



Attachment R PBA Services Mandatory Scored Response Worksheet

Suppliers must provide responses to all questions in the **Supplier Response section** in this document and submit them as a **single** PDF attachment **bookmarked** in sequential order with the title(s) provided in the question.

Each narrative response must adhere to any assigned page limits and be in Arial, size twelve (12) font. The narrative page count will begin after the page containing the question, i.e. the page with the question and response on the remainder of that page will count as page #0.

The narrative response, along with any required supporting material, will be evaluated and awarded points in accordance with Attachment A – Lead State eRFP, Section 6 Proposal Evaluation and Award. Documents not requested will not be evaluated.

Failure to provide responses and any required supporting documentation for all questions may result in disqualification of the proposal.

DO NOT INCLUDE ANY COST INFORMATION IN YOUR RESPONSE TO THIS WORKSHEET.

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| 1. | <p>Bookmark Title: <u>MSQ1 - Executive Summary</u>
The Executive Summary is limited to five (5) pages.</p> <p>Provide an Executive Summary that illustrates the Supplier's understanding of and capability to provide the requested services as described in Attachment F - Pharmacy Benefit Administrator Services Scope of Work and Attachment C - Common Scope Requirements and Security Standards.</p> <p>The Executive Summary must include a brief corporate background of the Supplier, including the date the Supplier was formed, established, or created, total number of employees, Equal Employment Opportunity policy and current percentages in key positions, and location of the Supplier's primary and any satellite offices.</p> |
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Supplier Response

MSQ1 - Executive Summary

Since 1989, Optum Rx has developed and refined a complete range of PBM services as we have grown into a pharmacy care services organization whose 28,000 employees, including 12,000 clinicians, serve 69 million members and more than 2,400 clients across all lines of business. Headquartered in Eden Prairie, Minnesota, our satellite offices include our specialty pharmacy fulfillment center in Jeffersonville, Indiana; our Medicaid rebate operations office in Atlanta, Georgia; seven home delivery pharmacies and over 600 Genoa behavioral health pharmacies nationwide embedded within Community Mental Health Centers (CMHCs) to provide high-touch relationship-oriented pharmacy services to improve medication adherence through a variety of interventions. For Fee-For-Service (FFS) Medicaid, Optum Rx's solutions are currently operational in 24 State FFS Medicaid programs where we have management and/or specialty pharmacy services responsibilities, serving more than 24.8 million FFS Medicaid lives and



delivering expertise across key areas of clinical management; drug rebate services; fraud, waste and abuse services; and overall pharmacy benefit administration.

Our parent company UnitedHealth Group has been and will continue to be an equal opportunity employer whose Affirmative Action and Equal Employment Opportunity policy hires and conducts personnel actions without regard to race, national origin, religion, age, color, sex, sexual orientation, gender identity, disability, pregnancy, genetic information, citizenship status, or protected veteran status. Employees and applicants are not subjected to harassment, intimidation, threats, coercion, or discrimination related to equal opportunity laws or requirements.

The table below provides UnitedHealth Group demographics by gender percentage for EEO-1 Job Category Executive/Senior Officials and Managers:

Georgia Snapshot: Optum	
Optum Rx Employees	498
Optum Corporate Employees	52
Optum Health Employees	2,240
Optum Insight Employees	1,691
Total Optum Employees	4,481

UnitedHealth Group Executive/Senior Officials and Managers, by Gender Percentage								
Gender	All Races	Hispanic	White	Black	Asian	Pacific Islander	American Indian	Two+ Races
Male	60.1	3.1	83.6	3.1	8.7	0	0.28	1.1
Female	39.9	3.2	81.8	6.2	6.6	0.21	0.42	1.5

Combining the economies of scale of a large PBM with advanced clinical and data analytics capabilities along with a focused high-touch partnership model of a smaller PBM that offers access to Optum's senior leaders such as executive sponsor Allison Davenport, we will continue to maintain our local presence in Atlanta as we partner with you across any and all areas of your Pharmacy Benefit Administrator (PBA) Services program.

Whether our interactions involve our wide-ranging resources available to you as a large-scale entity or our brick-and-mortar presence as your Georgia neighbor, what underscores our partnership with you are our core values. Foremost among those are **Integrity** and **Compassion**.

Like you, we are dedicated to providing Georgians with access to quality health care at an affordable price that improves their health status, promotes healthy lifestyles and eliminates disparity.

We drive that dedication by honoring our commitments to Georgia Department of Community Health (GA DCH) and to your beneficiaries without

Integrity Honor commitments. Never compromise ethics. Compassion Walk in the shoes of people we serve and those with whom we work. Relationships Build trust through collaboration. Innovation Invent the future, learn from the past. Inclusion Welcome, value, respect and hear all voices and diverse points of view. Performance Demonstrate excellence in everything we do.	CORE VALUES
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compromising our ethics. Moreover, we recognize that each member is a unique individual as we strive to deliver a pharmacy experience designed to meet and exceed their needs.

Scope and Understanding of the Project

The State's expectations from a PBA vendor include providing the design, development, implementation and maintenance of a modular Pharmacy Point-of-Sale (POS) Claims Processing Solution and PBA services for the FFS Medicaid pharmacy program.

We understand that the Pharmacy Benefit Administrator Program (PBAP) is comprised of the following components: Preferred Drug List (PDL) services, POS Claims processing, Third-Party Liability (TPL) and Coordination of Benefits (COB), Prior Authorization (PA) services, financial management services, and customer support (including a customer call center and web portal).

The State's intent and goals of this RFP are to provide cost effective utilization programs, improve pharmacy administrative services and comply with federal and state laws and regulations. We will continue to meet and exceed the State's expectations, intent and goals while simultaneously delivering excellent quality of care at optimized costs while improving the health of our population. We outline our aggregate abilities to continue to meet and exceed the State's overall scope and understanding of this project in the sections below.

Top Advantages for the State

As the incumbent, GA DCH will continue to have the advantage of our long-standing partnership and experience, which reflects our knowledge and understanding of your policies and procedures that are currently in place. The State benefits from the 18 years we have been supporting your PBA program and our organization's 45 years of Medicaid experience, offering industry-leading technology and cost-efficient solutions, coupled with expert and local staff to continue the superior service you provide to your members.

We are closely aligned with your goals and will continue to meet and exceed your needs. Continuing your partnership with Optum Rx not only offers stability and avoids disruptive change for members, but it also sets the stage for building upon the success we've already achieved together—in addition to continuing to benefit from the following advantages Optum Rx offers:



Experience and Flexibility: Optum Rx provides the State with the advantage of having a PBM that has the experience and flexibility to provide you with the pharmacy benefit services you see fit; whether that be for one specific pharmacy solution or all. We can configure our program and service offerings to align with how you serve your members—not the other way around—by plugging our solutions into

yours. Our goal is to provide the State with flexibility and we are ready to innovate around your areas of interest and continue to share in the value we create together.



Exemplary Customer Support: Your current GA DCH FFS Medicaid Account Team has earned an exemplary reputation as trusted advisors, as demonstrated by high client Net Promoter Scores (NPS) and driven by our rich history of supplying innovative technology and quality staffing resources to provide the State with exceptional client support. Our account management and customer service

departments promote and uphold a strong culture of client and member advocacy.



Our core client service staff is managed by leaders who are passionate about providing client and customer service support that exceeds client and members' expectations. To accomplish this, we use call quality and formalized training programs, multimodal communications and post-call surveys to provide the State and its members timely, satisfaction driven support. We review quality metrics regularly and report information during our quarterly utilization and performance reviews for appropriate action.

Our customer service technology platform incorporates a variety of systems, applications, and tools to assist our call center teams in delivering a positive member and health care provider experience.



Timely Ad Hoc Reports: Optum Rx will continue to provide the State with the flexibility to create your own ad hoc reports or to request them from your account management team. We make every effort to fulfill such requests as timely as possible. Our RxTrack online analytics and reporting platform enables the State to continue creating a broad range of ad hoc reports based on parameters you select.

Because it contains fields captured by our claims system, RxTrack gives the State the freedom to create real-time reports you can continue to save, download, and analyze to enhance benefit plan management.

Key Personnel

The State can expect to receive the same expert support from our credentialed staff that you have grown accustomed to, along with our innovative technology. Our leadership team brings over 250 years of combined pharmacy and clinical experience and consists of pharmacists, prescribers, clinical, technical, and operational leaders.

The State will be supported by our PBA leadership and our existing GA DCH Account Management Team, who have the resources and knowledge of the State's current programs in addition to the technical requirements needed to continue supporting the State. Your Account Team also brings the added benefit of having a local presence, with the current account and clinical team members, and a clinical leader, also located in GA. With a local presence, the State can rest assured in knowing that we have a dedicated account team that are responsive and able to provide the local support that the State needs and expects.

The team is responsive, promotes accountability across our organization, and delivers the transparency and compassionate care you seek for your program and the members you serve. Our clinicians provide expert support on clinical criteria, PDL management, and the management of other valuable clinical programs.

We help our clients manage pharmacy costs while focusing on quality programs that improve health outcomes and patient medication adherence. We leverage pharmacy and clinical expertise and combine comprehensive program administration, clinical management capabilities, and an innovative claims processing platform to control costs while improving patient medication adherence and health outcomes.

Integrated Programs and Services

Pharmacy, as the most frequent health care touch point, represents an incredible opportunity to connect the dots, engage individuals and coordinate care. We help our clients harness the power of



pharmacy by aligning with the State's Medicaid program goals. We promote transparency and connect touch points throughout the care continuum, making it easier to access and receive the best therapy, while managing the State's net costs.

We believe in leveraging data and analytics in support of our mission to make the health system work better for everyone, and to help people live healthier lives. Our broad reach across health care provides a unique ability to understand the system and tackle the biggest challenges in health care with our clients. By combining, refining, validating and continually enriching billions of data points from across the system, our proprietary health care data and analytics capabilities provide a comprehensive view while delivering dynamic and multi-dimensional insights that get smarter with every day. We identify and address all of our clients' health and savings opportunities.

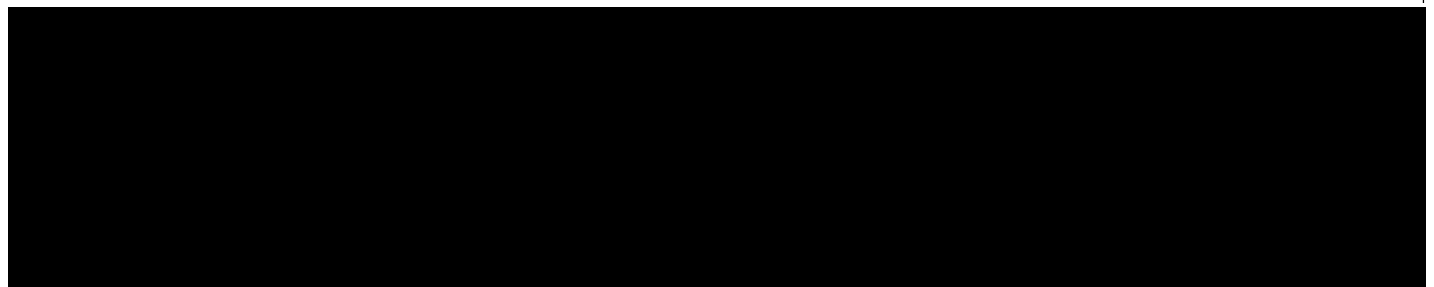
Commitment to Client Satisfaction

Our client-centric approach provides the foundation for continuing to grow a long-term relationship with the State. We consider a variety of factors, including your organizational philosophy, benefit goals and consumer attributes, to help us define and develop benefit management strategies that match your unique experience. By aligning with the State's values and interests, we drive value to the pharmacy benefit space, help people live healthier lives, and make the health system work better for everyone.

To monitor your ongoing satisfaction and continually improve our service, we conduct annual client satisfaction surveys across our book of business. In our satisfaction survey, clients provide us feedback on their level of satisfaction in the following areas:

- Overall performance
- Account Management team performance
- Pharmacy benefit products offerings
- Pharmacy benefit administration experience
- Member experience

For example, we demonstrate our ongoing performance commitment to GA DCH with the current specialized and local account management team that will continue their exemplary service to GA DCH, their stakeholders and programs' members, assuring continuity and no member disruptions. This GA DCH Optum Rx team has primarily been together since 2006 and has received top scores year after year from GA DCH on the annual Optum Rx Client Satisfaction Survey.





It is important that GA DCH is satisfied with our services, and we look forward to continuing to grow our strong and long-term relationship.

Moving Forward Together as Your Trusted Partner

We thank the State for considering continuing a partnership with Optum Rx. As your incumbent, we have the knowledge, resources, scale, and expertise to continue to help the State meet and exceed your goals in a rapidly changing regulatory environment. Our commitment represents true partnership with the State to work together to redefine health care.

We look forward to hearing from you and hope for the opportunity to expand on our responses/solutions during the supplier demonstration phase. We are eager to continue our partnership with you to combine what works today with innovative ways to meet tomorrow's evolving needs.



2.	Bookmark Title: <u>MSQ2 – PDL Workflow</u> Narrative description is limited to three (3) pages, excluding any diagrams or images. Describe, in detail, the process and the automated workflow tool that shall facilitate the review and approval of changes, modifications, deletions, or alterations to the Preferred Drug List (PDL), including any potential other (state and/or federal) program-specific PDLs, to meet the requirements. Refer to Attachment F – Pharmacy Benefit Administrator Services Scope of Work, Section 2 Preferred Drug List (PDL) Services.
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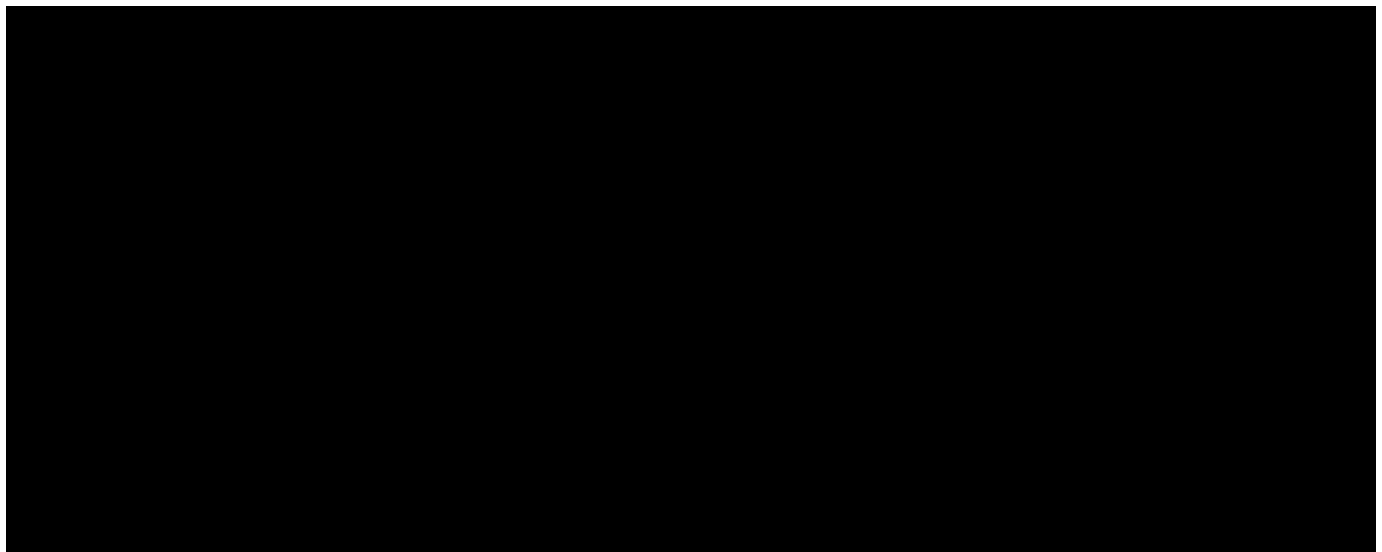
Supplier Response

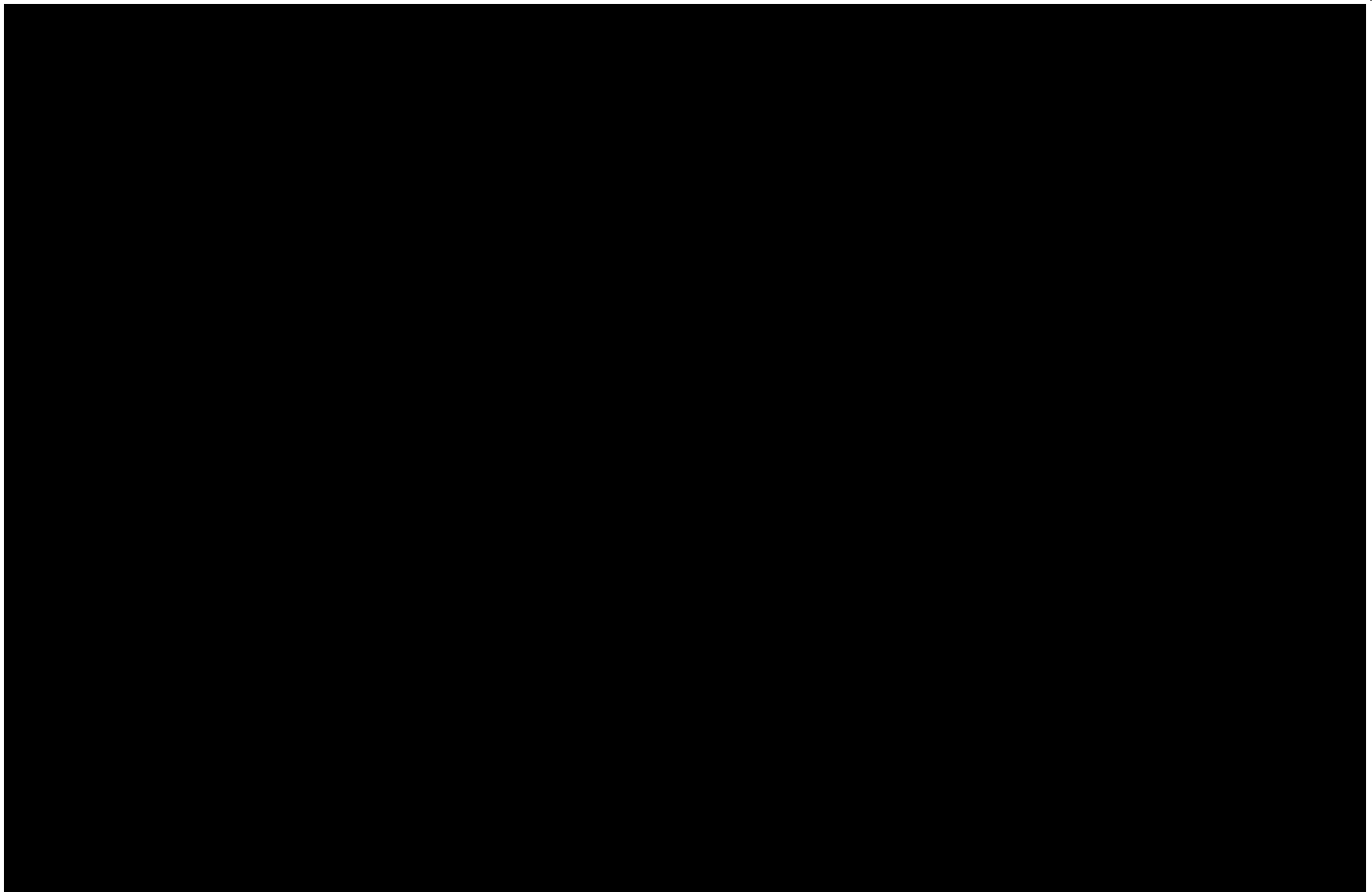
MSQ2 - PDL Workflow

Optum Rx employs an integrated, rules-based PDL management solution that supports multiple types of PDLs and formularies and aligns with the National Council for Prescription Drug Programs (NCPDP) formulary and benefit standard and includes support for e-prescribing. Through this application, we electronically communicate PDL and benefit information to prescribers. In addition, we utilize the application to provide PDL data to Managed Care Organizations (MCOs) to enable States to achieve a reliable single PDL across their entire Medicaid program.

Our PDL management tool, RxBuilder, is owned and developed by Optum Rx that provides flexibility to meet the challenge of accurately creating, maintaining, and sharing the PDL for the State. Configurable rule sets include:

- Preference status
- Clinical programs
- Utilization management strategies (quantity limits, PA, step therapy)
- Specialty products
- Tier (if applicable)





Tracking, Communication and Workflow Process

Utilization of spreadsheets to track the PDL process have often yielded inconsistent and frustrating results. There are many moving parts happening concurrently where requests can be in different stages of the process at the same time. At any point in time managing all the “in-motion” product status changes, the criteria development, approvals, testing, and systems deployment which accompanies these changes can be daunting.

Having a real-time picture of where a product is at any moment and where requests may be lingering is key to ensuring the process is working as efficiently as possible. To that end, Optum Rx utilizes our external dedicated State SharePoint site and capabilities to manage the workflow related to the PDL process including all handoffs, turnaround times, and event notifications to participants from potential multiple organizations.

From the time a potential change is identified to the moment it's in the RxClaim and PA systems, using the Power Automate features together with SharePoint lists, the State and external users share in the composite workflow required to execute PDL related changes while tracking them through inception to completion. Our Account Team, along with the Optum Rx SharePoint team, designs the custom workflow based on State requirements, reporting, allowance of authorized users, and maintains the site during the contract.



3.	Bookmark Title: <u>MSQ3 – POS</u> Narrative description is limited to ten (10) pages. Describe, in detail, how your Point-of-Sale (POS) Solution meets the requirements in Attachment F – Pharmacy Benefit Administrator Services Scope of Work, Section 3 Point-of-Sale (POS) Claims Processing Solution including, but not limited to, the following: a. The real-time interface between your POS adjudication system and the Prior Authorization (PA) system to support the automated PA system protocols utilized during Claims processing. b. The capability and limitations of your Solution to currently support submission of International Classification of Diseases (ICD) codes (ICD-10 version or later, as may be required by the State) at POS to allow PA review via an automated process. c. The methodology utilized to integrate the State's PDL into your adjudication platform. d. The methodology utilized to incorporate medical data into the POS adjudication logic. e. The approach utilized to determine the Prospective Drug Utilization Review (ProDUR) editing and recommendations to improve the usefulness and validity of the edits returned to the dispenser. f. The ability to utilize a Prior Authorization (PA) process that is specific to edits (i.e., authorize a particular drug for coverage without overriding the edit for non-rebated Products). g. The ability to process and price compound prescriptions using the multiple ingredient compound list at POS. h. The ability to adjudicate and price multiple ingredient compound Claims when multiple National Drug Codes (NDCs) contained within that Claim carry different disposition statuses (pay vs. deny vs. prior authorization) according to State's Pharmacy Benefit Design (PBD). i. The ability to process mass reversals and adjustments including any limitations that may exist. j. The ability to cross-reference National Provider Identifier (NPI), Medicaid Provider ID, State License Number, Drug Enforcement Administration (DEA) Number and other unique prescriber identifiers during the Claims adjudication, Prior Authorization, and reporting process. k. The ability to confirm Medicaid-enrolled Provider Prescriptions are processed. l. The quality assurance process utilized to assure accuracy of the Claims processing and ancillary systems proposed (if applicable). m. The ability to provide customized messages back to retail pharmacies through a POS return adjudication response, including any limitations.
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| | <p>n. The ability to deny Claims for Care Management Organization (CMO) Members and communicate the Member's CMO assignment back to the retail pharmacy.</p> <p>o. The system edits in place at POS to notify pharmacists of a potential Step Therapy program.</p> |
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Supplier Response

MSQ3 – POS

MSQ3,a

The Optum Rx PA system platform is fully integrated with our claim adjudication, PDL management, utilization management, and customer support systems for a seamless end-to-end process.

MSQ3,b

Optum Rx currently employs the capability to streamline the PA requests seamlessly at the point of service by leveraging a variety of member and prescriber data sourced from RxClaim. This includes member demographics such as age and sex, pharmacy claims, medical history, ICD-10 and CPT codes, and provider specialty. By analyzing this dataset, we validate PA criteria resulting in real-time approval determinations.

MSQ3,c

Optum Rx employs an integrated, rules-based PDL management solution that supports multiple types of PDLs and formularies and aligns with the NCPDP formulary and benefit standard and includes support for e-prescribing. Through this application, we electronically communicate PDL and benefit information to prescribers. In addition, we utilize the application to provide PDL data to MCOs to enable States to achieve a reliable single PDL across their entire Medicaid program.

Our PDL management tool, RxBuilder, is owned and developed by Optum Rx providing flexibility to meet the challenge of accurately creating, maintaining, and sharing the PDL for the State. Configurable rule sets include:

- Preference status
- Clinical programs
- Utilization management strategies (quantity limits, PA, step therapy)
- Specialty products



The rules-based capabilities of RxBuilder create efficiencies in PDL maintenance and in application of PDL and benefit characteristics (e.g., restrictions such as PA). RxBuilder integrates with RxClaim (the claims processing system) and augments the drug list capabilities resident in the core claim processing system to enhance the ability to adjudicate against benefit rules as approved by the State. During claim adjudication, the claims processing system initiates rule processing within RxBuilder for the drug product associated to the claim to retrieve selected attributes that can further drive claims processing activities. Claims processed utilizing these rules carry additional detail consistent with PDL attributes retrieved in this process.

Our PDL management personnel interact securely with RxBuilder through a Web interface to create and maintain drug lists and rules entries that comprise the State's PDL definition and other attributes with those entries/rules. The application allows maintenance of PDL details, product restrictions (quantity limits, gender restriction), alternative product recommendations, and contingent therapy (step therapy) rules. Users are able to create rules within RxBuilder that cover individual products or groupings of products (therapeutic classes).

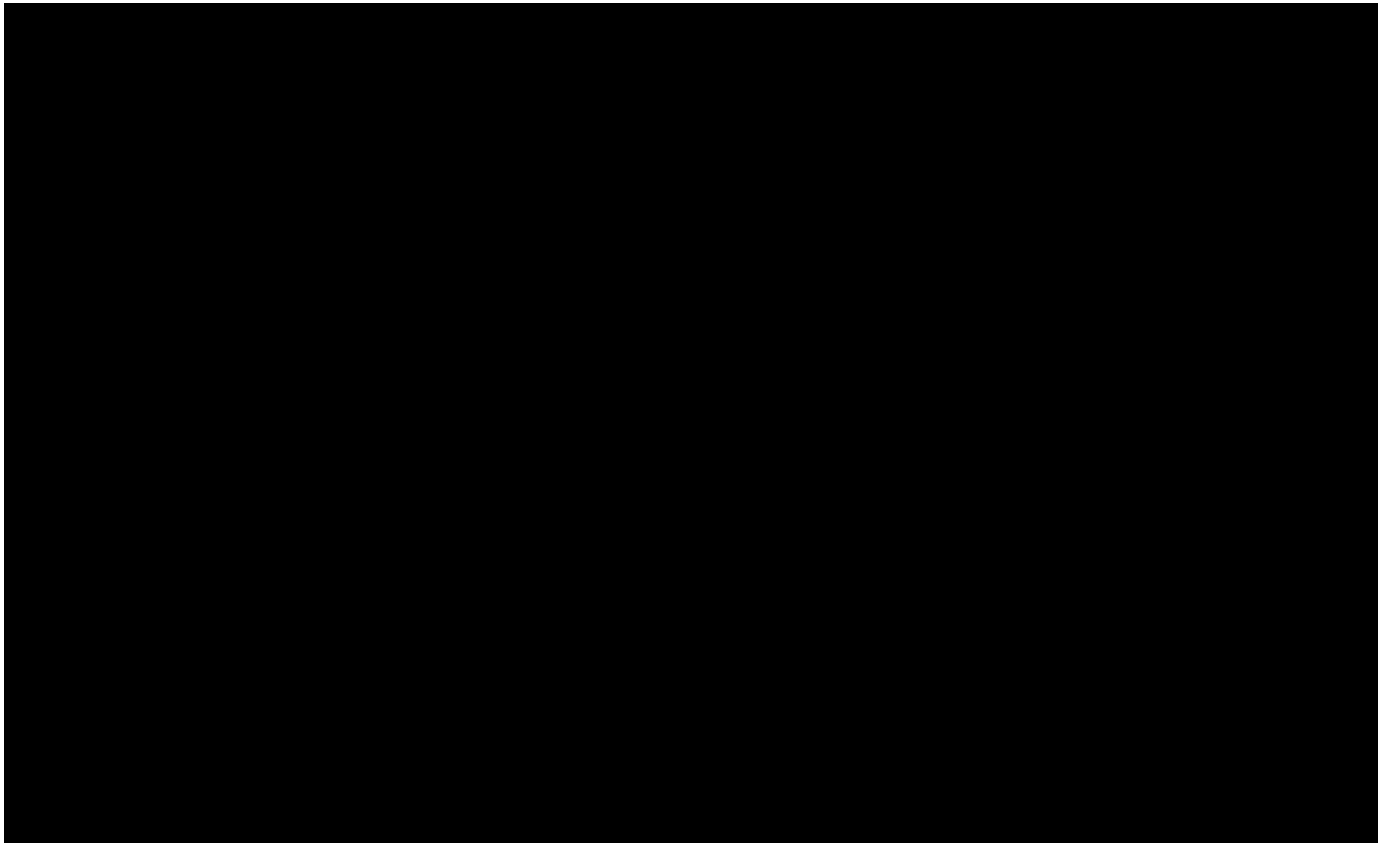
Likewise, PDL status, PA rules or other attributes or restrictions can be applied to individual products or groups of products represented by the rules. Notes or other pertinent detail (clinical information, PA designation) may also be associated with each level of rule definition. The PDL and components of the PDL that are created within the application are available for query by a query tool that is included within the product. In addition, the PDL or subsets of the PDL are also available for export through one of the many export formats, including CSV, Excel, XML, and e-prescribing. Further, we include a query tool that serves as a powerful PDL analysis and reporting tool. Our PDL management tool integrates with member websites to provide access to PDL information, restrictions and a member friendly, printable PDL document.

Our clinical team provides all required updates to the PDL management within RxBuilder as approved by the State. Our clinical team is able to support the PDL:

- As additional products are added or removed
- New classifications are delineated
- To view detailed changes through control reports



All products available within the Medi-Span® drug file are loaded into RxBuilder (including spacers, peak flow meters, diabetic supplies, over-the-counter supplements, etc.). Product attributes related to the Medi-Span drug file and First DataBank (FDB) drug file are maintained and reportable within the RxBuilder tool. The Optum Rx clinical team is able to provide detailed control reports to the State to demonstrate the PDL in its' entirety or just those drugs that were updated or changed. The figure below demonstrates a snapshot of a report that is available within RxBuilder for review.



MSQ3,d

Optum Rx integrates with the State MMIS system to accept medical claims history into the RxClaim POS system and we recommend processing files on at least a weekly basis. Prescriber claims and institutional claims are examples of claim types commonly used for these exchanges. Optum Rx performs a custom transformation of the Medicaid Management Information System (MMIS) supplied medical files into the standard load format for the Optum Rx Medical Information eXchange (MIX). The MIX has the primary task of maintaining consolidated member diagnosis and procedure information from sourced medical claims. This member profile information is then shared with RxClaim for assistance in the automated processing of prescription claims which may require PA through our Point of Sale Quick Check product (formerly known as SilentAuth), or which may have specialized diagnosis list rules in place for adjudication. Medical Claim Data is also pulled into the Integrated Data Warehouse (IDW) daily upon receipt from MMIS for further downstream disease management, clinical reporting, and/or analysis.



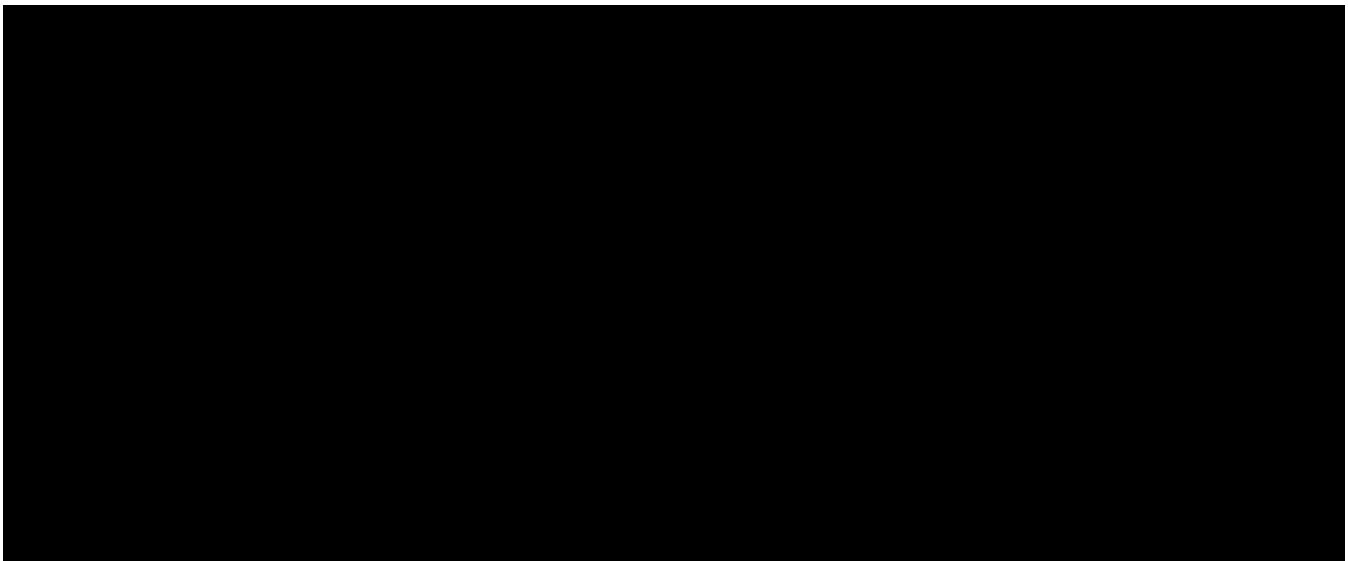
Today Optum Rx executes the process as written above for GA FFS Medicaid utilizing prescriber and institutional claims to override PA edits as directed by the GA Department of Community Health.

Point of Sale Quick Check

Optum Rx's Point of Sale Quick Check solution utilizes a variety of member and prescriber information to effectively automate PA requests at the point of service. Point of Sale Quick Check pulls member and prescriber information to validate PA criteria to determine approval or denial at point of service. Determining PA at point of service decreases pharmacist, member, and provider disruption, and reduces the number of members who walk away or never obtain their prescription due to the need for PA.

Optum Rx has utilized Point of Sale Quick Check to its fullest extent, and it has provided many valuable benefits to other FFS Medicaid states, prescribers and members. This system has decreased the prescriber PA burden and reduces member walk-away rate and ensures they have necessary medication immediately at point of service. Member and prescriber data utilized by Point of Sale Quick Check includes:

- Member demographics including age and sex
- Member pharmacy claims history
- Member medical history including International Classification of Diseases (ICD-10) and CPT codes
- Prescriber specialty via taxonomy codes



Point of Sale Quick Check processing enables the State to “silently” validate PA criteria for efficient and accurate processing. This innovation is evaluated for each utilization management criteria developed to determine most appropriate use.



MSQ3,e

Concurrent Drug Utilization Review

Optum Rx's Concurrent DUR is an ongoing drug monitoring program driven primarily by Medi-Span drug database edits and designed to check all incoming prescription claims real time within the adjudication platform against the member's prescription history. At the point of service, our system checks for potential drug-related problems to improve the safety, quality, and cost effectiveness of dispensed medications by ensuring all prescriptions are clinically appropriate.

