirect subsidiary of Magellan, MMA's financial information is reported in aggregate up through our parent company. For 2012, Magellan's D&B rating was 5A2.

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.

MMA is a wholly-owned indirect subsidiary of Magellan Health Services, Inc. (Magellan). We bring significant financial resources to support this engagement and the many projects that we operate for state, federal, and commercial healthcare organizations across the country. Our financial results demonstrate that MMA is a financially stable company that will be a long-term partner for DVHA. As we do with other projects nationwide, MMA will make a significant financial investment in the State's program to ensure consistent positive outcomes throughout the contract term. We have a strong financial profile with sufficient resources to meet potential project changes.

We are pleased to provide data for the fiscal year ending on December 31, 2012, in which Magellan reported net revenue of $3.2 billion and net income of $151 million. Segment profit for Magellan's business segments for the same period was $267 million.

The financial community assesses various financial measures as key indicators of a company's financial health and stability and Magellan's overall strong financial profile. We do not maintain long-term debt, the ratio of Assets/Liabilities is over 3:1, and the ratio of current assets to current liabilities is over 2:1. These ratios demonstrate a conservative financial position.

As a public company listed on the NASDAQ exchange (ticker symbol MGLN), we are subject to extensive public scrutiny and review by the Securities and Exchange Commission, the NASDAQ exchange, and the general investment community. We make available our publicly filed financial statements quarterly on Form 10-Q and annually on Form 10-K with extensive notes, as well as reporting any major events in Form 8K filings, as required. Magellan must also report

on and provide certifications under the Sarbanes-Oxley Act of 2002 regarding its financial controls, which are also reviewed by its external auditors, Ernst & Young. This provides for a much higher standard of financial transparency and rigor, with a higher reporting frequency, than a privately owned company.

Additional descriptive and financial information concerning Magellan, including audited financial statements, can be found on our parent company's Web site, at www.magellanhealth.com. A separate, independent audit is not conducted for MMA.

Below in Figure 9 we provide a highlight of key financial data for Magellan.

Figure 8. Financial Highlights for FY 2012

Please refer to **Section XII, Attachment F** for our two most recent SEC Forms 10K.

Change in Ownership

MMA is unable to comment on prospective merger or acquisition activity because:

- Of non-disclosure commitments associated with the evaluation of prospective transactions
- Select disclosure of prospective merger or acquisition activity would be a violation of fiduciary duties as a publically traded company.

We are in an exciting state of product growth. As such, the company may at some future time be involved in merger or acquisition activity. We do not anticipate that any potential merger and acquisition activity or stock repurchase activity will in any way diminish our ability to provide services to the State.

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

Credit References

Institution	Address	Phone Number

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.

Magellan Health Services, Inc. will unconditionally guarantee performance by MMA of each and every obligation, warranty, covenant, term and condition of the contract. We acknowledge and agree that if the State determines MMA does not have sufficient financial resources to guarantee MMA's performance, the State may require MMA to obtain another acceptable financial instrument or resource from Magellan Health Services or to obtain an acceptable guarantee from another entity with sufficient financial resources to guarantee performance.

4. General Assumptions

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

Table 7.Vendor Experience Assumptions

We do not have any assumptions to Template B. Vendor Experience.

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

We confirm that all required forms have been included with our proposal as requested.

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.

Table 8.Proposal Exceptions Summary Form

State of Vermont RFP Reference	Vendor Proposal Reference	Brief Explanation of Exception	State of Vermont Acceptance (sign here only if accepted)
(Reference specific outline point to which exception is taken)	(Page, section, items in Vendor's proposal where exception is explained)	(Short description of exception being made)	
1. Attachment F: Agency of Human Services' Customary Contract	Section 11, Page 27.	MMA has reviewed the State and AHS Customary Contracting, and agrees to all provisions, with one exception. We would like to delete "(including archival back ups)" from this provision. As part of Magellan's common data center architecture archival, offsite backups are encrypted and sent to iron mountain on a monthly basis. Those archives are backups of our shard data center environment and would include Vermont and other Client data. They are only retrieved when necessary due for Legal or to diagnose historic questions. Magellan treats all Client data in accordance with the contract terms and the monthly archived, encrypted, data stored off-site at iron mountain would adhere to those contract terms.	
2.			

Application Information Sheet

MMA has provided a completed Applicant Information Sheet as requested. The complete sheet is located behind this page. A copy of our W-9 has been provided in **Section XII, Attachment E.**

Certification and Assurances

MMA has provided a completed Certification and Assurances sheet as requested. The complete sheet is located behind this page.

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 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 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: MMA for the funding period beginning May 1, 2014 and ending December 31, 2019 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: 1/24/14

Title: President, Magellan Medicaid Administration, Inc.

Magellan Medicaid Administration, Inc.

Vermont Tax Certificate and Insurance Certification

MMA has provided a completed Tax Certification and Insurance Certification as requested. The complete sheet is located behind this page.

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 _51_ Days After Notice of Award

Terms of Sale Per requirements of RFP/Cost Proposal

Quotation Valid for ___180___ Days _____

Date: __1/24/2014_____

Name of Company: Magellan Medicaid Administration

Telephone Number: 508-562-2655

Fed ID or SS Number: __54-0849793_____

Fax Number: 804-548-0015

By: _____

Signature (Bid Not Valid Unless Signed)

Name: Timothy P. Nolan, President

(Type or Print)

This is NOT AN ORDER

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

Magellan Medicaid Administration, Inc.

SCHEDULE D RELATED PARTY DISCLOSURE

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

This section is not applicable to MMA's response. We do not have any related party relationships to disclose.

Nondisclosure

To be created as needed by vendor

This section is not applicable. MMA will not require a separate non-disclosure agreement.

Federal Lobbying Disclosure

To be created as needed by vendor

This section is not applicable. MMA does not have any disclosures.

Certification of Insurance

Provided by vendor

MMA has provided our Certificate of Insurance in **Section XII, Attachment G.**

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Template C

Vendor References

RFP # 03410-127-14

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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.

CONFIDENTIAL MATERIAL: CONTAINS HIGHLY SENSITIVE PROPRIETARY AND/OR TRADE SECRET INFORMATION; PUBLIC DISCLOSURE WILL CAUSE SIGNIFICANT COMPETITIVE INJURY AND DISRUPTION.

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.

CONFIDENTIAL MATERIAL: CONTAINS HIGHLY SENSITIVE PROPRIETARY AND/OR TRADE SECRET INFORMATION; PUBLIC DISCLOSURE WILL CAUSE SIGNIFICANT COMPETITIVE INJURY AND DISRUPTION.

Template C. Vendor References

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Table 6	Reference 1	NorthStar – Georgia Department of Community Health	18
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Template D

Project Organization and Staffing

RFP # 03410-127-14

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10. Project Organization and Staffing Assumptions 23

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.

MMA selected our proposed Vermont project team, key personnel, support staff, and project organization with the goal of optimally serving the State of Vermont and ensuring the successful implementation and operation of our PBM solutions without disruption to the beneficiary, provider, and system user communities. Our team of professionals is supported by experienced and expert staff members who have a proven track record of success in pharmacy implementations and operations. We will provide the State with a dedicated account management team that has over 40 years of combined experience in managing and supporting Medicaid customers. Our dedicated Vermont key personnel are comprised of all positions identified in Section 2.5 of the RFP and include:

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Visibility and access to key members of our organization are crucial components of our account management strategy. Providing clear reporting lines, both direct and indirect, helps us to promote internal efficiencies and in turn deliver superior service to the State. Our account management structure also incorporates linkage to our executive leadership. This allows us an added layer of top-level accountability and support, which ensures that high impact account concerns receive the attention, resources, and timely response required.

In addition, we provide oversight, guidance, and support through a firm accountability structure and application of disciplined processes in the following areas:

- Account management control methods
- Account reporting services
- Ensuring required staffing levels
- Response to State requests on a timely basis

- Interacting and coordinating with services with other business offices
- Identifying and resolving operational issues.

We understand that incumbent key project personnel currently working on the State's contract are valuable resources to the State. Therefore, we are amendable to offering employment to any of the incumbent's key staff for this account, with DVHA's recommendation and approval.

In addition to the Key Project Personnel identified above, we have identified support staff that is available to assist DVHA's dedicated team throughout the contract and during implementation:

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Subcontractor Support Staff

The support staff assigned by our proposed subcontractors for this project are described below.

NorthStar HealthCare Consulting Staff

_____, is a designated resource to the Vermont contract responsible for the State's pharmacy auditing program. As noted in the organizational charts provided in Figure 4 and Figure 5, below, _____ staff is accountable to _____ MMA's Compliance Officer.

MedImpact Healthcare Inc. Staff

_____ is a designated resource to the State's contract, providing support for MTM services. _____ is accountable to _____, MMA's Vendor Relations Manager as outlined in Figure 4 and Figure 5 below.

For both key project and support personnel, we have identified personnel hours by phase for the entire project in Figure 1. This includes staff from our subcontractors, NHC and MedImpact.

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Figure 1. MMA Personnel Hours, Level and Role.

Personnel	Role on Vermont PBM Project	Implementation Phase Hours[1]	Ongoing Operations Phase Hours[2]
Key Project Personnel			
Support Staff			

[1] Hours were determined based on an anticipated contract start date of May 2014, with go-live date of January 1, 2015.

[2] Hours noted in this column are for each year of ongoing operations, including any contract extensions that may be granted.

Personnel	Role on Vermont PBM Project	Implementation Phase Hours[1]	Ongoing Operations Phase Hours[2]

Shoulder-to-Shoulder Links

Critical to a successful implementation and ongoing support are clear and open lines of communication. To help facilitate shoulder-to-shoulder links with Vermont staff, we provide a detailed communication plan that is customized to the State's needs. The plan identifies key stakeholders and participants in the project including their roles and responsibilities. The established Communication Plan includes a monthly contract management report that provides:

- Progress toward achieving goals and initiatives stated in the business plan
- Activities by functional area
- Achievement of performance standards for the previous month and identification of any performance standards that were not met
- Summary of contractor activities and key volume indicators for the month and cumulative for the fiscal year
- Establish quarterly milestones and reporting schedules
- Establish dispute process trigger mechanism
- Reconciliation reporting on all claims/encounters processed.

Monthly reports are provided to the State within seven business days following the close of the month.

We will use our shared document repository to store implementation artifacts, key project documentation, and other State-facing information. The portal is available 24 hours a day, seven days a week and requires login credentials to view content. A Resource Documentation Log is also available to describe each document and to identify when it was created, revised, and approved by the State.

_____, our proposed Implementation Project Manager, will facilitate weekly status meetings by teleconference or in-person at State offices as needed during implementation. During these meetings, we present the current project status dashboard and cover milestones recently achieved and finished over the reporting period. _____ also facilitates conversation around issues and challenges and discusses an action plan when necessary.

The project status report provided during weekly meetings includes an update on overall project health including items that may affect schedule, budget, or deliverables during each phase of the project. The report highlights:

- Overall project health
- Status of deliverables
- Upcoming milestones
- Key assumptions
- Risk and risk avoidance strategies.

In Figure 2 below we provide a sample status report.

Figure 2. Sample Project Management Status Report

To help bolster shoulder-to-shoulder links between MMA and the State, our ongoing management process includes collaboration with the State to discuss and recommend additional programs, services, or modifications that are required or requested. To facilitate ongoing support, we adhere to a mutually agreeable schedule of in-person meetings as needed. We arrange for weekly touch-base meetings to assess ongoing projects and activities. On a quarterly basis, we will deliver detailed plan reports to discuss plan improvements, strategy, and recommendations for plan improvement. All meeting requirements will be mutually agreed to during implementation with key MMA personnel and State resources.

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.

MMA's corporate resources will be closely involved in the DVHA pharmacy program. Our corporate organizational chart is shown in Figure 3 below. Figure 4 below outlines the organizational structure proposed to carry out the implementation of the State's contract, including State resources. This chart outlines proposed subcontractors and their accountability to MMA staff. Figure 5 illustrates the ongoing operations and support staff. Together, these charts illustrate the continuity of our staffing plan and the important DVHA-specific knowledge base built through the hands-on experience gained during the Implementation Phase.

Our Board of Directors includes:

Rene Lerer, M.D. Executive Chairman Magellan Health Services, Inc.	Barry M. Smith Chief Executive Officer Magellan Health Services, Inc.	Eran Broshy Managing Director EBH, LLC
Michael S. Diament Former Portfolio Manager & Director of Bankruptcies and Restructurings Q Investments	William D. Forrest Managing Partner & Equity Owner Tower Three Partners, LLC	Robert M. LeBlanc Managing Director Onex Corporation
William J. McBride Retired President and COO Value Health, Inc.	Michael P. Ressner Retired Vice President of Finance Nortel Networks Corporation	Mary F. Sammons Retired Chairman of the Board Rite Aid Corporation

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Figure 3. MMA Corporate Organizational Chart

Figure 4. State of Vermont Implementation Chart

Figure 5. State of Vermont Ongoing Operations

MMA's proposed Key Personnel meet all qualifications and experience outlined in RFP Section 2.5. In accordance with the notification requirements identified in this section, we agree to:

- Seek and receive State approval before hiring or replacing Key Project Personnel
- Remove Key Project Personnel as requested and develop a replacement plan within 2 weeks of request for removal
- Provide written notification of anticipated vacancies within 2 business days of the individual's resignation, Vendor's notice to terminate, or the position otherwise becoming vacant
- Provide status update reports every 30 days on progress of replacement candidates recruiting process
- Have a qualified replacement in place within 90 calendar days of last day of employment of the Key Project Personnel
- Provide the first 30 days of a replacement resource with equivalent skill at no charge.

Below we have provided high level responsibilities for key project and support personnel assigned to the Vermont project.

Key Project Personnel

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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)

Table 1. Vendor Key Project Personnel

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

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)

Table 2. Subcontractor Key Staff

CONFIDENTIAL MATERIAL: CONTAINS HIGHLY SENSITIVE PROPRIETARY AND/OR TRADE SECRET INFORMATION; PUBLIC DISCLOSURE WILL CAUSE SIGNIFICANT COMPETITIVE INJURY AND DISRUPTION.

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

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.

During the earliest phases of project planning, MMA implementation staff determines the resources required for the project. Our primary considerations in developing a staffing plan include:

- Determining the number and type of personnel required
- Identifying the technical architecture requirement
- Reviewing functional elements of the operation to ensure optimization of FTE requirements.

To ensure that project deliverables and go-live dates are met, we cross-train staff on various functions to provide adequate coverage of duties for the entire contract. As necessary, we reallocate tasks among other staff members to provide support as needed. In Figure 6 below in Response 9 on page 21, we provide a staffing plan for the Vermont contract.

5. Staff Management

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

We use a four-pronged approach to finding the best talent in the industry:

- **Internal promotions and development:** We identify and track talented and motivated employees and then work closely with their managers to determine development opportunities and help them advance their career. When roles become available within the organization, they are posted internally and internal applicants are given special attention.
- **Job postings:** We post open positions to external sources, utilizing job boards such as Monster and Career Builder. Other resources include niche boards for IT and clinical staff, job posting aggregators, and minority business and women-owned websites, news outlets, and organizations.
- **Networking and referrals:** We use advanced recruiting techniques to source top talent for positions at all levels, including senior level executives, medical directors and clinical staff. The techniques include web-based technology, social media (Linked In), direct mail, email blast capabilities, and proven cold calling methods.
- **Recruiting firms:** We maintain strong ties with proven successful recruiting firms that specialize in healthcare staffing, both for temporary and full-time positions. In those rare situations where our internal staff does not identify the right candidate (which is less than 1% of the time), we can engage an external search partner. We also have excellent relationships with minority, women and veteran-owned businesses, which can assist in our recruiting as needed.

Our Hiring Approach

Once a candidate goes through our Talent Acquisition Team's screening phase, they are presented to the hiring manager. Our interviewing process includes: two-to-three meetings with subject matter experts, the direct hiring manager, a Human Resource Business Consultant, and the next level of leadership. Executive level candidates meet with senior leaders up to and including our CEO.

We use behavioral interviewing techniques to validate if the candidate's past professional experience is relevant. We also conduct a detailed reference check, drug testing, licensure verification (if applicable), and background checks for all staff.

Approach to Ongoing Development

To help retain our top talent, we foster an environment that includes open communication, virtual connections, succession planning for promotional opportunities, and a robust training program. Facets of this include:

- **Leader-employee communication** – We believe in a culture of open, candid, two-way communication between leaders and employees. We also encourage employees to understand and share in the company's mission, vision and values and how these relate to their work.
- **Annual all-employee survey** – In 2012, when asked if the employee planned to be working at MMA one year from now, 84% of employees said they did, exceeding healthcare industry norms by close to 10%.
- **Comprehensive benefits package** – We offer an excellent menu of benefits that includes medical, dental, vision, life, AD&D, 401(k), Employee Stock Purchase Plan and more. Our pay for performance culture ensures we reward and retain top talent.
- **Culture of caring** – As an active corporate citizen, MMA is dedicated to improving the lives of individuals and families in need through corporate resources and employee-driven volunteerism. We also focus on supporting each other through programs like eMbrace, which offer financial assistance to employees in the event of a tragedy, disaster or other extreme life event to cover basic living expenses while recovering and rebuilding, as necessary.

6. Training Policies and Procedures

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

We provide our employees with an LMS (Learning Management System) which is used to enroll, schedule, deliver, track, and manage learning materials and programs. Upon initial hire, personnel are granted access to the LMS and are required to complete compliance courses as well as job-specific learning plans. Using a combination of face-to-face, web-ex, and virtual techniques, our dedicated team of Learning and Development professionals provides customized training for employees at all levels of the organization. We also offer a tuition reimbursement program to assist with the costs associated with courses leading to an undergraduate or graduate degree.

In addition, we provide ongoing HIPAA security and privacy awareness training for all our employees, including temporary workers and consultants. Each individual must successfully complete applicable levels of training. Our parent company tracks evidence of completion via *Achieve*, our computer-based learning module. Each employee must complete HIPAA Tier-I training, which is an online, computer-based training module. New employees must complete this training prior to the end of their first 60 days of employment. If an employee has not taken the necessary HIPAA training, his or her supervisor is contacted to ensure that the employee completes the training. All clinical employees must also complete the annual HIPAA Tier-II training. Training for clinical employees is conducted via an online, computer-based training module. The care management center Compliance Officer and a trainer from the Learning and Performance department deliver the training for clinical employees. Each care management center monitors and enforces the required HIPAA training for the clinical staff. A Clinical Vice President and Compliance Officers from each call center also must complete annual HIPAA Tier-III training.

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.

Corporate-wide, MMA supports the health and well-being of our employees to ensure that they will be better empowered to take care of DVHA's beneficiaries. For Key Project Personnel in Vermont, this is even more important because the team will hold valuable knowledge and have the best understanding of DVHA's needs.

To attract the best talent, we provide employees a robust benefit package that includes generous paid holidays and annual paid time off. We also offer affordable health plan options from consumer driven health plans to traditional medical arrangements.

We monitor employee satisfaction on an annual basis through an all-employee survey. In 2012, 84 percent of our employees said they planned on working at MMA in a year from now. This exceeds healthcare industry trends by 10 percent.

Our process and methodology for staff retention includes:

- On-site health and wellness services, such as fitness rooms and wellness seminars
- Flexible work arrangements or telecommuting capabilities
- Tuition reimbursement programs to assist with the costs associated with courses leading to an undergraduate or graduate degree
- Team- and work-site specific activities including social events, contests, community volunteerism and involvement drives, and charity drives
- Reward and recognition program/awards
- Robust employee discount programs for computers, cell phones, automobiles, home office supplies and more
- Support for family and employee diversity through domestic partnership benefits, employment non-discriminatory policy and adoption assistance
- Education and tuition assistance with encouragement by managers to participate in continuing education, especially for purposes of maintaining clinical licensure credits
- Generous bonuses on his or her year-end evaluation
- Corporate-sponsored events and annual corporate celebrations for National HealthCare Quality Week including a formal Thank-Q award program that recognizes employees that excel in quality service.

We also use a combination of face-to-face and virtual techniques to provide customized training for employees at all levels of the organization.

Local Retention Activities

Employees and MMA leaders throughout the organization are encouraged to foster localized activities and creative team-based activities and approaches to the following:

- Promote a positive work environment and foster teamwork
- Focus on celebrating and respecting employee diversity
- Emphasize customer service and quality
- Increase staff retention and participation.

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.

Although the items listed below are not necessary for performance during implementation, our experience has shown that the following items provide for a smoother transition to MMA:

- Subject matter experts — Subject matter experts (SMEs) to validate program requirements as we develop documentation for the design and build-out of the DVHA program.
- Key decision makers— Key decision-maker and approver of project deliverables as we work through each phase of the project. We structure the project plan in logical phases (planning, requirements, design, construction, system testing, user acceptance testing, operational readiness, and post go-live), each with key tasks and milestones identified and managed by our Implementation Project Manager.
- Defined deliverables — each phase of our implementation process will include defined deliverables that represent completion, approval, and sign-off by DVHA. Examples of key deliverables for review and approval include Pharmacy Benefit Plan Design(s), Provider Network, beneficiary and provider communication materials, Specialty Drug Management Plan, User Acceptance Testing results, Training Plan, and Operational Readiness Plan.

Additionally, to achieve a timely and effective implementation, we would like to request the following items from DVHA:

- Mutually agreed-upon touch-point meetings and timely reviews and sign-offs
- Comprehensive and detailed communication from the State regarding direction and initiatives
- Clearly identifiable and measurable service level requirements
- Drug coverage requirements and sign off
- PDL approval
- Beneficiary financial requirements—patient share of costs, coinsurance, co-pays
- DVHA group structure (segment of populations within the State)
- Input and approvals on all beneficiary communications (open enrollment materials, beneficiary letters, ID cards, etc.)

- Approvals on MMA Call Center IVR greetings and messaging
- Identification of specific reporting needs for DVHA including any custom or ad hoc reports
- Outline or layout of the specific data that we will exchange with DVHA, so that the MMA EDI team can determine the data interfaces required and collaborate with Vermont on the desired exchange frequency for each interface.

In addition, we would like support from the State in gaining access to their outgoing PBM vendor's technical resources. This will help to support our historical data conversion efforts, such as claims history and prior authorization information. This is a critical component of the implementation effort to ensure a smooth transition and continuity of care for beneficiaries. Catamaran's technical resources will need to participate in mapping sessions with MMA, review test output from the transformation of converted data to MMA, and be available to answer specific questions about the historical data. Catamaran also needs to support the production data file transfers in the final stages of implementation.

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.

Below we have outlined the percent of time commitment for proposed key project personnel and our proposed support members for work. Ms. Roberts will be dedicated 50% of the time to the State's contract. All other key personnel team members are dedicated 100%. Identified support staff is shared resources among other contracts. Identified support staff will not be named as additional resources or support other projects that may run concurrently with the State's implementation.

MMA will dedicate a core team focused on the Vermont Pharmacy Program while leveraging other allocated corporate resources to provide both hands-on project management and broader shared expertise across our organization. MMA will staff dedicated resources as required in the Vermont Pharmacy Benefits Management RFP and use expert allocated resources as needed to meet all needs of the program as illustrated in Figure 6 below.

CONFIDENTIAL MATERIAL: CONTAINS HIGHLY SENSITIVE PROPRIETARY AND/OR TRADE SECRET INFORMATION; PUBLIC DISCLOSURE WILL CAUSE SIGNIFICANT COMPETITIVE INJURY AND DISRUPTION.

Figure 6. Time Commitment during Project

Name	FTE Allocation during Implementation	FTE Allocation during Operations

Name	FTE Allocation during Implementation	FTE Allocation during Operations

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

We do not have any exceptions to Template D. Vendor Project Organization.

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

Template D. List of Tables and Figures

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Template E

Staff Experience

RFP # 03410-127-14

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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.

CONFIDENTIAL MATERIAL: CONTAINS HIGHLY SENSITIVE PROPRIETARY AND/OR TRADE SECRET INFORMATION; PUBLIC DISCLOSURE WILL CAUSE SIGNIFICANT COMPETITIVE INJURY AND DISRUPTION.

Table 1. Staff Experience – Mary Roberts, Account Director

References (3)	
Reference 1	

# of Employees	Public Sector (Y/N)	Project Name and Description	Dates/ Duration (MM/YYYY)	DDI Implementation (Y/N)

Reference 2	

# of Employees	Public Sector (Y/N)	Project Name and Description	Dates/ Duration (MM/YYYY)	DDI Implementation (Y/N)

Reference 3	

# of Employees	Public Sector (Y/N)	Project Name and Description	Dates/ Duration (MM/YYYY)	DDI Implementation (Y/N)

Individual Qualifications		

Table 2. Staff Experience – Teresa Elam, Account Manager

References (3)

Reference 1

# of Employees	Public Sector (Y/N)	Project Name and Description	Dates/ Duration (MM/YYYY)	DDI Implementation (Y/N)

Reference 2

# of Employees	Public Sector (Y/N)	Project Name and Description	Dates/ Duration (MM/YYYY)	DDI Implementation (Y/N)

Reference 3

# of Employees	Public Sector (Y/N)	Project Name and Description	Dates/ Duration (MM/YYYY)	DDI Implementation (Y/N)

Individual Qualifications

Certifications (if applicable)

PMI/PMP	Member ID#:	
	Earned Date:	Expiration Date:

Other	Member ID#:	
	Earned Date:	Expiration Date:

Table 3. Staff Experience - Julie Pritchard, Clinical Pharmacist Manager

References (3)

Reference 1

# of Employees	Public Sector (Y/N)	Project Name and Description	Dates/ Duration (MM/YYYY)	DDI Implementation (Y/N)

# of Employees	Public Sector (Y/N)	Project Name and Description	Dates/ Duration (MM/YYYY)	DDI Implementation (Y/N)

Reference 3

# of Employees	Public Sector (Y/N)	Project Name and Description	Dates/ Duration (MM/YYYY)	DDI Implementation (Y/N)

Individual Qualifications

Certifications (if applicable)

Table 4. Staff Experience - Yijia Wang, Data Analyst

References (3)

Reference 1

# of Employees	Public Sector (Y/N)	Project Name and Description	Dates/ Duration (MM/YYYY)	DDI Implementation (Y/N)

Reference 2

# of Employees	Public Sector (Y/N)	Project Name and Description	Dates/ Duration (MM/YYYY)	DDI Implementation (Y/N)

Reference 3	

Individual Qualifications		

Subcontractor Staff Experience

CONFIDENTIAL MATERIAL: CONTAINS HIGHLY SENSITIVE PROPRIETARY AND/OR TRADE SECRET INFORMATION; PUBLIC DISCLOSURE WILL CAUSE SIGNIFICANT COMPETITIVE INJURY AND DISRUPTION.

Table 5. Staff Experience - Nekia Austin, NorthStar

References (3)

Reference 1

# of Employees	Public Sector (Y/N)	Project Name and Description	Dates/ Duration (MM/YYYY)	DDI Implementation (Y/N)

Reference 2

# of Employees	Public Sector (Y/N)	Project Name and Description	Dates/ Duration (MM/YYYY)	DDI Implementation (Y/N)

Reference 3				
# of Employees	Public Sector (Y/N)	Project Name and Description	Dates/ Duration (MM/YYYY)	DDI Implementation (Y/N)

Individual Qualifications		
Certifications (if applicable)		

Table 6. Staff Experience - Andrea Ziccarelli, MedImpact

References (3)				
Reference 1				
# of Employees	Public Sector (Y/N)	Project Name and Description	Dates/ Duration (MM/YYYY)	DDI Implementation (Y/N)
Reference 2				

# of Employees	Public Sector (Y/N)	Project Name and Description	Dates/ Duration (MM/YYYY)	DDI Implementation (Y/N)

Reference 3	

# of Employees	Public Sector (Y/N)	Project Name and Description	Dates/ Duration (MM/YYYY)	DDI Implementation (Y/N)

Individual Qualifications		
Certifications (if applicable)		
PMI/PMP	Member ID#:	
	Earned Date:	Expiration Date:
Other	Member ID#:	
	Earned Date:	Expiration Date:

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.

Table 7. List of Key Personnel Resumes

Name	Proposed Role	Experience in Proposed Role

In addition to resumes for key personnel, we have also included resumes for support staff, list below.

Table 8. List of Support Staff Resumes

Name	Proposed Role	Experience in Proposed Role

Key Personnel

Support Staff

Template E. Staff Experience

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

Template G

Functional Requirements Approach

Instructions for RFP Response

RFP # 03410-127-14

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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.

In Figure 1 below MMA has provided a description of our approach to meeting the requirements in Template F.

Figure 1. Overview of MMA's Solution for Response 1.1.1.

Template F Items Addressed by this Response	
Requirement Number	**Overview of MMA's Solution**
	•

Template F Items Addressed by this Response	
Requirement Number	**Overview of MMA's Solution**

MMA provides a versatile, high-performance, contemporary pharmacy solution that integrates with an MMIS or other large claims processing system. The system can be easily customized to meet Vermont's needs. FirstRx, our proprietary POS claims adjudication application, was developed to be a highly configurable, rules-based, parameter-based, and table-driven solution to offer unparalleled flexibility. We will provide DVHA with a HIPAA and NCPDP D.0 compliant solution built with clinical expertise and the public health sector in mind. FirstRx is a fully contained system that includes prior authorization and DUR modules, eliminating the need to communication with secondary systems at the POS. This results in faster response times with over 90% of claims adjudicating in less than one second and over 98% in less than three seconds.

Key Features of the FirstRx™ Solution

Simplicity: Implementation of business rules is simplified using our table-driven rules-based architecture.

Proven and modern technology: Proven database design with modern technology for an excellent user interface along with innovative configuration options.

Accuracy and responsiveness: Complex plan benefit changes can be made quickly and efficiently by business people, instead of relying on hard coding by developers.

Integrated features: Our PA and ProDUR, formulary management and coordination of benefits are fully integrated within our POS system.

Processing efficiency: The adjudication engine was created to effect claims processing in all domains from the most specific to least specific definition of rules. During the adjudication process, claim adjudication outcomes are reached within fractions of a second, improving response time to the provider.

Our proposed solution to the State of Vermont accepts and sends all electronic data interchange (EDI) formats in the current version and continues to conform to implementation dates set by CMS. The claims adjudication platform we

offer the State is configurable to process claims for mail, retail, and specialty. We are also able to accept web-submitted claims. All claims are filtered through the same set of adjudication edits and pricing methodologies. Or, at the State's request, the tool is configurable to use unique claims processing rules, edits, and payment methodologies. FirstRx can also be configured to deny claims received from non-participating providers returning NCPDP-compliant error code indicating a non-participating provider if the claim is not allowed or is not submitted in the required method (i.e., paper). In addition, the First DataBank (FDB) drug file and clinical criteria are implemented and integrated within FirstRx.

The solution offered to the State is able to support limitless reimbursement methodologies, including variable dispensing fees and fees for professional services and provider incentives. This system contains all customer-specific beneficiary eligibility, pharmacy providers, prescriber information, plan rules including COB/TPL, pricing files and payment rules, claim history and prior authorization capabilities utilizing patient historical drug information. Additional features of the system include the ability to support claim submission via web, batch, and paper claims submission.

The system is able to support unique edit and claims processing logic for each of the State's individual programs. FirstRx is able to support different copayment amounts for different pharmacy programs, for different drugs, and by beneficiaries as needed. To support the Department with possible benefit restrictions, the system accommodates lock-in functionality specific to a beneficiary to limit him or her to a specific pharmacy, doctor, and eligibility.

Submitted claims are validated for consistency with NCPDP guidelines and compliance with DVHA's benefit structure. Messages are returned with an appropriate NCPDP edit number and error description. FirstRx is customizable with DVHA-specific messaging that directs the pharmacy or provider to expedite the claims resolution. All edits are captured on the claim record and are available for reporting purposes.

The State of Vermont will receive a comprehensive solution that provides for:

- Prospective DUR (ProDUR)
- Utilization Management
- Processing and reimbursement of clinical services
- 340B eligible drugs
- Processing of NDC and UPC codes
- Drug formulary status
- Flexibility to adapt to the State's needs
- Multi-Ingredient Compound processing
- Paper and batch claim processing.

Prospective DUR

The ProDUR system is compliant with all federal regulations, including OBRA '90. It is designed to return only the most clinically relevant and critical alerts. DUR criteria are modified in accordance with Vermont programs and are modifiable through an online interface. The system provides the flexibility to create edits specific to a certain pharmacy, prescriber, or beneficiary. The database and algorithms used for ProDUR will be updated on a mutually agreed-upon

schedule. All new criteria are reviewed with Vermont and the DUR Board by our Vermont Clinical Pharmacist Manager.

Our solution provides DVHA with a tool that integrates both medical and pharmacy claims into a comprehensive beneficiary medical profile. Based on Vermont-specific criteria, incoming claims are evaluated at the POS against beneficiary profiles. If a ProDUR alert exists, the system returns a message to the pharmacist. Messages may be informational, result in a claim denial, or allow for an override by the pharmacist in accordance with NCPDP standards to capture outcomes and intervention codes. Our ProDUR messages are designed to be clear and concise and to address only the most clinically significant circumstances. We believe that a ProDUR program functions as an adjunct to the pharmacist's education and professional judgment and does not replace the human cognitive review process, it is important to offer retail pharmacists educational materials informing them not only of their legal obligations to provide immediate and accurate counseling to consumers, but of information on different levels of potential ProDUR therapeutic interventions. FirstRx is designed to minimize "false" positives and return only the most appropriate alerts. In our experience, the highest pharmacy provider satisfaction and response is achieved when pharmacists receive only critical ProDUR alert messages.

Providers may submit override codes using the NCPDP standard interactive DUR codes. Override codes may be submitted on the initial claim. A denied claim does not have to be on file. In situations where the provider can submit the override code, the codes must be entered each time the error occurs. In each case, the submitted data elements are stored with the claim submission and can be retrieved for viewing and reporting purposes.

Utilization Management

The goal of our utilization management programs is to evaluate and promote medication appropriateness. Our strategies include:

- Automated prior authorization
- Quantity limits
- Step therapy

Automated Prior Authorization

Integrated within our claims adjudication platform, AutoPA is an automated solution for processing prior authorization requests. As a fully integrated feature of FirstRx, the system helps to streamline the PA process through the use of automated decision-making. FirstRx has the ability to incorporate data from a beneficiary profile such as significant look-back periods of medication claims history in conjunction with other data to be used in the AutoPA process. **Since the AutoPA process is fully integrated in the point-of-sale claims processing flow, there is no response required from an outside system, thus eliminating impact to system response times, providing greater processing efficiency.** Data submitted on the claim are evaluated against clinical rules, and a decision is rendered in near real-time at the POS. Historical claims data, CPT codes, ICD-10 codes, and lab values are used to make a PA approval. Common data elements evaluated from historical claims data include:

- Drug(s) in patient history
- Drug(s) not in patient history
- Number of prescribers in patient history
- Number of pharmacies in patient history
- Accumulated day supply in patient history

- Accumulated quantity in patient history
- Number of scripts/occurrences for one or many drugs in patient history
- Same prescriber as incoming in patient history
- Same pharmacy as incoming in patient history.

If the criteria for approval are met, an approval is automatically generated and entered in our claims system. The dispensing pharmacist is notified of the approval and is able to dispense the medication. In Figure 2 below we have provided intelligent decision rules for Oxycontin as an example of the AutoPA decision tree.

Figure 2. AutoPA Decision Tree Example

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If criteria are not met, or additional information is needed, the dispensing pharmacy is notified that a manual prior authorization is needed. At this point, the prescriber is able to submit a manual prior authorization request through our WebPA system, fax, e-mail, or telephone. We have provided more details on our prior authorization process in Response 1.2.2.

For instances when a PA is needed and beneficiaries require a supply of medication, we are able to dispense a 72-hour emergency supply.

Quantity Limits

Quantity limit edits are designed to encourage appropriate, FDA-approved prescribing of Medicaid-reimbursed drugs. Our capabilities include limiting the quantity of a drug per fill by NDC, GCN sequence number, or therapeutic class. Our claims adjudication system includes accumulator logic that can be applied at the level defined by the State, including quantity limits. We configure the system to apply business rules based on whether the beneficiary has reached a specified pre-determined quantity limits.

As an extension of quantity limits, we establish dose optimization limitations that helps to provide beneficiaries with medications at the appropriate frequency. Dose optimization provides DVHA with program savings by encouraging that the fewest number of units are utilized within FDA-approved dosing intervals. The added benefit for beneficiaries is ease of compliance.

Step Therapy

The goal of our step therapy program is to drive utilization of the most cost-effective agents whenever clinically appropriate. Step therapy protocols are used in situations where the use of a certain drug should precede the use of a more expensive medication that was originally prescribed. We use a wide variety of step therapy programs before utilization of a second line therapy is approved. We evaluate claims history at the POS for a previous fill of a first line agent. If claims history does not indicate a previous fill for a first line agent, the claim is denied. The pharmacy contacts the beneficiary's provider for a new prescription. Or, if the provider feels that the second line agent is appropriate, the request is processed as a PA.

We also have step therapy protocols in place to ensure that drugs approved as adjunct therapy are only approved in the presence of the required therapy. For example, Hepatitis C agents,

such as Incivek® and Victrelis® are examples of products that would only be approved in the presence of concurrent use of required first-line therapy with interferon.

Through our ProDUR system, described in Response 1.2.3, we include two edits associated with step therapy that are structured to determine therapeutic appropriateness at the POS. These include the **prerequisite and exclusive** step therapy edit. The step therapy edits described below evaluates beneficiary history to determine if criteria have been met.

- ***Prerequisite Step Therapy:*** Require use of a drug from class A before allowing use of a drug in class B within a designated time frame. The Prerequisite Therapy check generates warnings regarding prior and concurrent use of associated therapies. These rules relate to a drug or drug class and optionally to a disease. For the current claim to be adjudicated, the beneficiary must have taken or be currently taking at least one of a list of associated therapies. The prerequisite therapy check looks for any "active" prerequisite drug claim within the period start date and the period end date for the current prescription. The period of history to review in determining active drugs cannot be greater than the Plan/DUR rules period of history to review. If one or more claims exist for a drug or drug class defined in the prerequisite protocol, the protocol has been adhered to and no action is required. If a single match is not found, an encounter is generated. The pharmacist receives a summary of the encounters. For example, the system can be configured to perform a look back for an ACE inhibitor or anti-diabetic agent prior to adjudication of a claim for an ARB. Additionally, the system can be configured to allow the ARB if the ICD-9/10 for diabetes is submitted on the claim or found in the beneficiary's medical history.
- ***Exclusive Step Therapy:*** Disallow use of drug class A if there is prior history of a drug within class B within a designated time frame. The Exclusive Therapy check generates warnings regarding the prior or concurrent use of associated therapies. These rules relate to a drug or drug class and optionally to a disease. For the current claim to be adjudicated, the beneficiary must not have taken nor currently be taking any of the associated therapies. The exclusive therapy check looks for any "active" exclusive drug claim within the period start date and the period end date for the current prescription. The period of history to review in determining active drugs cannot be greater than the Plan/DUR rules period of history to review. If no claim exists, the protocol has been adhered to and no further action is required. If one or more claims exist for a drug or drug class contained within the exclusive protocol list, an encounter is generated. The pharmacist receives a summary of the encounters.

Processing and Reimbursement of Clinical Services

FirstRx supports enhanced reimbursement for services related to covered products. Providers may submit values in either the "Level of Effort" or the "Level of Service" field to indicate activities that go beyond that of traditional dispensing. This NCPDP solution is used to support professional services like vaccination administration, sterile product admixing, or extensive multi-ingredient compounding.

340B Eligible Drugs

Claims for 340B programs are identified using NCPDP D.0. standards. During implementation, MMA's Vermont Account Director, Ms. Roberts, and our Clinical Pharmacist Manager, help to define all applicable parameters, such as price lists, claims tracking, and U&C submissions.

When a 340B claim is received, alternate pricing algorithms are used to determine the final claim cost if a net cost amount is not provided. If a net cost is provided, this is used to determine the final price. Alternate price calculations are used based on DVHA's direction using industry best practices.

Processing NDC and UPC Codes

FirstRx supports NDC and UPC code configuration through edits placed on the provider type and/or select drug programs in accordance with the State's benefits. We receive weekly updates from FDB that include additions, modifications, and deletions to the drug file, pricing information, as well as related drug clinical parameters. This file is then applied to the State's Medicaid Program according to its defined parameters. In addition, updates to pricing may be made in real time, as necessary, by authorized users.

Evaluation of Formulary Status

FirstRx is configured with State-specific benefit information, including drug formulary status for covered and non-covered medications. FirstRx supports drug coverage for beneficiaries through the formulary management tool. This tool contains multi-byte fields that are used during adjudication to determine drug coverage. Products identified as covered are assigned appropriate cost information as defined in the State's benefit package. If a drug is not covered, the claim is denied with an NCPDP-compliant error code message.

The tables associated with the State's drug and formulary benefit coverage drive our Web-Drug Lookup tool. This tool allows for user-friendly, real-time direct queries of the drug file that return DVHA-specified details related to coverage, limitations, and PA.

Denials of payments for drugs requiring PA, non-preferred, non-covered drugs or drug classes not covered by the beneficiary's pharmacy program are denied at the POS and the provider is notified immediately. These drugs are tagged as requiring PA and any transactions containing these drugs are subject to prior authorization rule editing. To enforce the PA rules, the system will automatically look for a beneficiary-specific PA as part of this edit check. If an appropriate PA is present and active for the date of service, and all other edits are met, the claim pays. If there is no active PA present, the system will deny the claim with the NCPDP error code 75 "Prior Authorization Required". Additional supplemental messaging will also be included to facilitate resolution by the provider. Detailed information is returned to the provider advising of appropriate telephone and/or fax number needed to initiate the PA process. Reimbursement to the provider for a prior authorization-required drug will not be enabled unless there is an active beneficiary-specific PA on record.

Flexibility to Adapt to the State's Needs

DVHA receives a user-friendly system that is in compliance with CMS guidelines for MITA and SOA. Built on a table-driven and rules-based engine, FirstRx is an agile system that provides for easy configurable benefit designs. Changes to program edits and benefit configurations

Testimonials from our Medicaid Customers

"I think my highest level of satisfaction with MMA is their willingness for customization and adaptation to our program needs. Idaho keeps a very tight control on our drug benefit. We make weekly changes on our drug file and set specific parameters for quantity, age, sex and dose on every line item in our drug file. New drugs do not receive coverage until after we have reviewed them, placed parameters and made decisions on prior authorization. MMA's plan administrators make these changes very efficiently and timely. Rarely are PDL changes, PA requirements or drug file changes delayed. As an example, they implemented a whole new pricing structure including a tiered dispensing fee with individual rate assignment to each provider within a three week time period. They currently help us maintain over 100 sets of prior authorization criteria. In addition, they are very proactive on global changes in requirements for such things as D.0 and ICD-10 changes. And unlike other vendors, when a change is made to the system for one of their clients, that change is available for all of their clients without an additional charge to each client in most cases."

Tami Eide, PharmD, BCPS
Medicaid Program Manager
Idaho Department of Health and Welfare

are accomplished by a Plan Administrator, using the GUI. Over 98% of changes are configurable within FirstRx and do not require programming or coding. The remaining 2% may require 3 – 10 business days, depending on complexity. DVHA's solution is scalable and flexible to meet the changing needs of the State over the duration of the contract.

Multi-Ingredient Compound Processing

Multi-ingredient compounds are processed using current NCPDP standards. The system evaluates each ingredient separately, performing appropriate edit checks and ingredient pricing. In some situations, ingredients that are not covered may be included in the claim. In these situations, the system is able to continue processing the claims without reimbursement for the non-covered item. To continue with the claim processing, dispensing pharmacies must submit the appropriate NCPDP code. If the dispensing pharmacy does not submit the appropriate NCPDP code, the claim is denied. In both situations, the claim is subject to PA review for the non-covered item.

Claims Receipt and Adjudication

FirstRx provides claims format validation to ensure compliance with all federally-named standards, performs quick and accurate claim adjudication, PA disposition, DUR evaluation and response, beneficiary benefit evaluation and accumulations, all pricing functions, real-time fraud and abuse capabilities. FirstRx processes pharmacy claims using interactive real-time processing meeting NCPDP Telecommunication Standard version D.0 for POS claims, Batch Standard v1.2, via web claim submission from authorized and credentialed providers, and claims entered manually from industry-standard paper claim forms. Pharmacy claims are evaluated according to DVHA-approved criteria and result in an immediate return message to the pharmacy with all appropriate NCPDP responses, including both ProDUR messaging and information regarding the claim's disposition. Consistency controls are in place to ensure claims comply with DVHA rules.

The Vermont Payer Specification document identifies the NCPDP fields, mandatory and situational, required for claim submission. FirstRx maintains data integrity through the strict enforcement of NCPDP field standards. The system ensures that the transaction data are consistent with the NCPDP field and valid code values.

FistRx allows the flexibility of adjudicating all claims using the same subset of edits/rules regardless of the mode of submission of the incoming transaction or applying different edits/rules based on the mode of submission. Unless exceptions are configured, all claims submitted via POS, paper, and batch are subject to the same validation and DVHA policy edits within the system. Additionally, FirstRx can apply edits differently based on the media type, e.g., applying timely filing edits, quantity limitations, copayments, reimbursement logic, PA, or PDL edits based on a specific media type.

Each incoming transaction is subject to syntax editing (e.g., number-only fields are numeric), and relational editing (e.g., the submitted beneficiary number is on file and eligible). FirstRx processes the transaction to the fullest extent possible and returns up to the maximum allowed number of edit responses as set by NCPDP. When the integrity of the data is compromised and the system encounters a fatal error such as a Missing/Invalid Beneficiary ID, transaction processing stops and the appropriate rejection message is returned to the submitter for correction. Messages are connected to the maximum primary message length; overflow is populated in the additional message field. All edits are recorded on the claim record and made available for reporting purposes. In cases where multiple claims are sent on a single transaction, FirstRx is configured to ensure that only those claims that hit denial edits are returned to the

provider in a non-payable state. The other claims within the transaction that do not hit any denial edits are processed through and deemed payable.

FirstRx supports the validation of date fields through format mask validation, but also contains edits related to date submitted versus system date. A claim submitted for a future date, or for a non-existent date, such as June 31, is denied with the appropriate NCPDP-defined error code.

FirstRx calculates and validates against defined edits or industry standards various data elements using submitted claim data including, but not limited to, quantity per day, dosage per day, rolling quantity limitations, patient and plan financial obligations or maximums. FirstRx also enforces unit of measure and package size edits (allow billing only for multiples of defined package size), to further mitigate risks associated with improper billing units or quantities.

FirstRx validates pharmacy provider and prescribing provider information received from the MMIS early in the adjudication process. If the submitted information does not pass the verification and validation checks, NCPDP reject messages are returned to the submitter with additional messaging identifying the issue to expedite resolution. FirstRx will perform validation of the prescriber last name, if last name submitted on the incoming transaction, does not match the prescriber last name on file, the claim will reject, NCPDP 56 – Non-Matched Prescriber ID.

FirstRx provides comprehensive lock-in functionality. Beneficiaries can be locked into a single pharmacy provider or a designated set of pharmacy providers, as well as locked into a prescriber or prescriber set. At a more granular level, beneficiaries can be locked into the use of specific pharmacies for certain types of drugs only, such as narcotics or specialty pharmacy drugs. Another feature of the system is the ability to always require prior authorization for a given beneficiary for all drugs or specific drugs. FirstRx edits based on submitted data for pharmacy lock-in or prescriber lock-in. If any edits are found for lock-in or other limitations, the transaction is processed, compiling relevant amounts towards quantity limitations, financial limitations, script limitations, or other similar limitation types. Based on the result of those edits, the claim is paid, and a message returned to the provider indicating the method of payment and the amount. If the claim is denied due to failed edits or prior authorization requirement, the appropriate NCPDP error code(s) are returned to the submitter for review and correction, as appropriate. If authorized by the State, restricted conditions may be overridden in designated situations by pharmacy support staff.

Paper Claim Processing

When a beneficiary or provider submits a paper claim for processing, it is received in our Glen Allen, Virginia, location by our Claims Administration department. All paper claims with any attachments are imaged into our document storage application, Alfresco. In the scanning process, a unique Internal Control Number (ICN) is applied to each claim. The ICN is the master index for all claim-related activity, including reversal transactions, quantity and financial accumulations, and all claim related extracts.

Claim Processors review each form along with all relevant information for accuracy. If there is missing information, the assigned Claim Processor returns the claim to the beneficiary along with a letter detailing the additional information required.

Once a paper claim is entered into FirstRx, it is processed through the State's prospective drug utilization review and formulary edits. If all criteria are met, the claim is processed for payment, subject to any applicable beneficiary cost sharing amounts. Beneficiaries and providers receive their appropriate reimbursement within 10 business days of receipt of a complete claim form.

Batch Claims Processing

We also process batch claims submitted in electronic media from authorized and credentialed providers using NCPDP D.0 Batch 1.2 formats. Batch claims are filtered through the same validation and policy edits as POS and paper claims. Inbound and outbound data interface batch files are received using SFTP (secure file transfer protocol) tools through several FTP HUB servers maintained by MMA. The FTP HUB monitors the receipt of data files on a mutually agreed upon schedule. We are able to accommodate daily transfers as frequently as every 15 minutes, to once per day, weekly, or monthly. Files are processed using predefined rules that are automatically triggered to transfer files to their appropriate end-point.

Each file is monitored using our enterprise file transfer tool, MoveIT. We will collaborate with Vermont to provide the data integration service necessary to accommodate the business requirements. Our data interface operations are available 24 hours a day, 7 days a week and process more than 1,000 files per week.

Value of Our Solution to DVHA

FirstRx stands apart from other solutions in the market place because it has been customized to address the needs of public health clients. With over 4,600 Medicaid-tailored claim checks and edits configurable to meet the needs of DVHA, 98% of benefit and adjudication rule changes are configurable within the system. This reduces the need for additional programming, coding and testing. This allows DVHA to take immediate action to address critical beneficiary health needs.

In addition, our solution is compliant with CMS certification guidelines. We have successfully obtained CMS certification for all customers who have requested it. We have a 100% success rate in obtaining CMS certification for customers without any major findings or corrective actions from CMS, including the post-CMS on-site review.

MMA understands that the CMS MECT checklist for PBMs has been expanded. We are working with a consulting firm to conduct a MITA self-assessment, as well as take other steps to ensure that we are successful in continuing our track record of successfully obtaining CMS certification of our solution for our customers. As part of this preparation, we will utilize ReadyCert, a compliance software tool that helps us track to MITA guidelines and the MECT certification, to obtain CMS certification for 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.

In Figure 3 below MMA has provided a description of its approach to meeting the requirements in Template F.

Figure 3. Overview of MMA's Solution for Response 1.1.2.

Template F Items Addressed by this Response	
Requirement Number	**Overview of MMA's Solution**
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	•
	•

The COB functionality within the FirstRx system is highly configurable and allows DVHA to follow a COB methodology where the Vermont Medicaid Program acts as a payer of last resort. FirstRx requires that each TPL record on file be cost avoided in order for the claim to yield a payable response. For example, if an individual has active primary insurance with three different carriers, the system requires that the provider submit a COB segment on the incoming claim for all three carriers. This functionality exists so that all active carriers are billed and all payment avenues are exhausted prior to billing the Vermont Medicaid Program. The net result ensures that FirstRx executes appropriate cost avoidance, minimizing State expenditures where appropriate while continuing to provide access to quality health care for Vermont's beneficiaries.

FirstRx will be configured to support COB editing as specified by the Department. FirstRx is maintained in compliance with NCPDP vD.0 to accept up to the maximum count of '9' other coverage types as allowed by NCPDP.

Common COB edits that affect the actual beneficiary cost sharing calculation include:

- **Other Coverage Code – Payment Not Collected Logic:** In the Other Coverage Code field, if a value of '3 – Other Coverage Exists – Claim Rejected By Primary Insurance.' Per DHVA guidelines, claims submitted with an OCC = 3 will be subject to an edit to determine if drug is OTC; if so, the State will pay the claim when all other State criteria are met.

  For non-OTC drugs, if the primary payer denies the claim because the drug requires a prior authorization, or is a non-formulary drug, the primary carrier's prior authorization must be followed. Also at the request of DHVA, FirstRx can be configured to accept the NCPDP Other Payer Reject Codes for the adjudication of Vermont pharmacy claims.

- **Other Coverage Code – Payment Not Collected Logic:** In the Other Coverage Code field, if a value of 4 – Other Coverage Exists – Payment not collected' is submitted, the total amount of the claim is for a beneficiary deductible or for coverage in the "donut hole" for Medicare claims. Our COB functionality ensures that claims are processed utilizing the 'lesser of' logic and paying the appropriate amount according to DHVA guidelines.

To help eliminate unnecessary payments, DVHA will have access to enhanced COB functionality facilitated through SureScripts Master Patient Index (MPI) database. The MPI database includes 90% of all commercial insurance companies with over 253 million covered lives. The enhanced COB process queries the SureScripts MPI and, when a positive result is identified, a HIPAA-compliant format for coverage request and response (ASC X12 270/271 transactions) is exchanged with the identified PBM/Processor to confirm beneficiary eligibility. The response data from the PBM/Processor is then loaded to the individual beneficiary other coverage record which is used to provide other coverage detail to submitting providers.

Approach to Coordination of Benefits

To ease DVHA's administrative burden for recovery, our automated solution utilizes information received from HP in combination with the MPI or other external sources of data. Utilizing both sources of data allows us to proactively identify other coverage that DVHA may not yet be aware of.

If a beneficiary has verified other insurance coverage, the claim denies at the POS with a message that the bill must be submitted to another payer. The message includes all necessary information for the provider to bill the primary payer: Carrier code, name, BIN (bank identification number), and policy number. Messages indicating Medicare Part D coverage are also returned. After deducting the primary payer's amount from the claim, our system compares the Medicaid-allowed amount to the submitted claim cost and pays the lesser amount. Our system is configured to sum all values present for primary, secondary, or tertiary payers and deducts this value from the final claim payment.

Medicare Part B Coverage

During implementation, products are coded appropriately as covered by Medicare, Medicare replacement products, or covered by a PDP. Appropriate values are assigned to each product based on one or more of those categories. At the point of sale, FirstRx evaluates the values assigned to the specific NDC to determine claim disposition status. When a claim is denied due to coverage by the beneficiary's other coverage (Medicare or PDP), the denial response provides the NCPDP-compliant error code indicating other coverage and, when available, any information

demonstrating the plan or plans that must be billed before submitting to DHVA as the payer of last resort.

1.1.3 Provider 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.

In Figure 4 below MMA has provided a description of our approach to meeting the requirements in Template F.

Figure 4. Overview of MMA's Solution for Response 1.1.3.

Template F Items Addressed by this Response	
Requirement Number	**Overview of MMA's Solution**
FR1.22	We will maintain a DVHA-specific telephone number for pharmacy and provider support 24/7/365. Our skilled clinicians manage this line for prior authorization (PA) requests and questions regarding formulary, claims submission, drug coverage, eligibility, PA status, payment status, COB payer information, policy and procedures information, and override authorization for early refill and ProDUR and clinical edits.
FR1.23	The provider support we offer the State of Vermont is scalable to meet all future needs: • Automated call distribution that is configurable with customized routing or messages specific to Vermont. • Capacity to handle all calls 24 hours a day, 7 days a week, 365 days per year with continuous monitoring through the call management system to ensure performance expectations and SLAs are met, • Real-time management tracking and reporting capabilities through the call management system that allows for immediate adjustment when performance interventions are needed. • Quality assurance program that records all calls via Verint. QA reviewers sample calls and follow-up on call outcomes with staff to ensure response quality and caller satisfaction. • Language translation services provided through Pacific Interpreters to facilitate communication in more than 200 languages. • Call response for hearing impaired callers through the use of TTY technology. Translation of materials into Braille for visually impaired

Template F Items Addressed by this Response	
Requirement Number	**Overview of MMA's Solution**
	callers. • Access to a registered pharmacists 24 hours a day. • State-specific reference documents with guidelines on how to handle caller inquiries accessible to all call center staff through the QuikTrack system. • Virtual environment call center that allows calls to be routed to the next available agent during telecommunication disruptions or office closures.
FR1.24	CPhTs in our provider support center will utilize FirstTrax, a proprietary online system to log calls received from prescribers, pharmacies, and beneficiaries. The system identifies the issue and describes the problem resolution utilizing free-form text fields. Key personnel assigned to Vermont will prepare analyses and review these with the Department on a mutually agreed-upon schedule.
FR1.25	We will prepare and distribute all provider communications in a variety of formats including direct mail, web portal, email, fax, and phone. Communications and methods of outreach are detailed in a Communication and Outreach Plan as part of implementation. This plan will be developed once we finalize the program requirements phase of the project and will be completed with the collaboration and approval of key DVHA staff.
FR1.26	When undelivered provider communication is returned to us, we will look in Vermont's MPI, NPPES (National Plan and Provider Enumeration System) and the Internet to locate or verify the most current contact information. If one is found, we will place the returned mail in an envelope and send to the updated address. If an address update is not found, we will reach out to the pharmacy via fax to deliver the communication.
FR1.27	We will design and develop a customized provider portal that meets the needs of the State. We will update and maintain the portal as required by the Department. We guarantee that data exchanged on our website is secure.
FR1.28	We will update our web portals after we receive approval from the Department. Postings to the website will include important communications to providers, DUR Board meeting schedules, agendas, notices, policies, meeting minutes, and contact information. The provider portal will include forms, reference policies, drug information include the Vermont PDL, special drug policies, MAC policies including pricing, and FAQs. We will also include the pharmacy claims processing manual and links to Vermont's Medicaid provider manual. Providers will also have the ability to submit prior authorization requests through WebPA.
FR1.29	MMA will publish the Department-approved pharmacy provider manual on the web portal. The pharmacy provider manual will include the payer sheets and instructions on how to submit claims via POS, batch, and paper. The manual will be updated, as needed, and submitted to the Department for approval prior to publishing the revised version to the portal.

Template F Items Addressed by this Response	
Requirement Number	**Overview of MMA's Solution**
FR2.1	We use an enhanced staffing approach using certified pharmacy technicians to serve prescribers, beneficiaries, and pharmacies.
FR2.2	We comply with Vermont PA requirements including providing a telephone call center that is accessible 24 hours a day, 7 days a week, 365 days a year. The call center will support PA processing through a toll-free number, facsimile, mail, and web-based requests through WebPA. We provide real-time PA processing through AutoPA utilizing current beneficiary information. The call center is staffed with CPhTs and clinical pharmacists during normal business hours. After hours, CPhTs are able to contact clinical pharmacists as needed via a pager.

MMA will act as the first point of contact for providers with questions, inquiries, and requests. Call center staff utilize FirstTrax™, a proprietary online system to log all calls received from prescribers and pharmacies. FirstTrax applies business rules to submitted requests and assigns them to a specific work queue, which is segregated by job function. FirstTrax utilizes Remedy, a COTS product that allows customization based on DVHA criteria. DVHA-designated call center staff record the source of the concern, the provider's information, and how the concern was received. The system allows staff to record the call category, call type, and response. FirstTrax allows for real-time progress tracking of each request so all stakeholders can see which steps have been completed. Open items are also displayed providing for an at-a-glance view of steps in the process that need completion. Once the problem is resolved, staff records the problem resolution in the tool using the free-form text field.

Our Glen Allen, Virginia, Support Center is proposed to be the primary location for handling Vermont's provider inquiries, including clinical and technical services. Initially, a core team comprised of five CPhTs and one registered pharmacist will be trained to handle provider calls. This core team would begin their training on Vermont's contract on November 1, 2014, eight weeks prior to Go-Live. In case of unanticipated call volumes, we will proactively hire two temporary CPhTs to support Vermont's contract beginning on November 1, 2014, through March 1, 2015, approximately eight weeks before and after Go-Live.

Call Center Performance

MMA's Pharmacy Support Center supported 15 public sector customers in 2012.

- Over 1,000,000 calls from prescribers, pharmacies, and beneficiaries
- 1,444,862 total PA requests
- 401,461 faxes for PA requests.

MMA Call Statistics for all public-sector customers demonstrate the high level of performance we will provide to the State:

- Average length per call was 3:02
- All calls answered within three rings by an electronic greeting
- Average speed of answer by live agent was 18 seconds
- Percent of inbound calls abandoned was <1.00 percent

Training is then expanded to include additional staff members so that they can easily transition to support peak volumes. This "workload balancing" process ensures that the Vermont pharmacy program has the necessary staff available to it whenever the need arises. Staff in our St. Louis, Missouri, Support Center will provide support during peak call volumes as needed. The Glen Allen facility will be fully staffed, with an on-site pharmacist, during normal business hours from 8:00 a.m. to 8:00 p.m., Eastern Time, Monday through Friday. After hours, holidays, and

weekends, CPhTs will have telephone access to clinical pharmacists to provide assistance with prior authorization needs, consultations or inquiries.

Our Support Centers are available 24 hours a day, seven days a week. DVHA's designated team is comprised of certified pharmacy technicians (CPhTs). This approach allows for quicker resolution through one point-of-contact. CPhTs are trained on information that will allow him or her to educate providers and answer questions based on data elements used in transmitting claims to the POS system. In addition, CPhTs provide assistance with PA status, PDL questions including cover drugs, a beneficiary's enrollment status, payment status, COB payer information, non-clinical inquiries related to ProDUR messaging, and policy and procedures information. CPhTs also assist providers with field software questions.

Support Center staff follows a defined workflow for escalations brought forth by providers. If the CPhT is unable to provide a resolution using available resources, he or she escalates to the Senior CPhT. If the Senior CPhT is unable to provide a resolution, it is immediately escalated to a beneficiary of management. Escalations and the steps taken are documented within FirstTrax.

DVHA's dedicated key personnel team provides a review of the analyses during regularly scheduled meetings. In Figure 5 below we have provided an example of a standard monthly call type report. DVHA-specific call types may also be used for tracking and reporting purposes:

Figure 5. Example of a Monthly Call Type Report

The solution proposed to DVHA also decreases a provider's administrative burden by allowing him or her to use our interactive voice response (IVR) for early refills and therapeutic duplications. By answering structured questions, an approval or denial decision is rendered based on responses to the criteria. Through messaging and telephone prompts, the IVR is able to fax PA fax forms, PDL lists, and other program documents.

When the call cannot be resolved via the IVR, the call is directed to Support Center staff. All information already provided by the caller within the IVR is retained and passed along with data accessed based on the caller's input. This is an advantage to the caller and to the CPhT, as the caller does not have to repeat information already given and the CPhT has information readily available to begin assisting the caller immediately.

Our automatic call distribution (ACD) system provides for efficient management of incoming calls by routing the caller to the first available CPhT. This helps to facilitate our virtual environment where pharmacy support center staff in both locations access all functions regardless of the center in which they work. Standardized applications and telecommunications infrastructures are duplicated to facilitate this "virtual" environment.

Provider Communications

As part of our Vermont Communication Plan, we develop an outreach plan during the requirements phase which is completed in collaboration with key DVHA staff.

We use our web portal to post information that is particularly helpful to physicians and pharmacist providers. We use a combination of direct mail and the web portal to communicate with physicians and pharmacists during implementation and throughout the operational phase of the contract. Examples of provider communications include:

- Direct mail to targeted providers announcing prior authorization requirements, a copy of the current PDL, and other pertinent information related to program changes
- Conference calls with identified practices to discuss changes or enhancements specific to the new contract implementation and readiness from a clinical criteria perspective
- Web portal to post policy changes, drug coverage requirements, and announcements that address program changes specific to the fee-for-service contract implementation.

Program introduction materials will include a cover letter describing the State's Medicaid Fee-for-Service Pharmacy Program, a copy of the current PDL with instructions on how to access the PDL and other drug lists on the MMA web portal, prior authorization request forms that can be faxed or used as a guide for telephonic requests, Frequently Asked Questions (FAQs) for providers, and any other materials deemed necessary by the State. MMA will coordinate all design, development, and the implementation of educational materials with the State. Special education sessions may be held for targeted providers that include, but are not limited to, the highest volume prescribers, pharmacy providers and long-term care pharmacy providers.

To ensure that providers receive communications, we utilize the NCPDP file as our source for provider contact information. When an undelivered provider communication is returned, we will utilize the State's Master Provider Index database and the Internet to verify the most current contact information. If one is found, we place the returned mail in an envelope and send it to the updated addressed.

Federal and State Statutes Communications

Provider manuals and communication bulletins address any changes to federal or state statutes, regulations, and policies. If a change is significant, provider training is offered prior to the anticipated effective date. We mail, fax, or email communication bulletins with details of the changes, and instructions on how to register for trainings. Trainings are facilitated approximately 15 – 30 days prior to the implementation via teleconference or Webinar.

