PREPARED FOR THE STATE OF IOWA,
IOWA MEDICAID ENTERPRISE

RESPONSE TO PROFESSIONAL SERVICES REQUEST FOR PROPOSAL
(RFP) MED-10-001: PHARMACY MEDICAL SERVICES COMPONENT

TECHNICAL PROPOSAL
ORIGINAL

Small Company. Big Results.
Quality Partnerships.

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

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Submitted on December 10, 2009

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This proposal has been formatted for double-sided printing.

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7.2.2 TRANSMITTAL LETTER

December 10, 2009

Mary Tavegia
Issuing Officer
Iowa Department of Human Services
Iowa Medicaid Enterprise
200 Army Post Road, Suite 2
Des Moines, Iowa 50315

Dear Ms. Tavegia:

On behalf of Goold Health Systems (GHS), I am pleased to present the State of Iowa with our response to the Professional Services Request for Proposals (RFP) MED-10-001.

Goold Health Systems is a privately-held corporation incorporated in the State of Maine. We are currently registered to do business in the State of Iowa. Our corporation number in the State of Iowa is 281415 and our Federal Employer Identification Number (FEIN) is 01-0475134. I will serve as the primary contact for all RFP-related communications, including any requests for clarification or other communication needed between the IME staff and GHS. My contact information is as follows:

James A. Clair	
Chief Executive Officer	
Goold Health Systems	P: 800.832.9672
45 Commerce Drive	C: 207.242.2715
P.O. Box 1090	F: 207.623.5125
Augusta, Maine 04332-1090	E: jclair@ghsinc.com

As instructed, we have provided one (1) original and eight (8) copies of the proposal, as well as two (2) electronic copies on CD-ROM

GHS makes the following certifications and guarantees regarding this proposal:

- GHS will comply with all contract terms and conditions as indicated in this RFP.
- No attempt has been made or will be made by GHS to induce any other person or firm to submit or not to submit a proposal.
- GHS does not discriminate in its employment practices with regard to race, color, religion, age (except as provided by law), sex, marital status, political affiliation, national origin, or handicap.
- No cost or pricing information has been included in this letter or the Technical Proposal.
- GHS' proposal is predicated upon:
    - the RFP published on September 17, 2009;

  - Amendment 1 received on September 30, 2009;
  - Amendment 2 received on October 2, 2009;
  - Amendment 3 received on October 16, 2009;
  - Amendment 4 received on November 12, 2009;
  - Amendment 5 received on November 19, 2009;
  - Amendment 6 received on December 10, 2009; and
  - The updated Answers to Questions received on November 20, 2009.
- GHS certifies that the prices contained in this bid proposal have been arrived at independently, without consultation, communication, or agreement, as to any matter relating to such prices with any other bidder or with any competitor for the purpose of restricting competition; and, unless otherwise required by law, the prices quoted have not been knowingly disclosed by GHS prior to award, directly or indirectly, to any other bidder or to any competitor.
- As Chief Operating Officer of GHS, I am authorized through Power of Attorney to negotiate on behalf of GHS and shall be responsible for the management of any potential contract that may result from this procurement process. As an officer of this company, my signature has the authority to bind any contract that may result from negotiations with the State of Iowa concerning this proposal to provide the Iowa Medicaid Enterprise with Pharmacy Medical Services. I am responsible for the costs being offered in the proposal and have not, and shall not participate in any action contrary to requirement 7.2.2.k, page 293 of the RFP as amended.
- GHS will not be using any subcontractors in the provision of the services contained in this bid proposal.
- GHS is not requesting confidential treatment of any information contained in this bid proposal.
- GHS affirms that the submitted Bid Proposal Security shall guarantee the availability of the services as described throughout this bid proposal.
- GHS acknowledges and accepts all term and conditions stated in the RFP.

We have been honored to be the IME's pharmacy-clinical vendor for the past 5+ years. It is our objective to continue providing the State of Iowa with cost-effective Pharmacy Medical Services solution that will improve clinical outcomes, and increase savings for Iowa tax payers. We have built our pharmacy support systems and services to be scalable, flexible and transparent. We are confident that our solution will continue to meet or exceed the IME's requirements. GHS' business model is based upon 100% transparency. Our only fees come directly from our clients; we receive no remuneration from the drug manufacturing industry.

GHS will carry out all contract responsibilities in the same highly professional and successful manner to which all our clients have become accustomed. Please contact me should you have any questions or need additional information.

Sincerely,

James A. Clair
Chief Executive Officer

7.2.3 Checklist and Cross-References

Bidders will complete three exhibits in each Technical Proposal to confirm their responsiveness to requirements:

- *7.2.3.1 Bid Proposal Mandatory Requirements Checklist*
- *7.2.3.2 General Requirements Cross-Reference*
- *7.2.3.3 Professional Services Requirements Cross-Reference*

7.2.3.1 Bid Proposal Mandatory Requirements Checklist

Bidder Check	Requirement	Confirmed by DHS
X Yes ☐ No	1. Did the issuing officer receive the bid proposal by 3:00 p.m., Central Time, on the date specified in RFP Section 2.1 Procurement Timetable?	☐ Yes ☐ No
X Yes ☐ No	2. Does each bid proposal consist of three distinct parts?	☐ Yes ☐ No
X Yes ☐ No	a. Technical Proposal	☐ Yes ☐ No
X Yes ☐ No	b. Cost Proposal	☐ Yes ☐ No
X Yes ☐ No	c. Company Financial Information	☐ Yes ☐ No
X Yes ☐ No	3. Is each bid proposal sealed in a box (or boxes), with the Cost Proposal and Company Financial Information volumes sealed in separate, labeled envelopes inside the same box or boxes?	☐ Yes ☐ No
X Yes ☐ No	4. Are packing boxes numbered in the following fashion: 1 of 4, 2 of 4, and so forth for each bid proposal that consists of multiple boxes?	☐ Yes ☐ No
X Yes ☐ No	5. Are all boxes containing bids labeled with the following information?	☐ Yes ☐ No
X Yes ☐ No	a. Bidder's name and address	☐ Yes ☐ No
X Yes ☐ No	b. Issuing officer and department's address as identified by RFP Section 7.1.d.2	☐ Yes ☐ No
X Yes ☐ No	c. RFP title (Iowa Medicaid Enterprise Procurement) and RFP reference number (MED-10-001)	☐ Yes ☐ No
X Yes ☐ No	d. RFP component for which the bid proposal is being submitted for consideration (such as Medical Services or Provider Services)	☐ Yes ☐ No
X Yes ☐ No	6. Are separate boxes utilized for each bid proposal if submitting bid proposals for more than one of the individual contract awards?	☐ Yes ☐ No

Bidder Check	Requirement	Confirmed by DHS
X Yes ☐ No	7. Are all bid proposal materials printed on 8.5" x 11" paper (two-sided)?	☐ Yes ☐ No
X Yes ☐ No	8. Is Technical Proposal presented in a spiral, comb, or pasteboard binder separate from the sealed Cost Proposal and Company Financial Information volumes? (Note: Technical Proposals in 3-ring binders will not be accepted.)	☐ Yes ☐ No
X Yes ☐ No	9. Is each Cost Proposal in a spiral, comb, or pasteboard binder separate from the sealed Technical Proposal and Company Financial Information volumes? (Note: This status will be determined when Cost Proposals are opened after Technical Proposals have been evaluated. 3-ring binders will not be accepted)	☐ Yes ☐ No
X Yes ☐ No	10. Is each Company Financial Information in a spiral binder, or comb, or pasteboard binder separate from the sealed Technical Proposal and Cost Proposal volumes? (Note: This status will be determined when Company Financial Information volumes are opened for the financial viability screening. 3-ring binders will not be accepted)	☐ Yes ☐ No
X Yes ☐ No	11. Is one sanitized copy of the proposal volumes included if any bid proposal information is designated as confidential? (Note: Bidders cannot designate their entire proposal as confidential or proprietary.)	☐ Yes ☐ No
X Yes ☐ No	12. Does each Technical Proposal package include:	☐ Yes ☐ No
X Yes ☐ No	a. One original	☐ Yes ☐ No
X Yes ☐ No	b. Eight copies	☐ Yes ☐ No
X Yes ☐ No	c. One sanitized copy (if applicable) in a separate binder (or set of binders)	☐ Yes ☐ No
X Yes ☐ No	d. Are the original, copies, and sanitized copy correctly marked?	☐ Yes ☐ No
X Yes ☐ No	13. Does each Cost Proposal package include: (Note: This status will be determined when Cost Proposals are opened after Technical Proposals have been evaluated.)	☐ Yes ☐ No
X Yes ☐ No	a. One original	☐ Yes ☐ No
X Yes ☐ No	b. Eight copies	☐ Yes ☐ No
X Yes ☐ No	c. One sanitized copy of Cost Proposal in separate, sealed envelope	☐ Yes ☐ No
X Yes ☐ No	d. Are the original, copies and sanitized copy correctly marked?	☐ Yes ☐ No

Bidder Check	Requirement	Confirmed by DHS
X Yes ☐ No	14. Does each Company Financial Information package contain one original of Company Financial Information (in a separate sealed envelope)? (Note: This status will be determined when Company Financial Information volumes are opened for the financial viability screening.)	☐ Yes ☐ No
X Yes ☐ No	15. Are all bid proposals also submitted on CD ROM copies per bid proposal?	☐ Yes ☐ No
X Yes ☐ No	16. Does one submitted CD-ROM contain one full version of each bid proposal part and the other submitted CD contain one sanitized version of each bid proposal part?	☐ Yes ☐ No
X Yes ☐ No	17. Are all electronic files in PDF format or in Microsoft Word 2000 format (or a later version)?	☐ Yes ☐ No
X Yes ☐ No	18. Are all electronic files individually identified by:	☐ Yes ☐ No
X Yes ☐ No	a. Component name	☐ Yes ☐ No
X Yes ☐ No	b. Bid proposal part (technical, cost, or company financial information)	☐ Yes ☐ No
X Yes ☐ No	c. Version	☐ Yes ☐ No
	Technical Proposal Content	
X Yes ☐ No	19. Does each Technical Proposal consist of the following sections separated by tabs with associated documents and responses presented in the following order?	☐ Yes ☐ No
X Yes ☐ No	a. Table of Contents (Tab 1)	☐ Yes ☐ No
X Yes ☐ No	b. Transmittal Letter (Tab 2)	☐ Yes ☐ No
X Yes ☐ No	c. Checklists and Cross-References (Tab 3)	☐ Yes ☐ No
X Yes ☐ No	d. Executive Summary (Tab 4)	☐ Yes ☐ No
X Yes ☐ No	e. General Requirements (Tab 5)	☐ Yes ☐ No
X Yes ☐ No	f. Professional Services Requirements (Tab 6)	☐ Yes ☐ No
X Yes ☐ No	g. Project Plan (Tab 7)	☐ Yes ☐ No
X Yes ☐ No	h. Project Organization (Tab 8)	☐ Yes ☐ No

Bidder Check	Requirement	Confirmed by DHS
X Yes ☐ No	i. Corporate Qualifications (Tab 9)	☐ Yes ☐ No
X Yes ☐ No	20. Does the Table of Contents in Tab 1 of the Technical Proposal identify all sections, subsections, and corresponding page numbers?	☐ Yes ☐ No
X Yes ☐ No	21. Does the Transmittal Letter in Tab 2 include the following?	☐ Yes ☐ No
X Yes ☐ No	a. The bidder's mailing address	☐ Yes ☐ No
X Yes ☐ No	b. Electronic mail address, fax number, and telephone number for both the authorized signer and the point of contact designated by the bidder	☐ Yes ☐ No
X Yes ☐ No	c. A statement indicating that the bidder is a corporation or other legal entity	☐ Yes ☐ No
X Yes ☐ No	d. Identification of all subcontractors and a statement included that indicates the exact amount of work to be done by the prime contractor (not less than 60 percent) and each subcontractor, as measured by a percentage of the total work?	☐ Yes ☐ No
X Yes ☐ No	e. No actual price information	☐ Yes ☐ No
X Yes ☐ No	f. A statement confirming that the prime contractor is registered or agrees to register to do business in Iowa and providing the corporate charter number (if currently issued), along with assurances that any subcontractor proposed is also licensed or will become licensed to work in Iowa	☐ Yes ☐ No
X Yes ☐ No	g. A statement identifying the bidder's federal tax identification number	☐ Yes ☐ No
X Yes ☐ No	h. A statement that the bidder will comply with all contract terms and conditions as indicated in this RFP	☐ Yes ☐ No
X Yes ☐ No	i. A statement that no attempt has been made or will be made by the bidder to induce any other person or firm to submit or not to submit a proposal	☐ Yes ☐ No
X Yes ☐ No	j. A statement of affirmative action that the bidder does not discriminate in its employment practices with regard to race, color, religion, age (except as provided by law), sex, marital status, political affiliation, national origin, or handicap	☐ Yes ☐ No
X Yes ☐ No	k. A statement that no cost or pricing information has been included in this letter or the Technical Proposal	☐ Yes ☐ No
X Yes ☐ No	l. A statement identifying all amendments to the RFP issued by the state and received by the bidder. (Note: If no amendments have been received, a statement to that effect shall be included.)	☐ Yes ☐ No
X Yes ☐ No	m. A statement that the bidder certifies in connection with this procurement that:	☐ Yes ☐ No
X Yes ☐ No	n. The prices proposed have been arrived at independently, with consultation, communication, or agreement, as to any matter relating to such prices with any other bidder or any competitor for the purpose of restricting competition; and	☐ Yes ☐ No

Bidder Check	Requirement	Confirmed by DHS
X Yes ☐ No	o. Unless other wise required by law, the prices quoted have not been knowingly disclosed by the bidder prior to award, directly or indirectly, to any other bidder or to any competitor	☐ Yes ☐ No
X Yes ☐ No	p. A statement that the person signing this proposal certifies that he/she is the person in the bidder's organization responsible for or authorized to make decisions regarding the prices quoted and that he/she has not participated and will not participate in any action contrary to items m, n and o	☐ Yes ☐ No
X Yes ☐ No	22. If the use of subcontractors is proposed, a statement from each subcontractor must be appended to the transmittal letter signed by an individual authorized to legally bind the subcontractor stating:	☐ Yes ☐ No
X Yes ☐ No	a. The general scope of work to be performed by the subcontractor	☐ Yes ☐ No
X Yes ☐ No	b. The subcontractor's willingness to perform the work indicated; and	☐ Yes ☐ No
X Yes ☐ No	c. The subcontractor's assertion that it does not discriminate in employment practices with regard to race, color, religion, age (except as provided by law), sex, marital status, political affiliation, national origin, or handicap	☐ Yes ☐ No
X Yes ☐ No	23. Any request for confidential treatment of information shall also be identified in the transmittal letter, in addition to the specific statutory basis supporting the request and an explanation why disclosure of the information is not in the best interest of the public	☐ Yes ☐ No
X Yes ☐ No	24. The name, address and telephone number of the individual authorized to respond to the Department about the confidential nature of the information (if applicable)	☐ Yes ☐ No
X Yes ☐ No	25. Is a completed copy of the Checklist and Cross-References included in Tab 3?	☐ Yes ☐ No
X Yes ☐ No	a. Mandatory Requirements Checklist	☐ Yes ☐ No
X Yes ☐ No	b. General Requirements Cross-Reference	☐ Yes ☐ No
X Yes ☐ No	c. Professional Services Requirements Cross-Reference	☐ Yes ☐ No
X Yes ☐ No	26. Is a General Requirements Cross-Reference in Tab 5 included for each Technical Proposal under consideration based upon the sample provided in RFP Section 9?	☐ Yes ☐ No
X Yes ☐ No	27. Is a Professional Requirements Cross-Reference in Tab 3 included for each Technical Proposal under consideration based upon the sample provided in RFP Section 9?	☐ Yes ☐ No
X Yes ☐ No	28. Are requirements numbers listed above the paragraph or set of paragraphs for all addressed requirements in?	☐ Yes ☐ No
X Yes ☐ No	29. Does information in Tab 9 (Contractor Qualifications) include the following?	☐ Yes ☐ No
X Yes ☐ No	a. Description of the Contractor Organization (Section 7.2.9.1)	☐ Yes ☐ No

Bidder Check	Requirement	Confirmed by DHS
X Yes ☐ No	b. Description of the Contractor Experience (Section 7.2.9.2)	☐ Yes ☐ No
X Yes ☐ No	c. Contractor References (Section 7.2.9.3)	☐ Yes ☐ No
X Yes ☐ No	d. Signed Felony Disclosures (Section 7.2.9.4)	☐ Yes ☐ No
X Yes ☐ No	e. A signed copy of Attachment E (Authorization to Release Information) which authorizes the release of information to the Department	☐ Yes ☐ No
X Yes ☐ No	f. A signed copy of Attachment D (Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion – Lower Tier Covered Transactions) which certifies that the bidder is not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any federal, department or agency	☐ Yes ☐ No
X Yes ☐ No	g. A signed copy of Attachment C (Certification of Independence and No Conflict of Interest) which certifies that the bid proposal was developed independently, and also certifiers that no relationship exists or will exist during the contract period between the bidder and the Department that interferes with fair competition or is a conflict of interest.	☐ Yes ☐ No
X Yes ☐ No	h. A signed copy of Attachment B (Proposal Certifications and Declarations) which certifies that the contents of the bid proposal are true and accurate.	☐ Yes ☐ No
X Yes ☐ No	i. A signed copy of Attachment J (Proposal Certification of Available Resources) which certifies that the bidder has sufficient available resources to provide the services proposed in the bid proposal.	☐ Yes ☐ No
X Yes ☐ No	j. A statement that stipulates that, with the submitted bid proposal, the bidder acknowledges the acceptance of all terms and conditions stated in the RFP. (Note: If the bidder objects to any term or condition, a specific reference to the RFP page, section, paragraph, and line numbers must be made. Objections or responses that materially alter the RFP shall be deemed nonresponsive and disqualify the bidder.)	☐ Yes ☐ No
X Yes ☐ No	k. A written guarantee regarding the availability of the services offered and that all bid proposal terms, including price, will remain firm for at least 120 days after the date set for completion of contract negotiations and execution of the contract.	☐ Yes ☐ No
	Cost Proposal Content	
X Yes ☐ No	30. Does the Cost Proposal include the following sections:	☐ Yes ☐ No
X Yes ☐ No	a. Table of Contents (Tab 1)	☐ Yes ☐ No
X Yes ☐ No	b. Bid Proposal Security (Tab 2)	☐ Yes ☐ No
X Yes ☐ No	c. Pricing Schedules (Tab 3)	☐ Yes ☐ No

Bidder Check	Requirement	Confirmed by DHS
X Yes ☐ No	31. Does Tab 1 include a Table of Contents of the Cost Proposal?	☐ Yes ☐ No
X Yes ☐ No	32. Does the Table of Contents identify all sections, subsections, and corresponding page numbers?	☐ Yes ☐ No
X Yes ☐ No	33. Is a proposal bid bond or proposal guarantee in the form of a cashier's check, certified check, bank draft, treasurer's check, bond or a original letter of credit payable to DHS in an amount equal to five percent of the total implementation and operations costs identified by Pricing Schedule A of the Cost Proposal included in Tab 2?	☐ Yes ☐ No
X Yes ☐ No	34. Are photocopies of the proposal bid bond included in Tab 2 in all other copies of the Cost Proposal submitted by the bidder?	☐ Yes ☐ No
X Yes ☐ No	35. If a bond is used, is it issued by a surety licensed to do business in Iowa?	☐ Yes ☐ No
X Yes ☐ No	36. Are pricing schedules as specified in the RFP included in Tab 3?	☐ Yes ☐ No
	COMPANY FINANCIAL INFORMATION	
X Yes ☐ No	37. Does the Company Financial Information include audited financial statements (annual reports) for the last 3 years?	☐ Yes ☐ No
X Yes ☐ No	38. Does the Company Financial Information include at least three financial references (such as letters from creditors, letters from banking institutions, Dun & Bradstreet supplier reports)?	☐ Yes ☐ No
X Yes ☐ No	39. Does the Company Financial Information include a description of other contracts or projects currently undertaken by the bidder?	☐ Yes ☐ No
X Yes ☐ No	40. Does the Company Financial Information include a summary of any pending or threatened litigation, administrative or regulatory proceedings or similar matters that could affect the ability of the bidder to perform the required services?	☐ Yes ☐ No
X Yes ☐ No	41. Does the Company Financial Information include a disclosure of any contracts during the preceding three year period, in which the bidder or any subcontractor identified in the bid proposal has defaulted? Does it list all such contracts and provide a brief description of the incident, the name of the contract, a contact person and telephone number for the other party to the contract?	☐ Yes ☐ No
X Yes ☐ No	42. Does the Company Financial Information include a disclosure of any contracts during the preceding three-year period in which the bidder or any subcontractor identified in the bid proposal has terminated a contract prior to its stated term or has had a contract terminated by the other party prior to its stated term.?	☐ Yes ☐ No
X Yes ☐ No	43. Does the Company Financial Information include the company's five-year business plan that would include the award of the state's contract as part of the work plan?	☐ Yes ☐ No

7.2.3.2 General Requirements Cross-Reference

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7.2.4 EXECUTIVE SUMMARY

Goold Health Systems (GHS) has a full understanding of the commitment needed to fulfill the services requested by the Iowa Medicaid Enterprise (IME) in the Pharmacy Medical Services component of this Request for Proposals (RFP). We are presently providing these services for the IME and look forward to the opportunity to continue providing these services in the future. We will call upon our highly skilled staff of physicians, pharmacists, pharmacy technicians, project managers, data analysts, data architects, database administrators, software developers, network staff, trainers and others to address the challenges that exist in the administration of this complex, multi-faceted program. The core values of the GHS team include accountability, integrity, innovation and commitment to community. GHS employees derive this commitment and dedication from years of providing excellent service to our clients. We have witnessed the clinical and financial outcomes of our services and have seen how they positively affect the economy, communities and people's lives.

In preparing this proposal, our team has carefully reviewed the RFP requirements and has determined which requirements our current processes support and which will require new customization. It is through this review that we have established a solid understanding of the requirements and objectives of the IME.

Qualifications to Serve as the IME Contractor for the Project

GHS is an experienced, national leader in providing Pharmacy Benefits Services Administration (PBSA) to a number of state Medicaid Programs as well as private-sector and non-profit pharmacy plans. GHS has over 35 years of experience with the PBSA solutions we provide. Our expertise and applications include:

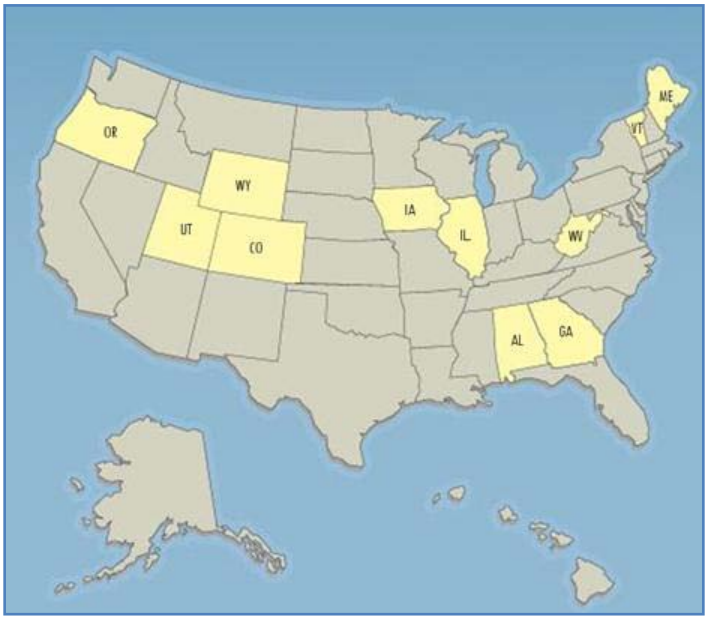
- Online, real-time Point of Sale (POS) pharmacy claims adjudication
- Drug utilization management
- CMS and Supplemental Rebate management
- Preferred Drug List (PDL) management
- Drug Prior Authorization Committee and DUR Board support
- Focused clinical pharmacy services, including Drug Class Reviews
- Prior Authorization (PA), and other related programs
- Multi-State Pool for Supplemental Rebates
- Pharmacy/Physician Help Desks to support POS and PA
- Medical Prior Authorization Services (beginning in 2010 for the Maine Medicaid Program)
- Robust reporting systems for our clients – including standard, ad hoc, decision support systems and pharmacy data "marts"
- Interfacing with Medicaid Management Information Systems(MMIS) and /or POS

The core values of the GHS team include accountability, integrity, innovation and commitment to community. GHS employees derive this commitment and dedication from years of providing excellent service to our clients.

vendors; and
- Consultation and implementation of cost containment and legislative proposals

Supporting our PDL and PA services is GHS' thorough understanding of the overall set of pharmacy benefit services. This includes 18 years of electronic POS pharmacy claims processing, 13 years of drug rebate management, 8 years of PDL maintenance, and 8 years of PA experience. GHS also helped form and manages the Sovereign States Drug Consortium (SSDC), a multi-state rebate pooling program.

Figure 1: GHS Public Sector Clients



GHS presently provides diverse, value-driven pharmacy services in eleven (11) states. We provide the full set of Pharmacy Benefits Services Administration (PBSA) to the Medicaid agencies in Iowa, Maine and Wyoming. GHS performs a variety of clinical pharmacy services for the State of West Virginia's and Alabama's Medicaid program. We provide Medicaid and Supplemental Pharmacy Rebate services for the State of Georgia and were recently selected to manage the Medicaid SMAC program for the State of Illinois. GHS also helped form and now serves as the pharmacy vendor for the Sovereign States Drug Consortium (SSDC), a multi-state drug rebate pool that presently includes Iowa, Maine, Oregon, Utah, Vermont, West Virginia and Wyoming. We are the Prescription Drug Monitoring Program (PDMP) vendor for the State of Colorado's Department of Regulatory Agencies and the State of Maine's Office of Substance Abuse.

All of the previously mentioned services are configured or customized to meet the individual needs of our clients; for some clients we constructed new programs, processes and systems solutions from the ground up within very tight development timeframes. GHS is continuously looking to improve and expand the services we offer and provide maximum value and expertise to our clients.

The pharmacy benefit represents one of the most significant expenditure categories for Iowa's Medicaid Program and is otherwise likely to be a growing cost center in the future. In the first five years of the IME, GHS has been successful in slowing the growth of pharmacy expenditures and decreasing the per user per year costs, as shown in Figure 2, included at the end of this section. The Medicaid Pharmacy Program must rely on the proper administration of this benefit to ensure access to appropriate and medically necessary drug therapies while maximizing effective program savings.

GHS has utilized its wealth of knowledge and experience in the industry to accomplish outstanding objectives for our clients, including the IME; achievements that have been recognized nationwide as leading edge and extremely cost effective in this ever growing business. GHS recognizes that the success of any endeavor is close communication with the client, the ability and willingness to think outside the box and provide comprehensive, cost savings solutions that meet the needs of the client. Identifying the customer's needs and accommodating them is an area where GHS excels, and we are prepared to continue these services for the State of Iowa so they can utilize leading edge technology with the ability to interface with all of their existing systems, and to benefit from an experienced industry leader.

As a Medicaid Pharmacy vendor, GHS has had to integrate with five MMIS applications/vendors-to-date. This includes the State of Maine's mainframe MMIS application, then the replacement Maine Claims Management System (MeCMS) application built by CNSI and the State (deployed in 2005); it includes integrating with ACS' MMIS application in the State of Iowa, then the takeover MMIS application run by Noridian Administration Services. We have successfully integrated data interfaces with Unisys' MMIS and POS applications in the State of West Virginia, as well as with ACS' MMIS and POS applications in the State of Wyoming.