Our standard Concurrent DUR edit categories include:

- Drug regimen compliance screening
- Drug-drug interaction screening
- Drug-diagnosis caution screening
- Drug-inferred health state screening
- Dosing/duration screening
- Drug-age caution screening
- Drug-sex caution screening
- Duplicate Rx screening
- Duplicate therapy screening
- Therapeutic dose limits screening
- Morphine equivalent dose (MED) limit screening

During adjudication, Concurrent DUR edits run simultaneously with the other plan benefit edits. When a medication issue is encountered, Concurrent DUR responses are sent to the pharmacy based on the severity of the issue and the State's set-up; these messages include both soft rejects, which require pharmacist intervention and outcome codes, and hard rejects, which require PA. The program is flexible and configurable to meet your needs. Standard program reporting includes monthly activity and quarterly outcome reports that can be provided to Centers for Medicare & Medicaid Services (CMS) in the CMS DUR Annual Report.

MSQ3,f

PA configuration can be set on a specific edit like days' supply, preference status, or quantity limit. When the PA team enters the PA, they can override specific edits only, ensuring that the edit for non-rebated products remains in place. This targeted editing allows for flexible and configurable PA entry without overriding areas that are not appropriate for override. For example, overriding preference status of a drug to allow for reimbursement will not automatically override the DUR edits in place unless it has been selected for override. This maximizes member safety and provides accurate processing of benefit design.

MSQ3,g

During the implementation, we review how your compound prescription drugs are to be paid and configured within our system. Optum Rx works with the State to understand which products



contained within a compound can be paid without a PA. We maintain this list at the GPI and NDC level in RxClaim to ensure that any claim request for a drug outside of this list will require a PA.

RxClaim supports NDC-based ingredient costs for determining price of compound drug claims, pricing compounds at the State's approved reimbursement methodology. We calculate the ingredient cost based on quantity submitted and the Medicaid allowed costs on each paid line item.

Another example of compound configuration is the ability to set different rules by member age and set a compound's preferred status. For example, in GA, Optum Rx sets the compound to not require PA if the member is less than a certain age when a prescriber deems it medically necessary and set the compound's default preferred status as non-preferred for those over the age as directed by the State.

MSQ3,h

Compound Drug Adjudication Logic

Optum Rx adjudicates compounds using "multiple ingredient logic" where pharmacies submit each ingredient in the compound. Standard pricing for compounds includes that each ingredient is priced according to the applicable contracted rate. We can apply unique reimbursement to compounds based on the States' requirements.

We process multi-ingredient compounds with the following recommended limitations that may vary based on client requirements.

- Apply a set number of minimum and/or maximum ingredients; the standard is a minimum of two and a maximum of 25
- At least one of the ingredients is a legend item
- Set a specific limited list of products that can be covered in a multi-ingredient compound depending on client requirements; the standard multiple ingredient set up does not contain such a list
- Automatically pay, deny, or prior authorize all multi-ingredient compounds depending on client requirements
- Allow pharmacies to accept payment for only covered products when applying the NCPDP submission clarification Code of '8' in the compound claim
- If multi-ingredient compound option is utilized, perform pricing (based on compound pricing rules) for each ingredient submitted.

In addition, DUR is applied to multiple ingredient compounds at an ingredient level. A maximum dollar amount for multiple ingredient compounds is applied at the State's direction. Cost sharing (copayment determination) for compounds is fully configurable and can be setup differently from single ingredient claims.

MSQ3,i

Adjustments can be run individually or in batch (mass adjustments). The latter typically occur with reimbursement rate changes, retrospective application of policy, retroactive eligibility changes,



processing errors, etc. In these situations, various parameters in the RxClaim 'payment profile' are set to define criteria for those claims to be adjusted. As with individual adjustments, mass adjustments can be run in an edit-only mode so that results can be checked, verified and State approved prior to actual data being modified.

MSQ3,j

Our RxClaim system maintains a number of provider and prescriber identification systems including the National Provider Identifier (NPI) and the Drug Enforcement Administration (DEA). While it is standard (HIPAA mandated) to exclusively use the NPI in identifying a prescriber for the claims adjudication process, we allow for searching and linking functions that include searching for a prescriber by their NPI, DEA number, unique prescriber identifier number (UPIN), or state license number. Other identification systems can also be specified and supported on a State-by-State basis. Each of these ID numbers (for example, DEA number or NPI) point back to a base record for that prescriber. Thus, the NPI and the DEA number (for instance) are linked through this base record and will be available when required as a data element on the particular exchange being implemented.

This allows for prescribing activity to be tracked and reported by NPI and any other of the available IDs for that prescriber. The system can also use other IDs in adjudication edits and other claim processing activities. For instance, a claim submitted with an NPI to identify the prescriber could still take advantage of edits that are dependent upon the DEA number (for example, prescriber lock-in or edits that involve primary care designations).

Our standard claim extracts and utilization files contain the DEA number for all prescribers who have a DEA number. It is important to note that certain prescribers may not have a DEA number on file. These include non-physician prescribers (where allowed) and prescribers who have specifically requested that their DEA number be removed from industry databases. We also support the identification of prescriber by DEA number in our ad hoc reporting package and throughout our data warehouse resources.

MSQ3,k

Optum Rx maintains provider master files for both pharmacy and prescriber on a daily basis as part of the base system functionality. We also maintain pharmacist provider master data in the prescriber master file to support vaccine and other federal product submission requirements. We have the capability to receive network files daily from the State for both pharmacy and prescriber and transform them into our standard network load formats to enforce the State's network editing where required.

At the State's option, Optum Rx validates the pharmacy and prescriber NPI numbers submitted with the optional format check ensuring the number matches the length and check digit algorithms. Additional editing ensures the pharmacy NPI submitted is active in the pharmacy network maintained by the load process described above. If a pharmacy is not enrolled on the date of service submitted on the claim, RxClaim will reject the claim with any standard or custom messaging as configured in the edit.

Further editing ensures the prescriber NPI submitted is active in the State's prescriber network maintained by the load process described above to enforce the State's network of ordering,



referring, prescribing (ORP) network. If a prescriber is not enrolled on the date of service submitted on the claim, RxClaim will reject the claim with any standard or custom messaging as configured in the edit.

In the RxClaim prescriber master file, DEA and other prescriber IDs are linked together with the NPI numbers. On the RxClaim detail screen, a user can click on the provider ID submitted to see all the other IDs associated, including DEA number.

MSQ3,l

We define and document our overall claims processing accuracy rate by the percent of claims processed and paid accurately based on the:

- Applicable coverage
- Pricing
- Plan design

This percentage is calculated as the number of claims audited and found to be processed and paid without error divided by the total number of claims paid. In addition, our audit team performs routine review of claims pricing, including both electronic and manually submitted claims, for accuracy.

MSQ3,m

Message codes are created and attached to actions in the claims system to communicate with pharmacies and members about a claim response. The most common places to attach messages are plan NDC/Generic Product Indicator (GPI) lists, preferred NDC/GPI lists, plan drug statuses, and member PAs.

The NCPDP standard rejection messages can be remapped to send a custom message based on the rejection code. When a custom message is used, we have the option of including or suppressing the NCPDP-defined system message associated with the reject code.

Our system allows the State to customize messages received by pharmacists at the point of service. The initial custom message allows up to 120 characters; however, the State may specify any number of extension message segments of 120 characters each. However, most pharmacies are limited to view only the first 40 characters.

We can customize messaging for a drug at the NDC or GPI level. For therapeutic classes, if a different message is at the drug level that will take precedence. For prescribers, we can have customization attached to the drug level with a prescriber edit.

Message customization can be applied at various levels within a state's hierarchy. Therefore, messaging may be global for the State's programs or customized for specific programs within a State's set up.

MSQ3,n

Optum Rx FFS Medicaid clients typically opt to maintain eligibility for all State Medicaid members in the FFS Medicaid pharmacy system. Members can move between FFS Medicaid and Managed

Care in some cases and the system's ability to provide eligibility related messaging can certainly reduce member and provider disruption.

For GA and other states, Optum Rx interfaces with upstream systems to interpret, transform, and load daily and monthly eligibility files. These files contain details related to member demographics; member aid categories; Medicare information; Long Term Care; Hospice; Managed Care status; and other data. When a member is in Managed Care, the eligibility vendor provides the Care Management Organization (CMO) eligibility segment with a value which determines the specific CMO to which a member is assigned. It's this CMO value which creates and maintains the member in a CMO plan in the RxClaim system. CMO plans are configured in RxClaim to have no drug coverage in GA although that can differ in other States.

When a claim is submitted for a member in CMO, the Optum Rx RxClaim system responds back with specific CMO pharmacy information including the PBM name, the BIN/PCN/Group and the PBM's published call center number for the Medicaid plan. It's this response message which directs the pharmacy to re-send the claim to the correct PBM for the CMO member.

Optum Rx's overall approach to eligibility file processing is outlined in our response to MSQ29 later in this document.

MSQ3,o

The goal of step therapy is to promote effective, safe or less costly first-line medications, including generic alternatives, as recommended by national guidelines and clinical evidence.

- When a member presents a prescription at the pharmacy that requires step therapy, select medications in claims history can automatically be checked to determine if the step therapy is met. The claim can also be set to reject for PA automatically depending on the State's set-up.
- If the member has the required claim(s) history for the prescription requiring step therapy, the prescription may be processed and reimbursed with minimal member disruption.
- If there is no or only partial claims history for the prescription requiring step therapy, the claim will reject requiring PA with messaging that provides step therapy requirements to the pharmacy provider. At that point, the prescriber may decide to switch therapy to the preferred prescription or request a PA review to determine if conditions allow for reimbursement of the medication. Keeping member disruption in mind, and should approval be delayed, an emergency override supply may be provided by the pharmacy.

Program benefits

Step therapy creates potential for plans to achieve the following benefits:



Member savings by using clinically preferred and/or more cost-effective medications



Reduced pharmacy costs



Improved PDL management and preferred utilization

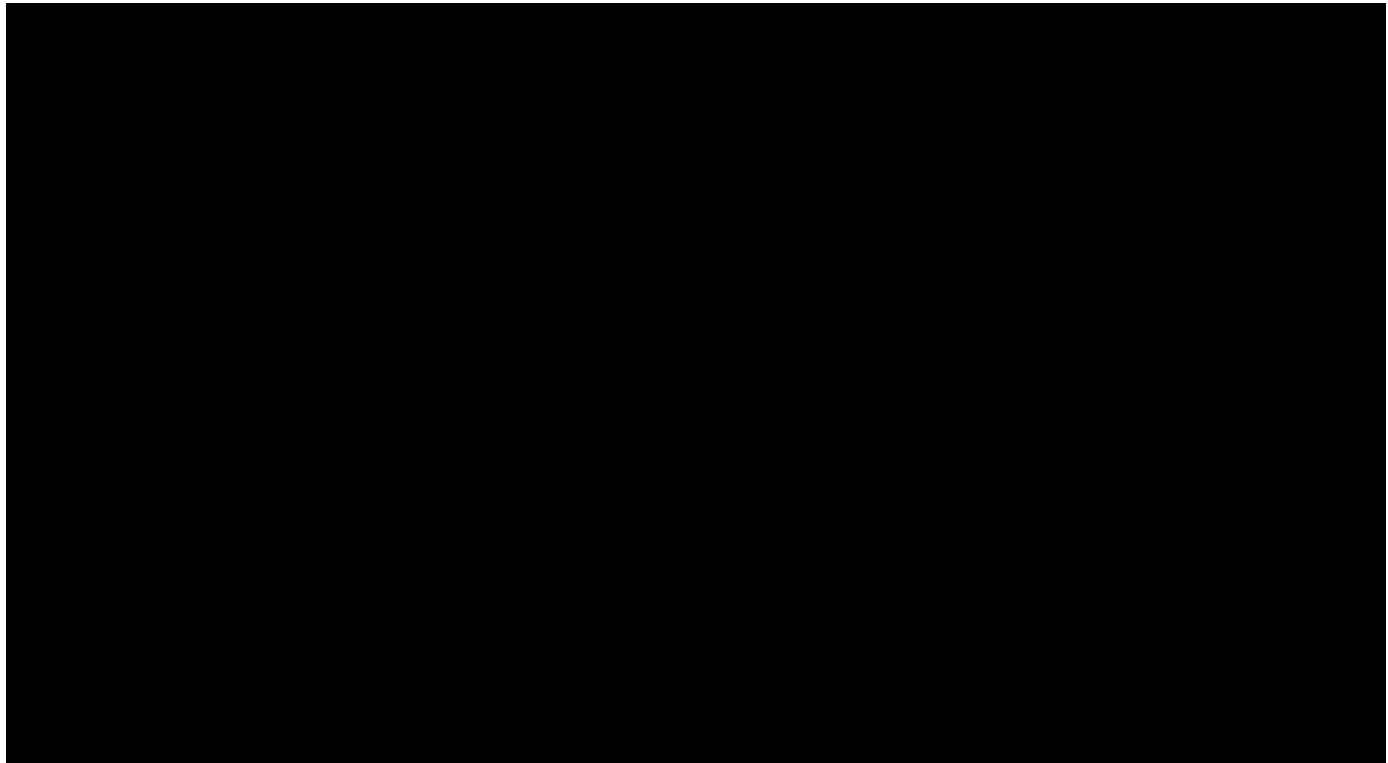
PreCheck MyScript

Another innovative tool to help streamline the PA process and provide information on prerequisite step therapy is PreCheck MyScript®, which provides prescribers with real-time, member-specific data within their EMR e-prescribing workflow. PreCheck MyScript directly improves the member experience and overall plan performance by supporting more informed and expedient clinical decisions.

Delivering member-specific price transparency for more than 64 million Optum Rx members at the point of prescribing, PreCheck MyScript leverages this exclusive information to provide real-time benefit transparency, preferred alternatives and step therapy requirements when applicable while enabling prescribers to see whether clinical programs such as PA are required. If so, they can submit documentation directly within the medical record before the member even leaves the office; prescribers may also avoid PAs altogether by selecting a preferred drug alternative.

Once the prescriber submits an e-prescription within the EMR, that initiates a trial claim with Optum Rx. In less than two seconds, PreCheck MyScript returns individualized, benefit specific coverage determination. Furthermore, it also returns member cost, pharmacy options, and preferred equivalent drug alternatives available under the member's benefit.





After the prescriber consults with the member to determine the preferred care path, the prescriber may easily select the chosen drug and proceed to send the prescription to the pharmacy. The provider may also elect to start a PA directly in the workflow and once the form is complete the prescriber submits for review.

Furthermore, all prescribers have access to our provider portal, which enables prescribers the ability to access PreCheck MyScript outside of the EMR.

Proven results of PreCheck MyScript include:

- More than 800,000 providers utilizing PreCheck MyScript
- Available to 90 percent of active prescribers and all major EMRs and integrators including Surescripts, Epic, Athena, RxRevu (Cerner), DrFirst, Allscripts, NewCrop and eClinicalWorks
- 50 minutes in time savings for prescribers and office staff per patient per avoided PA
- 50 minutes of time savings for providers when the PA is appealed
- 32 percent reduction in retail pharmacy administrative costs
- 30 percent of PA initiated electronically or avoided



4.	Bookmark Title: <u>MSQ4 – POS Claims Processing</u> Narrative description is limited to four (4) pages. Describe, in detail, the Point-of Sale (POS) Claims Processing Solution that will be utilized for the Pharmacy Benefit Administrator Program (PBAP). Your response should include, but is not limited to, the following: a. Current Claims processing capacity and future scalability (including timeframes that may be required to achieve scalability needs) b. The length of time the current POS Solution has been used and any known major upgrades for the system and the timing of those upgrades. c. POS adjudication capability, ease of configuration, and any limitations. Refer to Attachment F – Pharmacy Benefit Administrator Services Scope of Work, Section 3 Point-of-Sale (POS) Claims Processing.
Supplier Response MSQ4 - POS Claims Processing Claims Processing Activities Having supported the lead State's FFS Medicaid pharmacy program since 2007, we process approximately 14 million of your claims annually including pharmacy payment file production with the State's bank vendor. We fully understand the complexities of your pharmacy program, including your unique reimbursement structure as outlined in your pharmacy manual and State Plan Amendment (SPA). RxClaim Platform Central to our claims processing support for the State is RxClaim, our proprietary rules-based claims processing system that supports virtually every type of pharmacy benefit program and pharmacy delivery mechanism available. Its flexibility, capabilities, and capacity are virtually unlimited. In use since 1991, RxClaim is designed for online, real-time and fully integrated adjudication of prescription drug claims at the point of service, whether that is retail, home delivery or specialty. With operational support available 24 hours a day, seven days a week, staff constantly monitor the performance and availability of the system. Using sophisticated monitoring hardware and software, connections are automatically tested every five minutes to validate that the systems are performing as expected for you and the pharmacies your members visit that rely on us to process their claims efficiently and accurately. Accuracy and Verification Our standard for claim processing accuracy is at least 99.9 percent, with accuracy defined as the percent of all claims paid with no errors based on a statistically significant random sample of claims audited.	



RxClaim verifies your claim at the point of service prior to submission for processing. It checks that the claim is submitted in the correct format, that the member is eligible, that the pharmacy is in-network, and the drug is processed per the State's PDL criteria. Subsequent to a positive check, the claim is sent for further processing. If the claim does not pass the initial check, a rejection occurs.

As part of our claim adjudication process, 100 percent of claims are filtered through our Real Time Audit System at the point of service for clients using Optum Services for pharmacy auditing services. A set of algorithms identifies outliers, and a notification is sent to members of our auditing department, who then calls the pharmacy to resolve the concern. This process helps prevent mistakes and reduce fraud in prescription claims submission.

Established business process rules, benefit edits and logic within the RxClaim system allow for consumption of member eligibility and provider network data for real-time claims adjudication processing at point of service and reporting to downstream sub-systems and output to client. The system stores the data transactions as processed whether paid or rejected. The RxClaim system supports claims processing of NCPDP D.0 claims transactions submitted by pharmacies and routed to Optum Rx via switch vendors. Manual claims are also processed in the system.

MSQ4,a

Capacity planning is part of our proactive ongoing system management. This approach has allowed us to execute electronic claims adjudication transactions on average in less than one second.

We process an average of 135 million electronic transactions per month and can handle a virtually limitless number of transactions. We have the ability to add additional computer processing units, including servers, to meet expanding peak volumes, if necessary. However, our system may have limitations in terms of external feed systems. Limitations can be easily rectified with additional BIN numbers and routers.

Our proactive approach to system management confirms that our claim processing system is not at risk of reaching maximum capacity, which could result in delayed or intermittent processing.

The pharmacy claims processing system runs on an IBM i production platform. It uses an average of 35 percent CPU capacity during peak hours. We use this platform because of its serial and incremental scalability. The number of clients, members and claims is limited only by storage capacity, which we continuously review.

Multiple high availability performance systems process up to three million transactions daily with response times of less than 0.4 seconds. We have the ability to support at least 200 percent of this published capacity.

The claims communication design features redundant geographically dispersed high-speed links to QS1, Rx Connect, RelayHealth, and other switches with Integrated Services Digital Network (ISDN) dial backup as an added level of protection. A highly redundant, private Multiprotocol Label Switching (MPLS) network links to multiple datacenters of the Claims Switching companies. The IBM i systems are dispersed among the two data centers and are replicated to confirm smooth



failover should one of the hosts become unavailable. This architecture provides maximum availability and performance for around the clock pharmacy claims processing.

MSQ4,b

Since 1991, RxClaim is our proprietary rules-based claims processing system that supports virtually every type of pharmacy benefit program and pharmacy delivery mechanism available. Its flexibility, capabilities, and capacity are unlimited. This claims processing system is designed for online, real-time adjudication of prescription drug claims at the point of service. Retail, home delivery, and specialty claims are adjudicated through the same fully integrated online system.

With operational support available 24 hours a day, seven days a week, staff constantly monitor the performance and availability of the system. Using sophisticated monitoring hardware and software, connections are automatically tested every five minutes to validate that the systems are performing as expected for our clients and the pharmacies that rely on us to process their claims.

We own and develop our own claims processing system, RxClaim. We regularly schedule updates (new releases) to all of the components of this system to remain up to date with regards to industry standards, regulatory compliance, and the latest trends/demands in technology. The primary purpose of these updates is to meet the needs of our clients by offering innovative, differentiating products and services. These scheduled updates occur six to eight times per year (approximately every two months) and are scheduled with exact dates for deployment of each new release approximately one year in advance. We communicate this schedule to our clients.

Our installation of the software features not only the latest upgrades and features compliant with CMS and other regulations, but also custom features that we have internally developed and supported. We are able to offer the State capabilities and functions that are not offered by other PBMs using RxClaim.

Optum Rx upgrades and enhances its system regularly. In addition to minor weekly releases, we implement comprehensive upgrades to its system with six to eight major releases each year. Beyond these efforts, we regularly schedule maintenance activities throughout the year for our business-critical systems to maintain optimal system performance and security. Maintenance activities include system enhancements, upgrades and break fixes. Any such plans are communicated to the State at least 30 days prior to execution.

MSQ4,c

We use a custom version of the RxClaim online transaction processing system to adjudicate claims. RxClaim verifies the claim at the point of service prior to submission for payment. It checks that the claim is submitted in the correct format, that the member is eligible, that the pharmacy is in the network, and the drug is processing per the PDL criteria. Subsequent to a positive check, the claim is sent for further processing. If the claim does not pass the initial check, a rejection occurs.

As part of our claim adjudication process, 100 percent of claims are filtered through our Real Time Audit System at the point of service for clients who use our pharmacy audit services. A set of algorithms identifies outliers and a notification is sent to members of our auditing department, who then calls the pharmacy to resolve the concern. This process helps prevent mistakes and reduce fraud in prescription claims submission.



Our system also compares the requested reimbursement with the amounts we have on file. These amounts are based on the State's network negotiated usual and customary (U&C) cost, contracted dispensing rate, pricing that includes State MAC (SMAC) pricing, and member copayment.

We process more than 99 percent of all retail, home delivery and specialty claims electronically.



5.	Bookmark Title: <u>MSQ5 – ProDUR Editing</u> Narrative description is limited to five (5) pages, including any images or diagrams. Describe, in detail, the systems you utilize for Prospective Drug Utilization Review (ProDUR) editing including the edits available and any customization options, as stated in the requirements. Your response should include, but is not limited to, the following: - Description of the system(s) utilized for ProDUR editing. If purchased from a third party, include the name of the external data source. If self-developed, describe the similarities to available Products such as F, Medi-Span, or other similar sources. - The various payment disposition options that can be applied to each of the clinical edits. - Description of the ProDUR edits that can be suppressed at the State’s request, including any limitations. Refer to Attachment F – Pharmacy Benefit Administrator Services Scope of Work, Section 3 Point-of-Sale (POS) Claims Processing.
Supplier Response MSQ5 - ProDUR Editing MSQ5,a Concurrent Drug Utilization Review (ProDUR) Optum Rx’s Concurrent DUR is an ongoing drug monitoring program driven primarily by Medi-Span drug database edits and designed to check all incoming prescription claims real time within the adjudication platform against the member’s prescription history. At the point of service, our system checks for potential drug-related problems to improve the safety, quality, and cost effectiveness of dispensed medications by ensuring all prescriptions are clinically appropriate. Our standard Concurrent DUR edit categories include: • Drug regimen compliance screening • Drug-drug interaction screening • Drug-diagnosis caution screening • Drug-inferred health state screening • Dosing/duration screening • Drug-age caution screening • Drug-sex caution screening • Duplicate Rx screening • Duplicate therapy screening • Therapeutic dose limits screening	



- Morphine equivalent dose (MED) limit screening

During adjudication, Concurrent DUR edits run simultaneously with the other plan benefit edits. When a medication issue is encountered, Concurrent DUR responses are sent to the pharmacy based on the severity of the issue and the State's set-up; these messages include both soft rejects, which require pharmacist intervention and outcome codes, and hard rejects, which require PA. The program is flexible and configurable to meet your needs.

The State in collaboration with the clinical team can determine types of DUR rejects for categories and drugs. For example, level 1 drug-drug interactions can reject requiring PA review, while all other levels of drug-drug interactions could reject for messaging directly to the pharmacy. Therapeutic duplication could reject for a soft reject, requiring the pharmacist to enter their intervention outcomes codes and review. Standard program reporting includes monthly activity and quarterly outcome reports that can be provided to CMS in the CMS DUR Annual Report.

MSQ5,b

Dispositions for ProDUR alerts include:

- Extract – No reject or message was sent to the provider. Only maintain alert in claims detail for reporting.
- Hard Reject – Requires a PA to override the claim
- Message – Messages the provider with detailed information on the concurrent DUR alert but does not reject the claim.
- Soft Reject – Allows provider to submit intervention and outcomes codes in the DUR segment to override the alert resulting in a paid claim.

MSQ5,c

Optum Rx's Concurrent DUR program through Medi-Span is flexible to meet all of the State's needs. Any RxClaim ProDUR alert can be suppressed at the direction of the State. Should the State wish to activate available additional DUR edits, the RxClaim system is capable of performing these functions as well.



6.	Bookmark Title: <u>MSQ6 – NCPDP Formatting</u> Narrative description is limited to five (5) pages. Describe, in detail, your capability to promptly upgrade your Solution to new National Council for Prescription Drug Program (NCPDP) formats, as required in Attachment F – Pharmacy Benefit Administrator Services Scope of Work, Section 3 Point-of-Sale (POS) Claims Processing. Your response should include, but is not limited to, the following: a. Detailed internal, and any external, upgrade procedures required to accommodate the new NCPDP formats. b. The current format utilized for POS processing. c. Your participation in NCPDP committees.
Supplier Response MSQ6 - NCPDP Formatting MSQ6,a Optum Rx participates in multiple NCPDP task groups and attends the quarterly work group meetings. As new fields, values, and standards are released, Optum Rx reviews the changes, initiates development within our claims processing system and updates operational processes to ensure alignment with NCPDP standards. MSQ6,b Optum Rx currently processes claim transactions utilizing NCPDP Telecommunication Standard vD.0. We are aware of the Health and Human Services (HHS) proposed rule to transition to NCPDP Telecommunication Standard vF.6 and are monitoring guidance, as it is released. We are also reviewing the differences between vD.0 and vF.6 to ensure we are prepared to meet the final HHS timeline for the transition. MSQ6,c Optum Rx is an active participant in multiple NCPDP task groups, regularly attends NCPDP work group meetings, and serves in leadership roles within both the task groups and work groups.	



7.	Bookmark Title: <u>MSQ7 – State MAC List</u> Narrative description is limited to eight (8) pages. Describe, in detail, your methodology for partnering with the State to customize the State's Maximum Allowable Cost (MAC) list. Your response should include, but is not limited to, the following: a. Qualifiers for MAC consideration. b. Frequency of updates. c. Verification methodology for MAC recommendation made to clients. d. Ongoing monitoring efforts for MACs already established and processed for recommended adjustments. e. The ability to customize your existing MAC list(s), as directed by the State, and any restrictions associated with the customization. f. The ability to establish a MAC price on Products not traditionally included in a MAC program, such as medical devices (i.e., spacers). g. Proposal to assist the State in establishing a MAC process for new generics and over-the-counter (OTC) medications as they become available. h. The ability to apply all MAC rates across a therapeutic class. i. Your experience managing state Medicaid MAC lists, including identifying if the list was developed by the State or your company. Refer to Attachment F – Pharmacy Benefit Administrator Services Scope of Work, Section 3 Point-of-Sale (POS) Claims Processing.
Supplier Response MSQ7 - State MAC List Optum Rx's philosophy regarding the State MAC (SMAC) rate schedules starts with the understanding that the SMAC belongs to the State. Although we make recommendations on additions, deletions, and changes, no SMAC updates are implemented into RxClaim without the State's approval. We believe that chemically equivalent drug products in the same strength, dosage form, and package size available from multiple sources should be reimbursed similarly. Your SMAC is designed to maximize the cost-effectiveness of pharmacy services by setting reimbursement amounts for therapeutically equivalent drug products at the same price, based on the true cost of the products to pharmacies. MSQ7,a Optum Rx reviews and maintains the SMAC list frequently, while minimizing provider disruption and meeting the State's requirements. Your SMAC lists are reviewed weekly, quarterly, and more often as needed based on market forces and additional information. We routinely monitor pricing	



activity in the wholesale channel, expansion and contraction in the sourcing of products, new generic additions, and other factors to determine your custom SMAC pricing algorithms. Our SMAC team works with your Optum Rx Account Team to identify additional cost savings through the SMAC programs.

SMAC Additions

SMAC unit pricing methodologies vary based on the marketplace characteristics of a particular drug. In general, the number of product lines available at the weighted market price points Wholesale Acquisition Cost (WAC), Average Wholesale Price (AWP), National Average Drug Acquisition Cost (NADAC) and Federal Upper Limit (FUL) are captured and used in our proprietary MAC pricing algorithms. Products are selected for inclusion on your SMAC list based on availability and associated market forces. Once identified for inclusion, various pricing factors and benchmarks are reviewed during the determination of the MAC price.

We can also consider a drug for inclusion on your SMAC list when your custom conditions are met. In GA, for example, a product must meet the following criteria to be eligible for a SMAC rate:

- Have at least 2 A-rated suppliers that have a signed rebate on file with the CMS. Exceptions to this criteria include some covered OTCs, select smoking cessation products, devices (insulin syringes, pen needles, and respiratory supplies (peak flow meters and spacers)) cough and cold products, prescription iron products, multivitamins, and prenatal vitamins.
- Be readily available to providers from their wholesalers with ample supply

SMAC Deletions

Products are recommended for removal from the SMAC list if the following conditions exist:

- The drug is no longer available.
- The number of generic product manufacturers is reduced leaving one manufacturer.
- Product costs can no longer sustain SMAC reimbursement.
- Product quality and safety issues, such as a recall or FDA warning, exist.
- Products not on the SMAC list are priced using the next lowest price source using the State's lesser of reimbursement methodology. If warranted, Optum Rx may add a product back to the SMAC list once discounted pricing becomes stable again.

MSQ7,b

Your SMAC lists are reviewed weekly, quarterly, and more often as needed based on market forces and additional information. We routinely monitor pricing activity in the wholesale channel, expansion and contraction in the sourcing of products, new generic additions, and other factors to determine the SMAC pricing algorithms. Our SMAC team works jointly with your Optum Rx Account Team to identify additional cost savings through the SMAC programs. Once approved by the State, SMAC rate updates are commonly loaded systematically through a batch process and can be entered manually based on the number of changes and relative urgency.



MSQ7,c

As an added quality check, the Optum Rx Sr. Provider Relations Specialist reviews all SMAC recommendations before sending to the State. She verifies that the State specific criteria are being met and that the recommended SMAC price is lower than other available cost sources in the State's pricing logic.

MSQ7,d

Your SMAC program is designed with the overall goal of obtaining the lowest net prescription drug cost for our customers. Optum Rx reviews and maintains your SMAC list frequently, minimizing member disruption and meeting regulatory requirements. We use a variety of resources in determining the components of the SMAC list including WAC, NADAC, FUL, pharmacy acquisition costs, and competitive benchmarks. The SMAC is customized at the GPI level to provide maximum savings for our clients.

Optum Rx reviews and maintains the SMAC list frequently while minimizing provider disruption. SMAC lists are reviewed weekly and updated as needed based on market forces and additional information. We routinely monitor pricing activity in the wholesale channel, expansion and contraction in the sourcing of products, new generic additions, and other factors to determine appropriate reimbursements to pharmacies.

As an additional check, your Optum Rx Account Management Team develops a schedule to ensure that generic products from all therapeutic drug groups are reviewed at least once a year. The schedule includes therapeutic drug groups (at the GPI-2 level) that are reviewed each quarter by our MAC team who recommend additions, changes, and deletions to the current SMAC list. This schedule ensures that we are reviewing SMAC on all generic products at least once a year.

MSQ7,e

We can initiate additional SMAC reviews at the request of the State. The SMAC lists are reviewed weekly for comprehensiveness, verifying that eligible products are included in the SMAC list. We work with the State to achieve your desired level of comprehensiveness.

MSQ7,f

There are only a small handful of medical devices (such as Peak Flow Meters and Spacers) that meet the criteria for SMAC program eligibility. Optum Rx aims to provide a comprehensive SMAC list while making sure that products and pricing adheres to standards such as availability of generic NDCs, pharmacy prescription eligibility, and availability of market acquisition cost data for dispensing pharmacies to allow for fair reimbursement to pharmacies.

MSQ7,g

Optum Rx aims to provide a comprehensive SMAC list including the timely addition of new generic drugs and many OTC medications, assuming all requirements of the SMAC program are met.

MSQ7,h

Optum Rx configures a SMAC rate at any level in the GPI product hierarchy, including therapeutic class at the direction of the State.



MSQ7,i

Your Optum Rx Account Management Team develops a schedule to ensure that generic products from all therapeutic drug groups are reviewed at least once a year. The schedule includes therapeutic drug groups (at the GPI-2 level) that are reviewed each quarter by our MAC team who recommend additions, changes, and deletions to the current SMAC list. This schedule ensures that we are reviewing SMAC on all generic products at least once a year.

Optum Rx has been managing FFS Medicaid SMAC lists since 2006 and has served over fourteen State programs through both standard Optum Rx MAC development processes and custom State processes. We understand every State FFS Medicaid client is unique, and we are generally able to flex to the specific SMAC requirements in update frequency, methodology, and review process.



8.	Bookmark Title: <u>MSQ8 – Pricing Appeals</u> Bookmark Title for Supporting Material: <u>MSQ8.1 – Sample Provider Communication Plan</u> Narrative description is limited to two (2) pages, not including required supporting material. Describe, in detail, your pricing Appeals process regarding, but not limited to, Maximum Allowable Cost (MAC), National Average Drug Acquisition Cost (NADAC), Federal Upper Limits (FUL), Wholesale Acquisition Cost (WAC), 340B, and Actual Acquisition Cost (AAC), for Provider inquiries. Your response should include, but is not limited to, the following: a. Provider communication plan(s) (i.e., proposed receipt of and response to Provider inquiries). b. Turnaround time and routine communication of Provider inquiries and their resolutions. Refer to Attachment F – Pharmacy Benefit Administrator Services Scope of Work, Section 3.1 Contractor Responsibilities (of Section 3 Point-of-Sale (POS) Claims Processing).
Supplier Response MSQ8 - Pricing Appeals MSQ8,a Optum Rx provides a process for providers who have disputes on reimbursement in general and on specific published prices. Although we provide instructions on submission through a dedicated email used for your State account, we understand that disputes can come to your Account Team from various sources, including: The State, Optum Rx call centers, pharmacy associations, and directly from the providers. To that end, we provide a process which places your Account Team with the role of ensuring all disputes are tracked no matter what the cost source. The approach to managing the dispute, however, will depend on the cost source being questioned. In cases where the SMAC is disputed, we require the provider to provide a completed form which documents the appeal including requiring copies of invoices. Disputes on NADAC, for example, include an overview of the NADAC process and referral directly to the NADAC helpdesk as a first-line support. If the provider is insistent that the NADAC is significantly impacting them financially and requests further review, Optum Rx brings the case to the State to review for a possible Georgia Estimated Acquisition Cost (GEAC) rate consideration. The process and communication plan for dispute handling for these cost sources and others are outlined in the attachment MSQ8.1. MSQ8,b Optum Rx formally logs all pricing disputes and acknowledges all dispute requests no matter the requestor source or price type. The acknowledgement is either through email, voice or both depending on the channel the dispute is provided. The turnaround time for dispute resolution depends on the price type as Optum Rx and the State are not the owners of some price types, such as NADAC, FUL or WAC.	



For SMAC and Select Specialty Pharmacy Rates (SSPR) disputes as an example, the typical turnaround time from the initial communication of the dispute to a resulting system price change can take anywhere from 1-7 business days, depending on workload and priority. For urgent changes, the Optum Rx Account Team can make manual updates within hours.