Provider Web Portal

Through the provider portal of our secure Website, providers are able to view important news and announcements. We also post all important communication bulletins and updates to our portal for easy reference. The functionality offered through our web portal is based on our loosely-coupled SOA architecture which leverages such enterprise assets as our Enterprise Service Bus to manage access to our suite of web services. Doing so allows scalability and centralizes the business logic so that functionality delivered through our web portal leverages the same infrastructure used by our enterprise applications. Our tool offers the following self-service functionality:

- **Web Prior Authorization (WebPA):** A PA request can be submitted and a decision of approval or pending will be returned immediately for the prescriber.
- **Physician/Pharmacy Locator:** This allows providers to easily locate a beneficiary's preferred pharmacy, or one near their home.
- **Beneficiary Profile:** Providers are able to view their population-specific beneficiary information. This includes demographics, eligibility, and medications. This functionality also allows providers to review filled prescriptions written by other prescribers
- **Medicaid covered drug inquiries:** Drug-specific information tailored to DVHA's program is available online. A provider enters in the name or NDC and information returned includes links with clinically-appropriate criteria. In addition, providers are given a direct link from their search results to pertinent forms for submission.
- **Web Claims Submission:** Providers are able to submit claims via the Web utilizing the FirstRx claim template in real time.

We guarantee that any data exchange on our Website between MMA and the Department and/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.

In Figure 6 below MMA has provided a description of our approach to meeting the requirements in Template F.

Figure 6. Overview of MMA's Solution for Response 1.1.4.

Template F Items Addressed by this Response	
Requirement Number	**Overview of MMA's Solution**
FR3.39	FirstRx accommodates post-payment claim reversals in accordance with NCPDP standards for B1 billing transactions and B2 reversals. Reversal transactions will contain a unique claim identification number, as well as link to the unique claim number of the original claim which was reversed.

Post-payment claim reversals are facilitated through our claims adjudication platform. FirstRx is easily customizable with DVHA-specific recovery codes that help to facilitate tailored reporting and identification of all reversals.

Our preferred method for processing reversals is to void transactions. This method provides for an accurate audit trail within the system. For batch files, the system processes the file in

accordance with NCPDP standards for reversals and billing. The claim is then adjusted appropriately with the proper claim amount. Reversed claims are appended with a unique claim identification number and a link to the original claim. This unique number is kept within FirstRx and sent on the claims history file.

This method is utilized for all reversals, including TPL and recoveries made through our network auditing procedures.

FirstRx provides the functionality to automatically process mass adjustments at one time, eliminating the need for Claim Processors to make changes on a claim-by-claim basis. Claim Processors search for a subset of claims based on several items including, but not limited to:

- Drug code
- Beneficiary ID
- Adjudicated Group ID
- Specific rule ID effected during adjudication.

The mass adjustment functionality drills down to claims within a specified adjudication time period, or other search criteria, such as service date, adjudication date, and authorization number. In addition, the system allows claims to be identified by multiple clients, providers, and/or prescription numbers.

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.

In Figure 7 below MMA has provided a description of its approach to meeting the requirements in Template F.

Figure 7. Overview of MMA's Solution for Response 1.1.5.

Template F Items Addressed by this Response	
Requirement Number	**Overview of MMA's Solution**
FR1.30	SureScripts will have access to all information necessary to provide electronic prescribing for the Department's various programs. This will include beneficiary eligibility, PDL information, claims history, and other Department specified criteria.
FR1.31	We will work with the Department to meet electronic prescribing goals and promote the use of electronic prescribing as needed.
FR1.32	MMA's e-Prescribing solution includes a set of standard reports that provide information on the volume of requests for prescriptions, eligibility verifications, and medication history and drug coverage or restriction inquiries. In addition, MMA's quality assurance processes are designed to assure the program's integrity policies and standards are applied and adhered to.

Our electronic prescribing and prior authorization solution promotes electronic exchange of information and support for administrative simplification. Below we provide the State with details of our solution.

Electronic Prescribing

As one of the highest ranked utilizers of e-prescribing technology, DVHA's continued efforts to refine the PDL interface will be supported through our partnership with SureScripts, LLC. We have developed a unique integration of our portal, e-prescribing, claims adjudication, and electronic prior authorization functionality to provide a beneficiary-specific decision support that guides prescribers based on DVHA programs and PDL. Currently, we provide electronic prescribing functionality to Idaho, Florida, Pennsylvania, and Michigan.

Our approach is comprised of two core competencies. First, EMR and e-prescribing is supported through an agreement with SureScripts to provide eligibility, PDL, and medication history information at the point of care. SureScripts facilitates electronic pharmaceutical prescribing and utilizes their e-prescription network. We provide the necessary patient information (patient eligibility and patient medication history) and the patient's formulary and benefit information to SureScripts to facilitate the e-prescribing process. Eligibility and medication history data are provided in a real-time environment via defined transaction standards, with direct access to our databases.

Electronic Prior Authorization

In anticipation of states that wish to utilize ePA through the EMR, we have taken a proactive approach and developed a solution that is easily configurable with e-prescribing vendors when the functionality becomes available. Our approach to help facilitate this process is our proprietary clinical decision module (CDM). The CDM is a dynamic tool that drives consistency and accuracy by call center staff in interpreting criteria for PA requests. The CDM incorporates drug lists requiring PA with an alternative that does not. Each drug contains diagnostic information, age/gender considerations, and quantity limits.

Sophisticated questions based on the State's PA criteria are asked of the requestor. Based on the answers provided, a decision is reached and an answer is immediately returned. The CDM is designed to interface with our POS system to maintain required drug and diagnostic information. The system's clinical questions and questioning routines are global in nature and can be mixed, matched, or grouped as necessary to achieve the required adjudication outcome. This flexibility allows criteria changes to be made once and automatically apply across all drugs using a particular set of criteria for approval. If granted, the prior authorization approval is entered into the system and enables successful adjudication of the claim when all other conditions are met.

We will leverage the CDM to feed the ePA transaction question set at the point of care. We will work with AllMed and SureScripts to incorporate this functionality into the ePA solution. The solution will be developed in accordance with NCPDP standards and operated within the State's regulations.

The MITA-guided technical infrastructure that makes all of this possible leverages the Modularity Standard from the MITA Seven Conditions. The Modularity Standard calls for the separation of standardized business rule definitions from core programming. The CDM is an example of MMA's application of the Modularity standard in that the rules are centralized and leveraged by multiple applications, including prior authorization described in Response 1.2.2. below. Doing so reduces errors and maintenance costs and guarantees a consistent application of the rules.

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.

In Figure 8 below MMA has provided a description of its approach to meeting the requirements in Template F.

Figure 8. Overview of MMA's Solution for Response 1.2.1.

Template F Items Addressed by this Response	
Requirement Number	**Overview of MMA's Solution**
FR2.1 (3)	Prescribers are notified of PA decisions via telephone and fax. Beneficiaries are notified of PA decisions via letter. In addition to receiving a letter for PA approvals, the beneficiary also receives the medication immediately from the dispensing pharmacy upon approval through our AutoPA tool.
FR2.3	FirstRx contains functionality to automatically override PA requirements at the POS based on pharmacy and medical claims. With AutoPA, if all criteria are met, an approval is rendered.
FR2.4	The CPhT first determines eligibility and program coverage by viewing the beneficiary eligibility factors, including program eligibility, long-term care (LTC) status, managed care status, existence of authorized prescribers, existence of program coverage restrictions, alternate insurance and other elements specified by the Vermont. If eligibility is established, then the CPhT proceeds with the review. The CPhT reviews the patient's history and compares all information to the criteria for that medication or class of medications. The CPhT advises the prescriber if alternative drugs are available that are therapeutically equivalent and do not require a PA. If the information furnished by the prescriber satisfies the criteria, then an approval is logged. The approval will be verbally given to the caller while he/she is on the line.
FR2.5	MMA's PA process allows for determinations based on the first 9 digits of a product's NDC, FDB's therapeutic classification system. PA determinations also take into consideration medical information such as CPT codes, ICD 9/10 codes, and lab values.
FR2.6	We send required notifications to beneficiaries and providers when a PA is approved or denied. Non-emergent appeals receive a decision within 15 calendar days from receipt. Emergent appeals receive a decision within 72 hours from receipt to the date the decision is communicated to beneficiaries and prescribers followed by a written notification within 3 calendar days.

The goal of our utilization management programs is to enhance patient care while offering program savings to DVHA. Additionally, to support physician-administered drugs under the medical benefit, we provide functionality for web claim submission. This application allows providers to submit claims in real-time at the point-of-care.

We offer DVHA a proven prior authorization that is continually evaluated and enhanced for the changing Medicaid landscape. Last year we processed close to 2 million prior authorization requests for our customers. These requests were supported by the systems we propose to support Vermont's contract, FirstRx and FirstTrax,.

The web-based submission is applicable to physician-administered drugs processed through the medical benefit. Our utilization management programs for all claims are described below.

Prior Authorizations

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DVHA's dedicated Clinical Pharmacist Manager, , Pharm.D., reviews utilization trends for each therapeutic drug class on DVHA's PDL. Our MMA clinical pharmacists have developed and maintain Therapeutic Class Reviews to support each class on our Medicaid customers' PDLs. The therapeutic class review includes available single-source and multiple-source drugs in that drug class. Through a comprehensive review of medical references and pharmacy compendia, works closely with DVHA pharmacy staff and the DUR Board to develop and recommend clinical criteria for approval of drugs requiring PA.

In addition, reviews individual drugs and drug classes, not subject to PDL, as well as new drugs to market, for potential abuse or misuse and makes recommendations to DVHA pharmacy staff and the DUR Board for potential clinical prior authorizations. The goal of these edits is to ensure appropriate utilization of medications, while offering a cost savings to the State. As an example, Kalydeco® was introduced into the market in 2012. This costly drug represents a breakthrough in the management of Cystic Fibrosis (CF), but is only proven to be effective in a subpopulation of beneficiaries with CF. Our clinical pharmacists reviewed the available literature and developed prior authorization approval criteria recommendations for each of our Medicaid customers which ensure only those patients with the appropriate gene mutation are approved to receive this medication. This ensures access to care for those with an opportunity for therapeutic response, while avoiding the excess cost of this medication in patients who would not be expected to benefit from therapy.

Quantity Limits

Similar to our approach for PA development, , in collaboration with our other clinical pharmacists, evaluates drug products for recommended quantity limits. Our quantity limits are designed to encourage appropriate, FDA-approved, prescribing of Medicaid-reimbursed drugs. In collaboration with DVHA pharmacy staff, quantities may be limited by drug per fill by NDC (national drug code), GCN (generic code number), or therapeutic class. Limits may also be placed on specific or groups of pharmacy providers, prescribers, or beneficiaries.

As an extension of quantity limits, we establish dose optimization limitations that helps to provide beneficiaries with medications at the appropriate frequency. Dose optimization provides DVHA with program savings by encouraging that the fewest number of units are utilized within FDA-approved dosing intervals. The added benefit for beneficiaries is ease of compliance.

Step Therapy

Our step therapy programs focus on the appropriate utilization of drug products, in compliance with current prescribing guidelines. Our step therapy program identifies drug products for which less costly alternatives are available and are recommended as first line therapy. Beneficiaries are required to complete a trial of the first line product before progressing to the more expensive, less tried, newer products. For example, recent years have seen an introduction of numerous products to treat diabetes, but these products are typically more costly and have the potential for adverse events. Trial and failure on proven products, like metformin, are required before a claim will successfully adjudicate for one of these newer agents.

Developing and Disseminating Clinical Criteria

Our team of clinical pharmacists with expertise in various disease states collaborates to develop clinically sound recommendations fro clinical criteria that improve quality of patient care, as well as reduce DVHA's pharmacy program costs. Pharmacists throughout the country review program trends and bring recommendations for edits and clinical criteria to weekly clinical meetings. Edit recommendations are reviewed and input is solicited to improve criteria. Once a consensus is reached, the criteria become our model for that particular drug.

will meet with DVHA pharmacy staff to evaluate the potential benefit in each program. If appropriate, DVHA-specific changes will be made before implementation. In addition, edits and criteria are posted to the program Website and made available to the prescriber and provider community before implementation.

First Reconsideration Reviews of Denials

We base denials for claims of pharmacy services on DVHA-approved criteria. When a beneficiary or prescriber appeals a denial, a senior clinical pharmacist contacts our staff physician and provides the information and data supporting the initial decision. The staff physician reviews the information and considers any new documentation obtained after speaking with the prescriber. Within 24 hours of the reconsideration request, the staff physician makes the decision. The senior clinical pharmacist contacts the prescriber by telephone to inform him or her of the outcome. If the denial is upheld, the prescriber is given the clinical reasoning for that decision.

Notification of Denials and Approvals

We provide standard notifications of all PA denials and approvals in accordance with federal and State-specific requirements. Non-emergent appeals receive a decision within 15 calendar days from receipt. Emergent appeals receive a decision within 72 hours from receipt to the date the decision is communicated to beneficiaries and prescribers followed by a written notification within 3 calendar days.

If the PA decision is an approval, the prescriber is notified via telephone or fax. FirstTrax users have the ability to create a facsimile reply letter, for PA requests received via phone, facsimile, and communicate the PA decision to prescribers. Beneficiaries are able to receive the medication from the dispensing pharmacy immediately upon approval. We are able to provide beneficiaries with an approval letter. However, our experience demonstrates that beneficiaries receive the medication before receiving the notification letter.

If the PA decision is a denial, prescribers are notified via telephone or fax. Beneficiaries also receive a letter notifying him or her of the denial and providing information on the State's process for appeal.

Standard letter generations for prescriber and beneficiary notification are produced using data extracted from FirstTrax. Letters are customizable with variable text as needed.

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.

In Figure 9 below MMA has provided a description of its approach to meeting the requirements in Template F.

Figure 9. Overview of MMA's Solution for Response 1.2.2.

Template F Items Addressed by this Response	
Requirement Number	**Overview of MMA's Solution**
FR2.1 (1), (4), (6)	We maintain DVHA-specific processes to support drug coverage decisions for all clinical and non-clinical criteria. PA modules are developed and configured within the parameters established by DVHA. FirstRx is easily customized with Department PA rules, regulations, and policies regarding PA determinations. We provide detailed monthly reporting that includes details on the number of PA's that were approved, denied, or resulted in a change in therapy. Please refer to **Section XII, Attachment H** for a sample PA report.
FR2.2	We comply with Vermont PA requirements including providing a telephone call center that is accessible 24 hours a day, 7 days a week, 365 days a year. The call center will support PA processing through a toll-free number, facsimile, mail, and web-based requests through WebPA. We provide real-time PA processing through AutoPA utilizing current beneficiary information. The call center is staffed with CPhTs and clinical pharmacists during normal business hours. After hours, CPhTs are able to contact clinical pharmacists as needed via a pager.
FR2.3	AutoPA evaluates data captured at the POS and compares it to our internal database of beneficiary information. It utilizes diagnosis-specific requirements such as claims history, lab values, CPT codes, and ICD9/10 codes. If the criteria for approval are met, an approval is automatically generated and entered in our claims system. If criteria are not met, or additional information is needed, the dispensing pharmacy is notified that a manual prior authorization is needed.

Template F Items Addressed by this Response	
Requirement Number	**Overview of MMA's Solution**
FR2.4	MMA includes a review of the beneficiary's eligibility record as part of the PA process by viewing beneficiary eligibility, such as program eligibility, LTC status, managed care status, existence of authorized prescribers, coverage restrictions, alternate insurance and other elements as specified by Vermont. In addition, we review for: • Program eligibility by viewing the beneficiary eligibility factors, including program eligibility. • Existence of authorized prescribers by reviewing their ability to authorize the requested drug. • Reviewing coverage restrictions that might affect PA approval • Existence of alternative insurance coverage. • DVHA-specific elements specifically approved by the Department.
FR2.8	We will interface with the MPI to obtain current contact information for beneficiaries. We will make all reasonable attempts to identify a new address for beneficiaries.
FR2.9	When a PA is required, we will allow for a 72-hour emergency supply as specified by the Department.
FR2.10	MMA maintains an electronic copy of clinical criteria and PA requirements in QuikChek. Both documents are accessible to staff across all Support Center locations through our Intranet site and will be posted to DVHA's website and provider portal.
FR2.11	Designated State staff will have access to PA information through FirstCI. FirstCI is a read-only application that allows designated staff to query PA requests on the parameters identified below. The system also contains several search fields and standard search parameters.
FR2.12	State staff will be able to retrieve and track PA determinations using FirstCI for a specific beneficiary using his or her's unique identification number.
FR2.15	coordinates closely with DVHA pharmacy staff to review utilization, PA determinations, and current literature to provide recommendations for program enhancements. All recommendations are subject to Department approval prior to implementation.
FR2.16	MMA will provide the necessary monthly reporting to demonstrate the efficacy of the prior authorization program and to enumerate the volume of requests, approvals, and denials at the appropriate category level as outlined here.
FR2.17	In accordance with the State's benefit design, we will maintain approved protocols and criteria for non-covered products.

MMA understands the importance of providing savings and improving prescribing patterns to have a lasting effect on overall outcomes and quality of care. To help DVHA realize continued PA savings, we offer several state-of-the-art methods for PA submission. This includes:

- Automatic Prior Authorization (AutoPA)
- WebPA
- Manual PA entry.

These entry points are integrated through our FirstRx system to support prior authorization requests for both pharmacy and physician-administered drugs. Each approach utilizes our Clinical Decision Module (CDM) to drive consistent decisions for our PA process. The CDM was developed to provide consistency and accuracy in interpreting criteria for PA requests. The database maintains a complete record of the sequence of questions asked of the CPhT or provider and the final decision. The CDM incorporates drug lists requiring PA with an alternative that does not. Each drug contains diagnostic information, age/gender considerations, and quantity limits.

Sophisticated questions based on the State's PA criteria are asked of the requestor. Based on the CPhT or providers answer to the questions, a decision is reached and an answer is immediately returned.

The CDM uses the same criteria that are accessed by our AutoPA rules, eliminating data redundancy, while allowing users to enter and consider additional information pertinent to the prior authorization request and an individual beneficiary's situation. The CDM is designed to interface with our POS system to maintain required drug and diagnostic information. The system's clinical questions and questioning routines are global in nature and can be mixed, matched, or grouped as necessary to achieve the required adjudication outcome. This flexibility allows criteria changes to be made once and automatically apply across all drugs using a particular set of criteria for approval. If granted, the prior authorization approval is entered into the system and enables successful adjudication of the claim when all other conditions are met.

The MITA guided technical infrastructure that makes all of this possible leverages the Modularity Standard from the MITA Seven Conditions and Standards. The Modularity Standard calls for the separation of standardized business rule definitions from core programming. The CDM is an example of MMA's application of the Modularity standard in that the rules are centralized and leveraged by multiple applications. Doing so reduces errors and maintenance costs and guarantees a consistent application of the rules.

Below we have provided a description of these tools, including our FirstTrax and FirstCI functionality.

AutoPA

Integrated within our FirstRx claims adjudication platform, AutoPA is an automated solution for processing prior authorization requests. As described in Response 1.1.1, AutoPA evaluates data captured at the POS and compares it to our internal database of beneficiary information. If the criteria for approval are met, an approval is automatically generated and entered in our claims system. The dispensing pharmacist is notified of the approval and is able to dispense the medication. If criteria are not met, or additional information is needed, the dispensing pharmacy is notified that a manual prior authorization is needed. At this point, the prescriber is able to submit a manual prior authorization request through our WebPA system, fax, e-mail, or telephone.

As part of our automated PA process, the system utilizes ICD-10 codes to help make determinations. For example, before Truvada® is dispensed at the POS, our system uses an ICD diagnosis code look back for HIV so beneficiaries with active infections are able to access therapy without a lapse in coverage.

WebPA

WebPA gathers information from prescribers or support center staff regarding prior authorizations through a secure web interface. Prescribers and call center staff answer a set of questions that are customized based on DVHA-specific guidelines. Upon completion, the prior authorization request is submitted and the answers provided are evaluated. If the expected response(s) are given, the system approves the request, adds the required rule(s) to the FirstRx adjudication system, gives on-screen notification to the user, and records the data in the FirstTrax database. If the evaluation does not result in an approval, the system notifies the user that the prior authorization request requires clinical review, and data are added to the FirstTrax database causing a record to be added to a FirstTrax queue to be manually reviewed and adjudicated by a pharmacist within 24 hours.

WebPA uses our CDM to integrate benefit, beneficiary, and physician data. With the CDM as the basis for WebPA, criteria are consistently and accurately interpreted. This ensures that providers and beneficiaries are treated in a clinically sound and consistent manner. If the WebPA request does not meet approval criteria online, it is pended for review by a clinician in our Support Center. Support Center staff will render a decision within 24 hours of receipt.

Manual PA Entry

When a claim is submitted for an NDC that needs a manual PA, providers may contact our customer service center. This is facilitated through our FirstTrax solution, described below in more detail. Information from a denied claim is automatically populated on a template that is designed for the specific initiative associated with the PA condition.

CPhTs in our support center conduct an initial review of the medication. Once eligibility and program coverage rules have been reviewed, the beneficiary's history is reviewed to compare all information regarding the medication or drug class. If an alternative is available, outreach is conducted by a clinician to the physician to see if the substitution is appropriate for the beneficiary. If the physician elects to prescribe the alternative, the CPhT records that a therapy change was initiated in the prior authorization log.

If the physician chooses to proceed with the prior authorization request, the CPhT reviews the information submitted. If supporting documentation satisfies all criteria, the CPhT logs and approval and communicates it to the physician. If additional information is needed or criteria for prior authorization are not met, the CPhT escalates the review to a clinician. If the clinician is able to approve the request, it is finalized in our system and the decision is communicated it to the physician. If the request does not meet criteria for authorization, the request is submitted to AllMed for final determination. AllMed communicates its determination to the customer service center. A CPhT communicates the final decision to the physician.

In Figure 10 below we provide a visual representation of the process flow for a manual PA.

Figure 10. Manual PA Process Flow

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FirstTrax

MMA uses FirstTrax, a proprietary on-line, automated system, to access beneficiary information and our CDM to support the manual prior authorization process. MMA uses the FirstTrax automated PA and call tracking system as the repository for all automated and manual PA requests, dispositions, and clinical notes.

Since we receive approximately 41% of all PA requests via fax, FirstTrax includes an imaging solution that helps to facilitate a paperless manual PA process by creating a fax image, opening a contact record, and automatically routing the work to DVHA's work queue.

FirstTrax utilizes Remedy, a commercial-off-the-shelf (COTS) product that allows us to easily create client-specific forms, properties, and workflow rules. The use of this COTS product allows us to implement changes quickly and cost effectively. The workflow system allows for real-time progress tracking of each request so that all stakeholders involved can see what steps of the workflow have been completed (e.g., managerial approval), where the request is currently in the workflow, and what steps remain before the issues can be considered closed or "resolved."

MMA tightly integrates FirstTrax with the FirstRx system to provide streamlined entry and update of PA requests to support claims processing.

FirstCI

FirstCI is a read-only application that allows designated Vermont staff to view claims, call tracking information, and prior authorization information. Designated state staff is able to view PA requests based on the following parameters:

- Requesting provider name
- Date and time of request
- Beneficiary identifiers
- Requested drug name, strength, form and quantity
- Program eligibility of the beneficiary
- Request status
- Reason for denial or exception
- Authorization begin and end dates
- Date and time of action on the request
- Authorization of a 72-hour emergency drug supply.

The application is user-friendly and easy to use with standard Windows functionality, such as copy/cut/past, drop-down menus, application-specific toolbars, mouse-over, cascading or tiling of windows. It utilizes one-time entry of information with necessary information being carried from screen-to-screen within the application without the need for re-entry or cut and paste. It is capable of providing contextual on-line help as well as access to user manuals and data element dictionaries. FirstCI is available for use as a conventional desktop application or as a web-based version. The web-based version offers single sign-on capabilities.

Emergency Supplies

MMA realizes the urgency in accommodating emergency situations, and we have the experience and the ability to administer the State's unique POS requirements to address critical beneficiary health needs. When the incoming claim transaction has denied for NCPDP Error Code 75 – Prior Authorization Required, and the drug is eligible for an emergency supply, and the pharmacist deems dispensing of an emergency supply is warranted, FirstRx will bypass the PA required denial and allow a 72-hour emergency supply of medication (three-day supply) if the incoming claim transaction is submitted per the following DVHA Emergency Supply procedures:

- Prior Authorization Type Code NCPDP field 461-EU value submitted = 8.
- Prior Authorization Number NCPDP field 462-EV value submitted = 88888888888.
- FirstRx system will not charge the beneificiary co-pay for the emergency supply.
- FirstRx will count the emergency supply claim towards the beneficiary's monthly script limit if applicable. However, if in the same month a PA is approved, or the medication is switched to a preferred product, the remainder of the prescription and/or the prescription for the preferred drug product will not count against the beneficiary's script limit that month when NCPDP field 420-DK Submission Clarification code value 5 is populated on the incoming claim.
- FirstRx will limit the beneficiary to one 72-hour supply per single prescription.
- FirstRx will allow one 72-hour supply per patient, per drug, (GSN, GPI, or industry equivalent indicator) per month.
- FirstRx will distinguish the drug categories that can be overridden by the provider at the POS from the drug categories that require a telephone call to the Pharmacy Support Center for override consideration.
- For unbreakable packages, the system will allow the full package up to a 31-day supply to be dispensed.
- The pharmacy is required to display in public areas the Emergency Supply and Appeal Notices (written in English and Spanish) describing DVHA's beneficaries' appeal rights.

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.

In Figure 11 below MMA has provided a description of its approach to meeting the requirements in Template F.

Figure 11. Overview of MMA's Solution for Response 1.2.3.

Template F Items Addressed by this Response	
Requirement Number	**Overview of MMA's Solution**
FR2.18	MMA's RetroDUR program is supported by FirstIQ™. FirstIQ is supported by a fully integrated data warehouse of both pharmacy and medical data, which includes analytical tools, clinical rules, algorithms, profiling that identifies prescribing and utilization patterns that fall outside of best practice guidelines.
FR2.19	FirstIQ merges pharmacy and medical service claims to identify and monitor drug usage including over-utilization, under-utilization, therapeutic duplication, drug-disease contraindications, drug-drug interactions, incorrect drug, dosage, or duration of therapy. In addition, it also identifies drug-induced illness, beneficiary clinical abuse/misuse, therapeutic appropriateness, and other criteria as defined by the Department. This is accommodated through a catalogue of drug usage criteria for over 100 therapeutic classes. The catalogue contains over 3,000 drug therapy situations that could place beneficiaries at risk.
FR2.20	is responsible for monitoring claims data and making recommendations to the DUR Board pertaining to potential additions, deletions, or modification to ProDUR criteria. is also a member of our internal Drug Policy Development Committee, a group of MMA clinical experts who review new drugs and clinical literature to make recommendations regarding appropriate clinical edits. We generate educational materials for prescribers, pharmacies and members. In **Section XII, Attachment I** we provide an example of educational materials submitted to prescribers on Serotonin. **Section XII, Attachment J** includes an example of a RetroDUR newsletter that is posted to our client's Website. **Section XII, Attachment K** provides an example of educational materials submitted to pharmacists on Suboxone.
FR2.21	will document and monitor all educational efforts on a quarterly basis and present this information to Vermont for review. Reports will include information for pre- and post-intervention and note any savings.
FR2.22	The State's RetroDUR solution will have oversight by , the State's dedicated Clinical Pharmacist Manager. is supported by our RetroDUR Manager, , R.Ph. has over 13 years of specific Medicaid RetroDUR experience and will provide guidance to Dr. as needed.
FR2.23	will provide all necessary information for the CMS annual DUR report as described in Section 1927(g)(3)(D) of the Social Security Act and the required cost savings analysis report completion no less than 30 days prior to the due date. will perform additional research

Template F Items Addressed by this Response	
Requirement Number	**Overview of MMA's Solution**
	as needed and upload the final CMS-required DUR Annual Report to the Department at least 10 days prior to the due date for Department approval and submission.
FR2.24	will facilitate DUR Board meetings and prepare Department-approved meeting materials including distributing and posting meeting agendas 14 days prior to the meeting, present in person all items on the agenda related to DUR activities, PDL recommendations, and drug related information. will also record meeting minutes including all PDL changes, action items and forward them to the Department 3 days after the meeting for Department approval. She is also responsible for posting meeting minutes to the website 5 days after the meeting and assures that all DUR Board actions are implemented on a timely basis.
FR2.25	MMA has extensive experience managing DUR and PDL activities through our collaboration with over half of the Medicaid Programs in the country. will collaborate with the Department to ensure that these activities are managed to the complete satisfaction of the State.
FR2.26	will proactively research, analyze, present findings, and advise the Department and/or DUR Board on topics requested by the Department. She will collaborate closely to evaluate trends and make recommendations to enhance the Vermont Pharmacy Program. These recommendations will include drugs processed through the pharmacy and physician-administered drugs processed through the medical benefit.
FR2.27	facilitates DUR Board meetings in reviewing various drug classes or individual drugs as needed through detailed therapeutic class reviews (TCRs).
FR2.28	MMA maintains drug coverage lists as defined by the State. PDLs, clinical criteria, and coverage of OTC medications will be maintained by in collaboration with the Department. We will also maintain other coverage lists as necessary for the Department's program.

Drug utilization review (DUR) provides an ongoing, structured review of prescribing, dispensing, and medication use. MMA's proposed solution for Vermont provides a comprehensive review of beneficiaries' prescription and medication data during and after dispensing to ensure appropriate decision-making and positive outcomes.

Our solution is comprised of the following:

- **Prospective DUR –** evaluation of a beneficiary's drug therapy before the medication dispensed
- **Retrospective DUR –** review of drug therapy after the beneficiary has received the medication
- **Provider Profiling –** identification of inappropriate prescribing patterns with the greatest opportunity for improvement
- **Educational Outreach –** preparation of new documents and training materials to present to the pharmacist and prescriber populations during scheduled training sessions

- **Peer-to-Peer Education –** provision of academic detailing targeted at identifying outlier prescribers of expensive medications.
- **Drugs of Abuse and Psychotherapeutic Management -** integrated management of drugs of abuse and substance abuse treatments with DVHA's core PBM offering.

Below we have provided an overview of our proposed solution.

Prospective DUR

Our DUR program embraces the principles adopted jointly by the American Medical Association (AMA) and the Academy of Managed Care Pharmacy (AMCP):

> **Testimonial from our Medicaid Customer**
>
> "We have been very pleased with the DUR services they (MMA) provide. We are very hands on with our DUR program and they have worked with us to create some very innovative reviews and interventions. By changing to MMA as our DUR provider, the Department is saving over $300,000 a year and getting a superior service from what we were receiving from the previous contract with a University."
>
> *Tami Eide, PharmD, BCPS*
> *Medicaid Pharmacy Program Manager*
> *Idaho Department of Health and Welfare*

- The primary goal of MMA's ProDUR programs and criteria is to improve the quality of care for beneficiaries by ensuring appropriate drug therapy.
- MMA ProDUR criteria recommendations are clinically relevant.
- MMA approaches DUR criteria openly with our customers, fostering the interchange of ideas both between our clinical pharmacist and their assigned customers, and internally among all of our clinical pharmacists, ultimately facilitating the development of the best DUR criteria.
- MMA works to ensure that DUR programs and criteria are focused on improving outcomes. MMA provides the full spectrum of DUR services for many state Medicaid programs, including the operations aspects associated with point-of-sale claims adjudication, and MMA will bring that experience in working with the State to ensure that criteria really do improve healthcare for Vermont Medicaid beneficiaries.
- MMA understands that while DUR provides a useful tool in delivering clinically relevant information to pharmacy providers at the point of care, the patient-physician and patient-pharmacists relationships must be protected, and DUR can only facilitate a more meaningful exchange between healthcare providers and their patients.
- As a provider of both prospective and retrospective DUR, MMA understands the link between these two activities.

MMA's ProDUR solution is operated in accordance with the latest accreditation standards of telecommunications as defined by NCPDP version D.0. In addition, it is compliant with OBRA '90 regulations as it relates to prospective screening of:

- Therapeutic duplication
- Drug-disease contraindications
- Drug-drug interactions
- Incorrect dosages
- Drug-allergy interactions
- Clinical abuse or misuse.

Based on DVHA-specific criteria, claims are evaluated at the POS against beneficiary profiles during adjudication. The system is able to compile both medical and pharmacy claims on a daily basis into a comprehensive beneficiary record. Beneficiary profiles include:

- Current, historical, paid and denied claims
- PA history
- Pharmacy and prescriber information
- Plan rules and pricing files.

The system is designed to minimize false positives and returns the most appropriate alerts. ProDUR was designed as an adjunct to the pharmacist's professional judgment and stores DUR intervention responses as submitted by the pharmacist. DUR intervention codes are processed and stored for use in reporting or auditing, as necessary, in accordance with NCPDP standards. In Figure 12 shows the ProDUR flow within FirstRx.

Figure 12. ProDUR Flow within FirstRx

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CONFIDENTIAL MATERIAL: CONTAINS HIGHLY SENSITIVE PROPRIETARY AND/OR TRADE SECRET INFORMATION; PUBLIC DISCLOSURE WILL CAUSE SIGNIFICANT COMPETITIVE INJURY AND DISRUPTION.

, will be responsible for monitoring claims data and making recommendations to the DUR Board pertaining to potential additions, deletions, or modification to ProDUR criteria. These recommendations will be based on reliable, up-to-date clinical information, with common references including: the American Hospital Formulary Service - Drug Information, the United States Pharmacopeia - Drug Information, DRUGDEX, Facts and Comparisons, Hansten's Drug Interactions, FDA-approved product labeling, and peer-reviewed primary literature. Our pharmacy staff will have the added benefit of an internal Drug Policy Development Committee (DPD), a group of MMA clinical experts who review new drugs and clinical literature to make recommendations regarding, among other things, appropriate clinical edits. Our DUR criteria are currently in being utilized by a number of other state Medicaid programs, and MMA clinical staff will bring the benefits of that experience to the State.

Being involved in all aspects of pharmacy services delivery with many of our customers, MMA is unique in our scope of experience in all aspects of DUR programs.

will provide reports necessary to complete the ProDUR sections of the Medicaid Drug Utilization Review Annual Report. MMA's clinical staff is familiar with the information required to fulfill the requirements of the annual report, including the sections added to the recently released, web-based version. Our standard DUR reporting package provides all information needed to complete the annual report. MMA currently provides this service to a number of our customers, being involved with all aspects of the annual report preparation in some cases. In addition to responses to the objective questions, MMA's analytical capabilities also make it possible to measure the cost savings of DUR edits for inclusion as part of Attachment 6 of the CMS report. DUR edit savings can be reported apart from non-DUR edit-related savings, providing a more accurate estimate of the savings associated with DUR edits.

Additionally we provide quarterly update reports for presentation to the DUR Board. These reports are consistent with much of the information included in the annual DUR report, but tailored to facilitate discussion with the Board members.

In order to ensure the timely assignment of ProDUR clinical criteria to new products, MMA uses the drug utilization clinical criteria provided as part of the weekly First DataBank drug file. While the First DataBank criteria serve as the initial base for these ProDUR criteria, will provide review of the FDB criteria assignments to ensure that they drugs are placed in the appropriate categories. We will refine the FDB criteria as necessary to meet the needs of Vermont Medicaid.

MMA's DPD Committee will provide additional, central support to ensure appropriate assignment of new drugs. This includes the provision of New Drug Updates (NDUs) for new drugs to market, indicating suggested DUR edits. will monitor on-line ProDUR data and make recommendations to the DUR Board pertaining to potential additions, deletions, or modification to ProDUR criteria. This information will be presented as a report at the DUR Board's quarterly meeting. Recommendations for new ProDUR edits may be submitted to the state office and DUR Board on an ongoing basis or on a frequency established by the State.

ProDUR Functionality

The ProDUR module allows changes to be made as needed on a mutually agreed upon schedule. FirstRx supports online control of the DUR function through a direct user interface that allows for the transmission of new or revised edits within NCPDP standards. Edits are customizable for certain pharmacies, prescribers, or beneficiaries providing flexibility in defining outcomes. Below we have highlighted the edits we consider critical for a successful ProDUR system.

- *Therapeutic duplication* - The therapeutic duplication and ingredient duplication checks are very similar. While the duplicate therapy check is carried out at the Hierarchical Ingredient Code (HIC3) specific therapeutic class level, the duplicate ingredient check is carried out at the HIC4 level identifying the ingredients without the salt/ester portion. These checks generate warnings about a potential therapeutic overlap between prescribed drugs and other drugs currently active in the beneficiary's medication history.
- *Drug-to-Known Disease* - The drug-to-known disease check generates a warning when the use of a prescribed drug is contraindicated for beneficiaries with a specific disease in their health profile.
- *Drug-to-Inferred Disease* - The drug-to-inferred disease check generates warnings where the use of certain drugs is contraindicated by the beneficiary's inferred medical condition(s).
- *Drug-to-Allergy/ Prior Adverse Drug Reaction* - The drug-to-allergy/prior adverse drug reaction check determines any potential allergic reactions, cross-sensitivities, or adverse reactions to a prescribed drug. The beneficiary's hypersensitivity or allergy is registered in the clinical profile.
- *Drug-to-Drug Interaction* - The drug-to-drug interaction check creates warnings about potential drug interactions between the current prescribed drug and other drugs that are active in the beneficiary's medication history at the time of dispensing.
- *Dosing Precautions* - Dosing precaution checks are performed on three categories — drug-to-pregnancy, drug-to-geriatric, and drug-to-pediatric.
- *Drug-to-Pregnancy* - The drug-to-pregnancy check provides information on contraindications, potential risks, and precautions for the use of a drug that may not be appropriate for pregnant women.
- *Drug-to-Geriatric* - The drug-to-geriatric check generates warnings about drug therapy that may not be appropriate for geriatric beneficiaries.
- *Drug-to-Pediatric* - The drug-to-pediatric check generates warnings about drug therapy that may not be appropriate for pediatric beneficiaries.
- *Under-Utilization Monitoring* - Under-utilization monitoring, or the "Fill Too Late" edit check is processed on refill prescriptions to determine whether the beneficiary is refilling the prescription too late for the drug to have any useful effect.
- *Over-Utilization Monitoring* - The "Fill Too Soon" check is processed on prescriptions based on optimal therapeutic intervals and days supply of the most recent historical prescription for a drug with the same GCN sequence number as the new prescription.
- *Minimum/Maximum Daily Dosage* - The minimum/maximum (min/max) dosage check generates warnings about drug doses that fall outside the acceptable effective/safe dosage range.

- *Drug-to-Gender* - This edit generates warnings when a gender-specific medication is prescribed to a beneficiary of an incompatible gender.
- *Drug-to-lactation* - This edit generates warnings concerning drug therapy that may not be appropriate for nursing women.
- *Controlled Substance* - The Controlled Substance check alerts the pharmacist to potential abuse by a **beneficiary** and provides the capability to reject claims where a controlled substance abuse situation has been identified.

In addition, the ProDUR module includes two edits associated with step therapy that are structured to determine therapeutic appropriateness:

- ***Prerequisite Step Therapy:*** Require use of a drug from class A before allowing use of a drug in class B within a designated time frame. The Prerequisite Therapy check generates warnings regarding prior and concurrent use of associated therapies. These rules relate to a drug or drug class and optionally to a disease. For the current claim to be adjudicated, the beneficiary must have taken or be currently taking at least one of a list of associated therapies. The prerequisite therapy check looks for any "active" prerequisite drug claim within the period start date and the period end date for the current prescription. The period of history to review in determining active drugs cannot be greater than the Plan/DUR rules period of history to review. If one or more claims exist for a drug or drug class defined in the prerequisite protocol, the protocol has been adhered to and no action is required. If a single match is not found, an encounter is generated. The pharmacist receives a summary of the encounters. For example, the system can be configured to perform a look back for an ACE inhibitor or anti-diabetic agent prior to adjudication of a claim for an ARB. Additionally, the system can be configured to allow the ARB if the ICD-9 for diabetes is submitted on the claim or found in the beneficiary's medical history.
- ***Exclusive Step Therapy:*** Disallow use of drug class A if there is prior history of a drug within class B within a designated time frame. The Exclusive Therapy check generates warnings regarding the prior or concurrent use of associated therapies. These rules relate to a drug or drug class and optionally to a disease. For the current claim to be adjudicated, the beneficiary must not have taken nor currently be taking any of the associated therapies. The exclusive therapy check looks for any "active" exclusive drug claim within the period start date and the period end date for the current prescription. The period of history to review in determining active drugs cannot be greater than the Plan/DUR rules period of history to review. If no claim exists, the protocol has been adhered to and no further action is required. If one or more claims exist for a drug or drug class contained within the exclusive protocol list, an encounter is generated. The pharmacist receives a summary of the encounters.

Flexible Parameters for Generation of ProDUR Messages

The ProDUR system allows for additional refinement based on attributes of the drug, ProDUR alert and historical medications. As an example, diabetic beneficiaries require multiple agents to achieve therapeutic goals. In an attempt to return only clinically-relevant DUR information, drugs used in the treatment of diabetes may be eliminated from the Therapeutic Duplication DUR edit. This enhanced functional capability offers greater flexibility to meet Vermont population-specific needs by allowing a more focused approach to identification and control of the most clinically relevant ProDUR events for point-of-sale transactions. It also offers superior support to submitting providers by returning controlled messaging and requiring intervention only in

specifically targeted conditions. For example, the ProDUR system offers the option to perform the following:

- **Return "reject" or "message" responses** for claims with selected Drug-to-Drug Interaction criteria within a given severity level. For example, DVHA may wish to "reject" for one or several Drug-to-Drug interactions within Severity Level 1 and "message" on remaining criteria within the same Severity Level. This provides an enhanced level of granularity not available when edits are set to all criteria within a Severity Level.
- **Base the claim disposition on the specialty of the prescriber** when determining whether a Therapeutic Duplication alert for a particular drug or drug class should "reject" or "message." For example, DVHA may wish to return a message with a paid response for narcotic claims in cases where the prescriber is an oncologist and reject for other specialties.
- **Return a "reject" or "message" response** based on same or different prescriber or pharmacy provider status. For example, DVHA may choose to reject the claim if the prescriber of the historical claim is different from the prescriber of the incoming claim, and message only if the prescriber of both claims is the same.

MMA can assign any of the above levels of DUR parameters to edits that DVHA determines should receive automatic denials. This process ensures that maximum quality of care and patient safety is achieved. It also adds a review for overutilization within highly utilized and often over utilized classes of drugs that contribute to increased fiscal burden on DVHA and excessive number of claims per beneficiary.

Brief Summary of the Vermont ProDUR Solution

The solution proposed for DVHA provides only clinically appropriate alerts to the pharmacy. Based on DVHA specifications, edits are set to message, deny, or be used for reporting purposes only. In addition, we provide the following benefits to DVHA:

- **Comprehensive On-Line Beneficiary Health Profile:** FirstRx has the capability of compiling both medical and pharmacy claims data into a comprehensive on-line beneficiary health profile that identifies drug therapy problems prior to dispensing and evaluates current, historical, paid, denied claims data, prior authorization history, provider and

Real-Life Examples Lead to Customized Solutions

MMA collaborates with state Medicaid agencies to deal with the very real problem of adult beneficiaries trying to obtain medications for themselves through children's prescriptions. At the direction of the Department, POS edits can be constructed to review incoming transactions for children's prescriptions at POS to ensure therapeutic appropriateness and generate denials when the drug dose falls outside the acceptable effective/safe dosage range for children. The Pro-DUR capabilities of FirstRx allow state-specific Pro-DUR editing to identify drug therapy that may not be appropriate for children. In addition, our system performs Minimum/Maximum (Min/Max) Dosage check. The Min/Max check determines whether a prescribed dosage approaches an overdose or represents a sub-therapeutic dose of the prescribed drug. These edits prospectively identify potentially fraudulent dispensing quantities, and assist in identification of billing errors.

In addition, automated edits can be developed at a drug and age specific level to allow for automated processing of claims where prerequisites are met.

Risperdal® can be coded for specific requirements for different approvable age dependent diagnoses. Example of sample Risperdal age related coding could include:

- Age < 5: claims deny
- Ages 5 - 9: claims pay only if diagnosis present in patient history or included on claim = irritability associated with Autistic Disorder
- Ages 10 -12: claims pay only if diagnosis present in patient history or included on claim = irritability associated with Autistic Disorder or Bipolar Disorder
- Ages 13-17: claims pay only if diagnosis present in patient history or included on claim = irritability associated with Autistic Disorder, Bipolar Disorder, or schizophrenia
- Ages 18 and up: claims will pay.

prescriber information, plan rules, and plan pricing files. These data can then be used to determine the outcome (paid, denied) of a specific claim submission.

- **Variable Usage Time Frames for Early Refill**: FirstRx offers variable usage time frames for Early Refill logic by establishing different usage time frames based on the DEA Schedule designation of the drug, such as, using, different percentages for controlled versus non-controlled substances.
- **Intelligent Early Refill Logic**: FirstRx has the capability of intelligently determining if an early refill edit is due to an increased dose. Early Refill overrides are available if there is an increase in dose from the historical claim where systematic overrides can be applied to all claims or only to claims for non-controlled substances.
- **Selective ProDUR Edits:** FirstRx has the ability to bypass ProDUR edits for designated drugs or drug classes specifically for compound ingredients. For example, saline solution claims may be submitted as a single ingredient claim and as part of a multi-ingredient compound on the same day).

Retrospective DUR

Retrospective DUR (RetroDUR) is supported by FirstIQ™, a clinical management decision support tool designed to perform inquiries into State-specific data. DVHA's historical data are used to identify trends of interest and variables that are usable as reliable predictors of outcomes. The RetroDUR program is supported by a fully integrated data warehouse of both pharmacy and medical claims data, including diagnosis, procedure, hospital, and laboratory claims data.

The system allows for customized queries into State-specific data that is used to produce reports, files for further analysis, and graphs for monitoring clinical and economic trends. FirstIQ utilizes therapeutic criteria approved by the State and its DUR Board. Criteria are revised as therapeutic patterns are identified and new drug products are released. RetroDUR promotes therapeutic appropriateness of medications by checking for:

- Early refills
- Brand versus generic utilization
- Drug-to-drug interactions
- Therapeutic duplication
- Excessive use of medications
- Insufficient daily doses by comparing submitted daily doses to duration of therapy
- Medication compliance and adherence.

Key Benefits of the RetroDUR Solution

We provide a RetroDUR program that provides a basis for clinical improvement through identification of potential adverse drug events of incorrect drug utilization. These edits help to improve quality of car and conserve program funds. Examples of issues of appropriate drug usage that may be evaluated include:

- Evaluating whether physicians comply with appropriate drug use guidelines and protocols
- Determining pharmacy dispensing and physician dispensing and prescribing patterns

- Measuring beneficiary usage of specific drugs stratified by age, gender, diagnosis, or other demographic data
- Assessing beneficiary compliance, as well as the affect of compliance on efficacy and outcomes.

The primary component of our RetroDUR system is the catalogue of drug usage criteria for over 100 therapeutic classes. The catalogue contains over 3,000 drug therapy situations that could place beneficiaries at risk. Criteria are continually updated to reflect current medical literature. The module detects drug-to-diagnosis contraindications, treatment failure, adverse reactions, and iatrogenic effects by evaluating drug, diagnostic, and laboratory procedural information, when available. Other factors, such as the patient's age, gender, location, co-morbidities, and those beneficiaries receiving mental health and/or substance abuse treatment, are also incorporated into criteria as medically relevant.

The appropriate medical references, including CMS-mandated references, are documented for each therapeutic criterion. When new criteria are developed, the information regarding approved dosage forms, approved indications, doses, and duration of therapy, adverse reactions, and drug interactions is collected and carefully evaluated. These criteria are translated into sophisticated computer algorithms and entered into the Therapeutic Criteria Catalogue for additional analysis by team beneficiaries. Extensive automated testing is then performed using broad patient populations. The resulting exception profiles are then evaluated, and changes are made as necessary. We use these tools to evaluate the level of quality of care provided to the State and its beneficiaries and to identify possible overpayment due to inappropriate utilization.

MMA's RetroDUR systems logic identifies and profiles members, pharmacy providers, prescribers, and disease states. Program-specific historical data are used to identify trends of interest and variables that can be used as reliable predictors of subsequent outcomes. After interventions are made to either pharmacy providers or prescribers, follow-up ensures that members receive quality care, as well as cost-effective and therapeutically-sound treatment. MMA clinical staff detects therapeutically inappropriate treatment trends that are then targeted for intervention. MMA's RetroDUR programs include the standard beneficiary exception-based program, as well as pharmacy provider, prescriber, and disease state profiling.

Powered by the integrated data warehouse, FirstIQ provides user-friendly point-and-click processing with no programming needed to perform in-depth data analyses. Query results are usable in conjunction with other software packages, allowing seamless integration with spreadsheet, reporting and graphing tools. Figure 13 below provides an overview of FirstIQ's functionality

Figure 13. Overview of FirstIQ Functionality

Graphical User Interface	FirstIQ is a menu-driven system that works within a graphical environment. Its applications screens are easy to use and are similar to Windows-based word processing and spreadsheet packages.
Powerful Processing Capabilities	FirstIQ is a relational database that provides the ultimate flexibility as to the volume of data to be accessed — its robust processing capabilities can provide rapid results to queries.
Demographic Analysis	Using menu-driven, point-and-click commands, users can instantly subset cases (claims, beneficiaries, pharmacy providers, prescribers, or geographic area) that fall outside either norms or criteria residing within the database. For example, the system instantly ranks and prints subsets of highest-ranking prescribers in terms of cost, number of prescriptions, or number of beneficiaries receiving medications in specific drug classes.

DVHA-specific information in conjunction with FDB NDDF (First DataBank National Drug Data File Plus) builds the clinical framework to support evaluations and other clinical decision support products. This allows us to integrate data at the POS with NDCs (national drug codes), UPCs (universal product codes), GSN, HIC3 and 4(hierarchical ingredient codes), HSN (list sequence numbers), therapeutic classes, drug category codes, and pricing information at the NDC-11 level. Our solution also provides for customized interventions that will be developed with the State and its DUR Board to support specific business requirements. With the ability of the system to merge medical and pharmacy claims, we are able to assist the State in making holistic recommendations to the DUR Board to help facilitate improved outcomes.

RetroDUR Reporting

CONFIDENTIAL MATERIAL: CONTAINS HIGHLY SENSITIVE PROPRIETARY AND/OR TRADE SECRET INFORMATION; PUBLIC DISCLOSURE WILL CAUSE SIGNIFICANT COMPETITIVE INJURY AND DISRUPTION.

The State's RetroDUR solution will have oversight by , the State's dedicated Clinical Pharmacist Manager. is supported by our RetroDUR . has over 13 years of specific Medicaid RetroDUR experience and will provide guidance to as needed.

Provider Profiling

In addition to providing a robust RetroDUR solution, inclusive of detailed reporting, FirstIQ helps to identify inappropriate prescribing patterns through provider profiling with the greatest opportunity for improvement. An important feature of the system is the monthly summary that provides the current number of beneficiaries, prescribers and providers identified as violating each criterion in the active catalogue. This report includes the payment amount of the claims involved. The results can be sorted by total volume of beneficiaries per criteria, total number of unique prescribers and providers per criteria or the total payment amount for the claims in violation of the criteria. This report provides DVHA, their dedicated clinical account manager and the DUR Board a tool to review where concerns are with drug therapy. Provider profiles can then be produced that will give the prescriber and/or the provider a list of their patients involved in the criteria, allowing them to follow up on the information in an efficient manner. DVHA is also able to benchmark providers to their peers in the State of Vermont on a number of drug utilization measures.

FirstIQ includes the capacity to generate letters based on the concerns identified by the profile reviewers for specific patients. We perform this service for each of our RetroDUR customers, ensuring that their letters are tailored to meet the specific needs of the State. All letters will be reviewed and approved by the State or the DUR Board, before being sent to providers. A copy of the patient profile on which the intervention letter was based may be included with the letter, as well as other educational literature as appropriate. These letters are viewable within FirstIQ.

In addition, DVHA benefits from our academic detailing program because it targets outlier prescribers of expensive medications. The goal of our academic detailing program is to improve beneficiary care through educational outreach that:

- Is consistent with evidence-based medical practices
- Supports patient safety
- Promotes cost-effective medication choices.

We utilize pharmacy claims to identify and rank prescribers within geographically dense areas and provide opportunities for educational outreach via the telephone or direct mailings. As deemed necessary face-to-face outreach may be conducted by mutual agreement between DVHA and MMA.

Educational Outreach

We utilize a variety of training delivery methods to help meet training and outreach needs. Training sessions can also be delivered via webcast, one-on-one site visits, on-site hands-on classroom facilitation, telephone communications, or computer-based training. Training delivery methodology is determined based on the audience, class size, and training objective. We will schedule training sessions in conjunction with Vermont and will jointly conduct training sessions according to the Vermont-approved plan and schedule. We will perform the post-training evaluation, including the development of trainee evaluation forms and distribution, collection, and compilation of evaluation responses.

Our Training and Development Department staff will work with our Vermont staff to prepare new documents and training materials to present to the pharmacist and prescriber populations as appropriate. All training materials are scrutinized through an internal review and approval process that involves review by the management team and the clinical staff. Once internal approval is provided, MMA will submit the training materials to the State for review and approval.

In conjunction with Vermont, we will analyze training evaluation results and comments and identify deficiencies and areas for improvements. Based on our experiences in other states, we have noted that busy healthcare professionals rarely have time to devote to training seminars; however, they welcome telephone conversations and are very willing to participate in webinars that are available to be viewed at their leisure. We will continuously develop methodologies for measuring the success of the educational programs to ensure not only the content is appropriate but the delivery mechanism is convenient and reaches the targeted audience. Additionally, reports will be developed to look for changes in PDL compliance, over-utilization of the PA system, and other parameters as requested by Vermont in order to measure the success of our educational outreach programs on a quarterly basis.

Our academic detailing program and onsite provider training are ***optional*** programs available to the State. Should the State wish to implement these programs, we would be happy to negotiate terms during the contracting process.

Management of Drugs of Abuse and Substance Abuse Treatment

A key differentiator from our competitors is our ability to integrate the management of drugs of abuse and substance abuse treatments with DVHA's core PBM offering. Through Magellan Behavioral Health's Center of Excellence we develop and deliver innovative solutions focused on improving quality and changing behavior. This is accomplished through our comprehensive DUR solution that supports appropriate utilization of mental health medications and those used for substance abuse treatment. DVHA also receives support in encouraging appropriate utilization of mental health medications in children. Examples of our offering include:

- Prior Authorization for Children receiving Antipsychotics: Our evidence based criteria uses national guidelines and can be customized to meet DVHA's specific needs. We find it is best to analyze the data to determine what initial age threshold to target based on volume, provide educational resources for medical practitioners, and use our analytic capabilities to clearly identify the change in prescribing behavior after implementation.
- Prior Authorization for Antipsychotic Polypharmacy: Antipsychotic polypharmacy is often prescribed despite the paucity of clinical information in the literature to support its superiority over monotherapy. Our criteria use the latest clinical guidance in addition to our internal behavioral health specialist to create criteria supported by literature, but also adaptable to local practices.
- Prior Authorization for Low Dose Seroquel®: This quality DUR edit is focused on the inappropriate use of low dose Seroquel for indications such as insomnia, anxiety, and post-traumatic stress disorder. This criteria does not eliminate lower doses of Seroquel (e.g., 25 mg and 50 mg tablets), but looks over all Seroquel prescriptions to identify the true daily dose, while still allowing time for appropriate dose titration without a point of sale rejection.
- Prior Authorization for Mental Health Interclass Polypharmacy: Utilization of multiple prescriptions in the same mental health category can often be seen and potentially lead to adverse effects. This DUR edit will identify those beneficiaries who are taking multiple antidepressants from similar categories, and ensure that appropriate monitoring is being conducted or coordination of care between multiple medical practitioners is occurring.

- RetroDUR criteria for Controlled Substance Polypharmacy: Our clinical rules engine, FirstIQ, will allow the user to identify beneficiaries who have greater than a designated threshold of controlled substances in the previous 90 days (for example, 4 or more different drug products) and written by more than a designated number of prescribers and obtained at more than a designated number of different pharmacies. The variables are controlled by the clinical user and can be varied for any given activity.
- RetroDUR criteria for High Dose, Controlled Substances: FirstIQ contains criteria for high dose of many drugs, including controlled substances. The system will identify any beneficiary who had received a daily dose higher than the recommended maximum dose. These criteria can easily be created at the client level to use a different maximum than the FDA high dose standard, if desired.
- RetroDUR criteria for Suboxone® used concurrently with opioids: Through our drug to drug interaction algorithm, FirstIQ will identify beneficiaries who have received Suboxone and any opioid with supplies that will overlap at any point.
- RetroDUR criteria to identify top utilizers of controlled substances: The Cognos BI reporting system will identify top utilizers, prescribers and/dispenser of controlled substances using databases from FirstIQ.

We will conduct these activities in accordance with State and Federal regulations.

MMA also provides collaborative quality improvement initiatives through our pharmacy based WholeHealth Rx to drive improved member outcomes. As an optional and holistic pharmacy management program that addresses mental health and co-morbid conditions, Whole Health Rx addresses the fragmented drug management and delivery system across mental health, medical and pharmacy benefits. It uses medical diagnosis, pharmacy claims and lab data to identify patients, including the vulnerable pediatric and geriatric populations, taking behavioral health medications that also have common co-morbid conditions such as heart disease, diabetes, asthma, etc. It then works with providers (PCPs and mental health providers) to identify and resolve inappropriate prescribing, gaps in care and potential drug interactions to drive beneficiary safety, improved clinical outcomes and cost savings

Our provider education program includes personal contact by clinical pharmacists to the prescriber, either via telephone or in-person. These outreach opportunities are designed to familiarize the prescriber with potential issues facing individual patients and are supported by reference material from the current literature.

Our success in managing the pharmaceutical care of mental health patients is unmatched and we are excited to discuss our programs developed by the Magellan Behavioral Health Pharmacy Center of Excellence, capitalizing on our combined expertise of Magellan Pharmacy Solutions and Magellan Behavioral Health.

Through our combined expertise in mental health and total drug management, we are positioned uniquely to deliver innovative approaches for whole patient health management that include both beneficiary and provider interventions.

Additionally, our Drug Information Provider Education programs are offered for a variety of complex chronic conditions. MMA will work closely with DVHA to determine the scope of the program. Once the scope of the program has been developed, MMA, in a good faith effort, will work with DVHA to determine the final pricing of these programs and the anticipated ROI.

All of our initiatives are developed with the goal of improving the clinical and financial health of our customers and their members. Understanding the needs of the population being served is important to the clinicians at MMA and we take pride in providing programs that are designed for specific populations, not cookie cutter programs applied across all segments of our customer's members. We evaluate program trends and patient demographics to fully understand the population before creating any criteria or implementing any program.

Heroin and Opiate Addiction Drug Treatment

On January 9, 2014 Governor Shumlin in his State of the State address noted that one of the greatest threats to Vermont's economy is the increased use of heroin and opiate drug abuse. We offer Vermont the following optional programs to help treat heroin and opiate abuse in collaboration with our Behavioral Health division. Should the State wish to pursue these programs, we would be happy to negotiate terms during the contracting process:

- Medication Assisted Treatment (MAT) that reduces cravings for certain substances; and
- Office-Based Opiate Treatment (OBOT) that identifies physicians with the waiver to prescribe buprenorphine.

Our **MAT** program encourages the use of opiate antagonists and other FDA approved medications in the treatment of heroin and opiate abuse, and other substance abuse disorders, where clinically appropriate:

- Alcohol and Opiate/Heroin
  - Naltrexone
  - Vivitrol®
- Alcohol Only
  - Acamprosate
  - Disulfiram
- Opiate/Heroin
  - Buprenorphine
  - Methadone

The cornerstone of opiate/heroin outpatient treatment includes buprenorphine, which blocks the effect of heroin and other opiates at the receptor site in brain. Care managers in the MAT program have encouraged the use of these medications, in addition to other psychosocial supports, to help treat opiate addiction. As other FDA-approved medications for the treatment of substance abuse conditions become available, we will conduct a thorough review before recommending them as part of our MAT program.

The program focuses on patients who have been discharged from inpatient substance abuse treatment programs and outpatient case or disease management services. Through this program we monitor the number of cases in which physicians are prescribing medications and follow patient readmission rates.

The **OBOT** program is a physician assisted opiate treatment that occurs in the prescriber's office. It identifies physicians who have the waiver to prescribe buprenorphine and refers patients to these physicians for buprenorphine treatment. This program is a breakthrough in access for patients who find it difficult to attend an outpatient program daily and who are not able to travel long distances to obtain treatment.

We surveyed the DEA list of doctors who had the certification, and encouraged to join our network in order to increase the number of physicians who were prescribing the drug. In addition, we surveyed our network physicians' that used buprenorphine to discuss barriers they had that prevented, or limited, their use of this method for treatment. We convened a panel of physician experts who had successful histories using OBOT strategies. Based on their experience, the panel offered practical ideas to help remove barriers and assist physicians in administering the OBOT program.

DUR Board Participation and Support

We have supported state DUR Boards for more than 25 years. We currently support DUR Boards in 13 states, including one state using a local pharmacy association for RetroDUR services. Our Vermont Clinical Pharmacist Manager, , collaborates with the State pharmacy program staff to provide full clinical consultative and administrative support for DUR Board meetings.

In determining recommendations for products as preferred or non-preferred to the State and the DUR Board, we use the experience of our nearly 100 staff pharmacists dedicated to improving the clinical programs, specifically in Medicaid. All aspects of each product within a therapeutic class are considered for their efficacy and safety, taking into account the most recent FDA approvals and product launches. The financial component is then considered, and a value is assigned for each product. For those products that are not available within a reasonable amount of time prior to a P&T Committee meeting, products are reviewed during future DUR Board meetings or on its own or as part of the full class review.

MMA staff in attendance at the DUR Board meeting is available for presentations of PDL recommendations, clinical evaluation of products under review, and to facilitate, lead, and respond to discussion regarding the PDL and related professional programs. We also provide support for post-meeting activities which include generation of meeting minutes, assistance with bulletin development, and updated PDL postings. Our experienced staff has performed these duties for over 10 years and has worked for over half of the state PDL programs in the country.

Each therapeutic class is reviewed for comparative efficacy, safety, side effects, dosing, prescribing trends and indications, and cost efficiencies of each drug within the therapeutic class. We deliver these reviews as monographs or Therapeutic Class Reviews (TCRs). The materials disseminated in preparation for the DUR Board meeting include recommendations for each product in the classes scheduled for review. These recommendations appear in the form of cost sheets which contain financial and utilization data that supports the recommendation. The utilization data are representative of actual dispensing data from Vermont. The financial information is populated using the CMS rebate tape and supplemental rebate information. The cost sheet utilizes data from the most recent complete quarter for which both Vermont utilization data and the CMS rebate tape are available. Recommendations are based on the most recent clinical, financial, and utilization data available.

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.

In Figure 14 above MMA has provided a description of its approach to meeting the requirements in Template F.

Figure 14. Overview of MMA's Solution for Response 1.2.4

Template F Items Addressed by this Response	
Requirement Number	**Overview of MMA's Solution**
FR2.29	MMA utilizes indicators from national drug files to create drug groupings for inclusion on the MAC list. This helps us to capture new opportunities within the generic reimbursement environment promptly in an effort to maximize savings for Vermont. Our methodology for calculating MAC is available and transparent to DVHA.
FR2.30	We will evaluate and consider drugs rates as therapeutic equivalents utilizing FDA's "Approved Drug Products with Therapeutic Equivalence Evaluations. Eligible NDCs with therapeutic equivalents are assigned a MAC rate, including A-rated drugs. As a standard, OTC products tend to be less expensive than their generic counterparts. To allow Medicaid programs to become prudent payers, we establish a MAC based on pricing information for OTCs if the therapeutic equivalency rating is not "A" rated.