Based on our review of Iowa's current pharmacy services and the RFP requirements, GHS believes that we are the most suitable candidate for the following reasons:
1. GHS has been successfully providing the Pharmacy Medical Services requested in this RFP since 2004.
2. We have a proven track record of designing and implementing effective pharmacy solutions that save our State Medicaid Agency clients significant sums of money.
3. Our pharmacy solutions are flexible, in that they can be modified to meet each state's individual needs and specific requirements.
4. As the incumbent vendor, our systems and processes are currently in place and operating smoothly. The State will experience no lapse in the provision of these vital pharmacy solutions.
5. We have significant experience interacting with MMIS systems and other vendors. We always go the extra mile to ensure that we work cooperatively with those partners. Using lessons and experience from previous projects, we will work closely with Iowa's MMIS and other vendors as well as IME staff to ensure a seamless implementation and integration process for any new vendors joining the IME.
6. We currently provide diverse, transparent, value-driven pharmacy services in eleven states.
7. Our PDL program is highly-individualized and can be tailored to meet the balanced needs of the State and your Medicaid pharmacy providers.

Our integrated solution is made up of many component parts and we have the expertise and experience to effectively understand the details of how each component supports the overall goals of improving quality of care and controlling the costs of the Medicaid pharmacy benefit.

Preferred Drug List (PDL)
Efficient application of the PDL is an area of excellence for GHS. We have learned that a highly intelligent and flexible system reduces both administrative costs and provider burdens while

optimizing net savings for clients. GHS considers the Preferred Drug List to be one of the most important aspects of a high quality pharmacy solution. We take great pride in the PDLs we have helped to create and maintain, including the one developed and maintained for the State of Iowa. A carefully designed PDL, in combination with PAs and supplemental drug rebates allow state Medicaid Programs to realize significant savings without sacrificing clinical outcomes. In addition to Iowa, we have done this successfully in the States of Maine and West Virginia. Each state has realized significant savings in the pharmacy benefit since the implementation of their PDLs.

Supplemental Rebate Services
We are well positioned to continue providing cost-effective Supplemental Rebate services for the State of Iowa. We currently provide the same full CMS, supplemental and J-code rebate services that we provide in the State of Iowa in the States of Georgia and Wyoming. We provide support services for the States of Maine and West Virginia. We are the SR negotiator for the seven SSDC member states; we also provide full Supplemental Rebate services as a stand-alone solution for the State of Georgia.

The drug rebate process is a core function of GHS's Medicaid Pharmacy benefits program. It has enabled us to work effectively with the respective State Medicaid staffs to reduce the costs of the Medicaid pharmacy benefit for clients participating in our rebate programs. We have been performing the functions required in this RFP for Iowa, Maine and West Virginia for several years. GHS worked with Iowa, Maine and Vermont to form a Medicaid drug purchasing pool in 2005. Since then Oregon, Utah, West Virginia and Wyoming have joined the pool, which now represents over 2.4 million lives. As the negotiating vendor for the SSDC, we are uniquely positioned to provide the IME with a seamlessly integrated Supplemental Rebate program, as outlined in this RFP.

Pharmaceutical and Therapeutics Committee Support
GHS is fully capable and experienced in providing support to Pharmaceutical and Therapeutics (P & T) Committees. Our typical approach is to remain focused on expressed objectives and maximize the use of resources already available. We believe the committee usually makes the best decisions when all the necessary clinical information is made available to them. We are skilled at providing expertise when analyzing the financial and clinical impact of changes in PDL categories as well as value added (non-cash) agreements. GHS has served as the professional staff to the Iowa Medicaid P&T Committee since 2004, and looks forward to continuing these services.

Preferred Diabetic Testing Supplies
GHS implemented a Preferred Diabetic Supply Program for the State of Maine in 2007 and Iowa in 2008. We have been able to successfully negotiate with pharmaceutical manufacturers, lower costs in this area and replicate this process for all SSDC member states. GHS will continue to provide these kinds of enhancements to the programs we provide to the State of Iowa.

Proposed Schedule
GHS guarantees that our solution will meet or exceed all technical and pharmacy services requirements outlined in the State's RFP. We have demonstrated this ability in the State of Iowa

repeatedly since winning our first subcontract (to IFMC) in 2004. We have had similar success in the States of Georgia, Maine and Wyoming. As the incumbent vendor for the Pharmacy Medical Services component of this RFP, we stand ready to continue to work with the Department to deliver reliable, objective, and timely services to the IME. It has always been GHS' mission to provide effective, cost efficient services and pass those savings through to the State. There will be no interruption of services should we re-secure this work. A successful partnership with the IME, the IME's other Medicaid vendors, and the provider community will allow Iowa's pharmacy beneficiaries to continue to achieve improved health outcomes while the State of Iowa's taxpayers enjoy sustained pharmacy cost savings.

Project Management Approach

GHS has developed its management approach to leverage relevant experience and incorporate the proven strengths of our project team. We believe that this formula provides the highest level of service to our clients. GHS blends the four proven strategies outlined below into our operations. Our management team is empowered to make rapid and deliberate operational decisions in the field that are in your best interest. To manage this engagement successfully, it is imperative that our managers dedicated to the IME project be empowered with the capability to make timely decisions.

We utilize "clinical-data" teams that are comprised of our doctors and pharmacists working with our data analysts, data administrators and developers. They are available for "on-call" assistance with any clinical, operational, organizational, and developmental function throughout the life of the contract. Our Technical Advisors are among the most experienced individuals in the state in their designated specialties.

At the foundation of our management approach is a commitment to transparency, flexibility and responsiveness that ensures "seamless" operations and project administration. Our work plan is a "living document" designed for any changes as the project unfolds. Our management team understands this concept and will rely on experience with similar projects to manage this effort efficiently. GHS has made strong operational and philosophical commitments to a process of internal and external continuous quality improvement programs. GHS will continue to apply these standards to all our operations in the State of Iowa.

Throughout this project, GHS will seek to maximize the use of the time and resources required by the IME by leveraging our current, experienced senior level team that has hands-on expertise in the programmatic and financial aspects of your current service delivery system, and is well versed in the goals and objectives of the IME. Our project management approach includes the following:

- A dedicated Account Manager with extensive Iowa Medicaid experience who will ensure that our professional teams remain on task and on focus; and
- Continued close cooperation and communication with Department staff and other IME vendors to ensure the smooth operations.

Strengths GHS Contributes

GHS offers strengths that make us uniquely positioned to fill the needs of the needs of the Iowa's Medicaid Pharmacy Program:

1. GHS is the ***transparent*** Medicaid Pharmacy Vendor. All aspects of our services, including supplemental rebate pricing data, is presented to, and controlled by, our state Medicaid agency clients;
2. A focus on quality monitoring that includes producing management reports, conducting regular status meetings and convening periodic workgroup sessions for all groups involved;
3. We are an experienced Medicaid Pharmacy Benefit Services Administrator (PBSA) with proven results as the full PBSA vendor in the State of Iowa, as well as in both the States of Maine and Wyoming; and
4. GHS is a service-oriented healthcare management company, offering a package that is capable of expanding services when additional programs are needed.

GHS will work diligently to maintain and enhance the positive, reciprocal relationships we have developed with the IME staff, other vendors and Iowa's Medicaid providers over the past five years. We are prepared to follow all proper state approvals and produce essential clinical pharmacy rules, algorithms and recommendations so the State can maximize savings while improving quality of care. In our experience, success is achieved when a clear set of expectations is shared among program administrators, the provider community and beneficiaries of IME. This system of expectations, processes and relationship building will yield tangible benefits for one of the State's most important stakeholders – the taxpayer.

We have named the same experienced GHS staff to key positions in our staffing plan; all of whom have been a part of the Iowa GHS team since 2004. Early on, GHS endorsed the "IME concept" and continues to believe it is a model for the rest of the nation. Each of us feels we have a personal stake in the administration and services we provide and are concerned about the impact on the communities we serve. GHS employees derive this commitment and dedication from years of providing excellent service to our clients, witnessing the outcomes of our services and personally seeing how they positively affect the economy and people in the community.

Managing Risk

There are certain unknowns that can create risks in implementing strategies to control drug spending. These include the impact of potential health care reform legislation, the role of CMS as it pertains to allocation of OBRA 90 and Supplemental Rebates going forward and potential increases in eligibility for Iowa Medicaid due to the current economic situation. GHS stands ready to assist the IME with making adjustments and recommendations as these factors develop over the course of this contract. GHS' policy experts, clinicians, analysts and project managers will be available to work collaboratively with the Department and the Department's other vendors to address and mitigate these potential risks to the program.

Understanding the Iowa Medicaid Enterprise

The concept of the Iowa Medicaid Enterprise is revolutionary in the world of medical assistance programs; modeled after successful private sector HMOs. GHS is proud to have been a part of such forward thinking since its inception in 2004. With our involvement at the IME since its first day of operations, GHS understands better than anybody what it takes to create and maintain the "best of the breed" model, combining expert vendors and functions as one cohesive unit. Since first joining the IME, the employees of GHS have built and fostered relationships with the other

vendors and State Policy staff housed at the IME office. Together, we have worked towards a common goal and leaned on each other to solve problems and enhance the services provided to those reliant on the Iowa Medicaid program. Since so many different systems must integrate seamlessly to make the Medicaid program work, teamwork and communication is imperative. Many times over the past five years, employees of GHS have stepped in, when called upon, to lend their clinical and technical expertise to other vendors within the IME, to assist in the overall functioning of program. Some examples of these efforts, outside of the day-to-day pharmacy operations, include setting up benefits for Hurricane Katrina refugees relocated to Iowa, working with Provider Audit and Rate Setting on executing the State Maximum Allowable Cost program, collaborating with CORE in taking over the RetroDUR contract, working with Member Services, Provider Services, and CORE to develop and enhance the smoking cessation program, including *Chantix*, lending clinical expertise to the audits performed by SURS that involve pharmacy claims, switching providers from the Medicaid legacy numbers to NPI with Provider Services, facilitating changes to TPL policy with Revenue Collections, consulting with Medical Services on drugs administered pursuant to inpatient and in-office use, and the continued interaction with the State Policy Staff to ensure overall program integrity. The future success of the IME depends on this kind of continued vendor integration and teamwork, especially at a time of budget crunches and rising Medicaid eligibility. While GHS is prepared to work with any vendor at the IME, we feel as though we have demonstrated our ability to excel within the complex environment of the IME business model from both a systems standpoint, and a personnel standpoint.

GHS is a service-oriented company; we focus on doing what it takes to meet our clients' timeline, budget, and savings targets. We actively participate in the creation and development of new initiatives designed to maximize efficiency (cost and otherwise), enhance services, and improves patient outcomes. Most importantly, we demonstrate considerable flexibility with the various state Medicaid contracts we hold. Working in close partnership with the Department, we will provide the same level of commitment and service we've delivered to our other clients.

Closing

GHS' service performance in Iowa and Maine is unparalleled. In Maine, Medicaid enrollment has steadily increased at rates higher than other states in the U.S. With GHS' PBSA strategic practices, however, state Medicaid drug cost per user expenditures have increased less than any other state. This is represented visually in the per-user per-year costs analysis shown in Figure 3. Iowa has experienced similar results, after implementation of GHS' PBSA services, as shown in Figure 2. GHS has many resources at our disposal to provide cutting edge services, among them, skilled personnel backed by experienced administration and management, up to date technology and customized software.

In summary, GHS will carry out all contract responsibilities in the same highly professional, successful manner to which our clients have become accustomed. We will continue to enthusiastically support the IME concept. We will draw on the successful working relationships we have built at the Iowa Medicaid Enterprise to deliver the State unparalleled service and support. We offer the State a truly best-in-class solution designed to meet your needs now and into the future. Our team is ready to assist you with technical innovation and unsurpassed customer service for your beneficiaries and providers.

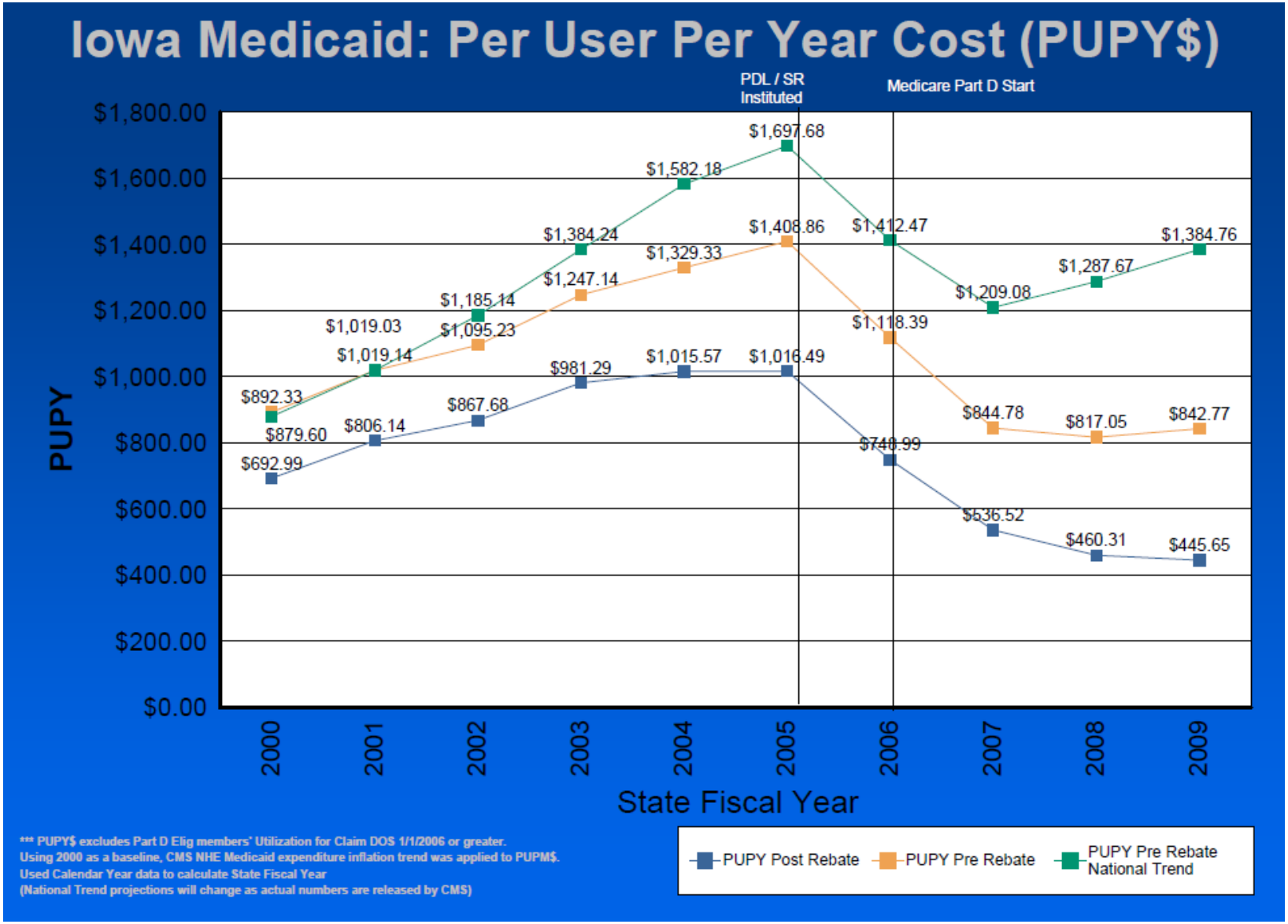


Figure 2: Iowa Medicaid Enterprise Per User Per Year Cost (PUPY$) Analysis.

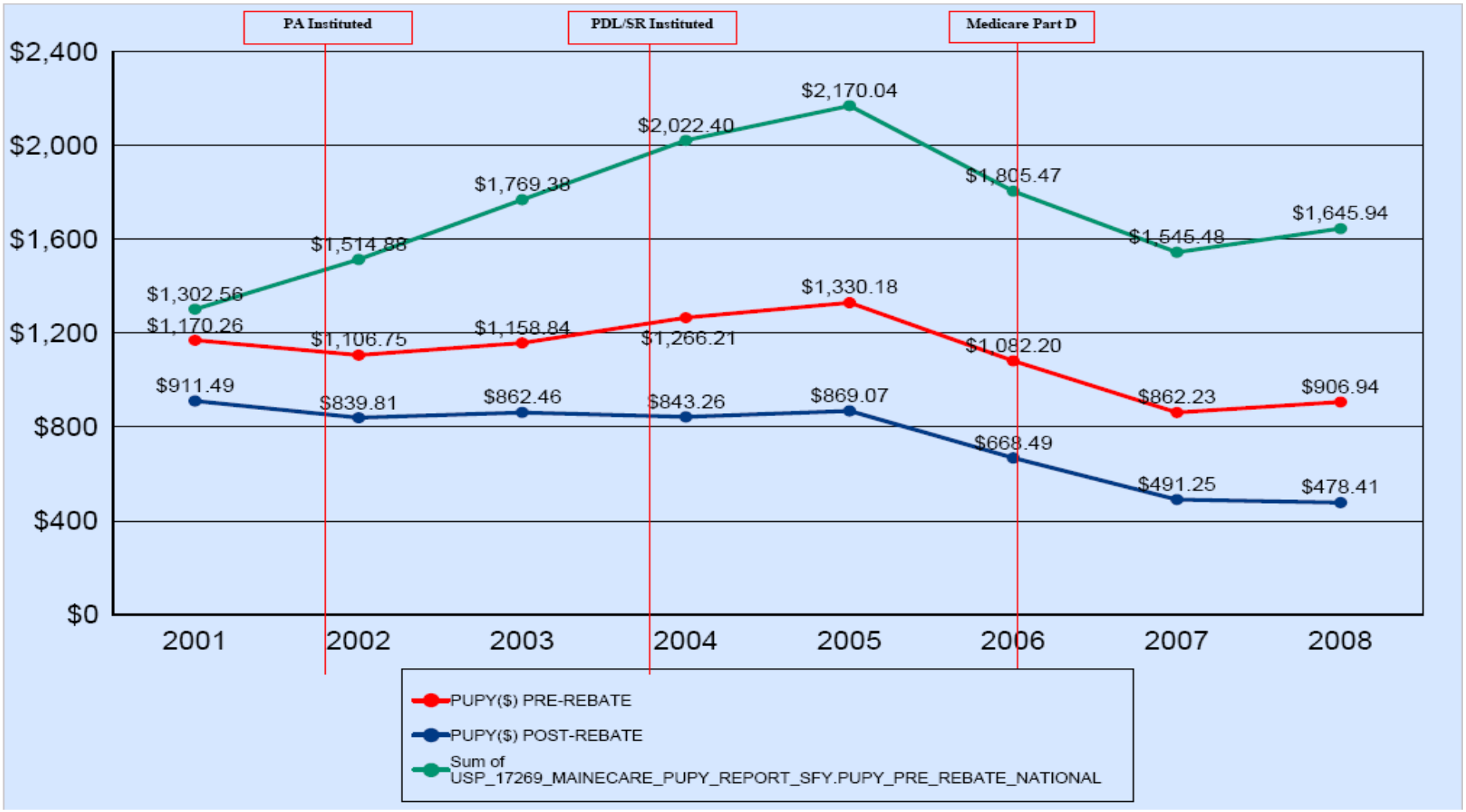


Figure 3: MaineCare Per User Per Year Cost (PUPY$) Analysis.

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7.2.5 General Requirements

In the General Requirements section, bidders will explain their approach to Section 6.1 General Requirements for All Components. For the General Requirements section of the Technical Proposal, the Department expects bidders to list the requirement numbers for addressed requirements above the paragraph or set of paragraphs that addresses them.

6.1 General Requirements for All Components

Following are the high-level general requirements for all components.

a. The Department's intent in this procurement is to maintain the state's seamless delivery of all professional services for the Medicaid program. All contractors and the responsible Department administrators will continue to be located at a common state location as part of the Iowa Medicaid Enterprise (IME) administration.

As the incumbent vendor, there will be no need to transition these services and responsibilities should GHS continue to provide the pharmacy medical services required in this RFP. There will be no gap in delivery of these crucial services to the IME's beneficiaries, service providers, staff or other vendors. GHS is prepared to continue to provide a seamless delivery of the services and responsibilities outlined in the Pharmacy Medical Services component. As a participant in the IME's best-of-breed model since its inception, GHS understands the importance of locating the majority of our staff and services at the common IME facility in Iowa and will continue to do so in the future. We look forward to continuing participation in this progressive program.

b. The Department continues to emphasize the importance of coordination of efforts among state staff and all contractors. No single contractor can perform their required responsibilities without coordination and cooperation with the other contractors. The Department expects all contractors to maintain communication with each other and with state staff as necessary to meet their responsibilities.

GHS has a complete understanding of the importance of the coordination of effort among state staff and all contractors. If awarded a contract as a result of this procurement, GHS will continue to carry out our required responsibilities in full coordination and cooperation with all appropriate parties. GHS has provided exemplary communication services to ensure that lines of communication remain open and accessible.

c. The Department, through its unit managers, retains the role of contract monitor for all Request for Proposal (RFP) professional services contractors. The Department will favor in this procurement bidders who have demonstrated success in cooperative, collaborative environments.

GHS recognizes that the success to any endeavor is close communication with the client, the ability and willingness to think outside the box and the ability to work together and collaborate with a diverse group of state staff, other vendors and interested parties. Having worked over the last 5+ years to foster cooperative, collaborative relationships with the other vendors and State Policy staff housed at the IME office, GHS understands the complexity of bringing numerous vendors together to create a cohesive unit focused on completing the tasks of the IME. In addition, GHS has proven our ability to work well not only with state departments but also with other Medicaid contractors during our three (3) decades of providing services to State Medicaid programs. GHS has repeatedly coordinated its work with other contractors to assure that our clients receive the best value for their efforts and will continue to do so for the State of Iowa.

d. All professional services contractors will interface with the IME data systems (Medicaid Management Information System (MMIS), Point of Sale (POS) system, Data Warehouse/Decision Support system (DW/DS), call center system and other state systems) as necessary to meet their responsibilities. Interfaces may be online updates to the IME data systems or file transfers among the respective professional services contractors' data systems and the IME data systems. A professional services contractor can have online access and authority to update files on the IME data systems (except systems that other state agencies operate) as necessary to perform their required responsibilities. These updates require ongoing effective communication between the respective contractors and the Department to assure timely maintenance that is transparent to the IME data systems. All professional services contractors must meet the interface requirements described in individual RFP component sections.

GHS is prepared to continue meeting all interface requirements designed by the State under this RFP. As the incumbent vendor GHS has successfully interfaced with the required systems and has done so in a streamlined manner**.** Over the past five years, GHS has successfully worked with all IME contractors and state systems to implement requested programming changes and facilitate daily operations. In addition to vendors at the IME, GHS has successfully integrated systems with other contractors in other states.

e. All professional services contractors will have access to the IME DW/DS system. To the extent that their responsibilities require analysis of data originating in the MMIS and POS system, the professional services contractors are required to bring skilled staff with demonstrated experience in querying Medicaid-related data and preparing reports for contractor and state use. Each professional services contractor will designate a primary contact for developing queries and requesting assistance from the DW/DS system manager.

GHS' team of analysts, who have extensive Medicaid experience, will continue to provide analytical requirements required by the contract. The Account Manager will serve as the primary contact for developing queries and requesting assistance from the DW/DS system manger.

f. All professional services contractors will require flexibility and balance to accommodate the program changes that are a natural occurrence in any health care program. The Department does not anticipate a need for contract amendments in such cases unless significant material changes occur in the scope of work. In such cases, the affected contractors must document the significance of the change and its impact on their ability to meet their service-level agreements and performance standards in their contracts.

GHS has been and will continue to be agile, flexible and responsive to the changes that inevitably occur in any health care program. GHS has demonstrated and will continue to demonstrate responsiveness to the Department's needs. GHS will continue to meet service-level agreement expectations as well as performance standards required under this RFP. We pride ourselves in being oriented to swift, thorough and accurate completion of deliverables without regard to marginal scope of work issues, and to finding ways to add value to our clients' programs. In the event of significant changes to the scope of work being performed, we are prepared to follow the established procedures for documenting and requesting changes.

g. All professional services contractors will respond to Department requests for information and other requests for assistance within the timeframe that the Department specifies.

GHS understands that it will be required to respond to requests for information as well as requests for assistance within the time frames specified by the Department.

h. All professional services contractors must meet all requirements within their areas of responsibility.

GHS has met and will continue to meet all requirements within our areas of responsibility.

i. All professional services contractors will deliver accurate, on-time reports according to the report production requirements for their areas of responsibility.

GHS will continue to provide reporting services in an accurate, timely manner according to the report production requirements as outlined in the Pharmacy Medical Services component of this RFP. Our reporting capabilities and procedures are described in further detail in our responses to section 6.3 of this response.

j. All professional services contractors will develop, maintain, and provide access to records required by the Department and state and federal auditors.

GHS will continue to develop, maintain and provide access to records as required by the Department and state and federal auditors.

k. All professional services contractors will provide to the Department reports regarding contractor activities for which the contractor will negotiate the content, format and frequency of these reports with the Department. The intent of the reports is to afford the Department and the contractor better information for management of the contractor's activities and the Medicaid program.

We will provide the Department with reports regarding program activities performed by GHS. We presently have in place contract activity reports the content, format and delivery frequency of which were created in collaboration with Department staff. We will revise and update these reports as needed and as requested by the Department. We consider administrative reporting to be a critical function of GHS' contract responsibilities. GHS uses reporting to monitor the performance of our systems and to assure that we are carrying out all our responsibilities effectively. Reporting allows Department policymakers to evaluate the impact of policy decisions on program operations and closely track expenditures. It is useful in the identification of issues of policy that require remediation and opportunities for cost savings and quality improvement. Reporting is also critical to the Department's ability to hold GHS accountable for performance of our contractual obligations.

Currently GHS provides a suite of reports to the Department, in the agreed upon format and frequency. These reports are delivered on a monthly, quarterly or annual basis. These reports consist of a telephone report, PA Statistics Report by PDL Category and Drug, PA Statistics Report by PDL Category with YTD Totals, PA Reports Exceeding over 24 hours, PA Statistics Report for Clinical Prior Authorizations, PDL Compliance Report, Drug, Pharmacy Program Report, Smoking Cessation Reports, Medwatch Report, and the Marketshare Report. GHS is also prepared to provide ad hoc reports to the Department upon request.

l. All professional services contractors will prepare and submit to the Department requests for system changes and notices of system problems related to the contractor's operational responsibilities.

GHS will continue to prepare and submit to the Department system change reports and requests for system changes as well as formal notification of system problems should they occur.

m. All professional services contractors will prepare and submit for Department approval suggestions for changes in operational procedures, and implement the changes upon approval by the Department.

GHS will prepare for Department approval formal reports with suggestions for operational procedure improvements and will implement changes when approval is received from the Department.

n. All professional services contractors will maintain operational procedure manuals in a format specified by the Department and update the manuals when changes occur.

GHS maintains policy and procedure manuals for corporate and program activities. Policy and procedure manuals are reviewed and revised as needed when changes occur. GHS policy and procedure manuals include operational procedures and systems documentation for users. As the incumbent vendor, GHS has in place the required operational procedure manuals for our areas of responsibility under the IME. We will continue to maintain and update these operational procedure manuals in a format specified by the Department.

o. All professional services contractors will ensure that effective and efficient communication protocols and lines of communication are established and maintained throughout the IME. The contractor will take no action that has the appearance or effect of reducing open communication and association between the Department and contractor staff.