MSQ8.1 – Sample Provider Communication Plan

Please refer to the PBA Exhibit Section, MSQ8.1 - Sample Provider Communication Plan.pdf in our proposal response.



9.	Bookmark Title: <u>MSQ9 – Drug Reimbursement Methodology Support</u> Narrative description is limited to four (4) pages. Describe, in detail, how your POS Claims Processing Solution fully supports the State's drug reimbursement methodology as it may be amended. Your response should include, but is not limited to, the Solution's ability to: - Accommodate an Actual Acquisition Cost (AAC) methodology using National Average Drug Acquisition Cost (NADAC), the State's model, or other CMS-approved methodology. - Receive and load at various frequency, up to real-time, the NADAC file and other data files as requested by the State to support the drug reimbursement methodology. - Fully support the State's professional dispensing fee structure as it may be amended periodically. Refer to Attachment F – Pharmacy Benefit Administrator Services Scope of Work, Section 3.2 POS Claims Processing Solution Requirements.
Supplier Response MSQ9 - Drug Reimbursement Methodology Support MSQ9,a Optum Rx's pharmacy solution processes and pays claims based on the State approved reimbursement methods, dispensing fee, and member copayments, for example. The flexibility and control of Optum Rx's RxClaim allows the State to define the edits that the claims must pass through. For example, after eligibility is confirmed, the claim passes through the series of chosen edits, such as the State's prescriber and pharmacy networks, drug PDL criteria, PA, and the State approved pharmacy reimbursement methodology. The Pricing edit links the system to pricing tables which determine the correct drug cost, dispensing fees, member copayments, and other pricing parameters. Our system also compares the requested reimbursement with the amounts we have on file, including but not limited to FUL, SMAC, WAC, NADAC, GEAC, and SSPR, and the 340B ceiling rate. RxClaim supports payment methodologies that incorporate ingredient costs that are reported by the pricing compendia (FDB, Medi-Span), such as WAC, plus ingredient costs determined and reported by CMS (NADAC, FUL) or ingredient costs approved by the client based on state specific pricing surveys, for example, Average Actual Acquisition Cost (AAAC), SMAC, and 340B ceiling price. Submitted charges such as U&C, Gross Amount Due, and Submitted ingredient costs are also considered as approved by the State. Any or all of these costs can be incorporated into a "lesser of" payment methodology to verify regulatory compliance with actual acquisition cost requirements and the State approved reimbursement methodology. MSQ9,b Optum Rx configures the RxClaim environment to load the daily and weekly files provided by Medi-Span and FDB as authorized. NADAC, WAC, FUL and other price sources are updated in	



RxClaim within hours after receiving the update files. Additionally, Optum Rx has the capability to make changes to the SMAC, and SSPR directly into the system at any time.

MSQ9,c

Utilizing GA DCH as an example, Optum Rx configures the Professional Dispensing Fee (PDF) at \$10.63 and applies this fee in alignment with the State Plan Amendment as follows based on the drug type and presence of the NADAC rate:

Reimbursement for specialty drugs dispensed under the Georgia Medical Assistance program shall not exceed the lowest of:

- a) Select Specialty Pharmacy Rate (SSPR) plus the PDF, or
- b) (NADAC) plus the (PDF), or
- c) The (PDF), or
- d) Georgia Maximum Allowable Cost (GMAC) plus the (PDF), or
- e) (FUL) plus the (PDF), or
- f) Provider submitted charges (including U&C Charges)

Reimbursement for non-specialty drugs, which have an active (NADAC) price on file, dispensed under the Georgia Medical Assistance program shall not exceed the lowest of:

- a) (NADAC) plus the (PDF), or
- b) Georgia Maximum Allowable Cost (GMAC) plus the (PDF), or
- c) (FUL) plus the (PDF), or
- d) Provider submitted charges (including U&C)

Reimbursement for non-specialty drugs, which do not have an active (NADAC) price on file, dispensed under the Georgia Medical Assistance program shall not exceed the lowest of:

- a) (GEAC) plus (PDF), or
- b) Georgia Maximum Allowable Cost (GMAC) plus the (PDF), or
- c) (FUL) plus the (PDF), or
- d) Provider submitted charges (including U&C Charges) NOTE:

Between May 15, 2002 – June 30, 2005, a \$0.50 cent generic incentive dispensing fee was paid to providers.

In accordance with GA DCH policy today, Optum Rx configures the RxClaim system to only allow one PDF for the same drug for the same member in the same month of service. In the event a member requires a second prescription for the same drug in the same month of service, the provider will be reimbursed only for the cost of the drug with the exception of the products listed in the pharmacy manual.

We understand that changes to the PDF policy can change from time to time. In planning for these changes, Optum Rx first works hand in hand with the State Pharmacy team to advise on State



Plan Amendment language which may be necessary for CMS pricing approval. Once changes are approved to the PDF, Optum Rx incorporates these changes into the system and provide the necessary outreach to providers through the banner process, fax blasts, and email blasts as required.



10.	Bookmark Title: <u>MSQ10 – Drug File Customization</u> Narrative description is limited to three (3) pages. Describe, in detail, your ability to support customization of the drug file. Include in your response, at a minimum, your ability to: - Customize pricing, including items such as Manufacturer-reported pricing that differs or is missing from the Supplier's reference drug file Provider. - Maintain customization as new drug pricing updates are received and uploaded into your system identifying if the process is automated or manual. - Support the addition of new NDCs, or Universal Product Codes (UPCs) formatted as NDCs on the drug file for Products not listed on the Supplier's drug file. - Process inactive, deleted, or reused NDCs including how inactive, deleted, and reused NDCs are stored and accessed for Claims billed retroactively by the Provider. - Maintain preferred status for selected branded Products over their generic option. Indicate whether the system is automated to maintain branded Products over the generic preference or if the system requires manual updates with each drug file upload. Refer to Attachment F – Pharmacy Benefit Administrator Services Scope of Work, Section 3 Point-of-Sale (POS) Claims Processing.
Supplier Response MSQ10 - Drug File Customization MSQ10,a Optum Rx understands that there could exist missing or incorrect pricing from the 3rd party drug file compendia vendors. In these cases, The Drug File Administration Team formally initiates a research request with the drug compendia vendor(s). While the issue is being reviewed, the Optum Account Team maintains a separate custom PRICEMAC file and adds a record with the product, State approved rate, and effective date. This PRICEMAC is separate and apart from the standard SMAC and is configured as a “conditional” component of the lesser of logic for pricing. In the lesser of logic, the system is configured to consider the PRICEMAC rate (when present) in place of the manufacturer reported WAC (for example) to compare against the other price sources such as Submitted costs, NADAC, FUL, SSPR, and SMAC or other cost sources as defined by the State. Once the WAC rate is corrected by the drug compendia vendor, the Optum Rx Account Team terminates the PRICEMAC rate as it's no longer needed. MSQ10,b Drug files are received each weekday and automatically loaded into the claims adjudication system and subject to automated daily audits to the source data. MSQ10,c In the event that a Product is not provided by the Medi-Span's Master Drug Database (MDDb) File loads, Optum Rx has a process to add the product so that State approved payment can be	



performed in the RxClaim system. The first step Optum Rx performs is to verify that there is not a different Product ID with a different Product ID Type for the same drug/product in RxClaim. Once verified, the following steps are necessary to manually add the Product ID to the self-managed RxClaim Platform:

- The Optum Rx Account Manager creates an Optum Rx ServiceNow Task assigned to the Optum Rx Foundation Data Services Team regarding the addition request.
- Optum Rx works with the State to confirm product details and necessary supporting information before manually adding the product.
- The Optum Rx Foundation Data Services team submits a support case to Medi-Span to add the Product ID(s) to their Drug File.
- Optum Rx Foundation Data Services and Drug File Administration will collaborate to review the drug/product and corresponding information for the manual addition to RxClaim.
- It's important to note that some clinical edits might not apply until the full product information is eventually included in a subsequent Medi-Span MDDB Load.
- Once the Product ID(s) are manually added to RxClaim, the Optum Rx ServiceNow Task will be closed.
- The Optum Rx Account Team will notify the State of the manual addition of the Product ID(s) to the RxClaim Platform and when the product is loaded by Medi-Span.

MSQ10,d

Product IDs have effective dates, termination dates and obsolete dates along with product status which indicates whether the product is active or inactive. Products are never deleted from RxClaim Product Master. Once the product is inactive, it can be used for retroactive billing as long as the submit date falls between effective and obsolete dates. All product and pricing information is stored historically by date to allow for retroactive billing.

MSQ10,e

Optum Rx understands that that the overall cost of a product, net of rebates, could favor the preference of a branded drug over its' generic counterpart. In these cases, RxClaim is configured to enforce the brand product's multi-source code as preferred while the generic equivalents are set to non-preferred. Included custom messaging back to the provider also indicates the brand preference. After the brand override is setup, the configuration is not impacted by the drug file update process.



11.	Bookmark Title: <u>MSQ11 – Authorized Solution User Access</u> Narrative description is limited to ten (10) pages, including screenshots. Describe, in detail, the capabilities and limitations with regards to the Authorized Solution Users' access to the POS Claims Processing Solution, including the web link. Include descriptions for the following in your response: - The type of functionality the State will be able to access. - The type of information the State will be able to access (i.e., Claim level status information, prior authorization information, plan performance information). - The type of information the State's vendors will be able to access (i.e., Claim level status information, prior authorization information, plan performance information). - Any limitations with accessing information, including the number of State users who can be given access to any of the Solution's platforms needed to meet the requirements identified in this eRFP. Refer to Attachment F – Pharmacy Benefit Administrator Services Scope of Work, Section 3 Point-of-Sale (POS) Claims Processing Solution.
Supplier Response MSQ11 - Authorized Solution User Access MSQ11,a and b Client Portal From the cloud-based Client Portal, the State users access information and resources to manage their benefit plan. Plan administrators commonly use the Client Portal to perform the following functions: - Access customer applications, including RxClaim, RxView and RxTrack - View our pipeline report and review information about drugs in development - Request plan changes, data reports or submit questions - Learn about drug recalls, expiring patents, and relevant clinical research - Review our book-of-business trend data report - Download financial reports Once in the Client Portal, State users have access to eligibility and claims information through our web-based claims application, RxClaim, and online reporting tool RxTrack, which enables the State to view claims transactions in real time. This direct connection to our claims processing system facilitates important plan maintenance and management functions, enabling the State to: - View, update and add member eligibility - See pharmacy information	



- Enter overrides and administrative PAs
- Verify State-specific plan designs

We provide clients licenses to access our web-based claims application, eligibility functions and our online reporting tool and services—including installation and training. These licenses can be provisioned to vendor or consultant contacts designated by the State.

We make it easy for the State to monitor and review plan performance at your convenience through our RxTrack web-based reporting platform. The online platform gives you flexibility to analyze and filter data through established parameters or create ad hoc reports and customized views to meet your needs. RxTrack captures claims data, utilization data and member eligibility files, as well as prescriber and pharmacy information to provide comprehensive analytics and reporting for the State.

RxTrack is anchored by our data warehouse and analytics technology giving you flexibility to create and work with reports and data views based on your preferences. Claims data is updated daily in the data warehouse to provide the State with up-to-date analytics to fit your specific reporting needs. The State can create its own configurable report views and save reports in a variety of file formats. Security parameters also enable you to set different access levels for different user groups.

We also provide consultative support services through the State's Account Management Tteam to collaborate with you on strategies for your pharmacy benefits.

When needed, Optum Rx provides access to State users to our PA system for those instances where the State would like to participate in the review and approval of PA.

MSQ11,c

Pending the approval from the State and the execution of system and data use agreements, other State Vendors can have access to our RxClaim and PA system to perform functions in support of their scope of work. An example of this today is where we provide RxClaim access to CMS PERM auditors to complete their review of the Pharmacy program. External users are granted access according to their specific function and can include claim level information, PA, and plan performance reporting if authorized by the State.

MSQ11,d

Within RxClaim, RxTrack and in the PA system, the State user access is limited to the specific role authorized and we do not limit the number of State users who can be given access.



12.	Bookmark Title: <u>MSQ12 – ePrescribe</u> Narrative description is limited to five (5) pages. Describe, in detail, your ability to process electronic prescriptions with complete adjudication processing edits applied in real time (i.e., Quantity Limits and prior authorization required). Your response should include, but is not limited to, the following: - Description of the ways those edits can be electronically supported (i.e., immediate submission and response capability for prior authorization processing). - Your capability to be NCPDP-compliant and any limitations associated with your services. Refer to Attachment F – Pharmacy Benefit Administrator Services Scope of Work, Sections 3.2 POS Claims Processing Solution Requirements, 4.1 General Requirements (Prior Authorization (PA)), and 6.3 Web Portal.
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Supplier Response

MSQ12 – ePrescribe

Our e-Prescribing capabilities comply with HIPAA and the Centers for Medicare and Medicaid Services (CMS) regulations and provide user-friendly electronic support for our customer's prescriber networks. Our capabilities help to:

- Influence best practices
- Promote preferred prescribing patterns
- Support access to member data
- Support verification of prior authorization
- Identify care management issues

Surescripts Network and Application

Our e-Prescribing vendor, Surescripts, operates the nation's largest e-prescription network and supports a rapidly expanding network of health care organizations nationwide. They connect prescribers in every state in the United States to the leading payers, chain pharmacies and independent pharmacies. They facilitate and help us process electronic prescriptions submitted by pharmacies and technology vendors who also have a relationship with them.

For physicians who e-prescribe using certified technology, the application supports the following functions:

- Electronic prescribing using handheld/mobile devices
- Electronic prescription transactions with our retail and home delivery pharmacies
- Electronic processing of prescription refill requests, authorizations, or denials
- Text messages with formulary information for specific drugs
- Access to claims history across physicians, eligibility information/history, and prescription drug list information



Prescription History Data

Our e-Prescribing system delivers member prescription history from payers and pharmacies to prescribers. This historical data includes:

- Date range of history
- Drug name (brand/generic)
- Oldest fill date, most recent fill date
- Number of fills, days' supply, quantity dispensed (future initiative)
- Pharmacies/prescribers

e-Prescribing Initiatives

We are actively working on and planning to implement upgrades to improve our e-prescribing process while moving towards seamless interoperability with our contracted network pharmacies.

RxClaim

RxClaim is our proprietary rules-based claims processing system that supports virtually every type of pharmacy benefit program and pharmacy delivery mechanism available. Its flexibility, capabilities, and capacity are unlimited. This claims processing system is designed for online, real-time adjudication of prescription drug claims at the point of service. Retail, home delivery, and specialty claims are adjudicated through the same fully integrated online system.

With operational support available 24 hours a day, seven days a week, staff constantly monitor the performance and availability of the system. Using sophisticated monitoring hardware and software, connections are automatically tested every five minutes to validate that the systems are performing as expected for our clients and the pharmacies that rely on us to process their claims.

We use a custom version of the RxClaim online transaction processing system to adjudicate claims. RxClaim verifies the claim at the point of service prior to submission for payment. It checks that the claim is submitted in the correct format, that the member is eligible, that the pharmacy is in the network, and the drug is processed per PDL criteria. Subsequent to a positive check, the claim is sent for further processing. If the claim does not pass the initial check, a rejection occurs.

As part of our claim adjudication process, 100 percent of claims are filtered through our Real Time Audit System at the point of service if the State elects to utilize the Optum Rx pharmacy audit services. A set of algorithms identifies outliers and a notification is sent to members of our auditing department, who then calls the pharmacy to resolve the concern. This process helps prevent mistakes and reduce fraud in prescription claims submission.

Our system also compares the requested reimbursement with the amounts we have on file. These amounts are based on negotiated (U&C) cost, contracted dispensing rate, SMAC pricing, and member copayment.

MSQ12,a

The RxClaim POS adjudication system subjects all claims to the State defined clinical edits (Quantity Limits, PA, Step Therapy, etc.). This means that regardless of the prescription origin, (written, fax, telephone, or e-prescribed) the claims submitted by the pharmacy process through



the same editing system with the same results. With respect to the edits the system allows for standard and/or custom messaging back in the response to ensure proper direction is provided real-time to the pharmacist. The submitted prescription origin is captured on the claims and is present on the State's claim extract files if required for downstream reporting.

MSQ12,b

Prescribers make treatment decisions—and help shape member decisions—that directly influence total health care costs. The more a prescriber knows about their patients' health and benefits, the more deliberate they can be in choosing the most appropriate tests, treatments and medications for each individual.

Optum Rx provides eligibility, PDL status and medication history data with our EMR Vendors to enable real time benefit transparency at point of care. PreCheck MyScript (further detailed below) enhances the e-prescribing workflow further by providing additional benefit transparency at a patient level. This data is provided following NCPDP and X12 standards.

PreCheck MyScript

PreCheck MyScript, the only app of its kind in the marketplace, displays member specific pharmacy information, including price transparency, therapeutically equivalent drug alternatives, pharmacy options and evidence-based medicine clinical alerts, at the point of prescribing. Prescribers also are alerted to any PA requirements, giving them the option to submit additional clinical documentation or select a drug alternative—all before the patient leaves the office.

PreCheck MyScript is accessed directly in the electronic medical record (EMR) prescribing workflow. As the prescriber submits an e-prescription within the EMR a trial claim is initiated with Optum Rx. In less than two seconds, PreCheck MyScript returns an individualized, benefit specific coverage determination. Furthermore, PreCheck MyScript also returns patient cost share, pharmacy options and preferred alternatives therapies available under the patient's benefit. After the prescriber consults with the patient to determine the preferred care path, the prescriber may easily select the chosen drug and proceed to send the prescription to the pharmacy. The provider may also elect to start a PA directly in the workflow.

In addition, all prescribers have access to our provider portal, which enables prescribers the ability to access PreCheck MyScript outside of the EMR.

Additionally, Optum Rx has multiple tools to streamline submission, review and approval of PA requests.

Electronic Prior Authorization

Optum Rx provides customizable NCPDP-compliant electronic PA (ePA) solutions through our relationships with CoverMyMeds and Surescripts, as well as ePA capabilities through PreCheck MyScript. Through these channels, we are able to return real-time decisions for nearly 50 percent of PA requests. Those needing further review are processed within one to three business days.

Features of ePA solutions include:

- Enables prescriber to interact directly with our PA system in real time through either a Web portal or their electronic health records (eHR) system



- Provides dynamic presentation of protocol questions
- Notifies the user of case outcomes
- Results in real-time authorization creation for approved requests
- Verifies the PA is progressing correctly through trial transactions
- Health care professionals may submit real-time PA requests through CoverMyMeds, or Surescripts, as well as through our integration with the following eHR systems: PreCheck MyScript, DrFirst, CenterX, Allscripts, or RxRevu.

CoverMyMeds

To submit an electronic PA, health care professionals log into their existing CoverMyMeds account or quickly create an account. They also may finish an electronic PA initiated by a pharmacy.

CoverMyMeds auto-populates the request with the health care professionals' administrative information, including electronic signatures, stored in their account. Final approval and denial messages are sent to the health care professionals' CoverMyMeds account dashboard for easy access in one location.

Surescripts

Health care professionals with access to Surescripts' Electronic Health Records software may submit PA requests using Surescripts' integrated solution, CompletEPA™. CompletEPA prepopulates member demographic data automatically.



13.	Bookmark Title: <u>MSQ13 – COB Activity</u> Narrative description is limited to five (5) pages. Describe, in detail, your ability to track and report all Coordination of Benefits (COB) activity including all deliverables. Your response should include, but is not limited to, the following: - Payments made by Third Party Liability (TPL) carriers as reported by retail pharmacies. - Your POS Claims Processing Solution's ability to provide the carrier ID, name, address, and phone number of the non-State carrier back through the National Council for Prescription Drug Programs (NCPDP) transactions to the Point-of Sale (POS) submitting Provider. - Methods used to identify non-compliant carriers as those who fail to respond to billings and continually deny Claims. - Proposal to report incorrect or missing TPL pharmacy information so the State TPL information and updates reflect the most current information. - The method(s) used to report Providers who potentially abuse any third-party related override codes. - Relevant third-party related issues you have encountered and have developed Solutions. - Your POS Claims Processing Solution's ability to message pharmacies real-time with the TPL data provided by the State including any messaging limitations. - Detailed system capabilities you can offer to the State to ensure Medicaid is always the payer of last resort and never pays more than the primary carrier(s) contracted amount. Refer to Attachment F – Pharmacy Benefit Administrator Services Scope of Work, Section 3.3 Third Party Liability (TPL) & Coordination of Benefits (COB).
Supplier Response MSQ13 - COB Activity RxClaim validates and cost-avoids individual claims against the primary payer(s). The system accepts other payers' secondary claims, supporting the NCPDP maximum of nine other payers if the pharmacy processes more than one other payer for a given claim transaction. In processing a COB claim, we store the primary member's payer data on the claim to the extent that it is reported by the submitting pharmacy according to NCPDP COB Segment field requirements. In order to cost-avoid as many claims as possible, we support the State in enhancing the use of standard NCPDP Other Coverage Codes (OCC) to reduce the number of claims that are paid without the application of other payer's pharmacy benefit coverage. We follow the rules for COB adopted in the most current National Association of Insurance Commissioner Coordination of Benefits Model regulation. The figure and description below present a high-level overview of our enhanced Coordination of Benefits process.	



Automating Coordination of Benefits

Our Enhanced Coordination of Benefits program (eCOB) is a service we make available to our Medicaid clients that identifies potential data sources that may make it possible to avoid health care costs that are attributable to a third party. This service delivers real time savings and substantially reduces a state's reliance on a "pay and chase" model and augments a state's supplied TPL data.

The eCOB program:

- Collects other health insurance (OHI) that is unreported by members
- Uses exclusive agreements with data aggregators and payment/revenue cycle companies to augment TPL data
- Centralizes member claims history to increase patient safety
- Cost Avoids claims where there is known or suspected other insurance.

By using data and technology in this new way, we can more accurately detect and identify TPL. The eCOB solution augments existing supplied TPL data residing in RxClaim with information collected from leading providers of revenue and payment cycle solutions, some of the largest national PBMs and through exclusive relationships we have with several data aggregators. Updated frequently, this data provides up-to-date results as claims are processed.

We identify members with other coverage and integrate our external data sources into a single eligibility database. Then, the claim editing process uses unique algorithms to identify matches with eligibility data. When the eCOB TPL data is used, a match is found, and the pharmacy has not indicated they have submitted a claim to any other payer, the pharmacist receives a NCPDP rejection code '41 – Submit to Primary Processor' for the claim with the available NCPDP COB Response fields along with the following other payer information provided in the text message portion of the claim response:

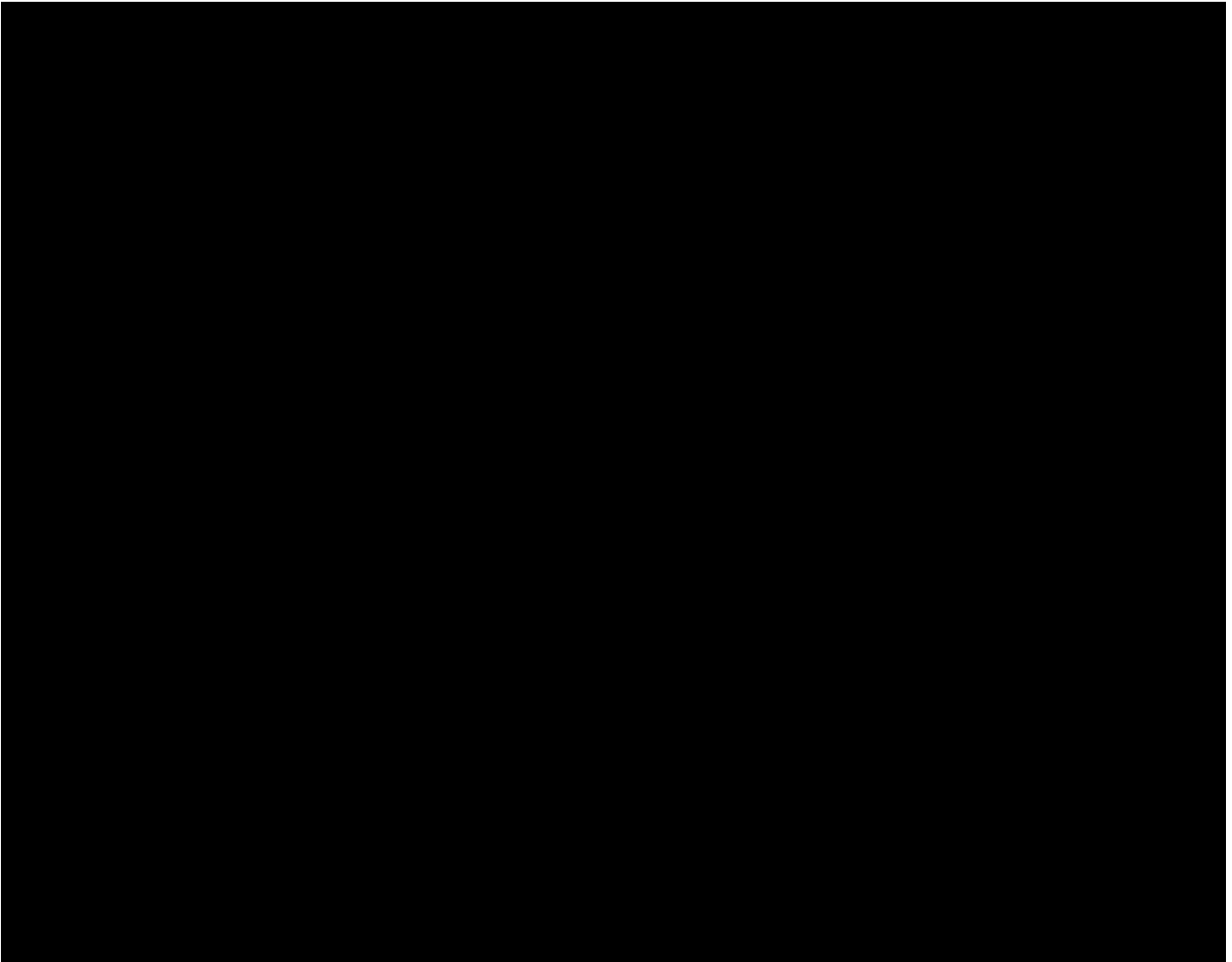
- BIN number
- PCN number
- Group number
- Cardholder ID
- Person code
- Processor help desk phone number

The following steps then occur:

- The pharmacist can override the TPL reject by indicating that the claim has been sent to another payer and has been paid or rejected through submitting the applicable OCC code.
- If the primary insurer covers less than the Medicaid allowed amount, Medicaid pays as secondary.



- If the primary insurer rejects the claim, Medicaid may pay the claim depending on the reason for the reject.



Our state Medicaid clients have achieved over \$50 million in savings using eCOB. eCOB leverages our relationships with numerous data sources and is a proven cost avoidance model using data-matching algorithms and innovative data sources. We significantly improve the identification of previously unknown primary coverage, reassigning benefit liability to the appropriate payer.

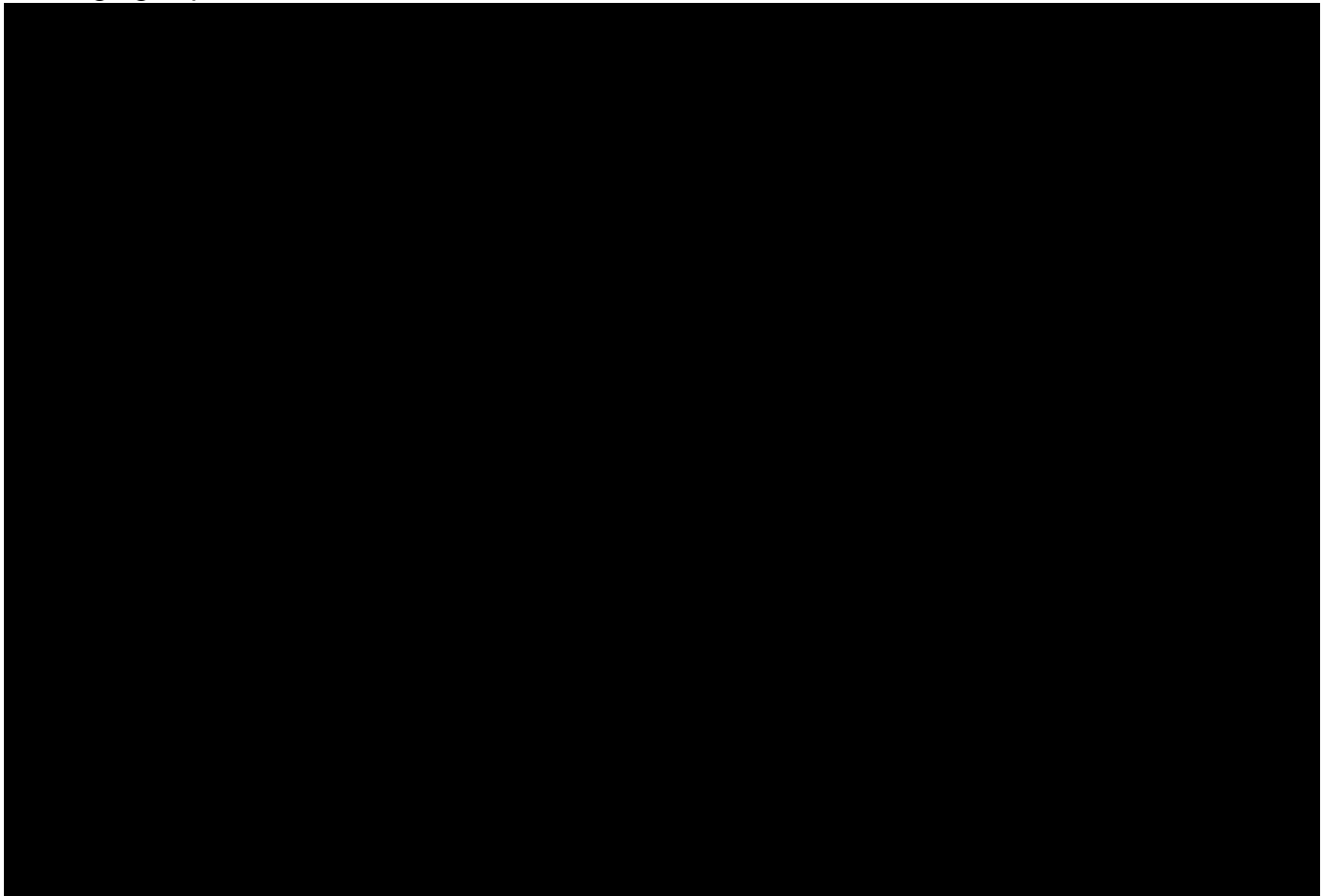
MSQ13,a

The Optum Rx RxClaim system captures provider reported third party payments as entered through standard NCPDP claim request transactions. We store the other payer amount details in the claim record which users can view.



MSQ13,b

Optum Rx's RxClaim plan and messaging configuration provides the State with the capability to customize COB related messaging. Carrier information, member ID, plan phone number and BIN/PCN/Group can be configured as part of the NCPDP response messages if the State can provide the information through the eligibility or COB files. A screenshot of response COB messaging is provided below on a test claim.



MSQ13,c

The data from COB claims transactions themselves can help identify where TPL data could be missing. Optum Rx configures COB process as directed by the State on which other coverage codes are allowable. The State can elect to allow the use of Other Coverage Code of "3" in which the provider conveys that other coverage is available, the payer has been billed and payment denied because the service is not covered. Optum Rx provides custom reporting on a monthly basis through RxTrack identifying the use of this Other Coverage Code where primary payers do not cover the product. We further group this claims activity by submitting provider and Carrier as provided in the State COB file and provide sorts based on the relative frequency by provider and Carrier to the overall submissions of the override by all providers. This report identifies which carriers and providers have higher rates of the override usage.



MSQ13,d

While it's always better for a Medicaid program to avoid the cost as a secondary payer, we understand the unique challenges of maintaining up to date coverage information with a member's record. Traditional sources of other coverage can lag between the time coverage is active and when the coverage is reported to a Medicaid agency. Optum Rx's standard claims extract provides a robust array of claim level detail including payment and TPL segment information, enabling downstream systems and processes to support subrogation related activities.

The data from COB claims transactions themselves can help identify where TPL data could be missing. Optum Rx provides custom reporting on a monthly basis through RxTrack identifying where other payer paid amounts were "voluntarily" submitted on claims and where no other coverage information is associated with the member. This report demonstrates where there is possible other coverage not yet identified for the member.

Additionally, member and pharmacy callers report inaccurate COB information to the Optum Rx call centers and these calls are escalated to the Account Team. The Account Team conducts an initial research with our access to GAMMIS and coordinates with the DCH COB team in cases to investigate requested COB data changes. In urgent cases, Optum Rx or the client can update COB data in RxClaim so that the member can receive their medications before MMIS COB changes are sent to RxClaim.

MSQ13,e

Optum Rx understands that COB data is not perfect. The State pharmacy plans generally allow providers to utilize all or a subset of NCPDP OCC to override a TPL reject. These codes describe the status of the primary claim and the reported amounts collected from the primary payers. With the use of the NCPDP OCC codes, there does exist the opportunity for providers to use the OCC inappropriately and increase costs to the State.

To combat this risk, Optum Rx provides a monthly COB detail report with separate tabs for detail by OCC code submitted. For OCC 2 claims where other payer payment information is submitted, this tab is sorted ascending by the other payer payment amount to identify where providers may be inputting low values for primary payments just to bypass the TPL reject. Secondly, we provide detail by all other State allowed OCCs and provide sorting and grouping to uncover providers who may be using these overrides with a frequency that exceeds set thresholds. The Optum Rx Account Manager provides a monthly report of providers exceeding override thresholds to the State Pharmacy team, Program Integrity, and the Fraud Waste and Abuse (FWA) vendor as directed for further review and follow-up.

MSQ13,f

The most common third-party issues related to COB are when the primary payer reported to the pharmacy system extends well beyond the actual termination date. Out of date COB information causes unnecessary confusion at the pharmacy and can cause delays in obtaining medications. Optum Rx understands that there is a tradeoff between the use of other coverage override codes and their corresponding potential for abuse. Optum Rx eCOB services reduce the risk of



inaccurate termination dates through a term by absence process with each monthly reconciliation process.

Additionally, we've seen where some providers enter small amounts in the other payer paid fields to bypass a COB reject. When warranted and at the approval of the State, Optum Rx sets a configurable minimum threshold for primary payer paid amount and monitors claims activity to see if behavior changes. After the monitoring period, Optum Rx makes a recommendation to maintain the threshold or adjust as needed.

MSQ13,g

Optum Rx's RxClaim plan and messaging provides for the capability to customize the NCPDP message segments in the claim response for COB editing if provided by the State. NCPDP message occurrence and field size and limitations exist for all messaging. As part of the data migration and interface development process, Optum Rx, the State and the State's COB vendor review the TPL source files to understand the data elements requested for messaging. We coordinate with our Benefit Operations team and the eligibility team to ensure that data is mapped into the appropriate RxClaim member fields to achieve the messaging required by the State.

MSQ13,h

Our claims adjudication system supports COB for electronic claims at the point of service and manual claims for the following scenarios:

- Primary coverage
- Secondary coverage
- Tertiary coverage
- Medicaid subrogation
- Medicare Part B
- Medicare Part D

We collaborate with the State to confirm that the correct COB information is provided in the eligibility file for members who have another primary insurance carrier. This data is stored as an element in the system and can be supplied on claims encounter files (and sent back to the State if requested). If a COB indicator is present on the eligibility file of a member who has coverage through another primary carrier, the system denies the claim unless a COB segment with a State approved other coverage code is submitted.