Template F Items Addressed by this Response	
Requirement Number	**Overview of MMA's Solution**
FR2.31	MMA will incorporate timely updates with the FUL in addition to other published price points upon receipt from our national drug data vendor.
FR2.32	MMA will monitor the State's MAC rates to assure products are available at MAC rates and are appropriate estimates of providers' actual acquisition costs.
FR2.33	MMA will make modifications to the MAC list and publish it on a weekly basis in a searchable/downloadable format.
FR2.34	MMA will notify DVHA at least ten business days prior to assigning a MAC on a product when a MAC has never been established.
FR2.35	MMA will ensure that the Department's MAC rates when compared with the FUL do not exceed FUL rates published by CMS by providing: • Monthly comparison of price points utilized in reimbursement for adjudication against utilization to evaluate the impact on expenditure if the known FUL were utilized. • Prepare a monthly summary comparing the current FUL and other price points to validate that reimbursement is at or below the FUL in aggregate for products. • Prepare an action plan within 10 business days if expenditures exceed the FUL in aggregate.
FR2.36	MMA will provide operational and cost savings reports to DVHA on a monthly basis.

MMA contracts with FDB to receive weekly updates to the comprehensive drug database used for claims adjudication and new FUL pricing data amongst other available price types will be included for NDCs impacted. FDB currently supports and is anticipated to continue delivering the FUL price type to ensure the most current information is available for claims adjudication. Upon receipt of FUL updates, MMA will proceed with loading to the claims adjudication system as a price point to be evaluated under the states "lesser of" reimbursement logic.

MMA will implement a systematic MAC solution designed to quickly identify new generic opportunities and capture changes within the volatile realm of the drug market (as frequently as weekly). MMA's solution accounts for unique requirements of Medicaid such as OBRA rebate requirements, federal and state reimbursement regulations and the premise that Medicaid pricing must not compromise enrollee access and should not discourage provider participation.

MMA will utilize specific indicators from national drug files to create drug groupings selected for inclusion on the MAC list. Several criteria that are initially considered include the number of manufacturers available for a product within a specific generic drug grouping, Omnibus Budget Reconciliation Act (OBRA) rebate status of the products, and the bioequivalence rating. MMA's systematic process allows us to capture new opportunities within the generic reimbursement environment promptly (as frequent as weekly as opposed to traditional programs that exercise monthly updates) in an effort to maximize the savings or cost avoidance for our customers. MMA will use a methodology that is transparent to the department to establish MAC rates for prescription and OTC multisource products. We will utilize the FDA's version of Approved Drug Products with Therapeutic Equivalence to set MAC rates.

To avoid adverse selection of Vermont's Medicaid Program, our clinical and technical staff ensures rates provide equitable reimbursement. We utilize market disruption reports and information gathered from the provider dispute process to identify shortages, pricing variances and other drug availability issues to refine the list with each update. We evaluate provider appeals and make changes to the MAC program as needed so that Vermont maintains a competitive advantage. Inquiries regarding MAC pricing are managed by our team of experts. Vermont providers may submit a MAC dispute by completing a MAC Price Research Request. Evidence of their pricing or difficulty obtaining the pharmaceutical at the set price must accompany this request. Once the MAC inquiry/dispute request has been received, the MAC team will review available resources and make a determination based on current market availability and other product intelligence. If a MAC price adjustment is not warranted, the MAC team will provide alternatives within the response (when possible) that demonstrate product availability below the current MAC rate.

Detailed MAC Reporting

DVHA will receive a monthly MAC Cost Avoidance analysis report that calculates the difference between what would have been paid without a MAC program versus the actual cost paid with the MAC in place. Utilizing the state specific reimbursement algorithms, each claim that paid with a MAC price is re-priced without the MAC price, using the pricing algorithm in effect on the date of service of the claim (e.g. the lesser of AWP-X%, WAC +X%, usually and customary, or FUL). These reports are in provided in MS Excel format with the ability to assist the end user in the analysis of the data. These reports are designed to assist the state in identifying the cost drivers in their generic utilization and are provided in an easy to use, interactive format.

As a quality control step, MMA will produce a monthly report comparing the current Federal Upper Limit (FUL) and other price points in an effort to validate overall reimbursement is at or below the FUL in the aggregate for products involved.

MMA will incorporate the following processes to support the MAC program for the State of Vermont.

- Determining the standard list of generic drug groupings for inclusion in MAC list: MMA will implement a MAC solution for the State of Vermont that is developed by utilizing specific data attributes/indicators found in a national drug database to create generic drug groupings for inclusion in the MAC program. Our process allows us to maximize the MAC opportunities for the Vermont using an automated process that promotes consistent application and is equipped to capture new opportunities within the generic reimbursement environment promptly (as frequent as weekly as opposed to traditional programs that exercise monthly updates). Several criteria considered include the number of manufacturers available for a product within a specific generic drug grouping, OBRA rebate status of the manufacturers/products within a specific drug grouping, and the therapeutic equivalence rating within a specific generic drug grouping.
- Calculating and applying MAC price points for drug grouping: MMA will use a methodology for calculating the MAC that is transparent to the department for prescription and OTC multisource products. Pricing information will be evaluated and considered for NDCs that are deemed eligible. Once a MAC price is determined, MMA will apply the rate to all NDCs within the eligible drug grouping.

- MMA will provide a full monthly MAC list that will include the following layout if deemed appropriate:
  - Generic Drug Name/Strength/Dosage Form/Route of Administration
  - MAC Price
  - Effective Date.
- A MAC price weekly updates list and full monthly MAC price list in Adobe PDF format can be generated and posted on specific website if desired. To access the list, the provider must click on the "OK" button under the Confidentiality Terms and Conditions of Use Statement indicating that they agree with the use of the list.
- These reports are provided in Excel format with the ability to assist the end-user in the analysis of the data. The reports are designed to assist the State in identifying the cost drivers in their generic utilization and are provided in an easy–to-use, interactive format.
- Managing provider inquiries related to MAC prices established: A key component in administering and managing a MAC program is to have a robust process to support provider disputes. MAC-related pricing inquiries will be directed and resolved by the MMA MAC team. Vermont Medicaid providers may submit a MAC dispute by completing a MAC Price Research Request form and providing evidence of their pricing or difficulty obtaining the pharmaceutical at the set price (usually an invoice from their wholesaler). Once the MAC inquiry/dispute request has been received, the MAC team will review available resources and make a determination based on current market availability and other product intelligence. The MAC team will provide a written response indicating the outcome (whether approved or denied) within a mutually agreed upon timeframe. If a MAC price adjustment is not warranted, the MAC team will provide alternatives within the response when possible that demonstrate product availability below the current MAC rate.

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.

Our specialty pharmacy program, ICORE, provides DVHA beneficiaries with a holistic approach to care that encompasses three key components:

- **Comprehensive specialty management** that features strategies for utilization, medication compliance, beneficiary education, and overall clinical and cost management.
- **Flexible, responsive, plan administration** that includes seamless implementation, hands-on account management, and meaningful report.
- **Seamless integration** with the medical benefit that provides a PBM-like approach to managing injectable drugs through network management, formulary optimization, prior authorization, and site-of-service management.

In addition, our program combines the expertise of our MMA clinicians who understand specialty Medicaid.

Comprehensive Specialty Management Program

ICORE provides DVHA's beneficiaries with:

- Help in promoting medication compliance by outreaching to beneficiaries to arrange a convenient time for delivery and contacting him or her 7 days before the next scheduled refill.
- Targeted condition and disease management education through our ICORE Cares. Beneficiaries receive one-on-one attention and disease-specific education with enrollment in the program.
- Tools to control side effects as part of our medication compliance and ICORE Cares consulting.
- Specialized handling and distribution of over 300 medications and 27 therapeutic categories through our two wholly owned specialty pharmacies.

The foundation of this program includes:

- **Utilization management** through prior authorization, step therapy, medication compliance, and risk assessment
- **Collaborative fulfillment** with a robust drug list and timely distribution of medications
- **Condition management education** through outreach and information on medications and diseases

Utilization Management

DVHA beneficiaries utilizing ICORE receive a comprehensive utilization management program that evaluates medication appropriateness. Utilization management strategies are built into our program and give guidance to providers based on peer-reviewed guidelines. Program components include:

- Prior authorization
- Step therapy
- Quantity limits
- Dose optimization
- Split fills

- Medication adherence and compliance
- Risk assessments

Prior Authorization

DVHA benefits from our prior authorization program because it helps to manage plan benefits and control drug costs through appropriate prescribing. We work with DVHA during implementation to determine medical necessity guidelines for both pharmacy and medical benefit medications and incorporate DVHA-specific criteria as necessary.

Step Therapy

This drug utilization review strategy focuses on specific drugs and drug classes to promote utilization of effective, safe, and less costly first-line medications. This program helps to influence provider prescribing patterns by encouraging the use of clinically and cost-effective drug alternatives for specific conditions. Coverage of non-preferred drugs must meet established evidence-based protocols.

Quantity Limits

Quantity limit edits focuses on appropriate medication utilization by limiting the quantity of a medication over a specific time period. Based on DVHA criteria, drugs may be limited by quantity per fill at the NDC, GCN or therapeutic class. We are also able to accommodate quantity limits on a specific group of providers or beneficiaries.

Dose Optimization

Dose optimization encourages providers and pharmacies to use fewer tablets of a higher strength as opposed to more tablets of a lower strength. This program promotes cost-effective drug utilization without compromising a beneficiary's quality of care. Dose optimization also helps to increase compliance by simplifying dosing regimens.

Split Fills

Certain oral, high-cost specialty drugs have a higher potential to be discontinued during the first few weeks of therapy due to toxicity or other factors. Implementing a split fill program for high cost specialty drugs limits initial fills to half month supplies in order to prevent full monthly shipments in case of patient adverse response or drug discontinuation.

Medication Adherence and Compliance

Continuity of care and compliance monitoring by CPhTs in our ICORE call center are critical to our adherence and refill reminder programs.

When a new prescription is received, a CPhT outreaches to beneficiaries to arrange a convenient time for delivery, verify demographic information, and identify special needs the beneficiary may require.

To support adherence and beneficiary compliance to ongoing therapy, ICORE contacts beneficiaries using a predictive dialer that begins outreach seven business days prior to the next anticipated refill date. Beneficiaries receive five calls on consecutive days to promote timely refill of prescriptions. In addition, beneficiaries receive three additional calls starting at 25% beyond the number of days' supply of the last refill. In tandem, the beneficiary's prescriber receives a faxed letter alerting them of the potential discontinuation of therapy.

We proactively work with prescribers to obtain necessary maintenance specialty prescriptions to facilitate beneficiary compliance. When the last refill of a prescription has been sent, our

operating system moves the beneficiary's order to 21 days before the next refill date. A dedicated team of CPhTs communicates with prescribers to renew prescriptions.

Patient Risk Assessments

Risk assessments are critical component of our ICORE Cares program. Enrolled beneficiaries receive a three-part adherence assessment conducted by registered nurses. Information is gathered regarding each patient's pre-program, self-reported medication possession ratio. Beneficiaries are stratified according to risk factor, as those assessed with a high-risk trigger a clinical intervention where their provider receives notification of the identified concern.

Collaborative Fulfillment

DVHA beneficiaries will have access to a robust specialty drug list that includes over 300 specialty medications across 27 therapeutic categories and disease states:

Anticoagulants	Hepatitis B	Macular degeneration
Blood cell disorders	Hepatitis C	Multiple sclerosis
Crohn's disease	HIV/AIDs	Oncology
Cystic fibrosis	Hormonal therapy	Osteoporosis
Endometriosis	Hyperimmune Globulin	Psoriasis
Enzyme disorders	Immune deficiencies	Psoriatic arthritis
Erectile dysfunction	Infertility	Prostate cancer
Hemophilia	Iron supplement	Precocious puberty
RSV	Transplant	

The dispensing of specialty medications will be limited to the specialty pharmacy for Medicaid beneficiaries when Medicaid is the primary insurer.

We own and operate two specialty pharmacies located in Astoria, New York and Orlando, Florida. DVHA beneficiaries receive:

- Overnight delivery using next day services free of charge for shipping.
- Proper handling, packaging and beneficiary instructions for proper storage
- Inclusion of educational materials that address medication administration, compliance, available programs, and general lifestyle topics.

During implementation, we establish a plan for the limited distribution drugs (LDD) for which ICORE does not have access. We establish an appropriate referral process for LDDs: while some require that prescribers and beneficiaries register with a clinical hub, others only need the referrals routed directly to a network pharmacy. Post implementation, ICORE will triage any orders for these products to the designated network pharmacy or communicate with the prescriber to direct the referral to the clinical hub as appropriate for the specific product.

Condition Management Education

DVHA's beneficiaries are educated on how to manage their condition effectively. Educated beneficiaries are more likely to adhere to therapy and make positive lifestyle choices. This may lead to improved outcomes, satisfaction, reduced medical events, and absenteeism.

Our condition management education strategies include:

- ICORE welcome brochure
- Personalized attention
- Information on medications and disease states

Welcome Brochure

Each new prescription receives a welcome brochure that details:

- Ordering
- Storing medications
- What to do in an emergency

The welcome brochure also includes details on our ICORE Cares disease management programs.

Personalized Attention

Beneficiaries receive one-on-one attention throughout the entire customer service experience. CPhTs provide guidance on medication storage, administration, compliance, and potential side effects.

Information on Medications and Disease States

Every order shipped from our facilities includes instructions and information on the medication, the importance of compliance, and specific drug- and disease state issues.

ICORE Cares – Disease Specific Care Management

To provide enhanced innovative clinical and cost reduction efforts to help manage complex medical conditions, we offer our ICORE Cares program. DVHA beneficiaries enrolled in ICORE Cares receive one-on-one support from a care manager. Care managers engage with beneficiaries to create a goal plan, provide education, and assess the potential for compliance with therapy and quality of life. Beneficiary's providers are also engaged as needed to provide a collaborative model of care.

ICORE Care uses a holistic approach to therapy management that helps move the patient through the *stages of change* by enhancing their motivation through goal setting and removing barriers to adherence. We provide care management free-of-charge for the following disease states:

- Multiple sclerosis (MS)
- Psoriatic arthritis
- HIV
- Hemophilia
- Rheumatoid arthritis (RA)
- Psoriasis
- Hepatitis C
- Oral oncology

By the State's January 1, 2015, go-live date, we will have implemented the following additional disease management programs:

- Transplant medications
- IV oncology
- Pulmonary arterial hypertension
- Hereditary angioedema
- Crohn's Disease and ulcerative colitis
- Osteoporosis

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.

Instrumental to the quality of our solution is our staff's high level of proficiency in Medicaid programs, processes, and protocols in the management of pharmacy benefits. MMA brings a strong understanding of the state and federal rules that govern Medicaid programs, like the State's project. Our IT team is laser-focused on ensuring that our technology continually advances our customers' efforts to manage Medicaid care and costs as the industry evolves. Using technology that has been customized and implemented specifically to address the evolving and dynamic needs of Medicaid programs, MMA's health management and analytics team is also specially equipped to offer insights that will allow the Department to make the wisest decisions for the future.

Collectively, the State's proposed key personnel team provides over 40 years of combined experience serving Medicaid clients similar in size and scope to Vermont.

Managing the Department's Complex Benefit Designs

During implementation, we develop a detailed Requirements Tracability Matrix (RTM) that details all of the Department's benefit designs, funding sources, and eligibility requirements. Test cases are developed to ensure that coded information is functioning properly before information is loaded into the production environment. Test cases are developed through Use Cases, which are defined, captured, and built by DVHA's Data Analyst, Mr. Yija Wang. From the use cases, detailed test cases are built and traced to the RTM. Test case results are documented in our database and mapped back to approved business requirements documentation. A final test case matrix is developed that is used for the implementation. Final Department sign-off is required prior to implementation.

After the go-live date of January 1, 2015, we develop a post- implementation operational monitoring plan. For 30 calendar days following implementation, we review all aspects of the implementation to ensure that the benefit design is accurate. We keep our team of programmers available during this time period. This allows for real-time modifications and testing.

Flexibility in Reimbursement Structure

FirstRx supports all industry-standard price types available today, including those outlined in Figure 15 below. In addition, we also support Vermont-specific AAC pricing as needed.

Figure 15. Pricing Benchmarks

Pricing Benchmark	Source	Frequency
WAC	FDB	Weekly
DP	FDB	N/A
AWP	Medi-Span	N/A
MAC	MMA	Weekly
FUL	FDB	Weekly
NADAC	CMS	Regularly scheduled downloads

We will make available price lists to support 340B pricing designs through mutually agreed upon interfaces on a weekly basis.

In addition to the pricing types noted above, in Figure 16 below we outline additional functionality allowed by FirstRx.

Figure 16. FirstRx Pricing Functionality

Pricing Algorithms	

Dispensing Fees	•
	•
Incentive/ Professional Fees	
Patient Financial Responsibilities/ Co-pays	

FirstRx provides the ability to configure drug coverage parameters through our innovative state formulary management configuration tool (FMT), which enables the establishment of drug coverage parameters through the use of customized indicators. The FMT is in production in multiple states, and our customers have found this to be a very user-friendly approach to managing coverage parameters. The primary advantage of the formulary management tool functionality is that it allows the user to easily decipher which products are covered, excluded, or require prior authorization.

The FMT offers an infinite choice of options to Vermont to define business rules and apply claims edits. Figure 17 below shows the formulary management screen in FirstRx. As part of our standard package, the following defined parameters allow the assignment of three-byte values for configuration assignments:

- Coverage
- Prior Authorization
- Maximum Quantity code
- Refill
- Medicare
- Formulary Indicator
- State Drug Class
- Minimum Quantity Code
- Limitation
- Co-pay.

Figure 17. Formulary Management Screen

Modify Plan Designs in a Timely Manner

FirstRx is easily modified to accommodate benefit plan changes in a timely and cost-effective manner. Most changes that do not impact claims adjudication are completed within 1 – 3 business days. Changes that directly impact claims adjudication following the Benefit Configuration Change Control process. Requirements are document in a Benefit Change Control Memo (BCCM) by the State, their Account Director, Account Manager, and Clinical Pharmacist Manager with the support of the Claims Operations Manager, Michele Kennedy. BCCMs are used to request a change in plan configuration for specific drugs, patients, groups, providers, or health conditions. Benefit configuration staff executes the necessary coding changes in the test environment and our QA staff performs the testing. The documented test results are submitted for review and approval. Once all approvals are documented, the changes are moved into the production environment and become available for claims adjudication. Immediately after a change is deployed to the production environment, a series of trial claims are submitted to further validate the edit functionality.

Department Changes to Benefit Design and Messaging

FirstRx is a very flexible claims engine that allows for over 97% of all program changes to be facilitated through the State's designated plan administrator. Working through the system's GUI, most changes are facilitated in the same day. For changes that are not supported through the system's GUI, we promptly schedule a software design change that is facilitated through our change control process. A change control memo (CCM) is created documenting the requested change. Each change request is reviewed with the Department to ensure that the change objective, the requirements, and the expected outcome are clearly defined and documented. Our change control process includes:

> ***Evaluation and Ticketing***: MMA will evaluate the reasonableness and complexity of the change, communicate the level of effort (LOE) and will work closely with the Department to ensure change requests are accurately prioritized. The CCM will then be attached to a Remedy Ticket. Remedy is the platform that houses the tickets for changes and access can be granted for customers, using the Security Access Process, so that they may monitor the progress of requests.
>
> ***Test Cases Review by Pre-Panel:*** As the change request progresses into development, MMA Plan Administrators will enter the coding changes into the system, review the request and provide test cases to the Teresa Elam, Vermont's Account Manager, for approval. Once approved, the request will go to a "Pre-Panel" of senior Plan administration staff who will review the CCM for appropriateness and provide approval. Once approved, the CCM is sent to the Department for signature. The signed CCM will be attached to the Remedy ticket for documentation purposes, and plan administrators will begin the process of coding and testing the change into a test region. Once this has been completed, the results will be taken once again to the Panel of senior Plan Administration staff for review and approval.
>
> ***Test Case Approval:*** Test case results are then sent to the operations manager for business approval. Once approved, the changes are moved into the production environment used for actual claim adjudication. Upon deployment into the production

environment, changes will be available immediately for claims adjudication. Following deployment to production, trial claims are submitted to validate the edit functionality.

Ongoing Approach to Program Enhancements

During each implementation we capture and apply lessons learned to enhance operational efficiencies and foster continual improvement. Lessons learned documents serve as a valuable tool for project managers working on similar projects because they capture the project type, project phase, what we could have done better, what we did well, and recommendations for future projects. Project Managers share related lesson learned documents with the project sponsor, key stakeholders throughout the organization, and the Project Management Office (PMO) so that positive outcomes can be repeated and problems can be proactively prevented. The PMO includes each lessons learned document in an archive as part of a lessons learned database.

Lessons learned that we apply to every project for a successful integration includes the following:

- Identifying and engaging key stakeholders (from all participating entities) at the appropriate operations, technical, and decision-making levels and including them in the kick off meeting
- Obtaining Mutual understanding and agreement of integration requirements through a formal sign off process on the technical design and project scope documents
- Clearly defining roles and responsibilities as part of project management documentation and as part of kick-off meeting discussion
- Developing and maintaining a mutually agreed-upon project schedule; holding all parties accountable to the schedule
- Fully engaging the customer to help ensure all stakeholders adhere to the schedule and meet their deliverables as agreed
- Documenting and communicating assumptions to provide consistent interpretation after implementation
- Updating and sharing changes as they occur; implementing change management to formally track additional customer requests
- Establishing, documenting, and communicating clear performance and tracking metrics for all stakeholders
- Creating and maintaining a detailed issue and action item tracking grid.

Below we have provided an example of a lesson learned and how we made modifications to future implementations.

Example

We implemented a pharmacy solution of comparable size and scale as DVHA. This particular State's prescriber file contained providers from surrounding states and utilized state license number as the unique identifier. At the same time, the state was implementing a new pharmacy RetroDUR functionality (through MMA) that would key on the state license number when identifying prescribers in the application. Consequently, prescribers with common license numbers (in their respective states) would be identified as 'the same' and aggregated in a beneficiary's profile causing HIPAA disclosure issues. The issue was identified in advance of any mailing so that unauthorized disclosure did not occur. Investigation revealed that this was a known issue within the MMIS vendor and

was not shared as part of requirements gathering. The vendor also did not share their internal solution for dealing with the problem with MMA. MMA worked diligently with both the MMIS and the state to explore multiple options, finally settling on working with the state to implement a national database solution, HCIdea - customized specific to the state's needs.

Lesson Learned

The specific lesson learned, was to partner early on with the outgoing vendor and data source vendors to understand specific state nuances that may or may not implement our solutions. In this case, understanding workarounds that were in place for handling their prescriber file would have allowed us to more quickly identify the risk. Our approach now includes a more detailed discussion with outgoing vendors and other trading partners in order to allow them to understand how we intend to use the data and for MMA to understand any limitations in their use of or ability to supply the data.

In addition, will work collaboratively with our Clinical Outcomes and Analytical Reporting (COAR) team to evaluate Vermont's contract performance on a quarterly basis. Through this detailed analysis, identifies opportunities for making enhancements to the State's contract. Each recommendation is submitted to the State for approval before it is implemented. Once approval is received, works with our team of clinical pharmacists to develop the program. Once the program is developed, changes are facilitated through our BCCM process, described above. On a quarterly basis the State's dedicated key personnel team holds comprehensive business reviews to review program performance results. These reviews include detail on the total value of the program, including operational metrics of the program, and ROI achieved, if applicable.

A unique resource that we are able to offer DVHA is mental health Center of Excellence. This Center of Excellence, comprised of board-certified psychiatric pharmacists, psychiatrists, nurses, psychologists and social workers, is focused on mental health. We are able to leverage this group of experts to provide Vermont with recommendations on PA criteria to help control the spend of drugs of abuse and substance abuse medications. PA criteria is developed through this specialized group who is committed to evaluating peer-reviewed literature on a timely basis to ensure prescribers have the most up-to-date information with which to provide pharmaceutical care to their patients.

Vermont's dedicated Clinical Pharmacist Manager, , is prepared to identify opportunities, collaborate with our clinical leadership team consisting of Medicaid experts, Specialty Pharmacy experts, and national thought leaders in managed care pharmacy who stay abreast of emerging trends. This comes together to create an innovative solution that delivers results. will provide consultative support by working closely with you and other departments within MMA to understand the care and cost goals desired. The team will then model benefits demonstrating how each may facilitate an improvement in the financial and clinical health of the State's beneficiaries.

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.

Our program provides the State with a structured approach to managing physician-administered drugs through:

- Unit cost management
- Claims management
- Utilization management
- Site of service management.

Since physicians are able to obtain high-cost medications at a more favorable rate, this can result in misaligned incentives to use certain drugs that may not be the most clinically advantageous to the beneficiary. We recommend that the State use a buy-and-bill model, because this approach results in a more coordinated treatment for the beneficiary at the most cost effective price. The key to capturing these savings its to implement the following services:

- **Variable Fee Schedule (VFS)**: The VFS is a proprietary reimbursement schedule for reimbursing physicians for drugs administered in the office. This list is updated quarterly and includes four tiers customizable to the State's physician reimbursement strategy:
    - MAC and LCA (Least Cost Alternative)
    - High cost, single-source brand tiers
    - Brand drug categories with alternative choices
    - Brand drugs without an assigned J-Code

The VFS rationalizes reimbursement and aligns the physician's interests with the States, shifting the product mix towards lower cost but equally effective agents. In Figure 18 below we provide program results.

Figure 18. Rationale Reimbursement Results

- **Post Service Claims Editing (PSCE):** Approximately 4% of all medical pharmacy claims are billed by physicians and outpatient clinics incorrectly. Our proprietary editing logic is designed to allow claims to pay correctly and that claims are not paid for multiple times.

  The PSCE allow for the management of drugs under the medical benefit with the same sophistication that is applied under the pharmacy benefit. Current edits are for maximum units (MU), eligible diagnosis (ED), and history check (HC). The MU edit logic is built on weight-based dosing for biologics that can be submitted for a wide range of units. MU edits allow payment within an expected range, yet not above calculated maximums. Edits ensure the correct ICD-9/10 coded claims are paid within an acceptable range of FDA approved indications, compendia approved uses, and the current standard of care. HC edits look for the correct combination and timing of supportive care, such as antiemetics and white blood cell stimulators, as per CMS, FDA, and NCCN guidance.

  Notably, we currently provide claim editing services for CMS drug claims through a subcontractor arrangement. This means our claims edits have been scrutinized by CMS to meet their criteria. MMA's post-service, post-payment medical pharmacy claim audit services to recover inappropriate and overpaid claims apply to non-government entities, as well.

- **Prior Authorization (PA):** We provide a comprehensive range of utilization management programs for drugs paid under the medical benefit and allows physician PA requests to be initiated either telephonically or online. Therapies in scope of the PA program include drugs used to treat autoimmune disorders, immunodeficiencies, cancer and drugs used in supportive care of cancer chemotherapy treatment. We implement prior authorization criteria for these high cost drugs that require strict enforcement of medical policy for appropriate indications and dosing. Our medical necessity reviews:
  - enforce step therapy requirements and lab validation for coverage when appropriate
  - incorporate genetic testing requirements for applicable drugs
  - manage off-label uses through evidence-based research in conjunction with medical policy criteria

  We continuously monitor the specialty pipeline, staying abreast of current medical literature to make policy recommendations through our National P&T Committee as criteria for injectable agents change. Our program is supported by dedicated prior authorization staff specially trained on these agents, pharmacists, oncologists and other physician specialists as appropriate to conduct prospective peer-to-peer reviews and deliver a high-touch service to manage these costly specialty drugs.

- **Site of Service Management** that addresses the cost and reimbursement of injectable drugs, which can vary widely based on the distribution channel and treatment site for administration. This solution combines strategies specific to your provider network, clinical programs, and beneficiary choice to guide medical injectable drug administration to the most economic and clinically appropriate site of service, delivering proven cost savings and value while maintaining quality of care. We customize our Site of Service

Management solution and scope of tactics to meet your needs taking into consideration your network dynamics and beneficiary drug utilization to align incentives and deliver the greatest value.

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.

In Figure 19 below MMA has provided a description of its approach to meeting the requirements in Template F.

Figure 19. Overview of MMA's Solution for Response 1.2.8.

Template F Items Addressed by this Response	
Requirement Number	**Overview of MMA's Solution**
FR2.1,5	We support the State's grievance and appeal process by performing first reconsideration reviews of denials. A notification is sent to our staff physician with data supporting the initial decision. The staff physician reviews the information and new documentation obtained after speaking with the prescriber. Within 24 hours of the reconsideration request, the staff physician makes the decision. The senior clinical pharmacist contacts the prescriber by telephone to inform him or her of the outcome. If the denial is upheld, the prescriber is given the clinical reasoning for that decision.
FR2.6	We send required notifications to beneficiaries and providers when a PA is approved or denied. Non-emergent appeals receive a decision within 15 calendar days from receipt. Emergent appeals receive a decision within 72 hours from receipt to the date the decision is communicated to beneficiaries and prescribers followed by a written notification within 3 calendar days.
FR2.7	We will coordinate and provide support to Department and other State

Template F Items Addressed by this Response	
Requirement Number	**Overview of MMA's Solution**
	personnel when a PA is denied. Our Vermont Clinical Pharmacist Manger will provide Vermont with all necessary information including reports and all documents which supports the denial within the timeframes required by DVHA.
FR2.14	We comply with State and federal policies and procedures for beneficiary or provider appeals including: • Notifying providers and beneficiaries of their appeal rights when a request is denied. • Coordinating with state personnel during implementation to make any necessary refinements and incorporate them into our procedures in the call center • We support DVHA with a written summary of events that led to the denial decision, all supporting documentation, and screenshots of any pertinent notes logged in the system under the beneficiary's profile • For denial decisions presents justification and all relevant documentation at the appeal hearing. As needed, is available on-site. • Complying with DVHA mandates and timelines as required.

MMA coordinates efforts with other members of the care management team to provide pharmaceutical care management expertise for complex clinical cases. Our approach ensures consistent pharmaceutical care to beneficiaries in the program and avoids the patient confusion that can result from multiple contacts with sometimes conflicting evidence. Our role in providing pharmaceutical care management expertise leads to optimal patient outcomes and also maximizes Vermont's investment in pharmaceuticals.

Appeal requests including prior authorization decisions are received by the CPhT who records pertinent information in the FirstTrax system before escalating the case to a Senior CPhT, Clinical Pharmacist or Support Center management depending on the type of concern and its severity. We base denials for claims for pharmacy services on DVHA-approved clinical criteria. When a beneficiary appeals a denial, we view this as a request for a clinical exception that the beneficiary feels is a unique situation and requests consideration. MMA ensures that the most clinically knowledgeable review takes place to provide a clinically sound decision.

A full review is made of the case using FirstTrax. The clinical pharmacist reviews the appeal and the notes of the CPhT, accesses the AllMed Website, enters the pertinent information regarding the first review decision into our prior authorization and tracking system, and attaches any documentation that accompanied the appeal request. AllMed is the right choice for Magellan because of its unwavering commitment to provide high quality, evidence-based review services. The company demonstrates that commitment by offering an unconditional quality and turnaround time guarantee on every medical review.

The physician reviews the case and documents the rationale for his or her decision and returns the documentation to the clinical pharmacist via the Web site. The clinical pharmacist enters the appeal decision along with the clinical rationale written by the reviewing physician into Magellan's prior authorization and tracking system, FirstTrax. FirstTrax generates the appropriate letter to the beneficiary according to the physician's decision.

Below we have described our approach for supporting the State's drug appeals process.

Notification to Providers and Beneficiaries

We notify both the beneficiary and his or her provider of their appeal rights based on Federal and the Department's regulations. When a PA request is denied, notification is sent to the prescriber via telephone. Beneficiaries receive a letter with notification of the denial along with the Department's specific appeals process.

For standard appeals, first level appeals receive a response for services not rendered, no later than 15 calendar days from the receipt of the appeal. For services rendered, the turnaround time is 30 calendar days from the receipt of the appeal. For expedited appeals, first level appeals receive a response within 72 clock hours from the receipt of the appeal to the date the decision is communicated to the beneficiary (via phone, fax, or e-mail) followed by a written notification within three calendar days.

Coordination with State Personnel

During the implementation period, our staff will review the appeals process and procedures with DVHA staff. Any refinements that are required will be made and incorporated into our policies and procedures for the Clinical Support Center staff to follow.

Procurement of Supporting Documentation

, the Vermont dedicated Clinical Pharmacist Manager, provides all necessary documentation for appeal denials. Information includes documentation that supports the denial within the time frames required by DVHA.

Registered Pharmacist Support

For denial decisions presents all relevant documentation at the appeal hearing. As needed, is available on-site.

Beneficiary Appeal Disputes

We support DVHA by providing all documentation to support beneficiary disputes. We provide DVHA with a written summary of events that led to the denial decision, all supporting documentation, and screenshots of any pertinent notes logged in the system under the beneficiary's profile.

Compliance with Mandates and Timelines

We will comply with DVHA mandates and state law as required. Please note that we are required to follow Federal law in situations where Federal law provides for richer benefits.

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.

- 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

In Figure 20 below MMA has provided a description of its approach to meeting the requirements in Template F.

Figure 20. Overview of MMA's Solution to Response 1.2.9.

Template F Items Addressed by this Response	
Requirement Number	**Overview of MMA's Solution**
FR2.37	MMA will provide DVHA with management reports on a mutually agreed upon schedule that will include utilization, financial, auditing, PDL, claims processing, COB, and net cost reporting.
FR2.38	Our reporting system includes data dashboard capabilities that facilitate real-time graphical display of data.
FR2.39	We use IBM's Cognos Business Intelligence (BI) to provide online reporting capabilities to the State. The tool includes a presentation layer that provides population, program, and client-based dashboard reports. Through the use of data cubes our data warehouse is easily configurable to accommodate population characteristics, program information and solution performance/quality assurance reports. The reporting tool features Dashboards that contain views of key program performance indicators consisting of dynamic reports on a secure website that program administrators can view at their convenience.
FR2.40	MMA's reporting system allows users to drill up or down on both dashboards and reports. Dashboards provide a quick, visual display of data with a predetermined level of drill-down and make information accessible through one screen. Reports also allow the ability for a user to drill down from a higher level of output to prescriber, pharmacy, claims, or drug level detail applicable to the report.
FR2.41	Our reporting system provides the capability to present data in a graphical format, including GIS map.

Template F Items Addressed by this Response	
Requirement Number	**Overview of MMA's Solution**
FR2.42	Reports are generated and sent to a local mailbox for distribution. The mailbox administrator creates Vermont-specific rules for report dissemination based on the mutually agreed upon reporting schedule.
FR2.43	The Cognos BI reporting system provides State users with a configurable reporting structure. Users are provided a flexible tool for creating customized reporting. It allows users to click and drag fields onto reports, queries or analysis. The tool automatically creates relationships between tables to provide a customized report.
FR2.44	Report distribution is managed through a centralized mailbox that automatically distributes reports to users through established rules and within reporting timelines. Users are able to subscribe to reports through the State's dedicated data analyst, Yijia Wang. Mr. Wang works with the mailbox administrator to subscribe to user to any report available, based on their role and user access rights.
FR2.45	Our reporting tool uses role-based access control to provide users with access to data based on their access rights. Access is restricted and defined with the user's log-in information. The process is operated from a secure site and employs detailed rules to prevent hacking or other unauthorized access.
FR2.46	The reporting system allows users to print formatted reports on standard paper sizes. Users are able to print portions of a document, such as individual pages, notes, forms, or annotations. Once a report is downloaded to a specific media format, the report is able to print as needed.
FR2.47	The reporting system keeps a log of all users that access the Cognos BI tool and the reports that are requested. If a user tries to access data or information that is not permissible based on their role, the denial is logged and the user receives an error message.
FR2.48	Reporting data sets will omit a sample size of zero or data that does not meet predetermined threshold. Each data cube that is built for DVHA will be built with logic that eliminates this information based on parameters established during implementation.
FR2.49	Each report that is requested through our online reporting system identifies the amount of time required to complete as a pop-up screen once the user selects to have the report generated.
FR2.50	Users will able to queue reports in order of importance. When one report is finished, the other will automatically begin compiling and will be queued for the user to download into their preferred format.
FR2.51	The reporting system allows the user to version control reports.
FR2.52	The reporting system allows storage of a pre-determined number of reports as determined by DVHA.
FR2.53	The reporting system displays standard reports defined by the Department that users can view and export.
FR2.54	The dashboard feature of our online tool provides user-specific favorite

Template F Items Addressed by this Response	
Requirement Number	**Overview of MMA's Solution**
	reports with a list of frequently used reports for ease of access.
FR2.55	As part of the dashboard, a list of standard reports will be viewable to the user that includes the reporting title, the last update, last run date, and the planned run frequency. Standard reports that will be viewable to the user are outlined below.
FR2.56	The reporting system allows users to create custom analytics by choose an 'as-of' date.
FR2.57	The reporting system will display a list of parameter-based reports on the dashboard that is viewable based on user's defined access. Parameters include existing reports that are currently generated and published, demographics utilization, and beneficiary-centric reporting.
FR2.58	By using the tool's drag and drop technology and data cube functionality, users are able to create reports using multiple parameters to manage program and financial outcomes. The tool will be customized to include a specific reporting period, population characteristics, geography, beneficiary/provider analysis, threshold-based and exception reporting, and changes in results over time.
FR2.59	The system allows users to perform detailed analysis of data through the use of filters. Filters are dynamically added which enables the creation of specific subsets of data by the user, upon which more focused analyses can occur.
FR2.60	Each user is able to upload a data set in a Microsoft Excel or Access format for use as a parameter. The reporting tool is customizable with a feature that will allow users to navigate to a location on their computer to upload the file containing the data set.
FR2.61	Users are able to save reports in their folder or a general public folder for easy retrieval to run as needed based on the parameters/filters previously created.
FR2.62	The self-service tool allows users to create customized reports including calculations as necessary to perform analysis.
FR2.63	The reporting tool allows users to view and compare data from different reporting periods via the Dashboards, standard reports, and self-service tool.
FR2.64	Users are able to identify statistical outliers through the use of data cubes. When a statistical outlier appears, the user can quickly drill-down into the detailed data to identify characteristics that could influence outliers through program changes.
FR2.65	Users are able to build and save reporting templates customizable to their specific user name and password. The user is able to create custom filters that are easily built upon and are able to be modified. Custom reports can be saved for reuse by the user or shared with other users having the same security access levels.

Template F Items Addressed by this Response	
Requirement Number	**Overview of MMA's Solution**
FR2.66	Based on parameters established for each individual user, a user is able to view all data sources within our solution based on their role, and data available through integration with other data systems. The data warehouse that is used to power the reporting system is easily configured to accommodate external sources that may be important to users when creating queries. This will include our subcontractors, MedImpact and NorthStar. During implementation, we will work with HP to import information necessary for reporting from other authorized systems. Authorized systems will include our subcontractors.
FR2.67	The reporting system allows users to share customized reports with other users having the same security access.
FR2.68	The reporting system is refreshed daily from the transactional systems so data available to report on is current though the previous days data.
FR2.69	The reporting system provides for appropriate class of reporting and business intelligence tools for different users based on their access.
FR2.70	Reports are available in PDF, Microsoft Excel, Microsoft Access, HTML, ASCII, GIF and TIFF.

MMA provides solutions-based reporting and analytics capabilities, which includes standard management reports and advanced analytic reports. The standard management reports consist of Utilization Reports, Financial Reports, Auditing Reports, Preferred Drug List Reports, Claims Processing Reports, Coordination of Benefits Reports and Net Cost Reports. The standard management reports, along with the standard interactive reports, will allow users to identify key performance indicators from a suite of over 100 reports focusing on utilization and expenditure trends, PDL compliance, rebates, and other key pharmacy metrics. The advanced analytic reports developed by MMA's teams comprised of clinical and technical contributors, offer enhanced decision-making tools to specifically identify key drivers of trend, monitor prescribing and dispensing behaviors, assess patient medication taking behaviors, and benchmark pharmacy program performance against other MMA customers. In Figure 21 below we provide an abbreviated list describing the reports that will be provided from different functional areas:

Figure 21. Reporting Description by Functional Area

Functional Area	Report Description
Prior Authorization (PA)	Our PA Reports provide summarization metrics on the disposition of our processed authorization requests in order to show the counts and quickly determine percentages of requests that involved changes to existing authorization or new requests that were approved or denied. In addition, our reports provide information on the various clinical decision rules that both our Pharmacist and Pharmacy Technicians use in the process of adjudicating and arriving at a decision for the requests that we receive. We categorize PAs and report on them based on the basis for the PA requirement, such as the product not being on a preferred drug list.
Clinical Utilization	Our Clinical Utilization Reports identify key performance metrics related to drug utilization, utilization within a particular therapeutic class, top drugs and therapeutic classes by utilization and expenditures. These reports will provide

Functional Area	Report Description
	valuable insight into how the pharmacy program is performing. Some of these reports will also have interactive capabilities to allow for drill-down and customization of specific variables.
RetroDUR	RetroDUR Reports include numerous utilization reports that show prevalence factors. These reports include many prompt-driven variations which allow the user to vary the way in which beneficiaries, pharmacies, or prescribers are ranked, including, but not limited to total payment amounts, total number of claims, payment amount per claim, number of enrollees per pharmacy or prescriber and average amount per claim.
Rebate	Our eRebate™ drug rebate application provides a comprehensive reporting package. Reports are distributed through Cognos and are parameter-driven for user flexibility.
Program Integrity	MMA's Program Integrity reports will assist in evaluating aberrant claims and behaviors by prescribers, providers, and beneficiaries. These reports will also include both desk and field audit reports. The comprehensive Program Integrity reporting suite will help MMA to identify and prevent fraud and abuse.

MMA's robust technology platforms, applications, resources, and clinical subject matter expertise will all be fully leveraged to deliver the most accurate and timely reporting and analytics services for effective and efficient management of the pharmacy program. The pharmacy management reports can be generated daily, weekly, monthly, and/or quarterly based on defined requirements; advanced analytics reports can be generated monthly. MMA will also make information available on a flexible schedule to meet the needs of the program, depending on the availability of data.

MMA will provide a web-based complete Business Intelligence (BI) and reporting solution that consists of an industry-standard toolset, such as IBM Cognos BI and SAS. MMA will provide the opportunity and capability for Vermont staff to access the reporting functions via our Business Intelligence portal. Users with experience in the syntax of SAS Programming can be extended access to SAS tools and access to subsets of data for more advanced analysis where needed. Cognos tools are offered to users with a need or interest in interacting with data, but without requiring a higher range of technical skills and experience.

MMA's business intelligence (BI) and decision support offering has been built with decades of experience using a flexible and continuously evolving BI architecture that ensures MMA can provide Vermont with the flexibility and intuitive set of tools to meet the needs of the Vermont program and community.

Dashboard Capabilities

To complement our set of reports, we provide an interactive dashboard that offers an innovative set of key program metrics. The dashboard also includes a flexible set of views that includes different timeframe, drug classifications, and expense categories that Vermont users can view at their convenience. As shown below in Figure 22 below we provide an example of Vermont's dashboard that provides a quick, visual display of key program performance indicators with a pre-determined level of drill-down, making critical information easily accessible within a single screen.

Figure 22. Interactive Dashboard with Quick Access to Data

CONFIDENTIAL MATERIAL: CONTAINS HIGHLY SENSITIVE PROPRIETARY AND/OR TRADE SECRET INFORMATION; PUBLIC DISCLOSURE WILL CAUSE SIGNIFICANT COMPETITIVE INJURY AND DISRUPTION.

Static Reports that are generated at pre-defined intervals or on demand by State users

The State will receive clinical utilization reports that identify key performance metrics related to utilization, auditing, preferred drug list, claims processing, COB, and net cost reports. These reports will provide valuable insight into how the pharmacy program is performing. DVHA has access to our online reporting tool, IBM Cognos Business Intelligence (BI) which is assessable through our client Web portal free of charge. We provide secure Internet-based provision for users to communicate and access MMA's systems and an automated secure Business to Business (B2B) Data Integration Gateway which allows predefined electronic data integration, transparency, and accountability needs. Information on our online reporting tool is updated on a daily basis with paid claims from the previous day. Authorized users at DVHA are given a user name and password to our online reporting tool. This tool allows DVHA to view the reports identified below on-demand.

DVHA will receive the following reports on a monthly basis. The Multidimensional Spend View report is provided on a quarterly basis.

- **Program Trend Snapshot:** The reports provides utilization and spend information for 12 key cost and utilization metrics, average and trend values for specific time periods.
- **Drug Trend Drivers:** The chart shows spend identified as being driven by 1) Utilization 2) Drug Mix 3) Price Change. The default time period of the graph is one year with ability for the user to select 1, 3, and 6 month values.
- **Top and Bottom 10 Drug Classes:** This report contains the top 10 and bottom 10 drug classes with their corresponding dollar values grouped at standard therapeutic class. One report will be generated for each client.
- **Sigma Outliers:** The graph provides 15 key cost and utilization metrics, average and trend values for varied time periods.
- **High Impact Drug Classes:** This report shows the top 10 high-impact drug classes by spend amount.
- **Total Paid by Age Range and by User:** The chart displays total paid amount for each age group and paid amount for each user. The default time period of the graph is one year with ability for the user to select 1, 3, and 6 month values.
- **User Distribution by Paid Amount Group:** The chart displays the number of users and the users categorized into different spend buckets. The default time period of the graph is one year with ability for the user to select 1, 3, and 6 month values.
- **Utilization Impact by Drug Classification:** This report identifies the total spend amount, claims and spend-to-claim ratio for high-impact drug classes and generic serial numbers.
- **Utilization Impact by Prescriber:** This report provides a view of claims activity at a prescriber level. The number of claims, the paid amount and the number of unique users are some of the key measures found on this report.

- **Standard Clinical Metrics:** Report provides 14 key cost and utilization metrics, and the average trend for a 12 month rolling period. Users are able to summarize data for 3 specific time periods as well.
- **Top 10 Therapeutic Classes by Payment Amount:** This report provides a view of top 10 therapeutic classes for both current and previous time periods sorted by payment amount.
- **Non-Specialty Drugs by Volume:** This report provides a view of Non-Specialty Drugs by Volume. The number of claims, plan/beneficiary paid amount, dispensing channel mix, formulary compliance and PMPM are some of the key measures found on this report.
- **Case by Site of Service:** This report provides a view of percentage of all prior authorization requests raised by specific place of service type. The report also provides an insight for prior authorization requests raised for a particular drug and the Site of service type.
- **Specialty Drugs by Volume:** This report provides a view of Specialty Drugs by Volume. The number of claims, plan/beneficiary paid amount, dispensing channel mix, formulary compliance and PMPM are some of the key measures found on this report.
- **Top Pharmacies by Amount Paid:** The reports display the top 20 Pharmacies sorted by total paid amount. Within the pharmacy report, submitted claims have been broken out by Generic, Brand and Specialty. This report is limited to the Top 20 pharmacies for a given time period.
- **Top Pharmacies by Volume:** The reports display the top 20 Pharmacies sorted by prescription Volume. Within the pharmacy report, submitted claims have been broken out by Generic, Brand and Specialty. This report is limited to the Top 20 pharmacies for a given time period.
- **High Rx Claims:** This report provides a view of Ingredient cost amount range buckets categorized by different beneficiary and prescription count.
- **Prescribers by Descending Amt Paid:** The reports display the top 20 Prescribers sorted by total paid amount. Within the prescriber report, submitted claims have been broken out by Generic, Brand and Specialty. This report is limited to the Top 20 prescribers for a given time period.
- **Drug Detail of Prescribers by Descending Amount Paid:** The reports display the top 10 prescribed Drugs sorted by total paid amount for top prescribers.
- **Controlled Substances:** The report displays the scheduled prescription count for different time periods varying across years for the prescriptions taken into consideration for the date of service / adjudication and also represented pictorially in the graph for the same.

Figure 23 below we provide a sample of the standard reports available that contain metrics for generic use, beneficiary utilization, and overall claim utilization and spend.

Figure 23. Sample Program Trend Snapshot

CONFIDENTIAL MATERIAL: CONTAINS HIGHLY SENSITIVE PROPRIETARY AND/OR TRADE SECRET INFORMATION; PUBLIC DISCLOSURE WILL CAUSE SIGNIFICANT COMPETITIVE INJURY AND DISRUPTION.

Parameterized Reporting

State users are able to create parameterized reports by selecting from a defined number of parameters. Parameters will be developed in collaboration with the State during implementation and will include: date or date range, beneficiary, beneficiary eligibility characteristic, program, drug, and pharmacy. Cognos BI includes drag and drop capability that enables flexible and intuitive report assembly and core BI capabilities. Charts, graphs and tables are all easily created from all available data sources.

Ad hoc querying and reporting capabilities

The various reporting studios available within the MMA Cognos environment empower end users with powerful ad hoc, user-driven reporting and analysis tools. They allow the user to click and drag fields onto reports, queries, or analysis. The Business Layer handles the complexities of joins and relationships between tables, allowing the business to interact with readily understood metrics, attributes, and dimensions. These tools include the ability to create formulas, drill-down from one report to another, create charts and graphs, and share what has been created with others in the organization. Filters can be dynamically added (based upon attributes, metrics, and dimensions), which enables the creation of specific subsets of data by the user, upon which more focused analysis can occur. The user can choose from predefined templates or a blank slate to get started.

We use data cubes to allow users explore and analyze a collection of data from many different perspectives, usually considering three factors (dimensions) at a time. We will design several data cubes to meet DVHA's needs. The data contained within any of these cubes would typically be summarized to show figures such as:

- Beneficiary age range
- Beneficiary gender
- Beneficiary location
- Beneficiary eligibility, including Medicare Part D
- Date range
- Beneficiary diagnoses
- Therapeutic drug classes
- Total paid (also broken out by each component pricing element)
- Number of medical providers
- Number of pharmacies
- Number of drug-related problems (DRPs)
- Types of services received.

Graphical Data Configurable by the End-user

Our reporting tool supports the presentation of data in a graphical format, such as GIS map format.

Export Data in Different Formats

Users are able to export reporting data as seen in the report to PDF, Excel, CSV, and XML formats.

Advanced Analysis Support

Users are able to identify statistical outliers through the use of data cubes. When a statistical outlier appears, the user can quickly drill-down into the detailed data to identify characteristics that could influence outliers through program changes.

Services to create Additional Reports

MMA's intellectual capital includes a well-established Business Intelligence Department that is committed to accuracy, effective analysis, management, and providing useful information that enables informed decision making. Our Business Intelligence Department is staffed by analysts who serve as a bridge connecting IT to the rest of our business areas, including clinical management. DVHA will have access to the resources of Business Intelligence Group for outcome analyses, drug trend forecasting and analysis, strategic planning, and ad hoc reporting requests. We will transform, mine, and analyze the data in order to manage payment, beneficiary, provider, and program information.

MMA is well positioned to meet all the reporting needs of DVHA. Understanding and promoting the effective organization, analysis, management, and use of information in health care is essential. To achieve this goal, MMA has the supporting technology to not only provide the requested reports, but to transform that data into meaningful and useful information used to enable more effective operational insights and informed decision making.

MMA understands DVHA's need for actionable information provided in the form of comprehensive reporting capabilities. Reports that are thorough, easily accessed, and made available in a timely fashion and in a format that allows manipulation of data will be produced in support of DVHA's information needs. MMA also understands that reporting needs are dynamic and that it is vital for DVHA to be able to access program information in a logical and meaningful way in order provide the means for program oversight to occur.

MMA has an extensive understanding of State and Federal guidelines, Medicaid program services, clinical best practices, the unique characteristics of the populations being served, and the changes in the Medicaid landscape as a result of economic constraints and healthcare reform. This experience, coupled with in-depth clinical expertise, enables the MMA team, better than any other prospective partner, to identify quality of care issues and opportunities to improve coordination of care across entities.

MMA will monitor, track, and trend service utilization patterns to assist the State in effectively managing program expenditures and outcomes. MMA offers robust reporting capabilities to accommodate DVHA's needs for routinely scheduled reports containing metrics and operational information as well as ad hoc analyses that are able to incorporate a full view of Medicaid service utilization. Our suite of reporting and analytical capabilities provides the means for the MMA team to meet the demand for just in time information and rapid responsiveness to requests for reports and analyses.

In collaboration with the State, reports will be designed to incorporate the necessary characteristics and attributes in order to provide the most value to the report user. The real value in these report offerings is not in the creation of the reports themselves, but in the content and visibility they provide into the trends and associated clinical operations of the program, thus enabling swift and intelligent recommendations to be made for policy changes, quality and process improvements, targeted provider education, and cost containment and reduction. Reports will be developed to isolate patterns and trends across various demographics and populations of beneficiaries and providers, as well as service and geographic areas. Clinical consultation and recommendations that result from such consultation will be data driven based upon utilization trends, policy, as well as national insights.

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.

In Figure 24 below MMA has provided a description of its approach to meeting the requirements in Template F.

Figure 24. Overview of MMA's Solution to Response 1.2.10.

Template F Items Addressed by this Response	
Requirement Number	**Overview of MMA's Solution**
FR2.71	MMA has developed and implemented quality assurance processes that adopt best practices from customer deployments, including: • Six-sigma DMAIC methodology and rely heavily on quantitative measures and the "voice of the customer" to drive improvements. • Continuous performance improvements that is fact-based and data-driven. Formal testing procedures, internal audit, process reviews, operational metrics and satisfaction surveys. When gaps are identified, improvements are initiated. • Ongoing vendor staff training solution with a team of dedicated trainers available to train new and existing staff. • Implemented a quality improvement processes to provide a closed-loop quality solution whereby improvement opportunities have been identified reported on month quality improvement committee meetings
FR2.72	We will work with DVHA during implementation to determine mutually agreeable intervals for client satisfaction surveys. We will partner with DVHA to ensure the appropriate metrics and criteria are measured at the correct frequency. Surveys will be customized to ensure they meet the needs of DVHA and are an accurate measure/representation of the services performed. Our Customer Satisfaction (CSAT) surveys typically include these types of inquiries and position us to focus on continuous improvement opportunities.
FR2.73	As part of our closed-loop solution to Quality, when errors or defects occur they are readily identified and root cause analysis is performed to ensure corrective actions address the issue(s) and not the symptoms.
FR2.74	It is within our standard operating procedures (SOPs) to provide a detailed Corrective Action Plan within 3 business days of discovery. Corrective Action Plans are always focused on addressing root cause(s) and

Template F Items Addressed by this Response	
Requirement Number	**Overview of MMA's Solution**
	eliminated the likelihood of reoccurrence.
FR2.75	FirstRx provides for an audit trail of all additions, deletions and changes to master file data, prior authorizations, beneficiary lock-ins, edits, and POS transactions. The audit trail contains the name of the individual that made the change, the date and time of change.
FR2.76	MMA will sample and reconcile the claims processing system to include a random sample of 500 claims each quarter, stratify the sample technique by Department-specific variables, report findings on a quarterly basis to the Department, and provide an action plan to address processing errors.
FR2.77	We use a Six Sigma DMAIC methodology and rely heavily on quantitative measures and the 'voice of the customer' to drive improvements. Formal improvement projects and process characterization sessions are led by Certified Six Sigma Black Belts and Green Belts, facilitating teams of subject matter experts (SMEs). Our Continuous Process Improvement program is directed by the Vice President of Quality and Performance Improvement, a certified Six Sigma Master Black Belt.

To provide the State with quality services, our quality improvement (QI) team monitors contract activities to provide timely adjudication, compliance, efficiency, and responsiveness to the State's contract. Contract performance is communicated in an agreed-upon format through mutually developed service level agreements (SLAs). SLAs are continuously monitored to ensure that agreed-upon SLAs are being met.

Our QI plan includes the following responsibilities:

- Internal audit of contractual requirements (e.g. reviews are scheduled and conducted)
- Administrative analysis of clerical and system errors
- Administrative analysis of automated and manual management reports to monitor contract performance (e.g., quality review and delivered timely)
- Standards for operations and documentation
- Analysis of criteria for development of system design enhancements and application testing.

In addition, our experience with 25 states and the District of Columbia offers Vermont deep experience with project management expertise and tracking and resolving issues that arise. We develop standard operating procedures with each client and agree to the process for Change Management and Issue Resolution, and we agree to resolution standards that may be subject to penalty if not resolved. MMA uses a CCM (Change Control Memo) process to implement coding changes to our system. Each CCM is added to the CCM Log for each client upon its creation. There is also an Issues Tracking Log for issues identified outside of a change request from the client. The CCM and Issues Tracking Logs provide the details and status of each request or issue. These logs are distributed 24 hours before weekly scheduled client meetings so that all parties are kept aware of the progress for each request and can discuss the requests and issues

if needed. In addition, the tracking logs can be added into the shared portal of documents which can be accessed by all registered parties. An Action Item is created by MMA upon request and contains such details as Action Item Title, Submitted By, Responsible Party, Item Description, Date Opened, Priority and Status. Comments can be added as needed and the Action Item Report would indicate all of the above details. This report can provide the aforementioned information on only open items or can include resolved items as well.

Quality Improvement Program and Ongoing Training

The corporate Quality Improvement Group has overall responsibility for monitoring compliance with performance criteria and reports findings to senior management and the Quality Improvement Committee. The Quality Improvement Group ensures that performance indicators are met for all aspects of the transition and operation and monitors the performance results on a daily, weekly, and monthly basis, identifying trends and anticipating processing and performance expectations.

Each functional area implements standards and quality control measures to determine the effectiveness of work performed within that area and identifies areas for re-training. Each individual must have an understanding of the requirements and performance standards associated with his or her job and how their role fits within the organization. The Quality Improvement Group supplements this effort by assisting with the development of training programs, performance standards, metrics, and quality control procedures.

Monitoring Day-to-Day Activities

Our established QA procedures provide foresight into daily operations to exceed the level of service expected of our clients. Our procedures identify steps, workflows, responsibilities, and measurement methods for all the quality control procedures to be used during the life of the contract with DVHA. Quality control results are used to identify individual and group training needs, to monitor individual performance, to identify functional processing inefficiencies and opportunities for improvement, and to ensure that performance is within prescribed performance expectations.

Part of our day-to-day activities includes monitoring rejected claims to assure that rejections are consistent with benefit designs. Each issue generates an issue report that the State is able to use to support disclosure to CMS. The report details the following:

- The issue that was identified
- How it was discovered
- When it was discovered
- When it was disclosed to the State
- Impacted beneficiaries and drugs
- Remediation activities with anticipated dates.

The denied claim report is comprised of three separate sections and is produced on a daily basis. This package includes:

- Denied claims detail report containing all denied claims and details associated to the claim
- Summary by NDC report that contains all NDCs associated to the denied claim rolled up to the plan level.

- Summary by reject code report containing all reject codes associated with the denied claims.

Continuous Improvements

Our methodology is continually reviewed and modified as needs change or challenges arise. Our plan is based on our pharmacy management experience and understanding of and commitment to meeting DVHA's goals, requirements, and expectations.

This Quality Improvement methodology is integrated into the job responsibilities of our employees to:

- Ensure timely delivery of reports, procedure manuals, and requested deliverables
- Perform accurate regression testing of all major system enhancements
- Identify and promptly correct identified processing and reporting errors
- Respond to DVHA inquiries regarding processing functions and contract deliverables
- Review and report on operational status to internal management and designated DVHA personnel.

In addition, we use a web-based portal to log operational, clinical, programmatic, and claims processing issues. Issues are reviewed with the Department on a weekly basis with the dedicated key personnel team.

Our call center monitors telephone line activity to ensure that we do not have busy signals and that calls are answered promptly. Real-time reports monitored by management provide a snapshot of the call center's performance and status to allow for agent split/skill adjustments when performance interventions are needed. Standard real-time reports show the current status of Automatic Call Distribution (ACD) activity and data for the current interval for agent, split/skill, trunk/trunk group, vector, and Vector Directory Number (VDN) activities, for example number of ACD calls, abandoned calls, and average talk time. Summary reports provided to Vermont will include inquiry volumes from beneficiaries, pharmacies, and physicians, and will include service level performance statistics for call center access for each constituent type. Telephone line activity is monitored on a continual basis to ensure that we do not have busy rings and that all calls are answered promptly MMA's management staff closely monitors the client queues, and can easily and quickly change answer priorities according to call volumes and wait times. This ensures that the staff is assigned appropriately to meet the call volume demands at the required service levels, all of which will be measured and reported. With the extensive reporting capabilities provided by our call management system, we are able to manage performance requirements to ensure that SLAs are consistently met.

Ongoing Training

The Training and Development department is responsible for ensuring that all support center associates are made aware of plan changes and are knowledgeable of what is being implemented. As plans change and clients are added, it is important to continue the education of the support center to be sure they have the most up-to-date and accurate information. As clients are upgraded to new platforms, new plans, and new technology, it is important to keep the support center appraised of the changes. This includes periodic reviews of various clients' individual plans with the support center associates. When confusion is recognized, the training group may provide check-up training. The Training and Development and Quality Assurance departments maintain a close relationship with support center management in order to assure compliance with the client's wishes, quality customer service, and accuracy.

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.

In Figure 26 below MMA has provided a description of its approach to meeting the requirements in Template F.

Figure 25. Overview of MMA's Solution to Response 1.3.1.

Template F Items Addressed by this Response	
Requirement Number	**Overview of MMA's Solution**
FR3.1	MMA will manage the Department's manufacturer drug rebate program for federal 'OBRA 90, state supplemental, and SPAP-only rebate programs.
FR3.2	We are in compliance with the provisions explained at www.cms.hhs.gov/MedicaidDrugRebateProgram and Section 1927 of the Social Security Act.
FR3.3	MMA will maintain a policies and procedures manual regarding the administration of the Department's manufacturer drug rebate programs.

Template F Items Addressed by this Response	
Requirement Number	**Overview of MMA's Solution**
FR3.4	MMA does not engage in contracts with pharmaceutical manufacturers that directly benefit MMA financially in the Medicaid fee-for-service population.
FR3.5	We will conduct a review of rebate contracting and program performance with the Department on a quarterly basis.
FR3.6	MMA's system allows for both NDC claims data and Physician-administered drugs (HCPCS) to be processed for rebates.
FR3.7	We are able to calculate total rebate amounts based on the number of units paid by NDC and the unit rebate amounts applicable to the Department's program.
FR3.8	We will invoice the State in accordance with CMS guidelines to include invoicing 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. We will submit the invoice to the Department for approval at least 3 business days prior to invoicing participating manufacturers.
FR3.9	We use the CMS standard R-144 format for rebate invoices.
FR3.10	We currently deliver electronic invoicing to over 350 manufacturers on a quarterly basis. Manufacturers can retrieve information in either a txt or pdf file format.
FR3.11	As a standard practice our audit process includes claims review where we seek to identify issues that may cause the invoice to be incorrect. These changes are made prior to invoicing and a pre-invoice adjustment report can be created and sent to the State.
FR3.12	We can accommodate unit of measure conversions with the eRebate system
FR3.13	Our system is capable of performing prior period adjustments as far back as the historical data takes us. We can go back to 1991 as long as the historical data is clean and to a detail that supports the adjustments made.
FR3.14	We will process prior period adjustments, calculate interest due amounts, and work to resolve outstanding rebate disputes originating prior to the Contract. This can be accommodated as long as the historical data exists and supports the adjustment
FR3.15	Our dispute resolution process is in compliance with CMS Best Practices for Dispute Resolution and will meet all State and Federal requirements for pursuing recoveries.
FR3.16	We offer a set of reports that document NDCs that are in dispute by the manufacturer. These will be provided to the State on a monthly basis.
FR3.17	Invoices are compared to ROSI's to determine what NDC's are in dispute and notes can be added to the system as needed
FR3.18	eRebate provides a note area that is utilized by our analyst to document any and all dispute resolution attempts.
FR3.19	Invoice records are corrected at the claim level and flow through to the NDC level so that the two are always in balance.

Template F Items Addressed by this Response	
Requirement Number	**Overview of MMA's Solution**
FR3.20	eRebate allows notes to be added to the system to describe dispute resolution attempts. These items are available for reporting through our Cognos reporting tools.
FR3.21	Each change that is made in our system is captured separately in order to maintain an audit trail. Adjustments made at the claim level automatically adjust the total units at the NDC level.
FR3.22	We will actively participate and attend CMS-sponsored dispute resolution meetings on behalf or, or in addition to, Department staff. We must be given adequate time to make necessary travel arrangements and information about the meeting in order to prepare.
FR3.23	Our system is capable of reconciling payments from the manufacturers invoice at the NDC level. This is the level of information that is received from the manufacturer. Payments received at the claim level can only be reconciled as an estimated percentage.
FR3.24	eRebate keeps track of the original invoice (source document sent to the manufacturer) and any changes made post invoice creation.
FR3.25	We will identify discrepancies between the rebate amount due and total amount paid to pharmacies as part of our pre-invoicing review. We will determine the reasons for discrepancies and resolve the discrepancy and log each resolution.
FR3.26	Our eRebate system tracks interest at two points in the process. Invoice is calculated and posted to the account as earned each time cash is posted. Interest is also calculated at invoice creation and is included on prior period statements for each manufacturer.
FR3.27	MMA has 15 years of experience in rebate processing. Our system follows all CMS guidelines. Information is contained based on YR QTR timeframes. It is capable of producing invoices for CSM, supplemental, MCO and diabetic supply programs. Each program can be reported on individually.
FR3.28	Our system is equipped to handle all historical data as long as it meets all data integrity issues. All data processed by our system during normal operations is available for reporting and/or viewing. All changes and updates are recorded as separate transactions in order to maintain an adequate audit trail.
FR3.29	Department staff is given access to rebate data through our Cognos reporting tool.
FR3.30	All records are maintained within the system so that adequate trails are available for changes and updates. Provided data integrity rules are met we can house data all the way back to the inception of the program in 1991.
FR3.31	Accounts can be aged through are Cognos reporting package, for management reporting purposes
FR3.32	As long as the historical data meets all our integrity requirements adjustments can be applied all the way back to the inception of the program if needed.