GHS strives to maintain open and effective communication with the Department and the Department's other vendors. GHS will continue to maintain and follow established lines of communication and protocols to ensure the same effectiveness and efficiency occurs under any new contracts resulting from this RFP process. As an example of our current efforts to maintain open lines of communication, GHS currently has a weekly meeting with the Department's pharmacy staff and a regularly scheduled monthly meeting with the Department and the Medical Services vendor to discuss overlapping pharmacy issues. GHS will continue these efforts and make our staff available to discuss any needs that arise outside these scheduled meetings. GHS will take no actions that have the appearance or effect of reducing open communication and associated between the Department and any contractor staff.

p. All professional services contractors will meet regularly with other IME contractors and Department management to review account performance and resolve issues.

GHS will continue to meet regularly with other IME contractors and the Department to ensure appropriate management review and to review account performance and resolve any potential issues.

q. In situations where the Department permits contractors to use external data systems, the contractors must provide electronic interfaces from those external data systems to the IME data systems to support automated performance reporting.

In situations where GHS uses external data systems, we will ensure that there are electronic interfaces between our external systems and the IME systems to support any required automated performance reporting.

6.1.1 STAFFING

Bidders are expected to propose sufficient staff who have the requisite skills to meet all requirements in this RFP and who can attain a satisfactory rating on all performance standards. ***The Department encourages bidders to leverage current IME staff.***

Bidders are required to include the number of proposed staff that they will use to fulfill the contract requirements.

GHS realizes our commitment to provide the necessary resources to continue operating the systems and programs described in this RFP. GHS currently has 7.5 FTE staff positions that are located at the IME facility in Des Moines and are devoted to fulfilling the requirements of the Pharmacy Medical Services component of this RFP. These staff are supplemented by support staff positions located at our headquarters in Augusta, Maine. The positions located in Augusta will continue to play an important role in our administration and operation of the Iowa project. They include members of GHS' fully staffed Network Services department, as well as administrative professionals, data analysts, clinical staff and other technical support personnel.

GHS has assembled a staff of extremely talented, competent and capable employees. The employees of GHS have always met the challenges placed before them and are dedicated to providing the highest quality services to GHS' clients. Employees working on the Iowa Pharmacy Medical Services contract are all capable and have extensive experience both with GHS' current systems and processes as well as in working collaboratively with other vendors as part of the Iowa Medicaid Enterprise.

GHS is not planning to make any changes to our current staffing configuration or personnel and will leverage the expertise and know-how of the employees currently in place to ensure that the Department continues to receive the same high level of customer service that we have been providing since taking over these services in 2004. Our staff is acutely aware of the importance of the health care programs we manage, not only in terms of the provision of services to the neediest citizens, but also in terms of the state budget. We understand the issues in Medicaid and their impact on a state.

6.1.1.1 Named Key Personnel

The Department is requiring key positions to be named for each component, consistent with the belief that the bidder should be in the best position to define the project staffing for the contractor's approach to the RFP requirements. The following named positions for the professional services contractors require identified personnel and current resumes:

a. Account manager

Sandy Pranger, R.Ph. is GHS' Iowa Account Manager. Ms. Pranger is a registered pharmacist in two states, including the State of Iowa. Her position is 100% dedicated to the Iowa Medicaid Project and is responsible for the daily management and oversight of all services performed under the Pharmacy Medical Services contract. Ms. Pranger is the primary point of contact for the GHS staff and coordinates communications between GHS, the Department and other IME vendors. Her responsibilities also include development and maintenance of the Iowa Medicaid PDL as well as coordinating and attending the quarterly P&T Committee meetings.

Ms. Pranger has twenty years of experience in the pharmaceutical industry, including 15 years of combined management experience and almost 10 years of experience in Medicaid pharmacy operations. She is a current employee of GHS, has worked on the IME pharmacy project since 2004 and will be dedicated to the IME project throughout the life of the contract.

b. Transition manager (may be same as account manager or operations manager)

Sandy Pranger, R.Ph. will also serve as the Transition Manager for GHS. For a more complete description of her qualifications, please see our response to requirement a. Account Manager. As the incumbent vendor, GHS will require minimal resources for the transition, as we are not proposing any changes to our staffing, systems or operations. Ms. Pranger, in her position as Transition Manager, will be responsible for ensuring that any interactions, required communication or integration between GHS, the Department or new IME vendors occurs efficiently and in a timely fashion.

c. Medical director (only for the Medical Services and Member Services contractors)

Though this position is not required for the Pharmacy Medical Services component, GHS' Medical Director will continue to play a vital supporting role under this contract. Dr. Timothy Clifford, MD is the full-time physician serving as Medical Director for Goold Health Systems.

Dr. Clifford has 24 years experience as a physician, 23 of those in Maine. He is a graduate of Boston College, Tufts University School of Medicine and the Maine- Dartmouth Family Practice Residency Program. Before joining GHS, and in addition to private practice, he served as the Medical Director for Maine's Department of Health and Human Services. While at the Department, Dr. Clifford was the chief clinical consultant for the Medicaid program. He provided considerable input into the development of the Medicaid Decision Support System and served on a wide variety of work groups and committees whose purpose it was to improve the well being of Maine residents. His tenure at DHHS allowed him to develop an understanding for and keen insight into the objectives of the Department in its administration of State-sponsored health care programs.

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

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

d. Operations managers (minimum of two key positions for the Medical Services contractor)

Erin Halverson, R.Ph. will serve as the Operations Manager for this contract. This position is 100% dedicated to the Iowa Medicaid Project. Ms. Halverson has been a pharmacist for over ten years. She has previous pharmacy manager experience which has strengthened her excellent leadership and communication skills. Ms. Halverson also serves as PA Pharmacist for this project and has been with GHS in this position for 5 years. Her responsibilities will include supervising the Iowa Medicaid Enterprise Pharmacy Prior Authorization staff; ensuring all

contract performance criteria are met; providing policy and technical assistance to the IME. She is also responsible for updating the prior authorization criteria chart, prior authorization forms and Preferred Drug List (PDL) and maintaining the PDL website at www.iowamedicaidpdl.com.

Ms. Halverson is additionally responsible for responding to calls from clients, providers and technicians regarding the processing of prior authorizations or pharmacy claims, as well as oversight of the PA process, including enforcement of business rules and policies, including timeline requirements. Ms. Halverson also has provided administrative support to the Pharmacy & Therapeutics Committee.

6.1.1.1.1 KEY PERSONNEL REQUIREMENTS

General requirements for key personnel are as follows:

a. *The bidder must employ the account manager when the bidder submits the proposal.*
b. *The bidder must employ all other key personnel or must have a commitment from them to join the bidder's organization by the beginning of the contract start date.*
c. *The bidder must commit key personnel named in the proposal to the project from the start date identified in the table below through at least the first six months of operation. The bidder may not reassign key personnel during this period.*
d. *The bidder must not replace key personnel during this period except in cases of resignation or termination from the contractor's organization or in the case of the death of the named individual.*

The key staff members named above are all current employees of GHS and presently serve in these positions, as described in this proposal. The key personnel named here will be committed to this project throughout the life of the contract. GHS will not be making any changes to the personnel currently in place and as described in this proposal, except in cases of resignation or termination, or in the case of the death of the named individual. Should GHS have to fill one of these positions due to one of the circumstances described, GHS will follow the Department's established procedures and policies for replacing personnel and will seek Department approval of all qualified, proposed candidates.

6.1.1.1.2 Key Personnel Resumes

Resumes must include the following information:

a. *Employment history for all relevant and related experience*
b. *Names of employers for the past five years, including specific dates*
c. *All educational institutions attended and degrees obtained*
d. *All professional certifications and affiliations*

Resumes for the named key personnel begin on the next page.

SANDRA PRANGER
Account Manager

EXPERIENCE

2005 – present **Account Manager**
Goold Health Systems, Des Moines, Iowa

- Manages, trains and directs staff of 13 to ensure adherence to contract requirements
- Serve as Liaison to DHS regarding pharmacy contract
- Ensure data integrity for Iowa Medicaid
- Administer the Pharmaceutical and Therapeutics Meetings for DHS

2004 – 2005 **Clinical Pharmacy Manager**
Goold Health Systems, Des Moines, Iowa

- Develop and maintain the Preferred Drug List (PDL) for Iowa Medicaid
- Manage the drug prior authorization department for Iowa Medicaid encompassing the pharmacy and point of sale services
- Develop cost saving recommendations to the State of Iowa such as clinical prior authorizations, procedure edits and quantity limits
- Develop agendas, drug monographs and research material for P & T meetings

1999 – 2004 **Pharmacist Consultant**
ACS State Healthcare, Des Moines, Iowa

- Duties, roles and responsibilities bulleted here.
- Develop relationships with physicians and pharmacists as a consultant pharmacist through the drug prior authorization program
- Receive, screen and adjudicate drug prior authorization requests
- Research and make recommendations to Iowa DHS regarding Exception-to-Policy requests
- Review medical literature to ensure prior authorization standards are current with medical practice standards

1990 – 1999 **Pharmacy Manager/Staff Pharmacist**
Osco Drug, Des Moines, Iowa

EDUCATION

1985 – 1999 **Drake University, Des Moines, Iowa**

- Bachelor of Science, Pharmacy

LICENSES AND CERTIFICATIONS

State of Iowa Pharmacy License Number 18720
State of Nebraska Pharmacy License Number 10417
Diabetic Educator – Osco Drug

ERIN HALVERSON
Operations Manager

EXPERIENCE

2009 – present **Clinical Pharmacy Operations Manager**
Goold Health Systems, Des Moines, Iowa

- Responsible for responding to inquiries from drug manufacturer representatives and pharmacy and prescriber providers regarding the Preferred Drug List and the Pharmacy and Therapeutics Committee
- Enforce business rules and policies, including timeline requirements
- Claims analysis, analyzing and forecasting drug trends
- Analyzing and summarizing data contained in large health care databases
- Pharmacy benefit management
- Report preparation

2004 – 2009 **Clinical Staff Pharmacist**
Goold Health Systems, Des Moines, Iowa

- Responded to calls from clients and providers regarding the processing of prior authorizations or pharmacy claims
- Responsible for the pharmacy prior authorization process
- Use the proprietary prior authorization software package and manual interventions as necessary
- Act as a resource for data processing personnel
- General office duties, including maintaining media libraries, equipment maintenance, creating mailings, and coordinating shipments with the mailroom

2004 – 2005 **Pharmacist**
Wal-Mart Pharmacy

- Relief Pharmacist

2000 – 2004 **Pharmacy Manager**
Wal-Mart Pharmacy, Ankeny, Iowa

- Oversee daily pharmacy operations
- Inventory and personnel management
- Ensure compliance with state and federal guidelines to advance company goals and directives
- Act as liaison between the healthcare team and the community to improve drug usage and therapeutic outcomes

1999 – 2000 **Pharmacy Manager**
Wal-Mart Pharmacy, Marshalltown, Iowa

- Oversee daily pharmacy operations
- Inventory and personnel management
- Ensure compliance with state and federal guidelines to advance company goals and directives

- Act as liaison between the healthcare team and the community to improve drug usage and therapeutic outcomes

EDUCATION

1998 **Drake University, Des Moines, Iowa**

- Bachelor of Science, Pharmacy

LICENSES OR CERTIFICATIONS

State of Iowa, licensed Pharmacist

DR. TIMOTHY CLIFFORD, MD
Medical Director

EXPERIENCE

2001–Present **Medical Director**
Goold Health Systems, Augusta, ME

- Full-time Medical Consultant on drug-related issues including:
  - Preferred Drug List development and management
  - Supplemental Rebate strategies and management
  - Drug rebate pool management
  - DUR Program
  - DUR Committee support
  - PDDI Program studies, analyses and clinical direction
  - PA Clinical direction, determinations, savings analyses, report oversight, new target identification
  - Recipient drug abuse
  - Prescriber issues
  - Maine MAC assistance
  - Drug waiver model development
  - Drug Program presentations
  - Drug related ad hoc requests
  - Attorney General's Office requests

1996–2001 **Medical Director**
Maine Department of Human Services, Augusta, ME

- Full-time Medical Director for Maine Bureau of Medical Services (Medicaid Program).
  - Provided direction in all aspects of Quality Assurance.
  - Directed medical data analysis.
  - Consultant for policy development, prior authorizations, out of state referrals, and medical necessity determinations.
- Performed extensive analysis of heavy narcotic prescribers to identify physician outliers.
- Created Covered Services Team implementing Eddy criteria for new covered services decisions.
- Member New England Dual Eligibilities Initiative Quality and Performance Measurement Work Groups 1997–2001. Participated in analysis of integrated Medicaid and Medicare data.
- Member of Health Care Financing Administration Quality Assurance Technical Advisory Group.
- Member of National Committee for Quality Assurance Advisory Panel member for adapting HEDIS measures to fee for service populations.
- Maine Medicaid Decision Support System: assisted in development of integrated data computer system incorporating data from medical and pharmacy claims, eligibility, vital statistics, and other sources.

- Maine Medical Assessment Foundation (MMAF) Study Group participant. Collaborated on development of guidelines for CHF, Otitis Media, Asthma, and Attention Deficit Hyperactivity Disorder.
- Early Periodic Screening Diagnosis and Treatment (EPSDT). Replaced the obsolete one-page form with a Maine physician adapted set of nineteen age-specific forms directly implementing the Bright Futures Guidelines—a standard of care supported by the American Academy of Pediatrics for well-child visits.
- Tobacco Prevention and Control Program Advisory Council. Appointed by Gov. Angus King, Nov. 1997–2001.
- Primary Care Physician Incentive Payment - Conceptualized and implemented a quarterly payment based on relative performance across a variety of measures including panel size, access, utilization (ER), and quality preventive services. In place since 1998.
- Maine Cardiovascular Health Council Board member, unique primary / secondary CAD prevention effort underway involving multiple payers including Medicare and Medicaid.
- Child Indicators in Policy Making Partnership, co-chair 1999–2001. Selected to develop Governor's Children Committee project. Comparative measures concerned with how children are doing in the State of Maine.
    - Member, HIV waiver team. Assisted in development and submission of first waiver of this type to HCFA.
- PDDI: developed voluntary physician program to promote more cost-effective prescribing by sharing data and using incentives.
- DURC: Chair of Medicaid Program Drug Utilization Committee 1999–2001, concerned with clinically appropriate prescribing and drug use safety.
- Pharmacy Advisory Group: appointed by Commissioner of DHHS to investigate methods of exerting more control over pharmacy benefit.
- Infectious Disease Work Group member- sponsored by BOH.
- Hepatitis C Work Group Member: BOH coalition concerned with improving the quality of care for Hepatitis C patients and increasing access to care.

1986–1996 Family Practitioner
Bucksport Regional Health Center, Bucksport, Maine

- Full-time physician. Concluded remainder of four-year N.H.S. commitment.
- Served as Medical Director from 1989 to 1996
- Quality Assurance Program Director since 1990, including tracking systems for referrals, PAP smears, mammograms, chronic hypertension, immunizations, etc.
- Medical Director of Maine Cholesterol Center, created after attending John Hopkins Lipid Training Center Program in 1993.
- Champion International Primary Care Network Plan Board physician member from 1993 to 1996.

1985–1986 Family Practitioner
Tri-County Health Systems, Warrenton, GA

- Fulfilled first year of National Health Service duty as primary care doctor in rural health center.
- Assistant Professor of Medicine for Medical College of Georgia with instruction of medical students and family practice residents.
- Served on Georgia Hypertension Committee in 1986.

1982–1985 Maine Dartmouth Family Practice
Augusta, ME

- Internship / Residency, Family Practice

EDUCATION
Boston College, Boston, MA
Dates Attended: 9/1974–5/1978
B.A., Psychology, May 1978, Summa Cum Laude, Phi Beta Kappa
Research Assistant. 3 years, Joseph J. Tecce, Ph.D.
Co-author of several papers, including:

- "CNV Rebound and Aging. II. Type A and B CNV Shapes"
- "CNV and Myogenic Functions: II. Divided Attention Produces a Double Dissociation of CNV and EMG"

Tufts University School of Medicine, Boston, MA
Dates Attended: 9/1978–5/1982
MD, May 1982

PROFESSIONAL LICENSES, CERTIFICATIONS, AND MEMBERSHIPS
Board Certification, July 1985: Diploma, American Academy of Family Physicians
Member, American Association of Family Practice
Member, American Heart Association
Member, Maine Medical Association

6.1.1.1.3 Key Personnel References

References for key personnel must meet the following requirements:

a. Must include a minimum of three professional references outside the employee's organization who can provide information about the key person's work on that assignment.
b. Must include the reference's full name, mailing address, telephone number and email address.
c. For any client contact listed as a reference, must also include the agency's or company's full name and street address with the current telephone number and e-mail address of the client's responsible project administrator or service official who is directly familiar with the key person's performance.
d. Must be available for the Department to contact during the proposal evaluation process.
e. Must reflect the key person's professional experience within the past five years.

The Department reserves the right to check additional personnel references at its option.

References for the key personnel named above are included in the table, below. These references all meet the above-listed requirements and will be available during the proposal evaluation process to provide professional references for the key staff noted.

References for: Sandra Pranger, R.Ph., Account Manager		
Dr. Thomas Kline Medical Director	Iowa Medicaid Enterprise 100 Army Post Road Des Moines, IA 50315	Phone: (515) 725-1297 Cell: (515) 240-5152 Email: tklin@dhs.state.ia.us
Jill Noehren, R.PH. Senior Director, Clinical Program Management	Express Scripts, Inc 6301 Cecilia Circle Minneapolis, MN 55401	Phone: (515)-978-6311 Cell: (314)-443-3789 Email: jill.noehren@express-scripts.com
Cathy Fosselman Core Operations Manager	Iowa Medicaid Enterprise 100 Army Post Road Des Moines, IA 50315	Phone: (515) 725-1086 Cell: (515) 537-6871 Email: cfossel@dhs.state.ia.us

References for: Erin Halverson, R.Ph., Operations Manager		
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6.1.1.1.4 Department Approval of Key Personnel

a. The Department reserves the right of prior approval for all named key personnel in the bidder's proposal.

GHS is not proposing to make any changes to our key personnel that are now in place under the currently-held Professional Services contract with the State of Iowa. GHS recognizes, however, the Department's right of approval for all named key personnel included in this proposal. GHS is prepared to find suitable replacement candidates if, for any reason, a proposed staff person does not meet the Department's requirements or expectations.

b. The Department also reserves the right of prior approval for any replacement of key personnel.

GHS recognizes the Department's right of approval for any candidates proposed as a replacement for any key staffing positions. GHS is prepared to find suitable, qualified replacement candidates if, for any reason, the original candidate does not meet the Department's requirements or expectations.

c. The Department will provide the selected contractor 45 days to find a satisfactory replacement for the position except in cases of flagrant violation of state or federal law or contractual terms. Extensions may be requested in writing and approved by the Department.

GHS will provide satisfactory replacement candidates for all vacant positions within 45 days. GHS understands that extensions must be requested in writing and approved by the Department.

d. The Department reserves the right to interview any and all candidates for named key positions prior to approving the personnel.

GHS recognizes the Department's right to interview any and all candidates for named key positions prior to approving the personnel. GHS will work with the Department to ensure that all requirements and approval processes are met in a timely and efficient manner.

6.1.1.1.5 Changes to Contractor's Key Personnel

a. The contractor may not replace or alter the number and distribution of key personnel as bid in its proposal without the prior written approval of the Department's project director during the transition phase or contract administration during operations, which shall not be unreasonably withheld.
   1. Replacement for key personnel will have comparable training, experience and ability to the person originally proposed for the position.
   2. Replacement personnel (whom the project director or contract administration have previously approved) must be in place performing their new functions before the departure of the key personnel they are replacing and for whom the project director or contract administration has provided written approval of their transfer or reassignment.
   3. The project director or contract administration may waive this requirement upon presentation of good cause by the contractor.

The staffing plan included with this proposal contains no changes to the staffing configuration now in place under the Professional Services contract currently held by GHS. GHS does not plan to make any changes to the number or distribution of key staff. Should changes be required during the transition or operations phase, GHS will seek the appropriate prior written approval from the Department's project director.

Any replacement candidates will meet the Department's requirements for training, experience, and ability, as outlined in the RFP. Pre-approved replacement personnel will be in place prior to the departure of the key personnel they are replacing whenever practicable. In cases where this is not feasible, due to termination, death or resignation of an employee, GHS will seek a waiver of this requirement from the project director and/or contract administration.

b. The contractor will provide the project director or contract administration with 15 days notice prior to any proposed transfer or replacement of any contractor's key personnel.
   1. At the time of providing such notice, the contractor will also provide the project director or contract administration with the resumes and references of the proposed replacement key personnel.

2. *The project director or contract administration will accept or reject the proposed replacement key personnel within 10 days of receipt of notice.*
3. *Upon request, the project director or contract administration will have an opportunity to meet the proposed replacement key personnel in Des Moines, Iowa, within the ten-day period.*
4. *The project director or contract administration will not reject proposed replacement key personnel without reasonable cause.*
5. *The project director or contract administration may waive the 15-day notice requirement when replacement is due to termination, death or resignation of a key employee.*

GHS will provide the project director and/or contract administration with 15 days notice prior to any proposed transfer or replacement of any contractor's key personnel, whenever feasible. Should we be unable to meet the 15-day notice requirement due to termination, death or resignation of a key employee, the Department will be notified immediately and GHS will seek a waiver from the project director and/or contract administration. At the time of notification of transfer or replacement, GHS will provide resumes and references for the proposed replacement personnel and ensure the proposed replacement staff's availability for an on-site meeting with Department staff in Des Moines, Iowa during the ten (10) day approval period.

6.1.1.2 Special Staffing Needs

All contractors must meet the following special staffing needs:

a. *All professional medical staff assigned to this account and working in Iowa must be licensed or certified for practice in the State of Iowa. In addition, professional medical staff must carry appropriate insurance.*

GHS' professional pharmacy staff assigned to this account and working in Iowa have and maintain all appropriate licensures and/or certifications to practice in the State of Iowa.

b. *The Revenue Collections and Estate Recovery Services contractors must provide a fidelity bond as specified in RFP Attachment O Sample Contract to protect against loss or theft for all staff that handle or have access to checks in the contractor's performance of its functions.*

This requirement does not apply to the Pharmacy Medical Services component for which GHS is submitting this proposal.

c. *The contractor will develop and maintain a plan for job rotation and cross-training of staff to ensure that all functions can be adequately performed during the absence of staff for vacation and other absences.*

GHS has in place a comprehensive system of cross-training and job rotation that builds in a level of redundancy to its operations. Employees are familiar with and competent in multiple roles within their area of operation. GHS intends to continue building on and leveraging this system in order to ensure that all functions are fully and consistently executed during the absence of staff for any reason – whether anticipated or not.

GHS' job rotation program is targeted not only at providing adequate coverage during vacations and absences, but also promoting understanding of the overall workflow and continually improving work processes. Rotating employees through similar jobs within the department allows a broader understanding of program objectives and requirements, improving communication between team members and aiding the overall flow of work. Exposing employees to work processes they do not routinely perform can also lead to innovations that may not be readily identified by those immersed in the day-to-day routine.

Within the primary operational units of the IME operation, qualified staff will periodically rotate horizontally between positions. In other words, positions that require similar expertise will be rotated. While a training period is necessary at the onset of rotations, rotation will continue over time to maintain a full understanding of job functions. The trainee moves from training to a position of full responsibility for job functions. Employees are then able to maintain the knowledge imparted in initial training and readily step in to assist as required.

Job rotation schedules will be based on the type of work being performed and the frequency required to retain full knowledge of functional responsibilities. When formal training programs are provided for the staff of an operating unit, staff that rotate into those positions will also receive the training.

d. The contractor will designate staff who are trained and able to perform the functions of sensitive positions when the primary staff member is absent.

GHS presently has staff members in place at the IME who are trained and able to perform the job functions of sensitive positions whenever the primary staff member is absent. GHS will continue to ensure that all functions are fully and consistently executed during the absence of staff for any reason – whether anticipated or not.

6.1.2 FACILITIES

The following topics describe the facility requirements for the professional services contractors during the operations phase.

6.1.2.1 Permanent Facilities

The Department expects that all staff directly associated with the provision of contract services to the IME during the Operations and Turnover Phases will be located at the IME permanent facility (with the exception of Medical Services field staff). Within the General Requirements section of the Technical Proposal, the bidder will provide the Department with the estimated total number of staff, specifying key personnel, other managers or supervisors, and Medical Services field staff.

GHS will continue to locate all staff directly associated with the provision of contract services to the IME at the IME facility in Des Moines, Iowa. We currently have 7.5 FTE staff located at this facility and dedicated to this project. We foresee no changes to this should we re-secure this work. Our staffing plan, included in section 6.1.1 of this response, describes our planned staffing configuration in further detail, including total staffing estimates and key personnel, including managers and supervisors.

6.1.2.1.2 Contractor Responsibilities

The Department expects contractors to provide the following equipment:

a. Proprietary or other software that is not commercially available (other than the standard commercial packages provided by the Department) as approved by the Department
b. Personal workstation printers and associated cables and software, as approved by the Department, to connect them to and use them at the workstations for which the contractor must sign over ownership to the Department
c. Office supplies (except for copier paper and envelopes)
d. Any special needs equipment for ergonomic or other purposes

GHS currently has 7.5 FTE staff members located at the IME facility who work on the Pharmacy Medical Services contract. GHS provides all of the equipment and supplies listed in section 6.1.2.1.2 of the RFP. Should GHS be awarded the contract to continue providing Pharmacy

Medical services to the IME, we will maintain our current office set-up and continue to provide all required equipment and supplies. Ownership of the personal workstation printers and associated cables and software will be signed over to the Department.

6.1.2.2 Courier Service

a. Because contractor and state staff are located at the IME facility during operations, individual professional services contractors do not need to provide courier service. The Core MMIS contractor provides courier service and arranges for pick-up and delivery of IME material to and from specific external entities, specifically the Capitol complex and the United States Post Office.

GHS understands that we do not need to provide individual courier service and will continue to comply with all applicable rules and procedures for pick-up and delivery of IME material to and from external entities.

b. All outgoing mail will go through the IME mailroom, including regular daily mail and small-volume mailings.
   1. For large-volume mailings, the Department will identify the most cost-effective way to print and mail.
   2. The contractor generating the mailing will be responsible for providing a print-ready copy of the documents to the printer the Department selects (such as the state print shop or a commercial print shop).
   3. The Core MMIS contractor will be responsible for the small-volume mailings, and the Department will identify the mailing entity for large-volume mailings.
   4. The Department will pay all postage and external entity mailing costs for IME operational costs.

GHS understands that all outgoing mail will go through the IME mailroom. GHS will comply with all established rules and procedures concerning regular daily mail as well as small- and large-volume mailings.

6.1.3 CONTRACT MANAGEMENT

The State of Iowa has mandated performance-based contracts. State oversight of contractors' performance and payments to the contractors are tied to meeting the performance standards identified in the contracts awarded through this RFP.

As the incumbent vendor for the Pharmacy Medical Services component, GHS is familiar with the State of Iowa's mandated performance-based contracts. GHS will continue to comply with these requirements and will continue to meet all performance standards indentified in any contract that may be awarded as a result of this RFP process.

6.1.3.1 Performance Reporting and Quality Assurance

a. The contracts awarded through this RFP will contain performance standards that reflect the performance requirements in this RFP.
   1. The standards will include timeliness, accuracy and completeness for performance of or reporting about operational functions.
   2. These performance standards must be quantifiable and reported using as much automation as possible.
   3. The Department will select a subset of the standards for the contractors to include in a quarterly public report.