RxClaim configuration and pricing logic ensures that COB claims are paid at no more than the Medicaid allowed. When primary coverage exists on the member record, the system first enforces a minimum amount threshold for primary payment at a level authorized by the State. This threshold prevents providers from placing a penny in the other payer amount field to bypass the TPL edit. After this check, the pharmacy submitted other payer paid amount on the Medicaid claim is automatically subtracted from the calculated due amount to the pharmacy, so no claim payment is greater than what Medicaid will allow. We note that there are times when the primary pays more than the Medicaid allowed. In these cases, the secondary Medicaid claim will show as paid and with \$0 due to the pharmacy.



14.	Bookmark Title: <u>MSQ14 – Electronic Prior Authorization</u> Narrative description is limited to five (5) pages. Describe, in detail, your POS Claims Processing Solution’s ability to support a fully Electronic Prior Authorization (ePA) process, including any limitations. Your response should address, at a minimum, the Solution’s capability to: - Access PA requests electronically and adjudicate automatically either online or in advance of a Claim being submitted. - Access PA requests during the Claims processing by reviewing or adjudication against pharmacy and medical Claims history. Additionally, describe your POS Claims Processing Solution’s algorithm based prior authorization capabilities. Your response should include, but is not limited to, the following: - Your algorithm based prior authorization Solution’s ability to utilize historical pharmacy and medical Claims data to make prior authorization decisions. - The method(s) and procedures to create and update prior authorization algorithms. - Your experience with development and management of an algorithm based prior authorization process. Refer to Attachment F – Pharmacy Benefit Administrator Services Scope of Work, Section 4.1 General Requirements (Prior Authorization (PA)).
Supplier Response MSQ14 - Electronic Prior Authorization MSQ14,a ePA Optum Rx provides customizable NCPDP-compliant electronic PA (ePA) solutions through our relationships with market-leading ePA vendors (e.g., CoverMyMeds, Surescripts) and PreCheck MyScript. Through these channels, we have seen 82 percent of PAs submitted electronically in 2023 and more than 62 percent of those approvals decisioned in real time. CoverMyMeds To submit an electronic PA, health care professionals log into their existing CoverMyMeds account or quickly create an account. They also may finish an electronic PA initiated by a pharmacy. CoverMyMeds auto-populates the request with the health care professionals’ administrative information, including electronic signatures, stored in their account. Final approval and denial messages are sent to the health care professionals’ CoverMyMeds account dashboard for easy access in one location. Surescripts Health care professionals with access to Surescripts’ Electronic Health Records software may submit PA requests using Surescripts’ integrated solution, CompletEPA. CompletEPA prepopulates member demographic data automatically.	



PreCheck MyScript

PreCheck MyScript displays member specific price and messaging transparency, therapeutically equivalent drug alternatives, and home delivery or specialty pharmacy options when applicable at the point of prescribing. Prescribers also are alerted to any PA requirements, giving them the option to submit additional clinical documentation or select a drug alternative—all before the patient leaves the office.

PreCheck MyScript is accessed directly in the EMR prescribing workflow. As the prescriber submits an e-prescription within the EMR a trial claim is initiated with Optum Rx. In less than two seconds, PreCheck MyScript returns an individualized, benefit specific coverage determination. Furthermore, PreCheck MyScript also returns patient cost share, pharmacy options and lower cost alternative therapies available under the patient's benefit. After the prescriber consults with the patient to determine the preferred care path, the prescriber may easily select the chosen drug and proceed to send the prescription to the pharmacy. The provider may also elect to start a PA directly in the workflow.

In addition, all prescribers have access to our provider portal, which enables prescribers the ability to access PreCheck MyScript outside of the EMR.

MSQ14,b ePA

Optum Rx utilizes Point of Sale Quick Check to evaluate medical data, member demographics, prescriber information, and claims history to evaluate predefined PA criteria for potential reimbursement at point of sale prior to any manual PA submission. If the member does not meet the specified criteria, the POS messaging sends to the provider that PA is required for reimbursement. Point of Sale Quick Check utilizes ICD-10 and CPT codes for processing, in the future, Optum Rx is working to further enhance the ability to pull in lab values, intolerances, and other medical history for review.

MSQ14,a Algorithm

We have an existing capability that leverages member-specific metrics contained in their claims data (such as member demographics, claim history, diagnoses, etc.) and provides a real-time review at the point of sale. Approvals of qualified drugs occur instantaneously.

MSQ14,b Algorithm

These algorithms are created and updated in tandem with the client and their clinical consultants, at least 30 days before production. After the criteria is developed and tested, the clinical consultants review and communicate the approved production date.

As part of the algorithm build process, analysts build algorithms in PA based on approved criteria. Once built, the drafted algorithm is validated by a clinical pharmacist and sent back to the analyst for revisions if necessary. Once the build passes this inspection, analysts create a case scenario in PA intended to trigger the algorithm in question. This test scenario does not "pass" to progress for deployment to production until all questions are presented to the user as dictated by approval criteria and clinical pharmacist guidance.



MSQ14,c Algorithm

During 2023, we completed more than 647,000 checks at the pharmacy point of sale that leveraged pharmacy and medical data with no additional action required by the provider or member, reducing the need to submit a PA. In addition, Optum Rx utilizes Point of Sale Quick Check to its' fullest extent with very robust clinical criteria. These algorithms are built, reviewed, tested and implemented regularly with new criteria and criteria changes.



15.	Bookmark Title: <u>MSQ15 – PA System Capabilities and Limitations</u> Narrative description is limited to five (5) pages, excluding any diagrams. Describe, in detail, how your PA system meets the requirements in Attachment F – Pharmacy Benefit Administrator Services Scope of Work, Section 4 Prior Authorization (PA). Your response should include, but is not limited to, the following: a. Your system’s ability to incorporate receipt of additional documentation to support PA criteria (i.e., lab values or Member chart notes) prior to approval or denial of a request, including the ability to report on this field. b. Electronic processes for the review of PA requests, review of Appeals, attachment of supporting documentation, and the transmission of that information to the State’s Providers. c. The method(s) that status Claims are incorporated (if at all) and how the 24-hour Centers for Medicaid and Medicare Services (CMS) mandated turnaround time for prior authorization shall still be maintained. d. The process and conditions for a PA request to be cancelled. e. The process and extent of capabilities to systematically “grandfather” current users when a new prior authorization requirement is implemented. f. Your system’s capacity for entering a PA code for a Member with temporary Medicaid eligibility in advance of that Member showing up in the eligibility file. g. Your system’s capacity for a PA approval code to be entered with a future Effective Date. h. All methods available for submission of initial requests and Appeals for prior authorization. i. Your ability to support a primarily telephonic PA request process and additional staffing needed. j. Process of tracking and reporting the status of PA requests and Appeals. k. Your system’s ability to create and utilize “reverse PAs” which restrict a Member’s access to particular medications by NDC or applicable drug classifications (Medi-Span, FDB). l. The detailed procedures for migrating all existing PAs into the Solution from a State’s Legacy System.
Supplier Response MSQ15 – PA System Capabilities and Limitations MSQ15,a Our PA operations department is made up of a team of licensed pharmacy technicians, nurses and clinical pharmacists. This team works with the prescriber’s office to gather information needed to	



make a decision based on the State's approved PA guideline criteria provided to their Clinical Consultant and Utilization Management teams.

Our pharmacists are trained to use all medical and prescription data available in order to arrive at a clinical decision. This may include prescription claims data, as well as medical data submitted by the prescriber, such as chart notes and lab values. All documentation received via fax, ePA, or other methods is stored with each PA request and is readily accessible for our clinicians to utilize in the review process. We also have the ability to report if additional documentation is attached to a PA request.

In the event that we do not receive all information at the time of the request, we attempt multiple outreaches by phone and fax to prescribers in order to complete a PA review. If we send a request to a prescriber's office, we wait the appropriate amount of time based upon the regulatory requirements of the line of business. If we are unable to obtain a response, we document the attempted outreach, including the dates and times of the outreach, and close out the request. A denial determination is issued to the prescriber with information on how to initiate an appeal.

The Prior Authorization System (PAS) is a workflow management system used by the PA Operations Department to process coverage determination requests for members. It has the following capabilities to support the receipt of documentation where required by PA criteria and is readily retrievable via system access.

- Prior Authorization System Management Solution
 - Intake/routing/tracking of PA requests
 - Fully integrated with RxCLAIM
 - Decision rules to determine if PA should be granted (automated or clinician reviewed)
 - Automated PA entry into RxCLAIM
 - Fully integrated with a Document Management Tool to allow access to view and store document images (i.e. chart notes, prescriber documentation, fax forms, etc.) and produce automated outbound notifications
- Workbasket/Queue Capabilities
 - Restricts Access to Requests to Authorized Users
 - Enables workflow creation for Requests, Protocols, and PA Detail Rules
- Protocol Questions
 - History checks for active PA's
 - Member demographics
- PA's Written to RxCLAIM in Real-Time
 - PAS automatically creates a prior authorization in the RxCLAIM system in real-time when protocol rules have been satisfied.
 - Prior Authorization details are predefined and specific to each situation



- Document Management Tool Integration
 - Inbound documents can generate a new request or be attached to a request within PAS
 - Preparation of outgoing communication
 - Approval, denial, and appeal notices
 - Additional information requests
 - User driven, automated, context appropriate text that details the reason(s) a request is denied or pended
 - Inbound and Outbound documents are attached to requests to allow for easy reference and retrieval

MSQ15,b

At Optum Rx, PA is a core component of our PDL and utilization management platform. Our PA offering provides precision and value for diverse clients by delivering clinical quality, accuracy, timeliness and intuitive member and provider experiences.

Optum Rx understands the importance of the prescriber and patient relationship. We continuously invest in our technology capabilities and leverage existing relationships with market-leading ePA vendors (such as, CoverMyMeds, SureScripts) and PreCheck MyScript® to drive ease the administrative burden and enable prescribers to spend time where it matters. Our intentional and selective application of automation led to more than 82 percent of PA's submitted electronically in 2023 and more than 62 percent of those approvals decisioned in real time.

OptumRx's prior authorization platform is used to manage the workflow for prior authorization and appeals business.

Intake

Coverage determinations are accepted by electronic prior authorization (ePA), fax, phone call, or written request from a member (if applicable), authorized representative, or prescriber. ePA is our preferred channel for prior authorization intake and can provide real-time automation for prescribers-and members. Prescribers are able to attach supporting documentation to the case through ePA and any supporting documentation sent in via fax is included with the case. Documentation sent in after the case is created is merged to the case to capture all supporting information.

Timeliness

All coverage determination decisions and notifications are made within turnaround times required by CMS, federal, or state regulations. The system can support multiple service level agreements based on regulatory requirements and client specific requirements and utilizes an urgency-driven review prioritization to ensure review for cases that are at risk before timeliness targets are missed.

Review, decisions and notifications

Review may be automated through decision tree style logic in ePA for instant approval. If instant approval is not warranted, or the case requires manual review of supporting documentation, a member of the clinical call center will review the case in detail to provide a decision based on



State-specific developed criteria. Once the decision is recorded in the Prior Authorization platform, a decision letter is automatically created and sent for printing and mailing. In addition, once a determination is made, notification of the approval or denial is provided to the prescriber by fax, electronic or written notification through the prior authorization platform. Oral member notification is made where required, in addition to the mailed notification.

Approvals

Our platform interfaces with the claim adjudication system to write the PA into the claim system in real-time through a series of API connections.

Reporting

We provide a variety of reporting to support compliance monitoring and enable our clients to assess, evaluate, and proactively manage their PA program.

Our PA platform is a CMS- and NCQA-compliant UM solution that is regularly updated and maintained to reflect the latest requirements from federal and state agencies as well as customer needs.

MSQ15,c

Optum Rx clinicians process PA and appeals cases on our proprietary PAS workflow platform. This system utilizes urgency-driven review prioritization and incorporates duplicate checks and process driven workflow automation. The system supports multiple service level agreements based on regulatory requirements and State-specific agreements, including the 24-hour turn-around time. These capabilities allow our compliance monitoring teams to oversee workflow in real-time, and to identify and solution for cases at risk before timeliness targets are missed.

MSQ15,d

In the event that a request meets the criteria for cancelation, our PA operations staff will cancel the case and apply the appropriate reason code. Some of the reasons a PA request may be canceled are the following:

- Failure to submit on the appropriate fax form,
- A request to re-review without an appeal,
- Duplicative requests
- PA is not required.

MSQ15,e

Continuation of therapy is an exception process when a member receives an exception to a benefit coverage limit or other plan restriction. It is applied at the direction of the State for new members that transition into the plan or when the preference status on a product is changed. Continuation of therapy can help minimize member disruption and support safety and continuity of care and may apply for a specific time period.

We are able to load historical PAs for PDL drugs with utilization management programs. In addition, when a product is moved from preferred to nonpreferred, Optum Rx will evaluate the



member utilization to determine the impact to members, prescribers and providers to see if continuation of therapy is warranted.

Optum Rx's preferred method for Continuation of Therapy for members who are taking medications that are subject to newly implemented PA requirements is to utilize the continuation of therapy functionality within RxCLAIM. This functionality allows the system to automatically look back in a member's claims history for a defined period of time (e.g. 90 to 180 days) to see if the targeted PA product has been utilized in the past. If the member history demonstrates the product has been utilized, the current claim for the PA medication is allowed to adjudicate without the need for a PA request.

Our technical platform fully supports programming of Continuation of Therapy policies within our claims system at the plan and member level. This enables us to implement exceptions in real time, which avoids member disruption at the point of service and reduces the need for pharmacist or Help Desk intervention.

MSQ15,f

As an example for the lead State, sometimes a prescriber's office may call in a PA for a product before a claim is submitted, and possibly before the member is even sent from GAMMIS to our RxClaim system. Since 2007 and as an example for the lead State, Optum Rx has addressed this requirement with our *Hold PA* functionality. We utilize the *Hold PA* process for the lead State's pharmacy program when a PA is needed for a member with only temporary eligibility.

For this process, we maintain a dedicated custom member in RxClaim with an ID named *UNKNOWN. This special ID is exclusively utilized for these requests and we tie the member's SSN, name, and sex to the record. If the PA request meets the clinical criteria and is approved, we then enter the specific authorization details on the record. RxClaim has an automated daily job which monitors eligibility updates to look for the forthcoming permanent member record. Once the permanent member record arrives in the eligibility file with the matching SSN, Optum Rx's automated daily job moves the PA from the temporary record to the permanent member record to allow claims processing.

MSQ15,g

Our system can support future effective dates after PA approval.

For example, Optum Rx currently supports future dating of PA approvals for the drug, Synagis, during the beginning of the Respiratory Syncytial Virus (RSV) season. Approved Synagis PA requests reviewed 1-2 weeks prior to the start of the season are authorized with a future effective start date. The illustration below demonstrates a future effective date entered into our system.

MSQ15,h

Optum Rx has the ability to accept initial PA requests and appeals by electronic prior authorization (ePA), fax, phone call, or written request from a member, authorized representative, pharmacist, or prescriber. ePA is our preferred channel for PA intake and can provide real-time automation for providers and members.



MSQ15,i

We can work with the State to establish a process that best suits your needs and determine staffing based on the unique requirements of your program.

MSQ15,j

Optum Rx can provide a standard suite of monthly client reporting that includes a breakdown of top medications approved and denied, categorized by specialty and non-specialty, along with key metrics that include approval and denial rate by line of business, case volume by urgency and case-level details for all approved and denied PA requests and appeals (as applicable). This data supports compliance monitoring and enables our clients to assess, evaluate, and proactively manage their PA program.

Optum Rx can also provide direct, real-time view only access to our PAS platform. This access provides a full view of all details and supporting information related to a PA clinical review (such as, inbound documents, notes and decision rationale, and outbound notifications).

MSQ15,k

RxClaim allows for PAs to be applied at varying levels, which includes the ability to apply for more or less coverage based on the the State's direction. PA can be applied at the NDC, GPI, NDC list, and GPI list where the products levels can be wildcarded to drill down to the drug category. The end user can define if the PA should be positive (covered) or negative (excluded). In addition, RxClaim permits the utilization of "taper" PAs to guide members down to a permissible drug dosage or to remove from therapy altogether as directed by the State. These PAs will prevent the member from receiving reimbursement at higher doses and lower the dosage over time.

MSQ15,l

We apply the standard business rules when converting historical PAs from the incumbent vendor:

- All other product ID (HICL, GCN, GSN, HIC3) will be converted to GPI14.
- The client has the option to cover excludeddrugs.
- QL is considered and compared to the PDL QL.
- If GPIs are provided, then GPIs are transferred over. We expand all GPI to 12 if they provide any GPI less than GPI12.
- If NDCs are provided, then NDCs are transferred over.
 - If the standard process doesn't fully meet the intent of the client's need, we modify the authorization with the ad hoc batch update.



16.	Bookmark Title: <u>MSQ16 – Financial Management</u> Narrative description is limited to five (5) pages. Describe, in detail, the methods you will utilize to handle the following financial management-related services: a. Positive and negative mass and individual Claims adjustments. b. Voids (checks and EFT transactions), replacement check(s) (if necessary), and the related Claim adjustments. c. Run-off Claims (Claims with Date of Service before the transition to a new contract, but not yet adjudicated or in need of adjustment). d. Recoupments. e. non-Claim-based Provider payouts requested by the State. Refer to Attachment F – Pharmacy Benefit Administrator Services Scope of Work, Section 5 Financial Management Services.
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Supplier Response

MSQ16 - Financial Management

MSQ16,a

In RxClaim, positive and negative adjustments can be run individually or in batch (mass adjustments). The latter typically occur with reimbursement rate changes, retrospective application of policy, processing errors, audit adjustments, claims after date of death, etc. The Optum Rx account manager executes the reversal and adjustment request from the State for the individual claim or batch of claims. As with individual adjustments, mass adjustments can be run in an edit-only mode so that results can be checked and verified prior to actual data being modified.

For the lead State and as an example, all adjustment activity flows through the weekly Accounting Interface and related finance reports which are part of the payment cycle.

MSQ16,b

Within RxClaim, payment processing for the client's claim transactions is run on a weekly basis. The result of that run is a set of batches and payment transactions that are handled either through checks or electronic funds transfers (EFTs). There are a number of scenarios where a payment process that has been run needs to be backed out of the system.

The State can specify to return all of the claims to their initial status (so that they can be selected in the next payment cycle). Alternatively, you can leave the claims flagged so that they are not selected in a subsequent payment cycle.

Reissue

From time to time a payment will be issued but not be usable by the payee. For example, if an EFT is rejected or a check that has been mailed is not received by the payee. In those instances, Optum Rx reissues a check payment for the same amount as the original, regardless of any other



transactions or receivables that have been created in the interim. Reissues do not flow through the Accounting Interface; however, the reissued payments appear on the check register and the reissue report.

Reopen

The term “reopen” is used in RxClaim to refer to the scenario where the claims are again candidates for payment and the situation is more involved than simply reissuing a payment. A typical example of this is when a payee discovers an uncashed check after it was stale dated and voided and wishes the State to honor the payment. The result of a reopen any claims that were flagged as paid are available for a subsequent payment run. Any receivables that were paid off or paid down by recoupments from the payment cycle are put back as receivables.

The newly reopened payment processes through the Accounting Interface as a 3020 voucher (positive adjustment) with the current FFP match rate and all other accounting attributes matching the claims being paid.

Void

The term “Void” in RxClaim refers to a scenario where the claims are not to be re-released to payment. A typical scenario of this is when a check has become stale dated.

A Void will operate similarly to a reopen, except that claims are not put back through payment. The result of a Void is that all aspects of the original payment are backed out. The Void flows through the Accounting Interface as a 3050 voucher for the amount of the check. FFP matches the date on the check, the State Chart of Accounts (SCOA) is based on the current date, the Department ID is equal to the table default, and the Category of Service (COS) follows the standard rules. The voided payment appears on the check register.

MSQ16,c

Optum Rx understands that the ideal situation is a clean cutover with minimal disruption to members and providers. We agree to handle runout claims after the term of this contract so long as the contract is amended to continue the O&M payment to Optum Rx for the length of the runout.

While it is more common to see runout requirements in other lines of business, we understand situations could arise which could require Optum Rx to process runout claims for your FFS Medicaid transition. Optum Rx maintains the RxClaim system with date-specific logic, claims history, and reference file information to process such claims. A date of service edit would deny and message to the provider that claims after the cut-over date should be submitted to the new contractor. Those claims and transactions (including adjustments) would be processed as if Optum Rx were the contractor at that time. Optum Rx would also coordinate with the State and its new vendor to deliver 4 files for activity during the runout period. During the runout period, Optum Rx continues to provide the payment interfaces for EFT and Positive Pay to the State’s bank, the Accounting Interface to the State, and all Financial Reports for the claims we process.

MSQ16,d

Utilizing the lead State as an example, the recoupment process typically starts when the State sends an accounting transaction request (ATR) to Optum Rx indicating that a gross level receivable should be created. On that request, the State identifies the payee, the amount of the



receivable, the high level reason for the adjustment, and the rules under which it should be collected from the payee.

Based on the provided information, Optum Rx applies funds from claim activity to the receivable rather than paying them to the provider. This is done through what is called an RxClaim adjustment. This differs from what the State calls an adjustment which is a change to an existing receivable.

If the claim activity is insufficient to address all receivables that are scheduled to be collected, they will be applied to the receivables starting with the oldest and proceeding to the newest. This includes claim level receivables as well as gross level receivables.

MSQ16,e

Optum Rx understands that there are circumstances which would require a payment to be made directly to a payee. In these instances and where authorized by the State Finance team, Optum Rx creates a positive adjustment in RxClaim which will create in cycle payment to the payee. A more likely scenario is when a payee sends payment to the wrong state lockbox. In order to reconcile the funds to the correct account, the State directs Optum to create an in-cycle payment to the State. To support this reconciliation, the State is setup as a payee in the RxClaim payment system.



17.	Bookmark Title: <u>MSQ17 – Cash Receipts</u> Narrative description is limited to three (3) pages. Describe, in detail, your procedures for processing refund checks from pharmacies, whether received by the Supplier or the State, as referenced in, Attachment F – Pharmacy Benefit Administrator Services Scope of Work, Section 5 Financial Management Services. Your response should include, but is not limited to, your Solution's ability to: - Account for the receipt of cash receipts from Providers. - Post the cash receipts against Claims, Claim receivables, and non-Claim receivables. - Send refunds to Providers. - Process the posting of these cash receipts without affecting the Provider's payment (except for refunding the cash receipt).
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Supplier Response

MSQ17 - Cash Receipts

MSQ17,a

Optum Rx connects directly with the State's bank to automatically retrieve lockbox images of pharmacy payments made into their account. On a weekly basis, the account management team records any deposits made on an Undispositioned Receipts Report and sends this information to the State along with the lockbox details retrieved from the bank. This report allows the State the ability to see the accounts receivables incurred and their balance. Each entry on the report is assigned a Financial Control Number (FCN), a *unique identifier* which includes the date of the deposit. This FCN is referenced in the Accounting Transaction Request (ATR) where the funds are forwarded to the appropriate treasury account and the transaction is closed.

MSQ17,b

The State may receive a payment from a provider for claims that the provider acknowledges as being paid out in error. This receipt may be related to specific identifiable claims or may not be able to be linked to any specific claims. The purpose of posting these cash receipts is so that these funds flow through as accounts receivable.

Claim Level

Claim level receivables are posted using the neutral claim amendment process. The State provides the ATR with the specific claim information, which is supplied by the provider, or is identified by Optum Rx in the Undispositioned Receipts Report. Since money has already been received for the claim, a reversal/recoupment is not applied, but instead receivables are tagged to the claim as an amendment. This amendment is recorded for referential and auditing purposes. This amendment also causes those claims NOT to reappear in the payment system as the cash receipt already compensates for the amended claims. This neutral claim amendment allows the cash posted to flow through the Accounting Interface as a 6000 voucher. The FFP, SCOA, Department ID, and COS matches the claim(s) that to which the funds are being applied, as of the original paid date.



Gross Level (Non-claim Receivables)

Non-claim receivables are posted using the gross level adjustment process. The State provides the ATR with the provider or payee details including the cash receipt amount. Once the gross level adjustment is added to RxClaim, the amount flows through the Accounting Interface as a 6000 voucher with the FFP and SCOA based on the current date, and the Department ID table applying based on the default and using the standard COS.

MSQ17,c

Optum Rx recognizes that there are circumstances which would require a refund to be made directly to a payee. In these instances and where authorized by the State Finance team, Optum Rx creates a positive adjustment in RxClaim which will create in in cycle payment refund to the payee.

We track reversed claims by comparing them to the original claim and sequence number. We identify reversed claims in our system with a status code of "X". Reversals performed during the billing are not charged to the State's billing account.

The system automatically deducts the value of any claim reversed after it has been paid to the pharmacy. The amount payable to the pharmacy for the reversed claim is deducted from any amounts due the pharmacy in the next payment cycle to the pharmacy (or chain) where amounts are to be paid.

Reversals performed after the billing cycle the State post with a transaction or administrative fee.

MSQ17,d

From time to time, a pharmacy may send the State funds to pay off or pay down an existing receivable (example audit findings settlement payments). In these instances, the State provides the ATR with the information required to identify how to apply the funds. By selecting the adjustment type in RxClaim, Optum Rx is able to distinguish cash application from write off activities. Optum Rx uses an adjustment type value of 072 to record the application of cash. The State is able to identify the adjustment ID in the Payment Adjustment Report to distinguish one receivable from another. The cash receipt flows through the Accounting Interface as a 6000 voucher. The FFP, SCOA, and COS is included on the ATR on the original receivable. The Department ID is either provided on the ATR or, if "default" is selected it posts per the default allocation. The cash application amount shows in the "Applied Amount" column on the Payment Adjustment Report.



18. Bookmark Title: MSQ18 – Accounts Receivable

Narrative description is limited to ten (10) pages, including any screenshots.

Describe, in detail, your system's ability to perform Accounts Receivable operations as described in Attachment F – Pharmacy Benefit Administrator Services Scope of Work, Section 5.2 Accounts Receivable (AR).

Supplier Response

MSQ18 - Accounts Receivable

Optum Rx configures the RxClaim payment processing to the State's schedule specifications for weekly payment processing, including the payment week (currently Friday – Thursday for GA) and the EFT and Check dates required. On an annual basis, at least 1 month prior to the end of the current year, the Optum Rx Account Manager confirms the holiday payment schedule for the following year with the State Finance Director. Once confirmed, the new annual schedule is then configured and operationalized for the upcoming year ensuring payments are made on schedule.

Federal Financial Participation (FFP), Children's Health Insurance Program (CHP), and Breast and Cervical Cancer (BCC) rate tables contain rate information representing the portion of Medicaid rates that the federal government pays.

The rate information is based on the claim's fill date, and is a parameter driven table that is updated each federal fiscal year using federal/state split percentage values supplied by the State. Each rate table (FFP, CHP, BCC) contains a free-form period field that is displayed on the Accounting Interface Report, and the dollar amounts are split based upon the federal/state percentages as directed by the State. During the COVID-19 epidemic, Optum Rx was easily able to accommodate changes in FFP values which were updated several times throughout a federal fiscal year using period values that the State designated to be easily identified in financial reporting.

Each week a Payment Adjustment Report is generated which itemizes transactions and roll forward receivable balances from week to week. These adjustments (partially or complete) contain all types of accounts receivable transactions which over time reduce the accounts receivable balance which is reflected on this report. This report separates receivables based on specific reason codes as outline by the State such as:

009 = Receivable Program Integrity Recovery

011 = Receivable Provider Recovery

012 = Receivable Audit Finding

013 = Receivable Fraud & Abuse

014 = Receivable Other

071 = Receivable Adjustment

These reason codes are designated for various types of dispositions and accounts receivable and are used for tracking and reporting purposes. Along with these reasons codes, a FFP period value may be included for proper state and federal reporting and claiming of federal moneys.



On a weekly basis, the Optum Rx account management team records any payments, receivables, and receipts made on an Undispositioned Receipts Report and sends this information to Authorized Solution Users as determined by the State along with the lockbox details retrieved from the bank. This report allows the State the ability to see the accounts receivables incurred and their balance. Each entry on the report is assigned a unique identifier (FCN) which includes the date of the deposit, and this FCN is referenced in the ATR where the funds are forwarded to the appropriate treasury account and the transaction is closed.

The State may receive a payment from a provider for claims that the provider acknowledges as being paid out in error. This receipt may be related to specific identifiable claims or may not be able to linked to any specific claims. The purpose of posting these cash receipts is so that these funds flow through as accounts receivable using criteria as defined by the State through an ATR.

Claim Level

Claim level receivables are posted using the neutral claim amendment process. The State provides the ATR with the specific claim information which is supplied by the provider, or is identified by Optum Rx in the Undispositioned Receipts Report. Since money has already been received for the claim, a reversal/recoupment is not applied, but instead receivables are tagged to the claim as an amendment. This amendment is recorded for referential and auditing purposes. This amendment also causes those claims NOT to reappear in the payment system as the cash receipt already compensates for the amended claims. This neutral claim amendment allows the cash posted to flow through the Accounting Interface as a 6000 voucher. The FFP, SCOA, Department ID, and COS matches the claim(s) that to which the funds are being applied, as of the original paid date.

Gross Level (Non-claim Receivables)

Non-claim receivables are posted using the gross level adjustment process. The State provides the ATR with the provider or payee details including the cash receipt amount. Once the gross level adjustment is added to RxClaim, the amount flows through the Accounting Interface as a 6000 voucher with the FFP and SCOA based on the current date, and the Department ID table applying based on the default and using the standard COS.

Optum Rx is able to recoup or apply a receipt to any accounts receivable balance to include the attributes requested on the ATR which flow through the Accounting Interface. Example of attributes are the Department ID, FFP, SCOA, and COS.

On a weekly basis Optum Rx converts the accounting interface activity into a text file format which is consistent with the requirements of the State's Accounting Office, or equivalent department, for interfacing with the State's financial accounting system. This text file is then loaded into the State's mainframe and applied to the General Ledger.

Optum Rx is able to set recoupments at a percentage or dollar amount as defined by the State. In turn, RxClaim may be configured to allow a maximum percentage or amount that should be withheld from payment for application to receivables. This maximum amount/percentage may allow a payee to receive at least a portion of their net claim activity within any cycle.



Void

The term “void” in RxClaim refers to a scenario where the claims are not to be re-released to payment. A typical scenario of this is when a check has become stale dated.

A Void will operate similarly to a reopen, except that claims are not put back through payment. The result of a Void is that all aspects of the original payment are backed out. The Void flows through the Accounting Interface as a 3050 voucher for the amount of the check. FFP matches the date on the check, the SCOA is based on the current date, the Department ID is equal to the table default, and the COS follows the standard rules. The voided payment appears on the check register.

Reopen

The term “reopen” is used in RxClaim to refer to the scenario where the claims are again candidates for payment and the situation is more involved than simply reissuing a payment. A typical example of this is when a payee discovers an uncashed check after it was stale dated and voided and wishes the State to honor the payment. The result of a reopen of any claims that were flagged as paid are available for a subsequent payment run. Any receivables that were paid off or paid down by recoupments from the payment cycle are put back as receivables.

The newly reopened payment processes through the Accounting Interface as a 3020 voucher (positive adjustment) with the current FFP match rate and all other accounting attributes matching the claims being paid.



19.	Bookmark Title: <u>MSQ19 – Customer Support</u> Narrative description is limited to five (5) pages. Describe, in detail, your proposed operations for a customer call center that must handle real-time calls related to both technical and clinical claims submission questions and PA requests as stated in Attachment F – Pharmacy Benefit Administrator Services Scope of Work, Section 6 Support. Your response should include, but is not limited to, the following details: a. Location of all customer call center(s) and identifying any primary locations. b. Size of all customer call center(s) including, but not limited to, staffing (identified by type: Member, technical, and prior authorization). c. Current call volume per year and call volume total capacity at each location. d. Type of calls each customer call center is equipped to handle, including, but not limited to, Member, technical, clinical, and prior authorization. e. Ability to handle multilingual requirements. f. Description of customer call center coverage during main operating hours, nights, weekends, holidays, and peak call periods for each location.
Supplier Response MSQ19 - Customer Support Optum Rx's approach to supporting the State's call center requirements leverages our capacity, our state-of-the-art infrastructure, and our understanding of the unique needs of FFS Medicaid programs. We're proud to serve your FFS program with our "high touch" model where we assign a core group of dedicated and designated agents who are skilled in your program, supporting your members, your pharmacies, and your prescribers each and every day at the highest levels of quality and performance. MSQ19,a Our call center locations are integrated through virtual call center technology to provide superior service to callers 24 hours a day, seven days a week. This design connects customer service advocates (CSAs), toll free numbers, and call center systems using the latest broadband technology while also facilitating efficient response times by automatically routing callers to the first available CSA across the nation. MSQ19,b Our Workforce Management team is responsible for daily oversight and monitoring of performance to make real-time adjustments for optimal service levels. Based on the lead State's current requirements we are anticipating a support team sizing of approximately 20-30+ with adjustments as needed.	



MSQ19,c

Optum Rx's total book of business call volume for 2023 was 19,717,411. In regard to capacity, we are a virtual call center, therefore there is no limit at specific locations nor is there a limit for capacity overall. The support team for the State is staffed to support the anticipated ongoing volume and may be adjusted as needed by our Workforce Management team based on any new increases due to changes in benefits, urgent updates, etc.

MSQ19,d

The customer call center is equipped to handle all delegated functions as outlined in contractual requirements. We offer a wide range of support that meets the needs of our customers.

- CSAs from member, provider, and PA call center operations have online access to real-time benefit plan details and test member claims information through our customer service system. CSAs can view the State's PDL, pharmacy networks, clinical guidelines, special programs and products and State plan benefits. Our online, real-time claims, PA, and eligibility system allows them to:
 - Resolve member issues, respond to member questions, and provide State Specific program information
 - Review and approve medications requiring PA including relaying information on preferred PDL products
- Handle PA appeals from phone or fax requests as directed by the State
 - Provide information on pharmacies, PDL, and plan-specific savings opportunities
- Review and provide overrides for pharmacies for lost, broken, stolen medications as directed by the State
- Provide information on the State PDL
- Provide overrides on ProDUR rejects as directed by the State
 - Support inquiries related to member eligibility
- Access member-specific letters and communications

We capture inquiry types and categories on member records using specific call tracking reason codes and source codes that include complaints, pharmacy support, benefit inquiries, accounting issues, drug lists and Home Delivery Pharmacy transactions. Our dynamic customer service system is used across the enterprise by several departments, including account management, claims operations, Home Delivery Pharmacy and Specialty Pharmacy.

MSQ19,e

We are able to handle multilingual requirements and currently accommodate these requirements for the State. We use a third party vendor "LanguageLine Solutions" for translation services to support our non-English speaking members. LanguageLine Solutions provides language access in more than 240 languages through spoken interpretation and written translation. Their on-demand interpretation is delivered via video and audio-only modalities.

**MSQ19,f**

Optum Rx provides 24 hours a day, seven days a week coverage during main operating hours, nights, weekends, holidays and peak call periods.



- 20.** Bookmark Title: MSQ20 – Call Center Staff
Narrative description is limited to five (5) pages.
- Provide details of the proposed core team of Dedicated Call Center Staff that will provide support as referenced in Attachment F – Pharmacy Benefit Administrator Services Scope of Work, Section 6.2 Call Center-related Requirements. Your response should include, but not be limited to, the following:
- How the core team will serve as subject matter experts on all call center shifts.
 - Identification of all roles in the call center (i.e., pharmacy technicians, managers, etc.).
 - Staffing levels and ratios (i.e., supervisors to phone technicians).
 - Details of responsibilities and qualifications for each role.
 - Expectation of the number of calls handled per CSR (core team of Dedicated Call Center Staff versus Non-Dedicated staff), and the rationale for the ratio of staff to calls to be maintained, along with the ability to increase staffing as needed.