Template F Items Addressed by this Response	
Requirement Number	**Overview of MMA's Solution**
FR3.33	eRebate has the functionality to allow multiple select keys and sort preferences, including by manufacturer, year/quarter, type of rebate, program or category code, and claim level.
FR3.34	All records are maintained within the system so that adequate trails are available for changes and updates.
FR3.25	We are able to house all quarterly rebate data back to 1991, the initial date of program inception.
FR3.26	We will assume all administrative and management tasks associated with historical quarters as long as the data meets our integrity requirements and is sufficient for the purposes intended.
FR3.27	We will transmit the CMS utilization file with all CMS required fields as required by CMS quarterly.
FR3.28	Our Cognos reporting tool incorporates all necessary reporting information needed for Quarterly CMS-64 reporting and will be delivered within the 15 day time frame.
FR3.29	MMA will work with the Department to establish a reporting deadline. Reports will be made available online in a downloadable format.
FR3.30	eRebate is able to accommodate separately online manufacturer drug rebate management systems and operational rebate reporting functionality by reporting separate rebate payments by quarter, program, and rebate type, drugs cross-walked from HCPCS codes to NDCS, prescription claim level, and funding source.
FR3.31	As a standard practice, MMA's process includes claims review where we seek to identify issues that may cause the invoice to be incorrect. These changes are made prior to invoicing and a pre-invoice adjustment report can be created and sent to the state.
FR3.32	We reconcile drug rebate data within the Department's fiscal records on a quarterly basis. We will include detailed reports that identify the adjustment, unit amount, write-offs, and other accounting transactions that impact the Department rebate reporting.
FR3.33	MMA's Cognos reporting tool supplies a multitude of standardized reports including rebate recoveries, current reporting period disputes, adjustments and recoveries resulting from dispute resolution, pre-invoicing adjustments, current/past accounts receivable, and interest billed. We will work with the State during implementation to define reporting parameters for the "feasibility determinations of rebate write-off" report. Additional reports that are not standard are requested on an ad hoc basis.

MMA has over 15 years of experience in administering rebate programs for state agencies. In the period of time from 2001 through the third quarter of 2013, MMA has invoiced over $24 billion with a 98% collection rate. MMA has active Federal CMS, Federal Managed Care, Federal Supplemental, Diabetic Supply and Commercial rebate administration contracts with 24 states and the District of Columbia. We are currently administering close to 60 individual programs on behalf of Alaska, Arizona, Connecticut, the District of Columbia, Delaware, Florida, Idaho, Kentucky, Louisiana, Maryland, Michigan, Minnesota, Missouri, Montana, North Carolina, Nebraska, New Hampshire, New York, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Virginia, and Wisconsin.

The current yearly volume of manufacturer rebate invoice amount generated by MMA is over $2-3 billion invoiced with a collection rate of 98% on adjusted invoices.

In addition to generating both current quarter invoices and prior quarter adjustments for these programs, our eRebate™ system also supports the reconciliation of historic and current payments from the manufacturers and supports the recording and tracking of manufacturer disputes, from payment to resolution, regardless of current or historic status.

MMA proposes use of our latest system technology, eRebate, to support our administration (process, invoice and collection) for the Vermont Federal, State, and Supplemental rebate programs. This modular rule- and association-based system allows for flexibility in establishing independent program needs to accommodate differences in the Federal (OBRA, MCO) and Supplemental contracts, as well as support of Diabetic Supply or Commercial programs when applicable.

The eRebate system has the flexibility to accommodate supplemental rebate processing that will support the State. As with the CMS program, a final calculated supplemental rebate rate file can be received and loaded to eRebate. It will then be applied to the applicable utilization for products covered under the supplemental contract. As each quarter file is delivered to MMA, changes in prior quarter rates will initiate an adjustment to the rebate amount owed and the manufacturer will be notified with an adjustment record on the invoice. Additionally, eRebate can manage the supplemental contract information and utilize its drug pricing records to calculate the rates prior to the invoice generation. Changes that occur to pricing elements within the contract calculation, such as Wholesale Acquisition Cost (WAC) or Average Wholesale Price (AWP) generate a supplemental rebate rate adjustment.

eRebate does not combine the data of our state customers. Federal, supplemental, and state rebate information specific to Vermont Medicaid is kept separate from all other states' contract information, with the same precautions employed for state utilization data. Invoices, payments, and all forms of reporting are derived from independent, customer program-specific databases and can only be accessed by authorized users. Under no circumstance, is it necessary to combine or share the information we receive on behalf of our state customers unless authorized by a representative of the state.

MMA's rebate processes are all OBRA '90 and HIPAA compliant for each of the rebate programs administered. We follow the CMS Best Practices for Dispute Resolution, use the mandated invoice format, submit quarterly invoices and utilization data by the deadline include institutional and medical claims, and utilize the CMS quarterly rate file for the appropriate rebate programs. All of these activities can be verified as our rebate system timestamps all activities and stores all completed historic activities. We are able to support all Vermont rebate programs and provide separate reporting of data for each one. As more regulations come forth from the Affordable Care Act of 2010, we will make necessary changes to remain compliant.

In the fall of 2010, MMA implemented our Electronic Invoice application so that registered manufacturers could retrieve invoices in a self-service manner**.** An MMA differentiator is the on-line capability for manufacturers to retrieve claim level detail in support of the invoice at both a specific NDC level and batch level for all claims related to their invoices. This offering greatly diminishes the need for third party data mining companies that require claim detail to support their manufacturer service offerings.

Figure 27 below provides a screen shot that shows the eRebate Electronic Invoice application and how manufacturers can access invoices with just a few prompts.

Figure 26. Electronic Invoice Application

CONFIDENTIAL MATERIAL: CONTAINS HIGHLY SENSITIVE PROPRIETARY AND/OR TRADE SECRET INFORMATION; PUBLIC DISCLOSURE WILL CAUSE SIGNIFICANT COMPETITIVE INJURY AND DISRUPTION.

Figure 28 below provides a screen shot that shows the eRebate Electronic Invoice application and shows how manufacturers can access claim detail at specific NDC or total Labeler Code levels.

Figure 27. Claim Detail Retrieval Screen

As a result of manufacturers being able to review their invoice totals on demand, the incidence of pre-payment dispute resolution has improved, resulting in more complete payment of invoices and faster turnaround in manufacturers' payments to their customers. Demonstrating the success of this approach, we have noted decided decreases in the number of manufacturers who seek us out at CMS conferences that are intended to bring manufacturers and rebate administrators together for dispute resolution and in attendance at MMA-hosted conferences for manufacturers experiencing dispute resolution issues.

Functions performed by the MMA Rebate Operations Team will include the following:

- Claim load reviews to ensure claim counts loaded to the eRebate system are balanced to the FirstRx and MMIS systems for pharmacy and physician-administered claims. Technical support includes automated conversion of POS units to rebate units and conversion of HCPCS units to rebate units. Record validation of inbound claim attributes is performed to ensure accurate records are received.
- A review of those loaded claims for quantity totals outside of normal range in order to audit the provider by telephone on the quantity and have the provider adjust the claims in the FirstRx POS system, if necessary, prior to the invoice generation.

- Retrieval of the CMS manufacturer and rate files directly from the CMS Drug Data Reporting for Medicaid site, as MMA is an authorized agent. This eliminates the need to establish a new FTP process so that the Vermont file can be transferred to MMA on the State's behalf.
- Invoice generation from eRebate within the CMS mandate of 60 days after quarter end. The system allows the Rebate Operations staff to generate invoices. There is no developer assistance required. This allows claims to be prepared as soon as they are all received, and once the CMS rate file is loaded, invoice summary is completed. This ensures that MMA provides invoices well ahead of the CMS mandate.
- Reconciliation of the manufacturer payment documentation (Reconciliation of State Invoice and Prior Quarter Adjustment Statements) against the invoice account receivables in eRebate is performed. Manufacturer checks can be sent directly to a State bank account or the State Fiscal office to ensure direct deposit to the appropriate budget account.
- Dispute resolution is performed with manufacturers for any utilization amounts in question. This includes providing claim level detail through secure electronic mail in support of the unit quantities invoiced.
- Dunning Letters are provided to manufacturers that have paid no amounts on their current quarter invoice at standard pre-defined intervals, currently at 45, 75, and 90 days.

We will provide DVHA with a MITA-compliant rebate application that facilitates the drug rebate program. eRebate is a web-based application that allows for flexibility in establishing parameters for managing DVHA's Federal, state, and supplemental contracts. It is compliant with all CMS regulations and provides DVHA with:

- Initial data conversion to provide for a seamless integration
- Ongoing data capture and auditing
- Processing the CMS Rebate Utilization File
- Producing and submitting invoices to drug manufacturers
- Reconciling and resolving disputes and inquiries
- Processing of payments
- Providing a comprehensive report package to the State.

Initial Data Conversion

MMA brings 15 years of experience in rebate administration to the area of history conversion and implementation (over 60 programs) and has never had a failed implementation. MMA proposes the transition of the rebate function from the current contractor in the following manner.

MMA will then take responsibility of all historic balances that are converted into eRebate™, as well begin the task of processing future data.

Historic conversion of the existing account receivables in the Federal program is accomplished by either providing our standard format to the current vendor for extracting data ready to load to our system or by receiving the current vendor extract and mapping the conversion into eRebate. Members of our rebate department working collaboratively with DVHA's dedicated key personnel team prepare a full conversion document, including any technical or business rules, and reviews the documentation with DVHA for approval. This helps to provide for a successful conversion

from system to system. A test conversion is required so that any existing data issues are resolved to minimize interruptions to the production rebate payment process. We then take responsibility of all historic balances that are converted into eRebate, as well begin the task of processing future data.

Ongoing Data Capture and Auditing, Including CMS Rebate Utilization File

After the initial data conversion, we capture several data elements that are loaded and audited to support DVHA's drug rebate process. This includes:

- Processing the CMS Rebate Utilization File
- Adding NDCs for current J-Codes
- Claims Load Review and Audit

Below we provide more detail on our ongoing data capture.

Processing the CMS Rebate Utilization File

As an authorized agent, we use our existing FTP connection to transfer rebate utilization files on behalf of DVHA. Our system automatically validates and loads the CMS manufacturer, rebate rate, and rebate offset files through this connection. Files are loaded to eRebate on a quarterly basis.

Adding NDCs for Current J-Codes

eRebates allows for the entry of NDC and J-code combinations as they become available. The entry also includes the applicable conversion factor needed to accommodate the billing unit of measure and rebate unit of measure differences. When both an NDC and HCPCS code are used, the system automatically validates the combination before billing and makes necessary unit adjustments. As a modular and user-configurable system, this information is maintained in the system's reference table and is not part of the system coding. This allows for ease-of-use and quick modifications as needed to support DVHA.

Claims Load Review and Audit

Claim load reviews verify claims counts received from FirstRx and the MMIS are accurate for pharmacy and physician-administered claims. Claims are loaded and validated on a mutually agreeable cycle that best fits DVHA's integration needs. As noted above, unit of measure differences are automatically adjusted as needed. Utilization rules are also configurable as necessary to allow for exclusion of 340B provider claims. Once the claims summary begins, rebate department staff reviews the results for accuracy. If changes are needed they are able to make necessary adjustments and approve for claims audit review.

Once the summary is approved for a claim audit, our rebate team reviews loaded claims for quantity totals outside of historically appropriate ranges. Staff proactively outreach to providers by telephone to verify information prior to invoice generation.

Producing and Submitting Invoices to Drug Manufacturers

eRebate validates and supports the load of the CMS manufacturer, rebate rate, and rebate offset rate files, which are retrieved directly from the CMS Medicaid Drug Rebate (MDR) website. In addition, pharmacy and physician-admixture claims are loaded and validated on weekly, monthly, or quarterly cycles to best fit customer needs of integration. Both adjudication unit of measure conversions and HCPCS/NDC unit of measure conversions are automated within the preparation of claims and are **business maintained through table entry, not system coding**.

Utilization rules are also business-configurable to allow for invoice exclusion of 340B provider claims.

eRebate supports separation of duties by user role and is business-configurable to support the supplemental program contract information. The contracted products and rebate cost bids are supported through load to the system. The rebate rate calculations are supported through a formula builder to allow for optimal flexibility by product. Market baskets (or drug classes) are supported by load to the system to allow for rules configuration based on P&T Committee decisions of coverage. These data are processed within a business workflow of rate generation after all information has been successfully loaded and validated.

An invoice generation workflow, initiated after receipt of the CMS Drug Rebate files and within 60 days of quarter end, allows for business users to prepare the quarter claim data into an invoice summary and apply the necessary rate data. Our additional secure Electronic Invoice process is also invoked, and the manufacturers are notified that invoices and associated claim detail are ready for retrieval. This process is completed within 20 days of the file receipt. MMA currently has 392 of the Manufacturer Labeler codes utilizing the Electronic Invoice delivery process which supports faster processing of Vermont invoices and subsequent payment delivery, the remaining paper invoices are mailed via the United States Postal Service. At the completion of the invoice generation, CMS is delivered the summary file, and MMA will resolve any issues or questions that CMS may pose in response to that delivery.

The MMA Rebate Operations Team will process the federal and supplemental rebate invoices. The team is highly familiar with federal requirements and receives all CMS State releases, just as the State representatives do. In addition, team representatives are registered with CMS for all notifications, so any new policy information that is posted by the entity, MMA is able to review and remain in compliance with all current requirements. Invoices will be generated in the CMS R-144 layout and sent no later than 60 days after quarter end. An advantage in operations that MMA possesses is that we have a secure web-based invoice application. Sixty-four percent of active CMS labeler codes are registered and using this application to retrieve not only the invoices, but the claim detail that supports the totals. This allows for less analyst time to deliver files as requested and fewer disputes being filed by manufacturers, leading to more efficiency and less staff required to manage the programs.

For the manufacturers who do not receive invoices via the web, we prepare and deliver paper invoices via USPS. Claims level detail is provided in a HIPAA-compliant format through a secured electronic format. For both electronic and paper invoices, supporting claims detail includes the following elements:

- Provider name and identification number
- Unit total
- Provider billed and paid amounts
- Internal claim number
- Paid date
- Source of claim (pharmacy or medical)

After Invoice Generation

The eRebate Cash Posting module allows for NDC level recording of drug rebate payments. Posting occurs at four levels: Deposit Batch, Check Receipt, Rebate Invoice and finally to the NDC summary invoice record. Our Rebate Operations Team monitors eRebate for applied payments. If a manufacturer does not submit the appropriate amount by the invoice postmark

date, late pay letters are produced at 45, 75, and 90 days past invoice postmark date to manufacturers who failed to submit any payment on an invoice and the Rebate Operations Team mails these letters to manufacturers. Interest is calculated based on CMS guidelines for all payments that are received late from manufacturers.

Reconciliation and Resolving Drug Rebate Disputes and Inquiries

The MMA Rebate Operations Team follows an invoice resolution process that follows the CMS Best Practices. Our process includes acknowledging a manufacturer's initial dispute within 48 hours of receipt and providing a resolution proposal within 3 to 10 business days, depending on the extent of the disputed NDCs and the responsiveness of the labeler. A Rebate Pharmacist and Analyst support the dispute resolution process by providing evidence in support of the submitted invoice. Our standard resolution proposal includes a summary letter of the resolution relating to the adjustments offered by NDC and supporting information on the specific claims that are in need of adjustment.

Questionable claims are audited via telephone with the provider to confirm the number of units dispensed. If a claim is billed in error, staff beneficiaries request that the provider reverse and resubmit the claim. These claim corrections will then be processed in the MMIS and FirstRx systems and will be transmitted to the eRebate system according to the established timeline, where a prior quarter adjustment will be made, resolving the accounts receivable balance. The Rebate Operations staff will record the resolution of the dispute. Since the MMA Rebate Operations Department uses common practices, additional analyst assistance, if needed, will be available.

The eRebate Dispute Resolution module allows for NDC level recording of disputes and will allow MMA to track them through to resolution. Disputes for utilization, as well as supplemental rate calculations, will be handled by MMA. Manufacturers are provided claim detail in support of the invoices either immediately through the eRebate Electronic Invoice application or by secure mail, within 15 business days, from the Rebate Operations Team Analyst that receives the request. MMA will also resolve questions related to disputes as manufacturer present them to the team.

Supporting Manufacturer Inquiries

MMA will provide staff coverage of one Rebate Pharmacist and one Rebate Analyst who will defend inquiries in the pursuit of drug rebates that are received. The staff will work with the manufacturer and provide the claim detail evidence in support of the invoice that is mailed.

MMA will provide HIPAA-compliant claim level detail to drug manufacturers for rebate dispute resolution purposes in two ways. MMA implemented our Electronic Invoice application so that registered manufacturers could retrieve invoices and claim detail in a self-service manner. Manufacturers can retrieve claim level detail at the specific NDC level and batch level for all Vermont rebate programs. In addition, the manufacturers that still continue to request paper invoices have Rebate Analyst contact information for requesting claim level detail at the NDC or batch level. The advantage of the Electronic Invoice application is that manufacturers don't have to blindly dispute utilization based on algorithms (cost/unit, unit/script, etc.) but they can immediately review utilization and avoid disputes which results in higher rebate payment to the State.

Processing of Payments

The MMA Rebate Operations Team will utilize our established common administration process. We propose that payments be sent to a Financial Institution Lockbox or the State directly. Payment information from the manufacturer with a check copy will then be routed to the Glen

Allen-based team. A Cash Posting workflow is utilized in eRebate where entry of the supplied documentation includes recording the units paid, the rebate rate paid, and the rebate amount paid, per NDC. Interest amounts paid are also input to the system and are recorded at the labeler quarter level, as presented. In addition, any disputed units are recorded and the dispute resolution will begin within the team. The resolution process includes providing claim detail to manufacturers to support invoice totals and working to determine if any adjustments to the invoice amount are needed. Prior period adjustments resulting from voided claims or adjusted rebate rates from CMS will be systematically applied in eRebate system as part of the invoice summary process. The Rebate Operations Team may also enter adjustments to rebate units and rates as a result of dispute resolution, especially where a provider is unable to re-process a claim through either of the adjudication processes.

At the completion of every month, Rebate Operations staff will provide designated Vermont Finance representatives a receipt listing report, containing all checks entered into the eRebate system. This report can be compared to any monthly bank statement provided to the State to confirm all payments are processed. Reporting on interest amounts owed and disputed invoice data is also provided through the Cognos Business Intelligence tool that will provide a standard rebate report package to DVHA.

Rebate Reporting to the State

MMA provides an extensive rebate report package, available on-line in real-time to DVHA to support and export information related to the CMS and Supplemental rebate programs.

DVHA reports are made available to DVHA quarterly or as needed. In Figure 29 below we have included a detailed listing of all available reporting, and the frequency with which DVHA will receive them,

Figure 28. Drug Rebate Report Listing

Drug Rebate Reports		
Report Name	**Report Description/Purpose**	**Report Frequency**
Contract Management		
HCPCS list		Quarterly
Unit rebate amt / offset amt received		Quarterly
Active Labelers		Quarterly
Terminated Labelers		Quarterly
Manufacturer Contract Terms		On Request
Client Contract Terms		On Request
Client Notes		On Request
Manufacturer Notes		On Request
Rate to Rate		Quarterly

Drug Rebate Reports		
Report Name	**Report Description/Purpose**	**Report Frequency**
Comparison Dashboard		
Manufacturer Market Basket Report		Quarterly
Client Drug List Report		Quarterly
Contract Pricing Report		Quarterly
Manufacturer Contract List		Quarterly
Client Contract List		Quarterly
Invoice Management		
NDC's not found on rate file		Quarterly
Zero rebate amount per rate file		Quarterly
Claim Level Detail - Quantity Threshold		On Request
Claim level detail without PHI		On Request
Batch claim level detail		On Request
Invoice Totals for Quarter		Quarterly
Rebate Totals by Claim Source (POS or physician-administered)		Quarterly
Rebate Totals by Group ID		Quarterly
Family Planning Drugs Invoiced		Quarterly
Pre-Invoice Adjustments		Quarterly
Medicaid Drug Rebate Invoice (Combined)		Quarterly
Quarterly Invoice Comparison		Quarterly

Drug Rebate Reports		
Report Name	**Report Description/Purpose**	**Report Frequency**
Quarterly Invoice Comparison, by NDC		Quarterly
HCPCS Quarterly list		Quarterly
Rebate exceeds reimbursement		Quarterly
Claim Load Audit		On Request
Invoice claim load audit		Quarterly
Excluded claims audit		Quarterly
Therapeutic Class By NDC by year, by quarter		Quarterly
Batch Listing		On Request
Cash Receipt Re Cap Support Summary		On Request
Receipt Listing		On Request
Manufacturer Receipt Allocation by Labeler		On Request
Rebate Amount Paid by Therapeutic Class		On Request
Aged Disputes Remaining		On Request
Labeler Account Balance, As Of and to/from Dates		On Request
Unit Adjustment at NDC Level		On Request
Summary of Adjustment by Quarter		On Request

Drug Rebate Reports		
Report Name	**Report Description/Purpose**	**Report Frequency**
64.9R report		Quarterly
Outstanding Balance Disposition		On Request
Manufacturer Dispute Details		On Request
Quarterly Labeler Account Balance		On Request
Family Planning Drugs Received		On Request
Interest Received		On Request
Labeler Paid amount vs. billed amount		On Request
NDC summary		On Request
Payment receipt detail		On Request

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 beneficiaries.
- Rebate bid negotiation annually and as needed: Negotiation that may occur at the request of a Beneficiary 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 beneficiaries 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.

In Figure 30 below MMA has provided a description of its approach to meeting the requirements in Template F.

Figure 29. Overview of MMA's Solution to Response 1.3.2.

Template F Items Addressed by this Response	
Requirement Number	**Overview of MMA's Solution**
FR3.34	MMA will provide all PDL program support except for supplemental rebate negotiation. MMA currently provides PDL services for another member state of the SSDC.
FR3.35	We will support the State in its engagement with the SSDC, which will include: • Provide utilization and rebate modeling analytic capabilities to support PDL recommendations. • Provide the SSDC with all necessary data files. Our existing relationship with the SSDC gives us an advantage in anticipating their needs and timelines. • Make recommendations and submit potential rebate arrangements by analyzing the Department's utilization data and all rebate offers to make PDL recommendations independent of the SSDC's guidance • Perform modeling that incorporates rebate data and determined net cost to the Department with associated individual PDL decisions that impacts Medicaid pricing in making PDL recommendations and uses costs to the State net of all rebates for financial comparisons.

Template F Items Addressed by this Response	
Requirement Number	**Overview of MMA's Solution**
	• Participate and represent the State in all activities involving rebate business
FR3.36	We will work with the SSDC to support the State administration of supplemental rebate program. This support will include: • Calculating, preparing, and issuing manufacturer invoices • Working with manufacturers to complete SRAs following delivery of applicable supplemental rebate rates from the SSDC • Working with Department on needed SRA revisions annually and assist with the CMS approval process • Track, reconcile, resolve all collections, disputes and adjustments • Provide a comprehensive set of PDL support reports for ad hoc evaluations.
FR3.37	We will maintain all systems required to calculate supplemental rebates. If a material discrepancy is identified, we will promptly make an appropriate adjustment.
FR3.38	We will maintain electronic claims records for the most recent four quarters in our claims adjudication platform that permits the manufacturer to verify supplemental rebate summaries through an audit process.

MMA is nationally recognized for delivering clinical excellence and substantial cost saving results to public-sector pharmacy benefit programs. Whether through a "single state" agreement or a "multi-state" purchasing pool, MMA utilizes our advanced degree clinicians to successfully support clinically sound PDL and Pharmacy and Therapeutics Committee (P&T)/DUR Board processes. Through proven processes and achievements with both individual states and two CMS-authorized multi-state pooling initiatives, MMA has demonstrated a clear understanding of federal and state statutes and regulations governing the Medicaid Program, Medicare Part D, as well as federal and supplemental rebates, which well prepares us to assist Vermont with the administration of its rebate programs.

Our strategy in support PDL development and maintenance, as well as supplemental rebate programs has evolved over the past decade. We have transformed our programs to focus more on PDL management to achieve high-quality clinical outcomes. We have implemented this strategy with over half of the nation's Medicaid clients, and it has resulted in producing enhanced savings on their behalf.

The State will receive effective coordination of clinical prior authorization criteria in determining the medical necessity of non-preferred drugs. We have experience in administering a PDL program for a current client in the SSDC. We have also successfully implemented an SPAP-only program.

We have collaborated with the SSDC since 2011. During this time we have developed a successful relationship with the SSDC vendor and have put processes in place to ensure the optimal situation for the state being represented. Our thorough understanding of the SSDC annual review process provides Vermont with a seamless transition in PDL program management.

Compiling Drug Utilization Data

We will work with the SSDC to fulfill their role in soliciting manufacturers for all necessary clinical information that is needed for upcoming reviews. This information is used to supplement our clinical research for PDL recommendations. We also use this information in side-by-side comparisons for the financial evaluation of PDL recommendations.

Bid Compilation and Presentation to the SSDC Members

The State is represented at meetings where rebate business is conducted, including annual SSDC vendor summits, conference calls for the presentation of rebate information, and DUR meetings. , our Vermont Clinical Pharmacist Manager, provides representation and all support documentation.

Preparation for Annual Review

The State receives support during its annual review and at other scheduled DUR meetings by suggesting classes for PDL consideration that are not currently offered through the SSDC. These recommendations may have significant savings potential for Vermont. A financial review of all Vermont utilization occurs annually regardless of planned PDL review. Occasionally, new products will come to the market resulting in an evaluation of an offer for that product and potentially others in the same class. Likewise, our clinical team produces clinical documents that explain the place in therapy for new products. Evaluations and PDL recommendations are provided to the State as needed to help support quick decisions for PDL status.

Selection Notification to Manufacturers

We complete the process of executing supplemental rebate agreements any time a contract revision or execution is needed. We provide comprehensive support for contracting, including quarterly invoice generation, monitoring and collection of rebates, and dispute resolution.

Support for General Administrative Functions

The State receives supports as needed with administrative functions, especially around communication with providers and manufacturers regarding the PDL review process.

Collaboration with SSDC and the State

Through MMA's involvement in the SSDC process, we have organized a process by which necessary file transfer occurs in order to meet the needs of the state, in addition to the requirements of the contract. We have developed timelines that meet the needs of all involved in this process. For the annual review, MMA receives a file complete with all SSDC offers (not just "accepted offers" so we can perform a thorough financial evaluation upon which to base PDL recommendations. We respect that the SSDC vendor also provides recommendations to beneficiary states, but our intimate knowledge of state wishes and related dynamics can lead to reconsideration of initially accepted offers. Following the DUR meeting for the annual review, MMA will have appropriate communications with the SSDC vendor to ensure that manufacturers are notified of any changes occurring outside of the typical SSDC process.

Bid Review and Rebate Acceptance

Utilizing the supplemental rebate rates negotiated for the SSDC, we provide cost analyses therapeutic classes selected for review with Vermont. We assess drug cost and utilization changes and trends by drug, drug category, price, PDL compliance, and population/demographics including age, location, eligibility category, medical condition, length of use, and other factors that may be specified by the State.

Well in advance of each DUR Board meeting, a cost analysis by drug class is produced with detail for each drug scheduled for review. This document is submitted to both the State and its DUR Board. Cost analyses are provided in our standard format in a mutually agreed upon timeframe that is finalized during implementation.

Cost analyses contain projections based on the most recent utilization data available specific to Vermont. Pricing includes detail on both federal and supplemental rebates as well as the rebate offset amount as they all impact the cost of drug products. State-specific Maximum Allowable Cost pricing is also used in calculations to determine relative costs of each drug in a class. Confidential rebate data in these analyses is provided only to the state on an “internal” set of cost analyses; relative costs per drug are coded on a set of “external” cost analyses for dissemination outside of the state offices to protect that information while still allowing for comparison of the relative net cost of the drugs in each class. The DUR Board may have access to the internal set provided that release to the public is protected by the state. In addition to cost and rebate information, these analyses include market share and utilization data, as well as projected market share and savings estimates based on various PDL scenarios.

Market shift savings occur when a patient on a product not included on the PDL changes therapy to a preferred medication that is less expensive net of all rebates. Essentially, this is a measure of cost avoidance for the Medicaid Program. For example, suppose that a non-preferred medication costs a Medicaid Program $40 per prescription (net of all rebates) and the physician changes a beneficiary’s drug regimen to replace that medication with one on the PDL that costs $30 per prescription (again, net of all rebates). As a result of the change, the Medicaid Program saves $10 each time the beneficiary receives the new prescription versus the cost had the patient not changed drugs. This assumes, of course, that the clinical outcomes are likely to be equivalent among the competitive products (the result of the MMA clinical review). The higher the PDL compliance, the more market share savings the State will achieve. The PDL compliance rate across our entire Medicaid book of business is 92 percent — including behavioral health drugs. In some cases, products are placed on the PDL as preferred and generate savings even without offering a supplemental rebate, either because they are less expensive at retail or have a large federal rebate that renders the effective price paid by the State lower than the cost of competing therapies. Supplemental Rebates are not required from manufacturers in order to achieve preferred status, but as mentioned above, MMA has extensive experience with pharmaceutical companies and receives offers from dozens of manufacturers.

MMA is experienced in predicting and reporting fiscal impact due to the exclusion or inclusion of specific products within each of the therapeutic classes on the PDL. We conduct fiscal analyses to monitor and report PDL cost-effectiveness and, where appropriate, we advise customers on the effects of State-specific policy. One of the benefits of utilizing MMA is the ease with which our clinical account managers can access expertise throughout the entire MMA community. This enables us to provide access to government relations experts and physician thought leaders in order to get up-to-the-minute knowledge of marketplace conditions. will collect and distill this information in order to advise the Department of changes that may impact the PDL operational function. Recommendations, including those regarding clinical safety and efficacy, are grounded in information gathered from far-reaching sources. For example, MMA’s expert

government relations team provides guidance on significant legislation and publications that provoke responses from state Medicaid departments. Recent scenarios include interpretation of the Affordable Care Act as well as the publications from the Lewin group and American Enterprise Institute regarding the utilization of generics in Medicaid. MMA's white papers and individual client responses to these events will enable the Department to steer PDL decisions and respond to internal queries in a timely and advantageous manner.

In order to aid the State in maximizing savings potential in managing costs of brands versus their generics, MMA creates a monthly Generic Drug Pricing Report for products with new generic market entries. A pricing evaluation is initially performed when a generic first appears on the market and is then incorporated into the monthly report from there. This report will use Vermont-specific utilization and pricing detail and enable to make recommendations to the Department when PDL status of brand versus generic products should be modified. MMA monitors patent expiration dates and ongoing litigation that affects the availability of generics in order to strategize with customers the most beneficial PDL movements in anticipation of lower net prices. These PDL recommendations also account for drug shortages; the MMA Drug Availability Surveillance team tracks production difficulties in all PDL classes in order to ensure continuity of care for Medicaid recipients. For new generic product entries, PDL status is recommended based on the current status of the brand drug within its PDL class. If a brand is non-preferred, its generic is also recommended as non-preferred. If the brand is preferred, the Generic Drug Pricing Report is consulted in order to guide decision-making. MMA reviews select brand versus generic drug prices on a monthly basis. When market conditions exist that indicate the status of brand versus generic PDL status should be changed, will make a recommendation to the Department.

Additionally, a Generic Drug Pricing Report is created monthly for products with new generic market entries. This report utilizes state-specific utilization and pricing detail and allows the Clinical Manager to make recommendations to the state when PDL status of brand versus generic products should be modified.

Manufacturer Contract Finalization

We understand that contracting will be performed by the SSDC. We will support it.

Rebate Reporting

Extensive reporting on rebate collection is included with MMA PDL services, such as amounts payable, amounts received, dispute resolution, and prior period adjustments. Please refer to Figure 29 in Response 1.3.1 for a detailed listing of available reports.

Clinical Management

CONFIDENTIAL MATERIAL: CONTAINS HIGHLY SENSITIVE PROPRIETARY AND/OR TRADE SECRET INFORMATION; PUBLIC DISCLOSURE WILL CAUSE SIGNIFICANT COMPETITIVE INJURY AND DISRUPTION.

MMA has more insight and experience than other PBM vendor in providing ongoing analysis and clinical review of new brand drugs and generic drugs, data supporting new or changed indications for existing drugs, and new formulations and strengths. MMA's Drug Policy Development (DPD) Committee continually monitors FDA actions (including new drug approvals and labeling changes to existing products), newly published clinical trials and treatment guidelines, market availability, and other sources of drug information. The DPD Committee provides a regular publication on these events in addition to dedicated evaluations of new products entering the market that detail their place in therapy.

An integral part of the clinical review process is conducting therapeutic class reviews (TCRs). Dr. is a beneficiary of the Drug Information Team that is responsible for drafting and reviewing TCRs, so she is familiar with the drug information that will be presented to the DUR Board. The TCR summarizes the clinical data most relevant for PDL review consideration. The TCR is developed and presented to the State in a format that allows for comparisons of efficacy and safety to other similar drugs and drug classes. TCRs are developed and produced to the State and the DUR Board in a mutually agreed upon timeframe prior to the scheduled DUR meetings.

Kaiser Commission on Medicaid and the Uninsured[1] Notes Satisfaction with MMA's TCRs

"Despite the public availability of DERP[2] and AHRQ[3] reports, states find the lag time between updates to reports, lengthy format, and lack of cost information all barriers to using them in decision-making. Ideally, from the states' perspectives, they would have a resource at their disposal that was timely, concise and included cost considerations. MMA's reports include all three of these factors, which is why states rely so heavily on them."

TCRs are concise, yet complete, in the information they provide to allow informed clinical and financial decisions by the P&T Committee. These in-depth clinical revie clinical team and updated according to relevance, typically every six to twelve months. TCRs may be updated more frequently as necessitated by new drug information, market changes, and other clinical detail, or supplemented by New Drug Updates that are compiled by the MMA DPD Committee. MMA is proud to be able to reference results of a study by The Henry J. Kaiser Family Foundation Kaiser Commission, which lauds our TCRs for effective translation of research findings so that they are useful to the end user. The Kaiser study notes that MMA's TCRs are complimented for their timeliness, conciseness, and inclusion of cost considerations. MMA has a library of over 120 TCRs and regularly assesses opportunities for expanding that count.

Each TCR contains up-to-date, FDA-approved prescribing information inclusive of contraindications and warnings, adverse effects, dosing, and recommendations for identified populations such as pediatrics and geriatrics for all drugs in the class. MMA develops an unbiased presentation of clinical trial data and other pertinent information, such as summaries of current clinical practice guidelines as applicable to each drug in the class and/or the class as a whole, to identify relative safety and comparative efficacy among the drugs reviewed. Each TCR clearly describes inclusion criteria for clinical trial data.

Therapeutic drug classes will be selected for inclusion in the PDL process based on their ability to bring value to the Department and its clients, as well as the ease with which the classes can be implemented. Once a drug class has been selected for inclusion in the PDL, MMA performs a thorough review of published, peer-reviewed clinical literature for drugs in the class and any related clinical practice guidelines. In addition, we request manufacturers submit all relevant data pertaining to their products in the class. MMA reviews each clinical trial and meta-analysis identified or submitted to ensure that it is unbiased, has valid results, and is clinically relevant to the Medicaid population. This is the mechanism by which MMA will communicate third party information to the State and P&T Committee beneficiaries.

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1 The Henry J. Kaiser Family Foundation Kaiser Commission on Medicaid and the Uninsured from September 2011, The Role of Clinical and Cost Information in Medicaid Pharmacy Benefit Decisions: Experience in Seven States

2 Drug Effectiveness Review Project (an Oregon Health and Science University program)

3 Agency for Healthcare Research and Policy

MMA will summarize in the TCR the clinical data most relevant for PDL review consideration. We will produce the TCR in a format that readily allows for comparisons of efficacy and safety. TCRs will be produced and provided to both the state and the DUR Board in a mutually agreed upon time frame prior to the scheduled DUR meeting by a means agreed upon by MMA and the State during implementation.

Through a comprehensive review of medical references and pharmacy compendia, including peer-reviewed literature and clinical practice guidelines published by nationally-recognized organizations, the team of MMA Clinical Pharmacists will work closely with the State's PDL pharmacy staff to develop and recommend clinical criteria for approval of non-preferred drugs within each proposed therapeutic class that leverage our experience from our customers across the country. We will further customize those criteria after taking into account the State's specific needs. Our clinical process is not intended to restrict medication utilization, but to promote the most appropriate and cost-effective medication utilization. Our solution is a highly flexible and dynamic claims engine backed by clinical intelligence allowing for maximum flexibility in benefit design and complex AutoPA capabilities.

works closely with the State's PDL pharmacy staff to develop and recommend clinical criteria for approval of non-preferred drugs within each proposed therapeutic class. Criteria are then customized based on the State's needs. As needed, off-cycle reviews may be recommended if the drug is removed from the market or new clinical and safety information becomes available.

New product entries to the market can be reviewed with the next annual review of the class or as single products at the next scheduled DUR meeting. reviews and recommends appropriate clinical criteria for determination of medical necessity through the PA process until the DUR Board can review new drugs. After MMA reviews the drug in its class, the DUR Board process determines the clinical and cost-effective place in therapy, and the drug can be added to the PDL with a preferred or non-preferred status. MMA will conduct regular meetings with the Vermont pharmacy staff to develop clinical criteria requirements for non-preferred products, as well as for other drugs requiring clinical review and approval. All of these parameters may be customized based on Vermont's requirements.

As part of the detailed clinical review, a cost analysis of therapeutic classes is also selected in collaboration with the State. Drug cost and utilization changes, as well as drug trends, drug category, price, PDL compliance and population/demographics are taken into consideration. The analysis also includes projections based on the most recent utilization data available.

In advance of each DUR meeting, provides the State with a detailed cost analysis for each drug class that is scheduled for review. The reviews also include details on both federal and supplemental rebates as well as the rebate offset amount. State-specific Maximum Allowable Cost pricing is also used in calculations to determine relative costs of each drug in a class. Confidential rebate data in these analyses is provided only to the State on an "internal" set of cost analyses; relative costs per drug are coded on a set of "external" cost analyses for dissemination outside of the State offices to protect that information while still allowing for comparison of the relative net cost of the drugs in each class. The DUR Board may have access to the internal set provided that release to the public is protected by the State. In addition to cost and rebate information, these analyses include market share and utilization data, as well as projected market share and savings estimates based on various PDL scenarios.

may recommend out-of-cycle reviews for a PDL drug/class if major developments occur within the market, including the removal of a drug from the market or the advent of significant new clinical or safety data. New product entries to the market can be reviewed with the next annual review of the class or as single products at the next scheduled DUR meeting. Dr.

will review and recommend appropriate clinical criteria for determination of medical necessity through the prior authorization process until the DUR Board can review new drugs. After MMA reviews the drug in its class, the DUR Board process determines the clinical and cost-effective place in therapy, and the drug can be added to the PDL with a preferred or non-preferred status. MMA will conduct regular meetings with the Vermont pharmacy staff to develop clinical criteria requirements for non-preferred products, as well as for other drugs requiring clinical review and approval. All of these parameters may be customized based on Vermont's requirements.

One of the benefits of utilizing MMA is the ease with which our clinical account managers can access expertise throughout the entire MMA community of experts. This enables us to provide access to government relations experts and physician thought leaders in order to get up-to-the-minute knowledge of marketplace conditions. The Clinical Pharmacist Manager collects and distills this information in order to advise the state of changes that may impact the PDL operational function. Recommendations are grounded in information gathered from far-reaching sources. MMA's government relations experts team with value-based purchasing staff to provide guidance on significant legislation and publications that provoke responses from state Medicaid departments. Recent examples include interpretation of the Affordable Care Act, as well as the publications from the Lewin group and American Enterprise Institute regarding the utilization of generics in Medicaid. MMA's white papers and individual client responses to these events allowed our clients to steer PDL decisions and respond to internal queries in a timely and advantageous manner.

MMA's Drug Policy Development (DPD) Committee continually monitors FDA actions (including drug approvals and labeling changes), newly published clinical trials and treatment guidelines, and other sources of drug information. The DPD Committee also reviews new generic entries to the market which supplements the weekly review of new entries to the FDB drug file.

The Drug Availability Surveillance Committee gathers information about drug shortages and the estimated timeframes for their resolution. The PDL team uses this information to ensure adequate preferred options for various drug classes. Clinical managers may use the knowledge to affect messaging and other communications to providers in the event that drug availability impacts Medicaid recipients.

State Representation

MMA will represent the state at all meetings where rebate business is conducted, including annual SSDC vendor summits, conference calls for the presentation of rebate information, and DUR meetings. MMA recognizes that a successful partnership with a P&T Committee requires a thorough understanding of the policies, procedures, and legislation governing the Committee. Our proven ability to respect the viewpoints of various stakeholders and confidently communicate based upon both therapeutic and cost-effectiveness models have made us a true pharmacy management partner. With a vested interest in conducting successful P&T meetings, MMA also can advise the State on the most appropriate policies for P&T Committees, such as conflict of interest guidelines. MMA offers a three-tiered approach based on the state's desired aggressiveness in ensuring that their P&T Committee goes about their work in an unbiased manner.

As an active member of the DPD Committee and Drug Information Team, will continue to have ready access to drug information and will provide timely recommendations on changes to the PDL or review schedule to the state and the DUR Board. At all DUR Board meetings, plays an active role, bringing familiarity with drug information from the TCRs and a national perspective to discussions. She will present clinical information, financial analyses, and PDL recommendations. In addition, she will respond to DUR Board questions regarding all information presented.

MMA will manage all PDL program activities including conducting clinical reviews of drugs, recommending preferred agents and potential PDL classes, and considering supplemental rebate offers and other financial metrics. Our strategy is to transform programs into a formulary management model with an eye toward cost-effective, quality clinical outcomes. If awarded the Vermont PBM contract, MMA pledges to develop and maintain a collaborative and flexible partnership with both the state and the SSDC vendor, adjusting our products and services to meet the needs of the continually changing market, CMS regulations, and healthcare reform.

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.

MMA provides multiple variants to help manage 340B claims processed for Medicaid recipients under the HRSA Medicaid carve-in model. During implementation, we will work with the State to configure the established solution through interactions with covered entities and DVHA. This includes documenting all existing program parameters and opportunities such as claim submission requirements, pricing algorithms, data element submission enforcement, as well as maintaining submitting provider classification.

In support of the existing 340B program deployed by DVHA, MMA will continue to accept, evaluate, and price claims in accordance with the established provider acquisition cost submission requirements. Additionally, MMA will maintain the shared savings program structure including the proper application of the 340B dispensing fee as well as the capture, review, and calculation of the shared overall savings true-up process.

Administratively, we provide DVHA with:

- Detailed reporting that provides
    - Documented claims transactions for compliance/auditing

        - This includes provider submitted data, including, but not limited to, submission clarification code, basis of cost, submitted ingredient cost.
        - Calculated pricing data, including, but not limited to, calculated dispensing fee, final claim cost, and other calculated price points for comparison.
    - Insight into program performance
        - 340B claims volume and tracking
        - Provider/covered entity claim trends
    - Financial reconciliation information
        - Management of true-up cost savings program used to incent covered entities to elect to carve in Medicaid claims

Additional benefits of MMA's model could include:

- Identification of beneficiaries that will benefit the most from using a 340B pharmacy
    - Reviewing common claims processed through covered entities to determine patterns of care or specific disease management programs that are available through a covered entity
    - Analysis of claims for DVHA beneficiaries who are not using the covered entity in there area but could benefit from a Disease Management or specialist care provided as a service of the covered entity (expansion of lives for Covered Entity and claims processed for both the entity and DHVA that may be included in the 340B purchasing program.
    - Consultative assistance to covered entity with programs or offerings that may expand their services as a direct result of the shared savings true-up process.
        - Patient education
        - Monitoring cognitive services, such as infusion, coagulation, diabetes mellitus
        - Expansion of provider locations

We view a 340B program as a complex opportunity for both covered entities and state programs to benefit from the reduced price point available to qualified purchasers. While the 340B program has come under recent scrutiny from OIG and congress, anticipated clarifications and codification through the established rule making process are already underway. We are confident that 2014 and 2015 NPRMs and published Federal regulations will further define and regulate the 340B program; providing vital direction and clarity needed to further enhance a position that will benefit DHVA cost position but will also facilitate the expansion of services that covered entities are able to provide to those uninsured and underinsured beneficiaries in the healthcare system.

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.

Figure 31 below MMA has provided a description of its approach to meeting the requirements in Template F.

Figure 30. Overview of MMA's Solution for Response 1.3.4.

Template F Items Addressed by this Response	
Requirement Number	**Overview of MMA's Solution**
FR3.39	FirstRx accommodates post-payment claim reversals in accordance with NCPDP standards for B1 billing transactions and B2 reversals. Reversal transactions will contain a unique claim identification number, as well as link to the unique claim number of the original claim which was reversed.
FR3.40	We will process financial gross adjustments to pharmacy payments, such as corrective actions. As part of the State's performance management plan, we include procedures for correcting operational concerns that may arise through a CAP.
FR3.41	We will cooperate with financial audits by DVHA staff, other State departments, the U.S. DHHS, State or Federal designees, or others authorized to perform audits relating to the work and deliverables rendered by MMA. We allow copying of files requested in advance of the audit as it relates to the audit being performed. We also allow access to computer resources, notification within 24 hours, ability to print and retrieve claims, and provide personnel and resources necessary for sampling of claims and reference file data.

FirstRx contains an integrated claim submission service where paid, denied, or rejected claims are available for review and analysis and if deemed appropriate, reversal or resubmission for the purpose of applying corrections or adjustments to the original claim. Resubmission transactions are processed, according to NCPDP guidelines, by creating a B2 reversal transaction and subsequent B1 billing transaction and processing those in sequence. In the event a claim is reversed, the reversal applies debits to any accumulations prior to the B1 billing transaction to maintain data integrity in the FirstRx database. Reversal transactions will contain a unique claim identification number, as well as link to the unique claim number of the original claim which was reversed. If a claim is adjudicated and paid in one cycle and then reversed or adjusted in a subsequent cycle, that adjustment will be sent in the claims file to the Department, preventing an imbalance in the claims process. All iterations of a claim are maintained and available for research, reporting, and audit purposes in the adjudication system.

In the State's performance management plan, we include procedures for correcting contract compliance or operational concerns that may arise through a Corrective Action Plan (CAP). We immediately report claims that have been erroneously processed to the Department. We perform random quality assurance reviews utilizing plan testing, operational checklists, and inspections to

detect variations from the expected results. Teresa Elam, MMA's Vermont Account Manager, provides a CAP that contains the following information:

- Information specific to the issue and root cause
- Impact analysis
- Proposed resolution and estimated date for resolution.

All CAPs are developed within the defined time frame and will be provided to the State for review and approval.

Performing Multiple Claims Adjustments

FirstRx provides functionality to automatically process mass adjustments at one time, eliminating the need for claims processors to make changes on a claim-by-claim basis. Claims processors search for a subset of claims based on several items including, but not limited to:

- Drug code
- Beneficiary ID
- Adjudicated Group ID
- Specific rule ID effected during adjudication.

The mass adjustment functionality drills down to claims within a specified adjudication time period, or other search criteria, such as service date, adjudication date, and authorization number. In addition, the system allows claims to be identified by multiple clients, providers, and/or prescription numbers.

1.3.5 Duel Eligible Demonstration

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.

In Figure 32 below MMA has provided a description of its approach to meeting the requirements in Template F.

Figure 31. Overview of MMA's Solution to Response 1.3.5.

Template F Items Addressed by this Response	
Requirement Number	**Overview of MMA's Solution**
FR2.79	Not applicable.
FR2.80	Not applicable.
FR2.81	Not applicable.

These requirements are no longer applicable. MMA has not answered the requirements pertaining to Dual Eligibles as instructed in the email announcement received from AHS – DVHA DHR on January 19, 2014, and as indicated in the revision to the Bid Description posted on the procurement website on January 21, 2014.

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*

As a pharmacy benefits manager to more than half of the Medicaid programs in the country, MMA is uniquely positioned to support Vermont in is efforts to transition to a statewide single formulary system by 2017. We believe a single formulary/single payer system provides consistency for providers and beneficiaries and that our technology and systems would facilitate and ease this transition. Our solutions would allow the State to control drug spend and administrative costs, obtain reliable utilization data for analytical review, and decrease plan movement to access appropriate care under a single payer/single formulary system. Furthermore, given current budget conditions and the rising costs of health care, we recognize how important it is that Vermont maximizes its investment in its pharmacy program.

A single formulary simplifies the process for prescribers, pharmacies, and beneficiaries. Under a single formulary, or even a formulary with a small number of drug lists with minor customization for specific populations within the statewide formulary health system, prescribers would have a significantly easier time managing patient care across the Vermont single payer population. Additionally, prescribers and pharmacies need only to be aware of a limited number of utilization management and prior authorization criteria and processes — easing their administrative burden and allowing them to spend more time with beneficiaries. Further, a single formulary/single payer would also provide one point of contact for providers to call with questions, to verify eligibility or for prior authorization.

At MMA, we believe in administrative simplification. We offer secure web portal capabilities that enable prescribers to review the patient's eligibility, formulary, and medication history, and fully adjudicate prior authorization requests, all of which make utilization management faster and easier. We also provide our ePrescribing solution to help expedite the prior authorization process and get prescriptions into the hands of beneficiaries quickly. In addition, our single formulary eliminates the need for multiple P&T Committees, Drug Utilization Review Boards, variation within MAC lists, and numerous change management processes. We also provide a call center staffed by Certified Pharmacy Technicians, pharmacists, and physicians who are patient-care oriented to support Vermont's beneficiary and pharmacy communities.

A single payer system would enable DVHA to leverage better pricing by negotiating additional rebates for the Medicaid population and enhancing the rebates for other populations. This would be especially effective as it relates to the dual eligible population, as this population would be

entitled to Medicaid drug rebates provided to Medicaid programs, bringing additional funding into the state to be reinvested into wellness and other preventive care programs or used to reduce premiums for exchange beneficiaries. With our vast experience of negotiating and managing rebates for 26 state Medicaid programs, we have the expertise and relationships to maximize the benefit of greater volume under total program management, and to increase negotiating leverage via potential market shift. In addition to rebates, including the dual eligible population into the Medicaid program would also promote uniformity of benefit management. This would require use of Medicare-specific rules, such as timeliness, access to clinical peers and evidence-based rationales, exemption processes and tracking and reporting data on prescriber satisfaction as required by Medicare.

We have a completely transparent rebate system, where 100% of all rebates are passed back to the state. As part of our rebate maximization processes, we have extensive experience managing a single formulary for our Medicaid clients. As the administrator of two different state purchasing pools, we understand the importance of developing a single formulary that ensures access to critical drugs while balancing cost-savings. One, single administrator over the entire Vermont pharmacy program for all Vermont residents ensures a seamless program for beneficiaries and administrative simplification for providers. MMA is ready to aid Vermont in the transition from a multi-payer, multi-formulary environment to becoming a leader in the single formulary/single payer market.

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 0 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.	Section 1.3.1	As it relates to FR3.11, we will provide the Department with a quarterly report of each adjustment and related justification by NDC. This report is provided after invoicing is complete.	Data for report completion is only available for reporting once the remittance is submitted.
2.	Section 1.3.1	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.	As it relates to FR3.25, data must be in a clean, mutually agreeable electronic file format between MMA and each of the State's vendors.
3.	Section 1.3.2	FR3.34. The Sovereign States Drug Consortium (SSDC) is a Medicaid	Contract rates for supplemental rebates

Item #	Reference (Section, Page, Paragraph)	Description	Rationale
		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.	will include one contract for the entire quarter.
4.	Section 1.3.2.	FR3.36, 5. Provide all required reporting and analysis	We will provide the State with a comprehensive set of reports for the data we receive. We depend on the SSDC to provide us with the necessary data for reporting.
5.			
6.			
7.			

Template G. Functional Requirements Approach

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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	

RFP Req #	Requirement Description	Response Code (Y or N)	Vendor Response Comment(s)
A1.19	The System will have rules based access control and display information	Y	
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	
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	
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	
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	
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	
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	
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	
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	

RFP Req #	Requirement Description	Response Code (Y or N)	Vendor Response Comment(s)
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	
A2.15	Message and data formats should be based on logical representations of business objects rather than native application data structures	Y	
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	
A2.17	Point-to-point integrations are to be avoided. Application integration, both internal and external, will go through the central ESB.	Y	
A2.18	All System services will be classified with one of the following values: Presentation, Process, Business, Data, Access, or Utility	Y	
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	
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	
A2.21	All WSDLs developed for Vermont will conform to the WSDL Development Standards	Y	
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	
A2.24	Implemented services will rely on WS-Policy configurations for message reliability (WS-Reliable Messaging)	Y	
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	

RFP Req #	Requirement Description	Response Code (Y or N)	Vendor Response Comment(s)
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	
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.	Y	
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	
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	
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	
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	

RFP Req #	Requirement Description	Response Code (Y or N)	Vendor Response Comment(s)
A2.36	The System will have the capability to work with a Service Registry that serves as an integration point for runtime tooling	Y	
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	

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)	Y	
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	
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	
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	
A3.11	The System will provide protection to maintain the integrity of data during concurrent access.	Y	

RFP Req #	Requirement Description	Response Code (Y or N)	Vendor Response Comment(s)
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	
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	
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	
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	

RFP Req #	Requirement Description	Response Code (Y or N)	Vendor Response Comment(s)
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	
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.	Y	
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	
A3.29	The System will provide the ability to create and maintain a directory of external providers to facilitate communication and information exchange.	Y	
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	
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	
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	
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.	Y	
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	
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	
A3.45	The System will provide the capability to integrate with existing authentication and authorization mechanisms	Y	
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	
A3.47	The System will provide the capability to override a role and restrict access to information by users or groups of users.	Y	

RFP Req #	Requirement Description	Response Code (Y or N)	Vendor Response Comment(s)
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	

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	
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	

RFP Req #	Requirement Description	Response Code (Y or N)	Vendor Response Comment(s)
A4.13	The System will speak the users' language, with words, phrases and concepts familiar to the user, rather than system-oriented terms.	Y	
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	

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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	
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	
A5.11	Produce, distribute and manage ad hoc reports in accordance with Business area, State, and Federal specifications	Y	
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	
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	
A5.14	Maintain report distribution lists to ensure accurate report distribution at all times	Y	

RFP Req #	Requirement Description	Response Code (Y or N)	Vendor Response Comment(s)
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	

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	

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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	

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	
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	
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	
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	
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	
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	

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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	
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	
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	
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	
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	
I2.12	The Vendor will schedule staff training in a manner that is least disruptive to the normal business operations.	Y	
I2.13	The Vendor will provide instructions to the State on Vendor tools and procedures used to support the training.	Y	
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	
I2.15	The Vendor will assist the State in developing end-user training on the System business functionality.	Y	
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	
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	
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	
I2.20	The Vendor will create a training approach and needs analysis early in each project Phase which will determine the training requirements	Y	

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	

RFP Req #	Requirement Description	Response Code (Y or N)	Vendor Response Comment(s)
I3.6	The Vendor will repeat the test life cycle when a failure occurs at any stage of testing.	Y	
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.	Y	
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.	Y	
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	
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	

RFP Req #	Requirement Description	Response Code (Y or N)	Vendor Response Comment(s)
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 retesting before the System enters production. Moderate and Minor defects will be fixed and tested to the State' satisfaction prior to System acceptance.	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	

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 interfaces. - Interface tools	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	
I4.7	The Vendor will assist the State in identifying root causes for all System interface related problems.	Y	
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.	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	

RFP Req #	Requirement Description	Response Code (Y or N)	Vendor Response Comment(s)
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	
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 - Roll-back plan	Y	

RFP Req #	Requirement Description	Response Code (Y or N)	Vendor Response Comment(s)
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	

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	
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	
I5.9	f. Maintain internal quality control procedures for functionality and data integrity	Y	

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	
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	
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	
O1.14	All system communications will be protected by at least 128-bit encryption.	Y	
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	

RFP Req #	Requirement Description	Response Code (Y or N)	Vendor Response Comment(s)
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	

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.	Y	
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	
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	
P1.4	The maximum response time for a Dashboard report is 5 seconds, 95% of the time.	Y	
P1.5	The maximum response time for a Static Standard report is 5 seconds, 95% of the time.	Y	
P1.6	The maximum response time for a parameter-based report is 20 seconds.	Y	
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.	Y	
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	
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	
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.	Y	
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.	N	MMA will agree to an average Call Answering Time of 30 seconds or less. All calls entering the queue within the month will be answered by an agent within a monthly average of 30 seconds.
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	

RFP Req #	Requirement Description	Response Code (Y or N)	Vendor Response Comment(s)
System Availability and Response Times			
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	Y	
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	
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	
P1.18	99.9% of all prescription claims will be processed accurately.	Y	
P1.19	99.9% of all prescription claims will be processed accurately.	Y	
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	
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	

RFP Req #	Requirement Description	Response Code (Y or N)	Vendor Response Comment(s)
System Availability and Response Times			
P1.25	Provide an automated performance monitoring system to measure operational performance against defined Service Level Agreements and report results using a Scorecard.	Y	
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	
Account Management			
P1.29	85% of all calls are resolved within two business days of receipt	Y	
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.	Y	
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.	Y	
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.	Y	

Template I

Non-Functional Requirements Approach

Instructions for RFP Response

RFP # 03410-127-14

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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.

In Figure 1 below, MMA describes our approach to meeting the General System requirements in Template H.

Figure 1. Overview of MMA's Solution to Section 1.0

Template H Items Addressed by this Response	
Requirement Number	**Overview of MMA's Solution**
A1.1	MMA currently meets all State and Federal privacy and security regulatory requirements, including those within the HIPAA Security Rule and HITECH Act. We employ safeguards on several levels to prevent unauthorized use or disclosure of protected health information.
A1.2	MMA will provide a system user interface that is easy to read, user-friendly, and displays all data elements necessary for a user to perform his/her job function. Our Web Design Team has many years of experience in user interface and user experience design. Careful consideration is given to provide the most intuitive and user-friendly design possible, while also adhering to W3C standards and 508 guidelines. All of our beneficiary communications, including our system, are written at a 6th grade reading level. Most standard web browsers offer the user the ability to increase the size of the screen which will assist some visually impaired beneficiaries. In addition, we develop our sites with support for screen readers. Our sites do not use sound and, as such, will not provide a degraded experience to the hearing impaired.
A1.3	The core beneficiary portal and applications directly contained within it can accommodate English to Spanish translation. We are open to having discussions about translating the system into additional languages. All of our beneficiary communications, including our system, are written at a 6th grade reading level. The core portal allows beneficiaries to price a drug, search for a pharmacy or physician, look at their claims history, and view healthcare balances.
A1.4	MMA's pharmacy claims processing, prior authorization, drug rebate, data warehouses, customer service, and production support systems are available 24/7 unless stopped for planned maintenance activities. These services currently maintain availability of over 99.99%. Monthly system uptime reports are provided to the MMA account managers for review and for customer distribution.

Template H Items Addressed by this Response	
Requirement Number	**Overview of MMA's Solution**
A1.5	Each Medicaid beneficiary has his/her own unique ID number (identifier), which is linked to all other beneficiary alias IDs.
A1.6	We use the standard NCPDP dataQ 3.0 as a reference file in FirstRx™ for NPI numbers for pharmacy service providers. Provider information, including the NPI number, is loaded into the FirstRx™ POS system for use in the adjudication process, which can be linked to all/any other beneficiary alias IDs.
A1.7	MMA supports many methods of data exchange, including secure file transfer protocol (SFTP), file transfer protocol secure (FTPS), file transfer protocol (FTP) with PGP encryption, network data mover (NDM), EDI, real-time SOAP/XML exchanges, and many other forms of media, to interact with other systems.
A1.8	MMA has developed an Enterprise User Provisioning System that facilitates provisioning of users who work on behalf of providers, state offices, etc., so that each user has a unique ID when accessing web applications. This facilitates HIPAA guidance and supports non-repudiation and role-based access to ensure delivery of correct information to the users on a need-to-know basis.
A1.9	The system will provide the option to save and print based on user role and program role.
A1.10	MMA's application systems are developed and delivered to reduce the amount of redo typing whenever practical. For instance, the FirstRx user interface allows a user to enter data and flip between screens without retyping so the interface retains the in-process transaction data. However, prior to exiting the application a save prompt is issued and the user must select save or exit without saving.
A1.11	The system validates the mandatory data fields before information can be submitted.
A1.12	The system informs the user of errors on validation.
A1.13	The system allows the user to review and update information if there are correctable errors.
A1.14	The system will provide a help function, as well as links to additional help documentation.
A1.15	The system will provide help links from the web application to documentation based on destinations within PDF versions of the help documentation.
A1.16	MMA produces letters from our FirstTrax™ system when such a notification is appropriate, necessary and the recipient meets all privacy and security requirements.
A1.17	MMA will associate delivery methods with the preferences of beneficiaries and users. These data will then drive the method of communication used when a notification becomes necessary.

Template H Items Addressed by this Response	
Requirement Number	**Overview of MMA's Solution**
A1.18	MMA has developed an Enterprise User Provisioning System that facilitates provisioning of users who work on behalf of providers, state offices, etc., so that each user has a unique ID when accessing web applications. This facilitates HIPAA guidance and supports non-repudiation and role-based access to ensure delivery of correct information to the users on a need-to-know basis.
A1.19	MMA will provide role-based access to ensure delivery of correct information to the users on a need-to-know basis.
A1.20	The system will have user interface in English, free of any errors.
A1.21	The system will provide easy-to-understand interface and language for users. All of our beneficiary communications, including our system, are written at a 6th grade reading level.
A1.22	MMA will associate a language preference with individuals and use that data to drive language specific content on communications. MMA will work with the State to develop the language-specific content.
A1.23	MMA maintains audit trails on all systems that process sensitive information. All production application systems that handle sensitive MMA information generate logs that show every addition, modification, and deletion to such sensitive information. This includes all of the items listed in Requirement A1.23. We regularly back up all audits and management trails and store them in a secure location. Audit trails are used for individual accountability, reconstruction of events, intrusion detection, and problem identification.
A1.24	MMA maintains audit trails on all systems that process sensitive information. At a minimum, the event record specifies the type of event, when the event occurred (i.e., time and day), the user ID associated with the event, and the program or command used to initiate the event.
A1.25	MMA systems use industry standard taxonomy.
A1.26	MMA will provide general information in the web application without requiring a login.
A1.27	Those using MMA's system will access the system through a unique sign-on (ID and password).
A1.28	MMA's imaging solution supports OCR, ICR, and OMR capabilities; however, recognition accuracy is dependent upon several factors, such as image quality, data type, and data format. MMA believes that given the small volume of paper claims (anticipated to be less than one tenth of one percent) the Pharmacy Contractor can reasonably expect to receive, our solution for OCR, ICR, and OMR provides a cost-effective means for imaging, while satisfying the State's needs for a vendor capable of imaging documents through OCR, ICR, and OMR processes.
A1.29	We will give the State final authority to approve our hiring and firing decisions.

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'.

In Figure 2 below, MMA describes our approach to meeting the Interoperability and Integration requirements in Template H.