GHS will ensure that it continues to meet all performance standards set forth by the Department. GHS agrees that performance standards will include timeliness and include accuracy and completeness for operational functions. GHS will use quantifiable standards approved by the Department and will automate these to the fullest extent possible. GHS further understands that the Department will select a subset of standards that will be required to be included in a quarterly public report.

b. Meeting the performance standard in the selected indicators will represent average performance.
   1. The Department and the contractors will finalize specific performance reporting and measurements during the first year of operations as listed in RFP Section 6.1.3.1.a.
   2. After the first full year of operations, liquidated damages can result from failure to meet the standards.
   3. The liquidated damages will comprise 1.5 percent of the monthly operations fee if a single performance measure or the total score falls more than five points below the acceptable standard for more than three months in a six-month period.

GHS understands that the Department will finalize specific performance reporting and measurements during the first year of operations as listed in the RFP Section 6.1.3.1a. GHS also understands that after the first year of operations, liquidated damages can result from failure to meet standards. GHS understands that the liquidated damages will comprise 1.5 percent of the monthly operations fee if a single performance measure or the total score falls more than five points below the acceptable standard for more than three months in a six-month period.

c. In addition, the professional services contractors are responsible for internal quality assurance activities. The scope of these activities include the following functions:
   1. Identify deficiencies and improvement opportunities within the professional services contractor's area of responsibility.
   2. Provide the Department with a corrective action plan within ten business days of discovery of a problem found through the internal quality control reviews.
   3. Agree upon timeframes for corrective actions.
   4. Meet all corrective action commitments within the agreed upon timeframes.

GHS has developed an internal quality improvement process that helps us continue to meet and exceed expectations with the clients we serve. GHS will indentify deficiencies and improvement opportunities using this process. GHS will provide the Department with a correction action plan within ten business days of discovery of a problem found through our quality improvement reviews. GHS will agree upon timeframes for corrective action plans and will meet all corrective action commitments within the agreed upon deadlines.

6.1.3.3 Contractor Responsibilities

The components contractors are responsible for the following contract management activities:
a. Develop, maintain, and provide access to records required by the Department and state and federal auditors.

GHS will continue to develop, maintain and provide access to records required by the Department and state and federal auditors.

b. Provide reports necessary to show compliance with all performance standards and other contract requirements.

GHS will continue to provide all reports necessary to demonstrate compliance with all performance standards and other contract requirements. The reports currently in place meet the established requirements under the current contract and have been reviewed and approved by the Department. GHS is willing to work with state staff to make any changes to the format, content or delivery frequency of these reports desired by the Department.

c. Provide to the Department reports regarding components contractors' activities. Individual professional services contractors are to propose and negotiate the content of these reports with the Department. The intent of the reports is to provide the Department and the component contractors with better information for management of the contractors' activities and the Medicaid program.

These reports are currently being provided to the Department as part of the services for which GHS is responsible. GHS will continue to meet the requirements and expectations regarding reporting on contractor activities within our areas of responsibility. GHS is proposing to continue using the Department-approved reports and processes currently in place; however, we are willing to work with state staff to make any changes to the format, content or delivery frequency of these reports desired by the Department.

d. Prepare and submit to the Department requests for system changes and notices of system problems related to the contractor's operational responsibilities.

Suggested system changes and notices of any system problems related to GHS' operational responsibilities will be prepared and submitted to the Department according to the established rules and procedures.

e. Prepare and submit for Department approval suggestions for changes in operational procedures, and implement the changes upon approval by the Department.

GHS will prepare and submit to the Department for approval any suggested changes to the current operational procedures. Approved changes will be implemented swiftly and efficiently.

f. Maintain operational procedure manuals and update the manuals when changes are made.

GHS will continue to maintain the operational procedure manuals used in the administration of these programs. Updates will completed whenever changes are made to the operational procedures of the programs and upon request by the Department.

g. Ensure that effective and efficient communication protocols and lines of communication are established and maintained both internally and with Department staff. No action shall be taken which has the appearance of or effect of reducing open communication and association between the Department and contractor staff.

GHS strives to maintain open and effective communication with the Department and the Department's other vendors. GHS will continue to maintain and follow established lines of communication and protocols to ensure the same effectiveness and efficiency continues under any new contracts resulting from this RFP process. GHS will take no actions that have the appearance or effect of reducing open communication and associated between the Department and any contractor staff.

h. Meet regularly with all elements of the IME to review account performance and resolve issues between contractor and the state.

GHS staff currently has a regularly-scheduled weekly meeting with the Department's pharmacy staff and a regularly-scheduled monthly meeting with the Department and the Medical Services vendor to discuss overlapping pharmacy issues. GHS will continue these efforts and make our staff available to discuss any needs that arise outside these scheduled meetings. GHS is willing to work with the Department to make any desired changes or adjustments to this meeting schedule.

i. Provide to the Department progress reports on professional services contractor's activity as requested by the Department.

Currently, GHS staff sends monthly report cards in a Department-approved format to the Department for review and approval. Once these reports are approved by the Department they are posted to a shared folder for reference and documentation purposes. GHS will continue to provide monthly progress reports to the Department. GHS will also provide any additional progress reports, as requested by the Department.

j. Meet all federal and state privacy and security requirements within the contractor's operation.

GHS is committed to protecting the confidentiality, integrity, privacy and physical security of protected health information (PHI), confidential information, data information, personnel, and supporting technological information resources created, obtained by, and provided to the organization.

GHS has established safeguards to:

- Ensure the security and confidentiality of covered data, information, personnel, and supporting technological resources.
- Protect against anticipated threats or hazards to the security or integrity of covered data and information.
- Protect against unauthorized access to or use of covered data and information.

GHS also has in place mechanisms to:

- Identify and assess risks that may threaten covered data and information maintained by GHS Employees
- Develop written policies and procedures to manage and control these risks.
- Implement and review the plan.
- Adjust the pan to reflect changes in technology, the sensitivity of covered data and information and internal or external threats to information security.

GHS has successfully implemented HIPAA transaction standards and security standards. The following information in the following list is provided in our HIPAA operations policies. Each employee receives a copy of these policies upon hire and acknowledges receipt and review of the policies in writing. As noted, all employees are required to certify their understanding of confidentiality requirements and HIPAA policies. GHS provides HIPAA privacy training to all employees related to keeping protected health information (PHI) confidential. Policies are applied to:

- Email
- Facsimile transactions
- Mail
- Paper destruction
- Caller verification
- Visitors
- Computer system access permissions (external and internal)
- Physical Transport of PHI
- Enrollment

GHS has implemented the following safeguards designed to assure the integrity of system hardware, software, records, and files, including but not necessarily limited to:

- Providing building access cards to all employees and frequent visit vendors (at the GHS Augusta facility).
- Establishing a security reception desk at the GHS Augusta location's front entrance, where a visitor sign-in log is maintained and escort services are initiated. Visitors or vendors who may come in contact with protected health information are also required to comply with GHS confidentiality policies, as evidenced by their signature on a GHS visitor's confidentiality form.
- In the main office, we limiting access to certain office areas to only those employees with a need to access.
- Requiring mandatory HIPAA and confidentiality training for all existing staff.
- Orienting new employees to security and confidentiality policies and procedures, including HIPAA and other State and Federal regulations.
- Conducting periodic review sessions on security and confidentiality procedures and maintaining a log of employee's attendance to these sessions.
- Limiting physical access to systems hardware, software, and libraries.
- Maintaining confidential and critical materials in limited access, secured areas.
- Maintaining back-up files and generator systems in the event of a catastrophic occurrence.

k. Work with the Department to implement quality improvement procedures that are based on proactive improvements rather than retroactive responses. The contractor must understand the nature of and participate in quality improvement procedures that may occur in response to critical situations and will assist in the planning and implementation of quality improvement procedures based on proactive improvement.

GHS prides itself on building proactive improvement into all areas of our operations. We look forward to continuing to work with the Department on making enhancements to our quality improvement procedures. Having been an active participant of the IME for the last five (5) years, we strive to maintain an internal quality plan that embodies this spirit of continual proactive improvements to our operations. GHS will evaluate our performance using the same measures currently in place to measure workflow performance and will continue to assist the Department in the planning and implementation of improvements to these procedures. By monitoring these metrics, managers and staff will be able to identify potential problem areas and take appropriate action in a proactive manner. Additionally, we will utilize our extensive experience and programming practices to prevent problems from occuring.

l. Monitor the quality and accuracy of the contractor's own work.

GHS is committed to providing the Department with high quality and accurate services and deliverables. GHS will continue to monitor the quality and accuracy of all work performed under this Professional Services contract as we do currently.

m. Submit quarterly reports (available electronically) of the quality assurance activities, findings and corrective actions (if any) to the Department.

GHS will continue to submit quarterly reports on the activities, findings, and any corrective actions implemented as we do presently. These reports are currently made available to the

Department electronically and GHS proposes to continue using the same format, content and delivery method that are currently in place. If, for any reason, the current process is not meeting the State's requirements and expectations, GHS is also willing to work with the Department to make any desired changes to the current procedure. Additional reports related to internal quality assurance will be created and submitted upon request, as necessary. If any of the performance standards are not met, GHS would include detailed analysis of the situation and a plan to prevent further deviations from occurring. GHS is committed to maintaining ongoing, effective and clear communications with the Department in the area of internal quality assurance. This continuous monitoring of quality in all areas of our work provides a thorough and ongoing awareness of all aspects of our operations.

n. Perform continuous workflow analysis to improve performance of contractor functions and report the results of the analysis to the Department.

GHS will continue to perform continuous workflow analysis to improve our performance. Results of the workflow analysis will be communicated to the Department, allowing GHS to maintain an ongoing dialogue with the Department on workflow process, and to receive feedback and input from the Department on any proposed changes

o. Provide the Department with a description of any changes to the workflow for approval prior to implementation.

Suggested changes to the workflow will be documented and submitted to the Department for review and approval prior to implementation. We look forward to continuing to work with the Department to make enhancements and adjustments to our process that will ensure our continued ability to deliver the kind of quality, efficient and accurate services for which GHS is known.

p. For any performance falling below a state-specified level, explain the problems and identify the corrective action to improve the rating.
   1. Implement a state-approved corrective action plan within the time frame negotiated with the state.
   2. Provide documentation to the Department demonstrating that the corrective action is complete and meets state requirements.
   3. Meet the corrective action commitments within the agreed upon timeframe.

Should any area of GHS' performance fall below state-specified levels, GHS guarantees that it will clearly identify and explain both the problem encountered and the corrective steps taken to improve the performance rating. GHS presently has in place procedures to be followed in any case where performance falls below a state-specified level. We will use quality improvement tools to evaluate barriers to meeting performance expectations and document corrective actions. Corrective action plans will be state-approved and implemented with the agreed-upon time frame. Documentation will be provided to the Department documentation demonstration that all corrective actions are complete and meet state requirements. If the proposed solution(s) does not improve performance, another solution will be rapidly implemented and the results will be evaluated and documented. Corrective action commitments will be completed within the timeframe approved by the Department.

q. Provide a written response to the Department via e-mail within two business days of receipt of e-mail on routine issues or questions and include descriptions of resolution to the issues or answers to the questions.

Written responses to e-mails received on routine issues and questions will be provided to the Department within two (2) business days of receipt. The majority of these responses, especially on questions or issues that do not require further research or examination, will be turned around well within the two (2) day timeframe. All such written responses will include descriptions of the resolution to the issues or answers to the questions.

r. Provide a written response to the Department via e-mail within one business day of receipt of e-mail on emergency requests as defined by the state.

Written response to the Department will be provided via e-mail within one (1) business day of receipt of any emergency requests. GHS will continue to follow all established policies and procedures, as we do presently.

s. Maintain Department-approved documentation of the methodology used to measure and report completion of all requirements and attainment of all performance standards.

GHS currently has in place Department-approved documentation on the methodology used to measure and report completion of all requirements and attainment of all performance standards. GHS will continue to update and maintain this Department-approved documentation should we re-secure this work.

6.1.3.4 Performance Standards

The following performance standards apply to all contractors for all components unless specified differently.

6.1.3.4.1 Reporting Deadline

a. Provide the required reports within ten business days of the end of the reporting period.

All required reports will be provided within ten (10) business days of the end of the reporting period.

6.1.3.4.2 Documentation

a. Update operational procedure manuals in the state-prescribed format within ten business days of the implementation of a change.

Operational procedure manuals will be maintained in the state-prescribed format. Revisions and updates required due to changes in programs, regulations or contract requirements will be made within ten (10) business days of the implementation of said change.

b. Identify deficiencies and provide the Department with a corrective action plan within ten business days of discovery of a problem found through the internal quality control reviews.

GHS will identify deficiencies and effectively address any performance issues in a written correction action plan within ten (10) working days of discovery of any problem found through internal quality control reviews, as specified in this RFP. The correction action plan will describe the circumstances surrounding the performance issue and the remedial steps that have been taken or will be taken to correct the deficiency, the timing of the corrective acts, who will be responsible for their completion, and who will be responsible for their communication and ongoing monitoring. We will submit the corrective action plan to the state staff person

designated by the Department. Any issues and/or concerns will be identified and brought to the Department's attention immediately upon discovery. GHS has collaborated with the Department on a quality assurance and correction action plan for the PA/PDL programs and will maintain this process going forward. Upon request, GHS is willing to work directly with the Department to make any adjustments or changes desired to improve this process.

In addition, GHS has developed the following change control process. This process, with State approval, will be used going forward for any changes to the program being requested by the Department. GHS has developed a sign-off sheet to document the scope and detail design of the requested changes to ensure that mutual expectations are met. The document includes the start date and/or programming charges. This document requires the signature and date from the approved, designated Department pharmacy staff. This process allows for clear communication/accountability and improved contract management. The following provides a detailed process if a change to this project is required:

1. A Change Service Request (CSR) will be the vehicle for communicating change. The CSR must describe the change, the rationale for the change, and the effect the change will have on the project.
2. The designated Project Manager of the requesting party will review the proposed change and determine whether to submit it to the other Project Managers.
3. All Project Managers will review the proposed change and approve it for further investigation or reject it with the appropriate reasons documented and communicated to the requestor.
4. GHS will specify any fees for the investigation of the change. If approved by the State the investigation is authorized, the Project Managers will sign the CSR, which will constitute approval for the investigation fees. GHS will invoice for any such fees.
5. GHS will perform the investigation to determine the effect that the implementation of the CSR will have on price, schedule, and other terms and conditions of the contract agreement.
6. The Change Service Request must then be updated to include signed authorization from both the State and GHS Project Managers to authorize implementation of the investigated changes.

GHS will provide a Change Service Request order form to the authorized agent at the Department. All changes must be documented in detail and signed by the authorized Department agent. Changes will then be review by GHS staff and presented for research and development to the appropriate parties. Once we have gathered relevant input, we will present draft documentation and an implementation timeline to the Department for final approval. GHS will need a Department-approved distribution list for the change request documentation. Once GHS has the approved documentation and distribution list from the Department, the changes will be implemented according to the agreed upon timeline and the appropriate materials will be disseminated. GHS can offer distribution by US Postal Service, and if the relevant and secure information can be obtained from all parties electronically, GHS can also provide it via an online email newsletter and fax notification.

c. Maintain Department-approved documentation of the methodology used to measure and report on all completed contract requirements and all performance standards. State the sources of the data and include enough detail to enable Department staff or others to replicate the stated results.

Currently, GHS has in place Department-approved documentation of the methodology used to measure and report on all contract requirements and performance standards. GHS staff sends monthly report cards in the approved format and in conformance with this methodology to the Department for review and approval. Once these reports are approved by the Department they are posted to a shared folder for reference and documentation purposes.

Samples of these performance report cards are included, below.

October 2009

PERFORMANCE MEASUREMENT	SCORING RULES	POSSIBLE POINTS	POINTS RECEIVED
FINANCIAL			
Not Applicable for this Monthly Scorecard			
CUSTOMER			
The contractor shall provide sufficient staff, facilities & technology such that 95% of all call line inquiry attempts are answered. The total number of abandoned calls shall not exceed 5% in any calendar month.	Award 30 points if 95% of all call line inquiry attempts are answered. Otherwise, deduct 1 point for each abandoned call under 95% of all call line inquiry attempts.	**30**	**30**
Calls must be answered within thirty (30) seconds. If an automated voice response system is used as an initial response to inquiries, an option must exist that allows the caller to speak directly with an operator. The Contractor shall provide sufficient staff such that average wait time on hold per calendar month shall not be in excess of thirty (30) seconds.	Award 20 points if calls are answered within thirty (30) seconds. Otherwise, deduct 1 point for each call not answered within thirty (30) seconds.	**20**	**20**
All call line inquiries that require a call back, including general inquiries, shall be returned within 1 business day of receipt one hundred percent (100%) of the time.	Award 5 points if call backs are returned within one (1) business day 100% of the time. Otherwise, deduct 1 point for each call back not returned within one (1) business day of receipt 100% of the time.	**10**	**10**
INTERNAL BUSINESS PROCESSES			
Respond to one hundred percent (100%) of pharmacy prior authorization requests within twenty-four (24) hours of receipt.	Award 40 points if pharmacy prior authorization request response is 100% within 24 hours of receipt. Otherwise, deduct 1 point for each prior authorization request not responded to within 24 hours of receipt.	**40**	**40**
LEARNING & GROWTH			
Not Applicable for this Monthly Scorecard			
TOTAL POINTS		**100**	**100**

Figure 4: October 2009 Monthly Scorecard by Functional Area – Prior Authorization

October 2009			
PERFORMANCE MEASUREMENT	**SCORING RULES**	**POSSIBLE POINTS**	**POINTS RECEIVED**
FINANCIAL			
Not Applicable for this Monthly Scorecard			
CUSTOMER			
Not Applicable for this Monthly Scorecard			
INTERNAL BUSINESS PROCESSES			
Provide DHS with access to all supplemental rebate agreements and related documentation within twenty-four (24) hours of request.	Award 40 points if DHS is given access within 24 hours. Deduct 5 points for each additional 24 hours after the first 24.	**40**	**40**
Provide the P&T Committee with required information a minimum of thirty (30) days prior to the meeting.	Award 30 points if info is provided to the P&T Committee at least 30 days prior to the meeting. Deduct 5 points for each additional day that info is not provided.	**30**	**30**
Provide DHS with a written report of the P&T Committees recommendations within three (3) business days of the conclusion of the meeting.	Award 30 points if written recommendations are provided to DHS within 3 business days of the conclusion of the meeting. Deduct 5 points for each additional day that the report is not provided.	**30**	**30**
LEARNING & GROWTH			
Not Applicable for this Monthly Scorecard			
TOTAL POINTS		**100**	**100**
Notes:			

Figure 5: October 2009 Monthly Scorecard by Functional Area – PDL & Supplemental Rebate

October 2009			
PERFORMANCE MEASUREMENT	**POSSIBLE POINTS**	**POINTS RECEIVED**	**COMMENTS**
FINANCIAL			
Not Applicable with this Monthly Scorecard			
CUSTOMER			
PRIOR AUTHORIZATION			
The contractor shall provide sufficient staff, facilities & technology such that 95% of all call line inquiry attempts are answered. The total number of abandoned calls shall not exceed 5% in any calendar month.	**30**	**30**	
Calls must be answered within thirty (30) seconds. If an automated voice response system is used as an initial response to inquiries, an option must exist that allows the caller to speak directly with an operator. The Contractor shall provide sufficient staff such that average wait time on hold per calendar month shall not be in excess of thirty (30) seconds.	**20**	**20**	
All call line inquiries that require a call back, including general inquiries, shall be returned within 1 business day of receipt one hundred percent (100%) of the time.	**10**	**10**	
INTERNAL BUSINESS PROCESSES			
PRIOR AUTHORIZATION			
Respond to one hundred percent (100%) of pharmacy prior authorization requests within twenty-four (24) hours of receipt.	**40**	**40**	
PDL & SUPPLEMENTAL REBATE PROGRAM			
Provide DHS with access to all supplemental rebate agreements and related documentation within twenty-four (24) hours of request.	**40**	**40**	
Provide the P&T Committee with required information a minimum of thirty (30) days prior to the meeting.	**30**	**30**	
Provide DHS with a written report of the P&T Committees recommendations within three (3) business days of the conclusion of the meeting.	**30**	**30**	
PROFESSIONAL SERVICES			
Update operational procedure manuals within two (2) weeks of the implementation of a change.	**5**	**5**	
Provide a response/resolution to DHS Project Management Team within two (2) business days of receipt to requests made in any form (e.g., e-mail, phone) on routine issues or questions.	**25**	**25**	
Provide a response within one (1) business day to DHS Project Management Team on emergency requests, as defined by DHS.	**30**	**30**	
Identify deficiencies and provide DHS with a corrective action plan within ten (10) business days of discovery of a problem found through the internal quality control reviews.	**15**	**15**	
Meet ninety-five percent (95%) of the corrective action commitments within the agreed upon time frame.	**15**	**15**	
Provide the monthly contract management reports within seven (7) business days of the end of the reporting period. (PA Statistics Report by PDL Category)	**5**	**5**	
LEARNING & GROWTH			
PROFESSIONAL SERVICES			
Provide training on operational procedure changes as a result of upgrades or other changes within two (2) weeks of the upgrade.	**5**	**5**	
TOTAL POINTS	**300**	**300**	
TOTAL SCORE		**100.0%**	

Figure 6: October 2009 Monthly Scorecard by Unit – Pharmacy Medical Services

6.1.3.4.3 Annual Performance Reporting

a. The following performance standards are in addition to any performance standards required for individual components. Those individual requirements (if any) appear in the subsections of RFP Section 6 Professional Services Requirements for the individual components.

GHS will continue to meet the performance standards for reporting required under the Pharmacy Medical Services component of the RFP. Additional details on our reporting can be found in our responses to section 6.3 of the RFP, which can be found section 7.2.6 of this bid proposal.

b. The contractor will provide annual performance reporting no later than October 15 of each contract base and option year for the state fiscal year (SFY) that ended in the prior month of June. (Example: Provide data by October 15, 2009, for the state fiscal year that ended on June 30, 2009.) The contractor will present the required data in Department-approved format and content for the following annually reported performance standards. DHS will publish the annual measurements by the following February 15.

GHS will provide annual performance reporting no later than October 15 of each contract base and option year for the state fiscal year (SFY) that ended in the prior month of June. GHS will present the required data in Department-approved format and content for annually reported performance standards.

6.1.3.4.3.2 Pharmacy Medical Services

a. The Pharmacy Medical Services contractor will provide state savings as follows:
1. $12.5 million in state savings in SFY 2011 (2009 number increased by 7 percent for 2010 and again for 2011)

GHS assumed responsibility for the initial Iowa PDL design and implementation during the summer of 2004. The PDL was officially launched in January 2005 but we were able to start some of the supplemental contracts in Q4-2004. Despite the restrictions imposed by the Legislature regarding certain drug categories including mental health drugs which comprised over one third of the entire budget, the Department was able to realize over $7 million of state savings in just over six months. The Recommended Drug List strategy was a key factor in allowing the State to collect several million in mental health drug supplemental rebates. The total savings represented 8.8% of the pre-rebate drug paid amount.

The total net state cost savings realized so far are $7 million in SFY 2005, $15.6 million in SFY 2006, $16.3 million in SFY 2007, $29.3 million in SFY 2008 (despite losing all the dual lives as related to Medicare Part D), and $30.7 million in SFY 2009.

We have projected $28.2 million in savings in SFY 2010 and $29.5 million in SFY 2011. This is 8% lower than the prior year due to unanticipated changes in the FMAP rate for the state. Iowa is currently enjoying an enhanced FMAP which reduces the state share to a blended average 28.66% rate for the year. This state share is 12.9% less than the prior year and 25% less than the state rate in SFY 2007. Despite this handicap the positive, reciprocal relationship that GHS has formed with the IME staff will allow the State's savings expectations to be maximized.

2. In every subsequent base and option year, an increase of 7 percent more than the SFY 2011 state savings or an increase of 7 percent more than the highest overall state savings in any year after SFY 2011, whichever is higher

GHS will continue to meet and exceed the required annual state savings targets projected forward using the $12.5 million base. As stated in the previous response, we would be unable to guarantee 7% annual improvements off our actual performance expressed in state dollars due to factors outside our control, most importantly the FMAP rate. Let us use SFY 2010 as an example again. We are projecting $98.5 million in total (state and federal) savings. The total savings will increase $5.3 million from $93.2 million but the state savings will decrease $2.5 million due to a decrease in the state share from 32.95% to 28.66%.

Iowa Pre-rebate PDL Rebate and Total Savings - Run November 2009

Quarter	Number of Claims	Actual Sum Paid Amount	Projected Sum Paid Amount	PA/PDL Savings		Number of Eligibles (Aid Plan IDs of 100, 200 and 300)	% change from previous quarter	Number of Users	% change from previous quarter	CMS Rebates	Supp Rebates	Total Rebates	SFY2005 (last 6 months)
Q1 CY2004	1,650,952	$ 93,755,148				327,848		182,416		$ 22,418,718		$ 22,418,718	
Q2 CY2004	1,645,312	$ 95,128,647				333,352	1.7%	178,128	-2.4%	$ 22,842,388		$ 22,842,388	
Q3 CY2004	1,643,012	$ 96,580,034				340,598	2.2%	175,049	-1.7%	$ 22,410,087		$ 22,410,087	
Q4 CY2004	1,756,405	$ 104,285,277				341,548	0.3%	192,296	9.9%	$ 24,166,297	$ 1,507,920	$ 25,674,218	
Q1 CY2005	1,787,432	$ 105,360,915	$ 108,645,103	$ 3,284,187	$ 3,284,187	343,292	0.5%	201,854	5.0%	$ 26,871,095	$ 3,901,393	$ 30,772,488	$ 209,432,578
Q2 CY2005	1,743,495	$ 104,071,663	$ 108,536,648	$ 4,464,985	$ 4,464,985	347,169	1.1%	189,123	-6.3%	$ 27,790,006	$ 3,934,986	$ 31,724,993	
Q3 CY2005	1,749,888	$ 105,636,933	$ 110,176,881	$ 4,539,948	$ 4,539,948	352,060	1.4%	183,275	-3.1%	$ 27,124,324	$ 4,608,496	$ 31,732,820	
Q4 CY2005	1,887,350	$ 114,022,769	$ 119,987,368	$ 5,964,599	$ 5,964,599	352,364	0.1%	197,068	7.5%	$ 29,214,763	$ 5,249,297	$ 34,464,060	
Q1 CY2006	963,912	$ 57,702,928	$ 62,423,820	$ 4,720,892	$ 4,720,892	354,303	0.6%	181,953	-7.7%	$ 18,265,965	$ 3,284,426	$ 21,550,390	
Q2 CY2006	910,406	$ 55,003,319	$ 60,303,074	$ 5,299,755	$ 5,299,755	356,641	0.7%	166,873	-8.3%	$ 15,386,243	$ 2,950,997	$ 18,337,240	
Q3 CY2006	908,988	$ 55,863,869	$ 60,856,176	$ 4,992,306	$ 4,992,306	356,717	0.0%	161,340	-3.3%	$ 15,048,847	$ 3,273,922	$ 18,322,769	
Q4 CY2006	939,838	$ 58,956,206	$ 63,484,932	$ 4,528,726	$ 4,528,726	352,130	-1.3%	171,656	6.4%	$ 16,558,461	$ 3,454,732	$ 20,013,193	
Q1 CY2007	964,893	$ 62,619,455	$ 66,307,189	$ 3,687,734	$ 3,687,734	351,286	-0.2%	179,927	4.8%	$ 19,402,894	$ 3,652,927	$ 23,055,821	
Q2 CY2007	907,783	$ 57,110,956	$ 63,737,961	$ 6,627,005	$ 6,627,005	353,234	0.6%	163,781	-9.0%	$ 18,766,364	$ 3,731,720	$ 22,498,084	
Q3 CY2007	897,996	$ 54,570,388	$ 63,701,532	$ 9,131,144	$ 9,131,144	358,968	1.6%	162,293	-0.9%	$ 17,949,049	$ 3,386,071	$ 21,335,120	
Q4 CY2007	968,644	$ 59,758,279	$ 69,283,552	$ 9,525,274	$ 9,525,274	358,334	-0.2%	175,333	8.0%	$ 23,411,767	$ 3,409,752	$ 26,821,519	
Q1 CY2008	978,934	$ 61,606,276	$ 71,173,152	$ 9,566,876	$ 9,566,876	360,688	0.7%	182,299	4.0%	$ 24,455,515	$ 3,505,768	$ 27,961,283	
Q2 CY2008	884,440	$ 54,118,514	$ 65,621,948	$ 11,503,434	$ 11,503,434	364,963	1.2%	166,939	-8.4%	$ 21,103,644	$ 3,854,519	$ 24,958,163	
Q3 CY2008	922,074	$ 56,613,498	$ 69,069,202	$ 12,455,704	$ 12,455,704	371,856	1.9%	166,475	-0.3%	$ 21,702,342	$ 3,692,195	$ 25,394,537	
Q4 CY2008	976,238	$ 61,965,921	$ 73,722,606	$ 11,756,685	$ 11,756,685	380,508	2.3%	178,107	7.0%	$ 24,286,343	$ 3,866,608	$ 28,152,951	
Q1 CY2009	1,023,005	$ 67,474,376	$ 78,479,161	$ 11,004,785	$ 11,004,785	387,474	1.8%	192,427	8.0%	$ 28,177,622	$ 3,174,549	$ 31,352,171	
Q2 CY2009	1,001,767	$ 64,152,187	$ 78,316,787	$ 14,164,600	$ 14,164,600	389,889	0.6%	184,224	-4.3%	**$ 25,748,755**	**$ 4,374,123**	**$ 30,122,878**	

Figure 7: Iowa Pre-rebate PDL Rebate and Total Savings

Looking at this phenomenon from the opposite direction, in a year or so the enhanced match will disappear and the state share will jump back up making it look like additional savings have been achieved when in fact we may not have actually done anything to merit such a claim.

b. The state savings shall be realized from the preferred drug list, improvements in rebate billing and collections not connected with increases in rebate rates, and any other new and quantifiable pharmacy cost recovery or pharmacy cost avoidance strategies (not connected with rebate changes or any rate changes) implemented by the contractor that do not conflict with or require changes in Iowa law.