Supplier Response

MSQ20 - Call Center Staff

Our call center locations are integrated through virtual call center technology to provide superior service to callers 24 hours a day, seven days a week. This design connects CSAs, toll free numbers, and call center systems using the latest broadband technology while also facilitating efficient response times by automatically routing callers to the first available dedicated State CSA across the nation.

The customer call center is equipped to handle all delegated functions as outlined in contractual requirements. We offer a wide range of support that meets the needs of our customers.

MSQ20,a

We will provide a dedicated call center support team that will cover all hours of operation. These advocate's expertise is targeted to understanding the State's unique calls and expectations of service and culture. These agents are proficient at the calls they support, allowing for a higher rate of first call resolution and an overall elevated member care experience. To maintain a high level of expertise, we continue to develop and reinforce the knowledge and skills of CSA trainees. This practice maintains quality of service, transfer of knowledge, and effective use of reference tools. The methods we use include:

- Regular coaching and development.
- Side-by-side quality monitoring by supervisors.
- Remote call observations, conducted by a staff of dedicated analysts, using NICE's performance management system and Sentiment scoring. This technology enables recording and playing back calls while observing the online screens used by the CSAs in addition to word choice and tone used during the member interaction.



- Skill Gaps, a proactive system for identifying and correcting operational deficiencies.
- MyLearning, an eLearning system that makes training available to every employee through our corporate network.
- Bulletins that alert CSAs to the latest business developments. CSAs can also search our knowledge management system to research work instructions and other information about our business processes.
- Message boards located throughout our call centers that provide instant information and performance feedback.
- Continuing education courses to fine-tune call flow and workflow skills, and provide new knowledge, up to 48 hours per year per individual.

A variety of coaching techniques and refresher training sessions are deployed to retrain call center staff members who do not meet our identified performance levels.

Additional support is offered to our member service teams by providing online resources with specific plan information and plan specifications that are routinely updated to reflect the latest information. These sources are complemented by electronic data to assist members with various inquiries. In addition, to maintain a continuous level of excellence, we hold frequent staff meetings to introduce and review plan specifications, medications, operating procedures, customer service skills and special topics.

There are also regular updates to our training curriculum for core business processes that are impacted by significant changes, such as regulatory requirements or process improvements.

In addition to our CSAs, our Specialty Pharmacy associates, which consists of our pharmacists and pharmacy technicians undergo a rigorous and documented training program to be considered subject matter experts.

For more information on training please refer to our response in MSQ31.

MSQ20,b

Call Center Staff

Customer Service Advocates

- **Tier 1 General Benefits**
- **Tier 2 Benefit and Eligibility**
- **Tier 3 Complex Pharmacy Support**
- **Lead and Supervisor Team Escalation**

Pharmacy Technicians

Pharmacists

MSQ20,c

The ratio of pharmacy technicians to non-clinical CSAs in our call centers is 1:25. The ratio of techs to pharmacists is 1:20. We currently employ a total of 3,246 CSAs and expand our call



center staff during high call volume periods like open enrollment. In addition to live support from CSAs, members can access automated support through our sophisticated IVR system and comprehensive website. To determine staffing levels, we use complex call pattern algorithms that factor in membership numbers, prescription volume and call arrival rates by the time of day, day of the week and week of the year.

In our virtual call center model, CSAs work remotely to provide superior service to callers. Personnel, toll-free numbers and call center systems are integrated with the latest technology, supporting rapid response times by automatically routing a caller to the first available State dedicated CSA. A relatively small percentage of provider calls are received at our customer service and pharmacy help desk, which include a combination of non-clinical representatives and some clinical personnel.

Our CSAs are trained to address non-clinical member inquiries and handle the majority of calls to your toll-free number. CSAs include both non-clinically trained personnel and team members with pharmacy technician certification. CSAs can escalate clinical questions to a pharmacist for consultative purposes. We staff our prior authorization and pharmacist consult teams with a combination of registered pharmacists and licensed pharmacy technicians.

MSQ20,d

Customer Service Advocates

CSAs provide an efficient and effective customer service experience to members, pharmacies and providers. Our CSAs include clinical and non-clinical staff, who address general and complex pharmacy inquiries as part of a tiered service model. CSAs are segmented into tiered groups, each focused on addressing specific, yet increasingly complex levels of inquiries. Our call routing uses artificial intelligence (AI) to seamlessly drive the call to the specialist with the expertise to handle that inquiry – enabling us to provide timely support based on inquiry complexity. This call routing improves the member experience by increasing first contact resolution (FCR).

Inquiries Handled by CSAs

We organize our tiers into three areas of responsibility:

- **Tier 1 General Benefits:** Standard questions for general benefits and Home Delivery Pharmacy benefits (for example, pharmacy refills, new prescription requests, order status and accounting inquiries).
- **Tier 2 Benefit and Eligibility:** Inquiries related to financial responsibility (for example and if applicable, drug pricing/copayments, price comparison support/information, accumulators, alternate insurance, benefit appeals and clinical programs).
- **Tier 3 Complex Pharmacy Support:** Inquiries related to PA process overview, status and appeals, opioid use and safety (for example, new member set-up and assistance in lowering prescription costs and claim overrides). These CSAs provide an increased continuity of support and a higher resolution rate since they are specialists trained to handle the most complex cases.

In addition, we offer service recovery, which supports escalations to quickly resolve complaints and issues. These expert agents also assist repeat callers, which we define as callers making



three or more inquiries within a time frame of 30 minutes to 10 days, to confirm whether the member received resolution.

Management Team Support

In some instances, CSAs require assistance to address the member's concerns. In these situations, the issue is triaged to an escalation lead who provides assistance with resolution. Our escalation leads track and monitor that issue until it is resolved and once resolved; they perform member outreach to determine a satisfactory resolution and close the inquiry.

- **Lead and Supervisor Team Escalation:** CSA escalates to the Customer Service Assist Line. The assist line team consists of customer service team leads and supervisors who handle escalated member inquiries. The majority of inquiries are resolved during the same day the call is placed. Resolution may require the lead or supervisor to work with operational support or cross functional teams to resolve the issue or inquiry.

Qualifications:

- High school diploma or general education degree
- Passing four pre-employment assessments
- Customer service skills – content simulation, cognitive ability
- Behavioral assessment – cultural fit for the customer service role
- One year of experience in an office setting, call center setting or phone support role
- Demonstrated ability in using computer and Windows PC applications, including strong keyboard and navigation skills, and learning new applications and programs
- Ability to remain focused and productive each day though tasks may be repetitive
- Ability to multi-task duties as well as the ability to understand multiple products and multiple levels of benefits within each product
- Ability to work regularly scheduled shifts within our hours of operation including the training period, where lunches and breaks are scheduled, with the flexibility to adjust daily schedule, and work over-time and/or weekends, as needed
- All new hires are required to successfully complete customer service training classes and demonstrate proficiency of the material

Clinical Call Center Staff Qualifications

We require our PA staff to be certified pharmacy technicians, registered and licensed nurses, or registered and licensed pharmacists depending upon job function. Before clinicians are allowed to work PA or appeal requests, they must pass a four-week hands-on classroom training course specific to this work.

This course covers the regulatory requirements for PA and appeal reviews, the clinical utilization management expectations and the workflow platform operations. Once the clinician has successfully passed the classroom training, they then move into a side-by-side training



environment where they work live cases. Before completing a live case decision, their work is reviewed by a subject matter expert.

Our nurses are trained over four weeks on workflow platform operations, clinical protocols, and other relevant processes specific to their role. Hiring trained nurses helps improve our ability to provide a clinical review and expedite approvals where not automatically approved by clinical criteria.

Our pharmacists are trained in the disease states, clinical protocols, formulary alternatives and other relevant information for the utilization management they perform. Hiring clinically-trained professionals improves the accuracy of decisions and improves the overall quality of the PA process.

Pharmacy Technicians

Our pharmacy technicians assist members with questions regarding refills, ordering, adherence and possible side effects. Pharmacist technicians must be licensed by their respective State Board of Pharmacy.

Preferred Qualifications

- Knowledge of specialty drugs
- Minimum of one to two years of experience in home infusion, hospital, or retail pharmacy setting

Pharmacists

Our pharmacists consult with members on more complex questions. Pharmacists must be licensed by their respective State Board of Pharmacy with no filed restrictions. Pharmacists with suspended or revoked registrations are not considered for employment.

Preferred Qualifications

- Minimum of two to three years' clinical pharmacy experience
- Pharm. D.
- Clinical pharmacy residency training and expertise in home infusion therapy or hospital practice.

MSQ20,e

In order to deliver on high service standards, we do not have a required goal around the number of calls handled per CSR and instead reinforce minimum call metrics surrounding the quality of service provided (ex. Speed of Answer, First Contact Resolution, Positive Member Experience, etc.). Based on the volume the State agents handled in 2023, their daily average was approximately 60 calls. Our Workforce Management team is responsible for daily oversight and monitoring of performance to make real-time adjustments for optimal service levels. The support team for the State is staffed to support the anticipated ongoing volume and may be adjusted as needed by our Workforce Management team based on any new increases due to changes in benefits, urgent updates, etc.



- 21.** Bookmark Title: MSQ21 – IVR System
Narrative description is limited to two (2) pages.
- Describe your Interactive Voice Response (IVR) system, including, but not limited to, customizable options, voice activation, and pharmacy locator functionality.
- Refer to Attachment F – Pharmacy Benefit Administrator Services Scope of Work, Section 6.2 Call Center-related Requirements.

Supplier Response

MSQ21 - IVR System

Member Services

Pharmacy is the most frequent consumer touch point in health care. That means every interaction is a chance to make the health system work better. The State's members and health care providers may contact us by phone, email, mail and fax. Our CSAs are ready to help 24 hours a day, seven days a week—including holidays.

We provide a toll-free number for the State with multiple prompt options to support varied inquiries and caller types. Members calling one of our toll-free numbers are greeted by the IVR system, which has user-friendly menus and instructions in English and Spanish to help members. Approximately 10 percent of member calls are resolved through the IVR system.

CSAs provide an efficient and effective customer service experience to members, pharmacies and providers. Our CSAs include clinical and non-clinical staff, who address general and complex pharmacy inquiries as part of a tiered service model. CSAs are segmented into tiered groups, each focused on addressing specific, yet increasingly complex levels of inquiries. Our call routing uses artificial intelligence (AI) to seamlessly drive the call to the specialist with the expertise to handle that inquiry—enabling us to provide timely support based on inquiry complexity. This call routing improves the member experience by increasing first contact resolution (FCR).

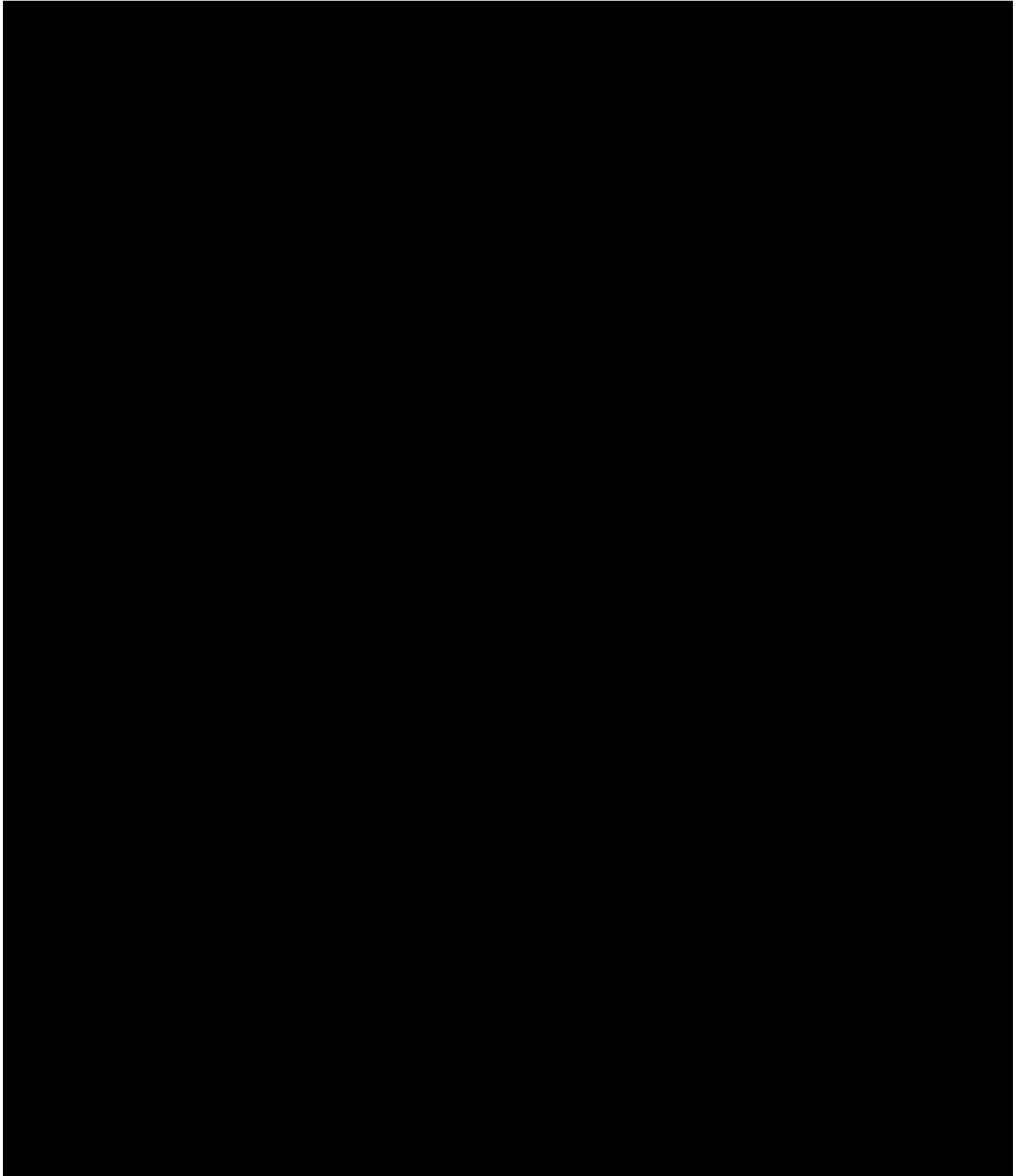
Member Inquiries

Members contact customer service by phone, email, webchat or mail.

- **Phone Inquiries:** Members calling one of our toll-free numbers are greeted by the IVR system. This sophisticated system features detailed menus and instructions that help callers perform routine functions and submit inquiries. Members may also choose to speak with a CSA, and if needed, one of our clinical pharmacists.
- **Email or Mail Inquiries:** Members can submit inquiries by email or mail. Members can also use our online feedback form through our member portal to submit questions related to benefits or to provide comments and suggestions to improve our website or services.
- **Webchat Inquiries:** Members can navigate to the chat with us feature on the portal to initiate their online interaction for real-time responses to questions related to benefits.



IVR System capabilities and customizable options:





22. Bookmark Title: MSQ22 – Call Center Monitoring

Narrative description is limited to four (4) pages.

Describe, in detail, your approach, tools used, methodologies, best practices, and application of lessons learned in monitoring and recording calls on Dedicated lines to meet the requirements of Attachment F – Pharmacy Benefit Administrator Services Scope of Work, Section 6.2 – Call Center-related Requirements.

Describe the State’s access to such call information and how this information will be useful for the State in decision-making and measuring the Supplier’s performance.

Supplier Response

MSQ22 - Call Center Monitoring

Our customer service technology platform incorporates a variety of systems, applications and tools to assist our call center team in delivering a positive member and health care provider experience. We have used this technology for more than 10 years. Our systems are constantly upgraded to remain current with manufacturer upgrades.

Updates to reference materials are a combination of internal curriculum updates identified through quality control and process enhancements, in addition to any client-initiated changes that are needed.

Below we outline the technology we use to help us respond to member and health care provider inquiries as quickly and efficiently as possible. Our workforce management tools and respective functionalities are described below.

Omni Genesys System

The Omni Program is a multi-year initiative that implements a single, cohesive Contact Center Technology (voice, chat, digital capabilities) strategy across the UnitedHealth Group enterprise. The Omni platform serves all lines of business, resolves current challenges, prepares for future business needs, improves operational models, and enables anticipation of and responsiveness to market demands.

The Omni capabilities provides us with automated, real-time redistribution of traffic with no impact to the customer experience, fewer applications on the desktop, consolidated, streamlined processes for business and technical support teams, improved visibility to the unified customer journey, single design powers interactions across all channels, and supports future growth with a flexible, scalable architecture.

Interactive Voice Response

IVR provides intelligent, speech-enabled, self-service capabilities to the State for member and health care provider services, home delivery service and PA inquiries. To better meet the needs of the caller, the IVR customizes the experience for the caller. Members may select from self-service options or opt to speak to a CSA at any time during the call. We use the Genesys Voice Portal (GVP), which has been in place since 2020.

We also enhanced our self-service IVR for pharmacies. They can perform self-service functions from the IVR instead of having to speak with a pharmacy technician. Self-service options include



point-of-service information such as BIN, PCN and submitted group information, accessing clarification codes and verifying PA.

Computer Telephony Integration Computer

The IVR technology relays information to the CSA through a “screen pop” so the call continues seamlessly with the authentication information previously entered by the caller. The screen pop includes the reason for the call when identified by the caller and presents the functional screen related to the reason for the call in the Customer Relationship Management (CRM) tool. This enables the CSAs to quickly preview the caller’s record in preparation for the interaction.

Computer Telephony Integration (CTI) capability is resident within the IVR and can be leveraged to present screen pops related to the custom menu of options for first level inquiries, reducing the overall call handle time for both call center agents.

IEX Scheduling Software

This software notifies CSAs on the desktop of their scheduled break, lunch and any training or meeting events. This enables us to provide a good member/provider experience by maintaining call answer service levels and targeted speed of answer for incoming calls.

IEX Back Office Support Tools

This tool enables our team to schedule non-phone work so our CSAs may complete the research, transactions or follow up necessary in response to a member or provider inquiry.

MyMetrics

MyMetrics provides a single web-based application that allows front line users as well as leadership to identify excellent performers as well as opportunities for improvement. Coaching sessions allow agents, supervisors and management to identify coaching effectiveness and provide a common platform that facilitates retrieving historic coaching information. This application includes all agent key performance initiatives as well as supporting metrics to enable users to drill into root cause behaviors for performance.

Customer Relationship Management Tool

The CRM tool combines and organizes client and member information for a unified presentation. The tool’s dashboard view enables CSAs to quickly access all details needed for a call, without losing visibility to key member or pharmacy data and without having to navigate between applications. Real-time information is presented on the desktop from the claims, eligibility and benefit systems, enabling CSAs to view plan benefits, perform call tracking, create cases, locate product details and locate pharmacies. CSAs may also view and process claims, view add and update PA data, and access member portal accounts for web support.

NICE/Sentiment Performance Management

Our call quality program applications routinely record incoming and outgoing calls for our customer service center is the NICE Performance Management system and Sentiment. We record a daily sampling of calls handled by our CSAs.



These applications use voice and screen capture; call and desktop activity may also be simultaneously monitored for a complete view of a CSA's performance. Our quality development specialists perform independent assessments using synchronized voice and screen playback.

Our quality auditors and supervisors are able to monitor interactions for performance and examine processes for best practice. Supervisors also have the ability to record interactions on demand, or to monitor calls in a live setting.

Additionally, the program analyzes specific call attributes, including word choice, phrasing, and overall tone to represent a more member-centric insight into the emotional state displayed during the interaction. Sentiment reporting is used for a variety of process improvement initiatives that reinforce positive member experiences.

Virtual Hold

This technology enables us to advise the callers of the expected wait time during periods of high call volume. Members are offered the option for a callback. The caller may schedule the callback for a specific date, time and phone number or may simply select to retain their place in line by a callback once a CSA becomes available.

Call Recordings

For quality assurance, calls placed to the PBM for State members can be reviewed during designated meetings to do so with the Optum Rx Account Manager. The call recording is not part of the Designated Record Set, as it is not used to make treatment decisions about the individual, these interactions are maintained solely for customer service reviews. To support the quality assurance review, call notes can also be made available to the State for its review and the State can select the calls for review.



23. Bookmark Title: MSQ23 – Call Tracking and Reporting
Narrative description is limited to three (3) pages.

Describe, in detail, your call tracking and reporting system including, but not limited to, its capacity for CSRs to enter customized information into the system and its ability to capture and track CSR-specific comments. Provide details about any tools available to CSRs to respond to Provider inquiries. Your response should also include, but not be limited to, the information regarding the fields that can be used for call center report queries (technical and clinical), including, but not limited to, the following:

- a. Drug name.
- b. Reject edit type.
- c. Therapeutic category.
- d. Prior Authorization (PA) criteria response.

Refer to Attachment F – Pharmacy Benefit Administrator Services Scope of Work, Section 6.1 Call Center-related Requirements.

Supplier Response

MSQ23 - Call Tracking and Reporting

Our customer service technology platform incorporates a variety of systems, applications and tools to assist our call center team in delivering a positive member and health care provider experience. We have used this technology for more than 10 years. Our systems are constantly upgraded to remain current with manufacturer upgrades.

Updates to reference materials are a combination of internal curriculum updates identified through quality control and process enhancements, in addition to any client-initiated changes that are needed.

Below we outline the technology we use to help us respond to member and health care provider inquiries as quickly and efficiently as possible. Our workforce management tools and respective functionalities are described as follows:

Computer Telephony Integration Computer

The IVR technology relays information to the CSA through a “screen pop” so the call continues seamlessly with the authentication information previously entered by the caller. The screen pop includes the reason for the call when identified by the caller and presents the functional screen related to the reason for the call in the CRM tool. This enables the CSAs to quickly preview the caller’s record in preparation for the interaction.

CTI capability is resident within the IVR and can be leveraged to present screen pops related to the custom menu of options for first level inquiries, reducing the overall call handle time for both call center agents.



Customer Relationship Management Tool

The CRM tool combines and organizes client and member information for a unified presentation. The tool's dashboard view enables CSAs to quickly access all details needed for a call, without losing visibility to key member or pharmacy data and without having to navigate between applications. Real-time information is presented on the desktop from the claims, eligibility and benefit systems, enabling CSAs to view plan benefits, perform call tracking, create cases, locate product details and locate pharmacies. CSAs may also view and process claims, view add and update PA data, and access member portal accounts for web support.

We strive to exceed customer expectations by achieving FCR of at least 90 percent or greater. To do so, our CSAs document, manage and report all inquiries communicated by the State's members. The system tracks multiple inquiry types and categories of member records using specific call tracking reasons, source and disposition codes. Tracking reason codes are grouped under categories (for example, benefit service inquiries and Home Delivery Pharmacy inquiries).

We document Pharmacy and member service inquiries, which include some of the following:

- Customer Service Inquiries
- Appeals and Grievances
- Benefit inquiries and formulary inquiries
- Claim processing – pharmacy support
- Eligibility
- Complaints
- HIPAA authorization
- Check available refills
- Pharmacist consultation
- Drug pricing copayments
- Refill order
- New prescription order or transfer prescription requests
- Out-of-stock prescription information

MSQ23,a

We track member inquiries, including provider service and PA inquiries, by annotating the member's record in our online customer service system. These inquiries are received through phone calls, email messages and direct mail communications. We track multiple inquiry types and categories, including complaints and grievances and annotate notes on member records. We use specific call tracking reason codes and sources (for example, member, pharmacy and prescriber) and also record the resolution time involved in addressing member inquiries.

We rely on several processes to track and improve on any reoccurring issues. Our client advocate team tracks escalations, including complaints, root causes and resolutions and conducts trend analyses. This process verifies that escalations were resolved and identifies opportunities to improve people, process or technology to optimize our customer service experience.

Account Management Team Support

In some instances, CSAs require assistance to address the member's concerns. In these situations, the issue is triaged to an escalation lead who provides assistance with resolution. Our escalation leads track and monitor that issue until it is resolved and once resolved; they perform member outreach to determine a satisfactory resolution and close the inquiry.



Escalation Types:

- **Customer Escalation:** Client's benefit administration representative escalates a member issue to the client's account management team, who forwards that inquiry to our Centralized Advocacy, Resolution, and Escalation Specialist (CARES) team. The CARES team works closely with the client's account management team to provide member service support and guidance for the overall delivery of prescription benefits. This team performs research and root cause analysis to identify operational, process, system and knowledge gaps, and conducts member outreach.
- **Lead and Supervisor Team Escalation:** CSA escalates to the Customer Service Assist Line. The assist line team consists of customer service team leads and supervisors who handle escalated member inquiries. The majority of inquiries are resolved during the same day the call is placed. Resolution may require the lead or supervisor to work with operational support or cross functional teams to resolve the issue or inquiry.

MSQ23,b

We support a variety of Medicaid reporting, including state and federal required reporting. During the implementation period, we work with the client to identify all required reports. A sample of the reports available to our Medicaid clients include:

- Concurrent Drug Utilization Review (CDUR) Edits Activity and Outcome reports provide information by CDUR edit (for example, drug-drug interaction, duplicate therapy, drug-age caution) by paid/reversed/denied claim status. Outcome reports assess savings by CDUR edit type.

We track and capture rejected claims in our claims adjudication system. Rejected claims are tied back to the original transaction with the claim and sequence number.

We are able to provide the State with an ad hoc report that details rejected claims for each semimonthly billing period. The State's account management team help develop reporting parameters during the implementation process.

RxTrack, our online reporting tool, is also available to clients to create ad hoc reports by claim status that would return the rejected claims for a given time period.

MSQ23,c

Our CSAs document, manage, and report all inquiries communicated by the States's members.

The system tracks multiple inquiry types and categories of member records using specific call tracking reasons, source, and disposition codes.

Tracking reason codes are grouped under categories (for example, benefit service inquiries and Home Delivery Pharmacy inquiries).

We document Pharmacy and member service inquiries, which include some of the following:

- Appeals and Grievances
- Benefit inquiries and formulary inquiries



- Claim processing – pharmacy support
- Eligibility
- Complaints
- HIPAA authorization

MSQ23,d

In a full delegation to Optum Rx agreement, we provide our clients view-only access through our online PA system. Clients may track their PAs using this system. In addition, compliance and oversight reporting can be provided to the customer for proactive and retrospective monitoring and oversight.

We make it easy for the State to monitor plan performance through our web-based portal, which provides access to claims information through the data warehouse. By using this application, you can analyze data online with a click of a mouse through flexible parameter-driven reports or reports customized to meet your needs. Through our reporting capabilities, we capture claims data, utilization data and full reference files of member eligibility, as well as prescriber and pharmacy information.

The portal is based on our industry leading business intelligence technology and gives users complete flexibility in executing and working with reports and data views. Our reporting capabilities are parameter driven, completely customizable, and flexible.

We provide predeveloped or customized reports. The State can create and save reports in a variety of flexible formats dependent on their needs and requirements. Our security requirements and parameters also allow us to set different parameters for different clients.

Optum Rx's well-rounded, comprehensive data warehouse enables the State to receive accessible information at any time through our claims system. We provide virtually any type of data for reporting purposes and can help you interpret and act on data. Our data warehouse is updated on a nightly basis for timeliness of claims data. Since we manage our own data process, we can provide a high level of customization to fit your specific reporting needs.

Our claims processing system stores all transactions, so each transaction type can be pulled up in a report. In addition, the data warehouse also contains each of these claims and provides for a methodology to tie the claims together, allowing for in-depth analysis.

The PA criteria response capture utilizes the same process as outlined in MSQ23,c.



24. Bookmark Title: MSQ24 – CSR Quality Monitoring
Narrative description is limited to four (4) pages.

Describe, in detail, your quality monitoring process for CSRs as required in Attachment F – Pharmacy Benefit Administrator Services Scope of Work, Section 6 Support. Your response should include, but not be limited to the frequency and number of calls monitored for new and experienced CSRs.

Supplier Response

MSQ24 - CSR Quality Monitoring

We use a variety of quality and satisfaction measures to promote courteous, comprehensive and responsive customer service support for member inquiries, as outlined below. Reporting needs are identified during the implementation process and are provided in accordance with contractual guarantees.

Predicting Volume

We monitor call volume and response times in 30-minute increments to identify peak call volumes. Trends are used to develop call forecasts in order to exceed service level goals.

First Contact Resolution

We heavily weight FCR in call quality evaluations, looking at factors like process accuracy, member education and the provision of complete and accurate information. A call is considered resolved if the member does not call back for the same reason within a specified lookback period.

Repeat Callers

Member data is analyzed daily to identify callers that make multiple inquiries within a 10-day period. Repeat call drivers are analyzed to identify trends, root causes and opportunities for improvement.

After Call Satisfaction Survey

We monitor member satisfaction daily by inviting callers to participate in a brief after call survey. This survey gathers real-time member feedback about customer service interactions which helps us adjust and personalize our support to exceed member expectations. Members respond to the following focused questions:

- (NPS) How likely are you to recommend us to others? Please use a scale of 0 to 10 where 0 means not at all likely and 10 means extremely likely.
- (Satisfaction) Thinking about the conversation you just had, overall, how satisfied are you with the level of service you received? Please use a scale of 0 to 10, where 0 means not at all satisfied and 10 means completely satisfied.
- (Resolution) How satisfied are you that your question was answered? Please use a scale of 0 to 10 where 0 means not at all satisfied and 10 means completely satisfied.
- (Understanding) Was the information you were given easy to understand? Please rate on a scale of 0 to ten, 0 being extremely difficult and 10 being extremely easy.



- (Source) Was your call about a mail delivery prescription or a prescription from a retail pharmacy store? Please select 1 for Mail Delivery, 2 for Retail or 3 for unknown or not applicable.

A non-scored question is also included to provide additional insight:

- (Verbatim) In order for us to learn about your experience, after the tone please tell us the one thing we could have done better for you.

Using survey data, Optum Rx quantifies the top opportunities to improve the member experience. Root causes of complaints and escalations are also reviewed to identify gaps or areas for improvement.

Our overall after call satisfaction rating is 96.9 percent. The mean score is the average of all responses, using a 0 to 10 satisfaction scale. Our target score is 10. While we recognize perfect satisfaction may be difficult to attain, we are committed to providing excellent service to our members.

Quality/Sentiment

Quality performance reporting is available through overall sentiment. This score reflects the emotional state of the call using specific call attributes, including word choice, phrasing and overall tone. Sentiment reporting is used for a variety of process improvement initiatives that reinforce positive member experiences.



- 25.** Bookmark Title: MSQ25 – Call Monitoring
Narrative description is limited to one (1) page.

Describe, in detail, your ability to comply with the State's requirements to monitor Member and Provider calls made to the Dedicated call numbers. Include in your response descriptions of the technology that will be used to perform this function and the State's ability to select calls without prescreening or preselection by the Supplier as stated in Attachment F – Pharmacy Benefit Administrator Services Scope of Work, Section 6.2 Call Center-related Requirements.

Supplier Response

MSQ25 - Call Monitoring

Our customer service technology platform incorporates a variety of systems, applications and tools to assist our call center team in delivering a positive member and health care provider experience. We have used this technology for more than 10 years. Our systems are constantly upgraded to remain current with manufacturer upgrades.

Updates to reference materials are a combination of internal curriculum updates identified through quality control and process enhancements, in addition to any client-initiated changes that are needed.

Below we outline the technology we use to help us respond to member and health care provider inquiries as quickly and efficiently as possible. Our workforce management tools and respective functionalities are described as follows:

Omni Genesys System

The Omni Program is a multi-year initiative that implements a single, cohesive Contact Center Technology (voice, chat, digital capabilities) strategy across the UnitedHealth Group enterprise. The Omni platform serves all lines of business, resolves current challenges, prepares for future business needs, improves operational models, and enables anticipation of and responsiveness to market demands.

The Omni capabilities provides us with automated, real-time redistribution of traffic with no impact to the customer experience, fewer applications on the desktop, consolidated, streamlined processes for business and technical support teams, improved visibility to the unified customer journey, single design powers interactions across all channels, and supports future growth with a flexible, scalable architecture.

Interactive Voice Response

IVR provides intelligent, speech-enabled, self-service capabilities to the State for member and health care provider services, home delivery service and PA inquiries. To better meet the needs of the caller, the IVR customizes the experience for the caller. Members may select from self-service options or opt to speak to a CSA at any time during the call. We use the Genesys Voice Portal (GVP), which has been in place since 2020.

We also enhanced our self-service IVR for pharmacies. They can perform self-service functions from the IVR instead of having to speak with a pharmacy technician. Self-service options include



point-of-service information such as BIN, PCN and submitted group information, accessing clarification codes and verifying PA status.

MyMetrics

MyMetrics provides a single web-based application that allows front line users as well as leadership to identify excellent performers as well as opportunities for improvement. Coaching sessions allow agents, supervisors and management to identify coaching effectiveness and provide a common platform that facilitates retrieving historic coaching information. This application includes all agent key performance initiatives as well as supporting metrics to enable users to drill into root cause behaviors for performance.

Customer Relationship Management Tool

The CRM tool combines and organizes client and member information for a unified presentation. The tool's dashboard view enables CSAs to quickly access all details needed for a call, without losing visibility to key member or pharmacy data and without having to navigate between applications. Real-time information is presented on the desktop from the claims, eligibility and benefit systems, enabling CSAs to view plan benefits, perform call tracking, create cases, locate product details and locate pharmacies. CSAs may also view and process claims, view add and update PA data, and access member portal accounts for web support.

NICE/Sentiment Performance Management

Our call quality program applications routinely record incoming and outgoing calls for our customer service center is the NICE Performance Management system and Sentiment. We record a daily sampling of calls handled by our CSAs.

These applications use voice and screen capture; call and desktop activity may also be simultaneously monitored for a complete view of a CSA's performance. Our quality development specialists perform independent assessments using synchronized voice and screen playback.

Our quality auditors and supervisors are able to monitor interactions for performance and examine processes for best practice. Supervisors also have the ability to record interactions on demand, or to monitor calls in a live setting.

Additionally, the program analyzes specific call attributes, including word choice, phrasing, and overall tone to represent a more member-centric insight into the emotional state displayed during the interaction. Sentiment reporting is used for a variety of process improvement initiatives that reinforce positive member experiences.

Virtual Hold

This technology enables us to advise the callers of the expected wait time during periods of high call volume. Members are offered the option for a callback. The caller may schedule the callback for a specific date, time and phone number or may simply select to retain their place in line by a callback once a CSA becomes available.



- 26.** Bookmark Title: MSQ26 – Reporting Approach
Bookmark Title for Supporting Material: MSQ26.1 – List of Proposed Reports
Narrative description is limited to five (5) pages, not including required supporting material.
- Provide a detailed listing of all proposed reports, including an outline of all utilization and performance reports that will be developed for the State to meet the requirements of this scope of work.
- Include in your response for each report, a synopsis, purpose, any limitations the State may have in accessing each report, and the frequency each report will be provided to the State.

Supplier Response

MSQ26 - Reporting Approach

Providing insights into every aspect of the State's pharmacy benefit, our comprehensive reporting is available to you online and through electronic delivery. Our reporting uses differentiated technology and analytics to help you understand and manage pharmacy cost and member health trends that support informed health care decision making. We provide you with the flexibility to analyze overall plan performance and drill down into specific areas to evaluate trends.