Figure 2. Overview of MMA's Solution to Section 2.0

Template H Items Addressed by this Response	
Requirement Number	**Overview of MMA's Solution**
A2.1	All systems activity, including user activity, is monitored in accordance with MMA IT Security policy. All deviations from accepted practices outlined in the policy are investigated and risks associated with these events will be mitigated accordingly.
A2.2	MMA has committed to using SOA and has implemented the Oracle Fusion Middleware SOA suite. In addition, MMA's strategy is to be compliant with the MITA Framework 3.0, which enables us to advance a robust integrated business and information technology between our systems and our partners. The Fusion Enterprise Service Bus orchestrates the exchange of data between applications, including the use of services that perform data look-up and retrieval. Our messaging capabilities include all those listed in Requirement A2.2.
A2.3	To help maintain the highest level of availability and to safeguard against a single point of failure for any critical operational component, the MMA Systems Infrastructure Team has employed industry best practices for all critical components. Specially trained, highly experienced system and network engineering staff actively manage and maintain the highly secure datacenter facility network operations center (NOC) 24 hours a day, 7 days a week, 365 days a year. Power, air temperature, humidity, fire, and water alarms are tied to the central management system within the NOC for immediate attention if necessary. All servers are protected by dual Uninterrupted Power Supply (UPS) systems capable of providing 48 hours of emergency power in addition to being backed by a 400 gallon diesel generator. Twenty security cameras strategically placed on the exterior and interior of the building and data center. Badge access required on every door and entry is authorized depending on the need of the employee. POS Server redundancy is handled by IBM's PowerHA technologies. Each of the Power 770 servers has a passive target server available for automated failover if the primary applications or database hosts incur a

Template H Items Addressed by this Response	
Requirement Number	**Overview of MMA's Solution**
	loss of service. System server settings and continuous monitoring and alerting will detect a loss of service and notify the technical teams if action is necessary. MMA has deployed EMC Corporation's BRS Time finder snap technologies to protect the critical application file system and database objects storage layers. This technology provides technical staff the ability to recreate the file system or operational data for a look back period of up to 48 hours. For added database redundancy we employ Oracle Dataguard to ensure rapid recovery of a failed database. The web applications are hosted on a collection of Oracle WebLogic servers, which sits on a VM Ware layer which is hosted by no less than six physical servers. The MMA networks provide redundancy for Internet facing connectivity as well as internal systems. Multi-Protocol Label Switching (MPLS) with redundant paths to ensure datacom bandwidth traffic is not under allocated. Redundant Checkpoint firewalls ensure incoming message traffic is not limited to a single entry point. Once inside the firewall MMA network traffics is controlled by Cisco's router's using host standby router protocol (HSRP).
A2.4	MMA has separate dedicated environments for development, QA, and production and we adhere to stringent and well-established change management and SDLC process for development, testing and roll-out. MMA currently supports numerous customers with high transaction volume and rapid processing times. Our infrastructure is scalable. The proposed adjudication system has been sized, and our technical staff has recertified the server's capacity, based on our current customer processing, to process up to 178,082 claims daily, 1.35 million claims per week, 5.416 millions claims monthly, and 65 million claims annually. MMA is widely recognized for delivering positive, measurable results in public-sector pharmacy benefit management. Our average weekly claim volume for our largest customer is approximately 1,450,000, or approximately 121,000 transactions a day. Below we have detailed some additional metrics regarding our current interfaces. • Customers supported: 22 • Total Number of Interfaces including Informatica, SAS and ODS: 730 • Average Total Monthly Enrollments: 31.9 Million • Average Total Monthly Claims: 16 Million. MMA currently supports the use of industry standard data exchange using industry leading tools, including Oracle Fusion, EDIFECS, and Informatica. These tools run on high performance AIX, Linux, and Windows servers that provide load-balancing, parallel processing, and concurrent file processing of all HIPAA/proprietary transactions. Our

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	environment is maintained and upgraded as needed to remain in compliance with all State and federal mandates. The environment is scalable and its architecture is designed for high performance in order to handle additional load.
A2.5	MMA's Software Development Team will work with Vermont SMEs to integrate with the ACCESS, HSE, and MMIS platforms. We use Oracle Fusion middleware to facilitate these batch and real-time interfaces. DIG is responsible for our Enterprise Service Bus, which is the portion of the middleware that has the responsibility of managing data interchanges.
A2.6	MMA is committed to the use of SOA within our product offerings. We use the Oracle Fusion SOA and Enterprise Service Bus for interfaces that are real-time in nature and require integration with other products/systems. We have successfully integrated with multiple third parties using these technologies. MMA also uses other technologies such as Informatica and PL/SQL to support batch interfaces depending on the volume, business logic, and amount of transformations.
A2.7	MMA has taken significant measures to ensure the validity and completeness of data as it moves through our systems and when exchanged via electronic means. Through the use of data quality controls, reconciliation processes, regular auditing, and other supportive measures, MMA ensures the appropriate mechanisms are in place to maintain data integrity. Additionally, MMA employs the Six Sigma philosophies, methods, and processes as the preferred method to solve problems, decrease errors, improve quality output, and improve communication between IT and the business users. We also apply the core concepts of ITIL® MMA builds data quality checks into all processes that touch data. Quality checks used to verify data integrity include comparisons against expected values, domain analysis, and comparisons to standard code sets/values. For reviewing data completeness, quality checks assess whether all data that came into the system were processed. The data quality checks record any data quality exceptions in standard tables to facilitate quality monitoring and reporting. MMA uses strict internal processes, procedures, and controls to maintain the quality and integrity of data received for and data conveyed to customers. MMA systems validate transactions at various control points through loads, audits, reconciliation processes, and cross-reference reports. Operations staff monitors process outputs and reports to validate data integrity. These procedural and automated controls operate at appropriate points throughout the cycle. MMA's standard data exchanges include the building of quality and monitoring measures using header, trailer, file counts, record counts,

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	totals, etc. whenever available. Header and trailer records are utilized to track the completeness of any feed. Record level edits track and report all data additions, deletions, and changes.
A2.8	MMA has adopted a strategy to be compliant with MITA Framework 3.0, which includes adoption and implementation of SOA. We consistently review the MITA principles to forward our advancement of integrated business and information technology within our systems and between us and our partners and vendors. In addition to MITA, our strategy commits us to meet the appropriate technology standards of our customers to ensure robust interoperability of our services.
A2.9	MMA will work with Vermont SMEs to integrate with the HSE using the Enterprise Service Bus within Oracle Fusion middleware. The capabilities of the Fusion Service Bus include the control of routing messages to services including resolving contention. In addition, our SOA environment contains components, including Fusion, to control the deployment and versioning of services.
A2.10	MMA's strategic commitment to SOA includes supporting approved W3C standards such as the use of WSDL to describe available service functionality. Important interface information contained in the WSDL includes the description of the service, port, binding, and data. The MMA development process can both produce and utilize WSDL files for use by consumers (MMA and partners) of services. WSDLs are currently in use by MMA with partners such as the states of New Hampshire and Florida.
A2.11	MMA has an organizational commitment to a SOA environment. This commitment means that services developed within the MMA environment comply with the W3C standards. To this end, MMA has integrated the industry-leading SOA suite developed and supported by Oracle Fusion. In addition, we use industry best practices for JAVA development.
A2.12	As part of our enterprise commitment to SOA, we have begun working on our SOA governance regimen, which is described in Template I, Section 2.0, Interoperability and Integration. As part of the governance control, we use a SOA registry. In keeping with our commitment to a standards-based SOA environment, the registry supports the UDDI specification to locate and invoke services as well as managing metadata. This UDDI Registry supports service classification through taxonomy. We are growing our governance regimen by employing the industry best practice SOA Governance Maturity Model.
A2.13	Our systems have the capabilities for a real-time Integrated Enterprise where common data elements are easily shared across organizational units. MMA adheres to Federal and State privacy standards such as HIPAA and MITA. Interactions are conducted on a secure site that uses 128-bit encrypted SSL. As part of our robust administrative, physical, and technical safeguards to protect the confidentiality, integrity, and availability of the electronic PHI, access to PHI data is provided based on the logged in user's role.

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A2.14	With our use of Oracle's Fusion middleware, we provide runtime synchronous and asynchronous communication among provider and consumer services. For example, we presently provide a synchronous interface through our portal to obtain drug pricing. Also, we presently provide an asynchronous interface with a Community Directed Health Plan (CDHP) to exchange pharmacy and medical claim data with a third party.
A2.15	In cases where we make a service available to an external entity, we define a canonical format for that data. Requests from consumers of the service that provide data in formats other than our canonical format go through a transformation in our Enterprise Service Bus before being forwarded for our standard processing. In this way, we get full reuse of our core functionality with the minimal effort of defining the transform from the client's format to our canonical format. Any additional transformation to our internal format is done further down the processing stack.
A2.16	Through our commitment to enterprise SOA, we are committed to information architecture. The information architects ensure that a canonical data model is developed and used for data so that we can efficiently perform necessary transformations. MMA leverages Oracle Fusion SOA stack for real-time and integration and also uses Informatica, PL/SQL for batch interfaces.
A2.17	Our enterprise commitment is to SOA, which means that point-to-point integrations are avoided wherever possible. Integration between endpoints is accomplished with the use of services and the Oracle Enterprise Service Bus.
A2.18	As part of our enterprise commitment to SOA, we have begun working on our SOA governance regimen, which is described in Template I, Section 2.0, Interoperability and Integration. As part of the governance control, we use a SOA registry and taxonomy. The taxonomy allows the classification of services which can include the required service categories, e.g., Presentation, Process, Business, Data, Access, and Utility.
A2.19	As part of our enterprise commitment to SOA, we have begun working on our SOA governance regimen, which is described in Template I, Section 2.0, Interoperability and Integration. We are growing our governance regimen by employing the industry best practice SOA Governance Maturity Model. Our governance regimen will adhere to industry best practices for processes and artifacts. Our enterprise architects and service designers will be creating artifacts that are compliant with the IEEE 42010 Architecture Template, which includes identifying stakeholders concerns, model used, operational views, rules, and examples.

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A2.20	As part of our enterprise commitment to SOA, we have begun working on our SOA governance regimen, which is described in Template I, Section 2.0, Interoperability and Integration. We are growing our governance regimen by employing the industry best practice SOA Governance Maturity Model. Our governance regimen will adhere to industry best practices for processes and artifacts. Our RACI matrix will include all stakeholders who are related to the SOA environment, e.g., developers, SOA engineers, administrators, Enterprise Architects, Business Leads, testers, etc. Our enterprise architects and service designers will be creating artifacts that are compliant with the IEEE 42010 Architecture Template, which includes identifying stakeholders and their concerns.
A2.21	MMA's strategic commitment to SOA includes supporting approved W3C standards such as the use of WSDL to describe available service functionality. The MMA development process can both produce and utilize WSDL files for use by consumers (MMA and partners) of services. WSDLs are currently in use by MMA with partners such as the states of New Hampshire and Florida.
A2.22	Presently, all SOAP-based services are defined by XSDs. As part of our enterprise commitment to SOA, we have begun working on our SOA governance regimen, which is described in Template I, Section 2.0, Interoperability and Integration. We are growing our governance regimen by employing the industry best practice SOA Governance Maturity Model. As part of the maturity level 1 of the Service Foundation Levels, we will be implementing a SOA Architecture Repository.
A2.23	Presently, our services are developed in JAVA.
A2.24	Our SOA environment includes Oracle Fusion, which supports the OASIS standard version 1.1 of the WS Reliable Messaging Protocol to ensure the delivery of messages between two web services.
A2.25	As part of our enterprise commitment to SOA, we have begun working on our SOA governance regimen, which is described in Template I, Section 2.0, Interoperability and Integration. As part of the governance control, we use a SOA registry and taxonomy. This will enable metadata attributes to be assigned and tracked for all services. Such metadata can include the required attributes such as name, lifecycle status, class, description, owner, version, deprecation policy, SLA, etc.
A2.26	As part of our enterprise commitment to SOA, we have begun working on our SOA governance regimen, which is described in Template I, Section 2.0, Interoperability and Integration. As part of the governance control, we use a SOA registry and taxonomy. The metadata can include the service's SOA Lifecycle Status, which can include the required values, e.g., Candidate, Justified, Defined, Designed, Implemented, Operational, and Retired. In addition, a SOA Architecture Repository can be available to the Vermont Enterprise Architects.

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Requirement Number	**Overview of MMA's Solution**
A2.27	As described in our response to Template I, Section 2.0, Interoperability and Integration, a SOA service is subject to a robust, governed SOA Life cycle that includes several managed phases. The phases include analysis, design, development, testing, and deployment. The cadence and environment in which each effort is performed for each of these phases is determined by the approved project plan. MMA agrees to the required cadence and the performance of activities in the required environments. We confirm that the system will undergo at least 2 iterations integrated with an HSEP development environment and each will have a maximum of 10 days.
A2.28	Oracle Fusion provides support for reliable once-only delivery of messages to web services. This capability is dependent on the protocol that the message uses. In the case of SOAP over HTTP, Fusion supports the WS-Reliability protocol to guarantee non-duplicative message delivery. In the case of JMS, Fusion guarantees message delivery by using persistent messaging by the JMS provider.
A2.29	Oracle Fusion has the components that provide B2B capability including EDI. Our Oracle SOA and Enterprise Service Bus support the HL7 data exchange. In addition, we use the Enterprise Service Bus to manage interactions as needed. MMA will work with the State to design the most cost-effective way to implement the desired B2B functionality. Specifically for our integrated health programs, we provide a series of web-based tools for use by beneficiaries, providers, community service workers, and others as appropriate and in accordance with privacy regulations and the beneficiary's permission. The overall objective of these unique tools is to facilitate the exchange of important clinical, lifestyle, and related information among all participants in the beneficiary's care. One example of these tools is the fact that MMA has developed a means to support the exchange of HL7 continuity of care documents (CCDs), which are the providers' electronic health records produced under international, HIE standards. While many states are working on systems for exchange, our technology facilitates information sharing in the meantime, even with providers in the network who are not yet ready for their own EHR.
A2.30	Oracle Fusion provides robust enterprise-level support of applications. The Oracle Fusion Middleware ensures high-quality service, security, efficient system management. The MMA SOA infrastructure has been architected for high-availability to ensure service reliability and availability. This infrastructure includes load balancers to ensure that the system responds to changes in demand. High-availability and Failover testing will be included in the test plan and complete prior to releasing the system to UAT.

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Requirement Number	**Overview of MMA's Solution**
A2.31	As part of our enterprise commitment to SOA, we have begun working on our SOA governance regimen, which is described in Template I, Section 2.0, Interoperability and Integration. As part of the governance control, we use a SOA registry. The registry will contain metadata that can be used to control the SOA environment, particularly the Enterprise Service Bus, so that it will locate and bind with the appropriate service. We are growing our governance regimen by employing the industry best practice SOA Governance Maturity Model. We are improving our maturity level among the Service Foundation Levels and are evaluating tools to automate SOA control processes so that there is a single holistic control point for the SOA environment.
A2.32	Our environment is built using Oracle Fusion Middleware, which supports the required protocols including WS-I, SOAP, WSDL, REST, HTTP, and XHTML. As part of the governance control, we use a SOA registry, which can provide UDDI support within the environment.
A2.33	The MDS facility of Oracle Fusion enables the end-to-end tracking of messages. The end-to-end logging of messages is server and database intensive and can be the source of performance issues. Therefore, the industry best practice is to enable this capability selectively for mission-critical services. Our infrastructure SMEs will work with Vermont to determine when logging is appropriate and configure the SOA environment appropriately.
A2.34	Our environment is built using Oracle Fusion Middleware, which supports the required protocols including TCP/IP, HTTP, HTTP/S, and SMTP. In addition, Fusion supports RMI and IIOP.
A2.35	Our environment is built using the Oracle Fusion SOA and Enterprise Service Bus. This industry-leading, standards-based middleware enables the robust integration of applications, data sources, and services within the our enterprise and those of partners and approved third parties. Oracle's middleware provides support for most technologies including databases and messaging. Our enterprise commitment to SOA enables the seamless integration with applications as point-to-point integration is transformed to a service interfaces that are consumed where needed. In this way, changes in end-points are isolated by the services and the enterprise seamlessly evolves to meet emerging needs.
A2.36	As part of our enterprise commitment to SOA, we have begun working on our SOA governance regimen, which is discussed in Template I, Section 2.0, Interoperability and Integration. As part of the governance control, we use a SOA registry. The registry contains metadata that can be used to control the SOA environment, particularly the Enterprise Service Bus so that it will locate and bind with the appropriate service. We are growing our governance regimen by employing the industry best practice SOA Governance Maturity Model. We are improving our maturity level among the Service Foundation Levels and are evaluating tools to automate SOA control processes so that there is a single holistic control point for the SOA environment.

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Requirement Number	**Overview of MMA's Solution**
A2.37	Oracle Web Services Manager (OWSM), which is included in the Oracle Fusion SOA suite, provides a robust framework for the management and security of web services within the MMA environment. OWSM provides policy management and monitoring. Oracle has a commitment to supporting web service interoperability. Therefore, OWSM supports the Web Services Interoperability Organization Basic Security Profile Standards, SSL, and XML Encryption.

MMA'S INTEGRATED PHARMACY SOLUTION FOR VERMONT

In Figure 3 below, MMA provides a diagram that illustrates the design of our proven pharmacy solution proposed for Vermont, including the relationship between the key components.

Figure 3. MMA's Pharmacy Solution System Architecture Model

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APPROACH TO INTEGRATION AND OPERABILITY

MMA uses a SOA approach to transform existing enterprise solutions to web services. SOA components use web services to improve system interoperability based on key business drivers and guidance from CMS through its MITA initiatives. We will leverage these technologies along with the guidance of our internal Enterprise Architecture and Solutions Group (EASG) and IT Leadership Team. We are continually evolving our solutions to meet the needs of our customers and to facilitate interoperability with our business partners.

For solutions that are not already SOA-enabled, MMA adheres to a set of architectural principles that allow us to incrementally migrate systems to SOA and web services without placing systems or customers at risk. Our current service-enablement practices, coupled with our use of ESB Architecture, will allow services to be connected through the State's ESB and to be securely used by the State, where applicable. With SOA and interoperability as key drivers, MMA supports the necessary security standards and practices to deliver functionality securely. Our SOA-enabled systems can support Single Sign-On (SSO), Transport Level, and Message Level security models. Additionally, we have developed an Enterprise User Provisioning System that facilitates provisioning of users who work on behalf of providers, state offices, or other stakeholders, so that each user has a unique ID when accessing web applications. This facilitates HIPAA guidance and supports non-repudiation and role-based access to ensure delivery of correct information to the users on a need-to-know basis.

The MMA application platform is built using open architecture and data standards. Our Business Services, Technical Services, Web Services, Portal, Enterprise Service Bus, Data integration, Electronic Data Interchange (EDI), Data services, Application Databases, Operational Data Stores (ODS), and Enterprise Data Warehouse (EDW) provide a complete interoperable solution. Our solution is both flexible and scalable to seamlessly integrate with State systems and technical environments of all trading partners. MMA uses industry standard LAN and WAN hardware to support robust network connectivity between key platforms and external partners.

Cisco and Check Point firewalls are examples of key infrastructure solutions utilized to support a fully redundant, reliable, and highly available network platform for support of our applications.

As an industry leader, MMA continually researches hardware, software, and methodologies to improve our own data center, development efforts, and operations. The Enterprise Architecture Steering Committee, comprised of members of the application development, data architecture, and security and infrastructure engineers, oversees the research, assessment, applicability, business case, and acquisition of all MMA software, and coordinates Strategic Business Unit acquisition and installation. Our architecture team meets on a regular basis to ensure our tools, technologies, and infrastructure are providing cost-effective solutions to our customers.

One example of MMA's many partner integrations is with electronic pharmaceutical prescribing through the Surescripts network, the Nation's E-Prescription Network. This partnership supports data, through which benefit information, including eligibility, insurance coverage, formulary, and prescription history, is transmitted electronically from a pharmacy benefit manager/administrator to a prescriber at the point of prescribing, and through which prescription information is transmitted electronically from a prescriber's office to the pharmacy of a beneficiary's choice. Surescripts supports hundreds of EMR vendors and is a leader of e-prescribing in U.S. retail pharmacies. MMA follows MITA SOA principles by incorporating web services design that uses Enterprise Service Bus Architecture as its foundation to integrate with other entities. Our ESB application layer allows us to create system integration packages with more standardization. We have successfully used the ESB approach when we delivered an integration solution between our provider management system and our business partners' MMISs to asynchronously deliver provider updates in real time. The ESB provides enhanced functions to validate, transform, and enhance data or messages that pass through it on a SOA platform.

IMPLEMENTING COMMON INTEROPERABILITY

MMA is committed to the transformation of existing enterprise solutions to web services to improve delivery using a service-oriented architecture (SOA) approach. SOA components use web services to improve system interoperability based on key business drivers and guidance from CMS through its MITA initiatives. We will leverage these technologies along with the guidance of our internal Enterprise Architecture and Solutions Group (EASG) and IT Leadership Team. We are continually evolving our solutions to meet the needs of our customers and to facilitate interoperability with our business partners.

MMA's SOA Goal

The goal of Service Oriented Architecture (SOA) governance is to ensure that services provide direct advantages to the business, provide

measureable business value, and are consistent with our enterprise architecture.

For solutions that are not already SOA-enabled, MMA adheres to a set of architectural principles that allow us to incrementally migrate systems to SOA and web services without placing systems or customers at risk. Our current service-enablement practices, coupled with our use of ESB Architecture, will allow services to be connected through the State's ESB and to be securely used by DVHA, where applicable. With SOA and interoperability as key drivers, MMA supports the necessary security standards and practices to deliver functionality securely. Our SOA-enabled systems can support Single Sign-On (SSO), Transport Level, and Message Level security models. Additionally, we have developed an Enterprise User Provisioning System that facilitates provisioning of users who work on behalf of providers, state offices, and others, so that each user has a unique ID when accessing web applications. This facilitates HIPAA guidance and supports non-repudiation and role-based access to ensure delivery of correct information to the users on a need-to-know basis.

It is the purpose of our governance to define clearly what decisions will be made so that SOA can be effectively managed, who will make these decisions, and how the decisions will be made. Our SOA governance processes include monitoring of the SOA artifacts and adherence to SOA policies; however, governance does not include the management of the SOA lifecycle - governance defines and influences it. As shown in Figure 4. SOA Governance Program Guiding Principles, SOA governance extends and uses our existing governance and is a component of our organization-wide governance.

SOA Governance Components

Guiding Principles

Our SOA Governance program is informed by a set of principles by which the elements of the program are decided and evolve. These Guiding Principles are described in Figure 4 below.

Figure 4. SOA Governance Program Guiding Principles

Principle	Reason

Governing Processes

The governing processes are those that the organization uses within its governance regimen. These processes comprise the governance activities of communication, compliance, and dispensation.

Communication

The purpose of the communication governing activities is to provide information about the SOA policies, standards, and guidelines throughout the organization. The purpose of a communication process is to educate and engender support for the SOA regimen by fostering understanding of SOA governance and providing access to the organization's SOA information.

Compliance

These ongoing processes ensure that the SOA standards, guidelines, and policies are abided by and followed. Where practical, these activities are an extension of existing governance compliance processes and include the review, approval, and rejection of SOA artifacts based on criteria established within the SOA governance regimen.

Artifacts found not to be in compliance result in an exception that is evaluated to determine the feasibility of aligning the artifact with the SOA governance regimen. When it is determined that it is not feasible to correct the exception, the resulting risk (e.g., increased cost, implementation delay, security vulnerability, etc.) should be determined and evaluated against established organizational risk standards.

Dispensation

The dispensation processes provide the mechanism to review and determine action on exceptions uncovered in the compliance processes. Similar to the compliance processes, the SOA dispensation processes extend the existing organization dispensation processes. The major dispensation activities reach one of the following decisions:

- **Acceptance -** The exception is permitted for a specified period and may require specific interim remedies
- **Remediate -** The exception must be remediated before proceeding with the artifact

Additional dispensation activities include:

- **Appeal -** Re-evaluation of the exception
- **Escalate -** Invocation of higher-level governance processes to review the exception
- **Vitality -** Re-evaluate the governance regimen because of an excessive number of exceptions, acceptances, appeals, or escalations.

Governed Processes

The governed processes are those planning, implementation, and operations processes to which the SOA governance regimen apply. These governed processes can pertain to organizational solutions and services. These governed processes make use of the SOA standards, guidelines, policies, and processes while the SOA governing processes provide continuous monitoring and enforcement within the governed processes.

The planning processes include the solution and service portfolio management processes, which prioritize and manage the artifacts within the solution and SOA lifecycles, respectively. Figure 5 below shows the SOA lifecycle; the solution lifecycle is not shown but is similar to the SOA lifecycle.

Figure 5. SOA Governance and Lifecycle Model

The phases of the lifecycle are model, build, deploy, monitor, and retire. These phases are briefly described below.

Model - The desired artifact is analyzed and designed. These processes ensure that from the onset the artifact complies with the appropriate governance standards, guidelines, and policies.

Build - The desired artifact is created and validated in compliance with the appropriate governance standards, guidelines, policies, and processes.

Deploy -	In accord with the applicable governance standards, guidelines, policies, and procedures, the artifact is made available for appropriate use by the organization.
Monitor -	The artifact is continuously monitored to ensure that its use and performance comply with the applicable governance standards, guidelines, and policies.
Retire -	Once the artifact no longer satisfies organization goals and objectives (e.g., deemed obsolete by portfolio management, superseded, deemed non-compliant by governance, etc.) it is removed from use by the organization in accordance with the applicable governance standards, guidelines, policies, and processes.

Artifacts

SOA artifacts are entities created and maintained to support the SOA governance regimen. The artifacts are available to stakeholders and kept current so that stakeholders can always be aware of the current governance regimen. There are a number of categories of artifacts including business, organizational, descriptions, standards and policies, and processes.

Business	The SOA governance guidelines, vision, and scope.
Organizational	The SOA governance organization structure and the roles and responsibilities.
Descriptions	Describe solutions and services including their purposes, service description, interfaces, schemas, etc.
Standards and Guidelines	The organizational SOA standards and guidelines to be used for design, implementation, and use of SOA artifacts.
Policies	The policies and metrics for monitoring SOA governance.
Processes	The description of the SOA governance processes for communication, compliance, and dispensation.

Systems Activity Audit/Monitor

All systems activity, including user activity, is monitored in accordance with MMA IT Security policy. All deviations from accepted practices outlined in policy are investigated and risks associated with these events will be mitigated accordingly.

Figure 6 below shows an example of the three-tier identification and authentication access control point diagram. Access controls and auditing is available at all tiers, as well as the tier transitions as depicted in the following diagram.

MMA utilizes Oracle Audit Vault Technology (storing and reporting on data access activities) for our highly secure database systems and for customers requesting additional audit capabilities. The audit vault allows for custom auditing and alerting of database access. Processes are in place to sample data access and update activity. If a database object is accessed or updated, a record is made. Periodically, these records are sent to the Audit Review Team and the team takes a sampling of the data access or changes made and they are compared to the change management system list of changes.

Figure 6. Access Control Points Diagram

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DATA SECURITY

The key to data security is identity management. The data security layer is depicted in Figure 7 below as the red block within MMA standard identity management framework. The database security framework is controlled through processes and database profiles. Security request and approval processes must be completed before access is granted to a database. Once the approvals are granted, the DBA Team or Security Team will create the necessary account and ensure the appropriate profiles are initiated. The profiles assigned to users are provided a 60-day password life, and service accounts are granted a one-year password life. Service account approvals require Vice President signatures and user accounts require the immediate manager approvals.

Processes are in place to sample data access and update activity. If a database object is access or updated, a record is made. Periodically, these records are sent to the audit review team and the team takes a sampling of the data access or changes made and they are compared to the change management system list of changes. The diagram in Figure 7 below is a standard information identity framework.

Figure 7. MMA Standard Identity Framework

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SAFEGUARDING AGAINST SYSTEM FAILURE

To help maintain the highest level of availability and to safeguard against a single point of failure for any critical operational component, the MMA Systems Infrastructure Team has employed industry best practices for all critical components.

Figure 8. System Redundancy

System Components	Built-In Redundancy for Operations with Minimal Disruption 24/x7 Availability
Data Center	
Application Servers	
Database Servers	
Telecommunications	
Network	
Storage	

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'.

In Figure 9 below, MMA describes our approach to meeting the Regulatory and Security requirements in Template H.

Figure 9. Overview of MMA's Solution to Section 3.0

Template H Items Addressed by this Response	
Requirement Number	**Overview of MMA's Solution**
A3.1	We are compliant with all Federal and State laws and regulations. Compliance with security requirements and safeguard requirements of federal agencies includes encryption of data at rest on servers, which is currently under advisement and being explored by our IT Operations Management Team. The FISMA requirements generally include a certification and accreditation process which we are willing to consider if required by the customer.
A3.2	We will conform to the sub-parts of Section 508 of the Americans with Disabilities Act (ADA). This is a regular part of MMA's business practice.
A3.3	Our system will comply with all State security policies, statutes, and regulatory requirements. In addition, we are compliant with all Federal laws and regulations which are often more stringent then State laws.
A3.4	MMA currently maintains security controls in accordance with Federal and State security policies and regulations. We will maintain these controls throughout the life of the contract.
A3.5	MMA complies with the requirements of Enforcement of Nondiscrimination on the Basis of Handicap in Programs or Activities conducted by DHHS.
A3.6	We will comply with branding standards as defined by the State.
A3.7	The principle of "Fail Safe" is a part of MMA's standard operating procedures.
A3.8	Web and data accessibility will be implemented based on user-defined roles.
A3.9	Our secure systems ensure that we are compliant with this requirement.
A3.10	The MMA Pharmacy Solution supports concurrent access to all system artifacts for those who have sufficient authorization to view that data, template, or document.

Template H Items Addressed by this Response	
Requirement Number	**Overview of MMA's Solution**
A3.11	The MMA pharmacy solution supports concurrent data access. This is accomplished through passive record locking (also known as optimistic locking). Passive locking avoids the issues of lockout and deadly lockout embrace. A last updated timestamp column is included in a table. The value of the timestamp is checked prior to updating the row. If it has changed since the row was read, an update error is returned. Otherwise, the record is updated and the timestamp is automatically adjusted. This widely used best practice (and the default behavior in Oracle databases), enables MMA to scale and support a large number of concurrent users.
A3.12	To prevent data loss from a system failure, MMA employs best practices for logging and backing up our database systems using COTS proven products and technologies. MMA transactions recorded in the databases are also recorded as database redo-logs and archived off periodically to the servers and then picked up during the daily backups. The Oracle databases and archive logs are backed up through Oracle's recovery manager (RMAN) to EMC Data Domain Servers and Symantec NetBackup's media management layer. Recovering a lost database to the last recorded transaction is accomplished using RMAN and restoring database files and recovering through incremental backups and applying the last archived or redo-logs. The SQL Server database and system change logging are backed-up through NetVault LiteSpeed to Symantec NetBackup's media management layer. Recovering a lost SQL Server database to the last recorded transaction is accomplished using LiteSpeed and restoring database files and recovering through the last archived logs. To prevent data corruption during a loss of operations, data integrity is controlled at both the database and application layers. In many instances, foreign key constraints are created on the physical data model to ensure the physical design is not compromised. The application layer controls referential integrity in instances where business logic determines the data relationship among the stored records. Essentially in-flight transactions are not committed until all integrity is checked and validated in the database this reduces the likelihood of corrupted data entering or getting saved to a database.
A3.13	MMA's systems comply with all industry standards applicable to health care, focusing on privacy and security of beneficiary PHI data. Our Compliance, Security, and Internal Audit Departments ensure that all systems are in compliance with HIPAA requirements and CMS standards, as well as with Sarbanes-Oxley (SOX) requirements and SSAE 16 SOC 1 auditing standards. Audits are conducted to evaluate the system's internal control design and effectiveness. This includes, but is not limited to, efficiency and security protocols, development processes, and IT governance or oversight.

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Requirement Number	**Overview of MMA's Solution**
A3.14	MMA has taken a multi-layered approach to security based on the International System Security Certification Consortium (ISC2) — the international standard for IT security — and the National Institute of Standards and Technology (NIST). MMA's Security Department has the task of ensuring that beneficiaries' health information is protected as it rests in our systems and when it is exchanged via electronic means. To address this, we have implemented technical, physical, and administrative safeguards to enhance physical security, personnel security, and information systems security. Our methods provide perimeter protection, segregated operations, business, and administrative architectures, and extra protective measures associated with our web presence. MMA also monitors all of these interfaces to identify inappropriate or unauthorized activity including network traffic, email, and attempts to connect to our systems. A traditional DMZ (de-militarized zone) structure is in place to support our e-commerce needs and is monitored via a state of the art managed intrusion detection systems provided by an external organization to ensure quality of service. The IDS service is monitored 24/7/365 by IBM Security Services, who specializes in incident response and intrusion detection capabilities for many corporations world-wide. MMA employs the latest technology standards and equipment regarding the protection of the critical internal infrastructure. All firewalls are placed, monitored and managed by qualified, dedicated MMA personnel. All perimeter protection equipment is installed, patched, and maintained in accordance with manufacturer standards and best security practices to ensure best possible protection. Some of the methods MMA employs around data encryption include: • Secure data exchanges (e.g., SSH, SFTP, FTP with PGP encryption, etc.) • Desktop and Laptop Hard Drive Encryption • Encryption of backup media (tape) • Secure email exchanges via the Internet using Cisco Ironport • The ability to write to removable storage devices such as flash drives and DVD/CDROM media has been disabled on endpoints • All WAN connections are encrypted to industry standards • All MMA internet facing sites incorporate the usage of SSL v3.0 and/or TLS 1.x. In rare cases where removable storage devices are used, all data written to removable media are encrypted with the AES cipher utilizing a minimum 128-bit key. Encryption is provided via a hardware

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	implementation in the removable media device or via a software solution on the computing device being used to write the data to the removable storage device.
A3.15	This is a standard business practice and we are compliant. Our system supports pre-login capabilities and will display a warning banner when a user is attempting to access PHI.
A3.16	MMA has corporate policies and procedures regarding the use of PHI which are updated on a consistent basis. MMA holds the privacy of beneficiary information as a key tenet of our operations and processes. We implemented policies and procedures for confidentiality that met or exceeded existing state and federal regulations. Our many existing policies detailing compliance with HIPAA (including the HITECH Act) and other privacy-related requirements include: • General Rules for Uses and Disclosures of PHI (Protected Health Information) • Uses and Disclosures of PHI for Treatment, Payment, and Health Care Operations • Oral and Written Transmission of PHI • Beneficiary Right to Request Privacy Protection of PHI • Beneficiary Right to Request Access to PHI • Beneficiary Right to Request Amendment of PHI • Beneficiary Right to Request an Accounting of Disclosure of PHI • Verification Policy • Beneficiary Representation • Notice of Privacy Practices • Minimum Necessary Uses and Disclosures of PHI • Uses and Disclosures of PHI Requiring No Permission From the Beneficiary • Uses and Disclosures of PHI for Marketing, Fundraising, and Underwriting • Uses and Disclosures for Specialized Government Functions • Uses and Disclosures of PHI Requiring Prior Internal Approval • Uses and Disclosures of PHI for Judicial & Administrative Proceedings • Limited Data Set and De-Identification of PHI

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	• Unauthorized Uses and Disclosures of PHI. For example, these policies touch on the following areas of confidential communications, accounting of disclosures, right of access and disclosure and transaction sets:
A3.17	We have completed all of our CMS certifications successfully, with "no findings or follow up action items required" using the most current MECT checklist version at the time of certification.
A3.18	Upon learning of any unauthorized breach/access, theft or release of DVHA data containing Identify Information, MMA shall immediately notify DVHA and any required agencies according to the terms of the Business Associate Agreement in place as a result of the contract. To date, MMA has never had a security breach with our customers' data. We will work with the State to mitigate any breaches and perform corrective actions to prevent future unauthorized uses or disclosures.
A3.19	Compliance will be governed by contract and/or BAA language.
A3.20	MMA will immediately notify the State of any breach of system or data security. We agree to undertake safeguards recommended by an independent security auditor.

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A3.21	MMA's systems are built with security frameworks and protocols that ensure the sensitive healthcare data in which we act as stewards is tightly guarded and protected from inappropriate access or use. The security solutions on which our information systems depend have been carefully chosen to align with industry expectations, not just regulatory requirements, and enable our security operations to safeguard against any potential misuse of the sensitive data that may reside in any information system or data repository. The MMA Data Architect Team maintains and publishes a list of database objects, file interfaces and servers that process PHI/PII. At every new implementation or system design session, the data architect team ensures the design applies identity protection rules and secured access controls relating to: a- Names: Beneficiary names, family members, and beneficiary proxy b- Geographic Location: Anything smaller than a country c- Contact information: Email Addresses, passwords, Phone Numbers d- Other identifiers: SSN, Driver License, credit card information e- Date of Birth: All but year is masked. To facilitate the detection of unauthorized access, MMA utilizes Oracle Vault auditing for highly secure database systems and for customers requesting additional audit capabilities. The audit vault allows for custom auditing and alerting of database access. Processes are in place to sample data access and update activity. If a protected database object is accessed or updated, a record is made. Periodically, these updates are sent to the Audit Review Team, and the team takes a sampling of the data accessed or changes made and the compare them to the Change Management system list of changes.
A3.22	Compliance will be governed by contract and/or BAA language.
A3.23	User authentication will meet contractual requirements or MMA policy, whichever is stronger.
A3.24	This practice is in place in compliance with the Information Technology Security Policy. MMA employs an automatic log-off process on all workstations, which will automatically blank the screen and suspend the user's session if there has been no activity on a computer terminal, workstation, or microcomputer for 15 minutes. Users must re-enter the unique sign-on (ID and password) in order to regain access after a session has expired.

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A3.25	This practice is in place in compliance with the Information Technology Security Policy. All MMA computer systems handling sensitive information securely log all significant security relevant events such as: password guessing attempts; attempts to use unauthorized privileges; authorized or unauthorized modifications to production application software; authorized or unauthorized modifications to system software; and attempts to modify or disable logging. To prevent password guessing attacks, the number of consecutive attempts to enter an incorrect password is limited. After six unsuccessful attempts to enter a password, the involved user ID is disabled until it can be reset by a system administrator.
A3.26	All Database Administrators' system access, including access to sensitive data, is audited and transmitted automatically to a central Audit Vault repository. MMA Auditors have access to this repository and run regular reports against it. This arrangement allows the database administrator to perform a wide variety of tasks including export/import of schema, performance tuning etc. while being audited for access to sensitive data. In addition, the Database Vault has the capability to prevent a database administrator from being able to view the data within the database.
A3.27	MMA supports grouping users by functional departments.
A3.28	The system will be able to provide this listing.
A3.29	The system will be able to meet contractual requirements for external provider access and information exchange.
A3.30	Access to information is segregated by user authorization groups.
A3.31	The System will restrict access to summarized information according to organizational policy, scope of practice, and jurisdictional law. MMA has consistently followed our security organizational policies, scope of practice and jurisdictional law to ensure access is restricted and monitored accordingly.
A3.32	Permissions with a user are based on Role-Based Access Controls (RBAC), users are grouped by role and access rights assigned to these groups.
A3.33	MMAs role-based security methods allows the Security Team, System Administrators, and Database Administrators to assign appropriate security roles to users requiring access to our systems. Application users must complete an Access Request Form when needing access to a specific application. The form is routed to his or her manager for approval and then through the MMA Security Team to complete the user creation action. IT staff requesting access to servers or databases must complete an Information technology user access request form. This form is also routed through the requestor's manager and then to the server or database manager for approval and appropriate access and role assignments. After the technology manager's approval, the administrators can complete the user creation actions. These workflow processes is in place to prevent unauthorized users or groups from accessing confidential information such as a beneficiary's SSN, medication information, PHI, and

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	other confidential data.
A3.34	Permissions with a user are based on least privileged.
A3.35	If required in an emergency and according to the language in the customer contract, this request could be honored.
A3.36	If required in an emergency and according to the language in the customer contract, this request could be honored. However, we can provide an audit trail.
A3.37	Permissions with a user are based on least privileged.
A3.38	Authorized administrators can assign privileges within the approved authorization process.
A3.39	MMA will ensure that only logical deletions from systems occur. The MMA security team periodically reviews system access and will disable accounts that have not been active for at least 60 days. Since many audit reporting systems require the user identity to be clear, actual removal of the account is disallowed. However, once an account is marked as logically deleted, all access approval steps must be taken to reactivate the account.
A3.40	MMA complies with ANSI healthcare permissions for RBAC.
A3.41	MMA complies with ANSI healthcare permissions for RBAC.
A3.42	Our system prohibits the creation of multiple, identical beneficiary IDs as a method to curb duplicate logins. This is done according to the Information Technology Security Policy outside of the "location-specific session timeout" feature. MMA employs an automatic log-off process on all workstations, which will automatically blank the screen and suspend the user's session if there has been no activity on a computer terminal, workstation, or microcomputer for fifteen minutes. Users must re-enter the unique sign-on (ID and password) in order to regain access after a session has expired.
A3.43	Our system has the ability to perform administration functions such as reference table maintenance and adding/ removing users. This is a normal business practice.
A3.44	Our system will allow access to users based on their roles, irrespective of their location.
A3.45	MMA has the capability to integrate with existing authentication and authorization mechanisms. We currently do this with MMIS vendors in two states. **Single Sign-on** Single Sign-on (SSO) allows a user to sign in once and gain access to all of the available applications without having to sign into each one of them individually. The MMA web portal offers SSO as a way of providing a seamless user experience and securing the applications and functions that are aggregated for the user through the portal. We have supported SSO implementations with outside vendors for a number of years

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	successfully. We integrate authentication and authorization using industry standards such as SAML. In addition, our portal solution features role-based dynamic content that can be customized to alert users of updates, changes, and new functionality upon login.
A3.46	MMA will ensure the creation of temporary and emergency accounts are provided in the security team operating procedures. It is not uncommon that emergency temporary access is needed by users in order to complete a time sensitive task. In most cases the emergency access request goes through a reduced approval workflow for the immediate need at hand will then post action approvals and notations are obtained to complete the security auditing compliance tasks. If the required access is defined as temporary in nature, the account lifetime will be obtained during the post action approval process and added to the account profile.
A3.47	MMAs role-based security methods allows the Security Team, System Administrators, and Database Administrators to override a role and restrict access to information by users or groups of users. It allows them to create appropriate security roles and assign users requiring access to our systems. Roles are defined to ensure only the minimum amount of access is assigned to a user to effectively complete his or her work assignments. Security processes for role definition changes are in place and are available to the Security Team, System Administrators and Database Administrators in the event a role must be altered or further restricted or if a user must be reassigned a specific role based on job duty changes.
A3.48	The IDS service is monitored 24 hours a day, seven days a week, 365 days a year by IBM.
A3.49	All systems activity, including user activity, is monitored in accordance with policy. The system can produce a report on user activity and inappropriate access. All deviations from accepted practices outlined in policy will be investigated and risks associated with these events will be mitigated accordingly.

MMA currently meets all state and federal privacy and security regulatory requirements, including those within the HIPAA Security Rule and HITECH Act.
We employ safeguards on several levels to prevent unauthorized use or disclosure of protected health information in our possession which include, but not be limited to, the following measures:

- Documented Privacy and Security Policies and Procedures
- Platform and technology specific logins and passwords
- Privacy and Security training
- Documented Disaster Recovery Plans, Business Continuity Plans, Data Security Plans, and Emergency Backup and Recovery plans
- Confidentiality language in each employee's Agreement Regarding Employment.

Our Corporate Compliance Director is responsible for ensuring that employees are aware of, and adhere to, the provisions of our HIPAA privacy and security policies and procedures.

Our Security Policies and Procedures are documented and available to all employees.

MMA Security

Strict workforce adherence to MMA's HIPAA privacy and security policies and procedures is vital to ensure the protection of protected health information and confidential information. Our employees must comply with the Privacy and Security Compliance Program, including all privacy and security policies and procedures.

Our workforce is trained upon employment and annually in Corporate Compliance. The training modules include privacy, security, and fraud and abuse. All employees are also required to receive MMA Compliance Training upon employment and annually thereafter.

In the event we have Teaming Partners or Subcontractors, our Business Associates Agreement requires they follow the requirements set forth by HIPAA and HITECH for work performed on behalf of MMA or our customers. Annual training ensures employees receive the most current information, legislative initiatives and requirements, and a refresher training of current mandates.

Our Privacy and Security policies and procedures are reviewed a minimum of once every two years and as necessary, and pursuant to changes in federal or state regulation or when a change to business operations impacts policy or procedure.

Our approach to security includes workforce policies and procedures to address authorization procedures that will meet the requirements of the "Minimum Necessary" rule of HIPAA, the Separation of Duties requirements of Sarbanes-Oxley (SOX), as well as the "Principle of Least Privilege", an industry-standard security best practice.

Our HIPAA policies fully document the operational requirements for our workforce to ensure the protection of system software files and libraries and applications. All users must follow the documented Security Access Request and Approval process.

Authorized users have access to and use only the minimum necessary PHI reasonably needed to perform the workforce member's duties for the company. No retribution of any kind will be taken against employees who report, in good faith, a suspected violation of this policy or other irregularity. We will treat reports confidentially, protecting the identity of the reporting employee consistent with fair and rigorous enforcement of this policy.
Violations of HIPAA privacy or security policies and procedures may result in disciplinary actions ranging from warnings and reprimands to discharge. Actions taken will vary depending on the circumstances surrounding the violation. Specific policies and procedures included in our training program include:

- Firewall Policy
- Access Control Policy
- Password Policy
- Internet Web Server Security
- Information Risk Assessment
- Wireless Network Security
- Permissible Uses and Disclosures of PHI
- Appropriate Safeguards to Protect PHI
- Workstation Security
- Physical Protection of Confidential Data
- Confidential Facsimiles
- Entire Medical Record

- HIPAA Privacy Compliance Program
- Business Associate Agreements
- Compliance with Minimum Necessary Requirements
- Mailing Confidential Information
- Protected Health Care Information in Email
- Cooperation with the Secretary and the Office of Civil Rights
- Continuing Protections beyond Contract End Dates
- Addressing Non-Compliance Issues with Subcontractors and Agents
- Disclosure of PHI to Subcontractors and Agents
- First Health Services' Privacy Official
- Privacy and Security Workforce Training
- Employee Sanctions for Non-Compliance
- Retaliatory Acts
- Waiver of Rights
- Uses and Disclosures for Treatment, Payment, and Health Care Operations
- Reporting Violations
- Reporting Inappropriate Uses and Disclosures to our Covered Entities
- Business Associate Agreements with Subcontractors and Agents
- Subcontractor/Agent Compliance
- Assisting Covered Entities with Individual Rights Activities
- Handling Psychotherapy Notes
- Handling PHI of Employees or their Family Members
- HIPAA Statement for Procedure, User, and Training Manuals
- Working Off-Site and Remote Access
- Visitor Confidentiality Agreement
- Facility Tours and System Demonstrations
- Disclosure Tracking Reports to Covered Entities Clients
- Handling Calls and Inquiries from Beneficiaries and their Representatives.

MMA will fully comply with all privacy and security requirements as required by the RFP and in accordance with state and federal regulatory requirements.

MMA will provide a plan for escalating the report of a security breach. The plan includes procedures, reporting flow, and time frame for escalation.

PURPOSE

The purpose of the Security Breach Report Escalation Plan document is to describe the processes and procedures that Magellan Health Services (MHS) has developed to ensure compliance with Federal security breach reporting and escalation plan requirements. This section describes the following:

- Procedures
- Reporting Flow
- Timeliness
- Non-retribution.

PROCEDURES

MMA views any security breach or interruption in processing to be a potential threat to the service organization. System Security Access is protected through corporate initiatives through Security Policies and Procedures. “Security Incident” is defined as the attempted or successful unauthorized access, use, disclosure, modification or destruction of information or interference with system operations in an information system. Security Incidents include:

- Unauthorized access to a computer system or its data
- Unauthorized use, disclosure, modification, or destruction of information
- Interference with system operations in an information system
- Violation of a security policy or procedure
- Failure of security-related infrastructure, whether physical or technical.
- Computer Security Incidents include specific circumstances wherein data that have been altered or destroyed and/or system access are denied outside of normal business procedures:
- Systems that display strange messages or that mislabel files and directories.
- Appearance or disappearance of files, or significant and unexpected changes in file size
- Editing of files when no changes should have occurred
- Unexpected processes, such as email transmissions, that starts without user input
- Sudden unavailability of files or data normally accessible to a user
- Facility and Physical Incidents are defined as follows:
- Unsecured doors or building access devices
- Detection of unauthorized personnel in controlled areas
- Facility security weakness or malfunctioning facility security device.

REPORTING FLOW

MMA employees who suspect they have discovered a Computer System Incident will report the suspected incident to the Corporate Compliance Office. The MMA employee will not, under any circumstances, attempt to test a suspected weakness, as this may be interpreted as a security violation.

MMA employees encountering a facility security incident, facility security weakness, or malfunctioning facility security device must report the incident to the Corporate Compliance Director, who will coordinate with the appropriate person(s) to document the incident, determine the severity and coordinate the appropriate remediation, if necessary.
The Corporate Compliance Director notifies the Chief Operating Officer of the Security Incident. The Corporate Compliance Director works with the person(s) who identified and reported the

issue, as well as other persons responsible for the systems or facilities involved, to verify the occurrence, document the incident, determine its severity and coordinate the appropriate response and mitigation. Responses may include, but are not limited to:

- Employee training and awareness
- Implementation of new administrative, physical, or technical safeguards
- Disciplinary action, up to and including employee termination.

Upon determining a Security Incident has taken place, DVHA will be informed of the Security Incident. Corrective Action Plans are documented and approved, when necessary. Employees must follow the instructions of and cooperate with the Corporate Compliance Officer and the Legal Department regarding investigation of the suspected breach or violation.

TIMELINESS

Any employee who suspects or identifies any potential or actual violation of the Privacy and Security Compliance Program is required to immediately report the violation to his or her supervisor. The supervisor is required to disclose such information to the Corporate Compliance Office Director. An employee may submit an anonymous report. All reports must contain sufficient information to investigate the concerns raised.

NON-RETRIBUTION

No retribution of any kind will be taken against MMA employees who report, in good faith, a suspected violation of this policy or other irregularity. Any reports will be treated confidentially, protecting the identity of the reporting employee consistent with fair and rigorous enforcement of this policy.

A traditional de-militarized zone (DMZ) structure is in place to support our e-commerce needs and is monitored via a state-of-the-art managed intrusion detection systems provided by an external organization to ensure quality of service. The Intrusion Detection Service (IDS) service is monitored 24/7/365 by IBM Security Services, which specializes in incident response and intrusion detection capabilities for many corporations world-wide.

During the establishment of the Vermont project office, MMA's Security Department will work with the business and technical staff to ensure security of the office/facility meets MMA's standards for physical and information security. This determination is made based on a thorough evaluation process that is conducted by MMA's IT Security Department. The classification of each physical site is determined based on the size, physical structure, number of users, and the importance of the site. We will work with the State throughout the implementation process to ensure a mutually-agreeable security plan is in place for securing the physical access and information networks of the facility.

We offer a multi-layered approach to monitor for system vulnerabilities whether they are to theft, mischief, tampering or even non-malicious factors such as natural disasters. Our security policies and plans are based on policies and best practices from the International Information Systems Security Certification Consortium (ISC) — the international standard for IT security — and the National Institute of Standards and Technology (NIST). Our Security Department ensures that beneficiary health information is protected as it rests in our systems and when it is exchanged via electronic means. To address this, we have implemented technical, physical, and administrative safeguards to enhance: physical security, personnel security, and information systems security.

Our methods provide perimeter protection, segregated operations, business and administrative architectures, and extra protective measures associated with our web presence. We monitor all of these interfaces to identify inappropriate or unauthorized traffic, email, and attempts to connect to our systems. We currently meet all state and federal privacy and security regulatory requirements; further, we are fully committed to remaining 100 percent compliant with all future HIPAA Security Rules and federal automated data processing requirements. In Figure 10 below we outline our HIPAA compliance methods.

Figure 10. HIPAA Compliance Methods

CONFIDENTIAL MATERIAL: CONTAINS HIGHLY SENSITIVE PROPRIETARY AND/OR TRADE SECRET INFORMATION; PUBLIC DISCLOSURE WILL CAUSE SIGNIFICANT COMPETITIVE INJURY AND DISRUPTION.

Type of Security	Approach
Network and Information Security	Our systems contain highly sensitive information and perform critical business functions for our customers. Therefore, we take the security of that information and those systems very seriously. We use modern technology and control techniques to safeguard our infrastructure and data, and we constantly monitor and regularly test our own security measures.
Firewalls/ Intrusion Detection	MMA employs the latest technology standards and equipment regarding the protection of the critical internal infrastructure. All firewalls are monitored and managed by qualified, dedicated MMA personnel, and all perimeter protection equipment is installed, patched, and maintained in accordance with manufacturer standards and best security practices to ensure the best possible protection. A traditional DMZ (de-militarized zone) structure is in place to support our e-commerce needs and is monitored via a state-of-the-art managed intrusion detection system (IDS) provided by an external organization to ensure the highest quality of service. The IDS service is monitored 24/7/365 by IBM Security Services, which specializes in incident response and intrusion detection capabilities for corporations world-wide.
Systems Activity Auditing/ Monitoring	All systems activity, including user activity, is monitored in accordance with policy. All deviations from accepted practices outlined in policy will be investigated, and the risks associated with these events will be mitigated accordingly
Encryption Capabilities: *Email/Wide Area Network|Internet*	The security of MMA email communications requires a blending of several (three) technologies to provide a diverse and flexible method of delivery. The method will involve the use of Virtual Private Networks (VPN), an encrypting email gateway, and a web-based secure email service. All WAN connections are encrypted to industry standards. All of the MMA Internet-facing websites incorporate the usage of Secure Socket Layer (SSL) protocol version 3.0 to protect sensitive information. Transport Layer Security (TLS) protocol version 1.0 is also used.
Vulnerability Assessments	We routinely conduct security assessments and vulnerability testing and mitigate any issues or risks found in a timely manner. MMA verifies security infrastructure. Our policy is not to disclose specifics regarding details or results

Type of Security	Approach
	of testing due to the proprietary and sensitive nature of the data. In addition, computer systems handling sensitive information securely log all significant security-relevant events such as: • Password guessing attempts • Attempts to use unauthorized privileges • Authorized or unauthorized modifications to production application software • Authorized or unauthorized modifications to system software • Attempts to modify or disable logging. Our Security Department contracts with external entities to conduct an impartial third-party review on at least an annual basis.
Data Center Facility Controls	Our systems are housed in our primary data center (located in Maryland Heights, Missouri) which is staffed 24/7/365. The data center is constructed with true floor-to-ceiling walls and has no exterior windows. The entrances to MMA-occupied spaces are secured with alarm sensors and a proximity access control system. We monitor the sensors and the access control system. A sign is posted at the data center entry requiring employees to use their own ID Badge (tailgating is prohibited). Closed circuit cameras monitor areas within, and all entrances to, the Data Center. The output of all cameras are displayed on a monitor and recorded to a digital video recorder. The Data Center Operations staff monitors the cameras 24 hours per day, 7 days per week. Additional output of the cameras is routed via secure fiber to secondary monitors and recorders in the Security Office. Visitors to the data center must be escorted by an authorized MMA associate and are required to sign in and out upon entering and leaving the data center. The fire suppression mechanism used inside the data center is a KIDDE_FENWAL FM-200 Clean Agent Fire Suppression. A Pre-Action Sprinkler System is also in the Data Center as required by local municipality code. Automatic detection is provided by addressable/intelligent ionization and photoelectric smoke detectors located on the ceiling and beneath the raised access floor. All computer systems and equipment, including telephone systems directly related to the functional operation of the computer systems are supported through a 750 kVA MGE Uninterruptable Power Supply (UPS) and distributed by five 150 kVA Power Distribution Units (PDUs), one 125 kVA PDU, one 300 kVA MGE Power Management Module (PMM), and one Functional Distribution Cabinet (FDC). The primary UPS is supported by emergency battery backup. The battery backup is used as a backup to the primary source of emergency power, a 2000KW Cummins Diesel Generator that is located just outside of the building. In the event of a utility power interruption, the load is automatically transferred to the emergency power source. The generator's fuel tank can provide 54 hours continuous standby power before refueling based on 100% load capacity. The generator is tested monthly and can be refueled while in use.

Type of Security	Approach
	Water detection devices are in place under the floor of the Data Center and in the UPS room located on the first floor. Additionally, there are seven 20-ton HVAC units and two 30-ton HVAC units providing redundant capacity to cool the Data Center and two 15 ton HVAC units for cooling the UPS room located on the first floor. The Data Center's environment is monitored by Data Center Operations personnel. Environmental equipment and activity is monitored by the Data Center operators using Liebert's Site Scan, APC's Struxureware, and physical observation. SiteScan and Struxureware are web-based applications that will automatically page/email designated personnel when an alarm is received. Once an alarm is received, the responsible facilities personnel will evaluate the situation and make necessary arrangements to resolve all issues, including initiating vendor support.
Protection from Viruses, Worms, or Other Threats	All external computers or networks connecting remotely to MMA and MMA internal computers or networks use active, MMA-approved virus scanning and repair programs and an active personal firewall system (hardware or software). We provide standard virus protection software on all workstations, which is also used to scan any removable media associated with the workstation (jump/thumb drives, etc.). Workforce members are also instructed to scan all media originating from outside the local office for viruses before use.
Policies and Procedures	In addition to our architecture and automated controls, we also have written security policies and procedures in place to meet compliance standards, as well as to solidify best security business practices. Some of our policies currently in effect govern: information technology security, information sensitivity, disaster preparedness, remote network access, Internet usage, computer and network usage, employee email usage, enterprise security, pre-employment background investigation, and termination of security accesses for employees and contractors. All employees and contractors are required to participate in security training at the point of hire and receive refresher training annually thereafter.
Application and User-Level Security	Application-level security is accomplished by controlling access starting at the front door of each application. Our login process is operated from a secure site (https) and employs detailed rules to prevent hacking or other unauthorized access. Additionally, our user-level security, which is described in further detail below, has been thoroughly reviewed and tested by both internal and appropriate external security agencies.
Role-Based Security	All of our security permissions are role-based; users receive access to only the information they need to know to do their jobs. The users and their roles are well-defined by our corporate security policies and meet Sarbanes-Oxley standards. Access to all of our systems and the levels of security within our systems are defined by a role-based account assigned by our corporate

Type of Security	Approach
	Network Administration Department. Our systems employ a detailed set of rules governing the setup and maintenance of login IDs and passwords. The user's role serves two primary purposes: provide the appropriate level of security to the application to read, write, update, delete, etc. and limit user access to certain screens, features, functionality, and data. Role accesses are reviewed annually by the Internal Audit Department. When an employee changes job roles within the organization, the user accesses assigned will be modified to reflect those appropriate for the employee's new role. Network Security Administrators have the ability to create new users, disable (inactivate) users, associate users to security profiles, lock users, and reset passwords for systems and application users.
Access Control	Access to system resources is controlled based on the user's security setup. Our standard access control rules are as follows: • All information is held under the control of a logical access control system that is approved by the Chief Security Officer. • User ID and Password Required for Computer-Connected Network Access • Unique User ID and Password Required • Passwords Not Displayed On-screen in Clear Text. • Periodic Password Expiration • No Disclosure of Incorrect Login Information • No Disclosure of Information in System Login Banner • Security Notice in System Login Banner • Security Notice First Banner Displayed • Notice of Last Login Time and Date • Automatic Log Off • Prohibition of Multiple Simultaneous On-line Sessions • User IDs Must Each Uniquely Identify a Single User • Periodic Review and Reauthorization of User Access Privileges • Signed Forms Required for Issuance of User IDs • User Profiles • Default User IDs disabled, removed, or amended from the default state • Standard Naming Conventions • Application Control • Dedicated Account Administration All our systems and applications comply with the HCA Information Technology Security Policy requirements.

MMA will have a third party perform penetration testing on a quarterly basis using OSSTM methodology.

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'.

In Figure 11 below, MMA describes our approach to meeting the User Interface requirements in Template H.

Figure 11. Overview of MMA's Solution to Section 4.0

Template H Items Addressed by this Response	
Requirement Number	**Overview of MMA's Solution**
A4.1	The FirstTrax contact tracking and prior authorization management system provides for two types of free-form text notes: Clinical Notes under the Prior Authorization area for PHI information related to the prior authorization decision and Work Log notes at the issue level to enter non-PHI information as a means of further documenting the interaction with callers. All notes are available immediately for online review as soon as the prior authorization or issue is saved in the database. The editing of a previously entered Clinical or Work Log note is not allowed for audit reasons. Additional Clinical Notes can be added at any point following the create date. Work Log Notes can be added to for up to 10 days from the date the issue is marked as resolved. After 10 days, the issue is systematically closed, and no further additions are allowed. Users have the ability to search and display the clinical notes and work log information.
A4.2	MMA's system services and system components are all accessed by end-users through a graphical user interface (GUI) including plans, benefits, and pricing.
A4.3	MMA will provide view, search, and query functions to the authorized users, as well the associated documentation.
A4.4	The system will allow for drilling down within reports and provides multiple and single criteria search functions and secondary and tertiary searches.
A4.5	The system will provide functions to save and name multiple user-defined search and sort parameters. These reports will be available to all users moving forward.
A4.6	The system will provide functions to view the results of wild card searches.
A4.7	Our intermediary, SureScript, captures digital signatures from prescribers at the point of care. The signed prescription is then transmitted to the beneficiary's pharmacy for fulfillment.

Template H Items Addressed by this Response	
Requirement Number	**Overview of MMA's Solution**
A4.8	MMA follows a Change Management process to implement system changes. A release schedule is published and documentation is updated by the Training and Development Department to reflect the autoload updates in advance of system change deployment. A revision history is maintained to indicate the revision date, as well as to provide basic information about the change. MMA provides system user guide that provides comprehensive step-by-step instruction on system functionality.
A4.9	The Training and Development department will collect questions during provider training sessions and provide answers to the questions in the form of a Frequently Asked Questions (FAQs) document. This FAQs document is placed on the web portal for provider access. The FAQs document will also be stored in our Learning Management System's (*Achieve*) Resource Library. The FAQs document will be updated on a regular basis for maximum benefit to the users.
A4.10	MMA will provide an on-line forum that will enable authorized users to search among the database of forum posts to find other posts in the same thread, by date, relevance and other attributes. With role-based security, MMA and the State will be able to control which users can only read the posts, which users may contribute to the forums, and which users may act as moderators. If the thread is still open, users will also be able to post questions, respond to existing questions, and create and comment on similar issues grouped together as 'threads'. This functionality is not available today but it will be available by the State's go-live date. MMA's overall strategy is to continually enhance beneficiary and provider engagement through the deployment of web based tools that leverage mobile as well as desktop devices. MMA will deploy an online forum as a place for authorized users to discuss program related issues. The forum will support searching by items such as key words, date, and relevance. The conversations found as a result of a search can then be continued by adding further questions or comments. This functionality will provide a rich communication environment in which the user community of the State's program may gather information, add knowledge, and feel connected.
A4.11	A linked glossary page containing narratives for codes and abbreviations will be provided.
A4.12	MMA employs various windowing techniques to limit the amount of information displayed at once and thus enhancing the user experience. Other UI elements are available to the user to allow for the expansion or retrieval of additional data.

Template H Items Addressed by this Response	
Requirement Number	**Overview of MMA's Solution**
A4.13	MMA will provide a system user interface that is easy to read, user-friendly, and displays all data elements necessary for a user to perform his/her job function. All training documentation is reviewed by our Communication and Documentation Development Department to ensure technical concepts are explained in everyday layman's terms. We also write our training documentation at a sixth grade reading level for maximum comprehension of all audiences.
A4.14	The web interface will be intuitive to easily navigate to through the application functions.
A4.15	MMA will provide a system user interface that is easy to read, user-friendly, and displays all data elements necessary for a user to perform his/her job function. A linked glossary page containing narratives for codes and abbreviations will be provided.
A4.16	MMA system will provide users with error checks and confirmation option before submission is possible.
A4.17	MMA will provide a system user interface that is easy to read, user-friendly, and displays all data elements necessary for a user to perform his/her job function.
A4.18	MMA systems provide easy consistent navigation which is familiar, predictable and reversible.

MMA will provide a system user interface that is easy to read, user-friendly, and displays all data elements necessary for a user to perform his/her job function. MMA's user interfaces are designed to support various display sizes and resolutions without truncating the work area of the application.

Our Web Design Team has many years of experience in user interface and user experience design. Careful consideration is given to provide the most intuitive and user-friendly design possible, while also adhering to W3C standards and 508 guidelines. The end result is a product that renders consistently across all current industry standard browsers and platforms, while also ensuring a pleasant interaction for the end user.

MMA's system services and system components are all accessed by end-users through a graphical user interface (GUI). This is the case for applications accessible to end users as well as to business and technical analysts who are configuring or monitoring shared services. Business process functions that are repetitive are automated to increase efficiency and reliability while decreasing costs.