We recognize what types of interventions the State wishes to count towards allowable savings. The savings currently primarily originate from three "buckets"- PDL and PA related cost avoidance and marketshare shifts in utilization, supplemental rebates and increased federal rebates (attributable to PDL design). SFY 2009 is a good year to use to understand the relative contributions of each bucket. The total state and federal net savings for the year was $93.2 million. The smallest portion of $15.1 million (16.2%) was due to supplemental rebates. The PDL and prior authorization induced changes in prescribing behavior accounted for $37.5 million in savings (40.2%). This bucket would also include other utilization controls imposed by the State such as pill splitting (which is one area that could be expanded for added savings). Improved CMS rebates account for $40.6 million in savings (43.6%). This is shown in Figure 7,

above. This last savings source is vital to maintaining optimal net costs. CMS rebates sometimes allow brands to cost much less than their generic counterparts, especially during the first six months after any exclusive generic is released. For a historical perspective the total of all CMS rebates due the State expressed as a percent of the pre-rebate drug expenditure averaged 23.7% in SFY 2004 prior to PDL implementation. Since then the federal rebate percentage has increased to over 40% in SFY 2009. Most of this increase (10 percentage points) was directly attributable to the PDL design and seen immediately in Q1-2005 (up 4.6% points). As proud as we are about this accomplishment we cannot take credit for all increased savings in the federal CMS rebates. In 2007 the CMS rebates improved an average 5 percentage points due to the redefinition of AMP imposed by the DRA. This increase was not uniform across all drugs and in fact some drugs experienced rebate decreases. We had to constantly monitor the fluctuating rebates and make timely revisions to the PDL in order to maximize savings opportunities.

Now that the State has been allowed to revise its SMAC methodology it will be possible to increase the generic utilization percentage and reduce net costs further. We will be able to delist a number of brands preferred over generic counterparts and thus reduce the State's exposure to any risk or uncertainty concerning staying under the aggregate FUL cap.

We have other cost savings ideas that may be suitable for Iowa. In Maine we are currently beta-testing an initial 15 day supply limit on certain medications. This is being tested on drugs that have high discontinuation rates, usually due to side effects or poor efficacy. As examples Chantix and nicotine patch wastage have been significantly reduced so far.

More and more drug categories will be suitable for alternative drug category- first trials. This strategy has been very successful with ACE inhibitors inserted before ARBs. It also works well with SNRIs, atypicals (for certain indications) and antineoplastics.

Splitting can be expanded beyond just scored tablets. Many long acting drugs, like statins, are viable candidates for splitting since moderate daily dosing variations do not affect the attainment or maintenance of vital outcomes.

Maximal daily dose and dose consolidation opportunities present themselves every year. Some drugs are much more prone to off-label use and abuse and it appears that this will warrant much more time and attention in the future. Although we do have quite a few other ideas the one last thought included here is to require proof of adequate outcomes in more drug classes. As an example for several expensive antidiabetic drugs we would propose collecting baseline hgbA1C levels and making PA renewals contingent on meeting target levels.

c. Using the SFY 2010 statistically valid survey as a baseline, the Pharmacy Medical Services contractor shall demonstrate the satisfaction rate of Medicaid pharmacy services and achieve the following results:
   1. An overall satisfaction rating of 3.85 (on a 5-point scale) in SFY 2011
   2. In every subsequent base and option year, an increase of 2 percent more than the SFY 2011 rating or an increase of 2 percent more than the highest overall rating in any year after SFY 2011, whichever is higher

Presently GHS conducts a yearly Provider Satisfaction Survey to demonstrate the satisfaction rate of Medicaid pharmacy services. We will continue to conduct these surveys to ensure that the results outlined above are met and/or exceeded.

d. The Pharmacy Medical Services contractor will use a Department-approved, consistent survey instrument and methodology. The Department will pay 50 percent of the cost of conducting each survey.

GHS will continue to use our current, Department-approved Provider Satisfaction Survey and methodology, unless otherwise requested by the State. GHS understands that it will be our responsibility to pay the percentage specified by the Department.

6.1.4 TRAINING

All contractor staff will receive appropriate training in the systems functions that they will use. The Department will require that the Core MMIS contractor provide MMIS and workflow process management training. The Department will arrange contact management (call center) and tracking system training for all professional services contractor staff members who interface with these systems. Likewise, the Department will provide DS/DW system training to all professional services contractor staff members who will use the system.

GHS will participate in any applicable training sessions required by the Department. GHS maintains a deep and long-standing commitment to ensuring a valued and highly trained staff and will continue to work with the Department to guarantee that our staff is appropriately trained to use any and all systems that they will use in the performance of work under any contract that may result from this RFP process.

a. Each contractor will be responsible for training its staff in the system and operational procedures required to perform the contractor's functions under the contract.

GHS' does not anticipate making any changes to the existing staff assigned to the IME project. Current staff has undergone all appropriate and applicable training in systems and operational procedures required to perform their individual job functions under the current contract. Our commitment to training, however, has developed into a comprehensive and thorough program of both initial and ongoing staff trainings. Our training program extends across the spectrum – from training new staff, to training current staff on new policies and procedures, to training staff on changes to existing policies and procedures. Current staff will continue to undergo training on any new policies or procedures or changes to the existing policies and procedures.

Any new staff that joins the GHS IME team will be required to participate in new staff training. Depending upon the position the new employee is filling, there are significant resources available to train the new employee and provide a conduit for further education and support of that employee in the capacity they have been asked to fulfill.

GHS maintains an electronic folder system containing all documentation to support the State's account. This information is available to existing employees as well as new employees. New employees are given a handbook if they wish to have a hard copy version of these program detailed memos and they are encouraged to set up a method that works best for them individually. Any new employee is assigned an existing staff member to mentor them throughout specific components of their training and all staff members are available for support at all times.

b. Each contractor will designate a trainer for its component who will train the professional services contractor's staff.

GHS' Account Manager is currently the designated trainer for the Pharmacy Medical Services component. The Account Manager is supported by both the Clinical Pharmacy Manager and

Operations Manager; however the Account Manager is ultimately responsible for ensuring that staff is trained and kept up to date on any applicable changes or additions to existing policies and procedures. GHS proposes to continue this arrangement under any future contracts, unless otherwise specified by the Department.

c. Each professional services contractor will provide initial and ongoing training to its staff in its operational procedures. The training will occur when:
1. New staff or replacement staff are hired
2. New policies or procedures are implemented
3. Changes to policies or procedures are implemented

GHS current training program is designed to provide initial and ongoing training for the situations outlined in this requirement. GHS will ensure that staff is adequately training in operational procedures, including any additions or changes to the existing policies and procedures.

6.1.5 Operational Procedures Documentation

a. The professional services contractors must maintain operational procedures in the Department-prescribed format documenting the processes and procedures used in the performance of their IME functions. RFP Section 4 Project Management provides further detail on the expected deliverables.

GHS will maintain operational procedures manuals documenting processes and procedures used in the performance of our IME functions. Further, GHS understands and agrees to follow the timeframes, formats, and guidelines for documentation and revisions as prescribed by the Department. As the incumbent vendor, GHS already has this documentation in place and is prepared to provide copies of any existing operations manuals and support information to the Department for review, upon request.

b. The contractor will document all changes within 10 business days of the change in the format prescribed by the Department. The contractor will provide to the Department updated documentation within 10 business days of the date changes are installed. The contractor must use version control to identify current documentation.

All changes will be documented within the prescribed timeframe. Updated documentation will be provided to the Department within ten (10) business days of the date changes are implemented. Version control is used with all documentation that GHS maintains to identify the most current version.

c. All documentation must be provided in electronic form and made available online.

All documentation can be provided in electronic form and made available online.

d. The contractor will maintain standard naming conventions in the documentation. The contractor will not reference the contractor's corporate name in any of the documentation.

GHS understands that standard naming conventions must be maintained in all documentation. GHS will not reference our corporate name in any of the documentation we maintain.

6.1.6 SECURITY AND CONFIDENTIALITY

a. When not occupying state space, the contractor must provide physical site and data security sufficient to safeguard the operation and integrity of the IME. The contractor must comply with the Federal Information Processing Standards (FIPS) outlined in the following publications, as they apply to the specific contractor's work:

1. Automatic Data Processing Physical Security and Risk Management (FIPS PUB.31)
2. Computer Security Guidelines for Implementing the Privacy Act of 1974 (FIPS PUB.41)

The majority of services performed under this contract will be performed at the IME location in Des Moines, Iowa. The remaining services are performed at GHS' headquarters located in Augusta, ME. GHS considers security and confidentiality of the utmost importance in the handling of all our customers' information. To protect the confidentiality, integrity and availability of information, GHS has in place appropriate physical site and data security measures. GHS is compliant with HIPAA and all other State / Federal / Client mandates regarding the confidentiality of Protected Health Information (PHI), including the Federal Information Processing Standards (FIPS) included in this RFP requirement.

GHS' technical staff is experienced and responsive to the needs of our clients. GHS' data center is located right next to an electrical substation, which reduces the plausibility of a power outage. Our data center is also housed in the same building as the State of Maine's Emergency Services, Public Safety Services, and E-911 Call Center. GHS has its own UPS and generator system. The building maintains 24/7/365 security.

GHS will house all database servers and communications in its data center on-site in Augusta, Maine. Our data center is comprised of current technology and can be expanded if needed to meet the growing storage and performance demands over the life of this project. We manage over a dozen accounts and process data extracts and loads on both a regular and ad hoc basis. We currently manage over 20 major databases and manipulate over 2 million records per day. We use database replication for performance and security purposes to support our developers and analysts in their own environment.

GHS implements industry-standard storage mechanisms to ensure the availability and integrity of all data for which we are responsible. GHS houses mission-critical data on a highly fault-tolerant Storage Area Network (SAN) infrastructure, and data is replicated to our secondary SAN. All critical data is backed up to tape and stored offsite. Our technical staff follows standard operating procedures and strict policies to ensure confidentiality, integrity, and availability of stored data.

To ensure continuity of data and processes in the case of a disaster, GHS maintains a comprehensive disaster recovery plan. This plan includes all policy related to backup and restoration of data, backup power supplies, redundant systems, offsite facilities, potential scenarios, and the procedures to follow in the event of a disaster.

We maintain two offsite facilities to house warm backups of mission critical application and data servers and storage facilities for tape backups. Our tape backup storage facility is at location remote from our home offices in Augusta, Maine. Our server co-location is located in a city

outside the city of Augusta, but within a reasonable distance for our Network Services team to access it in a timely manner in the event of a disaster.

The agreements for both of the facilities described above include a requirement for HIPAA compliance and maintenance of GHS' required levels of security. GHS property (servers, tapes, etc.) located at these facilities are locked and secured. Only properly trained members of our staff have access to these facilities. Communication to and from our server co-locations is over a secure and private point-to-point connection.

Included within our disaster recovery plan are the policies and procedures related to backing up all information housed within our data center. Our production servers are mirrored to our server co-location throughout the day. Incremental tape backups of our entire data center are processed on a daily basis, with full backups occurring once a week. These tapes are then moved to our secure storage facility the following business day.

In addition to data backups and our mission critical server co-location, we also have backup power and FM-200 gas fire suppression systems. These minimize the risk of failure due to power outages or fire, the most likely of potential disaster scenarios. Testing of the network Uninterrupted Power Supply (UPS) and generator is fully automated. A failure in any of the tested components triggers a notification to be sent to all network services employees and the Director of Management Information Services (MIS). Since the testing occurs during regular business hours, any deficiency that is found can be resolved quickly. In addition to weekly maintenance, maintenance of backup power systems is scheduled twice a year, at six month intervals.

In the event of a brief power failure, the UPS systems will immediately provide power to GHS' data center. The UPS system can provide power to the data center for approximately 20 minutes; however, the generator is programmed to activate within 30 seconds of a power failure. If a power failure lasts longer than a few minutes, the generator is capable of providing power to the data center and selected office facilities indefinitely, as long as it is fueled.

b. In all locations, the contractor must safeguard data and records from alteration, loss, theft, destruction, or breach of confidentiality in accordance with both state and federal statutes and regulations, including but not limited to Health Insurance Portability and Accountability Act (HIPAA) requirements. All activity covered by this RFP must be fully secured and protected.

Data transmission lines are located in rooms protected by secured doors. Only those technicians with a business need have access to those doors. Systems hardware and software is stored in secured rooms with limited access. Systems libraries are protected via access controls within the system. GHS employs the "minimum access necessary" principle, providing access only to those employees who need it to perform their job functions.

Visitors to the office and any secured areas must sign in/out and be escorted at all times by an employee who has been granted access.

GHS uses a shredding company to destroy any confidential paper and electronic media (CDs, floppy disks, tapes, etc). These items are placed in locked bins, and then transported by the shredding company for destruction.

Upon hire and annually thereafter, all employees read and sign the GHS Confidentiality Policy, which requires the protection of all patient identifiable and proprietary corporate resources. Employees who use systems that reside on the company servers are also required to read and sign an additional data usage Security Policy. New employees receive security and privacy training. Periodic security reminders are provided in multiple ways, including but not limited to training classes, posters, and various emails.

All data moved between GHS and business partners is encrypted using, at a minimum, 128-bit encryption. For transmission to and from our data center not made through a web interface we use 1024 bit DSA SSH Version 2 encryption. Because GHS processes medical claims data, were compliant with HIPAA and all other State / Federal / Client mandates regarding the confidentiality of Protected Health Information (PHI).

The primary goal of security is to make data available to users with the proper authorization while supporting data confidentiality and integrity. To comply with access control requirements, the following safeguards have been implemented:

- Unique user IDs are required for all users of the system. No shared user IDs have been or will be established.
- Emergency access procedures are implemented and enable access to the data should an emergency arise.
- Automatic logoff has been implemented.
- Encryption and decryption can be used for all Protected Health Information (PHI) transferred between GHS and its clients.

Systems at GHS have multiple layers of security on the components of the system, including:

- Networks
- Operating systems
- Firewalls
- Application systems and their programs
- Files and their data elements

The safeguards described below support the primary goal of security, which is to make the data available to users with the proper authorization while supporting data confidentiality and integrity within this GHS enterprise.

1. Audit controls are in place to enable the monitoring of activity in the system.
2. Integrity safeguards to protect the data are as follows:
    - Access to data on files and databases is restricted
    - Control totals on files are validated.
    - Procedures are in place to address situations where data load programs abnormally end.

3. When electronic transmission of Protected Health Information (PHI) occurs between clients, secure transmission and encryption methods can be utilized to protect the information in transit.

GHS provides secure login functionality for all web-based and non-web based systems. This applies to the web portal and ETL tools used for data collection from dispensers, as well as all web-based query and reporting tools. 128-bit internet/intranet encryption is used for registration and all login processes. GHS uses Thawte SSL digital certification to secure all web-based applications.

Users are required to change the initially assigned password at their first login and to follow the system password requirements below:

- Minimum length of eight characters and type.
- Must be changed every thirty (30) days.
- Minimum of five (5) new passwords must be used prior to a password being re-used.

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

There are five (5) primary role categories:

- Operating Systems and Network Administrators, who have the responsibility for setting up and maintaining the security for the operating systems, network, and firewalls.
- Web Administrators, who have the responsibility for configuration and maintenance of the security for web servers.
- Database Administrators, who have the responsibility for controlling access to data entry screens, programs, files, and databases. They are responsible for setting up user security access with the roles defined to perform their job functions.
- Developers, whose roles on production systems are limited to the privileges needed for data integrity purposes to research questions and issues, resolve and fix production problems, and generate end-user reports.
- Users, whose roles are defined during the implementation process. As part of the system setup, users are defined along with the roles needed to perform their job functions. These user job definitions are mapped to the appropriate role definition(s) and the user is assigned the appropriate role or roles required to complete their daily tasks. As the user's job responsibility changes, the user's profile is updated to remove and/or add the roles.

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

c. Safeguards designed to assure the integrity of system hardware, software, records, and files include:

1. *Orienting new employees to security policies and procedures*
2. *Conducting periodic review sessions on security procedures*
3. *Developing lists of personnel to be contacted in the event of a security breach*
4. *Maintaining entry logs for limited access areas*
5. *Maintaining an inventory of Department-controlled IME assets, not including any financial assets*
6. *Limiting physical access to systems hardware, software, and libraries*
7. *Maintaining confidential and critical materials in limited access, secured areas.*

GHS presently has in place sufficient safeguards to meet the Department's requirements for preserving the integrity of system hardware, software, records and files. These safeguards include all of the following and are described in further detail in sections 6.1.6.a and 6.1.6.b of this proposal:

1. Orienting new employees to security policies and procedures
2. Conducting periodic review sessions on security procedures
3. Developing lists of personnel to be contacted in the event of a security breach
4. Maintaining entry logs for limited access areas
5. Maintaining an inventory of Department-controlled IME assets, not including any financial assets
6. Limiting physical access to systems hardware, software, and libraries
7. Maintaining confidential and critical materials in limited access, secured areas.

d. The Department will have the right to establish backup security for data and to keep backup data files in its possession if it so chooses. Exercise by the Department of this option will in no way relieve the contractor of its responsibilities.

GHS recognizes the Department's right to establish backup security for data and to keep backup data files in its possession if it so chooses. GHS understands that the decision to exercise this option will in no way relieve us of our responsibilities.

6.1.7 ACCOUNTING

a. The contractor will maintain accounting and financial records (such as books, records, documents, and other evidence documenting the cost and expenses of the contract) to such an extent and in such detail as will properly reflect all direct and indirect costs and expenses for labor, materials, equipment, supplies, services, etc., for which payment is made under the contract. These accounting records will be maintained in accordance with generally accepted accounting principles (GAAP). Furthermore, the records will be maintained separate and independent of other accounting records of the contractor.

Our business model is based on complete program and fiscal transparency. This includes communicating fully and openly with Department staff (and other public officials as directed). GHS maintains accounting records to properly reflect all direct and indirect costs and expenses for which payment is made under the contracts we hold. All GHS accounting records are maintained by project, by cost center (direct/indirect), and by account (category, e.g., travel). All accounting records are maintained in accordance with Generally Accepted Accounting Principles (GAAP). This allows GHS to readily meet any requirements regarding the maintenance of records for each contract, all of which are maintained separately and independently of other GHS accounting records. All accounting records are maintained in accordance with legal and regulatory guidelines and timeframes.

GHS hires a major accounting firm to conduct a financial audit of the company every year, as well as a SAS 70 audit every other year. In recent years we've contracted with the firm Baker,

Newman and Noyes to conduct our audits. GHS can provide a complete copy of any new audit, including the management letter, to the State after it is produced, if desired. GHS can also provide other financial documents, like balance sheets and income statements, to authorized Department staff on an annual and semi-annual basis.

b. Financial records pertaining to the contract will be maintained for five years following the date of final payment for the contract.

All financial records pertaining to this contract will be maintained for five years following the date of final payment for the contract.

6.1.8 BANKING POLICIES

Professional services contractors in the IME may receive checks or money orders related to the work that they perform. These checks and money orders may be for refunds, recoveries, cost settlements, premiums, or drug rebates. All professional services contractors are to meet the following requirements for checks or money orders.

a. Any unit that receives checks or money orders will log and prepare all payments for deposit on the day of receipt and deliver them to the Revenue Collections contractor's designated point of contact for daily deposits.

b. Any unit that receives checks or money orders will assist in the maintenance and updating of the existing check classification code schematic, as necessary.

c. Any unit that receives checks or money orders will provide assistance to the Department, Division of Fiscal Management, in the reconciliation of the monthly Title XIX Recovery bank account if requested to do so.

Only the Revenue Collections contractor will make the deposits, as listed in RFP requirement 6.6.1.2.d.

GHS understands that only the Revenue Collections contractor will make deposits, as listed in the RFP requirements. GHS will continue to follow all established banking policies and procedures as outlined in section 6.1.8 of the RFP.

6.1.9 PAYMENT ERROR RATE MEASUREMENT (PERM) PROJECT

a. Pursuant to the Improper Payments Information Act (IPIA) of 2002 and federal regulations at 42 CFR Parts 431 and 457, all states are required to participate in the measurement of improper payments in the Medicaid and CHIP programs. Iowa's participation began in federal fiscal year 2008 (October 1, 2007, through September 30, 2008) and is scheduled to continue every three years. The PERM Project measures the following aspects of the Medicaid and CHIP programs:

1. *Eligibility – the eligibility of the Member for the program and, if applicable, enrollment in a managed care plan.*
2. *Medical Review – the medical necessity and appropriate medical classification of the service that was provided.*
3. *Data Processing Review – the appropriate processing of the paid claim in the claims processing system, taking into account all necessary edits. This includes verifying the appropriate rate cell and payment for managed care (capitation) payments.*

b. The Centers for Medicare and Medicaid Services (CMS) manage the PERM Project for all states, in which they contract certain aspects of the work. Required state involvement includes work that is performed by the IME and its contractors. During the course of the PERM Project, IME policy staff and contractors are responsible for the following:

1. *Department Program Integrity Director and Manager (Department Policy) – Project coordination between all IME units and overall project management for IME-related work*
2. *DW/DS – Submission of paid claims data, including details associated with the claims that are selected for review*

3. *Provider Services – Issuance of general project notifications, assistance with ensuring that providers submit their documentation timely, and provision of copies of licenses or other enrollment documents upon request.*
4. *Provider Cost Audits and Rate Setting – Assistance with repricing claims in cases of potential findings of overpayments or underpayments and consultation related to reimbursement methodologies and pricing of claims*
5. *Medical Services – Re-review of providers' documentation related to potential medical review errors and recommendation as to potential disputes*
6. *Core – Claims processing and MMIS expertise and consultation related to pricing and payment of claims*
7. *SURS – All follow-up provider recovery or repayment actions associated with findings of overpayments or underpayments*

While the requirements for the PERM Project, as outlined in section 6.1.9 of the RFP, do not pertain explicitly to the Pharmacy Medical Services component for which GHS is submitting a proposal, we will continue to provide any required support and assistance to the State, at the request of the Department.

6.1.10 SUBCONTRACTORS

a. Subcontractors must comply with all requirements of this RFP for all work related to the performance of the contract.

GHS will not be using any subcontractors in the performance of services required under this contract.

6.1.11 REGULATORY COMPLIANCE

a. All professional services components acquired through this procurement are expected to be fully compliant with state and federal requirements (including HIPAA requirements) in effect as of the date of release for the RFP and with any changes that subsequently occur unless otherwise noted.

GHS' programs and systems are fully compliant with all state and federal requirements, including HIPAA requirements, in effect as of the date of release for the RFP.

b. Bidders are responsible for describing how their proposed solution meets and will remain in compliance with state and federal requirements (including HIPAA requirements for transactions and code sets, national provider identifiers (NPI), privacy and security).

Compliance with these regulations, particularly the HIPAA requirements, is important to the health care industry at large. GHS understands that standards translate into processing efficiencies and improvements. Therefore, we are committed to staying ahead of changes to these regulations. We take a proactive stand regarding finalizing new standards and implementing them earlier than the published deadlines. GHS regularly reviews our systems, processes and procedures for HIPAA compliance and compliance with pertinent state and federal rules, regulations and guidelines.

6.1.12 AUDIT SUPPORT

a. All contractors are expected to support and provide assistance with any state and federal audits and certifications as the Department requests. Examples include but are not limited to the annual audit that the state auditor's office conducts, the Medicaid Integrity Group (MIG) review and the Office of the Inspector General (OIG) audits.

GHS has extensive experience in assisting our clients with audits. In 2006 we provided support, documentation and assistance to the Department when GHS' POS and Clinical Pharmacy Services were included as part of the overall Iowa MMIS certification process. In 2008, we assisted the State of Iowa in preparing for the audit process by providing documentation, access to files, and documented business processes as well as performing a variety of other tasks. We assisted the State of Maine with their Office of the Inspector General (OIG) audit in 2006 and are currently helping them to prepare for their follow-up OIG audit. We will continue to provide this kind of access and support to the State of Iowa for any state or federal audit or certification process.

6.1.13 NO LEGISLATIVE CONFLICTS OF INTEREST

a. *In the event that the bidder (prior to contract award) or contractor (after contract award) is directly involved with or otherwise supports legislation impacting the Medicaid program but outside the role as the IME contractor, notification to the Department is necessary.*

GHS understands and will notify the Department if ever we, outside of our role as an IME contractor, become directly involved with or in some way support legislation that impacts the Medicaid program.

b. *If this situation exists prior to proposal delivery, the bidder should reflect this status in the response to the requirements in this section. If it exists prior to contract award, the bidder must notify the issuing officer in writing. If it exists after contract award, the contractor must notify contract administration prior to the next legislative session.*

At this time, no such situation exists; however, should such a situation arise prior to contract award, GHS will provide the issuing officer with written notification. Similarly, if a situation arises post-award, GHS will provide the contract administration with the required notice prior to the next legislative session.

c. *At all times, the bidder or contractor must ensure that the legislation does not pose a conflict of interest to IME work in their proposal and contract. If a conflict exists, the bidder or contractor must do one of these things: withdraw their support of the legislation; or withdraw from consideration for contract award (while a bidder) or terminate contract according to termination requirements in the contract (while a contractor). This ongoing restriction applies throughout all phases of the contract.*

GHS understands the situations described in requirements a. and b. of this section must not pose a conflict of interest to our work with the IME. We will be diligent in ensuring that we do not enter into a situation that poses such a conflict. Further, GHS understands that if a legislative conflict of interest occurs outside of our control that we must withdraw our support of the legislation, withdraw from consideration for a contract award or terminate a contract according to termination requirements.

d. *At no time will the contractor use its position as a contractor with the Department or any information obtained from performance of this contract to pursue directly or indirectly any legislation or rules that are intended to provide a competitive advantage to the contractor by limiting fair and open competition in the award of this contract upon its expiration or to provide advantage the contractor during the term of the contract resulting from this RFP.*

GHS will not use our position as a contractor with the Department or any information obtained from performance of this contract to pursue directly or indirectly any legislation or rules that are

intended to provide us with a competitive advantage by limiting fair and open competition, either in the award of a contract, or by providing us with advantage during the term of any resulting contract.