Optum Rx provides a standard reporting package including a wide range of reporting insights, from comprehensive overviews of plan performance to detailed reporting of specific data elements. This standard package includes more than 40 individually unique reports, each with data filtering capabilities that enable the State to understand each aspect of your pharmacy benefit performance. The package also provides you with quarterly and annual executive summaries of key metrics across your pharmacy benefit. Standard reporting includes:

Standard Reporting Package Area	Report Examples	Frequency/Schedule
Account Management	Executive Summary, Claim Detail, Formulary/Non-Formulary, Mail/Retail, Specialty/Non-Specialty, DAW Utilization, Rejected Claims, Claims Lag Reports	Configurable
Membership Management	Top Members, Membership Trend, Member Lookup Reports	Configurable



Product Management	Top Drugs, Period-to-Period Comparative Drug Report, Drug Market Share Reports	Configurable
Pharmacy Management	Top Pharmacy, Pharmacy Lookup, Period-to-Period Comparative Pharmacy Reports	Configurable
Prescriber Management	Top Prescriber, Prescriber Lookup, Period-to-Period Comparative Prescriber Reports	Configurable
Clinical Management	Adherence, Controlled Substance Utilization, Multiple Providers Utilization, Concurrent DUR Reports, Personalized Rx Counselor, Optum Rx <u>RetroDUR</u> , Fraud Waste and Abuse, Adherence Reports that are dependent upon customer selection of the program as part of their benefit plan	Configurable
On-Demand Reporting	On-demand reporting functionality enables you to create your own reports through <u>RxTrack's</u> online tool, including a broad range of ad hoc reports.	Configurable

Standard Report Delivery and Timeline

Source data used for reporting is refreshed daily by 8 a.m. CT, and standard reports are provided monthly, quarterly and annually and can be run for custom date ranges as needed:

- Online access in a simple point-and-click environment
- Static reports in an electronic format, such as PDF and Excel

All RxTrack month-end reporting is available within 10 calendar days following the end of the respective prior reporting period. Claim detail reports can be generated with data from the previous day after the daily refresh.

Optum Rx also understands that the State may require reporting outside of what our standard reports provide. In those cases, the Optum Rx Business Analyst works with you to design, create, and schedule custom reports in PDF, Excel, or in PowerPoint on a schedule custom to your business needs.

Using the power of our RxTrack tool, typical custom reports include but are not limited to the following examples:



Reporting Area	Custom Report Examples	Typical Frequency
COB	Monthly Cost Avoidance Detail and Summary By Other Coverage Code	Monthly
Prior Authorization	Prior Authorization Detail	Monthly
Finance	Appeals Detail, Prior Authorization Turnaround Time, Accounting Interface Report, Federal/State Expenditure Report, Check Register, EFT Register, Payment Summary Report, Cash Requirements EFT, Cash Requirements Check, Payment Adjustment Report, Payment Reissue Report, Negative Balance Forward Transaction Report, Refugee Report, Triangle report, MAT Summary report, GA Pathways Summary, COVID Vaccine Utilization Report, Annual Payee Summary Report	Weekly/Monthly
Drug Cost Changes Management Reports	Proactive Price Change Report	Weekly
	Refill too Soon Overrides, Call Center Performance Detail, User Entity Control Report, Key Statistics, Top 10 Products by Amount Paid and Rx Count	Monthly
Quarterly Review Reports	SLA Performance Report, Network Utilization Statistics, Limited Distribution Providers (LD Network), SMAC/GEAC Recommendation Summary/Analysis/Savings, Call Center Statistics, Rx Count and Amount Paid, Eligibles and Utilizers, Top Multi-Source Brand Drugs, Specialty Analysis by Condition, Specialty Trending, Prior Authorization Statistics, PA Requests by Interaction Type, New Drug Dashboard, PA Approval Rates, Utilization Trends/Rankings	Quarterly

MSQ26.1 - List of Proposed Reports

Please refer to the PBA Exhibits Section, MSQ26.1 – List of Proposed Reports.pdf for a listing of the RxTrack Standard reports.



27. Bookmark Title: MSQ27 – Reports Customization
Narrative description is limited to four (4) pages.

Describe, in detail, your reporting tool's capability to provide customized and Ad hoc reports to meet the needs of the State as stated in Attachment F – Pharmacy Benefit Administrator Services Scope of Work, Section 7.1, Reporting. Include in your response the software used by your company for reporting.

Supplier Response

MSQ27 - Reports Customization

We make it easy for the State to monitor and review plan performance at your convenience through our RxTrack web-based reporting platform, powered by Cognos. The online platform gives you flexibility to analyze and filter data through established parameters or create ad hoc reports and customized views to meet your needs. RxTrack captures claims data, utilization data and member eligibility files, as well as prescriber and pharmacy information to provide comprehensive analytics and reporting for the State.

Creating On-Demand Reports

RxTrack provides an on-demand report resource with instant access to a broad range of plan metrics and performance data—including utilization and cost trends; prescriber and pharmacy metrics; member utilization; drug utilization; and more—that give the State the ability to create on-demand, ad hoc and configurable reports to analyze all aspects of your pharmacy benefit. Resources and features supporting the State's creation of on-demand reports include:

- Web-based information delivery: Access RxTrack on-demand reporting from anywhere using an Internet connection and web browser.
- Intuitive user interface: Our user-friendly interface facilitates easy navigation.
- Extensive portfolio of filtered standard reports: On-demand reporting for the State provides navigation and guidance in creating your own reports to analyze data including the ability to download reports directly into Microsoft Excel.
- Customized and ad hoc reporting: Our custom report builder makes it easy for users to focus on data that is important to your business. Further, most ad hoc reporting requests can be accommodated through our online reporting tool as part of our basic service.
- Secure data transmission: Our firewall, filter and encryption technology protect the integrity and confidentiality of your data.

RxTrack is anchored by our data warehouse and analytics technology giving you flexibility to create and work with reports and data views based on your preferences. Claims data is updated daily in the data warehouse to provide the State with up-to-date analytics to fit your specific reporting needs. the State can create its own configurable report views and save reports in a variety of file formats. Security parameters also enable you to set different access levels for different user groups.



Requesting Ad Hoc Reports

The State may also directly request ad hoc or custom reports by contacting your account management team who collaborates with you to determine the scope of reporting requirements and work with our reporting teams and other internal subject matter experts to create the reports and provide consultative support.

Turnaround Time

The turnaround time for ad hoc requests submitted through your account management team is 10 business days, however, the time can vary depending upon the complexity of the request. In most cases, ad hoc reports can be created well in advance of the 10-business day turnaround time. We make every effort to fulfill such requests as timely as possible especially during the States' legislative sessions.



- 28.** Bookmark Title: MSQ28 – Report Tool
Narrative description is limited to three (3) pages.
- Describe, in detail, your Solution’s ability to provide Authorized Solution Users with access to your reporting tool to create customized queries and generate Ad hoc reports. Include in your response a detailed list of the different levels of access that will be made available to the State Authorized Solution Users to meet the requirements of Attachment F – Pharmacy Benefit Administrator Services Scope of Work, Section 7.1 – Reporting.

Supplier Response

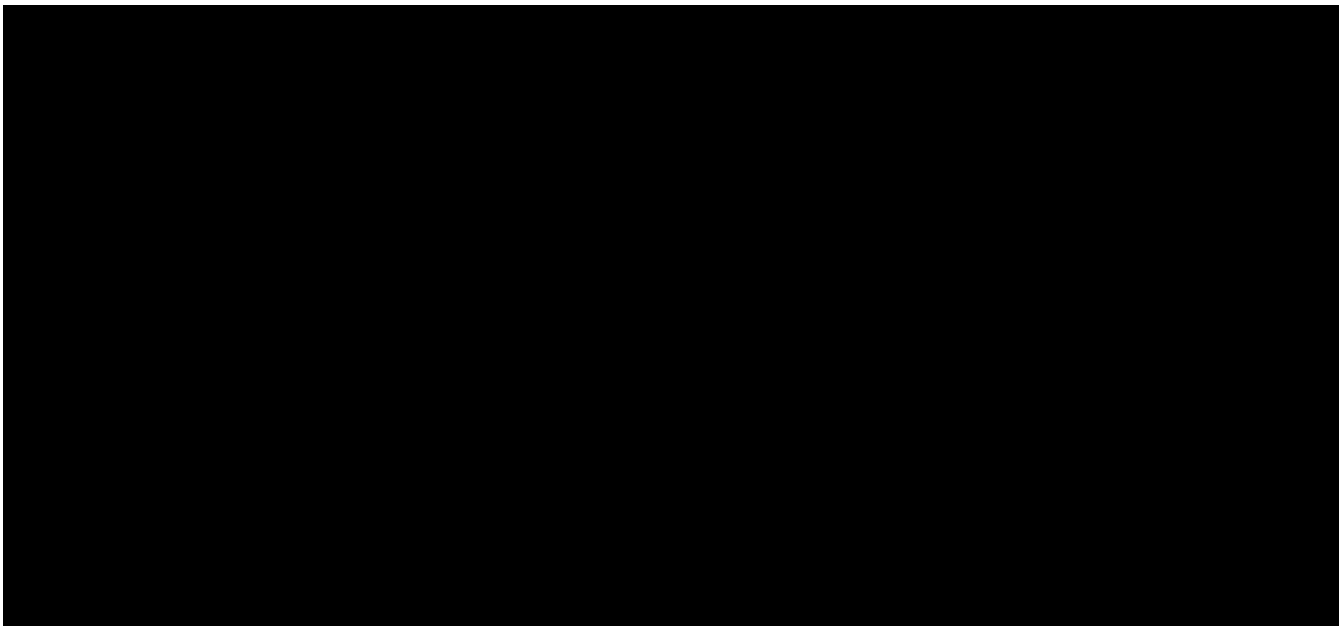
MSQ28 - Report Tool

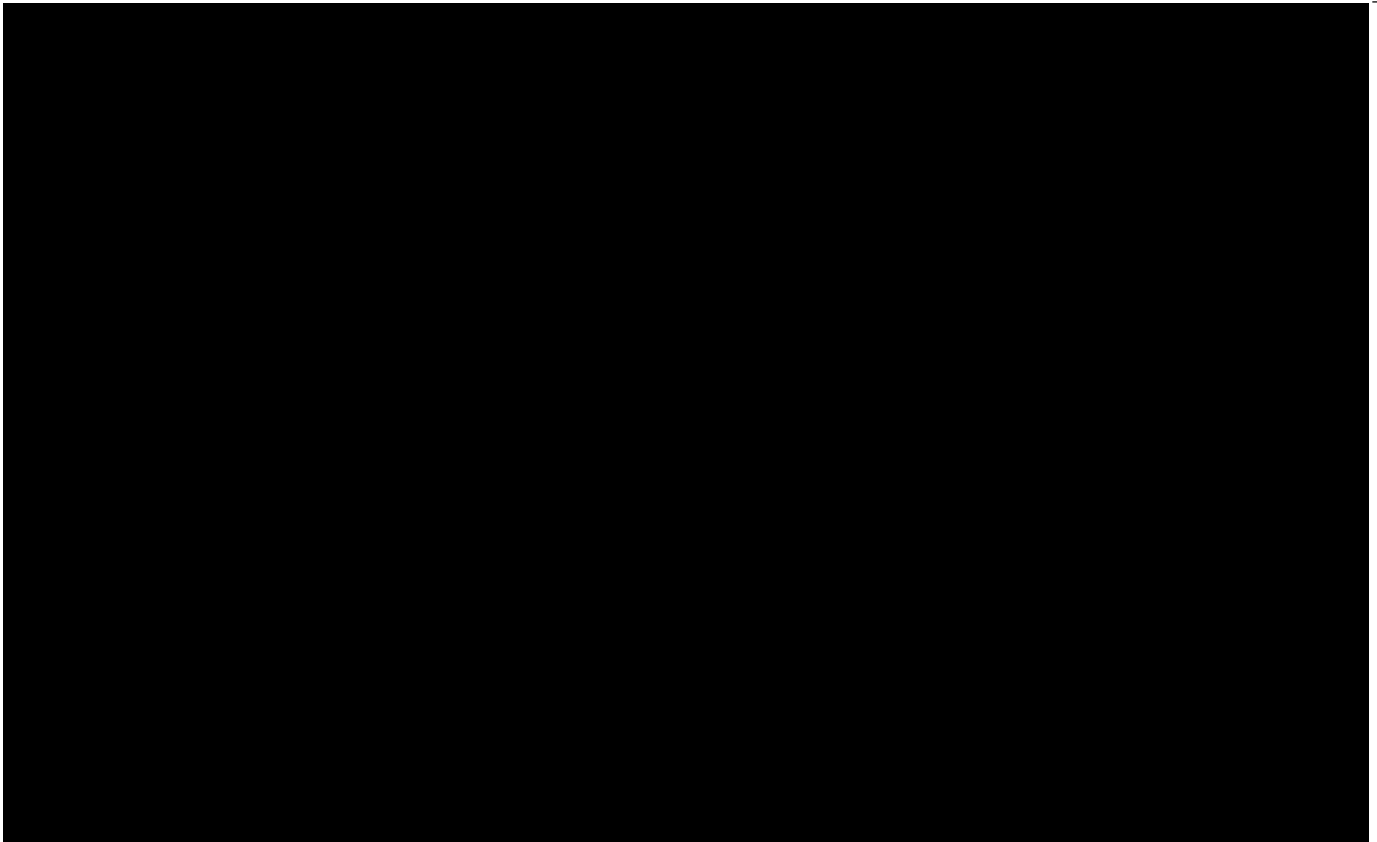
Client Portal: Access to RxTrack

We understand that timely, complete, accurate, and accessible information is needed to support the State’s benefit management goals. To address these needs, we offer a wide range of standard, optional, and ad hoc reporting capabilities; we are confident our reporting services meet and exceed your requirements.

Decision support access begins with our web-based Client Portal, which makes it easy for the State to monitor plan performance and access claims information residing in the data warehouse. Through the portal, the State analyzes data online with a click of a mouse through flexible parameter-driven reports or reports customized to meet your needs. Through our reporting capabilities, we capture not just claims data but utilization data and full reference files of member eligibility, as well as prescriber and pharmacy information.

State authorized users can access Optum Rx applications, including RxTrack (our decision support system), through the Client Portal. The Client Portal is a multi-functional tool which allows clients to access applications, find quick resolutions to issues, answers to user questions, and access to other relevant information.





In RxTrack, the Optum Rx Business Analyst, creates a folder to house all vetted custom reports which can be re-used by both Optum Rx and State report users. Ad hoc report users have the ability to include the following data elements in their RxTrack custom queries:

- Drug reference data such as: NDC, Drug Name, GPI, GPI Name, Therapeutic Class
- Pharmacy and Prescriber reference data
- Member information, including aid category (if supplied by eligibility data)
- PA detail such as approval status, drug, duration
- Claim detail (submitted and response data)
- Member detail
- Plan detail
- Pricing Detail
- Reject codes and messaging

User Access

User access to RxTrack begins with the request from the State or from internal Optum Rx teams. Requests from the State are directed to your Account Management Team either through the Client Portal or via email. The user details and access specifications are then entered by your Account Team through the Optum user provisioning system called SECURE. Internal Optum Rx user



requests are directly entered into SECURE by the user's manager. The SECURE system has a customizable workflow which allows the requestors to specify the level of access requested, the specific client environment, whether PHI should be suppressed, and any additional data sets above the standard tables assigned to the selected role. An example of a request for additional tables is when a user requests access to rebate data. In the event that Optum Rx is contracted for PDRS services, access requests could be made to specify the requirement for rebate tables within the provisioning request.

SECURE's decision tree based approval workflow is designed so that only Optum Rx resources who are in the United States and directly support the State's PBA scope of work will have access to your confidential data through RxTrack. As an added measure, designated Optum Rx approvers are able to approve or reject requests based on State specific access criteria. Typical turnaround times for provisioning are up to a week and can be expedited on a case-by-case basis.

When State and Optum Rx users no longer require access, the Account Team and Optum Rx Managers initiate a task to immediately terminate a user account. This type of request is executed within the same day.



29.	Bookmark Title: <u>MSQ29 – Data Management Plan</u> Bookmark Title for Supporting Material: ➤ <u>MSQ29.1 – Data Conversion & Migration Plan</u> ➤ <u>MSQ29.2 – Data Migration Layout</u> ➤ <u>MSQ29.3 – Rules Engine Capabilities</u> ➤ <u>MSQ29.4 – List of Reference Data Used by the System</u> ➤ <u>MSQ29.5 – Functional and Data Specifications</u> ➤ <u>MSQ29.6 – Conceptual and Logical Data Models</u> ➤ <u>MSQ29.7 – Data Dictionary</u> Narrative description is limited to five (5) pages, not including required supporting material. Explain your approach to exchanging and integrating data from multiple Data Sources into the proposed Solution as described in Attachment F – Pharmacy Benefit Administrator Services Scope of Work, Section 7.2 Data Management. Using Attachment EE – Pharmacy Benefit Services Data Exchanges as an example, explain how the proposed Solution will achieve integration of each of the Data Sources and how the Supplier will work with the data source vendors to ensure compatibility with the proposed Solution. Describe your level of experience collaborating with such vendors.
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Supplier Response

MSQ29 - Data Management Plan

Optum Rx has an extensive history of integrating pharmacy solutions into State Medicaid Enterprise Systems (MES). Across the country, each and every day, we trade eligibility, provider, prior authorization, claims, and other data with States, vendors, and other trading partners to support the country's most vulnerable populations.

During the implementation process, we work with the State and your vendors to establish mutually acceptable parameters for data capture, delivery and exchange. In addition, we manage the transformation of data when required for custom file formats. In addition, we work with the State to guarantee secure access to our systems and confirm that our numerous data interchange options (for example, FTP, PGP, Network Data Mover) are compatible with your operating procedures. We have constructed our IT infrastructure using industry-leading database technology, coupled with a complete set of data tools that allow for easy manipulation of the data into appropriate data collections for import and export operations. We also have implemented technology for data security and user authentication to protect our data so that only authorized activities are permitted.

We are able to offer a high degree of flexibility because we have made significant investments in infrastructure technology to meet the demands of our customers. As an example, we utilize the Sterling Integrator product, from the IBM/Sterling Corporation, as our enterprise Multi-Enterprise Services Architecture (MESA) for data exchange. MESA means that we have a single platform and toolset that allows us to cover nearly any conceivable form of business-to-business communication with our clients. This includes support for multiple protocols, various operating systems, business applications, platforms, and communication adapters. With this technology in place for our applications, data exchange is handled through the Sterling MESA which affords us great reliability, audit ability, flexibility, and ease of operations in a multi-protocol environment. The best



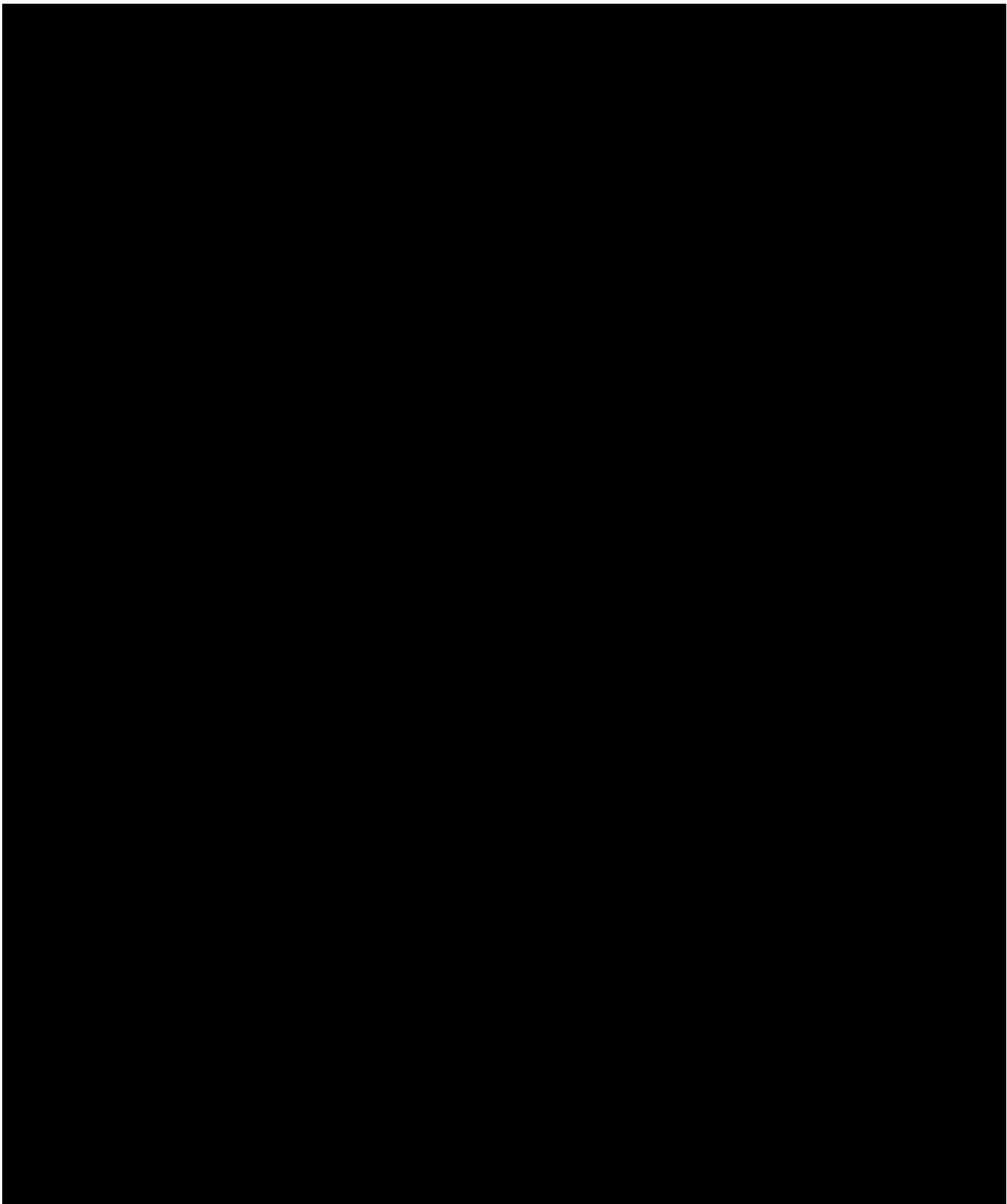
part of the equation is that the State does not need to do anything different or outside of their standard operation procedures to enjoy the benefits and protection that MESA provides.

As part of the RxClaim COTS product, hundreds of supported and maintained interfaces make up the foundation for moving data out of and into the pharmacy system. Clients have the option to utilize our interface formats or have Optum Rx perform the transformation of data. For the latter option, Optum Rx utilizes multiple methods depending on the type of source data and the complexity of the transformation.

We have incorporated state-of-the-art data manipulation capabilities into our platform used in the exchange of data. We use the Ablutio tools to allow for high-speed, data-driven, graphically controlled data manipulation capabilities. These tools offer significant data interface advantages and expand our abilities to extract, transform, and load (ETL) data.

We understand that data generated from the PBA system is critical to the State and the overall MES. Optum maintains multiple standard claims extract formats and supports the NCPDP post adjudication history file format as a standard feature of our RxClaim COTS product. We work with the State and your trading partners to understand what output data is required and plan for either a standard extract or a custom file built from the base of a standard extract. In addition to claims files, we provide prior authorization files, drug reference files, financial interfaces, and bank files as outputs from the PBA system.

The figure below demonstrates our understanding of the integration points the Pharmacy system has among the other State components and trading partners for the PBA solution.





In Georgia, Indiana, Arizona, Tennessee, South Dakota and in other states, we are integrating at the same or similar levels as required in this PBA module.

[MSQ29.1 - Data Conversion & Migration Plan](#)

Please refer to the PBA Exhibit Section, MSQ29.1 Data – Conversion and Migration Plan.pdf of our proposal response.

[MSQ29.2 - Data Migration Layout](#)

Please refer to the PBA Exhibits Section, MSQ29.2 – Data Migration Layout.zip of our proposal response.

[MSQ29.3 - Rules Engine Capabilities](#)

Please refer to the PBA Exhibits Section, MSQ29.3 – Rules Engine Capabilities.pdf of our proposal response.

[MSQ29.4 - List of Reference Data Used by the System](#)

Please refer to the PBA Exhibits Section, MSQ29.4 – List of Reference Data Used by the System.pdf of our proposal response.

[MSQ29.5 - Functional and Data Specifications](#)

Please refer to the PBA Exhibits Section, MSQ29.5 – Functional and Data Specifications.pdf of our proposal response.

[MSQ29.6 – Conceptual and Logical Data Models](#)

Please refer to the PBA Exhibits Section, MSQ29.6 – Conceptual and Logical Data Models.pdf of our proposal response.

[MSQ29.7 - Data Dictionary](#)

Please refer to the PBA Exhibits Section, MSQ29.7 Data Dictionary.pdf for a data dictionary of our RxTrack product.



- 30.** Bookmark Title: MSQ30 – Communication
Bookmark Title for Supporting Material: MSQ30.1 – Communication Examples
Narrative description is limited to five (5) pages, not including required supporting material.
- Describe, in detail, how you will furnish Pharmacy Providers, stakeholders, Members, and pharmaceutical software vendors all of the information regarding the program, as specified in Attachment F – Pharmacy Benefit Administrator Services Scope of Work, Section 8.3 Communication Management. Your response should include, but not be limited to, the following:
- Announcement of the contract
 - Bank Identification Number(s) (BINs)
 - Processor control numbers
 - Customer services numbers
 - Plan contact information
 - Policies and procedures
 - Billing tips
 - Changes in program administration
- As supporting material, provide ten (10) examples of materials historically used to accomplish such communications for a range of stakeholders and the frequency and medium of the communication materials.

Supplier Response

MSQ30 - Communication

Whether the State awards to a new Pharmacy Benefit Management vendor or the incumbent, the way the awarded vendor plans for and executes stakeholder communications goes a long way to minimize disruption and ensure a smooth transition to new program changes. Optum Rx's approach to communication starts with thoughtful planning and collaboration with the State team up front in the planning stage. Our knowledge of the current GA FFS Medicaid Pharmacy program and relationships we've developed with the GA provider community set us apart in this area.

Optum Rx provides the detailed approach and schedule for stakeholder communication in the DDI Communication Plan deliverable referenced in Attachment C. In that Plan, we outline and detail what information we will communicate, how and when it will be communicated and the targeted audience for the communication. Communication material examples are planned with the State and only released upon State approval. Examples of communications include the following:

- Announcement of Optum Rx as the awarded vendor for PBA
- Payer sheet which includes the BIN/PCN/Group information, all mandatory and optional fields, plus State specific logic for claims submission.



- Billing tips and frequently asked questions (FAQ)
- Key implementation dates, including provider test claim instructions if needed
- Key changes to program administration which occur alongside transition
- Optum Rx contact information including Call Center Toll-Free Numbers, Dedicated Optum Rx provider email address for the State
- Drug recall alerts

The Methods of communication are just as important as the planned content. The communication material mentioned above is packaged and delivered by way of the following channels:

- Directly to provider association and group contacts at GPHA, AIP and MAG via email, fax
- Fax and email blasts to independent pharmacies and chains plus out of state approved specialty providers
- Directly to members as needed based on the type of program changes, disruption risk, and other criteria as approved by the State
- Website posting on the Optum Rx provider and member portals, the GAMMIS website, and the State website
- Global call center messages for member and provider lines referring callers to web site announcements
- POS messaging where appropriate

MSQ30.1 – Communication Examples

Please refer to the PBA Exhibit Section, MSQ30.1 – Communication Examples.zip for samples of our standard stakeholder communications materials.



- 31.** Bookmark Title: MSQ31 – CSR Training Program
Bookmark Title for Supporting Material:
➤ MSQ31.1 – Training Materials
➤ MSQ31.2 – Training Plan
Narrative description is limited to four (4) pages, not including required supporting material.
Describe, in detail, your Customer Service Representative (CSR) training program to meet the scope of work requirements (refer to Attachment F – Pharmacy Benefit Administrator Services Scope of Work, Section 8.5 Training). Include in your response, at a minimum, the following:
- Information regarding initial training including the duration, required curriculum, and training based on specific areas of responsibility.
 - Training materials, i.e., presentations, videos, on-line references, support guides, and user manuals.
 - Information on new staff member training and ongoing training including frequency and required classes.
 - Description of client-specific plan, design and coverage rule training, frequency, and the method of training, including any limitations, and indication if client-specific training is limited to Dedicated core staff only.
 - Information on the methods that will be utilized to test and monitor CSRs to ensure they are prepared to handle direct inquiries from Members or Providers.

Supplier Response

MSQ31 - CSR Training Program

MSQ31,a

We define quality as meeting and exceeding the expectations of the people we serve, on their terms. So that our representatives assist our customers in getting the right therapy at the right price, we offer a comprehensive and robust training program for our team of CSAs. Our program is supported by an award-winning internal learning department and includes extensive initial and ongoing training that promotes quality, accuracy, and an enhanced customer experience.

Below we have provided details on our learning department and our initial and ongoing training activities.

Our Learning Department

Our learning department includes experienced, professionally certified trainers with various instructional skills, such as:

- Facilitating adult learning
- Assessing training needs
- Presenting and designing training



- Organizing and planning of training programs

Our staff trainers complete a 40-hour professional development program, that we provide as part of our trainer certification course.

Initial Training

During the initial training phase, our CSAs receive approximately 160 hours of materials-based, instructor-led classroom training and 40 hours of on-the-job training in a controlled environment.

Classroom training begins with instruction on key company expectations, systems, materials, and basic call-handling procedures. Next, our trainers focus on a capability training, which includes detailed instruction on how to use our integrated claims systems. Trainees receive detailed, hands-on training on specific tasks and view demonstrations on how to provide the following:

- Verify eligibility
- Check benefit design information
- Verify copayment structure
- Check PDL status
- Verify coinsurance pricing
- Provide information on appeals and grievance processes
- Provide forms
- Check member drug history
- Escalate calls to a member service supervisor
- Route calls to a pharmacist

Finally, our trainers highlight skills that are designed to create an optimal member call experience. This segment of training focuses on customer advocacy and includes:

- Connecting with the State's members
- Using tone of voice effectively
- Effective listening
- Understanding and meeting the State's member needs
- Educating the State's members
- Problem solving

After successfully completing classroom training, new CSAs spend approximately 40 hours in a controlled environment taking live calls under the supervision of training and operations professionals. We require CSAs to pass a rigorous skills test before assigning them to a permanent role on our customer service team.

New Client Training

We provide CSAs with tools to promote and maintain our philosophy of customer advocacy while supplying the State with a seamless transition to our PBM services. We educate our CSAs regarding the State and its benefit plans using the following resources:

- Monthly bulletins outlining specifics about the State's benefits plan, member demographics and preferences (for example, mandatory mail)
- Information on the State's special member programs, such as smoking cessation



- Media board slides throughout our call centers announcing the State as a new client
- Computer-based training modules and classroom training about the State's programs
- Secret shopper calls to provide pro-active coaching for CSAs. When a new client is implemented, CSAs participate in scenarios that simulate an actual member call using the State's programs' specific benefit set up.

Any changes to the State's benefit plan(s) are communicated to our CSAs as early as three weeks prior to the proposed changes.

Ongoing Training

We continue to develop and reinforce the knowledge and skills of CSA trainees. This practice maintains quality of service, transfer of knowledge, and effective use of reference tools. The methods we use include:

- Regular coaching and development.
- Side-by-side quality monitoring by supervisors.
- Remote call observations, conducted by a staff of dedicated analysts, using NICE's performance management system and Sentiment scoring. This technology enables recording and playing back calls while observing the online screens used by the CSAs in addition to word choice and tone used during the member interaction.
- Skill Gaps, a proactive system for identifying and correcting operational deficiencies.
- An eLearning system that makes training available to every employee through our corporate network.
- Bulletins that alert CSAs to the latest business developments. CSAs can also search our knowledge management system to research work instructions and other information about our business processes.
- Message boards located throughout our call centers that provide instant information and performance feedback.
- Continuing education courses to fine-tune call flow and workflow skills, and provide new knowledge, up to 48 hours per year per individual.

We also use coaching techniques and refresher training sessions to retrain call center staff members who do not meet our identified performance levels. This can include allowing the CSAs to listen to themselves on playbacks of mock calls for training.

We offer additional support to our member service teams by providing online resources with the State specific plan information and plan specifications that are routinely updated to reflect the latest information. These sources are complemented by electronic data to assist members with various inquiries. In addition, to maintain a continuous level of excellence, we hold frequent staff meetings to introduce and review plan specifications, medications, operating procedures, customer service skills and special topics.



In addition, we make regular updates to our training curriculum for core business processes that are impacted by significant changes, such as regulatory requirements or process improvements.

MSQ31,b

To remain compliant with applicable federal and state requirements, our clinical and business practices limit the customization of CSA training materials. However, we work with the State to modify and enhance our training materials to reflect client-specific cultural values and requirements and welcome the State's feedback and suggestions as we conduct CSA training for those unique needs. CSA training is delivered through virtual classes, online learning modules and job aids. We provide a high-level overview of CSA training materials upon request, but the final materials created for CSA training are considered proprietary and confidential and cannot be shared externally.

MSQ31,c

Our CSA training program is supported by an award-winning internal learning department and includes extensive initial and ongoing training that promotes quality, accuracy, and an enhanced customer experience. Our award-winning instructional design team reviews training curriculum on a quarterly basis to align it with operational process changes. In addition, we make regular updates to our training curriculum for core business processes that are impacted by significant changes, such as regulatory requirements or process improvements.

MSQ31,d

Policies and Procedures

Our customer service policies and procedures are proprietary materials that are not shared externally. However, we can provide an overview of our policies or procedures upon request.

Client-specific Training

For clients with non-standard or population-specific requirements, we supplement our standard training curriculum with information around those unique needs. Training is delivered in a variety of ways, including virtual classes, online learning modules and job aids. We welcome client feedback and suggestions related to CSA training, and while training materials are proprietary, we can provide the State with an overview upon request.

MSQ31,e

We use a variety of quality and satisfaction measures to promote courteous, comprehensive and responsive customer service support for member inquiries, as outlined below. Reporting needs are identified during the implementation process and are provided in accordance with contractual guarantees.

Predicting Volume

We monitor call volume and response times in 30-minute increments to identify peak call volumes. Trends are used to develop call forecasts in order to exceed service level goals.



First Contact Resolution

We heavily weight FCR in call quality evaluations, looking at factors like process accuracy, member education and the provision of complete and accurate information. A call is considered resolved if the member does not call back for the same reason within a specified lookback period.

Repeat Callers

Member data is analyzed daily to identify callers that make multiple inquiries within a 10-day period. Repeat call drivers are analyzed to identify trends, root causes and opportunities for improvement.

After Call Satisfaction Survey

We monitor member satisfaction daily by inviting callers to participate in a brief after call survey. This survey gathers real-time member feedback about customer service interactions which helps us adjust and personalize our support to exceed member expectations. Members respond to the following focused questions:

- (NPS) How likely are you to recommend us to others?
- (Satisfaction) Thinking about the conversation you just had, overall, how satisfied are you with the level of service you received?
- (Resolution) How satisfied are you that your question was answered?
- (Understanding) Was the information you were given easy to understand?.
- (Non-scored question) In order for us to learn about your experience, after the tone please tell us the one thing we could have done better for you.

Using survey data, Optum Rx quantifies the top opportunities to improve the member experience. Root causes of complaints and escalations are also reviewed to identify gaps or areas for improvement. Our commitment to providing excellent service to our members is reflected in our satisfaction scores. Using a 0 to 10 satisfaction scale, our overall after call satisfaction rating is 9.47 for year-to-date 2023.

Quality/Sentiment

Quality performance reporting is available through overall sentiment. This score reflects the emotional state of the call using specific call attributes, including word choice, phrasing and overall tone. Sentiment reporting is used for a variety of process improvement initiatives that reinforce positive member experiences.

MSQ31.1 - Training Materials

Please refer to the PBA Exhibit Section, MSQ 31.1 – Training Materials.zip of our proposal response.