DATA BACKUP

DATA SECURITY

CONFIDENTIAL MATERIAL: CONTAINS HIGHLY SENSITIVE PROPRIETARY AND/OR TRADE SECRET INFORMATION; PUBLIC DISCLOSURE WILL CAUSE SIGNIFICANT COMPETITIVE INJURY AND DISRUPTION.

MMA Data Security

MMA has taken a multi-layered approach to security based on the International System Security Certification Consortium (ISC2) — the international standard for IT security — and the National Institute of Standards and Technology (NIST).

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'

In Figure 12 below, MMA describes our approach to meeting the BI and Reporting requirements in Template H.

Figure 12. Overview of MMA's Solution to Section 5.0

Template H Items Addressed by this Response	
Requirement Number	**Overview of MMA's Solution**
A5.1	The Business Intelligence Portal is a decision support system (DSS) that was developed to provide MMA customers with a web-based tool that will meet continuously expanding data access needs. MMA's comprehensive solution for reporting consists of various tools targeted to meet the needs of a diverse set of users, including intuitive web-based tools aimed to provide flexibility self-service capabilities. We will work with the State business lead and architect during implementation to make sure our components conform to Enterprise Platform.
A5.2	The Training and Development Department maintains a training program for State staff and vendors on our reporting tool. The courses are tailored to the security level access of each user. A computer-based tutorial (CBT) is also available as a supplemental tool to the instructor-led training and user manual.
A5.3	Our BI infrastructure uses data from various sources and incorporates it into subject areas that assist in building the standard reporting tools, as well as end-user self-service reporting. We have built a Data Integration Infrastructure to handle the acquisition, transformation, and analysis of large volumes of data and organize it into several subject areas. Our reports will be based on all the data elements listed in Requirement A5.3.
A5.4	MMA has a well-defined and documented process for the development and maintenance of all data analytic capabilities.
A5.5	MMA has an established COAR Department that supports a full breath of clinical outcomes capabilities. COAR will proactively indentify opportunities for cost savings and quality of care improvement, and thus initiate data research and statistical analyses related to identify possible clinical programs target to contain costs and improve care. MMA will provide all findings associated with data discovery and mining to the State.
A5.6	MMA has a well-established methodology that we employ and maintain for the development and maintenance of production and system reports. MMA will work with the State of Vermont agencies to refine this methodology in order to meet the needs of the program and the various groups of stakeholders as necessary.

Template H Items Addressed by this Response	
Requirement Number	**Overview of MMA's Solution**
A5.7	MMA has a well established methodology that we employ and maintain for the development and maintenance of ad hoc reports. MMA will work with State of Vermont agencies to refine this methodology in order to meet the needs of the program and the various groups of stakeholders as necessary.
A5.8	MMA has an existing process that we leverage to manage the prioritization of incoming and outstanding reporting requests. Utilizing this process, a schedule for the delivery of reports is maintained and adjusted according to any change to prioritization that may occur.
A5.9	MMA will track and report the status of each data and reporting request. MMA will leverage existing processes and tracking tools wherever possible to meet the needs of the programs.
A5.10	MMA will produce, distribute and manage production reports in accordance with Business area, State, and Federal specifications.
A5.11	MMA will produce, distribute and manage ad hoc reports in accordance with Business area, State, and Federal specifications.
A5.12	In the event that a report can not be delivered in a mutually agreed-upon time frame, MMA will notify the requestor and interested parties of the target delivery date for any report request. In addition, MMA will deliver summary level reports, according to a predefined schedule, containing quality and timeliness metrics for all report requests during a specified period of time.
A5.13	MMA will ensure that all existing Federal, State, and Business area measures and reports continue to meet Business area, State, and Federal standards.
A5.14	MMA will maintain distribution lists to ensure report distribution to selected recipients at all times.
A5.15	MMA maintains detailed procedures documenting how reports are currently prepared, as well as the quality procedures utilized to validate and verify accuracy of information contained within reports.
A5.16	MMA's batch scheduled reports are archived for future retrieval. User initiated reports can either be saved by the user or a pre-defined timeframe of execution history can be established.
A5.17	MMA will provide data and information for Federal and State reporting in accordance with Business area, State, and Federal specifications.
A5.18	MMA will provide data to the State in support of the PBM's function of analyzing and reporting pharmacy program status to the State.
A5.19	MMA will provide ad hoc reporting and data analysis as agreed to through negotiation with the State.
A5.20	MMA will provide the ability to regularly and accurately produce operational reports using PBM system data.
A5.21	MMA 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.

Template H Items Addressed by this Response	
Requirement Number	**Overview of MMA's Solution**
A5.22	MMA will provide a static data dictionary/glossary function for codes and abbreviations.
A5.23	MMA has a robust set of industry standard transactions and data interfaces available in our standard set of interoperability solutions, enabling our solution to interface with internal stakeholder solutions and external business or trading partners with relative ease. Included in this set of standard offerings are those transactions associated with the HIPAA attachment transaction set for claims and prior authorization requests.
A5.24	MMA will provide system operational metrics from a decision support system that offers digital dashboards, online reporting and print capacity.
A5.25	MMA will provide routine, ad hoc, and complex analytical reporting.
A5.26	MMA 'S Business Intelligence portal offers dashboards with a variety of dimensional views, including time dimensions such as daily, weekly, monthly, quarterly and yearly views. These dashboards extend to users the ability to drill down into more details views of information.
A5.27	MMA's Business Intelligence tools enable designated users to customize their view of relevant business intelligence information through a user friendly interface according to evolving needs.
A5.28	MMA's reporting solution provides a means for batch reports to be retained in a static archive. In addition, users are able interact with reports and dashboards that are available through our interactive portal and save static version in unalterable formats as needed.
A5.29	MMA's reporting tools have a rich set of graphical representations that highlight important events, alerts, and metrics.

We realize that many of our customers have plenty of *data*, but what they really need is *information*. The usual approach to information management is fragmented and "siloed," but what is really needed to truly add value is an integrated approach. Understanding and promoting the effective organization, analysis, management, and use of information in health care is essential to building a next generation program in collaboration with DVHA. We use our technology, applications, analytics/health informatics resources, and clinical subject matter expertise to achieve our clients' goals.

MMA will identify high impact opportunities and analyze the potential impacts of cost reduction measures and other clinical management activities. The overarching goals are to:

- Determine where the greatest opportunities are
- Design innovative initiatives to impact those opportunities
- Increase the quality of health care
- Decrease the total cost of care.

To help DVHA manage their information and make informed decisions to increase the effectiveness of their programs, we provide a complete Business Intelligence (BI) and reporting solution that consists of:

- A highly sought after industry standard toolset (including IBM Cognos BI, SAS, and Business Objects tools)
- A constantly evolving and continuously improving BI organization that is both nimble and responsive, as well as being very experienced, knowledgeable, and well-versed in industry standards.

Business Intelligence Resources

MMA's intellectual capital includes a well-established Business Intelligence Department that is committed to accuracy, effective analysis, management, and providing useful information that enables informed decision making. Our Business Intelligence Department is staffed by analysts who serve as a bridge connecting IT to the rest of our business areas, including clinical management. DVHA will have access to the resources of Business Intelligence Group for outcome analyses, drug trend forecasting and analysis, strategic planning, and ad hoc reporting requests. We will transform, mine, and analyze the data in order to manage payment, beneficiary, provider, and program information.

MMA routinely conducts structured and systematic review of pharmacy, medical, and encounter claims data aimed at interpreting patterns of drug prescribing and dispensing in relation to established diagnoses and predetermined prescribing/dispensing criteria. Using defined criteria, current state of knowledge of drug therapy, and evidence-based clinical treatment guidelines, analysts evaluate patterns of prescribing and drug utilization at both beneficiary and provider levels. Such reviews focus on:

- **Utilization and formulary management** (e.g., surveillance for quantity limitations, early refills, optimal drug choice within a class, therapeutic duplication, use of a fixed combination drug when only one of its components is justified, use of a costly drug when a less costly equivalent drug is available, and conformance with prior authorization policies).
- **Safe prescribing and dispensing practices** (e.g., surveillance for multiple drugs within a class, drug-drug interactions, incorrect drug dosage, incorrect duration of drug treatment).
- **Disease state/condition management** (e.g., evidence-based appropriateness of drug therapy, prescribing patterns at high risk for drug-drug interactions or adverse drug effects due to documented co-morbidities).
- **Provider Profiling:** Provider-level analysis enables MMA analysts to identify consistent prescribing or dispensing patterns that can be improved or modified. Detailed reports are generated and transmitted to the providers containing a description of the review criteria, exceptions identified through the review, and recommended actions that are intended to enhance and improve the quality of pharmaceutical care and potentially improve beneficiary outcome by encouraging optimal drug use. MMA carefully documents receipt by the provider of these reports and reassesses at intervals to determine efficacy and effectiveness of the outreach to the provider for high impact issues.
- **Beneficiary Profiling:** Beneficiary level analysis enables MMA analysts to screen for and identify possible care coordination issues that might be evidenced, for example, in therapeutic duplication across multiple prescribing providers. These reports can be transmitted to case managers.

Our Business Intelligence Environment

MMA's Business Intelligence (BI) and online query tools put information into the hands of the business with easy to use, intuitive web interfaces. In addition to online access to our suite of standard reports, users can interact with information using our dashboards and ad hoc analytic tools. Users can easily switch between standard reports and dashboards to ad hoc query and analytics by selecting an option from the available menu.

Our BI environment consists of the following components, as described in Figure 13 below.

Figure 13. BI Environment Components

BI Environment Component	Description
Data Stores	Our analytic solution is based upon several types of data stores, each with their own defined purpose - some closely mimic source system structures and some support operational reporting. Each data store is updated at a frequency determined by the business need. Some of the frequencies include daily, near real time, and monthly updates.
Business Layer	The business layer provides a consistent place for definitions, metrics, and terminology, ultimately providing access to the various Data Stores. The rich and consistent metadata allow all users access via the presentation layer.
Presentation Layer	This component provides access to the underlying information via a variety of methods based upon the individual users' needs, skill-sets, and roles. Some presentation/access options include interactive dashboards, parameterized reports, scheduled reports, ad hoc query tools, advanced analytic tools, alerts, scorecards, and even accessing information directly from Excel.

Business Intelligence and Online Query Tools

The MMA BI and online query tools are supported by the suite of products offered by IBM Cognos Business Intelligence. Our current offering of tools provides a fully integrated and highly intuitive environment in which users can view and run reports that have been pre-authored or run their own customized queries and reports. MMA recognizes information management and use as a key to success. Some examples of analysis included in our offering and used to effectively manage the program include:

- Utilization Impact by Therapeutic Class
- Drug Trend Drivers
- User Age Distribution
- High Impact Drug Class
- Cost per claim by category of care (ABD, women and children, foster care, etc.) and in aggregate
- Generic Effective Rate
- Aggregate Brand Discount
- Generic Distribution Rate
- Month over month drug trend for total spend, specialty and non-specialty
- Top drug classes by volume
- Top drug classes by payment amount

- Average claims/beneficiary/month
- Generic substitution rate
- Mental Health PMPM
- Specialty Drug PMPM.

Cognos Business Intelligence query and reporting capabilities include professional report authoring capabilities that are easy to use and minimize the effort for report authors. Query and/or report capabilities are available for the categories listed.

- **Design and build –** Create report templates to include standard report objects, queries, and layouts. Drag and drop capability enables flexible and intuitive report assembly and core BI capabilities. Charts, graphs and tables are all easily created from all available data sources.
- **Analyze and share –** View, interact with and analyze the result set, and share the results to follow a train of thought and generate a unique perspective around information.
- **Interact and analyze –** Change display, add calculations, filter prompt, drill up/down, sort data.
- **Share and collaborate –** Output results to PDF, Excel, CSV, and XML formats.
-

In addition to Cognos BI tools, MMA's team of analysts routinely uses the following tools described in Figure 14 below to support reporting, data modeling, data management, and ETL activities.

Figure 14. Analytical Tools

Tool	Purpose
SAS	In depth statistical data mining/maneuvering/analysis; virtual data store
Qlikview	Prototyping and Data Mining
Informatica	Data extraction from source data stores, data transformation, cleansing, and loading into target data stores
Subversion	Version control and configuration management
Oracle	Database backup and recovery, database monitoring, database management, and disaster recovery.
ERwin	Data modeling and metadata management

Note: The tools in the above table are used by the engineers and architects that provide support for our business intelligence solutions and program and is not intended to suggest that users of the BI system will have access to these tools.

Our BI and online query tools enable users to interact with a broad set of data and metrics to effectively manage program operations and achieve positive clinical and financial outcomes. Using our standard analytics (Top and Bottom 10 Drug Classes, Utilization Impact by Drug Classification, Drug Trend Drivers, High Impact Drug Class, etc.), users are empowered to create custom analytics by various dimensions:

- Brand/Generic
- Claim Status
- Date (day, month, week, quarter, year)
- Drug Price Type and Classification
- Geography
- Formulary

- Practitioner and Specialty
- Service Provider
- Beneficiary Program and Age.

Users can author, design, and share their queries and analyses as needed.

Reporting and Analytics

We understand that DVHA needs the ability to analyze information to effectively oversee the program. We also understand the need to be able to asses the performance of pharmacies and prescribers. By providing robust and easy-to-use reporting and analytics tools that satisfy the distinct needs of our users, we can better conduct these assessments, which can improve the overall effectiveness of the program and lessen the administrative oversight needed to be done by DVHA.

Information for State Users

MMA is well positioned to meet all the reporting needs of DVHA. Understanding and promoting the effective organization, analysis, management, and use of information in health care is essential. To achieve this goal, MMA has the supporting technology to not only provide the requested reports, but to transform that data into meaningful and useful information used to enable more effective operational insights and informed decision making.

MMA Reporting

Our robust reporting capabilities will accommodate DVHA's needs for routinely scheduled reports containing metrics and operational information, as well as ad hoc analyses that are able to incorporate a full view of Medicaid service utilization.

MMA understands DVHA's need for actionable information provided in the form of comprehensive reporting capabilities. Reports that are thorough, easily accessed, and made available in a timely fashion and in a format that allows manipulation of data will be produced in support of DVHA's information needs. MMA also understands that reporting needs are dynamic and that it is vital for DVHA to be able to access program information in a logical and meaningful way in order provide the means for program oversight to occur.

MMA has an extensive understanding of State and Federal guidelines, Medicaid program services, clinical best practices, the unique characteristics of the populations being served, and the changes in the Medicaid landscape as a result of economic constraints and healthcare reform. This experience, coupled with in-depth clinical expertise, enables the MMA team, better than any other prospective partner, to identify quality of care issues and opportunities to improve coordination of care across entities.

MMA will monitor, track, and trend service utilization patterns to assist the State in effectively managing program expenditures and outcomes. Our suite of reporting and analytical capabilities provides the means for the MMA team to meet the demand for just-in-time information and rapid responsiveness to requests for reports and analyses.

In collaboration with the State, reports will be designed to incorporate the necessary characteristics and attributes in order to provide the most value to the report user. The real value in these report offerings is not in the creation of the reports themselves, but in the content and visibility they provide into the trends and associated clinical operations of the program, thus enabling swift and intelligent recommendations to be made for policy changes, quality and process improvements, targeted provider education, and cost containment and reduction. Reports will be developed to isolate patterns and trends across various demographics and populations of beneficiaries and providers, as well as service and geographic areas. Clinical

consultation and recommendations that result from such consultation will be data driven based upon utilization trends, policy, as well as national insights.

Additionally, MMA will provide the opportunity and capability for state staff to access the reporting function via our web portal. Although the reports available via the portal will be standard in nature, state staff will have the ability to customize the range of services review period for a report. Web-based reports will also be auto-generated, stored, and made available at any time to DVHA.

Following, in Figure 15**,** are some samples of the standard reports that contain metrics around Generic Use, Beneficiary Utilization, and overall Claim Utilization and Spend.

Figure 15. Program Trend Snapshot

CONFIDENTIAL MATERIAL: CONTAINS HIGHLY SENSITIVE PROPRIETARY AND/OR TRADE SECRET INFORMATION; PUBLIC DISCLOSURE WILL CAUSE SIGNIFICANT COMPETITIVE INJURY AND DISRUPTION.

Parameterized Enterprise Reporting/Dashboards

MMA's Dashboards are innovative and feature rich views of key program performance indicators consisting of dynamic reports on a secure website that program administrators can view at their convenience. We make a number of reports available via the web, which enables customers to drill down to current data of interest. Online summary information that can be made available through Dashboards includes:

- Provider network data
- Services requested
- Claims payment timeliness
- Authorization summaries
- Norms
- Outcomes reporting
- Utilization data by demographic categories.

Information is available on a flexible schedule that is tailored to the State's needs. Reports are generated on an agreed-upon schedule, depending on both the availability of data and DVHA's needs.

Figure 16, the dashboards provide a quick, visual display of data with a predetermined level of drill-down and make a great deal of information easily accessible via a single screen.

Figure 16. Dashboard Snapshot

CONFIDENTIAL MATERIAL: CONTAINS HIGHLY SENSITIVE PROPRIETARY AND/OR TRADE SECRET INFORMATION; PUBLIC DISCLOSURE WILL CAUSE SIGNIFICANT COMPETITIVE INJURY AND DISRUPTION.

Ad Hoc Query, Report Development, and Analysis

The various reporting studios available within the MMA Cognos environment empower end users with powerful ad hoc, user-driven reporting and analysis tools. They allow the user to click and drag fields onto reports, queries, or analysis. The Business Layer handles the complexities of joins and relationships between tables, allowing the business to interact with readily understood metrics, attributes, and dimensions. These tools include the ability to create formulas, drill-down from one report to another, create charts and graphs, and share what has been created with others in the organization. Filters can be dynamically added (based upon

attributes, metrics, and dimensions), which enables the creation of specific subsets of data by the user, upon which more focused analysis can occur. The user can choose from predefined templates or a blank slate to get started.

A report, whether printed on paper or viewed on-screen, is at best a two-dimensional (2-D) representation of data, a table using columns and rows. Two-dimensional analysis is sufficient when we have only two factors to consider, but in the real world, we need more powerful tools. A data cube is a type of multidimensional matrix that lets users explore and analyze a collection of data from many different perspectives, usually considering three factors (dimensions) at a time. A good visualization of a data cube is a Rubik's Cube.

Data cubes are not restricted to just three dimensions. The Cognos BI Suite can build data cubes with many more dimensions. We can think of a 3-D data cube as consisting of a series of 2-D sheets, though visualizing such higher-dimensional entities in spatial or geometric terms can be a problem. In practice, therefore, we often construct data cubes with many dimensions, but we tend to look at just three at a time. What makes data cubes so valuable is that we can index the cube on one or more of its dimensions.

We will design several data cubes to meet DVHA's needs. The data contained within any of these cubes would be summarized to show figures such as:

- Beneficiary age range
- Beneficiary gender
- Beneficiary location
- Beneficiary eligibility, including Medicare Part D
- Date range
- Beneficiary diagnoses
- Therapeutic drug classes
- Total paid (also broken out by each component pricing element)
- Number of medical providers
- Number of pharmacies
- Number of drug-related problems (DRPs)
- Types of services received.
-

With these data, an analyst or business user can efficiently analyze any or all of those figures for any or all beneficiaries, regions, diseases, problems, and more. In effect, we are twisting the Rubik's Cube until we get the combination of factors we want (e.g., all pediatric beneficiaries, with ≥ 5 medical providers, who have ≥ 4 DRPs, and are receiving at least one non-preferred drug, broken out by month). Thus, data cubes can be extremely helpful in establishing trends and analyzing performance.

Benchmark Analysis

MMA is focused on using information to effectively manage healthcare outcomes and spending. MMA's benchmark analyses identify financial and clinical outcomes which are used to monitor trends. Using this information, we will discuss data findings with DVHA staff and provide program recommendations to improve these outcomes.

The *Comparative Analytic Report*, shown in Figure 17 below, is used to assist our customers with assessing the performance of their programs by calculating and displaying a number of utilization, financial, and clinical metrics. The *Comparative Analytic Report* is one example of a benchmarking report that takes the information from multiple individual customers and compares the financial, utilization, and clinical metrics. This report will allow the State to identify

areas of opportunities for cost containment/savings and quality of care, while also being able to compare impact of clinical initiatives on utilization, financial, and clinical metrics.

The *Comparative Analytic Report* also benchmarks each customer's performance against each of our other customers, as well as benchmarking against an MMA index, which is a mean of the other accounts. Each benchmark is also statistically tested to determine if the percentage difference compared to the MMA mean.

Note: The *Comparative Analytic Report* is available to those MMA customers who agree to share their aggregate metrics with our other customers who have similarly agreed to share.

Figure 17. Comparative Analytic Report

Our BI Architecture

MMA is focused on using information to effectively manage health outcomes and spending. To do that, the BI tools must be supported by a robust data solution that is both readily accessible and well organized. Our comprehensive and flexible BI solution provides both standard and ad hoc reporting and is supported by the following:

- Atomic and Dimensional Data Models
- Data cubes
- Interactive dashboards
- Parameterized reports
- Advanced analytic tools
- Scorecards.

MMA understands that a business intelligence solution must cater to the information needs of various levels of users, including executives, managers, specialists, and key decision makers.

MMA Value

The value we bring to the State is that our BI offering's primary focus is not on providing the *data*, but on translating the data to meaningful, actionable *information* to enhance the quality of service while keeping the program's costs under control.

We believe that understanding and promoting the effective organization, analysis, management, and use of information in health care is essential. We pride ourselves on our ability to determine and provide the best, most cost-effective data solutions to our customers, either custom solutions that meet their specific program needs or ones that utilize our enterprise-level solutions (like our data warehouse). MMA is committed to assessing DVHA's needs and implementing the most appropriate BI, reporting, and data management solution.

MMA has developed a dimensional data model with dashboards and cubes that provide highly customizable reporting. Some dimensions include date, drug, PDL status, beneficiary demographics and location. The dashboard offers flexibility to create user-defined home pages with any combination of the standard IBM Cognos Business Intelligence offerings. below in Figure 18 we have outlined the available data dimensions within our model.

Figure 18. Data Dimensions

Data Dimensions	Description
Brand/Generic	Classification of an NDC as brand or generic
Claim Status	Status of claim as paid, denied, rejected

Data Dimensions	Description
Date	Day, month, week, quarter, year
Drug Category	Standard FDB drug classifications
Drug Price Type	Price type of NDCs such as AWP, WAC
Geography	ZIP Code, city, state, county
Formulary	Formulary status of NDC such as covered, non-covered, exceptions
Prior Authorization	Status of prior authorizations such as approved, denied
Practitioner and Specialty	HCIdea or DEA data about prescribers including taxonomy
Service Provider	NCPDP data details such as mail order or retail
Beneficiary	Beneficiary details such as enrollment segments and programs

Data Elements

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MMA offers a set of Cognos Business Intelligence report offerings that are highly customizable. New facts, dimensions, and subject areas can be added to support the State's needs.

The use of shared dimensions and data structures, combined with the use of industry-leading enterprise tools such as Informatica and Cognos, enables our information infrastructure to quickly adapt to changing business needs. Flexibility and reusability have been achieved through the use of table-driven design and common functions across transformations. Our Data Architects have the ability to dynamically add data elements from any data store into the business layer to make it quickly accessible to the business user, even before being incorporated into the enterprise data store.

MMA's Business Intelligence infrastructure uses data from various sources and incorporates it into subject areas that assist in building the standard reporting offerings as well as end-user self-service reporting. In our data model, our architects have "dimensionalized" these subject areas enabling the clinical and data analytics necessary to manage Medicaid pharmacy programs. These dimensions are comprised of numerous data elements to facilitate reporting. A sample of some of these data elements are listed in Figure 19 below. The Derived column indicates if an element is calculated or not.

Figure 19. Data Elements

Derived (Y/N)	Subject Area(s)	Data Element	Description/Purpose
N	Membership	Beneficiary ID	ID associated with the beneficiary

Derived (Y/N)	Subject Area(s)	Data Element	Description/Purpose

Our BI infrastructure uses data from various sources and incorporates it into subject areas that assist in building the standard reporting tools, as well as end-user self-service reporting. We have built a Data Integration Infrastructure to handle the acquisition, transformation, and analysis of large volumes of data and organize it into several subject areas. The subject areas listed below in Figure 20 are actively used to improve clinical outcomes, produce customer reports, manage the business, develop innovate products and services, track financial measures, and allow customers, providers, and beneficiaries to effectively manage care and benefits.

Figure 20. Data Analytics Subject Areas

Subject Area	Description	Source
Membership	Beneficiary eligibility, Benefits, Enrollment, Demographic, Program, LTC, Lock-in, Third Party Liability	FirstRx
Providers	Demographics, Specialties, NCPDP, HCIdea, DEA	FirstRx

Subject Area	Description	Source
Claims	Pharmacy	FirstRx/MMIS
Diagnosis/ Procedure	Diagnosis and procedure data from ICD-9 and CPT codes	FirstRx/ External Sources
Reference Data	First DataBank (Drug Pricing, Diagnosis Codes, Clinical Information), HCIdea (DEA information), NCPDP, Medi-Span	FirstRx/ External Sources
Prior Authorizations, Contact Management/ Call Tracking	Call (Support) Center Activity — calls, prior authorizations	FirstTrax
Part D Plans	PDE, Formularies, Enrollment, Invoice Data, Claims, PDL, Remittance Advices	WebPDM

Our BI solution is built around flexibility and customization to allow users to get at the data in the way they really want it. However, we also provide plenty of standard report tools that have proven to be useful to our customers. Please reference **Section XII, Attachment L** for a document which describes the standard report tools we offer.

Through the online query tools, DVHA staff will have the ability to create their own reports using the data elements available and parameters available through the system as well as those described above.

If the State needs additional reporting beyond what is available through the online query tools, MMA's advanced data collection methods and tools allow us to produce custom and ad hoc reports that will fulfill DVHA's reporting needs when additional information is needed. Any information that MMA collects but does not display in the standard reports can be made available to the State on an ad hoc basis.

MMA enables both a set of self-service report development tools as well as its Business Intelligence and Health Informatics support services in order to respond to customer inquiries for ad hoc report needs. An ad hoc report is a report designed for a specific problem or task or need and is not intended to be able to be adapted to other purposes.

MMA leverages the same tools and data sources, whenever possible, in order to respond to an ad hoc report request and can transition ad hoc requests into standard reports for future use with some additional effort.

Management Reports

A listing of the standard contract/program management reports that MMA currently provides to our customers is provided in Figure 21 below.

Figure 21. Standard Contract/Program Management Reports

Report	Description	Frequency
Billing Status Report	Historical account of all contracted NDCs, their discounts, start and end dates, and contract status	Monthly

Report	Description	Frequency
Contract Status Report	Status of contracts and products selected at P&T Committee/DUR Board Meeting	Monthly
Monthly Status Report	Monthly accomplishments	Monthly
Monthly Progress Report	Deliverables	Monthly
Class Review Report	Dates of each Therapeutic Drug Class Review	Quarterly
Quarterly Savings Report	Report of savings in each therapeutic drug class; includes breakout of supplemental rebate savings	Quarterly
Compliance Report	PDL compliance and switch rate data	Quarterly
Quarterly Supplemental Rebate Tracking Report (to include manufacturers invoiced, collected supplemental rebate amounts, outstanding amounts, and disputed amounts)	MMA provides all the standard CMS rebate quarterly and annual reports through our web-based reporting package	Quarterly
Revised Savings Report	Savings estimate from P&T Committee/DUR Board meeting with revisions based on P&T Committee/DUR Board's actions after final approval	Post-P&T Committee/DUR Board meeting
PDL Update	Revised PDL document — with each change to the PDL, update the PDL. The format must be agreed to and approved by the State	Post-P&T Committee/DUR Board meeting
P&T Analysis Follow-Up Log/Quarterly Industry Contact and/or Communication Record Log Report	Summary of communications with pharmaceutical manufacturers related to the state Medicaid program	Post-P&T Committee/DUR Board meeting
Annual Report	Comprehensive review and preview of program	Annually

We understand that any and all data collected/created/summarized/aggregated for DVHA, as well as any and all deliverables and reports created under this contract, will be the sole property of DVHA. We will not use any of these materials at any time or in any manner without the approval of the State.

Availability

MMA routinely performs maintenance on all of our information systems to ensure that systems are stable and accessible to support business operations. Using system virtualization, much of this maintenance can be performed seamlessly to our user communities and without having to take our systems offline. As a result of this capability, our online query tools are available during all business hours with scheduled maintenance to occur only during off-hours and at pre-defined intervals. In the event that a need arises to schedule downtime, MMA will work with the State to establish an agreeable and appropriate schedule so that maintenance can be performed.

In situations where unexpected disruptions occur, MMA will notify impacted users and DVHA along with timelines for resolution and restoration of full system access. In addition, MMA's Production Support Operations staff conducts post-issue review and root cause analysis and takes whatever steps are necessary to prevent future disruptions to our information systems.

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.

In Figure 22 below, MMA describes our approach to meeting the Project Management requirements in Template H.

Figure 22. Overview of MMA's Solution to Section 6.0

Template H Items Addressed by this Response	
Requirement Number	**Overview of MMA's Solution**
I1.1	MMA has established a long, successful history of managing large, complex Medicaid engagements with many states. Our Project Management Methodology (PMM), which is based on the standards and techniques developed by the Project Management Institute (PMI) and fully documented in the Project Management Body of Knowledge (PMBOK®) fifth edition, formally describes and gives structure to our project management approach.
I1.2	MMA will develop a Project Management Plan (PMP) to manage the entire project end-to-end, covering all project phases, from initiation through planning, execution and closure. The comprehensive plan covers all nine PMBOK knowledge areas and components necessary to support the Vermont HSE platform. The development and maintenance of a Detailed Project Work Plan is a critical tool with agreed-upon milestones and established deliverables. MMA has submitted a proposed Implementation work plan as part of the proposal. Please reference **Section XII, Attachment M** for a copy of our Work Plan.
I1.3	MMA will develop a Project Management Plan (PMP) to manage the entire project end-to-end, covering all project phases, from initiation through planning, execution and closure. The comprehensive plan covers all nine PMBOK knowledge areas and components necessary to support the Vermont HSE platform.
I1.4	A Project Charter is generated during the Project Initiation Phase of the project and represents the output of Stage Gate I – Project Charter Sign-off, gate process more fully described in Template I, Section 6.1, Program and Project Management.
I1.5	Project Governance is a critical element to the management framework with the overall structure. During projection initiation, MMA will work with DVHA to determine Project Steering Committee participants and to take into account and leverage the existing AHS governance structure.

Template H Items Addressed by this Response	
Requirement Number	**Overview of MMA's Solution**
I1.6	MMA's PMO Change Management Process is a systematic and structured way to formally document, receive approval for, and track a request for change to a project's schedule, scope, and application or system change after the implementation period has started. This process will be used during the Implementation Phase. MMA will work in collaboration with DVHA to ensure the Change Management Plan meets the requirements of the State to conduct change readiness assessment, gap analysis, and recommendations for organizational and process changes. MMA understands the Change Control Board will be managed by the State.
I1.7	MMA's Change Management Process includes technical change management plan to address Operational and System changes. MMA will work in collaboration DVHA ensure the Change Management Plan meets the requirements of the State.
I1.8	MMA agrees where templates for Project Management deliverables are available and agreed we will use the State's templates.
I1.9	The Communications Management Plan is PMI-compliant and will be developed as part of the PMP and describes roles, responsibilities, internal and external communications and needs of the project's stakeholders for information including communications protocol.
I1.10	MMA agrees to the leverage the DII EPMO Project Log template as applicable to issues, action items, and tracking to ensure accountability as agreed to with DVHA
I1.11	MMA agrees to provide electronically project management documents as specified using Microsoft products and/or pdf. We furthermore agree to use software version supported by the manufacturers and no less than a version still available on the common market. The State will approve software versions being used for the project.
I1.12	MMA agrees to regularly report and advise the State and vendor management of goals and schedule progress as contained in the approved work plan. Risks and issues will be logged, reported and discussed during weekly status meetings. We will walk through any deliverable as requested by the State staff.
I1.13	MMA will develop weekly status reports as specified and will provide to the State at a minimum of one working day before each weekly meeting. MMA will adjust frequency of reports as agreed to with the State. Our weekly written progress reports will include all the items listed in Requirement I1.13.
I1.14	MMA will develop monthly progress reports as specified and agreed to with the State. Monthly progress reports will be used by MMA and the State to measure progress and performance. MMA agrees that during the applications development phase of the project the Business Lead, Project Manager, and Enterprise Architect will sit in on weekly SCRUM meetings and will host meetings as the project approaches Go-Live.

Template H Items Addressed by this Response	
Requirement Number	**Overview of MMA's Solution**
I1.15	MMA agrees to submit to the State in writing notification of key staff substitution including a reason and provide resume and experience of the substitute personnel. The State has final approval or rejection of the substitution submitted by MMA.
I1.16	MMA agrees to provide contract closure plans to manage close-out activities in accordance with the plan and the contract.
I1.17	MMA has provided as part of the proposal, in Template D, our staffing approach and methodology used for the project to include the components required by the RFP.
I1.18	MMA agrees to provide the State with a description of the issue escalation process as it relates to roles, responsibilities and SLA variances or unmatched level of service along with the escalation path. MMA will work with DVHA to align with the State's escalation plan.
I1.19	MMA has described our Risk Management approach as part of the Risk Management section of non-functional requirements of the proposal. Mitigation strategies and responses will be developed to remediate and realign the project and plan in the event intervention has been identified and is required.
I1.20	MMA has named Joe West, PMP, as the full-time assigned PMI-certified Implementation Project Manager for Vermont. His resume and experience are provided as part of our proposal.
I1.21	We agree to use the State's repository to house project management documentation.

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.

MMA has established a long, successful history of managing large, complex Medicaid engagements with many states. Our Project Management Methodology (PMM), which is based on the standards and techniques developed by the Project Management Institute (PMI) and fully documented in the Project Management Body of Knowledge (PMBOK®) fifth edition, formally describes and gives structure to our project management approach.

MMA Project Management — Proven Approach

MMA has a 100% successful track record of implementing Medicaid pharmacy solutions. Some benefits of our approach include:

- Effective planning and control of the project
- Key resources with appropriate experience assigned
- Fully documented program requirements
- Established Change Management Process
- Proven Risk Management Plan
- Clear Communication and Outreach Plan
- Rigorous monitoring and adherence to quality standards.

Guiding principles built into our PMM include the following:

- **Maintaining focus on the project's goals and objectives.** MMA's project management team realizes that it is the project goals that establish the context in which we will accomplish our work. It is critical that the project management resources, as well as the delivery resources, fully understand the strategic goals and objectives for DVHA pharmacy system and services, as well as the tactical goals and objectives for the Implementation Phase. These goals and objectives are the foundation for all other project activities, including project scope, requirements definition, change management, and solution delivery.
- **Emphasize deliverables.** MMA's managers and staff are empowered and accountable. Our established and proven management process provides regular progress and performance evaluations based on strict adherence to task plan goals, deliverables that meet requirements, and deadlines. This plan focuses on the deliverables that must be created in order to satisfy the goals and objectives of the component. After the deliverables are validated, the detailed tasks that are required to create each deliverable will be defined and assigned to project resources. Creating the project plans at the detailed task level allows the project management resources to monitor the overall health of the project and the status of all the core project deliverables. During Project Initiation MMA will work closely with DVHA to review deliverables, timeline, RACI, and templates to be utilized. Where available and agreed upon, MMA will use State templates for project management deliverables. MMA agrees not to begin work on any deliverable until the Deliverables Expectations Documents (DEDs) has State written approval. A copy of the associated DED will accompany each project deliverable.
- **Implement industry best practices.** Our PMM defines a roadmap of best practices that focus on mutual, up-front agreement on the project's purpose, approach, and completion criteria. Our project management processes are effectively leveraged through the use of proven methodologies and automated management tools. Gate Reviews, when used in conjunction with the project management plan (PMP), are key techniques to help manage the balance among software cost, functionality, and quality.
- **Project lifecycle.** A strong project lifecycle is key to the success of a project. Ours follows a System Development Life Cycle (SDLC) which aligns with our customers.

As with a PMM, a project lifecycle provides the guiding principles we use to elaborate, create, validate, and implement on time and on target. Quality Assurance Gate Reviews are also an integral aspect throughout the SDLC, providing highly visible check points for key stakeholders and agreement to proceed to the next phase based on predetermined criteria. Our PMM, our history of success, and our goals and objectives oriented philosophy provide assurance of a successful project.

MMA has 30 years of experience implementing successful public- and private-sector pharmacy systems and services on time. The result of our well-honed project management methodology is a smooth implementation with minimal risk to beneficiaries, providers, and other stakeholders. In the table below**,** we demonstrate our successful PBM implementation experience — **on time, every time.** In Figure 23 below we have outlined our implementation track record.

Figure 23. Implementation Track Record

Contract	Scope of Work	Last Install Date	Time to Implement	Vendor at Time of Implementation	On-Time Implementation

MMA is known for our track record of successful Medicaid PBM implementations. We consistently deliver on schedule and with high customer, beneficiary, and provider satisfaction. We deploy the following key disciplines and processes to ensure a successful implementation:

- **Effective planning and control of the project** — we develop and follow a PMP to manage the **entire** project end-to-end, covering all project phases, from initiation through planning, execution and closure. The comprehensive plan covers all nine PMBOK knowledge areas and components necessary to support the Vermont HSE platform. The development and maintenance of the Detailed Project Work Plan is a critical tool with agreed-upon milestones and established deliverables. MMA will prepare and submit a proposed Implementation work plan, using Microsoft Project, within 10 business days from the contract effective date. MMA and DVHA together will review the schedule, and MMA will document any work plan or schedule changes from the plan submitted for DVHA approval prior to baselining the Work Plan and Schedule for the project.
- **Key resources** — subject matter experts from both MMA and DVHA are identified, assigned, and committed for the established implementation time frame, to support program build-out for their respective areas. MMA subject matter experts have extensive Medicaid program implementation experience and are not only experts in their own areas, but understand dependencies and impact of their tasks and deliverables on other areas. This helps ensure there are no unexpected delays in downstream tasks where dependencies exist.
- **Fully documented program requirements** — we have proven processes in vetting program requirements and will comply with DVHA deliverable requirements as described in the RFP for Functional and Non-Functional Requirements and confirmed and agreed upon during project start-up. Program requirements are meticulously captured and documented in a formal Business Requirement Document (BRD) and the Requirements Traceability Matrix (RTM) is updated to ensure we manage and track each requirement through the full development, testing, and operational readiness phases of the project in order to successfully integrate interdependent project components. MMA will additionally generate the Crosswalk of RFP Functional against Legacy System Functionality deliverable in our agreed-upon format.
- **Change Management Process** — we establish a structured Change Control Board with DVHA and MMA representatives. Changes to the pharmacy program are inevitable, and we use our proven process for working effectively with customers to manage requirements, prioritization, development, and deployment in a manner that meets the State's defined timelines.
- **Risk Management Plan** — the plan establishes a process for identifying and addressing risk areas in execution of the plan. Proper identification and escalation are key in deploying mitigation strategies.
- **Operational Readiness Review -** we will develop and maintain an Operational Readiness Plan jointly with DVHA to successfully demonstrate within the timeframe required to DVHA's satisfaction that services and solutions are production ready prior to deployment.

MMA Implementation Success

In 2008, we successfully implemented pharmacy programs in Nebraska and Florida. Barb Mart, RPh, Pharmacy Consultant for the Nebraska Medicaid Division provided these comments on the project implementation:

"Our implementation (with MMA) was very smooth."

"We were pleased with the claims history load which was 100%!"

"We received positive responses from providers regarding the Help Desk proactive level of service."

Alan Strowd, Bureau Chief, Contract Management for the Florida Agency for Health Care Administration, provided these comments on the project implementation:

"The (MMA) Team working on the Florida project pulled together its resources and was able to deliver a very good product. We have been pleased with the claims processing results and the dedication of the Team as well as its ongoing Operations staff and product delivery."

- **Communication and Outreach Plan** — a program implementation must be successful with an effective communication, education, and outreach plan targeted for all constituents. MMA will establish a detailed Communication and Outreach Plan as an implementation deliverable, and will collaborate and review that Plan with DVHA for approval of the final plan.
- **Project Implementation Portal** - We agree to use the State's repository to house project management documentation to satisfy DVHA requirement for the Project Information Library (PIL) to store implementation artifacts, key project documentation to include issues or comments to the Project Team, and other DVHA-facing information as mutually defined. This portal will be available 24/7 and requires login credentials to view and edit contents posted in DVHA PBM Implementation site. A Resource Documentation Log, shown in Figure 24 below will also be available to describe each document and to identify when it was created, revised, and approved by the State. The State will have access all project documents via this portal.

Figure 24. Resource Documentation Log

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Document Name	Audience	Description	Date Created by MMA	Date Approved by State	Date First Revision	Date First Revision Approved by State	Date Second Revision	Date Second Revision Approved by State	Date Third Revision	Date Third Revision Approved by State

MMA ensures that the PBM project will be provided with the resources and support needed to be successful. Our Project Management Office (PMO) is staffed with a Director and Project Managers who are committed to ensuring that all projects are completed on time and on schedule. Our commitment to standard methodologies enables us to deliver high quality services that are customized to the State's needs. All members of MMA's PMO employ best practices. The Implementation Project Manager will communicate regularly with the State to communicate the status of the project, including identifying issues, risks, and related mitigation activities.

PROJECT START-UP AND TRANSITON

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Our planning effort starts with Project Initiation and is led by our Vermont Implementation Manager, Mr. Joe West, PMP. He will work closely with the State to identify engagement of resources that will be involved in the planning for each component of this project. Mr. West's attention to detail and his background and experience with MMA and our customers makes him exceptionally qualified for this role. Mr. West's broad-based knowledge of MMA's systems, policies, and procedures will ensure the success of this project. He will be responsible for managing the outcomes of the defined implementation phases. For more details on Mr. West's qualifications, please refer to Template E in Section V of this proposal for his resume and profile.

We will begin the transition with a Project Kick-off Presentation to orient the project team members to the project to include the following topics:

- Project Schedule (high level)
- Objectives and Definitions
- Process (including change management, change control, and issue/risk management)
- Artifacts
- Roles and Responsibilities
- Keys to Success
- Next Steps
- Questions and Answers (Q&A)
- Resources.

MMA will have all key staff members on-site for the Project Kick-off Presentation. Mr. West will coordinate and schedule the kick-off meeting, providing an agenda to DVHA for approval no later than five business days prior to the meeting. MMA will create and distribute prior to the kick-off meeting artifacts such as:

- Team contact list, contact list that includes the name, responsibility, telephone numbers, and email address for each member of the project team
- Draft Project Charter
- Draft Work Plan
- Draft Project Management Plan
- Draft Project Governance Plan, which will need State input to incorporate governance to leverage existing AHS governance structure
- Requirements Traceability Matrix (RTM).

A Project Charter is generated during the Project Imitation Phase of the project and represents the output of Stage Gate I – Project Charter Sign-off, gate process more fully described in section below. The Project Charter establishes the authority to proceed with the project and engage resources and begin project planning activities. The Charter contains; Project Description, Project Goals and Objectives, Project Scope, Key Project Milestones, Preliminary Business Requirements, Assumptions and Risks and is input to the PMP. The Project Charter is one of the standard templates housed on our full library of standardized PMM document templates.

MMA's approach to meeting the Project Management Plan (PMP) deliverable is to provide a detailed plan composed of subsidiary management plans and other planning documents, including Integration, Scope Management, Time Management, Cost Management, Quality, Resource, Communications, Risk and Procurement Management. The PMP is a living document and will be updated by the Implementation Project Manager, Mr. West, continually throughout the project, as it is the controlling document for all activities and phases of the

project. MMA will, as outlined in the RFP, create a Vermont PBM Implementation-specific PMP consistent with PMI's PMM and at a minimum consist of the following sub-plans:

- Scope Management Plan — This plan documents the project vision and goals, items that are in-scope and out-of-scope and their prioritization, dependencies between the scope items, and risks associated with the inclusion and removal of items from scope. The plan also defines the process used to modify project scope.
- Cost Management Plan — This plan indicates how project costs/budget will be incurred, controlled, and reported. The plan will include the finalized cost and budget for the project. Cost-related progress report formatting will be developed and included by the Vendor, consistent with DVHA requirements and format, with inputs from State team members, and must include a tracking of costs to the project budget baseline.
- Risk Management Plan — Development of a Risk Management Plan is required. MMA, with the support of State team members, will submit a baseline Risk Assessment to the State's Project Manager within one month of the project initiation.
- Quality Management Plan — Our plan will have the following elements:
  - Defined quality assurance responsibilities
  - Detailed definition of all deliverables by phase and associated acceptance criteria
  - Defined deliverable review process
  - Disciplined deliverable review process
  - Regularly scheduled reviews of key project phases and milestones
  - Identified target performance areas and proposed methods of measurement; establish the baseline metrics for the agreed upon goal areas; and assist the State in determining the level of achievement of the performance goals.
- Human Resource Management Plan — The plan for this initiative will be tied to the proposed project timeline and phases. We will be responsible for proposing the potential roles and responsibilities for staffing the different activities, articulating what the Vendor will need to provide and what the State should provide.
- The Schedule Management Plan – The plan developed by MMA will include the following:
  - How the project schedule will be monitored for variances
  - What types of corrective actions will be taken to address schedule variances during the life of the project
  - The process, roles, and responsibilities involved in making changes to the project schedule.
- Communication Management Plan — The plan will detail the varying levels and needs of the project's stakeholders for information regarding the project, status, accomplishments, impact on stakeholders, etc. As part of Communication Management, issues must be logged and reported bi-weekly and the plan must detail the escalation mechanisms for issue resolution.
- Closure Approach — Upon the completion of the Base and Extension Operations Periods, we will perform all activities necessary to close out the Project. This includes:
  - Performing formal contract closure
  - Updating process documentation and transferring this to the State
  - Transitioning any relevant process and/or solution responsibilities over to the State Project team, or to another contracted vendor
  - This includes updating and transferring all solution documentation, performing formal contract closure, and transitioning any relevant solution responsibilities over to the State Project team.

- Change Management Plan — MMA will adhere to the Change Management Plan, which will be jointly developed by MMA and the State. The plan describes how the Change Control Board (CCB) will manage the process for review, acceptance and rejection of change requests. For any decisions that cannot be made by the CCB or project management team, the decision will be escalated.

In the Change Management Plan, change requests will be:

- Drafted by MMA
- Reviewed and edited by the State Project Manager
- Approved or rejected by the CCB with direction from State management, as necessary
- Implemented by MMA, as necessary

We will make updates to the project schedule and cost estimates when change requests are approved.

Project Governance

Project Governance is a critical element to the management framework with the overall structure. During projection initiation, MMA will work with DVHA to determine Project Steering Committee participants and to take into account and leverage the existing AHS governance structure. The Steering Committee will review a roll up of the project's performance to monitor trends and key indicators and to review escalated issues and risks. Processes for agendas and meeting minutes and escalation are defined in the Communications Plan, a subsidiary PMP plan.

Another key aspect of governance is the utilization of a gate review process providing various points during the project where an assessment of the quality key inputs and outputs is performed. MMA also uses a Stage Gate Process to ensure that key stakeholders are accountable for each phase of the project and that there is structure in the approach to project management. Figure 25 below shows a sample of the various project stage gates.

Figure 25. Stage Gates

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Project Tools and Techniques

Our PMM includes an extensive collection of tools that enable the project management resources to effectively define, monitor, and report status on the various project management components, including the schedule, resource utilization, milestones, deliverables, issues, and changes. A full library of standardized PMM document templates is available to our Vermont team and covers all phases of the project. Examples of project tools and techniques include:

- Organization Charts
- Contact Lists
- Documentation Repository
- Defect Management Tool
- Change Control Tracking Tool
- Deliverables Tracking Tool
- Status Reporting

- Operation Readiness Review Reporting.

MMA uses Microsoft Project as the work plan creation and management tool to track all aspects of each project. As a standard practice, work plans are converted to Adobe portable document format (PDF) for distribution to individuals who may not have access to Microsoft Project. Additionally MMA will provide project management documents using Microsoft products in a version no less than a version still available on the common market and supported by the manufacturer. During the planning phase of the project we will work with DVHA for approval of software versions for overall plan synchronization. We will utilize our Implementation Project Portal to store implementation artifacts, key project documentation, and other DVHA-facing information. This portal will be available 24/7 and requires login credentials to view contents posted in DVHA PBM Implementation site.

A Resource Documentation Log will also be available to describe each document and to identify when it was created, revised, and approved by DVHA. MMA will provide the opportunity and capability for DVHA to access all project documents via our Implementation Project Portal.

MMA's PMO Change Management Process is a systematic and structured way to formally document, receive approval for, and track a request for change to a project's schedule, scope, and application or system change after the implementation period has started. This process will be used during the DDI Phase. MMA will work in collaboration DVHA ensure the Change Management Plan meets the requirements of the State to conduct change readiness assessment, gap analysis, and recommendations for organizational and process changes. MMA understands the Change Control Board will be managed by the State.

The PMO Change Management Process consists of a nine-step workflow:

1. The State identifies need for Change Request and submits request to the MMA Contract Manager.

2. MMA Contract Manager leads a weekly Steering Committee Meeting to discuss the change(s). A determination is made regarding whether the change is project-related.

3. MMA Contract Manager contacts the Project Manager (PM).

4. The Project Manager enters the request into the Change Request Form on-line.

5. The PMO Director evaluates the request.

6. The Project Manager and the Project Team determine the level of effort and impact to the project's schedule and scope.

7. The request is reviewed by the MMA Senior Leadership Team.

8. The PMO Director informs the MMA Contract Manager and the PM of the Change Request disposition.

9. The Change Request follows the implementation process,

   Figure 26 and Figure 27**,** below.

Figure 26. PMO Change Request Process – Workflow Steps 1 - 3

Figure 27. PMO Change Management Process – Workflow Steps 4 - 9

During the operational phase of the project, our Vermont Account Manager ensures that changes are logged, tracked, and managed using FirstRequest™, our Remedy-based Change Management system used for tracking and reporting operational issues and Change requests. Figure 28 below shows a FirstRequest™ screen where change requests are entered.

Figure 28. FirstRequest™ Screen

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As a primary deliverable of the SDLC Requirements Phase, the Requirements Traceability Matrix (RTM) provides the ability to follow and audit the life of each system requirement, in both a forward and backward direction from its origins through its realization. For every customer implementation, MMA produces an RTM using Excel that maps every named requirement.

Mr. West, Implementation Project Manager, is responsible for ensuring regular updates to this document are provided to the team and to DVHA as requested. This method ensures accountability for both MMA and DVHA prior to release to production and subsequent operational phases of the project.

MMA recognizes that the RTM is a key deliverable utilized throughout the project as a tracking instrument that manages and confirms fulfillment of contract compliance, completeness, and consistency for all Federal and State requirements defined in this RFP, including the CMS certification.

Mr. West will work with project stakeholders to identify and track critical performance indicators that will provide management insight into the overall efficiency and effectiveness of the project. MMA's Weekly Status Reports and Monthly progress reports will comply with all elements as defined in the RFP. MMA will provide to the State one working day before each weekly meeting 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 MMA or the State).

Monthly progress reports will include deliverables, milestones, walkthroughs, the State approvals, and lessons learned and will be used by both MMA and the State in measuring the project'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, the Business Lead, Project Manager, and Enterprise Architect will be included in weekly SCRUMs or as needed. As the project nears completion, Business Lead, Project Manager, and Enterprise Architect will host meetings for daily status updates.

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.

MMA combines the work breakdown structure, project schedule, and resource assignments into a Microsoft Project work plan. The work breakdown structure separates the project into parts that represent deliverables, components of deliverables, and the activities or tasks required to build those deliverables, including meeting schedules. The Draft Project Work Plan begins on the contract signing date and will be refined as the planning team makes adjustments during the planning process. Each iteration of the Draft Project Work Plan results in it being more accurate and complete. In **Section XII, Attachment M** we provide a copy of the Draft Project Work Plan aligning with dates as outlined in the RFP Procurement Schedule. We also submitted an electronic copy in Microsoft Project.

The Draft Project Work Plan will be reviewed and modified after contract award and again after requirements confirmation and sign-off. During the Project Initiation and Planning phase of the project, MMA and DVHA together will review the schedule and will document any work plan or schedule changes from the plan submitted for DVHA approval prior to baselining the Work Plan and Schedule for the project. Once agreed upon, the Draft Project Work Plan will then be baselined for performance measurements and project reporting. MMA will deliver a Baseline Project Work Plan and Schedule, including a Work Breakdown Structure (WBS), Gantt chart(s), and a Project Calendar in Microsoft Project. Early recognition of schedule variances is crucial in being able take corrective action and minimizes potential impact. The Draft Project Work Plan will be updated bi-weekly by Mr. West, throughout the Implementation Phase and will include detailed activities with scheduled begin and end dates and dates for specified milestones and deliverables. The milestones and deliverables are clearly delineated and provide our project management team and the State with a tangible basis for performing quality assurance and a method to measure project progress and key dates.

To maximize resources, our project work plans require considerable preparation. Tasks must be planned and executed in a particular order. To begin a task before related tasks with precedence are completed is inefficient and generally unwise. An optimal plan is organized so that as many independent tasks as possible can operate simultaneously and/or overlap, given available resources, thereby reducing the overall duration. Applying superior resources allows individual tasks to be completed more efficiently, controlling the budget and meeting the schedule. For the Implementation Phase, MMA proposes staff possessing specific application knowledge, Medicaid program understanding, technical skills, and complex project management experience. We will leverage our previous and current projects involving interfaces with other fiscal agents (e.g., Molina, HPES, and ACS).

Our Draft Project Work Plan identifies discrete units of work activities with definable end products (deliverables). The emphasis on deliverables provides our project management team

and the State with a basis for performing quality assurance and a method to measure milestones and key dates. The project plan will be updated weekly or on an agreed-upon time frame and, at a minimum, will include the following:

- Activities are detailed with scheduled begin and end dates and delivery dates for specified deliverables. These activities are assigned to team members for completion.
- The Draft Project Work Plan structure includes the Scope of Work identified in the RFP, including all tasks and deliverables required by the State. Each subtask is further divided. At the lowest level is an activity, a distinct, measurable work effort that results in a defined output or deliverable that is necessary for the completion of the subtask.
- Subtasks are clearly defined. The subtasks listed on the Draft Project Work Plan will contain a short description, responsible resource, and the work product definition and hours for each resource attached to each task. The task will also identify the State's resource requirements, beginning and ending dates, dependencies, and assumptions projected.
- Deliverables are established, developed, and implemented in each phase of the Draft Project Work Plan, identifying MMA and DVHA personnel hours by deliverables for each phase.
- Deliverables have a date attached to indicate when they are to be completed. Before we proceed any further with the implementation, the State reviews the task deliverables and provides formal written approval of each.
- Activities on the critical path that fall behind schedule are identified and will trigger contingency and recovery procedures. To ensure adherence to the overall schedule, measures will be taken to restore the critical path schedule (additional resources will be applied to the activity; activities will be reassigned, restructured, or rearranged; equipment will be added; or other additional measures taken as necessary).

MMA incorporates contingency or risk management into all of our implementation activities and project activities. These contingencies or risk mitigation activities are included in the management of the deliverables for each project phase and are enumerated throughout our technical approach.

MMA's successful track record demonstrates a history of strong communications with our customers and effective risk management. In addition to connecting contingencies with the deliverables, we ensure that any dependencies between tasks are clearly outlined in the Draft Project Work Plan.

Mr. West will be responsible for managing the Draft Project Work Plan from the draft stage presented in the RFP through to the final Project Work Plan approved by the State.

MMA will utilize our Implementation portal to store implementation artifacts such as the Project Work Plan, key project documentation, and other State-facing information. This portal will be available 24/7 and requires login credentials to view/edit contents posted in DVHA PBM Implementation site. A Resource Documentation Log will also be available to describe each document and to identify when it was created, revised, and approved by the State. MMA will provide the opportunity and capability for designated State users to access all project documents via our Implementation portal.

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

Changes to the pharmacy program are inevitable, and MMA follows our proven process for working effectively with customers to manage requirements, prioritization, development, and deployment in a manner that meets the Department's defined timelines. Below we have detailed this solution.

Change Management Methodology

MMA manages all organizational change with a thoughtful, customer centric point of view. All organizational changes are designed to optimize effectiveness based on environmental and organizational influences.

Impact of Changes

All changes are vetted through a rigorous process that includes a thorough stakeholder analysis, business case analysis and customer impact analysis.

Methods of responding to the change, process harmonization

All changes are designed to optimize organizational effectiveness and stakeholder value. A formal change management process is executed that incorporates a change blueprint to understand all implications of the identified change as well as a plan for engaging and communicating with all impacted areas.

Communication and Planning

Organizational changes are designed through identifying a business case for change where key stakeholders and executives are included in designing the business criteria in terms that are definable and measurable. These stakeholders and executives drive the engagement and communication planning to include individual conversations, team and group meetings, town hall meetings, conversations with customers, formal announcements from executives through intranet postings and internal corporate blogs. All communications are developed to encourage feedback and input from all stakeholders at various stages of the communication plan.

Methods for Success

Our Human Resources Department offers dedicated specialists to design and create communication and change management plans who use a variety of organizational

development resources and tools to ensure a thoughtful and thorough process that leads to the desired outcome which always includes increased customer satisfaction. A variety of tools and resources are used including but not limited to the ***STAR*** model for organizational development; And ***Linkage*** tools and resources for change leadership.

Lessons Learned

Outcomes are continuously monitored through communication feedback loops, formal surveys and leadership check-ins. Formal lessons learned sessions are used to gain valuable feedback to establish best practices and continuously improve processes.

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.

Building strong relationships with our customers and other state stakeholders is always MMA's top priority, and we take pride in our reputation for providing excellent service. Below we discuss our approach to customer relationship management.

WEEKLY STATUS MEETINGS

MMA leadership will schedule and participate in weekly pharmacy system meetings during ongoing operations. We will prepare agendas and submit them one business day prior to the meeting, along with any documents to review including, but not limited to, a weekly status report. It is our intention that MMA and DVHA will utilize this forum to discuss outstanding service requests and work in tandem to set priorities and discuss the status of given service requests. Likewise, we will provide minutes summarizing the meeting within one business day after the meeting. DVHA will approve the final documents and MMA will archive copies in its document repository. Our pharmacy services account manager will participate in these meetings and we will include other leadership as needed or at the request of DVHA. Our weekly status report will include:

- Progress, issues, problems, and planning
- Current operations status
- Progress on PBMS maintenance
- Claims/ encounters inventory balances,
- Claims/ encounters backlogs
- Data entry backlog and suspense file status
- Modification activities.

OPERATIONAL MEETINGS

To facilitate strong, collaborative relationships between MMA, other stakeholders (such as the MMIS contractor), and DVHA, MMA will establish and lead cross-operational status meetings when determined necessary by DVHA. MMA will schedule the meetings, provide agendas and minutes, and coordinate with other stakeholders to obtain documents needed during the meetings. Agendas will be distributed no later than one business day prior to the meeting and minutes will be distributed within one business day after the meeting. All meeting documentation will be archived for future reference. Topics for these meetings could include interface/data exchange challenges, common processes/procedures, updates to data dictionaries, system changes impacting multiple systems, performance guarantee reporting and the like.

Also, we will coordinate other pharmacy services and other supporting system communications between and among DVHA and other entities contracted with DVHA. We will maintain a contactor contact list with email and phone number of the key stakeholder leadership, and technical staff with whom we need to communicate. For example, we will communicate with all affected stakeholders should there be a technical issue impacting the pharmacy system if that technical issue will also impact the other stakeholders. Likewise, we will use email to document change requirements and approval exchanges and to coordinate vendor testing when system changes involve changes to vendor's systems as well as the pharmacy system. When decisions are made between MMA and a vendor via a telephone conversation, we will follow up with an email summarizing the decision. We will include DVHA on these communications per their preference and/or requirements.

SUPPORT CENTER REPORTS

In addition to weekly status reports and operational meeting minutes, MMA will provide monthly call center telephone reports detailing information for both provider and customer calls. We will report on data such as calls total number answered, average length of calls, hold time, and number of abandoned calls. We will adhere to DVHA's requirements for submission, review, and approval as documented in our Communication Management Plan. All reports will be archived for future reference as needed. Support Center report examples are shown below in Figure 29 and Figure 30 below.

Figure 29. Performance Requirements – Support Center

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Performance Requirements – Call Center	
Statistics	MM/YYYY

Figure 30. Call Types

Call Types	MM/YYYY
Total	**4,140**

QUALITY ASSURANCE PROCESS AND ORGANIZATION

Quality is a key component integrated into the processes of MMA's Project Management Methodology (PMM) and our Systems Development/Integration Lifecycle Methodology (SDLC) for our projects. At the initiation of the project, the processes of the PMM and SDLC, along with DVHA's RFP are reviewed with each project team member. This approach promotes a clear understanding of overall project objectives and product requirements and defines our internal quality control monitoring to successfully produce those deliverables. We establish repeatable processes that are continuously reviewed for enhancement and reengineering opportunities.

We follow a project tracking and oversight process in order to provide visibility into actual progress so that management can take effective actions when performance deviates from plan. These controls and accountabilities are further defined for all deliverables associated with the project. Each person, identified by job title in the project work plan, is responsible for monitoring and reviewing commitments, plans, schedules, and progress associated with each deliverable and adjusting the work plan based on the actual accomplishments and results. Additionally, all deliverables proceed through our quality control and review process before being submitted to DVHA to ensure that the deliverables meet our high quality standards, as well as the standards defined by DVHA.

MMA Quality Assurance

MMA reviews the content of deliverables early in the process with DVHA to ensure common understanding and expectations for each deliverable. Our experience with joint deliverable definition and the deliverable walk-through process has resulted in an increased initial acceptance of the deliverable by our customers.

All deliverables will be submitted to DVHA in the required format on or before the specified due date. Should DVHA determine a deliverable to be non-compliant, we will receive written notification outlining specific non-conformances no later than a mutually-agreed-upon time frame (e.g., five business days) after receipt of the deliverable so that we can take steps to quickly remediate the deliverable to the satisfaction of DVHA. We will make any necessary corrective actions and resubmit deliverables within a mutually agreed-upon time frame of receiving notice. Our Implementation Project Manager will work with key staff at DVHA to ensure that all remaining issues are resolved and that the review process is successfully concluded. All project deliverables will be included in our approved Implementation Work Plan.

CONTRACT MANAGEMENT

MMA recognizes the importance of monitoring all service level agreements to ensure we are meeting our commitments set forth under DVHA – MMA Statement of Work. All key performance indicators (KPIs) are monitored on a daily basis and then compiled into a single performance guarantee report which is provided to the DVHA on a monthly basis. The report is reviewed with DVHA as part of our standard approach to account management and in the unlikely event of KPI non compliance, MMA will prepare and provide a Corrective Action Plan denoting the actions we are taking to address the deficiency to prevent reoccurrence and the time frame by which this will be resolved. We further understand and acknowledge the need to conduct periodic internal and external audits of our operational processes; we commit to providing all support necessary to facilitate and shepherd any audit request through to a successful conclusion and will also provide any supporting documentation necessary to meet this end. When required, MMA will include audit request(s) as a topic on the weekly account management agenda such that DVHA is informed of our progress over the life of the request. Please refer to the following, Figure 31, as an example of a monthly PG report used to measure KPIs.

Figure 31. Monthly PG Report Sample

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			December (October - December)					Year to Date		

			December (October - December)					Year to Date		

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.

ISSUE TRACKING AND REPORTING

MMA believes in delivering a high level of customer service, not just to DVHA, but also to DVHA's Medicaid beneficiaries and the providers who serve them. Therefore, we have a well-documented issue management process, supported by a database which we use to track and report issues. We will work closely and collaboratively with DVHA and other stakeholders as needed to quickly, efficiently, and effective research and resolve all issues, especially those impacting beneficiaries and providers.

The Pharmacy Support Center staff records and tracks all inquiries and requests received from prescribers, pharmacies, and beneficiaries in FirstTrax, as well as the pertinent aspects of the inquiry or prior authorization request. All data listed in this requirement are captured in FirstTrax. Additionally, our system can capture a variety of data to meet the plan-specific reporting requirements. An example of the FirstTrax contact detail is shown below in Figure 32.