6.1.14 NO PROVIDER CONFLICTS OF INTEREST

a. The contractor warrants that it has no interest and agrees that it shall not acquire any interest in a provider that would conflict, or appear to conflict, in any manner or degree with the contractor's obligations and performance of services under this contract.

GHS warrants that we have no interest and agrees that we will not acquire any interest in a provider that would conflict or appear to conflict in any manner or degree with our obligations and performance of services under any contract resulting from this RFP.

b. The contractor will meet the following specifications to preclude participation in prohibited activities:

1. *The contractor will subcontract with another firm to conduct any desk reviews or on-site audits of a provider if the provider is a client of the contractor and the provider also provides services for the Department. However, the subcontractor will not conduct desk review or on-site audit of provider if provider is a client of either the contractor or subcontractor when said entity also provides services for the Department.*
2. *The contractor will not use any information obtained by virtue of its performance of this contract and its relationship with the Department to provide what would be "inside information" to the contractor's clients who are providers of medical, social or rehabilitative treatment and supportive services on behalf of the Department or to the organizations that represent such providers.*
3. *The contractor will disclose its membership on any and all boards. The contractor will not use any information obtained by virtue of its contractual relationship with the Department to its advantage by voting, speaking to, or attempting to influence board members in the performance of services by that board's organization.*
4. *The contractor will not have ownership in any provider or provider organization that contracts with the Department or is approved by the Department to provide medical, social or rehabilitative treatment and supportive services on behalf of the Department.*

GHS understands and will comply with these requirements.

7.2.6 PROFESSIONAL SERVICES REQUIREMENTS

6.3 PHARMACY MEDICAL SERVICES

Pharmacy Medical Services functions include retrospective drug utilization review (RetroDUR), review and approval of prior authorization (PA) requests for prescription drugs, maintenance of the preferred drug list (PDL), and the supplemental rebate program. This section includes the following topics related to these functions:

- *6.3.1 RetroDUR*
- *6.3.2 Pharmacy Prior Authorization*
- *6.3.3 Preferred Drug List (PDL) and Supplemental Rebate Program*

6.3.1 RETRODUR

6.3.1.2 Contractor Responsibilities

a. Establish a DUR commission comprised of four Iowa-licensed physicians, four Iowa-licensed pharmacists, one member of the Department, and one full-time dedicated registered pharmacist as the project coordinator, all of whom the Department must confirm.

As the incumbent vendor, GHS has established a Department confirmed DUR commission made up of four Iowa-licensed physicians, four Iowa-licensed pharmacists, one member of the Department, as well as one full-time dedicated registered pharmacist who serves as the project coordinator. GHS strives to recruit and recommend only highly-qualified and skilled practitioners to the Department for confirmation to the DUR commission.

1. Secure the services of a professional staff to serve on the DUR Commission. Appointments to the Commission shall be made after input from the Department.

GHS has secured the services of professional staff to serve on the DUR Commission that have been previously confirmed by the Department. Their experience working with the DUR commission and the Department will provide an ongoing, high-level functioning of the initiatives put forth by the commission without any lapses. In past experiences, we have found that this level of continuity best suits the needs of the Department and the commission. GHS will continue to seek input from the Department on current staff to assure all the Department expectations continue to be met.

2. Enforce term limits as mandated by the Department for members of the commission.

GHS will continue to enforce term limits as mandated by the Department for members of the commission. As the incumbent vendor, GHS is familiar with the process of enforcing term limits and seeking out replacement commission members in a timely fashion. It has always been the goal of the GHS staff to recommend highly qualified pharmacists and physicians to the Department for confirmation. The process employed for such searches includes a variety of methods to access the Iowa Medicaid provider network. GHS works to ensure that candidates are recommended to the Department with adequate time for new members to get exposure to the functioning of the commission and go through a new member orientation prior to attending their first meeting.

3. Convene six meetings each year of the DUR commission as necessary to assure that the commission meets its purpose to review individual patient medication profiles, recommend intervention action, establish

drug review policy, conduct educational outreach activities, conduct retrospective drug utilization review, apply drug use standards, implement ongoing interventions, and review predetermined standards for prospective drug review from the Department or the pharmacy point-of-sale (POS) system contractor prior to application in prospective drug review.

GHS is prepared to convene six meetings each year of the DUR commission to assure that the commission meets its purpose to review individual patent medication profiles, recommend intervention action, establish drug review policy, conduct educational outreach activities, conduct retrospective drug utilization review, apply drug use standards, implement ongoing interventions, and review predetermined standards for prospective drug review prior to application. GHS has been successful in conducting the previously-required eight meetings each year and will work to ensure that this new schedule adequately accomplishes the DUR commission's goals and cover all required topics.

4. *Include in the review of predetermined standards of prospective drug review any recommendations to the Department on the therapeutic validity of the standards as well as the appropriateness of implementation of the standards for use in claim denials as requested.*

GHS will continue to include in the review of predetermined standards of prospective drug review any recommendations to the Department on the therapeutic validity of the standards as well as the appropriateness of implementation of the standards for use in claim denials as requested by the Department. Through a combination of monitoring claims data, prior authorizations, utilization trending, standards of care, updated professional guidelines, and strategies employed by private sector third parties, GHS constantly monitors for areas where successful prospective DUR edits would be appropriate. We have always felt that the prospective DUR program should strike a balance between accomplishing the fiscal goals of the Department, keeping in step with standards of care and evidence based medicine, while at the same time, not over-burdening the provider community. Our staff of pharmacists and physicians will continue to collaborate with clinical analysts and programmers to find ways to enhance to prospective DUR program and make such recommendations to the Department.

5. *Meeting packet, including 30 properly prepared patient medication profiles per commissioner for review, must be mailed to commission members at least three weeks prior to the meeting date.*

GHS will prepare meeting packets that will include 30 properly prepared patient medication profiles per commissioner for review and will be mailed to commission members at least three weeks prior to the meeting date. We are accustomed to this process and are prepared to provide these profiles three weeks prior to the meeting date as opposed to the current two week requirement. As the incumbent vendor, GHS is familiar with the importance of providing meeting materials to the commission members in a timely fashion to allow for adequate preparation in advance of scheduled meetings. Additionally, our experience working with the commission members has allowed for the development of an agreed upon format for the patient medication profiles such that thorough and timely reviews can be accomplished by the commission members.

6. *Convene meetings of any DUR subcommittees (such as the mental health advisory group) as necessary to perform specified function. This includes securing the professional staff to serve voluntarily on these subcommittees.*

GHS will continue to convene meetings of any DUR subcommittees, in particular, the Mental Health Advisory Group, as necessary to perform specified functions. GHS understands that this includes securing the professional staff necessary to serve voluntarily on these subcommittees.

7. *Follow and maintain the DUR commission policy and procedure manual updating annually at a minimum.*

GHS will continue to follow and maintain the DUR commission policy and procedure manual and will continue to update the manual annually or more often, as needed due to changes in policy or by request of the Department.

8. *Document and maintain procedures for making member appointments to the commission in writing in the policy and procedure manual.*

GHS presently has in place a documented procedure for making member appointments to the commission. This procedure has been approved by the Department and included in the policy and procedure manual. This process has been proven successful as evidenced by the committee members who have been confirmed since we began providing these RetroDUR services; the process will remain in place should GHS re-secure this work. GHS is happy to revisit and update this policy as necessary to meet any revised expectations or requirements or upon the request of the Department. We will continue to document and maintain procedures for making member appointments to the commission in writing in the policy and procedures manual.

9. *Use all relevant data and reports from the Department to assist the commission in performing their functions.*

GHS will continue to use all relevant data and reports from the Department to assist the commission in performing their functions. Our professional staff and team of analysts have established relationships with the existing MMIS vendor and Data Warehouse staffs to collaborate on ways to draw upon all available resources to ensure the commission is provided the most robust reporting possible.

b. Secure the services of experienced, properly trained administrative staff to provide all administrative support to the DUR commission including but not limited to:

GHS' experienced, trained administrative staff will continue to provide any and all required administrative support to the DUR commission. Our staff has been performing this function for the Iowa DUR commission for over a year and is knowledgeable and practiced at providing the necessary support to ensure the commission's ongoing success and effective operation.

1. *Ensure that meetings of the DUR commission are conducted in accordance with Chapter 21 of the Code of Iowa (regarding open meetings). Also provide notice pursuant to Department standards of the time, date and place of each meeting and its tentative agenda by publication in the news media, by appropriate posting of the notice. This includes e-mailing this information upon request to organizations or associations whose membership consists of persons who have an interest in the activities of the DUR commission.*

GHS is familiar with the requirements of Chapter 21 of the Code of Iowa as it pertains to open meetings and will continue to ensure that meetings of the DUR commission are conducted in accordance with the Code, as specified. Pursuant to Department standards, GHS will continue to provide notice of the time, date and place of each meeting and its tentative agenda by publication in the news media, in particular *The Des Moines Register*, and other appropriate posting of the

notice. GHS understands that this includes e-mailing of information upon request to organizations or associations whose membership consists of persons who have an interest in the activities of the DUR commission. From the beginning of GHS' involvement with the DUR commission, the professional staff has worked with *The Des Moines Register* and interested organizations to enhance the lines of communication and expand awareness of the commission's work. Through the use of the most current technologies, GHS has ensured that timely notifications and communications have been provided to date.

2. *Schedule the meetings including arrangement of the meeting location. This includes scheduling and conducting orientation of new members in coordination with the Department pharmacy consultant.*

GHS will continue to schedule the meetings, including arrangement of the meeting location. We have extensive experience providing this service to the Department and in other client states. We understand that this includes scheduling and conducting orientation of new members in coordination with the Department pharmacy consultant. GHS will ensure that orientation is provided to new members of the commission prior to first meeting. New members are given introductory materials such as sample reports, definitions, policies and procedures manuals, sample patient profiles and the bylaws. Our staff will walk the new members through the program goals, meeting procedures, and reports to ensure that they have a level of comfort prior to the first session. The DUR staff has always made itself available to accommodate commission members' schedules, to answer questions and provide training. We have found that in many cases, providing multiple training sessions, both before the first meeting and after the second meeting, is most successful. The GHS DUR staff is prepared to provide as many training sessions as necessary to get new members comfortable with preparing for and participating at the meetings.

We consider DUR commission members to be an extremely valuable resource and treat them accordingly. A new member must be carefully integrated into the existing team so as to give him or her the tools needed for the job, while not overwhelming the individual with a multitude of extraneous data. Interest and participation is maintained by discovering a new member's specific motivating factors and finding commonality within the commission.

3. *Provide an orderly mechanism for interested persons to speak at meetings of the DUR commission regarding issues coming before the commission including public comment participation by interested parties, according to the policy established by the DUR commission.*

GHS has developed and maintained a mechanism for interested persons to speak at DUR commission meetings. In accordance with all established policies, interested parties attending meetings are given an opportunity to address the commission. This opportunity is granted twice during the open portion of the meetings. In order to accommodate all interested parties, all speakers are requested to limit their comments to 5 minutes or less. Any party interested in addressing the commission during these public comment sessions are also required to review and sign a conflict of interest disclosure form. GHS will continue to employ this mechanism to allow all interested parties the opportunity to address upcoming issues and concerns. While this process currently fits the needs of the DUR commission, GHS also recognizes that this procedure may need to be adjusted over time. GHS is prepared to make recommended changes to this policy should the need arise, as was previously the case when the need became apparent for more clearly defined policies pertaining to the citing of literature during the public comment period.

GHS was successful in working with the members of the DUR commission in establishing a policy that best fit the needs and desires of the commission members.

4. *Maintain a Department-approved website on the DUR commission that contains at a minimum the meeting schedule and location, agenda, minutes, newsletters, members and other pertinent information and activities, as well as an e-mail address for questions.*

GHS currently maintains a Department-approved website for the DUR commission that meets the minimum requirements listed above. Figure 8 below shows the homepage of this website, with links to the required elements listed in the menu to the left.

GHS will continue to revise and maintain this website to ensure that the accurate, up-to-date information is posted to the site in a timely fashion. We are willing to review this website with the Department upon contract award and to make any required changes to ensure that it continues to meet the needs of the State and the DUR commission.

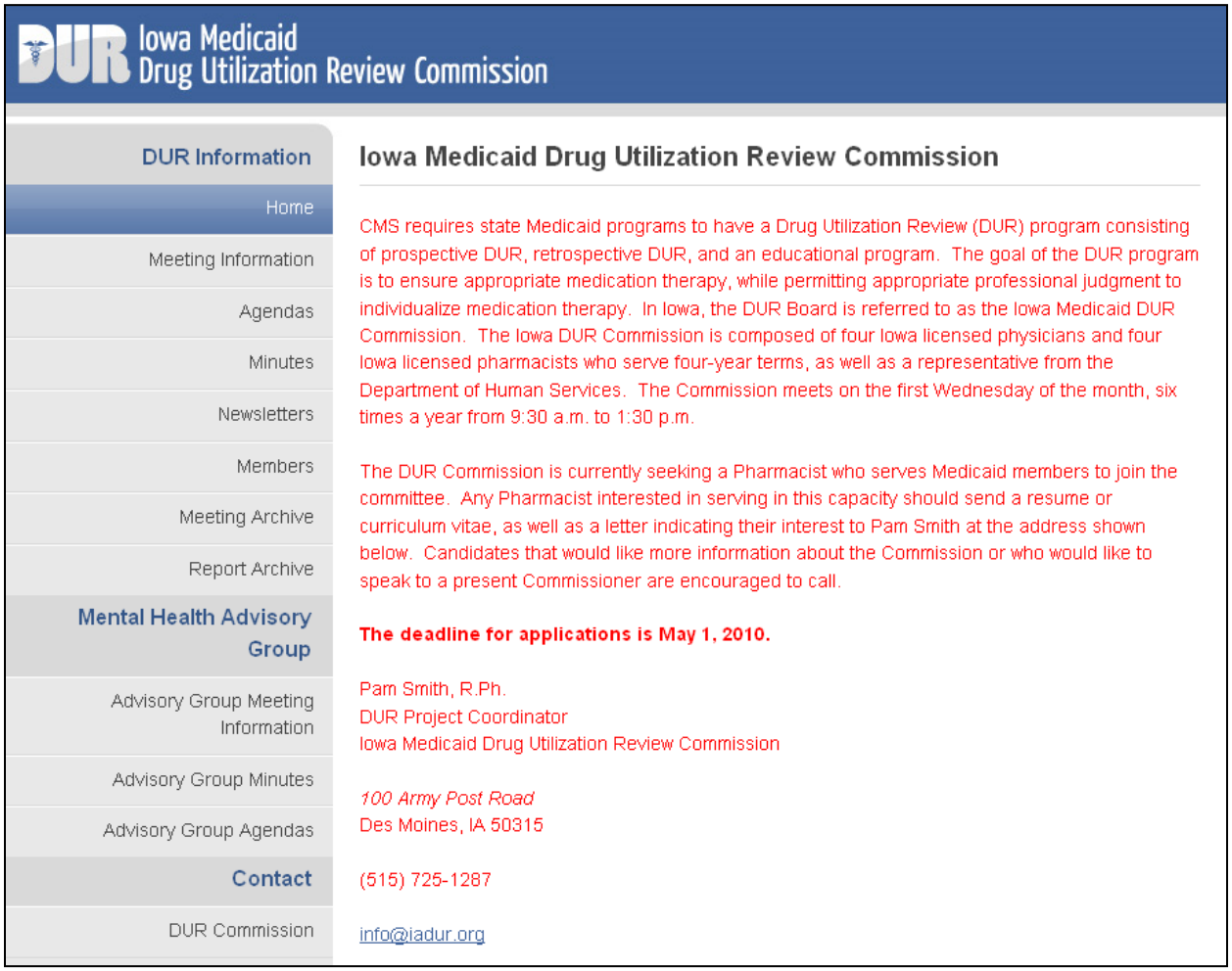


Figure 8: Iowa DUR Commission website

5. *Develop the agenda and meeting packet and provide to the Department for review and approval no less than 30 days prior to the meeting date. Patient medication profiles in a Department-approved format must be included in the packet. Mail the packet to the DUR commission members three weeks prior to the meeting. At the same time, post all non-confidential information to the web site for public review.*

GHS is prepared to develop the agenda and meeting packet and will provide this information to the Department for review and approval no less than 30 days prior to the meeting date. GHS understands that patient medication profiles in a Department- approved format will be included in the packet. GHS further understands that the packet will be mailed to the DUR commission members three weeks prior to the meeting. GHS will continue to post at the same time all non-confidential information to the website for public review. Please see our mutual website at www.iadur.org for samples of agendas and meeting packets (redacted to protect confidential information) that were prepared for recent commission meetings.

6. *Present a minimum of two new initiatives based on Iowa Medicaid trend monitoring at each meeting that will improve the effectiveness of the Iowa Medicaid program. Before presenting, each initiative must account for all collateral issues including programming capabilities and costs and impact to the PA and/or POS units as well as Medical Services.*

A minimum of two new initiatives based on Iowa Medicaid trend monitoring will be presented at each meeting. Each initiative will aim to improve the effectiveness of the Iowa Medicaid program and will account for all collateral issues, including programming capabilities, costs and the potential impact to the PA, POS and Medical Services units. GHS has extensive experience in monitoring and analyzing state and national trends in prescribing and dispensing patterns regarding the need for specified drugs. By monitoring national and state trends and comparing that data with Iowa Medicaid providers' prescribing patterns, we can provide timely analytical material to the commission. We will monitor for atypical usage patterns. We will, as a matter of routine, flag all rapidly increasing or decreasing drugs on the basis of both utilization and cost, so that the commission will be able to fashion responses in a timely manner. Often this involves being alert for off-label activity. The other aspect concerns quality of care. We can create and run reports that examine whether standards of care are being met and if certain diseases are becoming more prevalent. As one example, we can follow the incidence and prevalence of diabetes, especially in the pediatric population. We can describe the drug treatment preferences and the extent of polydrug therapy. We can integrate the medical claims data if desired and examine hemoglobin A1C testing frequency and examine how frequently home blood glucose monitoring is performed. We can examine the trend over long periods and make comparisons on some of these measures across other states.

7. *Must generate letters to providers based on patient-focused profile reviews for a minimum of 65 percent of the profiles reviewed.*

GHS is prepared to generate letters to providers based on patient-focused profile reviews for a minimum of 65 percent of the profiles reviewed. We have designed a custom application for the Iowa Medicaid RetroDUR program that has been in service for nearly two years now. It allows for timely letter generation, archiving, and retrieval. Additionally, this solution has a built-in fax application, such that providers may comment on the letters they receive by means of completing an included survey and faxing back to us toll free. By storing all this information in data, GHS can provide reports documenting how many reviewed profiles generated letters to providers.

8. *Must generate letters to providers based on problem-focused studies for 100 percent of members that meet the selected criteria.*

GHS is prepared to generate letters to providers based on the problem-focused studies for 100 percent of members that meet selected criteria. GHS utilizes the same application described above to generate and manage letters to providers based on the problem-focused studies.

9. *Record open and closed minutes of the DUR commission meetings for approval by the DUR commission and distribute the minutes as approved. Minutes must include a summary of the events that took place, including attendees, action items and outcomes, and follow-ups for subsequent meetings at a minimum.*

GHS will continue to record both the open and closed minutes of the DUR commission meetings and gain commission approval of the minutes prior to distribution. Samples of approved meeting minutes from the most recent DUR commission meetings can be found on the DUR Commission website at www.iadur.org. GHS has strived to make improvements in the quality of the minutes recorded at the meetings, and is acutely aware of the expectations of both the Department and the commission as to the quality of meeting minutes recorded. It has been our approach to provide a near transcript of the meeting as opposed to providing a high level overview of the topics discussed.

10. *Provide and collect required forms from commission members (including but not limited to conflict of interest disclosures, confidentiality forms, travel and meeting reimbursement forms), and provide copies as required to the Department. Contractor staff is responsible for providing all commission member reimbursement associated with the meetings.*

GHS will continue to provide and collect any required forms from commission members. These forms will be filed and copies will be provided to the Department upon request. Recent scrutiny of other states' P&T and DUR committees has reinforced the importance of keeping such forms as up to date as possible. We understand that we are also responsible for providing commission member reimbursement associated with the meetings. Recognizing the importance of timely reimbursement, the GHS accounting team works hard to ensure that reimbursement for travel expenses and payment of the professional consulting fee occur very shortly after a meeting. GHS currently performs these duties for the Iowa DUR commission and will continue to meet these responsibilities in a timely fashion.

11. *Provide lunch during the meeting for commission members and other staff in attendance.*

Lunch will be provided to members and staff in attendance at commission meetings, since the meetings take place over the noon hour. GHS understands that this responsibility will continue to be part of our duties in supporting the Iowa DUR commission.

12. *Provide information and staff support to the DUR commission as needed to ensure the commission completes all requirements.*

GHS will leverage our experienced, skilled staff to ensure that the DUR commission continues to receive the information and support required to complete their requirements and meet their responsibilities. We provide similar services in several states, including the State of Iowa. We look forward to the opportunity to continue working with the DUR commission to ensure that their duties and standards are being met and exceeded.

13. *Provide the Department with a written report of the DUR commission's recommendations within three business days of the conclusion of the meeting for review and final approval by the Department.*

A written report of the DUR commission's recommendations will be finalized and provided to the Department within three (3) business days of the conclusion of the meetings for review and final approval. GHS provides this service to the Department presently and will continue to do so, ensuring that the report meets the Department's expectations and is completed in a timely fashion, in accordance with the timeline given in this requirement.

14. *Assure drug utilization review is completed for no less than 1,800 Medicaid members annually. Appointments to the commission shall be made after input from the Department. While each commission member reviews 30 medication profiles each per meeting, during any orientation of new members, absences or vacancies on the commission, contractor staff is responsible for completing the remainder of the reviews.*

GHS will assure that drug utilization review is completed for no less than 1,800 Medicaid members annually. Appointments will be made only after input and approval by the Department. GHS understands that it will be our continued responsibility to complete the remainder of any reviews not completed due to commission member absence or vacancy.

15. *Secure outside expertise and information when necessary from professionals such as pharmacologists, clinical pharmacists, attorneys, specialist physicians and consultant pharmacists to answer questions. The services of these experts may also be required to update the criteria used in the data analysis system, which identifies profiles that are exceptions to standards established by the DUR commissioners.*

GHS realizes that the DUR commission members will not have clinical expertise to deal with every issue that comes before them. Therefore, we will facilitate and proactively seek the appropriate use of clinical subject matter experts through our network of clinical specialists and industry contacts. We provide the same service for several Medicaid programs, and find that this facilitates the commission's decision making process. In certain situations it may even make sense to enlist the input and more formal assistance of multiple members of one specialty as was the case with the DUR Mental Health Advisory Group.

16. *Assimilate the findings of the DUR commission or other review entities resulting from data evaluation activities and execute the follow-up educational recommendations of the reviewers to the physicians and pharmacists involved in the care of the patients. Include direct informational correspondence to providers and indirect information through periodic newsletters to providers. Additional educational measures may include face-to-face meetings with providers if determined necessary.*

GHS will continue to assimilate the findings of the DUR commission and any other review entities resulting from data evaluation activities and execute the follow-up educational recommendations of the reviewers to the physicians and pharmacists involved in the care of patients. GHS brings all of the resources at our disposal to this task, fully dedicating ourselves to the program's objectives. The success of the educational efforts is dependent on the professional insights of GHS' clinical staff. Their medical training and knowledge of both the pharmacy community and the broader health care environment enable them to identify new opportunities for savings and care improvement. We will continue to provide these services as we presently do and will provide direct information correspondence, periodic newsletters and any additional educational measures as may be necessary, up to and including face-to-face meetings with providers. Currently, GHS uses a custom DUR application as described previously to generate, track and archive letters to prescribers as part of a narrower provider educational initiative. GHS has also made enhancements to the *DUR Digest* to provide a method of distributing more wide-

spread provider education. We have also had success in contacting individual providers directly when anomalies are detected through our regular utilization reviews.

Samples of recent Iowa DUR newsletters can be found on the web at www.iadur.org.

17. *Use Department-approved evaluation criteria to measure the effects and outcomes of the drug utilization review process.*

GHS will continue to use our current Department-approved evaluation criteria to measure the effects and outcomes of the drug utilization review process.

18. *Coordinate communications with other state professional associations representing provider groups with an interest in drug utilization in the Medicaid program. This responsibility includes seeking input from these organizations prior to making final criteria recommendations to the Department.*

GHS will build upon our established relationships with the other Iowa state professional associations that represent provider groups with an interest in drug utilization in the Medicaid program. GHS has been providing this service for the State of Iowa for several years and has built cooperative relationships with these professional associations. We will leverage this experience to ensure that open lines of communication are maintained between GHS and these important stakeholders. We value their input on the process and will work to ensure that any input from these organizations has been fully considered and any potential issues addressed prior to making any final criteria recommendations to the Department.

19. *Maintain at least one full-time dedicated Iowa-licensed pharmacist available to the Department to discuss DUR-related questions and issues during the hours of 8:00 a.m. to 4:00 p.m. Monday through Friday. This pharmacist will be considered the project coordinator and will conduct all meetings in coordination with the chair and vice chair of the commission.*

GHS plans to retain the services of Pam Smith, R.Ph., GHS' current DUR Project Coordinator, should we be selected to continue providing these services. Ms. Smith is an Iowa-licensed pharmacist currently in the employ of GHS. She is and will continue to be dedicated to the Iowa DUR project. She is located at the IME facility in Des Moines and will remain available to the Department during the hours of 8:00 a.m. and 4:00 p.m. Monday through Friday to discuss any DUR-related questions and issues. In addition, Ms. Smith is currently responsible for coordinating and conduction the DUR commission meetings in cooperation with the chair and vice chair of the commission. She will continue to be responsible for these activities going forward. Pam has over 13 years experience as a licensed pharmacist. Prior to joining Goold, Pam worked as a manager at a Des Moines location of a large national chain pharmacy. In her first role at the IME, Pam was a prior authorization pharmacist. This background in the clinical prior authorization criteria and PA process has proved valuable in her role as the DUR Project Coordinator.

20. *Collaborate with the Iowa Plan (for managed mental health and substance abuse treatment) regarding prescription utilization as requested by the Department.*

GHS will continue to collaborate with the Iowa Plan regarding prescription utilization, as we do presently.

21. *Complete required reports accurately and timely. Unless otherwise indicated, monthly reports are due five business days following the end of the month, quarterly reports are due five business days following the end of the quarter, and annual reports are due the tenth business day following the end of the federal fiscal year, state fiscal year or other annual reporting period.*

GHS will continue to provide the Department with robust reporting services. All required reports will be completed in an accurate and timely fashion. GHS will continue to provide the Department with all required reports in the existing approved formats, unless otherwise requested, and will continue to deliver reports on the frequency and by the deadlines outlined above.