MSQ31.2 – Training Plan

Please refer to the PBA Exhibit Section, MSQ31.2 – Training Plan.pdf for an example of a training guide for RxTrack.



32.	Bookmark Title: <u>MSQ32 – PBA Architecture</u> Narrative description is limited to ten (10) pages, excluding pictures, diagrams, flowcharts, etc. Considering the Pharmacy Benefit Administrator Services (PBA) architecture needs and requirements (i.e., a means for vendors, the State, and Authorized Solution Users to visualize the Solution Components and interactions), provide a holistic, multi-dimensional data view (e.g., pictures, diagrams, flow charts) of the proposed Solution's architecture at both summary and detail levels. Show all operating systems, Database management systems, all Commercial Off-the-Shelf (COTS) software, and logical servers. Identify potential data bottlenecks and single points of failure, and a plan to mitigate Risks through preemptive alerts and automatic failover capabilities. Your response should include a narrative that provides any information needed to explain the diagram(s), how much of the proposed Solution is out-of-the-box, customized, or configured to meet the State's needs, and the way in which the proposed Solution will achieve and maintain the security, availability, and Data Management requirements. Refer to Attachment F – Pharmacy Benefit Administrator Services Scope of Work and Attachment C – Common Scope Requirements and Security Standards.
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Supplier Response

MSQ32 - PBA Architecture

Highly configurable system

RxClaim is our proprietary rules-based claims processing system that supports virtually every type of pharmacy benefit program and pharmacy delivery mechanism available. Its flexibility, capabilities, and capacity are unlimited. In addition, we maintain hundreds of interface and extract formats maintained as part of our products. In short, the out of the box interfaces and configuration capabilities of RxClaim typically result in a high percentage of business requirements implemented without the need for development.

Architected for reliability

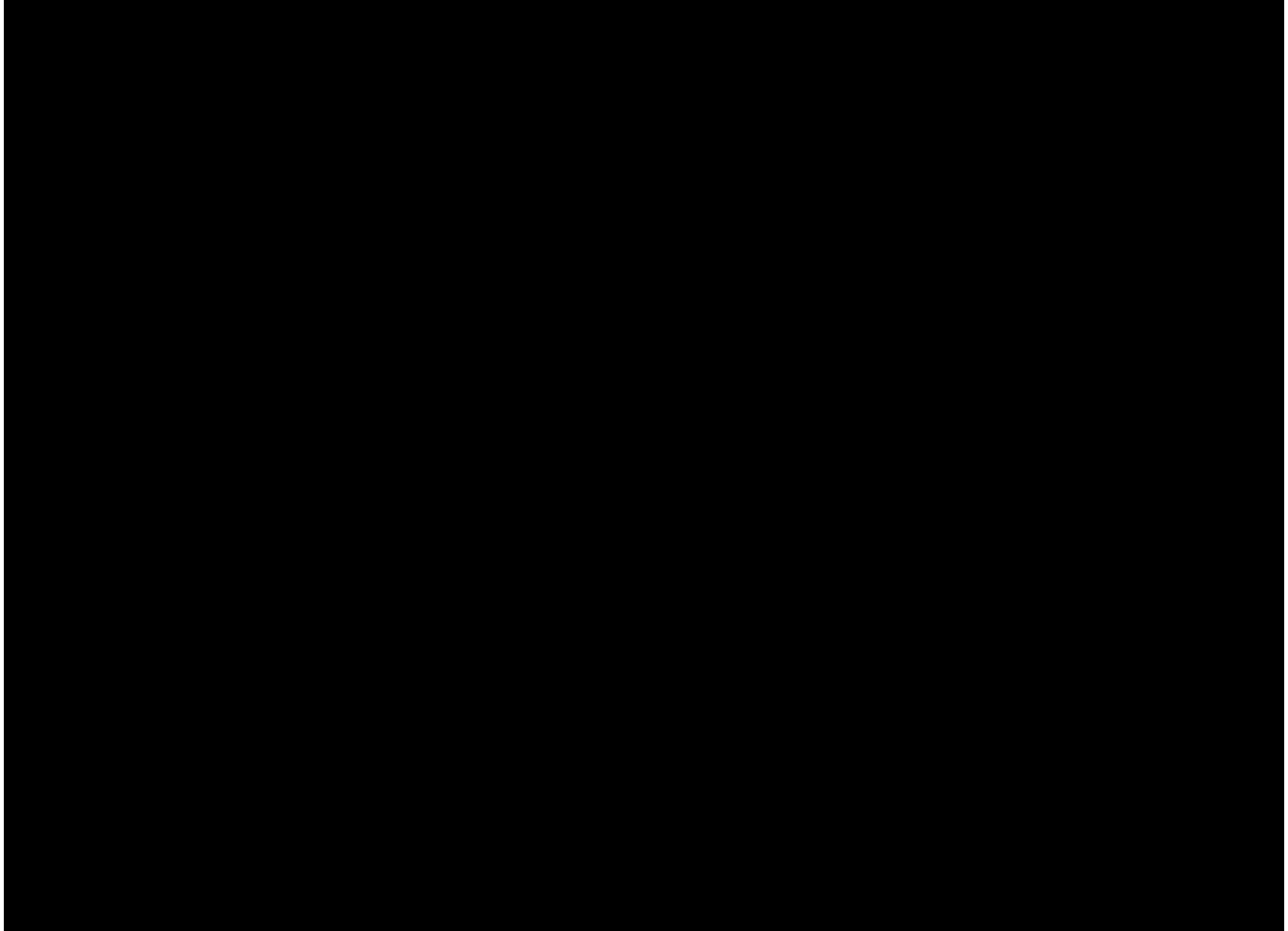
With operational support available 24 hours a day, seven days a week, staff constantly monitor the performance and availability of the system. Using sophisticated monitoring hardware and software, connections are automatically tested every five minutes to validate that the systems are performing as expected for our customers and the pharmacies that rely on us to process their claims.

The internal and external network connectivity between data centers and external clients has various services that can be accessed through different channels, depending upon the specific client needs. Most services, such as the RxClaim Web interface and SFTP file transfer, are inherently secure and can be utilized over the internet. For an additional layer of security, a VPN connection can be established to the client site. Finally, some clients establish permanent connectivity, through a leased line, such as a T1, or MPLS connection. We maintain primary and Hight Availability (HA) systems in our primary data center with a separate Disaster Recovery (DR) site which houses our DR systems. We can operate in full production mode independently on our primary, HA or DR systems. Data is continuously synchronized between systems and sites, and



Optum Rx switches on a regularly scheduled basis between primary, HA and DR sites to perform maintenance and to confirm the high availability of the systems.

Below depicts Data Network Connectivity showing the network connection rules for communicating with external information systems to support internal and external connectivity and pharmacy claims processing.



Hardware

We currently run our operation on a set of IBM System i Power 9 Processors, Model 9080-M9S. These systems and our applications are extremely scalable and can be easily expanded with additional data storage capacity, memory, and processors to accommodate future growth.

Software

Our claim processing system is built using a collection of proven software technologies that contribute to its security, scalability, flexibility and ease of deployment. These technologies include:

- The current release operating system (proprietary to the iSeries hardware platform) is OS/400 V7R4M0.R.



- The DB2 relational database (a full-featured DBMS) supports industry-standard data access methods and all industry standard features for journaling, commitment control, and similar functionality.
- We utilize Syncsort Technologies' MIMIX 10.1 software to replicate for the RxClaim database to an identical second IBMi machine which serves as our backup/High Availability machine, plus we also use IBM Hardware replication to a system located at our remote business continuity facility (hot-site backup). This configuration allows for recoverability for both equipment and site failures.

Security Measures

We have constructed our IT infrastructure using industry-leading technology in: firewalls, data interchange, end point and email data security solutions, as well as multi-factor authentication. During implementation, our team works with the customers to confirm secure access to our systems and make certain that, when it comes to data interchange, our numerous options (for example, SFTP, PGP and Network Data Mover) are compatible with operating procedures.

We are able to offer a high degree of security because we have made significant investments in infrastructure technology to meet the demands of our customers. A few examples include:

- Our GIS product, from the IBM/Sterling Corporation, is our enterprise Multi-Enterprise Services Architecture (MESA) for data exchange. In a nutshell, MESA means that we have a single platform and toolset that allows us to cover nearly any conceivable form of B2B communication with our customers. This includes support for multiple protocols, various operating systems, business applications, platforms, and communication adapters. With this technology in place for our applications, data exchange is handled only through the Sterling MESA. This affords us great reliability, audit ability, flexibility, and ease of operations in a multi-protocol environment. The best part of the equation is that the customer does not need to do anything different from or outside of their standard operation procedures to enjoy the benefits and protection that MESA provides.
- Our commitment to providing a wide variety of Web Services allows the State to securely connect your systems to our systems and databases to allow for true real-time integration. Also, our web portals are built on state-of-the-art security software with Multi-factor authentication, providing a safe online experience for users.

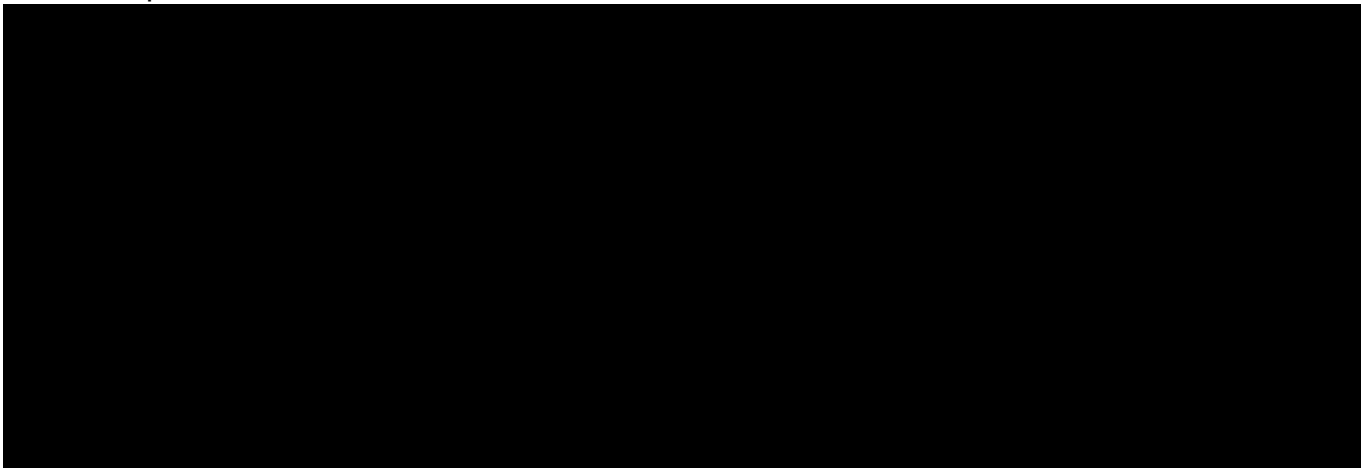


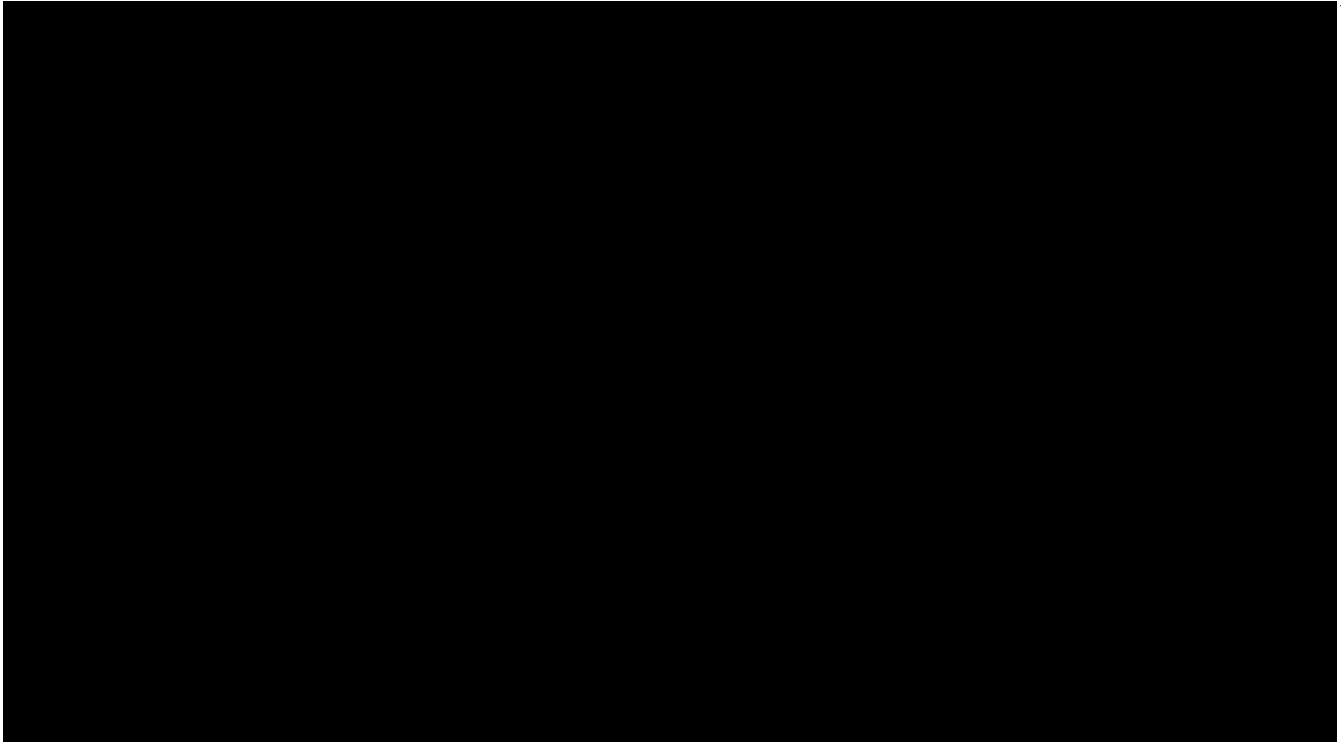
33.	Bookmark Title: <u>MSQ33 – Staffing</u> Narrative description is limited to five (5) pages, exclusive of organizational chart(s) and Subcontractor contract(s) or letter(s) of agreement, if applicable. Provide a narrative description of the proposed staffing plan that details policies, plans and staffing strategies. The proposed plan must include the following: a. Organizational charts that provide a complete and detailed description of the proposed organizational structure the Supplier will use, including Subcontractors and how they fit into the Supplier's overall organizational structure. b. Roles and responsibilities of staff. c. Job titles and the requisite qualifications, skills, and credentials, including clinical licensures relevant to this Contract. If Subcontractors will be used, provide the following: a. Subcontractor's name and address. b. Roles and responsibilities to be delegated to the Subcontractor for purposes of this Contract. c. Subcontractor's qualifications to perform these roles and responsibilities. d. Copy of the Subcontractor contract; the State will accept a letter of agreement with a prospective Subcontractor pending formalization of a final contract with details relevant to "c" in this section. Refer to Attachment F - Pharmacy Benefit Administrator Services Scope of Work and Attachment C - Common Scope Requirements and Security Standards, Sections 2.15 Staff Management and 3 Staffing.
Supplier Response MSQ33 Our approach to forming your Account Management team is built from over 18 years of experience in implementing and managing the unique demands of FFS Medicaid PBM programs. We leverage our immense experience in the FFS Medicaid PBM space to structure the account management team with the best mix of technical, management and clinical staff to support the PBA program. Our staffing model emphasizes training and education, employee satisfaction, and planning for personnel improvement to support low employee turnover rates, engagement, and commitment to assigned projects. We place the right people on the right tasks at the right time through a thorough roles and responsibilities review associated with major project milestones and deliverables. Finally, we integrate required key personnel to facilitate knowledge acquisition, knowledge transfer, and team building. We consult with the State regarding any unplanned change to key personnel and we provide 30 days advance notice of any planned changes. Additional characteristics of Optum Rx FFS Medicaid account management teams include:	



- Local Presence - We understand what it takes to operate State pharmacy programs in virtual, in-person, and hybrid work environments. There is, however, no substitute for face-to-face meetings and we assign local core Account team resources wherever possible. In addition, the trust and professional relationships our teams make in their own communities is a recipe for creating successful partnerships with States.
- Reach within the organization – Your Account Teams are extremely self-sufficient, however, they rely on getting work done through internal business partners within our organization. We assign account team resources who have fostered these critical relationships and have the “reach” within our organization to comprehensively deliver world class service to the State.
- Blend of technical and business competency – Your program requirements, overall complexity, and expected integration with other groups underscore the importance of selecting account team members with the right skill sets and experience. Your account management team understands FFS Medicaid, your program’s unique requirements, your policies, and possess the technical background to drive and support solutions impacting your PBA program.
- Leadership support – While your Account Director is the State’s primary contact, the entire team is an extension of the State pharmacy team and works one on one with other State team members daily. In addition, Optum Rx assigns an Executive Sponsor and VP of Account Management to both support our account management team and your program. Our executive team is available to your Leadership to help facilitate critical program initiatives and for any issues requiring escalation beyond the core account management team.

In GA the proposed account management team will continue their exemplary service to the State, to your providers, and to your members, assuring continuity and reducing the risk for disruptions. In GA, for example, the Account Team has primarily been together since 2006 and has received top scores year over year from the State on the annual Optum Rx Client Satisfaction Survey and through informal feedback opportunities. See below for examples of what State clients are saying about our Optum Rx account teams.





It is critically important that the State is satisfied with all staff assigned to PBA services and we look forward to continuing and developing our strong, long-term relationship.

MSQ33,a, b and c

Please refer to the PBA Exhibit Section, MSQ33,a,b,c - Staffing.pdf of our proposal response.

MSQ33,a, b, c and d (Subcontractors)

We are not using any subcontractors on the PBA Module.



- 34.** Bookmark Title: MSQ34 – Roles and Responsibilities
Narrative description is limited to four (4) pages.

Describe your understanding of your role and responsibilities in the project, your relationship to the other resources and stakeholders involved, including the State's Project Management Office (PMO), or equivalent unit, Clinical Management vendor, Fraud, Waste, and Abuse Audit Services vendor, Pharmacy Drug Rebate Services vendor, Independent Verification & Validation (IV&V) vendor, Data Source vendors (e.g., Operational Data Store or Data Warehouse), and legacy Medicaid Management Information System (MMIS) vendor.

Describe how you will collaborate and provide leadership among the various resources and stakeholders and provide examples of past successes in a similar environment.

Refer to Attachment C: Common Scope Requirements and Security Standards.

Supplier Response

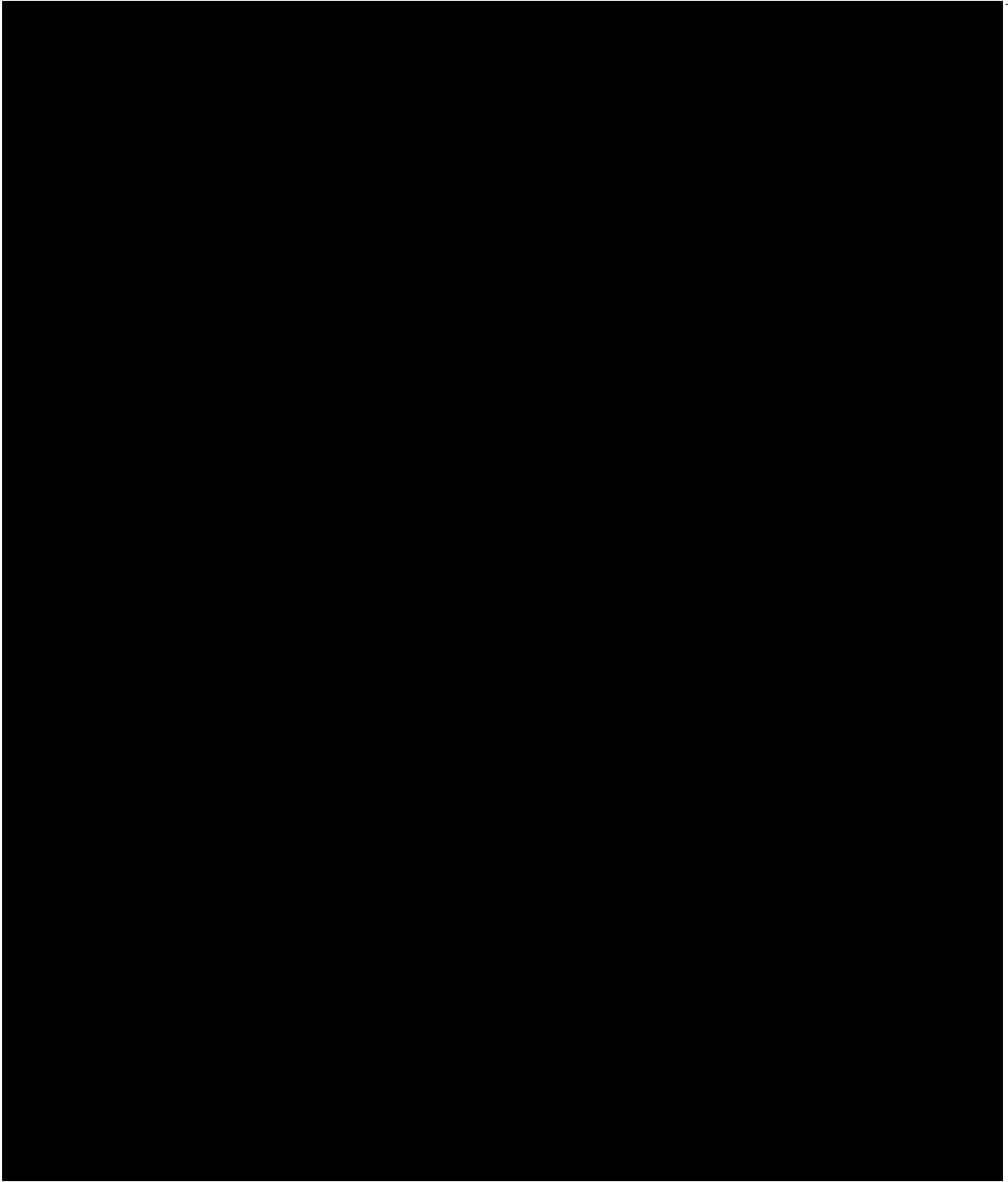
MSQ34 - Roles and Responsibilities

Roles and Responsibilities

As the Pharmacy Benefit Administrator (PBA), we understand our responsibility is to implement and operate your FFS Medicaid Pharmacy program as directed by the State and in alignment with the commitments contained within this proposal and resulting contract. We notice the distinction the State makes by using the term, 'PBA' instead of 'PBM' for this opportunity. While we are responsible for providing expert recommendations and consultation for your program areas such as PDL development, POS claims processing, PA and Finance, our role is to be the 'Administrator' of your FFS Medicaid Pharmacy program. To that end, we only execute changes to utilization management, SMAC rates, PA criteria, and other program components at the express approval of the State.

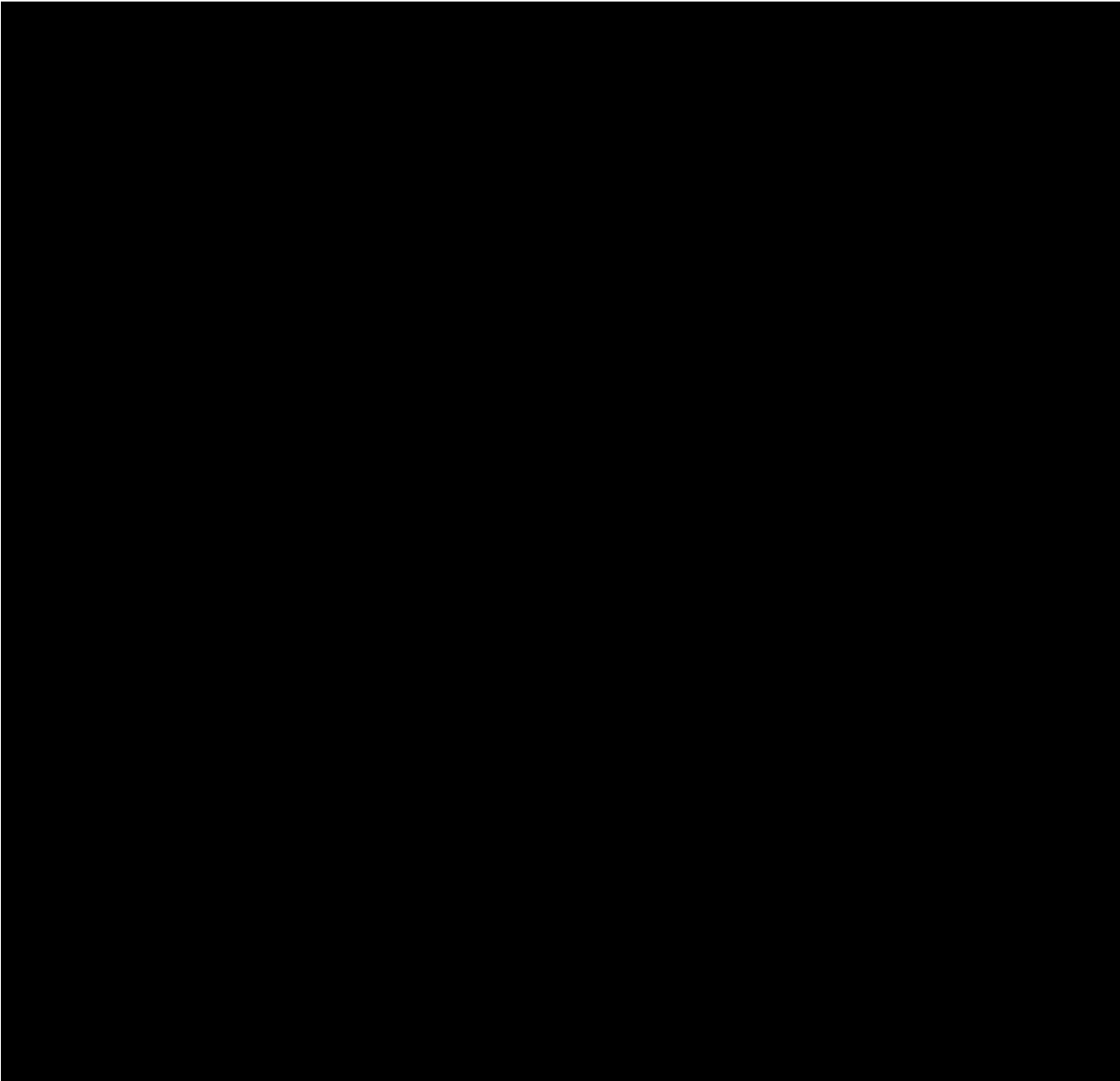
Our experience as the PBA vendor in GA and other States requires a high level of integration with State teams such as: Pharmacy, Program Integrity, Finance, Eligibility IT, Project Management Organization PMO, and Provider enrollment to name a few. A modular solution has the potential for requiring multiple organizations to work together to accomplish common state Medicaid program objectives. Optum Rx has proven time and time again that we work in a spirit of partnership with other vendors and State teams to accomplish the mission. We always make sure coordination with other State teams includes participation from a member of the Pharmacy Team and we encourage other teams to do the same.

Although the PBA solution can be different from State to State, there is usually a high degree of integration and coordination required with other State vendors and external entities for data exchanges, process handoffs, and joint meeting responsibilities. Figure 16: PBA Integration in the Overall MEST highlights the complex level of integration and dependencies tied to the FFS Medicaid pharmacy solution.





While Optum Rx is proficient in partnering with other vendors and stakeholders, a single vendor for multiple modules permits the most cohesive model and strategy. For example, Optum Rx clinicians are able to strategize with the Optum Rx rebate team to determine the best approach for PDL management and potential utilization management criteria that can be negotiated for use with specific rebates. In addition, if Optum Rx also holds the PreCheck MyScript scope, our clinicians are able to develop utilization management criteria (including automated processing) with understanding of our system capabilities allowing us to make the most prudent recommendations.







35. Bookmark Title: MSQ35 – Project Stages and Phases

Bookmark Title for Supporting Material:

- MSQ35.1 – Best Practices
- MSQ35.2 – Lessons Learned

Narrative description is limited to five (5) pages, exclusive of required supporting material.

Demonstrate your understanding of the Project Stages, Project Phases, timeline, expectations, and responsibilities as outlined in Attachment C - Common Scope Requirements and Security Standards, Section 2.2 Project Stages and Project Phases. If your plans for the proposed services differ from the suggested outline, please explain the differences, how the proposed plan is a better fit for the State's needs.

Include best practices and lessons learned that may be applied in the execution of these services and identify any additional proposed Milestones for the project.

Supplier Response

MSQ35 - Project Stages and Phases

Optum Rx's Project team utilizes the Project Management Institute (PMI) methodology, defined in the Project Management Body of Knowledge® (PMBOK), as the overarching framework for Client Implementations. We add, alter, or remove components depending on the scale of the project, the mechanisms used by client, and overall judgement of what works best for each phase of the project.

Optum Rx's Implementation phases closely align with the outlined data in Attachment C, section 2.2.

Optum Rx is prepared to submit a proposed Microsoft Project work plan within 10 business days from contract effective date. A representative Work Plan includes all operations phase activities and assigned responsible parties, as represented in the **PBA Exhibit Section, 37.1_2 - PBA Work Plan.pdf of this proposal.**

Our Project Work Plan includes, but is not limited to:

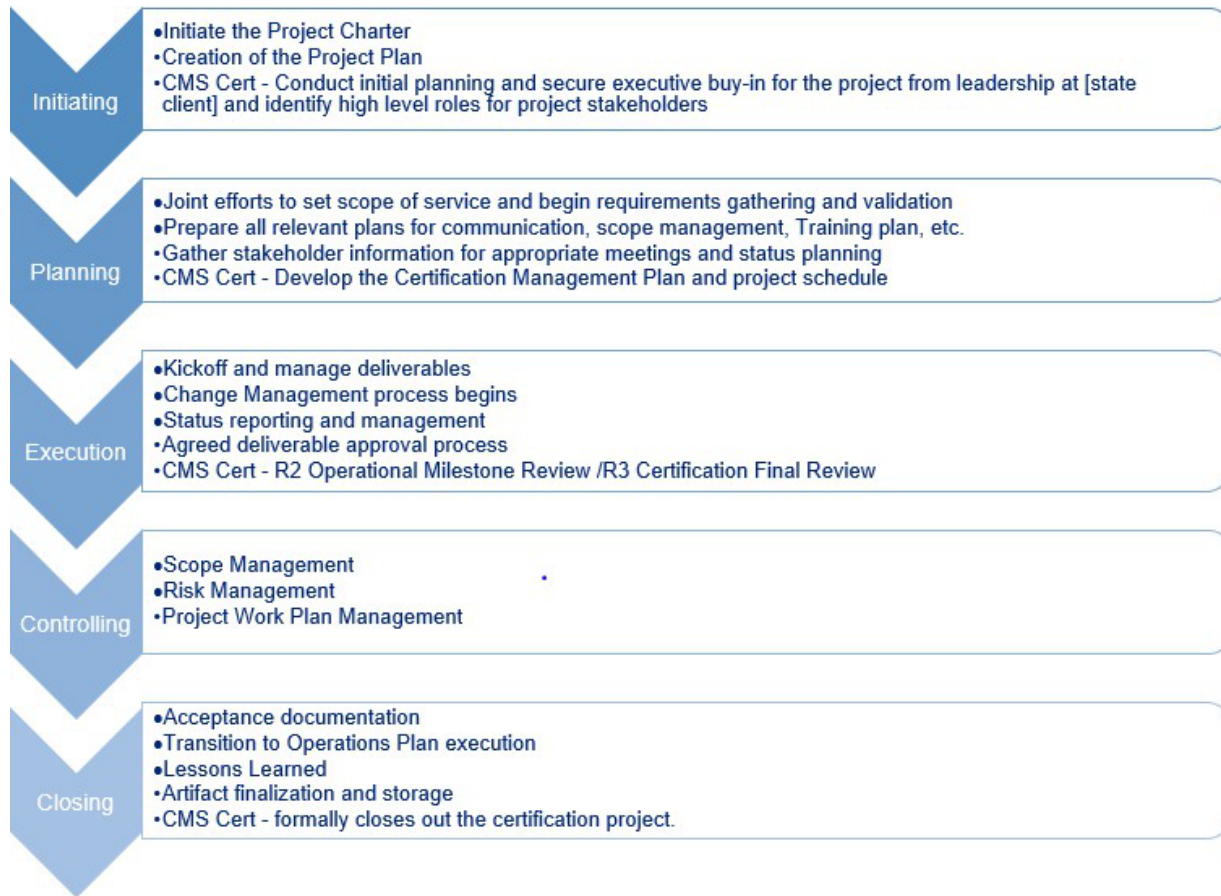
- Project timeline
- Resource loading
- Milestones and dates
- Critical path
- Dependencies
- Dates for submittal of deliverables



The following figure is a sample Project Plan representing milestones and key implementation phases.

Task Name	Duration	Predecessors	Start	Finish
RFP Project WBS	426 days		Wed 6/1/22	Wed 1/17/24
Key Milestones	301 days		Fri 8/5/22	Mon 10/2/23
PROCUREMENT INITIATION AND PLANNING	0 days	28	Fri 8/5/22	Fri 8/5/22
DDI INITIATION AND PLANNING	0 days	85	Tue 9/6/22	Tue 9/6/22
SOLUTION PLANNING COMPLETE	0 days	123	Tue 10/25/22	Tue 10/25/22
SOLUTION CONFIGURATION DESIGN	0 days	197	Tue 12/13/22	Tue 12/13/22
SOLUTION CONFIGURATION BUILD	0 days	259	Tue 1/31/23	Tue 1/31/23
SYSTEM INTEGRATION TESTING COMPLETE	0 days	340	Tue 4/11/23	Tue 4/11/23
SOLUTION USER ACCEPTANCE TESTING COMPLETE	0 days	355	Tue 4/4/23	Tue 4/4/23
SOLUTION OPERATIONAL READINESS COMPLETE	0 days	360	Tue 4/11/23	Tue 4/11/23
DEPLOY TO PRODUCTION COMPLETE	0 days	381	Mon 4/17/23	Mon 4/17/23
MAINTENANCE AND OPERATIONS	0 days	387	Mon 10/2/23	Mon 10/2/23
Implementation Plan	349 days		Wed 6/1/22	Mon 10/2/23
▷ PROCUREMENT INITIATION AND PLANNING	48 days		Wed 6/1/22	Fri 8/5/22
▷ DDI INITIATION AND PLANNING	35 days		Wed 7/20/22	Tue 9/6/22
▷ SOLUTION PLANNING	35 days		Wed 9/7/22	Tue 10/25/22
▷ SOLUTION CONFIGURATION DESIGN	35 days		Wed 10/26/22	Tue 12/13/22
▷ SOLUTION CONFIGURATION BUILD	35 days		Wed 12/14/22	Tue 1/31/23
▷ SYSTEM INTEGRATION TESTING	85 days		Wed 12/14/22	Tue 4/11/23
▷ SOLUTION USER ACCEPTANCE TESTING	45 days		Wed 2/1/23	Tue 4/4/23
▷ SOLUTION OPERATIONAL READINESS	50 days		Wed 2/1/23	Tue 4/11/23
▷ DEPLOY TO PRODUCTION	54 days		Wed 2/1/23	Mon 4/17/23
▷ KMS: MAINTENANCE AND OPERATIONS	120 days		Tue 4/18/23	Mon 10/2/23
CMS Certification	390 days		Thu 7/21/22	Wed 1/17/24
▷ Phase 1: Initiation	25.5 days		Thu 7/21/22	Thu 8/25/22
▷ Phase 2: Planning	147.5 days		Thu 7/21/22	Mon 2/13/23
▷ Phase 3: Execution	268 days		Mon 1/2/23	Wed 1/10/24
▷ Phase 4: Project Closeout	5 days		Thu 1/11/24	Wed 1/17/24

All project deliverables, as well as milestone dates and key dates are contingent upon the State's approval.