Figure 32. FirstTrax Contact Detail Screen

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Within the Support Center, MMA also offers customer service representatives who handle prescriber calls, and an IT Support Center (ITSC) which addresses system-related issues and calls. MMA has proven success in merging these functional areas together and centralizing management. We monitor the entire operational environment and provide oversight of performance requirements and up time. In combination with FirstTrax, our Prior Authorization Support Center (PASC), and ITSC tracking applications will enable us to report issues to DVHA quickly, thoroughly, and clearly, and to provide issue resolution information.

For DVHA problem identification research, MMA will incorporate a systematic ongoing quality management process into day-to-day operations. Included in this process are organizational and administrative activities in support of process improvement planning, organization, and measurement. Continuous Process Improvement components include, but are not limited to root cause analysis and reporting.

Following the resolution of a pharmacy services incident, our Vermont Account Manager, , will work with appropriate MMA corporate resources to identify the impacts and root cause. It will be documented as the recommended resolution to the problem through the issue management process and corrective action plans where needed and delivered to DVHA. Depending upon the recommendation, the team may find it necessary to document a change request and obtain approval through the change control process. Once the appropriate resources approve the resolution approach, the team implements the resolution, and then the Quality Assurance Department monitors the process to ensure executed improvement initiatives produce the results expected.

In some cases, a more formal approach may be warranted to arrive at the root cause and corrective action for an issue. In these instances, we will employ our Six Sigma discipline in the form of the DMAIC methodology as shown in Figure 33 below.

Figure 33. Six Sigma DMAIC Methodology

Six Sigma DMAIC Methodology	
DEFINE	Define opportunities and key stakeholders. Understand customer needs and specify measures that are critical to quality.
MEASURE	Determine possible barriers and develop measures of performance to ensure valid, reliable, timely data.
ANALYZE	Analyze data, using statistical tools to verify root causes and opportunities for improvement.
IMPROVE	Improve performance through development of prioritized, measurable interventions.
CONTROL	Control performance by establishing mechanisms to sustain and replicate improvements.

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.

During the course of any project, it is inevitable that risks will be identified. For example, users of a software deliverable find they require additional features; problems are discovered in a process that requires workarounds and additional project activities; or a particular implementation method does not work and so the team must try a different approach, with different tasks and activities. MMA's Implementation Project Manager, Joe West, PMP, formally documents and tracks all project risks and mitigation strategies throughout the life of the project.

MMA will develop a Risk Management Plan as a subsidiary management plan in the Project Management Plan that will, at a minimum, contain: process description, identification of risk, performance of qualitative and quantitative risk analysis, risk response and monitoring and control of the process. MMA will submit a baseline Risk Assessment to the State within one month of Project Initiation to include a description of the risk, description of the impact to the project, an impact scoring, a probability of occurrence, description of the mitigation plan, dates and times associated, priorities. MMA will confirm with DVHA at project kick-off assessment

elements required. The Risk Management Plan will continuously be updated throughout the project. Risk Management may include, but is not limited to:

- Understanding and clarifying the request for changes to the project and analyzing the impact of each change to the cost and schedule
- Analyzing a change of direction, timelines, deliverables, etc., and the impact of each to the project
- Keeping track of all the different Change Requests that have been received that may be a risk for the project and the status of each
- Deciding whether to accept the change and incorporate the revised definitions into the project plan or reject the change and continue with the current plan
- Communicating with the project team the risk associated with each issue or change

Upon completion of the risk assessment, specific responses will be developed, reviewed, and documented in a Risk Mitigation Plan by . Mitigation strategies and responses will be developed for highest priority risks first. It is possible for lower or unmanageable impact risks that the strategy will be limited to awareness, taking no action, and developing a contingency workaround if the risk materializes. The steps to develop mitigation strategies include these key components:

- Define the approach or steps to mitigate/respond to the area of risk
- Document a contingency plan for the worst-case scenario(s)
- Assign an owner
- Define criteria for closure and date.

MMA begins the project by identifying the total scope. We will work with DVHA to reach a mutual agreement on this scope. When, during the course of the project, new or varying scope is identified, we use a structured model for the identification, requirements analysis, and definition process. Included in this review is an identification of benefits to the project, as well as the risks to the project's success, that are also being added with the new scope. We encourage a consistent approach to delivering the identified scope and adding new scope as additional projects when the initial delivery and scope have been completed. We have been successful in managing this process to the benefit and satisfaction of our customers, while still delivering projects on time and within budget.

RISK ANALYSIS PROCESS

Risk analysis is the process of evaluating risks to determine their probability of occurrence and magnitude of impact. This is done to prioritize risks to determine which ones warrant response, to reduce uncertainty, and to keep the team's attention on those risk issues most likely to cause cost, schedule, or performance problems for the project. Mr. West, Implementation Project Manager, will work with team members and stakeholders to analyze project risks. Risk analysis activities occur throughout the project's lifecycle, whenever new risks are identified. Figure 34 below defines our approach to analyzing risks and the categories of risks. Figure 355 below is a sample outline of a standard report.

Figure 34. Analyzing Risks

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Analyzing Risks

Rating	Probability	Impact
High		
Medium		
Low		

Figure 35. Sample Risk Report Format

RISK SECTION				

Risk ratings guide risk responses and determine risks requiring project monitoring and strategies for positive and negative opportunities. The risk register is updated with assessment outcomes, and mitigation planning occurs to identify early action to reduce the probability and impact of risks. Risk management updates tracked and reported and are discussed during regularly scheduled status meetings.

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.

Neither Magellan nor its employees or leadership have an ownership interest or other financial relationship with any of our subcontractors or vendors. Magellan and its leadership have no known or perceived conflict of interest that would impact any phase of this project.

MMA's parent company, Magellan Health Services (MHS), is a publicly-traded company. County employees could own publicly traded shared of MHS.

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:

In Figure 36 below, MMA describes our approach to meeting the Knowledge Transfer and Training requirements in Template H.

Figure 36. Overview of MMA's Solution to Section 7.0

Template H Items Addressed by this Response	
Requirement Number	**Overview of MMA's Solution**
I2.1	During implementation, MMA, along with the State, will define all activities required to provide on-site employee and provider training to the managers, end users, and technical personnel. Once the training requirements are determined and agreed upon, a detailed training plan will be designed to address the use of the applications along with which audiences require that training for their skill set. A schedule of training courses will be included as part of the training plan. The training plan will be submitted to the State as a deliverable for approval in Phase I.
I2.2	The Knowledge Transfer and Training Plan will outline how we will utilize our experience and industry expertise to address training needs for providers, DVHA staff, and MMA staff. This document details approach, methodology, goals, curriculum and training documentation, targeted audience and schedule, and evaluation tools we will utilize to achieve a customized learning program and address the needs of DVHA. All training materials will be provided to the State for approval prior to the training taking place.
I2.3	Utilizing an online repository, MMA will provide DHVA with the most up-to-date electronic versions of all training materials. Provisioning of all primary, secondary, and third level personnel will be completed prior to the start of UAT.
I2.4	The Training and Development Department will provide a detailed course agenda for review and acceptance by the State at least 30 calendar days prior to the beginning of scheduled training. Sample syllabi are provided as appendices in the Knowledge Transfer and Training Plan.
I2.5	The Training and Development Department will submit all training curriculum to the State for review and acceptance at least 21 calendar days prior to the beginning of the scheduled training.
I2.6	The Training and Development Department will provide hard and soft copies of training manuals for classroom training and soft copies for online training.

Template H Items Addressed by this Response	
Requirement Number	**Overview of MMA's Solution**
I2.7	Utilizing an online repository, MMA will provide DHVA with the most up-to-date electronic versions of all training materials. All of our documentation is considered proprietary and confidential, and we retain ownership of the documents.
I2.8	Through our experience with other state Medicaid customers, we have developed an efficient change management process. As your vendor of choice we believe that it is our responsibility to assist the State in matters such as updating training documents. Our highly trained account management staff welcomes DVHA's recommendations and will work with the State to make any requested updates. DVHA will then review and approve the updates before MMA puts them fully into effect.
I2.9	As our applications are improved via our change management process, the Training and Development Department will revise the training documentation as needed. We will provide the most up-to-date version of all training manuals on the document repository.
I2.10	All training courses will be scheduled during regular work hours unless otherwise approved by the State. The training schedule is a component of the Knowledge Transfer and Training Plan.
I2.11	All MMA training courses will take place at State of Vermont-approved locations as required by the State.
I2.12	The Training and Development Department realizes that the training schedule needs to be built around the business operations workload. We will offer multiple iterations of each course to ensure current work demands are not jeopardized.
I2.13	The Training and Development Department will provide written instructions to the State on how to access and utilize our applications.
I2.14	The Training and Development Department will assign a Lead Trainer to the State's implementation. However, we will have additional Training resources available to ensure that critical path development is not jeopardized.
I2.15	The Training and Development Department will work in partnership with the State to ensure end-user training of the system functionality is acceptable and meets all business needs.
I2.16	The Training and Development Department will partner with the State to determine the best mode of training for each course and audience. The Knowledge Transfer and Training Plan includes a training schedule along with location and mode of training.
I2.17	MMA will make recommendations to the State on how many staff members need training on our PBM applications to successfully complete all job requirements.
I2.18	The Training and Development Department will provide training for all technical support staff including State staff and contractors.
I2.19	The Training and Development Department will offer additional training sessions, as needed, due to system enhancements and upgrades to all

Template H Items Addressed by this Response	
Requirement Number	**Overview of MMA's Solution**
	technical staff.
I2.20	The Training and Development Department will work with the State to complete a Needs Analysis early in each project Phase to determine all training needs and requirements. The results of the needs analysis will be utilized to define the training approach, methodology, and schedule and will be documented in the Knowledge Transfer and Training Plan.

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.

MMA's Change Management process, which DVHA will approve with written sign off, establishes an orderly and effective procedure for tracking the submission, coordination, review, evaluation, categorization, and approval for release of all changes to the project's baselines.

MMA will establish a structured Change Request Advisory Board with DVHA and MMA representatives. MMA will create a structured method to facilitate change requests and approvals following PMBOK industry standards. MMA understands changes to the pharmacy program are inevitable, and we use our proven process for working effectively with customers to manage requirements, prioritization, development, and deployment in a manner that meets DVHA's defined timelines.

Joe West, PMP, Implementation Project Manager, creates the Change Management Plan, which will contain:

- Change management process flow
- Change request form
- Change management log
- Control board contacts for approval
- Instructions.

MMA is dedicated to ensuring that Change Control is performed effectively from project inception through completion. MMA's PMO Change Control Process, illustrated in Figure 37 below, is used when there is a change to schedule, scope, and/or budget identified during the DDI phase of the project and/or a system change that directly correlates to an approved project requirement is identified.

Figure 37. Change Request Process

The PMO change process starts with the completion of a Change Request Form that is submitted to the PMO Director for review to ensure accuracy and clarity of the request. The

PMO Director then returns the Change Request Form to the project manager for evaluation by the team for level of impact. Once the level of impact has been determined, the PMO Director places the Change Request on the weekly agenda for review by the senior leadership team. If

approved, the project manager meets with the project team to re-baseline the project work plan to accommodate the approved change.

During the Operational phase of the project, changes are logged, tracked, and managed by our Vermont Account Manager using the Change Management Module of the Remedy change control management system (FirstRequest™). Both processes have an event log with approvals and authorizations to ensure no unnecessary changes are made, that all changes are documented, and that services are not disrupted.

Our Change Management procedures are designed to ensure the effective process of planning, scheduling, communicating, and implementing changes successfully.

Figure 38 below shows an overview of our Change Management Process.

Figure 38. Change Management Process

System changes are tracked in FirstRequest, our Remedy-based Change Management system. During ongoing operations, we track progress of customer requests through the Change Management system. This system is a comprehensive tool that assists in implementing changes in a controlled environment, and it supports assessment of risk and resource requirements associated with each change. FirstRequest can be used to create plans and to automate approval processes in order to expedite implementation of the change. FirstRequest also provides scheduling and task assignment features, along with tools to monitor and review performance. To enforce our process, all Change Requests received and issues identified during ongoing operations will be logged in the Change Management system.

MMA Change Requests indicate impacts at from a Level 3 (minimal impact) to a Level 12 (major impact) as part of each Change Request. As part of each Change Request, a risk assessment is performed. This risk assessment determines the level of approval required to implement the

change into an MMA production environment. Figure 39 below shows our Risk Assessment page from our Change Request software. As the risk assessment moves from left to right the score increased to calculate the overall risk assessment. Each section is scores 1 (the lowest) to 4 the highest.

Figure 39. Risk Assessment

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The MMA Change Management Process requires State approval to proceed with development, configuration, and testing. Once approval from the State is received, MMA will proceed with development, configuration, and testing. Supporting documentation will be maintained with each Change Request processed. After the development work is completed, User Acceptance Testing and Integration Testing are performed by the MMA Operations staff and the State. The change process requires State approval of testing prior to implementation. End-user training will be provided, if necessary.

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

OPERATIONAL READINESS TRAINING

The MMA Training and Development Department will review an initial draft of the Training Plan with DVHA. The information will be based on details contained in the RFP. MMA will develop

the operational readiness training in collaboration with DVHA to address all MMA and DVHA staff training needs. The Pharmacy Training Plan outlines how MMA will use our experience and industry expertise to address training needs for providers, client staff, and MMA staff, a component that is fundamental to the success of the pharmacy implementation. This document details the approach, methodology, and curriculum MMA will use to achieve a customized learning program and address the needs of each individual customer. Any changes identified are discussed, and the Training Plan is updated. A final version of the Training Plan is then signed.

All system courses delivered by the Training and Development Department have three basic support tools that are distributed to attendees to optimize learning:

- The first tool is a system user guide that provides comprehensive step-by-step instruction on system functionality.
- Job aids are another support tool for systems training that provide concise, detailed instruction on system functionality as it relates to a user's job function. These two tools provide the perfect reference for users when they must use the system independently.
- The final tool utilized in all systems training is a hands-on component that provides additional practice and application for a user either during the training or at the comfort of their own desk. This component provides case studies and examples as well as hands-on activities for participants to practice their new skills.

MMA Training

MMA's dedicated Training and Development Department is comprised of qualified instructors who understand pharmacy services, systems, and the rules and regulations that govern Medicaid programs. These instructors incorporate this knowledge in our approach to ensure that staff is well trained in various areas of service.

Coordinate and Schedule Trainings

MMA will Coordinate and schedule Contractor training for DVHA. MMA Training and Development staff facilitates these sessions for MMA Support Center staff. Training topics include a review of the entire plan, any system enhancements, and a review of reference materials. Small groups of existing support center associates attend overview sessions where the entire plan is reviewed, system enhancements are explained, and all questions are answered. Important aspects of the plan are highlighted, especially those that will have a significant impact to the support center.

The Training and Development Department will provide training via the following delivery methods to help meet internal and external training needs:

- Webcast
- On-site hands-on classroom facilitation
- Computer-based training.
-

Pharmacy Support Center Staff Training

Training for the Pharmacy Support Center staff is slated for the week prior to go-live. Training lasts several hours. All questions are recorded and the information is disseminated to support center management in the form of a Frequently Asked Questions (FAQs) document.

Pharmacy associates are given a QuikChek (customer overview) prior to Go-Live. This document serves as a desktop reminder of important issues and a quick reference for the entire plan.

Orientation and Training for Department Personnel

MMA will conduct orientation and training for DVHA personnel on MMA's organization, functional responsibilities, and operational procedures. The Training and Development Department works with DVHA to identify all of the individuals who will be affected by the implementation. This planning will pinpoint the professionals that will need access to systems and subsequent training considerations. Topics include an introduction to MMA, various systems, processes, and documents.

Provider Transition Training Plan

The Provider Transition Training Plan will be developed in collaboration with DVHA to capture training requirements for providers training content and topics. The goal is to directly target the provider community in sessions conducted jointly by both MMA and DVHA to explain the new program. This presentation allows the State providers to meet the MMA team and assures them of our dedication to providing excellent service. MMA representatives will talk specifically about DVHA's plan and address DVHA issues. Providers may ask questions and voice concerns they may have.

Course Evaluations

To evaluate the effectiveness of our training and identify any gaps that may need to be addressed, we ask that training participants complete a course evaluation form at the conclusion of the training. The evaluation form gives trainees an opportunity to provide feedback on documentation, activities, the instructor, technical issues, and overall training effectiveness. Course evaluations collected from each session conducted by the Training and Development department are compiled into two reports: *Course Evaluation Report* and a *Training Report*. These reports are shared with the Training and Development Department staff, the requestor, and client and management staff as appropriate.

The *Course Evaluation Report* provides a tally of the scores received on each course evaluation form as well as any comments written in by the trainee. The report provides graphs and percentages to better evaluate the course effectiveness. If a need arises that has not been captured in the plan, the training plan is updated.

ORIENTATION, TRAINING, AND CONVERSION

Through our final training and knowledge transfer, MMA will assist DVHA in providing the skill set proficiency and required expertise to successfully deliver on DVHA's Medicaid obligations and services. The MMA Training and Development Department will require that each trainee complete a course assessment to determine knowledge transfer. If unsatisfactory scores are discovered, the trainee will receive remedial training until a satisfactory score is achieved. The scores of these assessments will be provided to DVHA in the Operational Readiness document. The Training and Development department performs a needs assessment to determine the necessary skills training for internal staff. A Staff Skills Development Plan will be created and presented to DVHA for approval. Training sessions are tailored to address all operational staff skill needs. On-line tutorials are utilized to provide refresher training opportunities and to raise the skill set proficiency of the operations staff.

MMA's training efforts will not cause disruption to the conduct of DVHA business. The Training and Development Department offers two separate training opportunities for DVHA staff prior to implementation. DVHA staff training is initially provided to prepare users to perform User Acceptance Testing (UAT) as a part of the implementation process. Additional training is also scheduled just prior to implementation to maximize retention. The Training and Development Department also provides follow-up or refresher training for DVHA staff as requested.

The Training Plan outlines how MMA will utilize our experience and industry expertise to address training needs for providers, DVHA staff, and MMA staff, a component that is fundamental to the success of the pharmacy implementation. This document details the approach, methodology, curriculum, and schedule MMA will utilize to achieve a customized learning program and address the needs of DVHA.

, CPhT, Lead Documentation and Training Specialist, is responsible for coordinating training, trainers used to conduct various training sessions, and training manuals and materials. She pays special attention to classroom equipment and layout to ensure that both are optimal for learning. The layout of a training room will allow the trainer to interact with DVHA staff and designated stakeholders easily. A projector will always be utilized to provide the trainer with the ability to display all visual aids to participants throughout the training session. There will also be adequate workspace and the environment should be free of distractions. Prior to any training sessions, the trainer ensures all logons are working, that network connectivity is working, and that there is sufficient equipment necessary at the designated training facility. Instructor-led training will be conducted on-site for DVHA staff and designated stakeholders.

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.

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, CPhT, Lead Documentation and Training Specialist, is responsible for the Training Plan as well as all training activities. As manager, , Director of Pharmacy Solutions Training, will provide support to Ms. Farrell during the training phase. Ms. Farrell will conduct a training needs analysis to identify key stakeholders and all training requirements.

Our Training Plan and resulting training processes and documentation will ensure that MMA staff, DVHA staff, and any affected DVHA contractors are thoroughly and appropriately trained to be proficient in system functionality and to ensure efficient, effective business operations related to the pharmacy solution.

During implementation, MMA, along with DVHA, will define all activities required to provide on-site employee and user training to the Project Team, State business users, providers, and MMA staff in all positions. Once the training requirements are determined and agreed upon, a detailed training plan will be designed to address the use of the applications along with which audiences require that training for their skill set. A schedule of training courses will be included as part of the training plan. The training plan will be submitted to the State as a

MMA Training

The key to planning and preparing for a comprehensive training initiative involves the identification of your audience, the information/skills they need to know to perform their job function, and the tools needed to enable the learning to take place.

deliverable for approval.

The Training and Development Department will also provide a detailed training agenda for review and acceptance by the State at least 30 calendar days prior to the beginning of the scheduled training.

The strategy used by the Training and Development Department to identify these things entails performing a needs analysis. A needs analysis can encompass a variety of activities, including meeting with key managers, to sending out brief questionnaires to be completed by training participants. The needs analysis serves to identify relevant links to the content of the jobs affected in order make the training more meaningful and effective.

If updates are required to the training materials, the State can provide the information to the Training Lead. The Training Lead will incorporate the changes and return to the State for approval.

Our applications and training documentation are proprietary.

ORGANIZATIONAL READINESS SUPPORT

MMA is committed to providing support to DVHA as part of Organizational Readiness, including providing a minimum of one organizational readiness lead and a minimum of two staff members who will be available as required to address questions and concerns. During the Implementation, MMA's Implementation Project Manager, Joe West, PMP, will provide organizational readiness support in general, and Ms. Farrell, will provide training-related support.

These leaders will provide regular updates via meetings and written communication on Operational Readiness as outlined in the Project Plan and the Communication Management Plan. They will also ensure that the Resource Management Plan is submitted according to DVHA's deliverable requirements; the Training Plan is a component of the Resource Management Plan and the Provider Training Plan is a subset of the overall Training Plan. DVHA must review and approval all plans during the Organizational Readiness and Training Phase.

Our team will schedule a walkthrough with DVHA to review the training plan and training materials, which will give DVHA an opportunity to validate we have met entrance and exit criteria for training, including implementation of the training environment and completion of all scheduled training sessions. Our Training Lead will also participate in this meeting; MMA will make updates to our plans and materials as needed based on feedback from this walkthrough.

TRAINING PLAN

MMA will provide a Training Plan that details the stakeholder training for applications in the test framework. MMA's training program objective is to integrate and balance the needs and interests of the stakeholders with that of the organizational objectives. MMA's Training Team conducts a Training Needs Analysis which identifies stakeholders at each step, identifies their contributions and expectations, obtains the key training requirements and incorporates them in the training agenda, and estimates the number of resources required for conducting the training. A Needs Analysis can encompass a variety of activities including, but not limited to, meeting with DVHA and MMA's key managers and/or sending out brief questionnaires to be completed by training participants. Needs Analysis helps to ensure training is meaningful and effective. MMA's training team takes into consideration the following in the design and delivery of the training program:

- Who are the participants?
- Who are the trainers?
- What methods and techniques will be used?

- What is the estimated duration, time, and location of the training?

The Pharmacy Training Plan outlines how MMA will use our experience and industry expertise to address training needs for providers, state staff, and MMA staff. The Pharmacy Training Plan will detail the approach, methodology, curriculum, and schedule that we will use to achieve a customized learning program and address the needs of DVHA. The Pharmacy Training Plan also outlines the delivery methods available to provide training. These delivery methods include webcast, on-site hands-on classroom facilitation, computer-based training (CBT), and web-based training (WBT). The Pharmacy Training Plan, along with training materials, will be presented to DVHA for sign-off during the Operational Readiness Phase of the project. MMA will update the plan annually during the Operations Phase.

We will develop a training schedule for internal and external stakeholders in collaboration with DVHA. Our Lead Documentation and Training Specialist will consult with appropriate DVHA staff to complete the Needs Analysis and schedule classes accordingly. At a minimum, the schedule will detail course name/content, course type (in-person, CBT), dates/times, and target attendee list. We will ensure all stakeholders who require training have access to the training schedule. MMA will maintain an Attendee Tracking Log to ensure all appropriate personnel who are required to attend a particular set of training sessions, in fact, do attend.

The Resource Management Plan will contain a Training Plan that outlines our approach to meet State staff and Provider training needs. The plan will indicate which courses will be offered, the schedule, and method of delivery. Face-to-face training will be offered to DVHA staff on a mutually agreed upon schedule. These plans will be updated annually, at a minimum, based on course evaluation results and collaboration between our Lead Trainer and state staff.

TRAINING ENVIRONMENT

MMA will provide a training environment with training data for staff training purposes. This environment will be used for all training courses and documentation needs during the Operational Readiness Phase of the project. The Lead Trainer, along with technical resources as appropriate, will ensure the training environment requirements are established and met, including ensuring the proper data is initially loaded and then refreshed on an ongoing basis.

Training may be conducted on-site, via the web, or via CBT. MMA uses Adobe Connect for web-based training and Adobe Captivate for CBTs. MMA uses the Microsoft Office suite to create training materials.

SYSTEMS ACCESS

All MMA and DVHA staff will be given access to the system per their user profile. System access requirements and tasks will be outlined in the project schedule and monitored by the Implementation Project Manager. Staff will be given access to the training environment for training purposes and access to the production environment once the system goes live.

CONDUCT TRAINING

MMA’s Training and Development Department is responsible for ensuring that all support center associates are made aware of plan changes and are knowledgeable of what is being implemented. Depending on the topic or the audience, training may be via live, instructor-led courses or CBTs to supplement classroom training. Both internal refresher classes and provider training are offered in CBT form. For each training topic MMA will create a course syllabus, training content, and schedule. We will provide these documents to DVHA for review prior to the start of training.

As plans change it is important to continue the education of the support center to be sure they have the most up-to-date and accurate information. This includes periodic reviews of the plans with the support center associates. When the training group identifies knowledge gaps or confusion they will provide refresher training. The Training and Development and Quality Assurance departments maintain a close relationship with support center management in order to assure compliance with DVHA's requirements, quality customer service, and accuracy.

The MMA Training and Development Department believes in providing a high level of training to our trainees. To evaluate the effectiveness of our training throughout the life of the contract (initial and ongoing) and identify any gaps that may need to be addressed, we ask that training participants complete a course evaluation form at the conclusion of the training. Not only do we seek feedback from internal staff but we also want feedback from trainees, from the customer, and other pharmacy system supporting stakeholders. The evaluation form gives trainees an opportunity to provide feedback on documentation, activities, the instructor, technical issues, and overall training effectiveness.

In addition, we provide ongoing HIPAA security and privacy awareness training for all our employees, including temporary workers and consultants. Each individual must successfully complete applicable levels of training. Our parent company tracks evidence of completion via Achieve, our computer-based learning module. Each employee must complete HIPAA Tier-I training, which is an online, computer-based training module. New employees must complete this training prior to the end of their first 60 days of employment. If an employee has not taken the necessary HIPAA training, his or her supervisor is contacted to ensure that the employee completes the training. All clinical employees must also complete the annual HIPAA Tier-II training. Training for clinical employees is conducted via an online, computer-based training module developed in collaboration by our Compliance and Learning and Performance departments. Each care management center monitors and enforces the required HIPAA training for the clinical staff. A Clinical Vice President and Compliance Officers from each call center also must complete annual HIPAA Tier-III training.

TRAINING SCHEDULE

MMA expects to start training approximately 90 days prior to the implementation and complete all training approximately one week before Go-Live.

A sample schedule is shown in Figure 40 below.

Figure 40. Sample Training Schedule

Course	Duration	Audience	Date and Time	Location
MMA POS Advanced	8 hours	Super Customer Users*	MM/DD/YY 9:00 a.m.	Customer Training Room
MMA POS Standard	4 hours	Standard Customer Users**	MM/DD/YY 9:00 a.m.	Customer Training Room
Business Intelligence Portal	8 hours	Customer	MM/DD/YY 9:00 a.m.	Customer Training Room
QuikChek	2 hours	MMA Support Center staff	MM/DD/YY – MM/DD/YY 9:00 a.m., 11:00 a.m., 1:00 p.m., and 3:00 p.m.	MMA Training Room

Course	Duration	Audience	Date and Time	Location
Introduction to MMA	2 hours	Provider	MM/DD/YY – MM/DD/YY	Various locations, as appropriate

*Super users have add/update capabilities.
**Standard users have view-only capabilities.

TRAINING REPORTING

We compile course evaluations collected from each session conducted by the Training and Development department into two reports: *Course Evaluation Report* and a *Training Report*. These reports are shared with the Training and Development Department staff, the requestor, and customer and management staff as appropriate.

Course Evaluation Report

The *Course Evaluation Report* provides a tally of the scores received on each course evaluation form as well as any comments written in by the trainee. The report provides graphs and percentages to better evaluate the course effectiveness. We will use results in this report to ensure that authorized system users are proficient and efficient in business operations.

Training Report

The *Training Report* allows the instructor to provide details about the following:

- Type of Training provided
- Purpose of the Course
- Attendees
- New Training Requested
- Evaluation Scores
- Issues/Concerns that arose during Training
- Revisions to Documentation
- Overall Comments.

All course evaluations and training reports are further examined at mid-year and end-of-year when a summarized *Course Evaluation Report* is completed and shared with management. Our Training Plan and course materials are modified as appropriate based on evaluation results.

The Training and Development Department will collect questions during provider training sessions and provide answers to the questions in the form of a Frequently Asked Questions (FAQs) document. This FAQ document is placed on the web portal for Provider access.

An example of the report is shown in Figure 41 below.

Figure 41. Training Report Example

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OPERATIONAL READINESS TRAINING ACTIVITIES SUMMARY

During Implementation, the Lead Trainer will collaborate with DVHA to ensure the report meets DVHA's needs. The Lead Trainer will also provide DVHA progress updates once training begins

and continue until training is complete; the format of and schedule for the updates will be mutually agreed upon between MMA and DVHA.

When training is complete, MMA will send DVHA a complete summary of training facilitated for operational readiness that includes the final list of all training conducted along with a list of attendees for each training session. The report will be based on the Attendee Tracking Log. DVHA can use this summary to validate MMA completed all scheduled training sessions and that the expected MMA and DVHA staff participated.

TRAINING FOR PROVIDERS DURING IMPLEMENTATION

MMA has extensive experience supporting the informational needs of providers of all types. We are dedicated to providing quality, accurate, and user-friendly materials to all providers.

We have learned that a well planned and executed Outreach Program for practitioners and pharmacy providers is key to a seamless transition. Our implementation project team develops a detailed Implementation Communication and Outreach Plan for State review and approval. This plan includes a series of communication materials which are mailed and/or posted to the web portal for the program for all stakeholders. We often partner with the state Pharmacists Association and leverage our key contacts with all major pharmacy chains and independents to facilitate their proper configuration of POS billing software and testing to ensure readiness. We produce a Pharmacy Provider Manual and provide web-based training for the pharmacy provider community in advance of the implementation. Once the POS system goes live, we monitor claims real time and produce hourly reports to evaluate adjudication results and target any providers experiencing a high volume of claims rejections. We proactively make outbound calls to these providers to address billing issues, often before they call into our Pharmacy Support Center.

Provider Outreach during Implementation

Our "early" PBM Go-Live and post-production provider outreach minimize overall risk and impact to the provider community and to the State.

Florida PBM Implementation, June 2008

To facilitate a smooth transition to what ultimately would be an entire new MMIS, the State of Florida staged an early (pre-MMIS) Go-Live for PBM. MMA, Inc. provided our proven provider outreach and hands-on support of the provider community to ensure full training on State-specific payer specifications, proper functioning of their software for billing via point-of-sale, and smooth execution of switch vendor functionality. Florida Medicaid and their provider community were very pleased with the overall results and the proactive support provided by MMA during this phase of the project.

Idaho PBM Implementation, February 2010

Kelly Baer, a Walgreens provider in Boise, Idaho, contacted MMA, Inc. on February 12 to let us know that the training we provided prior to Go-Live was "amazing." She said "the change over was fantastic." She was especially impressed when part way through the first day, she was called by an MMA Go-Live team member who told her that, as part of a claims monitoring review, they identified that her claims were not processing. They were able to immediately assist her, enabling her claims to pay. She advised us that she told everyone at her store and at the Walgreens her daughter works at in northern Idaho about "how great this process was."

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'.

In Figure 42 below, MMA describes our approach to meeting the Testing and Validation requirements in Template H.

Figure 42. Overview of MMA's Solution for Section 8.0

Template H Items Addressed by this Response	
Requirement Number	**Overview of MMA's Solution**
I3.1	MMA will provide a testing methodology that accommodates a comprehensive coverage of the many types of testing required for this project. Our Lead Documentation and Training Specialist will work with the State to fine tune our testing approach.
I3.2	MMA will provide a comprehensive Test Plan for this project. MMA employs a comprehensive and organized approach to testing our core PBM claims processing system (FirstRx), as well as our supporting systems and processes, which include rebate (eRebate), business intelligence (Cognos), web portal, prior authorization (FirstTrax), and interfaces. All testing will take place in a production environment, not a live environment.
I3.3	MMA will provide a comprehensive Test Plan for this project which will include testing approach, procedures and basic strategy.
I3.4	MMA will provide a testing methodology that accommodates a comprehensive coverage of the many types of testing required for this project.
I3.5	MMA maintains separate environments for development, testing and production.
I3.6	MMA will retest any and all defects that are discovered, at any time during implementation as well as during the life of the contract. MMA QA performs focused testing of all changes made to any system and subsystem, and runs regression testing on each core release, prior to release to production.
I3.7	MMA will build test plans and execute and create reports.
I3.8	MMA will document the testing tools, test configurations and related documentation and provide performance testing scripts to the State.
I3.9	MMA will provide the State with test scripts, test results and quality reports.
I3.10	MMA will address any questions or issues raised by the State during testing.
I3.11	MMA will refine the test documents, procedures, and scripts throughout development and through full system acceptance when required.

Template H Items Addressed by this Response	
Requirement Number	**Overview of MMA's Solution**
I3.12	MMA agrees to provide the State with the unredacted results of network audits conducted by MMA's Security Department upon request. Additionally, MMA agrees to provide the unredacted results of a vulnerability assessment/penetration test conducted by a third party at least annually. Due to security and system availability requirements, MMA meets similar customer requirements with our annual security tests referenced above. If the above testing does not meet the State of Vermont's needs, MMA will allow the State to run annual, validation and testing against our externally facing Internet applications as long as that testing is done in coordination with our Security Department. The specific tools employed and the configurations options for those tools must be coordinated with MMA Security Department staff. Additionally, the specific IP address range to be tested must be provided prior to any testing.
I3.13	MMA maintains multi-test level architectural systems: Development / Unit Testing, System and Integration Testing, Regression Testing, User Acceptance Testing (UAT), Parallel Testing are standard environment. The database, the file systems and the application configuration layers will serve as the isolation point of each System environment. These environments maintain a level of integration that allows for System date changes for time related testing needs, on a test-per-test basis, and that does not affect other testing platforms or scenarios. Our Quality Assurance Team is well versed in of time-sensitive testing needs and use various methods of altering and synchronizing the System date across all type of integration and validation testing without effecting progress of other test phases.
I3.14	MMA will develop and submit a comprehensive Defect Resolution Management Plan.
I3.15	MMA will install and test a single Defect Resolution Tracking System to be used by the State and MMA.
I3.16	MMA will provide a Defect Management system as per State specifications. Our system is customizable and we can create fields to correspond to the State's "Defect Levels". The standard fields are: Blocker, Critical, Major, Minor, and Trivial. The State will have access to our defect tracking system but access will be limited to only the State's data. We can't transfer ownership of the entire system. However, the system does provide a number of import/export capabilities, including utilities to transfer data from one system to another. Additionally, issues can be exported to either structured formats (Excel or XML), or unstructured formats, like Word.

Template H Items Addressed by this Response	
Requirement Number	**Overview of MMA's Solution**
I3.17	MMA's system will accommodate leap year processing and daylight savings time start/end dates.
I3.18	MMA will design system components according to CMS architectural standard and provide performance scripts to the State for final approval. We welcome input from the State's Business Units

MMA will provide a testing methodology that accommodates a comprehensive coverage of the many types of testing required for this project. Our methodology is summarized in the following narrative.

Testing Strategy

MMA's QA Team's testing strategy addresses the following goals:

- Full Coverage – Test all key functionality separately and integrated with other modules
- Efficiency – Test as much as possible within a test case, while maintaining clarity of purpose, prioritize testing to build on previous tests, and to focus on highest risks
- End-to-End Effectiveness – Test the entire process to assure the client's expectations are met or exceeded.
- Clarity – Be able to demonstrate what's been tested with ultimate clarity.

TESTING ENVIRONMENTS

On an ongoing basis, MMA will assess and/or establish suitable test environments and facilities at the required locations and ensure sufficient time is allowed for set-up and maintenance of such facilities and environments. Testing activities require that several test environments are available and equipped to satisfy each level of testing. The following outlines the test activities and the test environments characteristics needed to support them.

- **Unit Test (Development) Environment** — The Unit Test Environment allows the programmer to test a single component (i.e., program) as a stand-alone entity. Unit testing ensures that a single component is resilient and will function correctly on a stand-alone basis.
- **Enterprise Testing (System and Integration Test) Environment** — MMA's isolated system testing environment allows testing modifications to a single component within the context of the system/subsystem in which it functions. System testing ensures that the entire system functions as designed after modification to a single component. MMA's integration testing ensures that a defined set of interconnected systems/sub-systems will perform as designed after modification to a single component. The integrated system may involve systems/subsystems interfaced together. The testing will ensure that interfaces are exchanging data**.**
- **Staging User Acceptance Test (UAT) Environment –** The UAT environment allows users to perform system functions to ensure that the system meets the requirements and expectations of the user community. Users perform scenarios that mimic production work to ensure that the system acts and performs as expected.

TEST PHASES/CATEGORIES AND OBJECTIVES

- Unit Testing — Tests designed to ensure that the code functions on a stand-alone basis, according to the functional specifications, are executed by the development

team.

- System Testing — MMA creates a comprehensive set of test scenarios, with applicable cases and expected results to demonstrate that applications function correctly on MMA's hardware in a production-type environment. Tests are designed to ensure that the new code acts as expected when impacted by other systems, and to a limited extent, that other systems function as expected when the new code is activated.
- Integration Testing — A variety of system interfaces exist between MMA's primary POS system and its ancillary systems, including eRebate and the contact tracking and prior authorization system, FirstTrax. Testing across these systems, by designing test cases that include data and decisions from the supporting systems ensures that the systems are functioning accurately together, sending and receiving transaction data in standard specified formats in a timely way, and producing results consistent with the business and functional requirements.
- User Acceptance Testing — Scenarios are defined to ensure that requirements are thoroughly tested by the user. User Acceptance Testing will include scenarios that test all components and interfaces. Business and UAT testers at MMA are seasoned and highly experienced with creating scenarios that incorporate all aspects of data, coverage criteria, exceptions, and drug edits. MMA encourages customer testing as well, and provides training and defect management process support to customer UAT testers throughout the process.
- Operations Acceptance (End-to-End) Testing — End-users and system technicians perform end-to-end tests to assess the interoperability of an application and other system components such as databases, hardware, software, or communication devices. End-to-end testing is necessary to make certain that business continuity is not disrupted. Testing end-to-end ensures paired or dependent transactions are working together correctly. Testing will be conducted to verify accurate claims processing occurs and data can be viewed and reported in ancillary systems.
- Regression Testing — MMA employs a quarterly patch release schedule, which is first unit tested by the development team. During this phase, regression testing is performed for all major FirstRx modules, including the ones not directly involved.
- Performance (Stress) Testing — MMA technical resources will perform stress testing. The purpose of stress testing is to validate the systems are meeting the contract-defined service level agreements (SLAs) so that the systems can handle an unusual load if it should occur.

Test Plans

The test plans will encompass the State-developed criteria by which success or failure of each testing phase allows us to move onto the next testing or development phase, and the severity levels for testing. Elements of the test plans include the following elements:

- Test Philosophy or Approach
- Scope
- References
- System overview and key features
- Test Overview
  - Organization
  - Schedule
  - Roles and Responsibilities
  - Prioritization and order of testing

- Communication Plans
- Testing process
- Test cases
  - Requirement ID
  - Test Case ID
  - Expected Results-detailed description
  - Actual Results
  - Defect ID (if applicable)
  - Version ID.

Test plans are tailored to business requirements and will be developed after committed business requirements are fully documented and approved.

Individual test plans will be developed for at least each of the following:

- FirstRx (POS)
- FirstTrax (Workflow Management/PA)
- Interfaces/Conversion Data
- eRebate
- Web Services (Portal, lookup functionality)
- Web Services – Role-based security
- Switch and Software Vendor testing (third-party software)
- UAT
- Operations Acceptance (End-to-End) Testing.

TEST DELIVERABLES AND ARTIFACTS

- Test Plan — A Test Plan is created for each customer implementation. The Test Plan will encompass the State-developed criteria by which success or failure of each testing phase allows MMA to move onto the next testing or development phase, and the severity levels for testing.
- Requirements Traceability Matrix (RTM) — This document maps each and every committed business requirement to functional specifications and test cases.
- Test Cases/Scripts — Comprehensive test cases are written and executed for the POS system, FirstRx, as well as for each of the ancillary systems including rebate, reporting, web portal, and prior authorization. Test cases include all required data elements for the system being tested and are executed during each phase of the testing process.
- Test Conditions – Conditions that must exist in order for a test case to be run successfully.
- Test Results — The test cases are updated with results, as testing progresses. This becomes one of the final deliverables to allow the State to review all of the testing performed during the implementation.
- Testing Status Meeting Minutes – The Lead Documentation and Training Specialist will communicate the testing status in the weekly testing meetings, and document them in weekly meeting minutes.
- Test Reports — These reports will be used to document the overall results of a test and will recommend a course of action based on these results. The report describes the testing being done and enumerates and evaluates the results.
- Defect Reports — MMA uses an interactive defect tracking tool to maintain defects and manage the resolution process. From this system, reports are generated and will be

used to document anomalies, deficiencies, or discrepancies between expected and actual behavior, whether testing runs to completion, or ceases due to the issue that has arisen.

- Defect Log — This log includes the exact steps taken, data entered, and screenshots.
- Project Lessons Learned Documentation.

ROLES AND RESPONSIBILITIES

The following roles and responsibilities are involved in the testing process.

Testing Manager/Test Lead:

- Provides management oversight
- Creates strategy for testing
- Provides direction to testers
- Acquires appropriate resources
- Management reporting
- Evaluates effectiveness of test effort
- Test documentation sign-off authority.

FirstRx Test Lead:

- Assesses Rx testing priorities
- Assigns testing activities
- Reports regularly to Implementation Project Manager (PM), Test Coordinator
- Liaison with the UAT Coordinator.

Tester, QA Team:

- Identifies, creates, prioritizes, and implements test cases
- Creates test cases
- Executes tests
- Logs results
- Recovers from errors
- Documents change requests.

Database Administration/Database Manager:

- Ensures test data (database) environment and assets are managed and maintained
- Administrator for test data (database)
- Monitors DB during performance/load testing
- Provides DB performance reports.

Business Owners/Subject Matter Experts (SMEs):

- Ensures requirements are coded and assists in resolving issues found in the system
- Assists in root cause analysis of issue
- Supports test case strategy
- Defines new test cases as needed.

TESTING PREPARATION, TOOLS, AND TECHNIQUES

SQL and SAS queries are used routinely by testers to pull claims samples, using specific criteria for testing specific edits, groups, coverages, etc. This enables testers to identify the types of

test cases that must be created that are most highly impacted by the specified edit or functionality.

Test Automation

To test the adjudication server, the automated Regression Tool within the POS system is used. Results are documented and provided to the business owners, and approved by the State, prior to release to production. For ancillary systems and portals, Selenium is used to automate test scripts for regression testing.

Test Data, Scenarios, and Use Cases

Comprehensive test cases are written and executed for the POS system, FirstRx, as well as for each of the ancillary systems including rebate, reporting, web portal, and prior authorization. Test cases include all required data elements for the system being tested and are executed during each phase of the testing process. All results are documented in the test case database and mapped back to approved business requirement documentation. A final test case matrix is produced, which contains all testing documentation for the implementation project. This document will be approved by the State prior to promotion to the production environment.

Test Results and Status Reporting

Test results are documented in the test case database and mapped back to approved business requirement documentation. A final test case matrix is produced, which contains all testing documentation for the implementation project. This document will be approved by the State prior to promotion to the production environment. The Testing Manager or Test Lead will communicate defects in the defect tracking tool. The disposition of the defects and any comments are entered into the defect management tool. Reports are created and forwarded to management. A quality review is conducted of the testing activities executed by the Test Team by the Project Management Team, and lessons learned are documented.

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:

In Figure 43 below, MMA describes our approach to meeting the Data Conversion and Migration requirements in Template H.

Figure 43. Overview of MMA's Solution for Section 9.0

Template H Items Addressed by this Response	
Requirement Number	**Overview of MMA's Solution**
I4.1	Having successfully performed more than 30 data conversions for state Medicaid and similar programs, MMA is experienced with both converting data to our PBM system and testing to ensure quality results. We combine our experience and sound approach with a suite of industry-standard data integration and management tools.
I4.2	MMA will deliver, maintain, and execute a Data Conversion Plan (Migration) that describes the planning, development, testing, coordination, and processes required to seamlessly migrate data from the State's pharmacy system and its vendor systems to our pharmacy system.
I4.3	MMA's Data Center management ensures Disaster Recovery planning documentation is maintained and consistent with current hardware/software configurations. Business Continuity plans are developed and maintained by the operational leadership at each of our service center locations.
I4.4	MMA delivers Inventory, Standards, Specifications, and Configurations for Interfaces so they are well documented and understood between all trading partners.
I4.5	MMA understands and agrees to deliver Inventory, Standards, Specifications, and Configurations for Interfaces so they are well documented and understood between all trading partners.
I4.6	MMA will validate that each MMA interface is working correctly and resolve any interface-related issues. All interfaces are monitored by Operational team 24/7 and any failures in executions are corrected by the Production Support Team within 24 hours. Each interface produces reports containing execution statistics that are analyzed by the Account Management and Operational Team.
I4.7	Reports and system logs play a big part in problem identification and resolution. MMA will collaborate with the State in identifying problems, classifying them with appropriate priority, discussing the controls and measures and applying a solution with fully tested quality. MMA's team of highly experienced SMEs are experts at getting to the root of the issue, drafting the problem and possible fixes to discuss with state and agree on solution. MMA will assist the State in identifying root causes for all system interface-related problems.

Template H Items Addressed by this Response	
Requirement Number	**Overview of MMA's Solution**
I4.8	User Acceptance Test (UAT) Environment – The UAT environment is a near replica of the production environment and allows users to perform system functions to ensure that the system meets the requirements and expectations of the user community. Users perform scenarios that mimic production work to ensure the system acts and performs as expected. User Acceptance Testing — Scenarios are defined to ensure that requirements are thoroughly tested by the user. User Acceptance Testing will include scenarios that test all components and interfaces. Business and UAT testers at MMA are seasoned and highly experienced with creating scenarios that incorporate all aspects of data, coverage criteria, exceptions, drug edits. This environment will also contain reference and converted data.
I4.9	MMA will deploy updates only after all applicable sign-offs have been attained. If defects are found during testing, our iterative process cycles to the appropriate step which triggers activities such as defect tracking, test scenario modification and additional testing.
I4.10	MMA will deliver to the State a requirements traceability matrix as per State specifications.
I4.11	MMA will assist the State with testing and release preparation in the pre-production environment.
I4.12	MMA will develop a Migration Support Plan.
I4.13	MMA will provide support staffing information required by the State for on-going support.
I4.14	MMA will assess and document the readiness of each part of the organization 10 days prior to cutover at each part of the organization.
I4.15	MMA will work with the State and develop a Release Plan consisting of a pre-production release notification.
I4.16	We have developed an effective approach to preparing the system for roll-out that is beneficial to both MMA and the State. By the time the system is prepared for this phase, it will have been fully tested end-to-end to ensure it is ready for training, test case review, user-acceptance review and operational readiness review. MMA strategically schedules system training at the beginning of this stage to best prepare pilot participants. We have found that fresh training prepares participants with the knowledge they need to best understand testing results, conduct their own testing, and confidently conclude the system is ready for its production roll-out.
I4.17	MMA prides itself on being credible and transparent throughout the implementation life-cycle and we anticipate the State will become familiar with our processes, procedures and standard approach well before the Vermont PBM pilot begins. We feel the most important step in the pilot process comes at the end of pilot testing when we conduct our operational readiness review with the

Template H Items Addressed by this Response	
Requirement Number	**Overview of MMA's Solution**
	State. The goal of the operational readiness review is demonstrate to the department that MMA has completed each deliverable as required and as promised for initial roll-out of the system. We will also show we are prepared to fully support the Vermont pharmacy program through our operational process and procedures. Each of our subject matter experts will speak to their area of work and provide examples of how we have met each requirement of the implementation, doing so by cross-referencing implementation artifacts uploaded to the State's document repository with the Vermont PBM Requirements Traceability Matrix. Finally, we will walk through our Go-Live Plan. This plan will fully describe our strategy for decommissioning operation of the outgoing PBM system and transitioning all claim adjudication and services to MMA. The Go-Live Plan will include shutdown procedures for the outgoing vendor, start-up procedures for MMA, description of the teams supporting the transition onsite, remotely and from the MMA Support Center, contingency planning, issue escalation procedures and a description of how we plan to provide go-live support to the State after claim adjudication has been transitioned.
I4.18	During pilot testing and user acceptance, MMA will confidently demonstrate to the State that the claims adjudication system, its supporting systems, and its operational services have been tested end-to-end. We will provide examples of how eligibility data coming into MMA is leveraged to properly adjudicate an incoming claim against previously established utilization rules, how the claim is processed for payment, how the claim flows down to reciprocal systems and how the existence of the claim in our data warehouse enables us to better serve the State through program optimization for cost savings, cost avoidance and fraud and abuse prevention. Furthermore, MMA will demonstrate to the State our Support Center and on-site operational staff is prepared to exceed our service level agreements for the program and ensure a pleasant experience for the beneficiaries, the prescribers and the State.
I4.19	MMA will produce a lessons learned document after conducting the system component pilots and provide recommendations for changes to the Migration process.
I4.20	MMA provides PBM services to a total of 31 customers. Approximately half actively use POS offering and one customer is in transition to use our full POS offering. We work closely with our clients' vendors to ensure smooth flow of data between MMIS, Customer and PBM systems.

Template H Items Addressed by this Response	
Requirement Number	**Overview of MMA's Solution**
	Interfaces are scheduled using industry standard Tidal Scheduler and they are monitored 24/7 to ensure continuous movement of data.
I4.21	MMA has more than 40 years of experience in converting and loading all types of data from many sources. Our conversion process has successfully produced results of over 99.8% - 100% in past Medicaid POS implementations; data integrity issues account for the variance. Our established conversion process produces reports and metrics that list all files loaded, number of records loaded, number of records failed, percentages of success and failures, running totals, dates, run times, etc. Having successfully performed more than 30 data conversions for state Medicaid and similar programs, MMA is experienced with converting data to our PBM system. MMA will work closely with the State to transfer 10 years of data as required.

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.

DATA MIGRATION EXPERIENCE

Having successfully performed more than 30 data conversions for state Medicaid and similar programs, MMA is very experienced with both converting data to our PBM system and testing to ensure quality results. Depending on the file quality, we have achieved a 99 percent or 100 percent conversion rate. The value of our approach is that we combine our experience and sound approach with a suite of industry standard data integration and management tools, to create a successful process that maximizes conversion rates and minimizes risk, as shown in Figure 44 below.

Figure 44. MMA's Data Integration Technology Stack

CONFIDENTIAL MATERIAL: CONTAINS HIGHLY SENSITIVE PROPRIETARY AND/OR TRADE SECRET INFORMATION; PUBLIC DISCLOSURE WILL CAUSE SIGNIFICANT COMPETITIVE INJURY AND DISRUPTION.

DATA CONVERSION PLAN

MMA will deliver, maintain, and execute a Data Conversion Plan that describes the planning, development, testing, coordination, and processes required to seamlessly migrate DVHA's existing pharmacy data and interface its vendor systems to our system. Relying on our extensive experience converting data and using lessons learned from previous implementations, our Data Conversion Plan documents our current understanding of the business processes involved in the interrelated systems as described during requirements sessions. This plan is a component of the Project Management Plan, which remains the controlling document for this phase and all other phases of the project. The Data Interface Group is responsible for all data conversion activities and will develop the Plan leveraging a standard template.

The MMA Data Conversion and Project Management Teams will begin the data conversion process by first facilitating requirements sessions with DVHA from both DVHA and other contractors to identify and evaluate all sources of data needed to support the PBM processes. MMA will work with each data source and target system including DVHA's system(s), data warehouse, decision support, business intelligence, and other identified vendors. MMA has extensive breadth and depth in establishing conversion schedules, based on the duration of data that needs to be converted, defining the frequency and recommending a format.

The Data Conversion Plan describes the overall conversion strategy, scope, and approach, and to converting the data from the source systems to the target systems. The Plan will be based on defined conversion processes used for: deriving requirements, planning, designing, testing, pilot testing, implementing, and integration aspects of data to be converted to ensure the highest quality conversion. The Plan will also include:

- Relevant data sources
- Reporting migration requirements such as functionality validation or third-party tools and/or Legacy System and Source data
- Documentation of success and failure metrics
- Post migration cleanup process
- Final validation and acceptance procedures.

While MMA has a successful conversion track record, our plan will include emergency rollback contingency procedures in the event of unforeseen conversion issues.

This deliverable document summarizes the key areas to focus on in organizing, planning, and executing the conversion project tasks and deliverables with participants, process roles, and expected outcome and serves as a critical document to guide the Data Conversion Lead, developers, QA Team, and other staff in performing their roles relating to DVHA data conversion.

We anticipate DVHA will play a key role in the process, including reviewing and approving the plan; providing contact information for other contractors involved in the data conversion; providing input to, reviewing, and approval requirements documents; attending meetings;

answering questions to help MMA understand the data; reviewing, validating, and approving results reports and other documentation timely. MMA will work closely with DVHA and expects DVHA's assistance in obtaining timely data from the incumbent. We also expect that DVHA and the incumbent will respond timely to MMA inquiries relating to data conversion so data can be converted per the agreed-upon schedule and with a high conversion rate. Figure 45 below provides a high level summary of our view of the collaborative effort.

Figure 45. Data Conversion Roles and Responsibilities

Roles	Responsibilities
MMA Data Conversion Lead	• Supports the Implementation Manager in the management of the Data Conversion processes and related reporting. • Participates in the Data Conversion meetings. • Makes technical decisions relating to the configuration of data exchange and transform features. • Contributes to the system specification document to ensure that data conversion standards are addressed. • Gathers conversion requirements including mappings, layouts, and transformation rules. • Prepares and owns mapping documents. • Obtains State approval of mapping documents. • Helps to identify a potential cause if bugs or defects in the conversion process are detected. • Facilitates walk-through during the conversion validation.
MMA Data Conversion Team (Developers)	• Develops programs to map data fields to PBM system. Develops the translation rules for each conversion process. • Unit tests and validates conversion processes to ensure that the migration of data is compliant with the conversion requirements. • Analyzes rejected records, iteratively adjusts programs to resolve or work with State to correct issues. • Iteratively runs and monitors batch conversions to migrate data from the source system to the PBM system. • Performs data migrations between test and production environments. • Provides DVHA error reports for data anomalies during iterations of automated conversion execution. • Facilitates fix to data errors if the errors are a result of the conversion programs.
State	• Review and approve all documentation associated with data conversion and testing. • Assist the vendor in identifying sources of data for conversion. • Clarify, at the vendor's request, data elements definitions, record layouts, and file descriptions. • Review and authorize the number of data elements to be converted to the new system. • Review and approve the Conversion Test Results, including the approval of test result metrics. • Provide staff time for walkthroughs of the Data Conversion Plan and results.

MMA will include Key Performance Indicators in our plan, identifying success and failure metrics. These metrics include:

- Record Count
- Success conversion rate
- Failed conversion rate
- Rejection categorization.

DATA CONVERSION ACTIVITIES

The Data Conversion Plan supports the capture of converting data from the source systems into the target PBM system. MMA and DVHA staff will jointly perform a series of activities in accordance with the phases and timelines a defined in the MMA work plan. The process begins with the analysis phase in which all player will agree on what data is converted, what duration, how it will be transformed, what are the formation rules, and how the validation is performed. Conversion activities include:

- Develop, maintain, and successfully execute the Data Conversion Plan
  - Submit plan to DVHA for review and approval
- Coordinate, identify, and document all data interfaces with DVHA and vendors
- Support DVHA and vendors in conversion activities, such as but not limited to:
  - Schedule meetings
  - Prepare agendas, minutes, and other documentation for review
  - Maintain action item list
  - Prepare and distribute roles and responsibilities matrix (with contact business hour and emergency information)
- Identify, validate, and document the source data elements within the source systems
- Implement the data migration environment
- Identify and convert data to current industry standards
- Capture and document all data conversion requirements to the target system
  - Share documents with all effected stakeholders, obtain formal agreement/approval of requirements
- Establish secure data transfers with all vendors
- Confirm all conversions are accurate before migration to target system and transfer data from the source to the target system based on approved requirements
  - Provide conversion test plans to vendors to ensure they are complete and other vendors agree with expected results
  - In the event data is loaded out of sync either due to accidental transmission or an error, data can be either restored using hot and cold backups or physically deleted or records can logically be deleted by inactivating them.
- Confirm the output of the conversion process
  - Each migration activity generates a load report that compares the counts of the source systems against what has been converted. Evaluation is done using conversion reports
  - Submit results reports to DVHA and share with other vendors as appropriate
- Perform post conversion clean up as needed.

Figure 46 below graphically shows our data conversion process flow.

Figure 46. Data Conversion Process Flow

The following data conversion components are representative of those that have to be completed to successfully implement the PBM system for DVHA. Additionally, during the requirements definition period of the implementation, we will work with DVHA staff to identify all other conversion and interface needs and will implement those tasks during the implementation of the project.

- Eligibility History Conversion
- Historical Claims Conversion
- Provider Data
- Prior Authorization (PA) History Conversion
- Rebate History Conversion.

RISKS, ISSUES, AND MITIGATION

below, in Figure 47, are risks common to a PBM implementation and how MMA mitigates them.

Figure 47. Risks Common to a PBM Implementation

Risks/Issues	Mitigation

IMPLEMENT A DATA MIGRATION ENVIRONMENT

MMA's Data Interface Group maintains a secure data migration environment that allows us to perform staging, analysis, develop Extract Transform and Load (ETL) processes and verification of output data. All of these steps are necessary as we work with our customers to convert legacy data from their enterprise and the incumbent into MMA's pharmacy solution. We provide an economy of scale by utilizing a shared hardware and software environment for the transformation of data, which is then placed into the production environment configured specifically for each customer.

In the case of DVHA, MMA agrees to transfer ownership of all licenses for tools purchased specifically for the DVHA data migration. In addition, appropriate access to the environment will be granted to state designated personnel for the purposes of review and analysis of the data as it moves through the process. Based on MMA's experience with many other state programs, reports generated from the conversion activities, along with the use of converted data during User Acceptance Testing, will likely be sufficient to receive state sign-off which is the exit criteria for this phase.

MMA's Data Interface Group will provide a data migration environment for each computing environment including those used by DVHA's local agencies and remotely throughout Vermont. To support the successful implementation of a data migration environment, MMA will acquire

the hardware and software needed for a successful data conversion. We will begin the procurement process as soon as our contract with DVHA is signed and have the environment installed and ready well in advance of starting conversion activities. Separate servers will be used for each environment.

MMA's approach to data conversion addresses the security and privacy concerns of the technical infrastructure, the computing environments, and all the systems and services authorized users, including exchange data services partners' or trading partners' rights to data security, data privacy, and data confidentiality.

SYSTEM TEST AND DATA CONVERSION TEST RESULTS REPORTING

Our Technical Implementation Team will perform data integrity and conversion integration testing to include record counts, record sampling, and balancing using validation reports comparing the converted data with the source system. The automated methods will be used to convert and validate converted data.

Our established conversion process produces reports and metrics that list all files loaded, number of records loaded, number of records failed, percentages of success and failures, running totals, dates, run times, etc. The process will automatically build files of records rejected by reject type to be easily reviewed and once remediated, easily rerun through the process. The conversion method will provide exception reports to identify those instances of missing field values, failed editing routines (beneficiary not on file, provider not on file), invalid data format, etc. Reports will be delivered to DVHA for review. We will track problems identified as a result of the conversion process using our automated tool by issue type, description, and owner and will follow the resolution process. MMA will produce pre and post-conversion reports for each interface and table as well as detailed reports of all converted data.

We will send test result reports to DVHA and request that DVHA validate the reports, review the rejects, and work with MMA analysts in addressing them. In MMA's experience rejected records can be due to a variety of reasons such as source data issues, changes to default values and changes to transformation logic. As needed, we will include stakeholders from whom we received the data to convert to resolve any conversion issues.

DVHA will formally approve the conversion reports prior to the start of operations. The formal documentation will be archived in our document management system for future reference.

REVISE SYSTEM AND USER DOCUMENTATION

MMA will revise system and user documentation to reflect changes made during the conversion process. The Data Migration Manager will coordinate with the Document Management Team (led by the Director of Quality and Process Improvement to ensure a high quality product and ensure proper archiving.

MMA will create or revise the following system and user documentation:

- Technical Specification Agreement (TSA) Document listing all interfaces layouts.
- Interface Listing document that states the interfaces, source, destination, frequency, format
- Data Conversion Plan that documents MMA's approach to converting the data.

We will submit revised documents to DVHA for review and approval. MMA will publish the documents in our document management system after we receive formal written approval. DVHA will be able to view documents posted to the document management system.

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.

MMA will support and assist the transition by providing the data and information about the meta-data in a timely manner. MMA will further provide the control totals and record counts for each of the file transfers to help with the testing for a successful and complete data transfer. As part of the migration plan MMA, will provide the interface listing of currently supported interfaces, layouts, samples, actual data (with prior approvals from DVHA), trading partner setup information, and reports.

Approach to Data Conversion

MMA's strategy begins with the use of a custom-designed System Development Life Cycle (SDLC) to manage projects and transition our healthcare solutions on time and within budget. We focus on ensuring data integrity and maintaining data validity throughout the conversion process. We will work with the new vendor as it develops and submits to the state a Data Conversion Plan that defines the conversion process and implements the plan upon state approval.

The purpose and goals of the Data Conversation Task include:

- Successfully and accurately converting and loading all claims and claims-related data, such as provider and beneficiary eligibility and prior authorizations. We take into account the required time frame to account for the proper measure of historical data necessary to support the transition.
- Successfully and accurately converting benefit design information, including but not limited to: classification of inclusion or exclusion based on First DataBank classification information (for example, GSN, Therapeutic Class, route code, and NCPDP category code); quantity limits applied per claim by GSN, Therapeutic Class; age limits applied by GSN, Therapeutic Class.
- Tracking and correcting all conversion problems.
- Ensuring no data are lost.
- Ensuring the accuracy of the converted data.

The success of the Data Conversion Task depends on well-documented conversion models and data mapping to support efficient problem identification and acceptance testing. Data conversion also includes the development, testing, and documentation of all data conversion programs.

MMA's responsibilities for data conversion will include:

- Assisting in the development of a Data Conversion Plan that defines the following:
  - A complete list of data, files, and tables to be converted, including the sources of the data
  - A list of default data values and new requirements as needed
  - A data mapping between the current system and the proposed system
  - The plan for conversion, including a description of the methodology and processes for the completion and validation of full conversion
- Following the Conversion Test Plan
- Identifying, tracking, and resolving data anomalies (including historical data)
- Completing all required manual cleanup of data
- Conducting walk-throughs of deliverables as needed.

GAP ANALYSIS/RESOLUTION

We will profile the source system data elements and document the conversion requirements based on a series of requirements sessions with DVHA and its vendors. During the analysis of the source data elements and conversion facts gathering, MMA will provide DVHA with identification of presumed gaps. Meetings will be scheduled with DVHA to address gaps with the purpose of resolving gaps in the conversion requirements. Our Data Conversion Team will document findings and submit the findings to DVHA for approval.

In addition to interface requirements, MMA will validate all of the other functional requirements as well. A large part of this effort will focus on the gathering and articulation of the adjudication rules so that we may document them as the first step to configuring our adjudication engine, FirstRx. This process will start with a template based on a similar program which we will modify base on our understanding of DVHA specific rules, prior to our first meeting with DVHA's experts. That template will then become a living document that we will collaboratively refine until we are both satisfied that we have captured all the necessary rules. The exit criteria for this phase will be the receipt of sign-off from the State on all such documents.

MMA follows a Change Management process to implement system changes. A release schedule is published and documentation is updated by the Training and Development Department to reflect the autoload updates in advance of system change deployment. A revision history is maintained to indicate the revision date, as well as to provide basic information about the change.

Data Conversion Strategy

MMA has converted hundreds of data files from various vendors and clients into or out of the FirstRx™ pharmacy system and ancillary applications. We are prefpared to convert 10 years of data from DVHA as required. The details of the data conversion will be captured in the Data Conversion Plan that MMA will assist in creating. Interfaces in the pharmacy program include the following:

- Implementation/Conversion:
  - All active PAs
  - Defined number of months of PA history
  - Defined number of months of claims data
  - All claims history related to rebates
  - All Federal and supplemental rebates records
  - All A/P including check and EFT history
  - All A/R records.