22. *Provide appropriate follow-up reporting and measurement of success of DUR activities. Specific reports are to be generated by the contractor and provided to the Department.*
    a. *Annual state report within 90 business days of the state fiscal year end. Include in this report:*
        1. *Focused study activities performed*
        2. *The cost impact tabulated by month, resulting from the initial patient profile review, intervention, and re-review process*
        3. *Annual savings in total outlays for prescription drugs as a result of retroDUR activities including an explanation of the Department-approved methodology for calculating savings*

GHS will continue to produce the annual state report within ninety (90) business days of the state fiscal year end, as required by the Department. GHS will continue to use our current, Department-approved format which includes the components as described in this requirement.

    b. *An annual DUR report as required by the Centers for Medicare and Medicaid (CMS) following the federal fiscal year end, containing the CMS-specified items and submitted within CMS guidelines*

GHS will continue to produce and provide an annual DUR report as required by CMS. This report will contain all CMS-specified items and will be submitted within CMS guidelines. GHS currently performs this function for the States of Iowa and Maine.

c. *Data Analytics*

1. *Provide data analytics that aggregate multiple sources of evidence-based medical information pertinent to the review of member utilization of services (such as laboratory, pharmacy, clinical, physician office, mental health and other selected high cost services) and provide analysis of resource utilization.*

GHS plans to continue using its staff of physicians, pharmacists, and clinical analysts to review evidenced-based medical information pertinent to the review of member utilization services in order to provide data analytics that aggregate these multiple sources. GHS' team of clinical analysts have been successful in building modules to screen profiles for the most current standards of care with respect to laboratory, pharmacy, clinical, physician office, mental health and other selected high cost services and provide analyses of resource utilization. To augment these modules, GHS has established a process with the current MMIS vendor whereby medical claims are delivered to the GHS Data Warehouse on a regular basis. These modules are regularly monitored, updated and revised in order to stay on the cutting edge of current medical practices.

2. *Provide reviews that evaluate member drug utilization based on both the quality of care provided according to evidence-based standards and the appropriate level of resources expended.*

GHS will provide reviews that evaluate member drug utilization based on both the quality of care provided according to evidence-based standards and the appropriate level of resources expended.

3. *The contractor must be able to:*
   a. *Identify patterns of inappropriate health care using evidence-based rules and by assessing resource utilization, including for high-cost and high-risk Medicaid beneficiaries;*
   b. *Perform in-depth analysis of the utilization of high-cost and high-risk Medicaid beneficiaries, many with co-morbidities and receiving mental health and substance abuse services;*
   c. *Build individual provider and member utilization history files and profiles reflecting evidence-based rules and resource utilization;*
   d. *Identify deficiencies in the level of care or quality of service by providers and their treatment protocols;*
   e. *Provide documentation of excessive Medicaid program payments due to inappropriate utilization;*
   f. *Identify providers who may benefit from education or other intervention concerning more appropriate service utilization*

GHS has been successful in building modules that screen and identify patterns of inappropriate health care using evidence-based rules by assessing resource utilization, analyzing high-cost and high-risk beneficiaries, building individual provider and member utilization history files and profiles, identifying deficiencies in the level of care or quality of service provided, and identifying providers who may benefit from education or other intervention concerning more appropriate service utilization. With constant monitoring of these and other areas, GHS has been successful in providing the DUR commission with up-to-date analyses, member profiles, and areas of potential problems by means of problem-focused reviews to assist them in ensuring the highest quality of care for Iowa Medicaid recipients.

Recently, one of our interventions found several instances of inappropriate billing practices at one pharmacy. Following established procedures, we then referred the results of this sampling to the appropriate recovery unit within the IME and the result was the recovery of $36,000. Another specific example of a recent success was our work with members with mental illness who were being managed by clozapine. Clozapine requires frequent blood monitoring in order to avoid potentially serious side effects, some of which are potentially life threatening. For those members we identified as using clozapine, we checked to ensure they were receiving the proper monitoring at the recommended intervals to help reduce the likelihood of drug-induced complications. We have also collaborated with the Magellan Medical Director to contact a physician who was prescribing multiple atypical antipsychotics in a young child to provide additional education regarding the use of more appropriate measures.

4. *Conduct utilization analysis of Medicaid claims within 30 days of receipt of an accurate data file to allow for the following:*
   a. *Improving the quality of care of individual enrollees*
   b. *Timely identification of inappropriate provider practices*
   c. *Timely modification of treatment protocols*

GHS has developed RetroDUR initiatives and analyses which will be used to influence the prescribing behaviors of physicians and will also provide valuable information to pharmacists. The rules sets developed from RetroDUR analysis assist prescribers in determining appropriateness, effectiveness, and compliance regarding drug therapy. Presently, GHS uses RetroDUR to identify patterns of fraud, misuse, and abuse among individual recipients. RetroDUR also provides our clients (or their payer) the opportunity to examine utilization of

different categories of drugs (non-preferred, generic, narcotic, etc.) which assists in PDL development and maintenance.

d. Have computer hardware and software capabilities to select patient-specific profiles and to produce prevalence reports as specified below:

1. Patient Specific Profile – The system shall be able to select from the entire Iowa Medicaid population those patients at greatest risk for potential problems with drug therapy. The program shall assess data on drugs using predetermined standards consistent with the following compendia: United States Pharmacopeia Drug Information, American Hospital Formulary Service Drug Information, DRUGDEX Drug Evaluations, and peer-reviewed medical literature.

GHS will continue to select patient-specific profiles from the entire Iowa Medicaid population that are at greatest risk for potential problems with drug therapy using predetermined standards set forth by the United States Pharmacopeia Drug Information, American Hospital Formulary Service Drug Information, DRUGDEX Drug Evaluations, and peer-reviewed medical literature.

2. The system shall assign a utilization index to each Medicaid member. This index is determined by the application of weighted criteria which include the number of pharmacies dispensing prescriptions, the number of physicians prescribing medications, the total number of claims submitted, and the total dollars paid for claims.

Once problematic profiles are identified selected from the entire Iowa Medicaid population, GHS will continue to apply its weighted criteria to select from the patient-specific profiles those members who are most likely to experience a sub-optimal therapeutic effect due to the number of pharmacies dispensing prescriptions, the number of physicians prescribing medications, the total number of claims submitted, and the total dollars paid for claims. The algorithms used for the weighted criteria are constantly updated in response to new drugs coming onto the market, new drug warnings issues, new interactions identified, and new standards of care. GHS' senior clinical analyst oversees this process.

3. The system shall provide a therapeutic exception screen involving at least 30 major therapeutic categories of the prescription drugs most frequently dispensed in the Medicaid program. The process shall include, at a minimum, drug-drug interactions, drug-disease contraindications, patient-drug considerations, dose limit exceptions, and drug-laboratory considerations.

The patient-specific profiles selected for review will continue to be screened for potential problems involving at least 30 major therapeutic categories of the prescription drugs most frequently dispensed in the Medicaid population. This screening process will continue to include drug-drug interactions, drug-disease contraindications, patient-drug considerations, dose limit exceptions, and drug-laboratory considerations at a minimum. As previously mentioned, the modules used for this process are constantly updated in response to the new drugs, new warnings, new interactions, etc. It is imperative that these screening tools be as up to date as possible.

4. The system shall have the capability to select a number of patient profiles by passing each patient's six-month medication claims history through the therapeutic screen until the appropriate number of profiles have been selected. This process shall begin with the patient with the highest utilization index and continue until the specified number of profiles have been selected.

Each month, the members whose profiles have the highest utilization index will be selected for a review of their most recent six-month medication claims history. Additionally, GHS includes the

most recent two-year diagnoses codes history on the profiles to help reviewers match up drugs to disease states, or lack thereof.

5. *These profiles shall be printed in a format showing the patients' most recent sixmonth prescription claims data. Specific information included on a profile shall include patient ID number, age, sex, race, county of residence, dates of service, drug name and strength, quantity dispensed, days supply, new/refill indicator, prescription number, pharmacy identification number, physician identification number, total charge, and claim amount paid. Multiple copies of the patient profiles shall be printed according to the number of different providers identified on the profile.*

GHS has provided multiple formats for patient-specific profiles and will continue to provide profiles in the agreed upon format by the members of the DUR commission and the Department. This format will include the patients' most recent six month prescription claims data, patient ID number, age, sex, race, county of residence, dates of service, drug name and strength, quantity dispensed, days supply, new/refill indicator, prescription number, pharmacy identification number, physician identification number, total charge, and claim amount paid. We will also provide the members' most recent two year diagnoses codes history on the profiles. Multiple copies of the patient profiles will be printed according to the number of different providers identified on the profile

6. *Prior to meetings, the system shall select profiles six times each year for a period of nine months and sequester those profiles selected for the initial review. After this nine-month period, the system shall access the holding file and automatically reselect the sequestered profiles. These reselected profiles shall then be evaluated to determine the extent of improvement in drug therapy as a result of DUR intervention. The contractor shall report the data obtained in the annual report.*

GHS will continue to sequester those profiles selected for the initial review for a period of nine months. At the close of that nine month period, the profiles will be re-evaluated to determine the extent of improvement in drug therapy as a result of the DUR intervention and include these data in the annual report. GHS has been successful in demonstrating cost savings and improvement in patient care through this process. We typically present at least 4 interventions that are clinically interesting to the DUR Commission during our meetings. These interventions generally are ones that have resulted in a large net savings to the State. For the first two months after GHS began performing these interventions, there was a net savings of nearly $40,000 on medication (including both state & federal dollars). Our custom RetroDUR software system allows for easy tracking and reporting of these profiles that are selected for review.

7. *The contractor shall perform the report data processing using the two-year paid claims history file plus monthly updates maintained by the POS contractor for the Department.*

GHS will continue to provide the two-year paid claims history plus monthly updates maintained by the POS contractor for purposes of reporting.

8. *Prevalence Reporting – The system shall produce reports that identify the prevalence of certain factors within the Medicaid drug program. Prevalence reports shall include, at a minimum, utilization based on age and sex, utilization based on age, pharmacy activity report, prescription claims analysis, prescription claims analysis by pharmacy, physician activity report, quarterly drug category analysis, top 100 prescribers by number of prescriptions written, top 100 prescribers by total dollar amount, therapeutic class ranking by total dollar amount and therapeutic class ranking by total number of prescriptions. These reports shall be produced six times each year. The reports shall be provided to the members of the DUR commission in an easily interpreted report format.*

GHS will continue to provide the requested prevalence reporting on a monthly basis. At each of the six meetings of the DUR commission, GHS will continue to provide a summary report of this information in an easily interpreted report format. GHS is prepared to work with the Department in identifying areas where this process of reporting to the members of the DUR commission can be enhanced.

e. Evaluation, Intervention, and Follow-Up: The DUR commission shall provide for the evaluation of individual patient profiles by a qualified professional group of Iowa physicians and pharmacists.

1. These professionals shall have expertise in the clinically appropriate prescribing of covered outpatient drugs, the clinically appropriate dispensing and monitoring of outpatient drugs, drug use review, evaluation and intervention, and medical quality assurance.

2. Members of this group shall also have the knowledge, ability, and expertise to target and analyze therapeutic appropriateness, inappropriate long-term use of medication, overuse/underuse/abuse/poly-pharmacy, lack of generic use, drug-drug interactions, drug-disease contraindications, therapeutic duplication, drug cost versus, therapeutic benefit issues, and use of cost-effective drug strengths and dosage forms.

3. Members of this group, based on profile reviews, may refer members to the member health education program (MHEP) or the lock-in program.

4. Members of this group shall collaborate with the Iowa Plan (managed mental health and substance abuse treatment) regarding prescription utilization as requested by the Department.

GHS will assist and support the DUR commission in the evaluation of individual patient profiles. GHS will ensure that the physicians and pharmacists appointed to the commission meet the requirements outlined above and will seek Department input and approval as needed during the appointment process. GHS presently provides these services and will continue to assure that only qualified professionals with the appropriate skills and expertise are appointed as members of the DUR commission. GHS will also provide initial training, assistance and support for the members of this group in reviewing profiles and referring members to the MHEP or the lock-in program, as needed and will ensure continued collaboration with the Iowa Plan as requested by the Department.

f. Intervention: The DUR commission shall include a process of provider intervention that promotes quality assurance of care, patient safety, provider education, cost effectiveness, and positive provider relations. The methods used for communication and intervention among physician and pharmacy providers shall include:

1. Letters to providers generated as a result of the professional evaluation process that identify concerns about medication regimens of specific patients. These letters shall be informational in nature and not accusatory and threatening. These letters are to be generated at the Iowa Medicaid Enterprise (IME) by the administrative staff to allow for timely retrieval by the Department and physician and pharmacist reviewers.

GHS will continue to generate letters to providers that identify concerns regarding medication regimens of specific patients. These letters will follow our current format and will be informational in nature. Our RetroDUR software solution allows for swift generation of letters at the IME office following DUR meetings. This ensures timely delivery of information to the identified prescribers and pharmacies. GHS does not generate letters that are accusatory or threatening in nature. All provider correspondence for the DUR program is generated at the Iowa Medicaid Enterprise facility to allow for timely access and retrieval by Department staff and reviewers.

2. At least one IME-located Iowa-licensed pharmacist available to perform the following functions:

a. Reply in writing to questions submitted by providers regarding provider correspondence

b. Communicate by telephone with providers as necessary

c. Coordinate face-to-face interventions as determined by the DUR commission

GHS' DUR Project Coordinator, Pam Smith, R.Ph., is an Iowa-licensed pharmacist presently employed by GHS and located at the IME facility in Des Moines. The DUR Project Coordinator's responsibilities include responding in writing to questions submitted by providers regarding provider correspondence, communicating by telephone with providers to answer questions and address concerns and coordinating face-to-face interventions as determined necessary by the DUR commission. Our present DUR Project Coordinator has 1.5 years experience in performing these duties and will leverage that experience and the knowledge of the IME and the Iowa Medicaid program gained during that time to ensure that the Department's expectations in this regard are met and exceeded.

3. *Production of an electronic provider newsletter at least three times per year to communicate prevalence information, drug therapy information, and appropriate medication use to Iowa Medicaid physicians and pharmacy providers. These newsletters will be posted on the IME web site.*

GHS currently produces a newsletter called the *DUR Digest*. This newsletter is produced at least three (3) times per year and contains educational information, prevalence information, drug therapy information and appropriate medication use guidelines. These newsletters are posted to the www.iadur.org website. Iowa Medicaid physicians and pharmacy providers are made aware of such postings by way of quarterly informational letters that are sent out alerting providers of changes and updates to the Iowa Medicaid pharmacy program. Medical and Pharmacy associations located within the State of Iowa who take an interest in the business work of the commission also receive an electronic copy of the newsletter to be distributed to their membership. GHS will continue to use the established formats, unless otherwise requested by the Department. Samples of recent volumes of the *DUR Digest* are available for review on the web at www.iadur.org.

4. *The administrative staff must track and provide a written report prior to the next meeting of:*
   a. *All communications sent to providers and other entities.*
   b. *Profile intervention tracking including but not limited to issue addressed in communication, person to whom the issue was communicated, dates for communication and responses, outcome and any additional follow-up or intervention, including any referrals to member health education or lock-in programs.*

GHS administrative staff will continue to track and provide written reports to the Department and the commission that address any and all communications sent to providers and other entities, and profile intervention tracking as described in this requirement. GHS will continue to use our current Department-approved formats and delivery methods for this report, unless otherwise directed by the Department.

g. *Prior Authorization: The DUR commission shall advise the Department regarding criteria development and professional standards for drug prior authorization.*
   1. *On request of the Department, the DUR commission shall review drug products and make recommendations for prior authorization.*
   2. *The DUR commission shall, at a minimum, annually conduct reviews of drug prior authorization criteria and make recommendations to the Department on criteria that should be retained, revised or removed.*

GHS will assist and support the DUR commission in advising the Department regarding criteria development and professional standards for drug prior authorization. We will work closely with the PA/PDL staff and rebate staff to develop PA criteria recommendations to present to the Department and commission. GHS presently performs this service for the Iowa DUR

commission and the Department with great success. GHS will ensure that the DUR commission reviews drug products and makes recommendations for prior authorization, conducts at least annual reviews of drug prior authorization criteria, and makes recommendations to the Department on any criteria that should be retained, removed and/or revised. GHS will ensure that the DUR commission performs these duties and will provide the support, reporting, analysis and coordination required to complete these responsibilities efficiently and in a timely fashion.

6.3.1.3 Performance Standards

a. Cases from profile review must be completely resolved in an average of 90 days from the meeting date at which the profile was discussed.

GHS will continue to completely resolve cases from profile review in an average of 90 days from the meeting date at which the profile was discussed.

6.3.2 PHARMACY PRIOR AUTHORIZATION

Pharmacy prior authorization (PA) involves obtaining approval for dispensing a drug before providing it to a member as a condition for provider reimbursement. PA is requested at the prescriber level. The PA process includes several components:

a. Prescriber PA fax-only system using the forms provided by the IME
b. Adjudicating the actual requests for authorization
c. File interfaces to upload the authorization to the point of sale system

Pharmacy Prior Authorization (PA) is a successful cost saving tool for Medicaid programs. Our PA system allows Medicaid pharmacy program managers to reduce costs by requiring physicians to receive authorization before prescribing cost prohibitive and/or clinically inappropriate drugs to patients. This process allows the Department to limit expensive pharmaceuticals to only those patients for whom the drug is therapeutically necessary. Our PA processing procedures and systems support toll-free telephone, toll-free facsimile, mail and web-based requests from in-state and out-of-state providers.

Our PA process is broken down into three steps, each of which relates to a particular job function, demanding a range of qualified individuals for its proper administration. We designed the PA process to ensure that a PA pharmacist decides upon the submitted PA request. Pharmacists will approve, deny, incomplete, or state no PA required. Presently in the State of Iowa, thousands of physicians and hundreds of pharmacies submit PA requests to us for processing in the course of a year.

The PA Technicians manage Step One of the process. They receive the requests via fax which is automatically inputted into our PA Decision Support System (PADSS). The Technicians input the Medicaid member's ID number, prescriber NPI number and pharmacy NPI number

In Step Two, a PA Technician verifies the loaded information from Step One. The Technician researches the requested drug, examines patient profiles to view the patient's prescription drug use history to determine previously used drug regimens that may be required as part of the determination process, looks up generic equivalents and prepares any relevant notes that might facilitate the pharmacist's decision making process. Oftentimes, this preliminary screening results in a non-required PA (the PA Tech finds an alternative drug for the patient that is available without a PA), discovers that the patient is ineligible, or discovers information for the

PA pharmacist that speeds her/his determination time. The PA Tech must have knowledge of pharmaceuticals, a pharmacy technician background, the State's PDL, and a thorough PA procedure understanding.

Step Three consists of the PA Pharmacist making a final determination on the PA request. In this step the pharmacist will approve, deny, incomplete or state no PA is required at this time. The pharmacist makes a clinical determination based upon PA criteria established by the P&T Committee and approved by the Department, which are integrated into the PA process. In addition to the PA Pharmacist, a physician on staff will provide clinical support to the pharmacist. This physician/pharmacist team is able to utilize Department criteria and evidence-based clinical resources on appeals made by the requesting pharmacist or physician.

Our system provides clinical assurances to the public; with our process sound determinations are being made by qualified clinical pharmacists in a timely manner. This is particularly important, as more classes of drugs are being listed as PA-required on Preferred Drug Lists.

PA determinations are made by GHS' staff of clinical pharmacists, facilitated by our Prior Authorization Decision Support System (PADSS). Completed PA forms, either transmitted to GHS, are stored electronically and loaded into PADSS. In Iowa, we currently average 350 PAs per day with an average determination time of two hours or less. This rapid turnaround is attributable to the optimized workflow of our system and the professional staff we have dedicated to PA inquiries.

Once the Prior Authorizations have been determined, they are grouped into batches four to five times daily for delivery. PADSS allows each batch to be quickly archived, faxed (and/or mailed) and loaded into the POS via a customized file interface.

Our PA process has been designed to be flexible and can be customized to meet any additional needs and requirements of the Department. We consider the Prior Authorization program to be one of the most important functions we carry out for the Department. Its proper administration is critical to efforts to influence prescribing patterns and drug use, and is integral to the management of programmatic costs. The PA system is compliant with all relevant State and federal statutes and regulations, including OBRA 90. Our Prior Authorization program exhibits the following characteristics:

- Our Prior Authorization Decision Support System (PADSS) verifies client eligibility, pharmacy eligibility prescriber eligibility and NDC eligibility;
- The system verifies each PA request form for completeness;
- The system incorporates a secure fax back capability for incomplete forms and for required additional information;
- We research and validate PA criteria rules, including research of patient profiles for drug history;
- All PA determinations are made by clinical pharmacists;
- The system can receive a PA request via mail or fax and is able to accept PA's 24 hours a day 7 days a week;
- All PA's are compliant with applicable federal and State laws and regulations;

- The system archives all PA forms, determination dates and supporting documentation as a read-only database record;
- PADSS interfaces with the POS, which accepts PA loads as frequently as required or desired;
- A website is maintained with downloadable PA criteria forms, PA criteria charts, latest news releases, copies of informational letters and educational material; and
- Help Desk support is provided for PA inquiries from prescribers, pharmacists and State staff for assistance, education and status of PAs in process.

6.3.2.2 Contractor Responsibilities

a. Monitor toll-free telephone line and facsimile access and respond to contacts from providers regarding drug PA 24 hours a day, seven days a week.

GHS is able to accept prior authorization requests any hour of the day, any day of the week via our fax receiving system. Faxes are not printed, but captured on our system. PAs are determined during normal business hours. In case of emergency PA requests that need to be made outside of normal hours, we utilize an on-call paging system. Our experience has shown that off-hour PA requests are relatively minimal and that our system is suitable for meeting recipients' PA request needs. With an average two hour turnaround time in the State of Iowa, prompt processing of PA requests is not an issue.

b. Ensure qualified personnel respond to PA requests and handle all routine inquiries and correspondence regarding PAs; have the capacity to handle all telephone calls and facsimiles at all times and have upgrade ability to handle additional call or facsimile volumes.

GHS currently provides clinical help desks to assist with any PA related requests for several of our current state clients, including the State of Iowa. The staffing plan currently in place ensures that we have sufficient, qualified personnel to respond to PA requests and to handle all routine inquiries and correspondence. Our PA staffing plan and procedures are designed to handle the current capacity of calls and facsimiles at all times and are flexible enough to accommodate any future changes to call or facsimile volumes.

c. Assist in the development and recommendation of PA criteria for drugs in conjunction with the Department, the DUR commission, and the pharmaceutical and therapeutics (P&T) committee using CMS-approved reference books as well as current medical literature.

We will continue to work in close collaboration with the Department, the Iowa P&T Committee and the DUR Commission to design PA criteria. Prior to implementation, Department approval will be sought for all PA guidelines and criteria.

We will develop, maintain, and update internal and external criteria for those drugs that fall in the scope of the PDL, as well as for those drugs currently on Prior Authorization that fall outside the scope of the PDL. Studies, reviews, and guidelines are being constantly released. They are difficult to keep up with but vital to assure that the PDL rules remain current and rational. PDL and PA criteria need to be reassessed whenever new evidence appears.

Deciding which drugs to make preferred and which to make non-preferred is a relatively simple process. The tricky part is setting the PA criteria that will allow access to non-preferred drugs. If

they are too easy, the savings will be eroded or nonexistent. In many cases, requiring just one trial of any preferred drug is too easy. In most cases a PDL needs to require multiple preferred trials (if available). Even better are PA criteria that require trials of drugs with demonstrated superior outcomes (as measured by lower NNT). Iowa has clearly moved in this direction as evidenced by their approach to fibromyalgia treatments or migraine prophylaxis. This strategy is becoming increasingly important. Drug labels and CMS specified references help in this matter but even more important are comparative studies, drug reviews and meta-analyses since the CMS approved compendia often lag considerably in incorporating recent publications.

Many drugs residing outside of PDL managed classes may still require clinical Prior Authorizations to determine medical necessity. The following scenarios may also require further action

- Drugs become unavailable due to shortages or discontinuation;
- New products and new forms enter the market and require prompt attention;
- Generics become available but are often financially unattractive initially;
- New FDA approved indications appear often and necessitate revisions of existing criteria;
- FDA warnings are released on drugs and corresponding alterations must be made in the PDL or in an unmanaged drug class;
- Significant price fluctuations; and
- Companies reneging on deals or not honoring the terms of existing contracts.

Unique PA criteria are supported by all necessary programming requirements. The structure of the PA criteria can greatly leverage the concepts of step care therapy. Promoting an optimal sequence of medications can be extremely beneficial in both a clinical and financial sense. There is a significant amount of incremental savings to be realized by developing PAs that support more than a single preferred drug, but also a preferred order of drugs.

Not only can we collaborate with the Department in devising unique PA criteria, we also have the ability to refine and customize these criteria for different subpopulations. The rules can be modified depending upon demographics, clinical information, duration of therapy and the use of prior alternative therapies.

We will continuously review and evaluate PA protocols and criteria, pharmaceutical use and received requests to determine the appropriateness of continued PA. We will provide the Iowa P&T Committee, DUR Commission and the Department with analysis and recommendations using historical PA and pharmacy claims data to ensure that all decisions made regarding the PA process and PA criteria are up-to-date and clinically appropriate.

d. Ensure that PA review criteria is easily understood and widely available to providers, Medicaid members, and identified stakeholders through various media, including listing on the web site and updated through informational letter releases.

This is an area that requires continuing focus and attention in order to maintain effectiveness and to continue to meet performance expectations. Medicaid PDLs are significantly more complex to understand than commercial formularies. Why is this? The answer involves primarily two differences between Medicaid and commercial insurances. First, Medicaid has nominal, largely non-mandatory co-pays while the commercials have large, mandatory co-pays that allow them to

strongly influence drug choices. Second, Medicaid has two layers of rebates, one of which is mandatory, determined by complex rules and affects all drugs while commercials only collect relatively miniscule rebates on a limited number of competitive drugs. The net effect of these differences is that Medicaid programs have many more savings opportunities than commercial plans and they are all driven by net price which are (and must be) obscured from the public. This means the vendor and the State have a huge education responsibility. Advice needs to be presented clearly but also succinctly since providers are pressed for time. Timely informational releases and postings are vital as is not just the content of the website but its organization. Although we always endeavor to make the criteria easily comprehensible we still encounter providers that have interpreted messages differently than intended. We will continue to refine the criteria and redouble our efforts to reduce confusion.

Although it is very difficult for existing e-prescribing tools to adequately convey all the complexities, rules and exceptions contained within a PDL it is clear that this is the direction that health care is heading. This means we must invest time and resources in the same direction. The major limitation at present is the technical inability of the e-prescribing tools to accurately present all drugs affected by a variety of rule exceptions.

e. Continue the administration of pharmacy PA services, which requires the prescriber to submit all PA documents for drugs.

1. Provide PA services for prescriptions written for non-preferred drugs and for preferred drugs with conditions to achieve the objective of compliance with the PDL without unduly disrupting access to care or increasing provider costs.

GHS has been providing PA services for prescriptions written for non-preferred drugs and for preferred drugs with conditions to the State of Iowa since 2004. Should GHS be chosen to continue to provide these services, we will provide consistent, efficient and timely PA services. There would be no need for a transition or implementation period that could potentially cause disruptions to the beneficiaries' access to care or undue increases in provider costs. Our process has been streamlined and tailored to fit the needs of the State of Iowa and we would continue to provide the same high-level of PA service to which Iowa beneficiaries, providers and the Department have become accustomed.

GHS will continue to provide all PA services as currently required for non-preferred and preferred with conditions drugs. We fully recognize the importance of balancing the objectives of maximizing PDL compliance while minimizing access to care interruptions and/or increasing provider costs. Compliance has always been high with the Iowa PDL. In CY 2008 the PDL compliance was 95.4%. The PDL compliance for the third quarter of 2009 was 95.7%.