Transition to Operations

Optum Rx participates in an Operation Readiness Review (ORR) prior to solution implementation. Before the final transition can take place, the following tasks are completed by our project management team and approved by the State:

- Execution of the data conversion and migration activities described within the Data Conversion Plan
- Execution of the activities described within the Testing, Validation, and Operational Readiness Plan including contingency plans for mitigation of risks, managed according to the Risk Management Plan
- Demonstration of the Disaster Recovery process and procedures prior to implementation
- Demonstration of the system operation at the performance levels specified by the State
- Demonstration that all the system access and security measures of the System Security Plan are in effect at the point of system implementation
- Execution of the Project Communication Plan
- Execution of the Implementation Plan



- Review and approval by the State at designated checkpoints during the implementation process

Turnover Activities

Upon completion of Optum Rx's contract for the State, we will work closely with the incoming vendor and the State to provide a controlled turnover of data, documentation, file layouts, and non-proprietary code, at no cost to the State and based on the turnover plan provided during implementation of the project.

We fully understand our responsibility to coordinate an orderly transition of work and ensure the accuracy of data in collaboration with the State, and the incoming vendor.

An initial turnover plan is submitted to the State 12 months prior to the end of the contract. We will submit a written report to the State prior to the end of the contract detailing the status of any open work orders at that time. We will develop and provide the State with a finalized turnover work plan, based on your comments to the initial turnover work plan. The approach to contract turnover is similar to our prove and effective implementation approach; close collaboration with the State, and the incoming vendor to ensure minimal impact of services to your members.

During a turnover plan from Optum Rx to the successor vendor or the State, appropriate reporting and status updates are provided throughout the turnover process and in closing. We use the standard suite of reports to bring transparency of the project to the team and work partnership with the successor vendor and the State to agree on the reporting that will be most helpful to the entire turnover team. This process will include but may not be limited to:

- Overall project health
- Project work plan updates, including a summary of updates and activities for the reporting period and scheduled and anticipated activities for the upcoming reporting period
- Plan updates for the reporting period
- Escalated risks and risk avoidance responses for the agreed reporting period
- Escalated issue and issue resolution plans for the agreed reporting period
- Deliverable updates for the agreed reporting period
- Technical assistance from all relevant areas of the business
- All standard policies, procedures, and documentation are tracked for appropriate transition to the successor vendor and the State
- Training plan to include training areas as well as training material

To ensure a successful turnover plan, we leverage our proven project management standards. This includes but may not be limited to a full and capable project plan, risk planning, communication planning, training needs, documentation requirements, and overall project health reporting.



All departmental areas work through the transition of the project to the incoming vendor. By approaching the turnover plan in the same way as the takeover plan, we can deliver a smooth transition to the new vendor.

MSQ35.1 - Best Practices

Please refer to the General Exhibits Section, Best Practices.pdf of our proposal response.

MSQ35.2 - Lessons Learned

Please refer to the General Exhibits Section, Lessons Learned.pdf of our proposal response.



- 36.** Bookmark Title: MSQ36 – SDLC & Transition Activities
Bookmark Title for Supporting Material: MSQ36.1 – Cutover/Transition Plan
Narrative description is limited to five (5) pages, exclusive of required supporting material.
- Describe your recommended Software Development Life Cycle (SDLC) that covers all Project Stages and Project Phases. Please include how you plan to develop and test your plan to meet the requirements of providing all the PBA services and operating a CMS-certified Solution (hardware and software).
- Describe how you will handle the transition activities from the incumbent PBA vendor. Include the value-add of your approach and techniques in terms of cost savings, quality improvement, and/or savings to the project schedule to the State.
- Refer to Attachment C - Common Scope Requirements and Security Standards, Section 2.2 Project Stages and Project Phases and Section 6.2 Security Requirements.

Supplier Response

MSQ36 - SDLC & Transition Activities

Optum Rx has thorough testing and code promotion procedures in place that comply with the Software Development Life Cycle (SDLC) best practices from organizations like the Institute of Electrical and Electronic Engineers, Inc. (IEEE®), National Institute of Standards and Technology (NIST), and the Project Management Institute (PMI®). We maintain separate development, testing, and production environments to facilitate a well-managed SDLC. There is a set of controls in place to ensure code promotion and system deployments are thoroughly documented, and deployment procedures are tested before being promoted to production.

Optum Rx has procedures in place whereby system implementation is transferred to a deployment team who follow the deployment documentation to promote new code and data into production. These controls are available for the State's review upon request. Within the implementation procedure, Optum Rx ensures that system changes are reviewed and approved prior to being promoted into production.

Optum Rx's Development Policy includes strict version control procedures that establish full regression testing as the standard. Regression tests are performed whenever a code change or new software version is installed. It also includes maintaining an established baseline of test cases that are executed before and after each update to identify differences. The SDLC supporting workflow is backed using issue and project tracking software, source control, and a central automated build server.

All software artifacts, including applications, back-end systems, and modules, are clearly defined in their specifications and are appropriately versioned throughout. Features are tracked by product version, including all supporting use cases and test cases, and are cross-referenced back to the original requirements.

We conduct tests to meet system and configuration requirements. We work closely with the State to develop a comprehensive test plan and approach, inclusive of requirements, clear tasks, timelines, accountabilities and results. This plan is managed by a testing lead and a testing team



that is responsible for all testing. Deliverables are monitored, tracked and executed on time and to your satisfaction.

Testing Phases and Objectives

Each testing phase builds upon each of the previous phases, concluding with end-to-end testing in a client accessible test environment that simulates the PBA experience by validating the State, stakeholders and member experience.

The major phases of our testing are highlighted below:

Planning and Governance (Optum Rx, the State)

- Develop a comprehensive testing plan, process and timeline to support the business and technical objectives.
- Execution - System / Quality Assurance Testing (Internal-Optum Rx)
- Design and execute internal quality assurance (QA) to test any the State customizations and configurations meet the documented business requirements. This testing occurs prior to user integration/joint testing with the client customer.
- Execution – User Integration/Joint Testing (External-Optum Rx, the State)
- Design and execute user integration/joint testing between the State and Optum Rx to verify that the expected results, actual results, and the interfaces/file exchanges performs as expected.
- Parallel Testing / Claims Compare (External-Optum Rx, the State)
- Design and execute parallel testing to verify claims adjudication matches previous benefit designs/clinical rules and meets expected outcome Thresholds.
- End-to-End Testing (Optum Rx, the State) An end-to-end test process that enables the State to recreate the pharmacy experience from the health plan, group, member, and provider perspectives prior to go-live.

Planning and Governance

Our upfront planning and test case strategy are critical to the success of any implementation. Early engagement (“shift to the left” strategy) allows for clear expectations and smoother execution throughout the implementation process. We work with the State’s test leads and have early discussions to align on environment alignment and the inputs, outputs, and reporting needs. Our testing lead and testing team oversee planning and execution. The testing team is tightly integrated with the overall implementation lead and has a clear line of sight into the status of the overall implementation, system testing and configuration activities. We also leverage our standard tools and templates for managing the test strategy, execution and reporting. We collaborate with the State to customize and refine the process to meet your unique needs. These tools provide a standard framework along with a playbook and test beds which can be used as a starting point for finalizing the State's testing coverage.

**Key tools we leverage include:**

- Master Test Strategy
- Testing Project Plan
- Document Manage/Versioning Repository for

Testing Artifacts

- Defect Management Process and Tool
- Status Reporting and Metrics

Execution - System / Quality Assurance Testing (Internal)

We spend significant time and resources to support the testing of our infrastructure, code-base, system enhancements and integration points within the adjudication platform. System and QA testing occur internally at Optum Rx prior to starting any of the other testing phases. Our objective provides a quality environment and platform prior to user-integration testing. This testing phase focuses on any custom coding, configuration, or development to support the State.

We use several levels of audit and testing strategies, including the following:

- System/unit/regression testing
- System integration testing
- Internal user acceptance testing

Key tools used for system testing and QA testing include:

- Test bed of test scenario and test data
- Test case templates which include expected and actual results
- Defect tracker and internal triage meetings

Execution – Functional / User Integration (External)

User integration testing starts with joint testing and focuses on those touchpoints between the State and Optum Rx. Prior to moving into user integration testing, we verify the system readiness by conducting a system smoke test (test readiness verification).

The user-integration testing sub-phases include:

- System Readiness/Smoke Test: Verifies the readiness to conduct claim adjudication administration – including system access, interfaces, platform/code and network connectivity.
- Function/Integration: Workstream-level testing to verify configuration and interfaces between the State and Optum Rx function as designed.

Key tools which we leverage include:

- Test bed of test scenario and test data
- Test case templates which include expected and actual results



- Test execution metrics
- Defect tracker and triage meetings

Parallel Claims Compare

During this phase, we review the previously adjudicated claims to confirm member liabilities, group and eligibility loads, network set-up, benefit set-up, clinical/PA/step therapy rules and client pricing fields are in alignment with expected results.

We leverage existing health plan claims history and select a subset of claims, which is mutually agreed upon, to re-adjudicate in RxClaim Suite and verify the results of adjudication.

Key testing tools include:

- Historical claims data
- Dashboard summary results
- Test summary details report
- Defect tracker and triage meetings

End-to-End Testing

During this phase, Optum Rx provides the State secure access to the Client Test Environment (CTE) for the execution of end-to-end testing. CTE is a test eco-system containing RxClaim Suite, Optum Rx ancillary systems, and Optum Rx portals (member, open enrollment). The State has access to the member and open enrollment portals to validate the member experience including but not limited to benefits, PDL, pharmacy search and drug pricing. Testers will also have access to the test claims processing instance to validate and test group and member eligibility, claims adjudication (including accuracy of benefits, network, PDL, PAs, and accumulators), claims extracts, and billing/invoicing. Optum Rx will work with the State to define implementation requirements and design documents. This includes establishing an agreed upon Master Test Strategy document. Requirements and design documents are a pre-requisite for the development of functional and end-to-end test plans, and all test cases will be reviewed and require approval prior to test initiation. Optum Rx will maintain a regular cadence of governance and test meetings that will include planning, test case review, test results, and defect management in accordance with the agreed upon Master Test Strategy. Optum Rx provides testing to verify that we meet all functional and nonfunctional system and configuration requirements. We will collaboratively work with the State to mutually agree upon the scope of the desired validation needed to ensure success. If deemed within the scope of the testing, external user access will be granted to designated users for the duration of the testing period. Optum Rx provides a comprehensive suite of testing to verify that we meet all system and configuration requirements. We support UAT testing as it provides certainty that all pharmacy point-of-sale functions are tested by users, including but not limited to, proper functioning of benefit plans, authorizations, and business rules; the accuracy of claim records and file maintenance; and the format and content of all point-of-sale outputs. The UAT approach should leverage the prior testing activities conducted, such as system and integration testing, as much as possible. UAT is conducted in a controlled and stable environment, where a predictable process for code migration and defect resolution can be managed. As required, external user access will be granted to designated users for the duration of



the testing period. Optum Rx will provide systems and tools necessary to complete all types of testing to ensure proper system operability. We employ both manual and automated tools to support our testing tasks. Optum Rx will work with the State to define implementation requirements and design documents. This includes establishing an agreed upon Master Test Strategy document. Requirements and design documents are a pre-requisite for the development of functional and end-to-end test plans, and all test cases will be reviewed and require approval prior to test initiation. Optum Rx will maintain a regular cadence of governance and test meetings that will include planning, test case review, test results, and defect management in accordance with the agreed upon Master Test Strategy. As applicable for the deployed solution, our implementation model supports working with vendors and system integrators to perform necessary system integration and performance testing prior to Implementation. As applicable for the deployed solution, our implementation model supports working with vendors and system integrators to perform necessary system integration and performance testing prior to Implementation. Optum Rx is experienced in training not only our own staff on new software, but also our clients. We have capabilities to permit test environment demonstrations that will illustrate step-by-step instructions. Optum Rx has experienced trainers for all systems included in the PBA solution. Post implementation, we provide training support for new staff or additional training needs. Our goal is to ensure the State is fully comfortable with using the PBA solution. Optum Rx performs rigorous testing of configuration and system enhancements. All validation is completed in non-production environments that have functionality that mimics the production environment. We maintain various non-production environments, including those for:

- Developer testing
- System testing
- Performance testing, particularly for select high volume mission-critical applications
- Regression testing
- User Acceptance Testing (UAT), specifically on the various application platforms with stringent change management controls.

End-to-end integration testing is performed in this environment for each respective application. Client specific requests (e.g., enhancements that are requested and paid for by the client) may utilize the UAT environment for validation prior to deployment to the production environment. Optum Rx performs rigorous testing of configuration and system enhancements. When applicable, performance testing is completed to ensure the environments ability to handle projected load volumes. We use automated tools to simulate predicted load volumes and evaluate system monitors and telemetry to ensure system stability at increased workloads.

Our professional, clinical, and industry experiences are based on lessons learned over the years and translate to best practices for the State. Our combined expertise includes the consolidation and transition of pharmacy benefits, to and from different providers and vendors, driven by a transition plan which is supported by an array of tools including, but not limited to, a configurable claims processing system, fully transparent pharmacy payment practices, and a modern advanced clinical solution that focuses on driving positive health outcomes for program beneficiaries. Marrying value-driven business administration capabilities with high-quality clinical management capabilities and a cutting-edge benefits platform enables us to provide unparalleled cost-effective



and technologically mature pharmacy benefit solutions. Optum Rx's legacy of providing world class service to the State combined with our highly configurable, installed solutions significantly reduces the transition risk for the State.

[MSQ36.1 - Cutover/Transition Plan](#)

Please refer to the PBA Exhibit Section, MSQ36.1 – Cutover_Transition Plan.pdf of our proposal response.



37.	Bookmark Title: <u>MSQ37 - Project Management</u> Bookmark Title for Supporting Material: ➤ <u>MSQ37.1 - Project Schedule/Project Work Plan (Sample)</u> ➤ <u>MSQ37.2 - WBS tasks and Project Outputs (Sample)</u> ➤ <u>MSQ37.3 - Implementation Plan (Sample)</u> ➤ <u>MSQ37.4 - Quality Management Plan (Sample)</u> ➤ <u>MSQ37.5 - Requirements Management Plan (Sample)</u> ➤ <u>MSQ37.6 - Change Management Plan (Sample)</u> ➤ <u>MSQ37.7 - Risk Management Plan (Sample)</u> ➤ <u>MSQ37.8 - Communications Management Plan (Sample)</u> ➤ <u>MSQ37.9 - Integration Plan (Sample)</u> ➤ <u>MSQ37.10 - Operations & Maintenance Plan (Sample)</u> ➤ <u>MSQ37.11 - Training Plan (Sample)</u> ➤ <u>MSQ37.12 - Cost Management Plan (Sample)</u> ➤ <u>MSQ37.13 - Stakeholder Management Plan (Sample)</u> Narrative description is limited to five (5) Pages, exclusive of required supporting material. Provide a description of the project management approach, including, but not limited to, the methodology and implementation of the system to be used for monitoring and control of scope, schedule, and cost. Additionally, describe any previous experience managing similar projects using the Project Management Lifecycle (PMLC) and Project Management Book of Knowledge (PMBOK) throughout the life of the contract. Refer to Attachment C - Common Scope Requirements and Security Standards, Section 2 Project Organization and Management and Attachment F – Pharmacy Benefit Administrator Services Scope of Work. In the Supporting Material, include a draft or sample project management plan representative of this project. In your narrative response, explicitly identify any differences between the State’s project management approach from your proposed approach, including all responsibilities.
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Supplier Response MSQ37 - Project Management Implementing and executing the State’s multifaceted program requires project management capabilities that are equally extensive and broad-ranging including methodologies necessary for monitoring and control of scope, schedule and cost. We follow PMI® standards and agree with the approach laid out in Attachment C – Common Scope Requirements and Security Standards. We offer our partners a configurable implementation and project management plan based on the RFP scope. Within two weeks of contract execution, we assign an Implementation Project Manager (IPM) and project team who will collaborate closely with your internal project team to develop a custom implementation project plan according to your unique business needs and goals. A representative bio for the IPM is provided below.
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Implementation Project Manager

The IPM assigned to the State is responsible for ensuring project compliance and stakeholder management through the identification of project goals, objectives, and scope. With this data the IPM will create series of project management plans including but not limited to a Work Breakdown Structure (WBS) Project Workplan, scope and change management plan etc. This resource will communicate with all team members of the project and present status updates via weekly status review meetings. They will work in collaboration with clients to present and finalize the project management plan documents.

- Manages the project to the agreed upon project management plan
- Manages risks and issues through mitigation and resolution
- Monitors project the project schedule and presents any deviations to the project teams
- Maintains control of scope, schedule, and budgetary requirements
- Manages the CMS certification process throughout the implementation and the certification phase
- Provides the project structure to the team
- Coordinates and tracks the deliverables activity

The IPM's credentials include:

- 5 years technical project management experience with 3+ years in the healthcare industry specifically in Medicaid and/or Medicare required.
- 3+ years' experience leading projects using SDLC, Agile and Lean methodologies required.
- Management of large-scale health care projects with teams of 10 or more and budgets greater than \$500,000 required.
- Bachelor's degree specializing in business, accounting, finance, or related field.
- PMP Certification required

In addition to product configuration, the project implementation scope includes project planning, project tracking, and regularly scheduled conference calls throughout implementation to assure a successful implementation. All project team members attend regularly scheduled conference calls throughout implementation. The project work plan is a living document updated appropriately throughout the project lifecycle. Optum Rx manages the plan throughout the project and provides periodic updates to the State on a mutually agreed upon frequency.

The project team will refine and elaborate upon the draft project plan following project kickoff to assure the joint project team agrees on resources, tasks, and durations for the transition project. Optum Rx provides updates no less frequently than bi-weekly—sometimes weekly, depending on the project phase.

Our overall approach to project management follows the PMI® PMBOK® Guide.



Our project team members have in depth experience with implementing claims processing solutions and will develop an executive summary and project work plan that will include management of:

- Integration
- Scope of Work
- Cost
- Scheduling
- Quality
- Communications
- Stakeholder

In addition to a comprehensive Project Management Plan, Optum Rx will provide a series of stand-alone management plans that address other critical elements of the project.

As described in the Scope Management Plan above, Optum Rx's project manager works collaboratively with the State's assigned project management team to define, document, control, and manage the scope using the project work plan. The project work plan is a living document updated appropriately throughout the project lifecycle.

Optum Rx aligns with the State interests to drive value to the pharmacy benefit. Our synchronized and transparent approach adds value to the health system and aligns with client goals. Our implementation team and implementation manager employ a customized project management methodology to determine the State's requirements to deliver agreed-upon services.

This methodology describes key project management processes that represent the best practices for managing projects, as described below.

Initiation

The implementation team creates an implementation project plan based on the RFP, proposal, and the participating addendum. The plan includes:

- Products and services to be set up during the implementation
- Roles and responsibilities of the project team

The primary purpose of this documentation is to obtain a mutual agreement of what products and services are included in the implementation. The documentation is completed after the initial internal call with the sales and account-clinical management team. We review this document with new clients during the initial implementation meeting to confirm that the information provided by the sales team is current and accurate.

Planning

Since the majority of activities performed during the implementation process are predefined, the generation of activities may not be applicable, unless the client has custom requirements. In these situations, the implementation project manager generates activities for those custom requirements. This information is documented in the client's project plan.



Determine Roles and Responsibilities

Roles and responsibilities of the project team are pre-defined by the company and industry standards and are published, provided, and discussed with all new customers during the initial external meeting.

Define Activity Dependencies/ Analyze Critical Path

The critical path for a new client implementation is defined by the milestones and tasks that are directly related to those components necessary to adjudicate claims.

The implementation team has critical components and tasks documented based on the timeline of the implementation, depending on the complexity of the plan. The department modifies this document to support an advanced implementation as needed.

Finalize the Plan

This is a standard practice within the implementation team. Project plan templates are broken out by client type. A finalized project plan is generated once all requirements have been determined and discussed.

The project plan is reviewed both internally and externally at the beginning of the implementation process, documenting mutual agreement to the plan.

Additionally, as defined by our implementation team and industry standards, we:

- Develop a risk management plan
- Track and manage the performance of the project
- Perform a post-implementation project review

Please refer to the General Exhibits Section, Project Management Plan (Sample).pdf for a sample project management plan representative of this project.

[MSQ37.1 - Project Schedule/Project Work Plan \(Sample\)](#)

Please refer to the PBA Exhibit Section, 37.1_2 - PBA Work Plan.pdf of this proposal.

[MSQ37.2 - WBS tasks and Project Outputs \(Sample\)](#)

Please refer to the PBA Exhibit Section, 37.1_2 - PBA Work Plan.pdf of this proposal.

[MSQ37.3 - Implementation Plan \(Sample\)](#)

Please refer to the General Exhibits Section, Implementation Plan (Sample).pdf of our proposal response.

[MSQ37.4 - Quality Management Plan \(Sample\)](#)

Please refer to the General Exhibits Section, Quality Management Plan (Sample).pdf of our proposal response.

[MSQ37.5 - Requirements Management Plan \(Sample\)](#)

Please refer to the General Exhibits Section, Requirements Management Plan (Sample).pdf of our proposal response.



MSQ37.6 - Change Management Plan (Sample)

Please refer to the General Exhibits Section, Change Management Plan (Sample).pdf of our proposal response.

MSQ37.7 - Risk Management Plan (Sample)

Please refer to the General Exhibits Section, Risk Management Plan (Sample).pdf of our proposal response.

MSQ37.8 - Communications Management Plan (Sample)

Please refer to the General Exhibits Section, Communications_Stakeholder Management Plan (Sample).pdf of our proposal response.

MSQ37.9 - Integration Plan (Sample)

Please refer to the General Exhibits Section, Integration Plan (Sample).pdf of our proposal response.

MSQ37.10 - Operations & Maintenance Plan (Sample)

Please refer to the General Exhibits Section, Operations & Maintenance Plan (Sample).pdf of our proposal response.

MSQ37.11 - Training Plan (Sample)

Please refer to the General Exhibits Section, Training Plan (Sample).pdf of our proposal response.

MSQ37.12 - Cost Management Plan (Sample)

Please refer to the General Exhibits Section, Cost Management Plan (Sample).pdf of our proposal response.

MSQ37.13 - Stakeholder Management Plan (Sample)

Please refer to the General Exhibits Section, Communications_Stakeholder Management Plan (Sample).pdf of our proposal response.



38.	Bookmark Title: <u>MSQ38 – Audit Laws</u> Bookmark Title for Supporting Material: <u>MSQ38.1 – Identity and Access Management</u> Narrative description is limited to five (5) pages, not including required supporting material. Describe, in detail, your internal or independent third-party assessment (audit) processes for ensuring compliance with HIPAA Privacy and Security Laws, Regulations and Standards, as well as revisions to applicable laws and regulations as they may occur to meet the requirements. The required supporting material must detail the Supplier’s full HIPAA compliance. Refer to Attachment C – Common Scope Requirements and Security Standards, Section 6.2 Security Requirements.
Supplier Response MSQ38 - Audit Laws We are supported by numerous independent assessments performed by well-known independent audit or security firms. We investigate the audit and security firms to ensure assessment practices and protocols are appropriately leveraged and managed independently. We are committed to taking reasonable steps to mitigate and remediate areas of improvement identified in audit findings in accordance with our policies. Our internal monitoring controls, including internal audits, are documented in accordance with our policies, HIPAA, and other applicable state and federal laws. We have taken reasonable steps to mitigate and remediate areas of improvement identified in audit findings in accordance with our policies. MSQ38.1 - Identity and Access Management Please refer to the PBA Exhibit Section, MSQ38.1 – Identity and Access Management.pdf	



39.	Bookmark Title: <u>MSQ39 – ORR Plan</u> Narrative description is limited to five (5) pages. Describe your methods and approaches to meet the Operational Readiness Review (ORR) requirements for PBA services to go-live. The approaches should include, but is not limited to, the following: - Determining the type of readiness review which is appropriate to the Project. - Developing the breadth and depth (scope) of the ORR. - Developing the procedures and conducting an ORR. - Confirming that the necessary infrastructure (procedures, staffing, compliance with the State rules, and other requirements, etc.) is in place. Refer to Attachment C – Common Scope Requirements and Security Standards, Section 6.2 Security Requirements.
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Supplier Response

MSQ39 - ORR Plan

MSQ39,a

Throughout the lifecycle of the DDI, the Project Team, subject matter experts and State subject matter experts will work in collaboration to finalize the ORR plan at least 30 days prior to go-live.

MSQ39,b

The Project team including appropriate State resources will work together to ensure all aspects of the business are covered within the ORR plan that will be developed utilizing requirements and lessons learned throughout the DDI phase of the project.

MSQ39,c

Optum Rx is committed to supporting the State during the transition phase of the project by tracking project processes to include risks, timelines, status reports, and other activities that may be occurring within the Transition Phase, including the development of the completion certification and all associated documentation.

We will supply a mutually agreed upon Transition to Operations Plan to the State that will contain the required components necessary for a full and successful transition with no interruption of services. Our approach to transition processes mirrors our implementation approach. The Transition Plan includes the following components:

- Fully scaled work plan to include scheduled tasks and sub-tasks that will need to be completed
- Operational resource requirements
- Training Plan to include the topic, length of training and as well as a training schedule
- Documented data conversion requirements



- Data migration plan and how data is tested to validate the successful and complete transfer of data

Strategy for processing and validating demographic and identification information prior to start-up uses a one-time data feed including, but not limited to, the following:

- Member, including lock-in and managed care status
- Provider
- Prescribing provider
- Prescription drug limit
- PAs
- Pricing
- Coordination of services
- ORR, at least 30 calendar days prior to production start, by demonstrating to the State's satisfaction that the solution is ready to be deployed.

Demonstration for operational tasks for each functional area including, but not limited to:

- Organization tasks
- Functional responsibilities
- Claims processing
- PDL management
- Drug rebate administration
- Financial management
- Information systems interfaces and operations
- Diabetic supply program (DSP) management
- Samples of input and output for each functional area
- Samples of required reports
- Participation in and evaluation of the ORR enablement of the State to test all system functions

We will adjust the Transition Plan as needed prior to final implementation:

- Transfer of all appropriate documentation
- Transitional plan for current comprehensive policy and procedure manuals

Optum Rx will support and be accountable for the following project/program milestones:

- Obtaining the State signatures for approving user acceptance testing as set forth in the Master Test Plan
- Facilitating the ORR as described in the operational readiness plan



- Overseeing PBM go-live activities as described in the approved ORR plan and detailed in the ORR checklist
- Overseeing demonstration of CMS outcomes during Certification Review, Certification Review Progress Reports, and draft of adjudication of certification criteria as set forth in the CMS Certification Plan

MSQ39,d

Optum Rx's plan will include all State rules, requirements, and procedures that will move into the Operations and Maintenance phase of this implementation. All final ORR documentation will be approved through the requirements approval process defined by the State and in compliance with this RFP.



40.	Bookmark Title: <u>MSQ40 – DR & BC Plan</u> Narrative description is limited to five (5) pages. Describe, in detail, your Disaster Recovery and Business Continuity Plans, including the method(s) you will utilize to ensure the continuity of business operations. Include in your response all services necessary to support and access data during emergency operations for the program and services identified in this eRFP. Refer to Attachment C – Common Scope Requirements and Security Standards, Section 6.2 Security Requirements.
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Supplier Response

MSQ40 - DR & BC Plan

Optum Rx has developed an enterprise resiliency and response program that minimizes client impact from disrupted service in a significant event or disaster, while aiding compliance to published regulatory guidelines. Our business continuity plans focus on critical business functions and planning for the worst-case scenario so we can react quickly and efficiently, adding value to our business and clients through effective risk reduction, compliance with industry, contractual and regulatory standards, and safeguarding of operations and assets.

Optum Rx's business impact analysis and subsequent business continuity plans are written to accommodate the following four scenarios:

- Loss of Facility: Complete interruption of facilities without access to its equipment, local data and content. The interruption may impact a single site or multiple sites in a geographic region. Recovery from anything less than complete interruption is achieved by using appropriate portions of the plan.
- Loss of Critical Resources: Complete interruption with 100 percent loss of personnel within the first 24 hours and 50 percent loss of personnel long-term. The interruption may impact a single site or multiple sites in a geographic area. Recovery from anything less than complete interruption is achieved by using appropriate portions of the plan.
- Loss of Critical Systems: Complete interruption or access of critical systems and data located at the various Optum Rx data centers for an extended period of time. Recovery from anything less than complete interruption is achieved by using appropriate portions of the plan.
- Loss of Critical Vendors: Complete interruption in a service or supply provided by a third-party vendors. Recovery from anything less than complete interruption is achieved by using appropriate portions of the Plan.

The impact of the operational loss due to one, or all, of these scenarios is assessed as part of the original business impact analysis and annually thereafter. Business continuity plans are updated at a minimum of twice annually and tested annually.

Business continuity plans are leveraged when needed to address all forms of emergencies, which may impact business operations including short and long-term events. Examples of short term



events include power outages and winter-weather office closings. These plans have also been invoked to address more severe, long-term situations, such as building fire and major hurricanes.

Business functions classified as critical generally provide for near immediate failover of core services by leveraging geographically dispersed, redundant operations and maintaining a recovery time objective of 72 hours or less. The plans are written to respond to a disaster lasting a minimum of 90 days.

Disaster Recovery Plan

Our Enterprise Disaster Recovery Program anticipates and plans for the common types of disasters by designing solutions to address them. Disaster protection addresses recovery from the most probable disaster scenarios to the worst-case scenario. Highlights of the disaster recovery protection components include:

- Optum Rx data centers allow system administrators to monitor and manage data centers by remote control (lights-out mode) for up to three days. Additionally, our plans with redundant suppliers provide for continuous fuel deliveries, allowing the data centers to run in this mode indefinitely.
- Recovery solutions have active-active and active-standby components located in two geographically separate data centers, where either site can support the production application in the event of a disaster with minimal manual intervention.
- Multiple recovery designs use various methods for storage, SAN or native database replication. These solutions use asynchronous data replication between the production and geographically dispersed recovery data centers.
- Some distributed systems employ recovery from media using failover of production to geographically separate non-production systems using virtual tape data restoration.

Each critical application has a disaster recovery plan that is refreshed and tested at least annually.

Optum Rx relies on a diverse array of interconnected information systems to meet our customers' needs. The goal of disaster recovery planning is to protect the organization in the event that all or some key aspects of our operations are unusable. Preparedness is the key. First, our Enterprise Disaster Recovery Program eliminates or reduces disaster recovery risk in critical technology areas, and then it plans for timely, predictable restoration of key applications, data and supporting critical infrastructure.

The mission of the Enterprise Disaster Recovery Program is to minimize the aggregate risk and impact to Optum Rx from the occurrence of disaster recovery events. These Enterprise Disaster Recovery Program objectives support this mission by:

- Providing a systems solution that accommodates the interdependencies between business processes and applications
- Establishing disaster recovery requirements as part of our systems architecture, delivery and operations as opposed to as an afterthought once a new application goes into production



- Developing and deploying a modular, adaptive set of capabilities, rather than one-size-fits-all solutions
- Considering the most probable disaster recovery scenarios in addition to worst-case scenarios

We tailor client-specific disaster recovery plans to the unique needs of each client if an interruption of services occurs. The State disaster recovery plan includes:

- Purpose and Executive Summary
- Program Overview
- Application and Recovery Overview
- Recovery Contacts
- Recovery Requirements
- Recovery and Validation Procedures
- Non-production Recovery Strategy
- Exercise Plan
- Exercise Results Summary
- Supplemental Information
- Approvals

Lifecycle Maintenance

Existing disaster recovery plans follow standard lifecycle maintenance, which we update as changes occur to the applications or associated systems and at least annually. The dedicated management team and enterprise disaster recovery team validate the plans.

We review the plans to identify:

- Equipment updates
- Recovery or validation process changes
- Employee changes or changes in responsibilities
- Changes in business requirements not reflected in specific plans

Business Continuity

UnitedHealth Group has both Business Continuity Plans and Disaster Recovery Plans in place to minimize client impact in a significant event or disaster, while aiding compliance to published regulatory guidelines. Our plans are developed to address all natural and human-caused disasters (e.g., hurricanes, floods, fires, terrorism, and pandemics). The program focuses on critical business functions and systems and planning for the worst-case scenario so that we can react quickly and efficiently, adding value to our business and customers through effective risk reduction, compliance with industry, contractual or regulatory standards, and safeguarding of our operations and assets. Business continuity plans are part of UnitedHealth Group's overall



Enterprise Resiliency & Response program designed and structured to respond to disaster events, restore critical business function processes, and resume normal business function operations in a prioritized manner. These worst-case scenarios cover impacts from all types of disasters, both natural and human-caused. The following scenarios are provided as planning recovery objectives:

- Loss of Facility
- Loss of Critical People
- Loss of Technology
- Loss of Vendor

Business functions classified as critical generally provide for near immediate failover of core services by leveraging geographically dispersed, redundant operations and generally maintain a recovery time objective of 72 hours or less. The plans are written to respond to a disaster lasting a minimum of 90 days. UnitedHealth Group's critical business functions include, but are not limited to, customer and provider call services, claims processing services, clinical and pharmaceutical services, banking operations, and core corporate functions.

A variety of business continuity strategies are deployed depending on the business function, criticality ranking, and established recovery time objectives.

- Remote working
- Resilient operations
- Multiple shifts
- Buddy up
- Off-loading
- Displacement
- A "do nothing" strategy may be acceptable for certain non-urgent functions identified in the business impact assessment

In addition, a Disaster Recovery plan must be developed and maintained for each business application identified as critical in a Business Continuity Plan in order to support the needs of critical business processes and functions in the event of a disaster. The procedures for execution of such a capability are documented in a formal Disaster Recovery Plan, which is reviewed at least annually and updated as necessary by the Application DR Coordinator or Service Level Owner, in conjunction with the Enterprise DR Services DR Coordinator.



41.	Bookmark Title: <u>MSQ41 – Post-Implementation Experience</u> Narrative description is limited to five (5) pages. Describe, in detail, your experience and expertise in conducting post-implementation CMS Certifications for projects of similar scale and complexity. Include information on the number of certifications performed, industry sectors, and any relevant certifications or accreditations held by your team members. Refer to Attachment C – Common Scope Requirements and Security Standards, Section 6.3 Certification Requirements.
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Supplier Response

MSQ41 - Post-Implementation Experience

Optum Rx understands the impact and importance of obtaining CMS certification for the State's Medicaid pharmacy solution and maintains the related tasks, resources, and schedule within the overall project workplan. We have never failed to meet CMS certification for our customers where required. In 2008, Optum Rx successfully achieved CMS certification for the GA FFS Medicaid Pharmacy system retroactive to the go-live date. Optum has gone on to achieve certification for 12 additional states including: Illinois, Indiana, Iowa, Maine, Nevada, Ohio, South Dakota, Tennessee, Utah, Vermont, Washington, and Wyoming.

In each of these certifications, we have demonstrated compliance with federal security and technical standards as well as with state-specific requirements. Our CMS certification and project management team has experience and knowledge directly related to the Medicaid Certification Life Cycle (MECL), the Medicaid Enterprise Certification Toolkit (MECT), and the Outcomes-Based Certification (OBC) process identified for Electronic Visit Verification modules.

Moreover, in December 2020, we completed the CMS OBC for the State of Tennessee's pharmacy system, making it the first state to achieve the certification under the newer CMS OBC model and to obtain 75 percent federal financial participation.