MMA utilizes standard data interfaces to manage outgoing claims history, beneficiary, provider, drug, and other ancillary/reference files. All data interface jobs include error handling, which is used to alert the appropriate operational staff for problem resolution. MMA has a dedicated staff responsible for file transfers, currently supporting several transmission protocols, including Secure File Transfer Protocol (SFTP). All operational file transfer, load and extract processes are scheduled using the MMA enterprise scheduler and are monitored by a 24/7 support staff.

Data Conversion Testing

MMA uses a documented approach to define the scope, constraints, and accountability of the participants of the testing phase. This provides clear ownership definition for testing risks, schedule, and scope. Below, we detail our approach to testing and we will work with the new vendor and encourage them to provide a similarly rigorous process.

Quality Risk

Test cases and outcomes are prioritized by high-risk areas and allow us to focus on delivery of quality data conversion software. Risk definition allows the team to reduce the possibility of failure in the operational capability of the software. We recommend testing high-risk areas first to mitigate risk.

Test Case and Defect Tracking

MMA tracks cases using the specified data elements in Figure 48 and Figure 49 in a centralized repository. One output will contain test case detail for the effort that will address the business-defined risk. The other output will contain the prioritized defect list. The testing team will use both outputs to conduct testing. The Testing Manager or Lead is accountable to maintain and communicate the summary data.

Figure 48. Case Tracking Output Format

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Spreadsheet Column	Definition

Spreadsheet Column	Definition

Figure 49. Defect Tracking Output Format

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Spreadsheet Column	Definition

Testing Management Process

Scheduled Communication is built between third parties and the MMA Testing Team. Communication is planned up front and includes both steering mechanisms and detailed release sessions to handle testing requirements. This type of communication:

- Allows confirmation of testing strategy, test plan, test cases, and weekly testing status
- Includes case coordination, defect resolution status, and issue resolution status
- Allows the project managers to work with business representation to communicate weekly to address open requirements issues and review with the testing team
- Allows the team to coordinate and mitigate software risk concerns, defect resolution, and development effort priorities for testing with the software development workflow
- Confirms installation of the modified release or adjustment of system configuration/ documentation including release notes and defect fixes.

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?

MMA's dedicated Vermont Implementation Project Manager, Joe West, PMP, develops and submits Implementation and Rollout Phase Deliverables in accordance with DVHA's schedule. A full library of standardized PMM document templates is available to the team and customizable to DVHA. These tools ensure that the project management and delivery teams fully understand the tactical goals and objectives for all phases of this project.

IMPLEMENTATION AND ROLLOUT PHASE STRATEGY

Our team of Medicaid specialists, extensive clinical expertise, proven technology, advanced analytics, and 100 percent on-time implementation record provide the foundation for MMA to deliver an established pharmacy solution that will be customized to meet the specific needs of DVHA's program and its beneficiaries. Our Implement Project Team Management Team is responsible for determining the Implementation Strategy and schedule, with approval from DVHA. MMA's project team will continually monitor and be flexible in tailoring our services, staffing, and business processes to meet DVHA's needs. A Requirements Traceability Matrix (RTM) will be created which will be reviewed and approved by DVHA. MMA will invest the requisite time, thought, and effort to enhance systems, processes, analytics, and expertise to manage and adapt to meet the ever-changing requirements for success.

MMA's Project Management Methodology (PMM) includes an extensive collection of tools that enable the implementation project management team to effectively define, monitor, and report status on the various project management components, including the budget, schedule, resource utilization, milestones, deliverables, issues, and changes. A full library of standardized PMM document templates is available to the team and covers all the phases of the project. These tools will ensure that the project management team, as well as the delivery team, fully understands the tactical goals and objectives for all the phases of this project. MMA will obtain formal DVHA approval for the implementation of the system.

In addition, MMA proactive project management approach eliminates rework. MMA uses tools such as project norms to enable the project manager to proactively communicate whether the project is on or veering off track. See Figure 50 below for an example of project norms.

Figure 50. PMO Project Health Check Indicators

OPERATIONAL READINESS WALKTHROUGH

MMA will conduct an Operational Readiness Walkthrough with DVHA prior to the initial Pharmacy Implementation. MMA will perform specific implementation and PBMS operations functions to ensure operational readiness. In preparation for operations, MMA will perform final file conversions, recruit, and train operations staff, and conduct provider and DVHA staff training.

A draft of deliverables will be presented to DVHA for review and comments to ensure the requirements are met and processes and systems are functioning correctly. An Operational Readiness Checklist will be used to document completion dates and track the status of deliverables as the “Go-Live” date approaches. The checklist lists each deliverable task/activity and maps them to the appropriate requirements in the RTM and RFP. The checklist also lists the assignee for each task/activity and identifies artifacts used during the implementation. Upon review, DVHA will sign off on the status of each deliverable.

“GO-LIVE” SUPPORT PLAN

MMA will develop a “Go-Live” Support Plan, with DVHA approval, that documents the onsite and offsite authorized PBMS user support provided by the implementation. We proactively work with all switch vendors supporting pharmacies in the State to ensure they configure the software properly, and successfully execute test claims in our test environment before Go-Live. We also coordinate closely with the switch vendors in the hours prior to Go-Live to ensure claims successfully transmit in our POS production environment. Once the POS system goes live, we monitor claims real time and produce hourly reports to evaluate adjudication results and target any providers experiencing a high volume of claims rejections. We proactively make outbound calls to these providers to address billing issues, often before they call into our Pharmacy Support Center. The Go-Live Support Plan ensures DVHA receives exactly what has been asked for.

PILOT PLAN

Our pilot process and user acceptance process takes several days to complete. As afore mentioned, this stage begins with full training of MMA and DVHA operational staff, and concludes with a full operational readiness presentation by MMA subject matter experts who will demonstrate to the State how MMA has met each deliverable within the contract, and citing key artifacts that can be mapped back to the Vermont PBM requirements traceability matrix.

- Operational staff training (1-2 days)
- Executed test case review (1 day)
- Hands-on system testing (As required by the state)
- User-acceptance approval
- Operational readiness review (1 day).

IMPLEMENTATION AND ROLLOUT PREPARATIONS PLANS

Our Implementation Project Management Team is responsible for determining the Implementation Strategy and schedule, with approval from DVHA. We believe in vigilant monitoring and evaluation of our solution and continue to tailor our services, staffing, and business processes according to DVHA’s needs in serving the population continue to evolve.

As noted above, the Go-Live Support Plan documents the onsite and offsite authorized pharmacy system user support provided by the implementation.

Our rollout plan details planning and roadmaps for managing system releases. Our plan is composed of subsidiary management plans and documentation and remains the controlling document for activities and phases of the project. User guides, job aids, and on-line tutorials utilize production screenshots to display accurate representations of the application environment. We ensure these documents are up-to-date. Online tutorials allow participants hands-on training in production-style environments. MMA also uses a stage gate process to ensure that key stakeholders are accountable for each phase of the project and that there is structure in the approach to project management. Figure 25 above shows a sample of the various project stage gates.

POST-IMPLEMENTATION OPERATIONAL MONITORING PLAN

MMA will develop a Post-implementation Operational Monitoring Plan, including methods and schedules for DVHA and MMA to conduct post-implementation monitoring of pharmacy systems operations related to performance. For 30 calendar days following each facility or function, or work group implementation, MMA will review the aspects of the implementation to ensure everything is performing as expected and that nothing has adversely affected other processes. Post-implementation we share with DVHA documentation demonstrating our compliance with the requirements outlined in the proposal.

MMA will deliver the Facility Post-implementation Report after a facility, function, or work group has been determined to be ready for production cutover in accordance with DVHA approved scheduled time frames. We keep our team of programmers and developers available for 30 days to correct any concerns that might arise during Go-Live. This allows for real-time modifications and testing to be made and prevents delays in the process. If defects are identified, they are immediately corrected and the corrections migrated to production. (A QA and production environment is maintained during the life of the contract to allow for thorough testing prior to promotion to production.) During this period, the project team solicits feedback necessary for continuous improvement of work processes and products.

MMA Project Team will monitor and document system operations, performance and user experience through an Issues Register, which DVHA will have access to through a portal. The MMA Project Team will update the register as frequently as daily, if necessary and will include issues reporting through testing, gate reviews and other methods.

MMA will develop a Corrective Action Plan (CAP) if significant operations defects or deficiencies are encountered post-implementation. The CAP will provide a detailed schedule of events for the resolution of defects or deficiencies encountered. MMA understands and agrees to describe problems and root causes identified during post implementation as part of the CAP.

MMA will deliver to DVHA post-implementation evidence project requirements have been met. The Facility Post-Implementation Summary Report will include the Post-implementation requirements listed below:

- MMA understands and agrees to provide a complete description of deficiencies, defects, and issues encountered along with the resolution as part of the Facility Post-Implementation report deliverable.

MMA Post-Implementation Support

Ongoing, the MMA team dedicated to DVHA's program will work with applicable business and systems leaders within MMA to ensure the

- The Implementation Project Manager is responsible for documenting and submitting to DVHA for approval recommendations for any improvement to the system identified during both the Implementation Phase and the Operations Phase of the implementation as part of the Facility Post-Implementation Report deliverable.
- The Implementation Project Manager is responsible for providing updates to the Project Management Plan (PMP). MMA will provide the opportunity and capability for DVHA to access the PMP via our Implementation Portal.
- The Implementation Project Manager is responsible for documenting and submitting to DVHA for approval updates to the Security and Privacy Plan as needed.

committed and necessary support to meet our contractual obligations and the overall program needs.

The MMA team dedicated to DVHA's pharmacy program will continue to lead initial operations support and post-implementation support throughout the life of the contract. Specific business and technical project team members involved in the implementation stay engaged post-implementation for at least 30 days to monitor system and operational performance activity, and make any adjustments as necessary. Ongoing, the MMA team dedicated to DVHA's program will work with applicable business and systems leaders within MMA to ensure the committed and necessary support to meet our contractual obligations and the overall program needs. Routine meetings will be held to review system and operational activity and service levels.

Performance levels will be reported to DVHA on schedules to be determined in requirements sessions. Routine meetings will be held with key DVHA leaders to review needed program changes on an ongoing basis, and to manage the overall change control process, as well as tracking and expediting the resolution of identified errors, deficiencies, and/or problems. Claims, prior authorizations, and call center activity will be monitored after implementation, and successes, problems, and issues will be included in the status reporting presented at the routine meetings between MMA and DVHA. We will support DVHA in its evaluation of the PBM system and operations to ensure that all facets of the PBM operation are ready for CMS certification. We will provide a certification manager to oversee the process. We will resolve any issues or deficiencies identified. We will prepare any certification documents requested DVHA, generate reports, and ensure PBM certification requirements are met within the scope of the pharmacy operations.

In addition, MMA will prepare Business Continuity and Disaster Recovery Plan updates and testing results.

LESSONS LEARNED FROM THE IMPLEMENTATION AND ROLL OUT PHASE

A quality review is conducted of the testing activities executed by the Test Team by the Project Management Team, and lessons learned are documented. Test results are documented in the test case database and mapped back to approved business requirement documentation. A final test case matrix is produced, which contains the testing documentation for the implementation project. This document will be approved by DVHA prior to promotion to the production environment. The Testing Manager will communicate defects in the defect tracking tool and weekly testing meetings, and document them in weekly meeting minutes. Issue resolutions will be examined to gain insight into root causes. The disposition of the defects and any comments are entered into the defect management tool. Reports are created and forwarded to management to be discussed with DVHA during the lessons learned meeting.

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'.

In Figure 51 below, MMA describes our approach to meeting the Quality Management requirements in Template H.

Figure 51. Overview of MMA's Solution for Section 10.0

Template H Items Addressed by this Response	
Requirement Number	**Overview of MMA's Solution**
I5.1	MMA will submit a Quality Management Plan (QMP) to cover all phases of the contract. The plan will identify quality requirements and standards for the project. It also documents how the project will demonstrate compliance. The Quality Management Program ensures proper internal controls are in place and validates review sign offs, documentation, requirements tracking, and DVHA approval of all deliverables. The Quality Management Plan establishes the organization, roles and responsibilities, and processes and procedures for project implementation. It also establishes the quality standards and processes that will be employed over the life of the contract.
I5.2	MMA's approach to quality is reflected in our Quality Management Plan. The standard plan can be altered to include mutually agreed-upon components requested by the State. The State's goals will be captured early in the implementation cycle to ensure the appropriate metrics are developed and reported on at regular intervals during implementation and throughout the contract period. Metrics are captured from the systems and reported on. The major components of our standard plan are: • Formal requirements Gathering process and documentation templates • Requirements Traceability Matrix • Project Management Office protocols including work plans, action items, meeting minutes, use of SharePoint sites, regular meetings, issues tracking, action items log • Training programs (internal and client) • Documented operational procedures • Organizational structures • Full testing of all changes to all systems • Defect management using tool • Corrective Action Plan templates Client approval stage gates for changes and decisions, post implementation random sample and focused audits.

Template H Items Addressed by this Response	
Requirement Number	**Overview of MMA's Solution**
	Organizationally, MMA places considerable importance on Quality Assurance and Process Improvement, as evidenced by an autonomous PMO, QA Department, QC Department, Training and Documentation Department, Compliance Department and Process Improvement Department, which uses the DMAIC approach to process improvement.
I5.3	MMA welcomes the State's review of all QA policies, procedures and security measures.
I5.4	MMA maintains separate development and testing environments from our production environment. These test environments are a copy of the production environment and are regularly refreshed from production to ensure the latest coding and data with which to run regression and perform testing of ongoing changes.
I5.5	MMA allows real-time inquiry of all data repositories in the test environment to simulate the production environment.
I5.6	MMA documents all test cases and results in our test environment in an Access database, allowing them to be researched, reversed and rerun. Changes are made for impact analysis and/or to enhance the system.
I5.7	All interfaces come with well-established and documented controls and safeguards at each step from file delivery to loading and reporting. Each execution produces a report documenting what records have been read, loaded, error, rejected, and how they balance. There are extensive structural integrity checks done, field validations performed, and many infrastructure checks and exceptions tracked.
I5.8	MMA complies with PERM requirements, legislated requirements, NCPDP standards, as well as other quality assurance programs required specifically by the State.
I5.9	On a weekly basis, claims are randomly sampled and audited by our QC Department. Additionally, with every change made to our system or benefit structures, the changes are tested prior to production release, and audited after production release.

MMA will submit a Quality Management Plan (QMP) to cover all phases of the contract. The plan will identify quality requirements and standards for the project and documents how the project will demonstrate compliance. The Quality Management Program ensures proper internal controls are in place and validates review sign offs, documentation, requirements tracking, and DHVA approval of all deliverables. The Quality Management Plan establishes the organization, roles and responsibilities, and processes and procedures for project implementation. It also establishes the quality standards and processes that will be employed across the project.

The plan will identify the stakeholders and key participants in the quality process and their respective roles and responsibilities. The plan will support our efforts to deliver a quality solution by outlining the project approach and criteria for performing quality reviews at project levels, as well as defining the approach for verifying and validating product quality throughout the project lifecycle. Our Quality Management Plan will provide the mechanism to build quality into the project and to maintain that level of quality throughout the contract term. The Quality

Management Plan will confirm that the resolution or cure period will commence upon approval by DVHA of the defect resolution and priority, as well as confirmation that written notice has been received. The Quality Management Plan will be presented to DVHA for approval.

In order to ensure quality, the Program Management Office (PMO) will share knowledge and best practices with DVHA regularly. MMA understands the importance of empowering the client and makes sure DVHA retains ownership of the project. DVHA will be able to make decisions without having to be dependent on MMA. Each Implementation Project Manager in the MMA PMO is cross-trained to manage client RFP responses, project implementations and IT infrastructure projects. In the unlikely event that our Vermont Implementation Project Manager is out of the office, another Implementation Project Manager will manage the project. The result will be that no time will be lost on the project and DVHA always has a focal point at MMA.

We define and implement change in cases where the performance does not meet the requirement, and we look for ways to improve the process to increase productivity and efficiency. Our full-circle approach to quality performance and ongoing improvement is shown below in Figure 52.

Figure 52. Approach to Quality Performance and Improvement

CONFIDENTIAL MATERIAL: CONTAINS HIGHLY SENSITIVE PROPRIETARY AND/OR TRADE SECRET INFORMATION; PUBLIC DISCLOSURE WILL CAUSE SIGNIFICANT COMPETITIVE INJURY AND DISRUPTION.

MMA understands and agrees that DVHA may modify the time-to-fix period after consultation with MMA if it is judged to be in the best interest of DVHA or its stakeholders.

MMA follows a project tracking and oversight process in order to provide visibility into actual progress so that management can take effective actions when performance deviates from plan.

Whenever a defect is identified, MMA will perform all necessary steps to quickly remediate to the satisfaction of DVHA and within all time frames as specified by DVHA.

MMA understands and agrees to modify our project tracking and oversight process in accordance with the final guidelines approved in DVHA Defect Identification and Resolution Plan defined and administered by DVHA.

MMA's Quality Management Plan puts focus on requirements management by using our established Requirements Template and standardized process which emphasizes version control, appropriate client approvals, and a formal internal validation step, prior to development or testing. A sample of the template and the process can be provided. We employ a Test Plan which includes all aspects of the testing process, including but not limited to the Table of Contents outlined in Section I3. This plan covers all levels of testing including system test, system migration, data migration, and systems operations.

We use a solid defect management tool which tracks defects and reports on defects/resolutions from the beginning to end of the defect life. Reports and metrics are generated from this tool. Our RTM (Requirements Traceability Matrix) maps each and every business requirement to one or more test cases, and includes expected and actual results. DVHA approval must be obtained before moving the tested system into the production environment. This is true both for the first time implementation, as well as ongoing operational change releases.

After the initial implementation of the program, MMA maintains a fully operational ongoing change management process for operations and system and benefit changes as described below:

Configuration Management Plan

The Configuration Management Plan specifies how the project team will manage the configuration of the software system under development to ensure:

- Proper identification and description of deliverables
- Systematic control of changes to the configuration
- Integrity and traceability of the configuration.

Our Configuration Management Plan includes the following elements:

- Configuration Management Team identification
- Team responsibilities
- Team security levels
- Baseline library management plan
- Versioning methodology, including controls for storage and handling and delivery of software releases
- Documentation
- Reporting/communication
- Configuration items and owners
- Configuration tools and resources.

Operational Change Management

MMA provides an experienced Operational Team that will work closely with Vermont throughout the contract to identify, discuss, and document all clinical criteria and business rules to be implemented in the FirstRx system. The Implementation Requirements Document will be maintained as a living document throughout the term of the contract. The MMA Plan Administrator will configure Vermont specific business rules and all clinical criteria required on an ongoing basis as directed by the State of Vermont. The MMA Business Analysts will craft, execute, and document implementation requirements test results. MMA will provide all test results for approval and will be also available to review and discuss the results with Vermont staff if necessary.

After obtaining Vermont approval for ongoing changes, MMA will operate the POS system, maintain benefit plans, update pricing and PA rules, and make configuration changes as needed and approved by Vermont through the Change Control Benefit Configuration Process after Go-Live. A Change Control Memo (CCM) is a request to change plan configuration for specific drugs, beneficiaries, providers, groups, health conditions, etc. The CCM is initiated by the Account Director or one of the Clinical Administrative Pharmacists on behalf of Vermont. MMA Plan Administration staff will execute impact analysis testing of proposed business rule changes and test results for review with Vermont staff as defined in our Change Control Benefit Configuration Workflow Process (see Figure 53 and Figure 54 below). Upon deployment, changes will be available immediately for claims adjudication. Following deployment to the production environment, trial claims are submitted to validate the edit functionality.

Figure 53. Change Control Benefit Configuration Process, page 1

Figure 54. Change Control Benefit Configuration Process, page 2

Our corporate compliance auditors perform regular random sample claims audits, as well as focused audits on high impact changes. After implementation, the following activities occur:

Quality Audit:

- Routine daily, weekly or monthly claims audits are performed by the clinical managers and/or compliance auditors; any discrepancies are reported, and fixed, if necessary, through the change control process, and via the use of the Change Control Memo (CCM).
- Compliance Department Auditors perform audits on each CCM once it is released to the production environment. If no claims are affected by the change, the auditors will revisit at regular intervals.
- Compliance Department Auditors perform weekly claims audit samples of paid and denied claims for each client. Results are reported to Account and Clinical Management and Plan Administration.

Quality Control:

- On at least a quarterly basis, every customer's plan is regression tested to ensure that system functionality remains stable over time. A customer's regression test bed includes test cases for every section in the CSA that pertains to claims processing. The regression testing cycle is timed with the core claims processing release cycle to ensure that all changes made to the system are fully tested, and are not affecting existing functionality.
- Regression testing documentation is reviewed with Plan Administration, and the customer, upon request.
- Regression test beds are updated at least quarterly to incorporate all known changes initiated internally, or by the customer.
- All testing documentation is stored in a database, from which reports can be generated.
- Testing environments remain objective and separate from the development and production environments.

Our Test Evaluation and Management Plan addresses the steps we take to ensure the integrity of services and the processing and storage of data, including testing environments, which are a copy of our production environment and tested by our independent QA Department.

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'.

In Figure 55 below, MMA describes our approach to meeting the System Administration and Disaster Recovery requirements in Template H.

Figure 55. Overview of MMA's Solution for Section 11.0

Template H Items Addressed by this Response	
Requirement Number	**Overview of MMA's Solution**
O1.1	MMA's Data Center management ensures Disaster Recovery planning documentation for our non-production environment is maintained and consistent with current hardware/software configurations. Business Continuity plans are developed and maintained by the operational leadership at each of our service center locations.
O1.2	MMA's Data Center management ensures Disaster Recovery planning documentation for our production environment is maintained and consistent with current hardware/software configurations. Business Continuity Plans are developed and maintained by the operational leadership at each of our service center locations.
O1.3	Failover testing within our business continuity plan will be considered. Because we recognize that redundancy with failover is the preferred strategy for ensuring the continuity of business critical applications and their supporting IT infrastructure, we have data centers located in Maryland, Arizona, and Virginia. MMA has taken steps to eliminate or reduce to a minimum, unplanned data and telecommunication systems outages using current hardware and software technologies. Unplanned downtime exposure during day-to-day operations is significantly reduced with backup power generation systems, hosted environmental and systems monitoring applications, computer system and network hardware redundancies, mirrored disk, and data replication. Some of these technologies also serve to expedite critical systems recovery following a catastrophic event.
O1.4	The State will have 24/7 access to MMA's IT Service Center (ITSC) (Help Desk), ensuring any system-related issue that may arise will be handled in a swift and efficient manner. The ITSC maintains detailed contact information to ensure issues reported to them are escalated to the appropriate support group in a timely and efficient manner.
O1.5	Help Desk staff is available 24/7/365 to receive communication from and offer support to our customers and our internal users. This group has a well-defined escalation procedure including criteria to assess a severity level, designed to quickly engage the personnel necessary to effectively resolve issues that arise.

Template H Items Addressed by this Response	
Requirement Number	**Overview of MMA's Solution**
O1.6	The MMA Data Center is staffed 24/7/365 by a qualified operations team. This team is the first responders to environmental alerts and potential system processing problems. Each functional area IT manager maintains continuous automated alerting and monitoring on his or her system. The alerts are programmed to notify the operations teams via SMS Text messaging and Email to the on-call professional technician. For critical systems, such as errors in claims processing, Support Center applications, server connectivity, security and network operation, the alerts are also sent to Senior IT management to ensure the systems in question are getting the necessary technical attention needed to review and or correct an issue.
O1.7	The Data Services Team publishes daily, weekly and monthly response time reports for review by MMA management and for use in contract SLA reporting requirements.
O1.8	We monitor the systems throughout the 24-hour period in accordance with ITIL best practices. System capacity is forecasted regularly to ensure adequate system resources are available to support current and future business. Many of our personnel are ITIL v3 certified, including all members of our Quality Performance Improvement department. Each morning during non-business hours (4:00-5:00 a.m. Eastern) we conduct a routine check of our applications, systems, and services to ensure they are operational and working properly. MMA's Data Center Operations team has an extensive checklist of systems and applications that are tested every morning to ensure that all are working as expected prior to the start of the normal work day. A few examples of the tests performed are: • Availability of critical mid-range and web applications • FAX lines and servers • Voice recording service components • Citrix and Imaging servers • E-mail and internet services Automated tools proactively monitor our IT infrastructure, perimeter, systems, and databases 24/7/365 and report on issues or items that are outside of thresholds set to define optimum operation and performance. This includes tools to monitor the facilities and environmental conditions, the WAN, local area network, Intel server infrastructure components, and midrange systems. Some of the tools and resources used in the monitoring of our processing environment include, but are not limited to: • Microsoft SCOM (Systems Center Operations Manager) • HP Insight Manager • Solarwinds • Oracle Enterprise Manager • Foglight • RX Monitor • WhatsUp Gold (A network management and server monitoring tool)

Template H Items Addressed by this Response	
Requirement Number	**Overview of MMA's Solution**
	• MOM (Microsoft Operations Manager) • ECC (EMC Control Center) • Fluke Netflow • Halcyon • XYMON • SiteScan (Web centralized monitoring and control tool)
O1.9	MMA has detailed procedures and processes that define the data backup, archiving, and file restoration processes. Backups are performed daily (incremental) and weekly (full save) for all mid range platforms. Full backups are performed nightly for Intel systems. Archive tapes are stored permanently offsite. Archives are full system backups performed on the last full weekend of the month for most mid range systems, or on the last day of the month for Intel systems and the mid range iSeries production systems. The Remedy database that records PA and Contact detail data for all clients is incrementally archived periodically at the Oracle database level. At the application level, records for a specific state can also be archived to the Remedy database per state defined criteria. Database logs for FirstTrax are backed up daily. A full database backup is conducted in three day intervals. At the application level, records for a specific state can also be moved or copied to an archive table per state defined criteria as frequently as every 24 hours.
O1.10	MMA's Quality Management Plan puts focus on requirements management by using our established Requirements Template and standardized process which emphasizes version control.
O1.11	MMA recognizes that we are a key business partner with our customers and will continue to provide all of our services in accordance with the relevant audit policies of all Medicaid and Federal agencies, MMA's Security Department has the task of ensuring that beneficiaries' health information is protected as it rests in our systems, accessed by our employees, or when it is exchanged via electronic means. To address this, we have implemented technical, physical, and administrative safeguards. All systems activity, including user activity, is logged, monitored and the activities are available for reporting and auditing in accordance with policy. All deviations from accepted practices outlined in policy are investigated and risks associated with these events are mitigated accordingly. To monitor internal systems activity, Audit trails are maintained on all applications and systems processing personal, private and confidential information. All production application systems containing personal, private, and confidential MMA information generate logs that show every addition, modification, and deletion to such personal, private, and

Template H Items Addressed by this Response	
Requirement Number	**Overview of MMA's Solution**
	confidential information. These audit trails: • Contain a unique log-on or terminal ID, the date, and time of any create/modify/delete action and, if applicable, the ID of the system job that effected the action • Include the date and identification "stamp" displayed on any on-line inquiry • Include the ability to trace data from the final place of recording back to its source data file and/or document • Are supported by listings, transaction reports, update reports, transaction logs, or error logs. All audit/management trails are backed up on a regular basis and are stored in a secure location. They include sufficient information to establish what event occurred and who (or what) caused it. The scope and contents of the audit trail will balance security needs with performance needs, privacy, and cost. At a minimum, the event record must specify: • Type of event • When the event occurred (time and day) • User ID associated with the event • Program or command used to initiate the event. All computer systems running our production application systems must include logs which record, at a minimum, the following data: • User session activity including user IDs, log-in date/time, log-out date/time, and applications invoked • Creations, changes, and/or deletions to critical application system files • Additions and changes to the privileges of users • System startups and shutdowns • Password activity, specifically when and who last changed a password, and when and who last changed account privileges. The database audit function also collects and maintains information concerning security-related events for later review and analysis. At a minimum MMA tracks and records the database activities that include, information concerning database level access, database DML activity, database restore activities, and invalid access attempts. These audit report records are generated by the Oracle Audit Vault activity logging which is capable of tracing this database activity up to the constituent level of the identity management framework diagramed below. The sensitivity of the resource, or the nature of the transaction, may require the recording of additional information or additional types of events (for example, transaction logging).

Template H Items Addressed by this Response	
Requirement Number	**Overview of MMA's Solution**
O1.12	MMAs multi-layered approach to security provides perimeter protection, segregated operations, business, and administrative architectures, and extra protective measures associated with our Web presence. MMA also monitors all of these interfaces to identify inappropriate or unauthorized traffic, email, and attempts to connect to our systems.
O1.13	MMA applications, databases, and servers log every access to systems, including an audit trail for successful logins, web-pages accessed, information (data) accessed for each web page, etc. We ensure that audit trail for system access is maintained (in active and/or archive state) for the last seven years, as required by contract. MMA utilizes Oracle Vault auditing for is a highly secure database system and for customers requesting additional audit capabilities. The audit vault allows for custom auditing and alerting of database access. Processes are in place to sample data access and update activity. If a database object is access or updated a record is made. Periodically, these updates are sent to the audit review team and the team takes a sampling of the data access or changes made and they are compared to the change management system list of changes. All access to security audit data is limited to the Security Department and other privileged users as necessary and as designated by the Security Department. This limited access is strictly enforced. The Security Department is responsible for reviewing all security audit trails. All trails are analyzed regularly and within a scheduled time frame
O1.14	MMA follows the NIST guidelines for encryption wherever necessary to ensure the security and safety of our data while in transit. We use a minimum of 256 bit algorithms when calculating hashes and a minimum of 1024 bit keys for our SSL certificates. All applications are vetted by our security team to validate that they use the appropriate level(s) of security and/or encryption prior to the application being released to production.
O1.15	MMA is fully compliant with the HIPAA Standards for Privacy, Electronic Transactions, and Security (including the HITECH Act and its implementing regulations). Our Corporate Compliance Department works in conjunction with each of MMA's business units, departments, and regional offices to monitor ongoing compliance efforts and maintain various reporting mechanisms that are required by law or requested by MMA's state Medicaid customers. MMA will work with the State throughout the Implementation Phase, and ongoing thereafter, to ensure continued compliance with State-owned asset security and privacy safeguards, and to ensure project materials, work products, and deliverables are secured to maintain confidentiality at all times.
O1.16	MMA has taken a multi-layered approach to security based on the International System Security Certification Consortium (ISC2) — the international standard for IT security — and the National Institute of Standards and Technology (NIST). MMA's Security Department has the task of ensuring that beneficiaries' health information is protected as it rests in our systems and when it is exchanged via electronic means. To address this, we have implemented technical, physical, and administrative

Template H Items Addressed by this Response	
Requirement Number	**Overview of MMA's Solution**
	safeguards to enhance physical security, personnel security, and information systems security. Our methods provide perimeter protection, segregated operations, business, and administrative architectures, and extra protective measures associated with our web presence. MMA also monitors all of these interfaces to identify inappropriate or unauthorized traffic, email, and attempts to connect to our systems.
O1.17	MMA adheres to the security concept of Users, Roles, Policies, and Resources, implementing policies that meet or exceed all HIPAA and State regulations related to the privacy and security of PHI. MMA routinely conducts security assessments and vulnerability testing and mitigates any issues or risks found in a timely manner and conducts Annual SSAE 16 and SOX audits to assess the effectiveness of the controls in place and to develop and deploy control improvement plans. Our Security Department uses both open source and commercially available tools to conduct network vulnerability assessments. These assessments are targeted at various systems from both an internal and external perspective.
O1.18	Our security levels will be commensurate with the risk and magnitude of harm that could result from the loss, misuse, disclosure, or modification of information. MMA follows best practices especially with the handling of beneficiary PHI. All newly hired employees receive the HIPAA training during their new employee orientation period and all staff members are required to participate in annual HIPAA refresher trainings.
O1.19	MMA currently maintains security controls in accordance with Federal and State security policies and regulations. We will maintain these controls throughout the life of the contract.

System Administration

Figure 56. Dashboard Performance Chart

CONFIDENTIAL MATERIAL: CONTAINS HIGHLY SENSITIVE PROPRIETARY AND/OR TRADE SECRET INFORMATION; PUBLIC DISCLOSURE WILL CAUSE SIGNIFICANT COMPETITIVE INJURY AND DISRUPTION.

- XYMON
- SiteScan (Web centralized monitoring and control tool)

CONFIDENTIAL MATERIAL: CONTAINS HIGHLY SENSITIVE PROPRIETARY AND/OR TRADE SECRET INFORMATION; PUBLIC DISCLOSURE WILL CAUSE SIGNIFICANT COMPETITIVE INJURY AND DISRUPTION.

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.

below in Figure 65 we describe our approach to meeting the performance standards set forth in Template H – Non-functional Requirements, Tab O2 SLRs and Performance.

Figure 57. Overview of MMA's Solution for Section 12.0

Template H Items Addressed by this Response	

Template H Items Addressed by this Response	

Template H Items Addressed by this Response	
	•

Template H Items Addressed by this Response	

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

Business Process Performance Measures		
SLR Name	**Service Level Requirement**	**Frequency of Measurement**
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

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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 Lookup queries Response Times	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 agreed to exclusions.	Monthly
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

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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.	Vermont PBM RFP Final document, Section 3.13, Additional Terms and Conditions, Subsection 3.13.1, Hosted System Requirements, Page 91	MMA's data center and technical infrastructure will serve as the foundation for delivering Vermont's PBM solution.	
2.			
3.			

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Template J

Work Plan

RFP # 03410-127-14

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1.0 Instructions

The Vendor must submit an Implementation Phase Work Plan that will be used to create a consistent and coherent management plan. This Work Plan will demonstrate that the Vendor has a thorough understanding for the scope of work and what must be done to satisfy the project requirements and implement a pharmacy benefit management system and services that meet the requirements of the State.

The Work Plan must include detail sufficient to give the State an understanding of how the Vendor's knowledge and approach will:

- Manage the Work;
- Guide Work execution;
- Document planning assumptions and decisions;
- Facilitate communication among stakeholders; and
- Define key management review as to content, scope, and schedule.

At a minimum, the Vendor's Work Plan must include the following:

- Work breakdown structure;
- High Level Project schedule for all project deliverables and milestones;
- Who is assigned responsibility for each deliverable within the work breakdown structure to the level at which control will be exercised;
- Identification of deliverables that require a more prompt State acceptance than described in the RFP including the proposed acceptance period for the deliverable;
- Performance measurement baselines for technical scope and schedule;
- Major milestones and target date(s) for each milestone that are consistent with this RFP's dates;
- Description of the Vendor's proposed organization(s) and management structure responsible for fulfilling the Contract's requirements and supporting the work, in terms of oversight and control;
- Definition of the review processes for each milestone and deliverable (e.g. mandatory design review) and a description of how the parties will conduct communication and status review;
- Description of the project issue resolution process including an escalation plan, where the escalation plan includes contact information for each person identified in the proposed problem reporting and escalation procedure and describes the amount of time elapsed before a problem is escalated within their organization; and
- If the Vendor chooses to use subcontractors, this part of the Vendor's proposal must describe its approach to managing its subcontractors effectively.

MMA has extensive experience and an outstanding track record for successful Medicaid PBM implementations; we have been on-time or early (at customer request), *every time* — delivering a smooth transition that ensures no disruption of services to beneficiaries and provider satisfaction. Our proven approach to project management and pharmacy program implementation has been fine tuned over the years and further strengthened by our enhanced tools and experienced professionals in the Medicaid PBM space. We have successfully worked with every MMIS vendor; additionally, our prior background as an MMIS fiscal agent gives us a greater understanding of the interfaces required to successfully exchange data, the need to effectively coordinate programs, and the essential nature of communicating clearly and timely.

Our project work plan details the implementation approach through each key phase as identified by DVHA and includes a comprehensive Readiness Review. We are accustomed to this structured project management methodology, with defined System Development Life Cycle (SDLC) phases and deliverables. Our SDLC methodology is focused on proven, repeatable processes and continued improvement. We will leverage our existing PBM project deliverable templates, system documentation for the proposed systems, and operational procedures to customize as we detail requirements and technical specifications for the DVHA program.

Our team of Medicaid specialists, extensive clinical expertise, proven technology, advanced analytics, 100% on-time implementation record, and prior experience in Vermont provide the foundation for MMA to deliver an established pharmacy solution that will be customized to meet the specific needs of DVHA and its beneficiaries. We believe in vigilant monitoring and evaluation of our solution and will continue to tailor our services, staffing, and business processes as the State of Vermont's needs in serving the population continue to evolve and our understanding deepens. We will invest the requisite time, thought, and effort to enhance systems, processes, analytics, and expertise to manage and adapt to meet the ever-changing requirements for success.

Testimonials from our Medicaid Customers

"Please convey my thanks to all of the MMA people that have been so responsive to our immediate needs so quickly."

"I really appreciate the great team that you put on this project. You've been great to work with, and I'm very glad we ended up contracting with you."

"I was extremely impressed with the way the implementation process was handled. It was very good knowing that issues that were addressed in one meeting would be corrected by the next time the meeting occurred. That was awesome."

"Our implementation (with MMA) was very smooth."

"We were pleased with the claims history load which was 100%! We received positive responses from providers regarding the Help Desk proactive level of service."

Our customer testimonials regarding our implementation approach for their programs speak to our success and overall customer satisfaction. We have competitive manufacturer rebate and MAC programs focused on serving Pharmacy Benefist Management customers and state-of-the-art pharmacy call centers using fully integrated contact management tools. Our industry-leading analytical tools and data warehouse provide an easy way to actively analyze cost savings opportunities, through identification of cost drivers and trends, in order to optimize patient health outcomes and make efficient use of State resources. Our staff members are experts in pharmacy programs, processes, and protocols, as well as the management of pharmacy benefits. We provide responsive service to our customers with a goal of exceeding expectations. MMA will provide Vermont with industry-leading best practices, innovation, transparency, reliability, credibility, and integrity.

We have included a detailed work plan provided in **Section XII, Attachment M** that will be used to create a consistent management plan for Vermont. The work plan provides a work breakdown structure (WBS), Gantt chart, and a project calendar in Microsoft Project®.

Our project management methodology is aligned with internationally accepted Project Management Institute (PMI) standards, and Project Management Body of Knowledge (PMBOK®) is carefully followed to ensure the highest possible quality of implementation. We follow these key principles and processes to ensure a smooth implementation:

- **Effective planning and control of the project** - MMA develops and maintains a detailed Project Work Plan with agreed-upon milestones and deliverables established. MMA creates and obtains internal stakeholder signoff on the Project Charter, which includes identifying initial requirements, assumptions, and risks.
- **Key Resources** - MMA establishes the Project Team and identifies the Subject Matter Experts/Owners for each milestone. Subject Matter Experts from both MMA and DVHA are identified, assigned, and committed for the established implementation time frame, to support program build-out for their respective areas. All project resources are involved at the start of the project.
- **Fully Documented Program Requirements** - We use templates for each program component and MMA's proven process for fully vetting program requirements with customers. MMA creates a Requirements Traceability Matrix (RTM) identifying every requirement. In addition to the detailed business requirements, rules, and data needs, our documentation captures project objectives, scope, dependencies, assumptions, risks, and constraints. We will submit our documentation to DVHA for review and approval.
- **Quality Plan** - MMA will create a Quality Management Plan that promotes a project environment focused on quality outcomes. The plan will identify the stakeholders and key participants in the quality process and their respective roles and responsibilities in the delivery of a successful implementation.
- **Risk Management Plan -** The plan establishes a process for identifying and addressing risk areas in execution of the plan. Proper identification and escalation are critical in deploying mitigation strategies.
- **Disaster Recovery Plan -** The MMA Business Continuity Plan (BCP) consists of our Disaster Recovery, Business Continuity, and Contingency Plans. It is our comprehensive plan of action for responding to any natural or man-made disasters, preventing interruptions to normal business, protecting critical business processes, and providing strategies for resumption of normal business activities.
- **Review of the Project Budget and Time Reporting** - MMA Project Managers closely monitor actual project budget expenditures versus the plan and track the hours of every project participant to help ensure budget and schedule adherence.
- **Change Management Process** - We establish a structured Change Control Board with State and MMA representatives. Changes to the program are inevitable, and we use our proven process for working effectively with customers to manage requirements, prioritization, development, and deployment in a manner that meets the State's defined timelines.

The WBS provides the State with an understanding of our approach to:

- Manage the work;

- Guide work execution;
- Document planning assumptions and decisions;
- Facilitate communication among stakeholders; and
- Define key management review as to content, scope, and schedule.

Below we provide more detail on our approach to the State's implementation.

Manage and Guide Work Execution

Vermont's WBS is organized into the seven task-related deliverables outlined in section 2.7 of the RFP. As outlined in the work plan, the project is divided into the following project phases:

- **Task 1 – Project Initiation and Planning:** This phase of the project plan includes the kick-off meeting and review of the project management plan and schedule.
- **Task 2 – Requirements Validation:** During this phase the Requirements Specification Document (RSD), which outlines requirement methodology is created. Once the RSD is approved by the State, the detailed Requirements Traceability Matrix (RTM) is developed in collaboration with the State's designated project and testing manager. The RTM contains a crosswalk of RFP functional requirements to legacy system functionality. It also includes details on functional and non-functional requirements, with test cases, results, and system mapping information.
- **Task 3 – System Design:** During this phase, we begin the designing of the system specifications. The MMA Vermont Account Manager, Teresa Elam, works collaboratively with the Implementation Project Manager, Joe West, PMP, to coordinate design sessions to gather requirements for the configuration design document and data integration/interface document. Through the use of control tools, all sessions are formally documented. We use a detailed system design plan to keep track of all discussions. In Figure 1 we provide a sample detailed system design plan that will be used during this phase.

Figure 1. Sample Detailed System Design Plan

Detailed System Design Plan	
Action	Description
Joint planning kick-off meeting	MMA staff confirms the scope of services, establishes firm baselines for all plans, initializes project tools and techniques and prepares for the management and administration of all six implementation phases. Initial requirement identification session dates are agreed upon.
Initial Requirements Identification	MMA staff reviews Department-specific materials including RFP and contract documents to begin the requirements identification/collection process in preparation for confirmation sessions. Requirements gathering/ confirmation session dates are agreed upon.
Requirements Gathering/Confirmation	MMA staff schedules and conducts facilitated sessions and records project requirements and business process model revisions. MMA staff reviews/revises and documents Business Process Models (BPMs), as well as roles and responsibilities for

Detailed System Design Plan	
Action	Description
	all parties. Standardized processes/templates are utilized in the collection/documentation process to facilitate a collaborative and efficient approach.
Research	MMA and/or DVHA-designated staff researches any materials provided during the requirements sessions that need further clarification.
Follow-up Meetings	MMA meets with DVHA to review and agree on the understanding of the requirements and reconcile any issues raised. At the conclusion of these meetings, the RTM deliverables will be updated as needed. Walk-through session dates are agreed upon.
Walk-Through	MMA presents a draft of the deliverable to DVHA for review and comments. Any identified gaps will be reviewed during these sessions in order to prioritize the gaps for closure. This meeting is intended to validate and close any outstanding issues before the deliverable is formally presented to DVHA for review and approval.
Correction	MMA incorporates revisions/corrections as appropriate based on the comments received within the specified time frame.
Formal Submission for Department Approval	MMA submits the deliverable to DVHA for formal review/comments and approval.

Using the parameters in Figure 1 above, we develop a schedule outlining when each of these actions will occur. The schedule is submitted to the State for approval.

- **Task 4 – Configuration and Development:** During this phase we will create wireframes, mockups, and proof of concept prototypes as necessary to support the efficient development of new functionality required for this contract. We will also establish testing and appropriate checklists to monitor progress. Below we outline the test activities and environments we use:
    - ***Unit Test Environment*** – Allows programmers to test a single component as a stand-alone entity before it is incorporated into the rest of the environment.
    - ***System Test Environment*** – Allows for isolated system testing modifications to a single component within the context of the system/subsystem in which it functions. System testing ensures that the entire system functions as designed after modification to a single component.
    - ***System Integration Test (SIT) Environment*** – Integration testing ensures that a defined set of interconnected systems/subsystems will perform as designed after modification to a single component. The integrated system may involve systems/subsystems interfaced together. This testing will ensure that interfaces are exchanging data.
- **Task 5 – Testing:** We develop a detailed System Test Plan that focuses on the overall approach to testing to ensure that the final system meets the relevant acceptance criteria. Our System Test Plan also documents how and in what format test results will

be reported to the State. Our testing progress reporting is provided on a weekly basis, and as we approach the go-live date, reports are generated on a daily basis. Testing results are coordinated through the MMA Vermont Account Manager, Teresa Elam, and Implementation Project Manager, Joe West, PMP.

To ensure integrity during this phase, we have seven test levels with unique objectives. Our testing environment allows for full transparency. DVHA is able to monitor the accuracy of the pharmacy system testing and all proposed changes. Below we have provided an overview of each test level and its objectives:

- ***Unit Testing:*** The objective of this phase is to document that the code functions on a stand-alone basis, prior to integrating into our systems. We validate that the code is in compliance with all specifications.
- ***System Testing:*** Vermont's Test Manager creates comprehensive test scenarios with expected results. During this phase we validate that the code is functioning as expected when impacted by other systems, and to a limited extent, that other systems function as expected when the new code is activated.
- ***Integration Testing:*** A variety of system interfaces exist between MMA's primary POS system and its ancillary systems, including eRebate™ and the user interface and prior authorization system, FirstTrax™. Testing across these systems, by designing test cases that include data and decisions from the supporting systems, ensures that the systems are functioning accurately together, sending and receiving transaction data in standard specified formats in a timely way, and producing results consistent with the business and functional requirements.
- ***User Acceptance Testing:*** Scenarios are defined to ensure that requirements are thoroughly tested by the user. User Acceptance Testing will include scenarios that test all components and interfaces. Business and UAT testers at MMA are seasoned and highly experienced with creating scenarios that incorporate all aspects of data, coverage criteria, exceptions, and drug edits. MMA encourages customer testing as well, and provides training and defect management process support to State UAT testers throughout the process.
- ***Operations Acceptance (End-to-End)Testing:*** During this phase we ensure that all end-to-end testing for incoming and outgoing data transmission and system interaction is functioning appropriately. The objective is to test across all project components in an isolated integration test environment. We validate that all components are functioning well together, sending and receiving transaction data in standard specified formats in a timely way, and producing results consistent with the business and functional requirements.
- ***Regression Testing:*** The objective of this phase is to ensure that the system remains stable over time, as changes are made. We employ a quarterly patch release schedule, which is first tested by the development team. A set of test cases that reflect core functionality is created and executed each time the system is changed, to ensure that earlier coding remained stable with each new change.
- ***Performance (Stress) Testing:*** The objective of stress testing is to validate the systems are meeting the contract-defined service level agreements so the system is able to handle an unusual load, if it should occur.

- **Task 6 – Training:** To provide for seamless training, we schedule a walkthrough of the Training Plan with DVHA staff to validate that all entrance and exit criteria have been met. Our Training Plan details all stakeholders at MMA and DVHA for applications testing. Our Training Team conducts a Training Needs Analysis which identifies stakeholders at each step, identifies their contributions and expectations, obtains the key training requirements and incorporates them in the training agenda, and estimates the number of resources required for conducting the training. We also develop a detailed Training Plan that outlines the approach, methodology, curriculum, and schedule that we will use to achieve a customized learning program and address the needs of the State. This plan also documents the delivery methods that are to be utilized, which may include webcast, on-site hands-on classroom facilitation, computer-based training (CBT), and web-based training (WBT). Prior to beginning any training, we obtain sign-off on our plan from DVHA.

  MMA staff is trained on all aspects of DVHA's plan. As changes are made to the plan, our Training Team provides refresher training. Our Training and Development and Quality Assurance departments maintain a close relationship with support center management in order to ensure compliance with the State's requirements, quality customer service, and accuracy.

  When training is complete, MMA sends DVHA a complete summary of training facilitated for operational readiness that includes the final list of all training conducted along with a list of attendees for each training session. The report will be based on the Attendee Tracking Log. DVHA can use this summary to validate that MMA completed all scheduled training sessions and that the expected MMA and DVHA staff participated.

- **Task 7 – Deployment:** During this phase we provide a Deployment Plan, CMS certification, system documentation, performance SLA documentation, and rollout.

  - ***Deployment Plan:*** We conduct a walkthrough as part of our Deployment Plan to ensure operational readiness. In preparation for operations, we perform final file conversions, recruit and train operations staff, and conduct provider and Department staff training. A draft of deliverables will be presented to DVHA for review and comment to ensure the requirements are met and processes and systems are functioning correctly. A deployment checklist is used to document completion dates and track the status of deliverables as the Go-Live date approaches. The checklist lists each deliverable task/activity and maps them to the appropriate requirements in the RTM and RFP. The checklist also lists the assignee for each task/activity and identifies system documentation used during the implementation. Upon review, DVHA will sign off on the status of each deliverable.

    As part of the Deployment Plan, we create a go-live support plan that documents the on-site and off-site authorized user support provided by the Implementation Team. We proactively work with all switch vendors supporting pharmacies in the State to ensure they configure the software properly, and successfully execute test claims in our test environment before Go-Live. We also coordinate closely with the switch vendors in the hours prior To Go-Live to ensure claims successfully transmit in our POS production environment. Once the POS system goes live, we monitor claims real-time and produce hourly reports to evaluate adjudication results and target any providers experiencing a high volume of claims rejections. We proactively make outbound calls to these providers to address billing issues, often before they call into our Pharmacy Support Center.

- ***CMS Certification:*** We coordinate with DVHA to customize all PBM-related MECT checklists, and we will utilize software (ReadyCERT) to assist in the process. We help DVHA in completing the checklists by collecting all necessary data to fulfill necessary requirements. We also assign resources as needed to assist with the certification effort. These resources are dedicated to DVHA throughout the project lifecycle. During the CMS on-site visit phase, we will provide on-site staff to assist in resolving any action items or providing any clarifications necessary to satisfy the CMS system review criteria.
- ***System Documentation:*** We develop a system documentation template that includes hardware and software descriptions of the services and infrastructural components. The system documentation template is part of the Design Specification Document (DSD). The IT Lead will produce DSDs and submit them to DVHA for approval. After submission, MMA will schedule a walkthrough so that the technical SMEs who contributed to the document can answer any questions and make clarifications to the document. This will be an iterative process that continues until DVHA accepts the document. The MMA Technical Lead will conduct technical reviews of the DSD with DVHA to verify the design. The Technical Lead, Business Analyst and system subject matter expert will work together to drive the meetings, walk through the document, and update the document.
- ***Performance SLAs:*** As part of Vermont's final contract, performance SLAs are included.
- ***Rollout:*** Our Rollout Plan details planning and roadmaps for managing system releases. Our plan is composed of subsidiary management plans and documentation and remains the controlling document for activities and phases of the project. User guides, job aids, and on-line tutorials utilize production screenshots to display accurate representations of the application environment. We ensure these documents are up-to-date. On-line tutorials allow participants hands-on training in production-style environments. MMA also uses a stage gate process to ensure that key stakeholders are accountable for each phase of the project and that there is structure in the approach to project management.

Document planning assumptions and decisions

Initial work plan assumptions are included in Section 2.0 of this document, and any planning assumptions and/or decisions identified during implementation will adhere to the controlled correspondence process as defined by DVHA and be stored on the Project Information Library (PIL) for project duration. Requests for decisions and/or information and the subsequent response to those requests will be tracked and will require signature by both the State Project Manager (or designee) and MMA's Implementation Project Manager, Mr. West (or designee). MMA understands no Controlled Correspondence document is effective until the signatures of both are attached to the document. Process specifics will be reviewed during project planning and will be incorporated into the Project Management Plan (PMP).

Facilitate communication among stakeholders

Our PMM includes an extensive collection of tools that facilitates communications and enables the project management team to effectively define, monitor, and report status on the various project management components, including the budget, schedule, resource utilization, milestones, deliverables, issues, and changes. These tools will ensure that the project management team, as well as the delivery team, fully understands the tactical goals and

objectives for the phases of this project. MMA will obtain formal DVHA approval for the implementation of the system.

In addition, our proactive project management approach eliminates rework. MMA uses tools such as project norms to enable Mr. West to proactively communicate whether the project is on or veering off track. In Figure 2 below we provide an example of the project norms used to enables Ms. Elam and Mr. West to communicate project status.

Figure 2. PMO Project Health Check Indicators

Define key management review as to content, scope, and schedule

Our PMM approach includes an extensive collection of tools that enable the implementation project management team to effectively define, monitor, and report status on the various project management components, including the budget, scope, schedule, resource utilization, milestones, deliverables, issues, and changes. The stage gate process is a structured review to ensure that key stakeholders are accountable for each phase of the project and that there checkpoint approach to project management.

Figure 3 below shows a sample of the various project stage gates. Inputs and outputs would be modified during the Task 1, Project Initiation process to align with DVHA's implementation.

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Figure 3. Project Stage Gate Reviews

Work Plan:

Our work plan, provided in **Section XII, Attachment M**, provides details on:

- Work breakdown structure
- High Level Project schedule for deliverables and milestones;
- Responsible individual to the level at which control will be exercised;
- Identification of deliverables that require a more prompt State acceptance including the proposed acceptance period for the deliverable;
- Performance measurement baselines for technical scope and schedule;
- Major milestones and target date(s) for each milestone that are consistent with this RFP's dates;
- Description of the Vendor's proposed organization(s) and management structure responsible for fulfilling the Contract's requirements and supporting the work
- Definition of the review processes for each milestone and deliverable
- Description of the project issue resolution process including an escalation plan, with contact information
- Approach to managing our subcontractors effectively.

Work Breakdown Structure

Our proposed Implementation Work Plan is provided in **Section XII, Attachment M** of the proposal and includes a WBS, Gantt chart, and a project calendar in Microsoft Project. The WBS encompasses all activities from Project Initiation and Planning to Project Closeout and identifies all project tasks, milestones, and deliverables.

Responsible individual to the level at which control will be exercised

The work plan provides an at-a-glance schedule of all project deliverables and milestones and who is responsible for delivery. During the Project Initiation and Planning phase of the project, MMA and DVHA together review the schedule and will document any work plan or schedule changes from the plan submitted for DVHA approval prior to base lining the work plan and schedule for the project. MMA will maintain and update project schedule no less than bi-weekly to reflect the current status of the project with a comparison made to the initial and the and baseline project schedules. the project schedule will be updated with State resources as identified by the State and communicated to MMA prior to implementation. The project schedule, as well as all project documents and deliverables, will be available 24 hours a day, 7 days a week for immediate review and stored on the PIL.

In addition, the WBS identifies each person's responsibility. During the planning phase of the project, MMA and DVHA review and approve assigned task and milestone ownership.

Identification of deliverables that require a more prompt State acceptance than described in the RFP including the proposed acceptance period for the deliverable

The deliverable schedule will be reviewed with the State during the Project Planning Phase where identification of deliverables that require prompt State acceptance will be discussed. The proposed work plan has a built in acceptance period of 10 days for most deliverables with an additional five days for MMA revisions. Deliverables with extensive documentation or technical in nature may include an additional five-day review period by DVHA and a deliverable walkthrough. Walkthroughs of deliverables are available to the State as requested to facilitate understanding and acceptance.

Performance measurement baselines for technical scope and schedule

The project management team monitors and reporst status on the various project management components, including the budget, schedule, resource utilization, milestones, deliverables, issues, and changes. Baselines will be agreed upon at the onset of the project for ongoing performance reporting. Performance reporting will be generated weekly or as agreed upon with DVHA and incorporated into the established status reporting. Status reporting metrics include reporting work completed against the work plan and actual/projected project work plan dates versus baseline project work plan milestone dates.

Major milestones and target date(s) for each milestone that are consistent with this RFP's dates

The work plan provides an at-a-glance schedule of all project milestones and target dates aligning with the State's task statements and objective to be fully operational January 1, 2015. As part of Project Initiation and Planning Phase of the project, MMA and DVHA together will review the schedule and will document any work plan or schedule changes from the plan submitted for DVHA approval prior to base lining the Work Plan and Schedule for the project.

Description of the Vendor's proposed organization(s) and management structure responsible for fulfilling the Contract's requirements and supporting the work, in terms of oversight and control

MMA's proposed organization and management structure is fully described in Template D Project Organization and Staffing. MMA is excited to partner with DVHA, and we possess the clinical, technical, quality assurance, financial, and data processing resources, coupled with the vast Medicaid pharmacy management expertise, necessary to meet and exceed all RFP requirements.

Definition of the review processes for each milestone and deliverable (e.g. mandatory design review) and a description of how the parties will conduct communication and status review;

Milestones will only be marked as complete with agreement from DHVA that the milestone has been completed and to the State's satisfaction. Milestones are clearly marked in the work plan and will be reviewed and agreed upon during the project planning phase as defined in the WBS 1.3.1.3.7. Formal communications will be documented in accordance to the Communications Plan and agreed to by the State.

All deliverables are subject to review by the State prior to final approval, acceptance, and payment. Deliverables generally have a built-in acceptance period of 10 days for each deliverable with an additional 5 days for MMA revisions. The proposed work plan takes into account those deliverables that may be extensive or are technical in nature and include an additional DVHA 5-day review period. Mandatory walkthroughs will be scheduled and conducted to facilitate understanding and acceptance. Acceptance of all deliverables will be

completed via a Deliverables Acceptance Document (DAD) to be drafted by the State. Deliverables will be tracked in a tracking tool approved by State, and project documents will be available 24 hours a day, 7 days a week for immediate review and stored on the Project Information Library (PIL).

Description of the project issue resolution process including an escalation plan, where the escalation plan includes contact information for each person identified in the proposed problem reporting and escalation procedure and describes the amount of time elapsed before a problem is escalated within their organization; and

In order to successfully integrate interdependent project components, MMA depends on our PMM to illustrate the project's execution and management structures, decision-making hierarchy, span of control, and contact information that includes escalation points.

For operational reporting, budget and schedule deviations will be controlled by ongoing assessments and re-planning triggered during project reviews held after each project phase, as well as through ongoing performance monitoring and status reporting. Problems, their resolution, and opportunities for improvement are identified, and risk assessment or escalation procedures are invoked, if appropriate.

The organizational structures proposed to carry out the implementation along with the lines of authority for this project will be provided to the State. The organization structure will be housed in the Implementation portal. All approved changes to the organization structure will be documented during the implementation phase. Mr. West, Implementation Project Manager, will ensure that the organization charts and contact lists are maintained current throughout the project implementation period.

Approach to managing subcontractors effectively.

We follow an established process in managing subcontractors. The purpose of our Subcontractor Management Plan is to select qualified contractors and subcontractors and to manage them effectively. Subcontract management involves selecting a subcontractor, establishing commitments with the subcontractor, and tracking and reviewing the subcontractor's performance and results. These practices cover the management of a software (only) contract, as well as the management of service contract or contracts that combine both systems and services. A subcontractor is selected based on its ability to perform the work. Many factors contribute to the decision to contract a portion of our work. Subcontractors may be selected based on strategic business alliances, as well as technical considerations.

The Subcontractor Management Plan defines procedures for selecting and managing vendors and subcontractors for a particular project, as well as providing a mechanism for tracking the status of each contract and the deliverables covered under that contract. The Subcontractor Management Plan will contain several items that define and clarify the relationship between MMA and our subcontractors. We have highlighted some of the items included in key points of the Subcontractor Management Plan in Figure 4 below.

Figure 4. Highlights of Key Points for Subcontractor Plan

Category	Items
Scope of work assigned to the subcontractor	• Specific elements of RFP assigned • Inclusions or exclusions from the RFP requirements • Due dates for each deliverable • Quality expectations, including standards the subcontractor must perform to (e.g., general industry standards) • Process for review and approval of the deliverables

Category	Items
	• Documentation required for each deliverable.
Organization, lines of reporting, and authority	• Individual to whom the subcontractor reports to (name or job title) • Range of authority of that person with respect to subcontractor actions • Primary point of contact at the subcontractor.
Compensation	• Compensation of the subcontractor (e.g., fixed fee, time and materials, cost plus fixed fee, per piece or transaction costs) • Time intervals for billing and payment • Incentives and penalties applied to or flowed down to the subcontractor • Process for review and approval of payments (approval must be linked to performance in terms of schedule and quality of deliverables) • Incentives for process improvements resulting in overall cost reduction and quality improvement.
General management issues (project or operations)	• Communications process between MMA and the subcontractor • Handling of change orders • How overall project plan or operational plan updates will be transmitted from FHS to the subcontractor • How project plan or operational plan updates (for the assigned scope of work) will be transmitted from the subcontractor to MMA • How status reporting will be handled • Requirements for subcontractors to attend MMA status meetings • Process for dispute resolution • Risk management process • Identification/reporting/escalation of issues • Subcontractor development of risk management plans and communicating to MMA these plans.
General contract issues	• Termination • Conditions under which MMA may terminate • Conditions under which subcontractor may terminate • Audit rights for the prime contractor • Handling of correspondence • Key staff that the subcontractor agrees to provide and that will not be replaced or substituted without approval of the prime contractor • Confidentiality of information • Ownership rights in deliverables • Whether the work is subject to re-acquisition on a periodic basis • Term of the contract.

2.0 Assumptions

Document the assumptions related to the work plan in Table 1. The Vendor may add rows as necessary.

Table 1 Work Plan Assumptions

Item #	Reference (Section, Page, Paragraph)	Description	Rationale
1.	1.0 Instructions, Attachment N, page 4.	The Microsoft Project Work plan schedule is based on dates provided in the Expected RFP Schedule Summary table.	We provide a flexible work plan that can easily accommodate changes to the Expected RFP Schedule Summary table noted on page 1 of the “Vermont PBM RFP Final” document.
2.			
3.			

Template J. Work Plan

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Figure 3. Project Stage Gate Reviews 11
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Template K

RFP Response Checklist

RFP # 03410-127-14

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2.0 Vendor Response Checklist 2

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** ☐	**Vol 1., Section I.**
B	Vendor Experience	**YES** ☒	**NO** ☐	**Vol 1., Section II.**
C	Vendor References	**YES** ☒	**NO** ☐	**Vol 1., Section III.**
D	Organization and Staffing	**YES** ☒	**NO** ☐	**Vol 1., Section IV.**
E	Staff Experience	**YES** ☒	**NO** ☐	**Vol 1., Section V.**
F	Functional Requirements	**YES** ☒	**NO** ☐	**Vol 1., Section VI.**
G	Functional Requirements Approach	**YES** ☒	**NO** ☐	**Vol 1., Section VII.**
H	Non-Functional Requirements	**YES** ☒	**NO** ☐	**Vol 1., Section VIII.**
I	Non-Functional Requirements Approach	**YES** ☒	**NO** ☐	**Vol 1., Section IX.**
J	Work Plan	**YES** ☒	**NO** ☐	**Vol 1., Section X.**

Template	Proposal Response Item	Completed and Provided as Instructed??		Reference to Proposal Response Section
K	Response Checklist	**YES** ☒	**NO** ☐	**Vol 1., Section XI.**
L	Cost Workbook	**YES** ☒	**NO** ☐	**Package 2, Vol 1.**

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	MMA Cover Letter	**YES** ☒	**NO** ☐	Section I., Template A, Response 1
2	MedImpact Subcontractor Letter	**YES** ☒	**NO** ☐	Section I., Template A, Response 2
3	NorthStar Subcontractor Letter	**YES** ☒	**NO** ☐	Section I., Template A, Response 2
4	List of Magellan Corporate Office Locations	**YES** ☒	**NO** ☐	Section II., Template B, Response 1
5	Magellan W-9 Form	**YES** ☒	**NO** ☐	Section II., Template B, Application Sheet
6	2011 and 2012 SEC Forms 10K Report	**YES** ☒	**NO** ☐	Section II., Template B, Response 3.2

Item #	Attachment Name	Attachment Provided?		Reference to Proposal Response Section
7	Certificate of Insurance	**YES** ☒	**NO** ☐	Section II., Template B, Response 5
8	Sample PA Monthly Report	**YES** ☒	**NO** ☐	Section VII., Template G, Response 1.2.2
9	Sample Prescriber Educational Material	**YES** ☒	**NO** ☐	Section VII., Template G, Response 1.2.3
10	Sample RetroDUR Newsletter	**YES** ☒	**NO** ☐	Section VII., Template G, Response 1.2.3
11	Sample Pharmacy Educational Material	**YES** ☒	**NO** ☐	Section VII., Template G, Response 1.2.3
12	Standard Reporting Package	**YES** ☒	**NO** ☐	Section IX., Template I, Response 5.0
13	Work Plan	**YES** ☒	**NO** ☐	Section X., Template J, Response 6.2
14	Compliance Handbook	**YES** ☒	**NO** ☐	Section IX, Template I, Section 15

Template K. RFP Response Checklist

Tables

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