2. Pretest the PA procedure with select prescribers and pharmacists prior to implementation to ensure the process is working as designed.

As the vendor currently providing PA services to the Department, GHS is proposing no changes to the PA procedures currently in place. Our procedures and systems have been in place and operating since 2004. As a result, there would be no lapse in PA services should GHS be chosen to continue providing Pharmacy Medical Services for the IME. Should the Department request any major changes to the current PA procedure, these changes can be pre-tested prior to implementation to ensure that the process continues to operate smoothly and as designed.

3. *Provide prior authorization review by a licensed pharmacist to ensure that all predetermined clinically appropriate criteria have been met before approving or denying the drug PA.*

Only PA Pharmacists (and the PA Physician consultants) are authorized to make prior authorization determinations. All determinations are made based upon criteria approved by the Department. Once such a determination is made, the requesting physician, pharmacy and patient are notified of the decision. In addition to letters being generated and sent to these three parties (beneficiary, prescriber, and pharmacist), a fax is immediately transmitted to the pharmacy (assuming the pharmacy has facsimile capability) so the prescription may be promptly filled. Internally, we process the PA request, making it available for claims adjudication and validation. It is also made available to our Help Desk staff for future reference and is usable for reporting and analytic purposes.

4. *Ensure sufficient clarity of PA criteria so that all staff understand it.*

It is imperative that the PA criteria are clear enough for the PA unit staff to understand, because they are responsible for ensuring that providers are well-informed of PA criteria and their proper interpretation. Everyone on staff must interpret the criteria the same way in order to communicate the criteria clearly and uniformly to providers and other interested parties. This means all criteria must be presented, discussed and clarified in regularly scheduled meetings. Anomalies in approvals between pharmacists in specific drugs must be looked for in periodic audits or when approval rates change dramatically. Rarely used specialty drugs that require considerable supporting documents are more prone to interpretational variances.

5. *Subject to Department approval, develop and implement a staffing plan to reflect anticipated PA volume, broken down by skill set and how the contractor will revise this staffing plan when necessary.*

GHS considers the PA program to be one of its most important functions. Proper PA administration is critical for shrinking prescribing patterns and drug use, and is integral to prudent programmatic cost management of pharmaceutical expenditures. In GHS' PA system, we created a high patient safeguard standard, implementing State and Federal statutes to enforce these standards. The PA system is compliant with all relevant statutes and regulations, including OBRA 90. GHS and our systems are flexible enough to accommodate changes and updates.

Our current staffing configuration includes 3 full time PA pharmacists, 2 PA pharmacy techs and one administrative coordinator who devotes approximately 50% of her time to the PA and PDL programs. This full time staff is supported by the Account Manager and GHS' Medical Director who functions as a consultant. The PA program also receives some minimal technical support from our network services staff and other technical positions based out of our Augusta office. This technical support represents a very small portion of time, but is important to ensuring that our systems and processes continue to run smoothly and without interruption.

GHS is proposing to maintain our current staff and staffing configuration as it is presently exists. We do not foresee making any changes to our staff or staffing plan. Our current set up is reflects the staffing necessary to handle the current PA volume and the normal fluctuations in volume that may result from normal program operations. Our current staff is more than sufficient to

ensure that all PAs are turned around within 24 hours, in accordance with federal regulations. Presently we average a 2 hour turnaround on PAs in the State of Iowa.

As stated, our staff and systems are flexible enough to handle changes and updates and will be supplemented as needed, should we anticipate any major shifts in PA volume due to changes in policy or program operations. We will estimate any changes in staffing based on our experience providing these services over the last five years. Should we need to make any staffing changes in the future, we will follow all established rules and procedures and gain Department approval for any proposed changes.

6. *Ensure that all PAs meet the required service and quality standards.*

GHS will continue to provide a PA process and procedures that ensure the IME's required service and quality standards are being met and/or exceeded.

7. *Revise current and develop new PA forms, subject to Department approval, for prescriber PA submission.*

GHS currently has in place a variety of PA forms to be used for prescriber PA submission. We will continue to update and maintain these forms and to create new ones, as needed. All new or revised forms will be submitted to the Department for approval.

We make these forms available in a variety of ways—in our educational outreach seminars, via the website and as part of both general and targeted mailings. In addition, our PA help desk distributes forms via fax and mail to prescribers and pharmacies upon request. Help desk technicians and pharmacists are available via toll-free telephone to assist with any questions regarding PA submissions and forms.

8. *Obtain Department approval for the PA process flow.*

GHS currently operates based on a Department-approved PA process flow. We are not, at present, proposing to make any changes to this Department-approved flow. Upon renewal of this contract, GHS will collaborate with the Department to ensure that this process flow is still meeting the needs of the IME, their beneficiaries and providers. Should the Department require any changes to the current process flow, we will submit a revised process flow to the Department for approval prior to implementation of any changes.

9. *Update the pharmacy PA manual within three business days of state approval of a change or state request for a change.*

GHS will continue to ensure that the pharmacy PA manual is maintained and kept up-to-date. The manual will be updated and revised within three business days of state approval of a change or a state request for a change.

10. *Comply with all federal and state laws on PA, protocols and standards regarding responsiveness, timeliness and availability of appropriate clinical staff 100 percent of the time.*

GHS operates a flexible prior authorization process that complies with the individual requirements of each of our client states, and all applicable State and Federal rules, laws and regulations.

11. *Respond to 100 percent of pharmacy prior authorization requests within 24 hours of receipt.*

The Prior Authorization process, as administered by GHS under the guidance of the state, will be compliant and will remain compliant with all of the Federal and state laws and regulations. OBRA '90 stipulates that a response to a complete PA request must occur within twenty-four hours and that, except for non-covered drugs, a seventy-two hour supply of medication must be provided in emergency situations. GHS has and will continue to devote all resources necessary to maintain the efficient performance of its PA processing system and to meet these requirements. In Maine, complete requests are currently turned around, on average, in just under four hours and in Iowa, our average turn-around time is currently just under 2 hours. We presently respond to 100% of pharmacy prior authorization requests within 24 hours of receipt in every state where we perform this service.

12. *If an automated voice response system is used as an initial response to inquiries, include an option that allows the caller to speak directly with an operator.*

The current hours are 8:00 a.m. -5:00 p.m. Pharmacies or prescribers with questions after hours have an option to speak to on on-call pharmacist or during regular business hours they may leave a message on the voice mail system.

13. *Return all call line inquiries that require a call back, including general inquiries, within one business day of receipt 100 percent of the time.*

100% of call line inquiries requiring a call back will be returned within one (1) business day of receipt or less.

14. *Assist the Department with:*
    a. *The appeals process by writing and providing the Department-approved appeal summary and attend the appeal hearings to support the decision made on PA requests.*
    b. *The exception to policy process by evaluating the request and writing the medical review and upon request, the exception to policy letter of response.*
    c. *Reviewing and writing the response to judicial proceedings and any other clarifying inquiry at the request of the Department.*

GHS will continue to assist the Department with the appeals process, as we do currently. GHS, upon notice of appeal to the Department, will prepare and submit appeal summaries in a format approved by the Department, to the designated parties and in accordance with the required time frames. GHS shall comply with and is familiar with all state and federal laws, regulations, and policies regarding the content and timeframes for appeal summaries. GHS shall attend all appeal hearings or conferences, whether informal or formal, or whether in person or by telephone, or as deemed necessary by the Department. GHS will assist the Department with the exception to policy process by evaluating requests, writing medical reviews and creating exception to policy letters of response, as needed. GHS will also continue to review and write responses to judicial proceedings and/or any other clarifying inquiries at the request of the Department.

15. *Collaborate with the Pharmacy POS contractor to provide an automated approval process for PA based on the member's specific drug history with an emphasis on reduction of transactions and manual interventions.*

As both the current Pharmacy POS contractor and the Professional Services contractor providing Pharmacy Medical Services, GHS is able to offer the IME a seamlessly integrated solution for providing automated approval of PAs based on a member's specific drug history. We presently have in place several mechanisms for "automated" or fast-track approvals of non-preferred drugs. These include grandfathering, step therapy, therapy exceptions and age exceptions. Briefly, grandfathering involves looking at a recipient's drug profile to see if the non-preferred drug has been recently used. Step therapy requires that preferred drugs be tried in a particular order. Therapy exceptions are a way of examining a profile to discern if a recipient is on a particular regime of drugs. Age exceptions are a way of allowing an age group unrestricted access to a non-preferred drug. All of these mechanisms are to be established on non-preferred drugs on a case-by-case basis. They are a way to control unnecessary PA volume.

Should GHS be replaced as the Pharmacy POS contractor in the future, we will leverage our experience in providing these services and in collaborating with other Medicaid Pharmacy vendors to ensure that the State of Iowa continues to receive seamlessly integrated, efficient services in this arena. GHS has the capability to feed PDL data to the POS, and then the POS needs to perform the profile reviews. We will work with the POS contractor to discern the best way to implement them on Iowa's system; however continued success of automated mechanisms will depend upon POS implementation.

16. *Submit monthly reports in a Department-approved format summarizing all PA activities including but not limited to, approvals and denials by PA criteria defined categories, to the Department. Provide tracking on PAs logged as incomplete including the final outcome. Include recommendations for changes to decrease the number of incomplete PAs in each area.*

For all our PA clients, we provide an extensive suite of reporting. The list below is a sample of reports provided currently being provided to the State of Iowa. The suite of reports, report contents, and frequency of creation can be modified to meet any new or additional Department requirements. The following PA reports can be created on a daily, weekly, monthly, quarterly, annual, or ad hoc basis:

- Emergency script fills- by drug and drug category
- PA average determination time – by drug category
- PA statistics report-time range performance
- PA statistics report-greater than 24 hours
- PA statistics report- by drug name descending volume
- PA statistics report- approval and denial rates by category
- PA activity report-volume and decisions by day
- PA approval rate-by day and week
- PA approval rate by pharmacist by day/week
- PA statistics report-deferred SAs beyond 30 days
- PA statistics report-clerk SA assignment volume
- PA statistics report-pharmacists determination volume
- PA statistics report-determination time of day

- PA statistics report- prescriber performance, volume of deferred, incompletes and abandoned
- PA statistics report-prescriber performance, approvals and denials, descending volume

GHS will also continue to provide tracking on any PAs logged as incomplete, including the final outcome. Recommendations for changes to decrease the number of incomplete PAs will be included with these tracking reports.

17. *Submit an annual state fiscal year report in a Department-approved format summarizing all PA activities including but not limited to, approvals and denials by PA criteria defined categories to the Department. Provide tracking on PAs logged as incomplete including the final outcome. Include recommendations for changes to decrease the number of incomplete PAs in each area.*

GHS will continue to submit the annual state fiscal year report in the current Department-approved format, unless otherwise requested by the Department. This report summarizes all PA activities, as outlined above. Tracking will be provided for any PAs logged as incomplete, including the final outcome and recommendations will be made to decrease this number in each area.

18. *Submit quarterly reports in a Department-approved format on monitoring parameters for PA staff quality assurance to the Department.*

GHS currently uses Department-approved formats for the quarterly PA staff quality assurance monitoring reports required by the RFP. GHS will continue to provide these reports as required by the Department and is open to discussing any changes to the format of these reports that may be desired by the Department.

19. *Submit quarterly reports in a Department-approved format on trend reporting for exception to policy and appeal requests to the Department.*

Quarterly reports for trend reporting on exceptions to policy and appeal requests will be submitted to the Department in the current approved format. GHS will continue to provide this service as we do presently for the State of Iowa.

20. *Complete required reports accurately and timely. Unless otherwise indicated, monthly reports are due five business days following the end of the month, quarterly reports are due five business days following the end of the quarter, and annual reports are due the tenth business day following the end of the federal fiscal year, state fiscal year or other annual reporting period.*

GHS will continue to provide the Department with robust reporting services. All required reports will be completed in an accurate and timely fashion. GHS will continue to provide the Department with all required reports in the existing approved formats, unless otherwise requested and will continue to deliver reports on the frequency and by the deadlines outlined above.

6.3.2.3 Performance Standards

1. *Provide sufficient staff such that 95 percent of all call line inquiry attempts are answered. The total number of abandoned calls shall not exceed five percent in any calendar month.*

GHS will continue to provide sufficient staff to ensure that at least 95 percent of all call line inquiry attempts are answered. GHS currently maintains a call abandonment rate of less than five percent in any calendar month and will continue to do so should we be selected to continue providing the Pharmacy Medical services to the Department.

2. *Provide sufficient staff such that average wait time on hold per calendar month shall not be in excess of 30 seconds.*

Current staffing levels will be maintained such that the average wait time on hold for callers in any given calendar month does not exceed 30 seconds.

3. *Zero percent of appeal decisions overturned due to nonspecific prior authorization criteria.*

GHS will ensure that prior authorization criteria are developed and implemented so as to ensure that no appeal decisions will be overturned due to nonspecific prior authorization criteria.

6.3.3 Preferred Drug List (PDL) and Supplemental Rebate Program Contractor Responsibilities

6.3.3.2 Contractor Responsibilities

a. *Within 10 business days of signing the contract provide the Department with a PDL base line analysis.*

GHS will provide the Department with a fresh PDL baseline analysis within the ten day time frame noted. Since we manage other states, some with different PDL designs, it may be most beneficial for Iowa if we compare Iowa to other states across common PDL categories. This way we can identify which states have superior cost outcomes and try to determine possible relationships to design differences. We will also compare how the PDL is doing across time in net costs per PDL category. This can highlight categories trending down in cost, those holding steady and especially those trending up faster than inflation. It might make sense to concentrate our attention on high dollar drug categories with trends outpacing inflation or moving contrary to expectations based on PDL design changes or other DUR interventions. As one example we have provided a copy of a quarterly report that we use internally in our states. Figure 9, on the next page, shows the change in average net cost per script since the 4th quarter of 2004, sorted in descending order by PDL categories. Some of the categories with the largest percent increases had a monopoly, like Boehringer with a 665 increase due to Atrovent HFA and Spiriva in the antiasthmatic anticholinergic category. Other categories with large increases, like antiretrovirals, have so far not been subject to the competitive pressures of a PDL, which explains their relatively greater cost increase trend.

	Q2 CY2009									
Iowa PDL Category Description	Sum Pre-rebate Paid Amt	% of Total Pre-rebate Paid Amt	Sum CMS Rebate Amount	Sum SR Amount	% of Total Rebates out of Sum Pre-rebate Paid	Total Net Costs	% of Total Net Cost	N of Scripts	Avg Net Cost per Script	% Change in Avg Net Cost per Script from Baseline Q4
ANTIPSYCHOTICS - ATYPICALS	$10,953,726.29	17.26%	$4,066,235.41	$ 140,151.50	38.4%	$6,747,339.38	20.19%	38,377	$ 175.82	-0.5%
ANTICONVULSANTS	$ 5,587,559.19	8.80%	$3,067,080.36	$ 47,624.35	55.7%	$2,472,854.48	7.40%	50,909	$ 48.57	-28.4%
ANTIDEPRESSANTS - SELECTED SSRI's	$ 4,349,408.03	6.85%	$1,891,421.75	$ 194,059.87	47.9%	$2,263,926.41	6.77%	74,201	$ 30.51	-40.8%
ANTIHEMOPHILIC AGENTS	$ 1,872,303.57	2.95%	$ 120,662.72	$ -	6.4%	$1,751,640.85	5.24%	90	$19,462.68	-4.5%
ANTIASTHMATIC - LEUKOTRIENE RECEPTOR ANTAGONISTS	$ 1,692,578.31	2.67%	$ 732,622.84	$ 57,278.60	46.7%	$ 902,676.88	2.70%	15,484	$ 58.30	0.9%
STIMULANTS - METHYLPHENIDATE - LONG ACTING	$ 2,306,980.45	3.63%	$1,379,377.03	$ 90,703.80	63.7%	$ 836,899.62	2.50%	17,016	$ 49.18	-16.7%
STIMULANTS - AMPHETAMINES - LONG ACTING	$ 3,467,373.12	5.46%	$ 846,328.65	$1,815,188.18	76.8%	$ 805,856.30	2.41%	20,217	$ 39.86	-42.8%
ANTIASTHMATIC - ADRENERGIC COMBOS	$ 1,481,932.83	2.33%	$ 658,554.41	$ 116,490.64	52.3%	$ 706,887.77	2.12%	8,038	$ 87.94	8.3%
NARCOTICS - MISC.	$ 724,189.35	1.14%	$ 79,237.61	$ -	10.9%	$ 644,951.74	1.93%	49,780	$ 12.96	-28.7%
MACROLIDES / ERYTHROMYCIN'S / KETOLIDES	$ 665,830.64	1.05%	$ 36,955.01	$ -	5.6%	$ 628,875.63	1.88%	23,723	$ 26.51	-23.2%
CEPHALOSPORINS	$ 859,055.58	1.35%	$ 199,558.43	$ 83,565.32	33.0%	$ 575,931.83	1.72%	19,764	$ 29.14	-5.8%
ANTIASTHMATIC - BETA - ADRENERGICS	$ 1,059,215.94	1.67%	$ 397,429.44	$ 159,535.22	52.6%	$ 502,251.27	1.50%	28,293	$ 17.75	-12.9%
BETA-LACTAMS / CLAVULANATE COMBO'S	$ 534,737.40	0.84%	$ 56,831.93	$ 233.87	10.7%	$ 477,671.60	1.43%	37,359	$ 12.79	-44.2%
NARCOTICS-LONG ACTING	$ 884,910.32	1.39%	$ 431,207.09	$ 6,060.35	49.4%	$ 447,642.88	1.34%	4,630	$ 96.68	-26.1%
ANXIOLYTICS - BENZODIAZEPINES	$ 415,514.80	0.65%	$ 13,977.32	$ -	3.4%	$ 401,537.48	1.20%	46,589	$ 8.62	-34.0%
ANTIASTHMATIC - STEROID INHALANTS	$ 826,864.99	1.30%	$ 395,038.86	$ 42,963.65	53.0%	$ 388,862.48	1.16%	5,243	$ 74.17	1.3%
CHOLESTEROL - HMG COA + ABSORB INHIBITORS	$ 916,216.18	1.44%	$ 322,973.51	$ 207,570.84	57.9%	$ 385,671.83	1.15%	16,022	$ 24.07	-59.5%
STIMULANTS - OTHER STIMULANTS / LIKE STIMULANTS	$ 768,074.85	1.21%	$ 386,498.34	$ -	50.3%	$ 381,576.51	1.14%	4,815	$ 79.25	-13.1%
GI - PROTON PUMP INHIBITOR	$ 1,742,216.45	2.74%	$1,118,429.09	$ 271,177.78	79.8%	$ 352,609.58	1.06%	14,304	$ 24.65	-69.1%
RSV PROPHYLAXIS	$ 740,916.83	1.17%	$ 407,015.82	$ -	54.9%	$ 333,901.01	1.00%	468	$ 713.46	-28.5%
STIMULANTS - METHYLPHENIDATE	$ 910,368.76	1.43%	$ 376,756.17	$ 227,266.40	66.3%	$ 306,346.19	0.92%	10,789	$ 28.39	3.2%

Figure 9: Iowa Rebates and Net Cost by PDL Category

It is our overall belief that a PDL needs to provide a selection of preferred drugs that allows primary care physicians to care for the majority of their patients without prior authorization requests being necessary on a daily basis. The driving force for or against recommending PDL placement is the drug's unique clinical contribution. Each state's drug Committee must primarily rely on evidence-based guidelines, rather than clinical experience, expert opinions, professional relationships, pathophysiology, community standards, publications, or other sources, to determine this value of this contribution.

Whenever we partner with a State, we continuously reassess the existing PDL each quarter. As the incumbent vendor providing Preferred Drug List and Supplemental Rebate services to the IME, we already have extensive knowledge of the current PDL, utilization patterns, PDL adherence and other important factors. Our physicians and pharmacists, working with our analysts, are experts at understanding what is working well in a PDL and what might be improved. They will provide a thorough base line analysis to ensure that the PDL is working well and meeting the needs of the IME.

b. Use pharmaco-economic modeling to formulate recommendations for preferred drugs in each class to the Department.

GHS will provide complete financial modeling scenarios for the therapeutic categories identified for discussion. The models will include separately, identified CMS and supplemental rebates and the resultant net drug costs. The model will demonstrate the financial impact to the class and allow for changes in drug mix, pricing assumptions and marketshare shifts. We will provide recommendations to the Department that were derived from the financial modeling results.

Most PDL categories do not require complex pharmaco-economic modeling. When comparator drugs are already available, similar in terms of daily dosing and similar in terms of expected outcomes (no proven inferiority or superiority) then the model is simple and only requires net cost calculations involving actual net costs of established drugs and estimated net costs of new drug entries lacking historical CMS rebate data or SR offers. If on the other hand a new drug appears stronger than existing competitors then we have to anticipate erosion of existing drug utilization and the potential deflective strengths of proposed PA criteria (assuming non-preferred status will be recommended).

Some drug categories are more important than others by virtue of their fiscal significance. The mental health drugs and the antidiabetic classes are two examples of drug categories that warrant close attention all the time. These two areas required special models earlier this year.

We first modified these models during the SR negotiation process that we currently perform in our other role as the negotiation vendor for the SSDC pool this past summer. Initially we created a model using large scale pool data to determine comparative savings. We then took this model and customized it with state-specific data. An individual state's savings scenarios may differ due to varying PA criteria, baseline drug utilization differences and generic SMAC pricing. We have included two models, below, that we recently used in preparing for the annual Iowa P&T meeting.

The first pharmaco-economic model, shown in Figure 10, on the next page, concerns the TZD class. Actos has always displayed disproportionate variations in CMS rebates across its three strengths. Over time the Actos 15mg tab has become much cheaper per mg than the two higher strengths (Q1-2009 Actos 15 mg net $0.33, Actos 30 mg net $3.40, Actos 45mg net $3.72). Recognizing this anomaly we modeled out the potential savings that might result from only preferring the use of the Actos 15 mg strength. This required identifying all the drugs that could be substituted with Actos 15 mg or multiples thereof and then calculating the net costs using CMS rebates only versus accepting TZD supplemental rebates and resulting savings. As you can see from examining this model, the net savings in excess of those resulting from just taking supplemental rebates on the TZD drugs was $1.1 million annually. This type of analysis is crucial in developing accurate net cost savings projections that can be used to guide committee recommendations and State decisions.

IOWA MEDICAID

ACTOS 15 MG PDL Exhibit

ONLY ACTOS 15MG PREFERRED W/O SR

Drug Name	Utilization (1q09)	converted actos 15 mg	Actos 15 net	(Combo) net w/o sr	Metformin costs	Extra Disp fee/day	q1 Actos 15 savings	Annual Actos 15 savings	vs SR savings/yr
Actos Tab 15 MG	11304	11,304	$0.33	$ 0.33			$ -	$ -	$ -
Actos Tab 30 MG	21596	43,192	$0.33	$ 3.40			$ 118,346	$ 473,384	$ 80,953
Actos Tab 45 MG	21967	65,901	$0.33	$ 3.72			$ 179,910	$ 719,640	$ 233,511
Avandia Tab 2 MG	480	480	$0.33	$ 1.86			$ 720	$ 2,880	$ 306
Avandia Tab 4 MG	6300	12,600	$0.33	$ 1.88			$ 15,372	$ 61,488	$ 23,802
Avandia Tab 8 MG	3747	11,241	$0.33	$ 4.43			$ 38,669	$ 154,676	$ 44,139
AVANDAMET 2-1000MG	960	960	$0.33	$ 2.01	$ 0.080	$ 0.153	$ 1,389	$ 5,556	$ 3,490
AVANDAMET 4-1000MG	1374	2,748	$0.33	$ 3.31	$ 0.080	$ 0.153	$ 6,642	$ 26,568	$ 9,509
AVANDAMET 2-500MG	2643	2,643	$0.33	$ 1.62	$ 0.070	$ 0.153	$ 2,741	$ 10,964	$ 5,207
AVANDAMET 4-500MG	1725	3,450	$0.33	$ 2.64	$ 0.070	$ 0.153	$ 6,062	$ 24,248	$ 10,434
ACTOPLUS MET15/500MG	3530	3,530	$0.33	$ 1.84	$ 0.070	$ 0.153	$ 4,543	$ 18,172	$ 6,994
ACTOPLUS MET 15/850MG	8541	8,541	$0.33	$ 1.84	$ 0.050	$ 0.153	$ 11,163	$ 44,652	$ 15,540
								$ 1,542,228	**$ 433,885**

Savings Potential	
Actos 15 Mg Only Preferred	**$ 1,542,228**
Take All TZD SR	**$433,885**
Actos 15 Mg Net Savings Incr.	**$1,108,333**

Figure 10: TZD Exhibit 2010

We can also perform financial modeling that shows the recent utilization with all CMS rebates, supplemental rebates and net costs clearly identified. Then we demonstrate how these variables might change under different sets of assumptions and their probabilities. In a number of categories this involves comparing rebated brands to each other and then possibly to non-contracted brands and/or generics potentially affected by SMACs/FULs. To the extent that data is available, we use other states' utilization changes after they adopted a similar PDL category design. A second pharmaco-economic model concerning the Serotonin Norepinephrine Reuptake Inhibitors (SNRIs) is included in Figure 11, on the next page.

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

Current Status A: Supplemental rebate offers are not taken yet

	PDL Status	# Units	# Scripts	Weighted Avg Pre-Rebate Ingr $/Unit	Weighted Avg CMS Rebate $/Unit	Weighted Avg Supp Rebate $/Unit	Weighted Avg Net $/Unit	Total Pre-rebate $	Total CMS Rebate	Total SR	Total Net $	Weighted Avg Pre-rebate $/Script	Weighted Avg Post-rebate $/Script	Total Net Savings off Current
EFFEXOR XR	NR	203,122	6,094	$ 4.34	$ 2.41	$ -	$ 1.93	$ 880,658	$ 489,131	$ -	$ 391,528	$ 169.69	$ 75.44	
PRISTIQ	N	17,585	598	$ 3.80	$ 0.83	$ -	$ 2.96	$ 66,770	$ 14,681	$ -	$ 52,088	$ 112.44	$ 87.72	
VENLAFAXINE ER	N	270	9	$ 5.30	$ 1.82	$ -	$ 3.49	$ 1,432	$ 491	$ -	$ 941	$ 159.08	$ 104.57	
CYMBALTA	NR	1,480,724	50,008	$ 4.24	$ 1.37	$ -	$ 2.87	$ 6,279,469	$ 2,033,706	$ -	$ 4,245,762	$ 125.57	$ 84.90	
SAVELLA	N	960	16	$ 1.80	$ 0.24	$ -	$ 1.55	$ 1,724	$ 233	$ -	$ 1,491	$ 107.74	$ 93.21	
EFFEXOR	P	13,216	244	$ 0.58	$ 1.55	$ -	$ (0.97)	$ 7,604	$ 20,474	$ -	$ (12,870)	$ 17.26	$ (29.22)	
VENLAFAXINE	N	5,502	94	$ 0.58	$ 0.02	$ -	$ 0.56	$ 3,166	$ 104	$ -	$ 3,062	$ 24.99	$ 24.17	
		1,721,379	**57,063**					**$ 7,240,822**	**$ 2,558,819**	**$ -**	**$ 4,682,002**			**0**

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

	PDL Status	# Units	# Scripts	Weighted Avg Pre-Rebate Ingr $/Unit	Weighted Avg CMS Rebate $/Unit	Weighted Avg Supp Rebate $/Unit	Weighted Avg Net $/Unit	Total Pre-rebate $	Total CMS Rebate	Total SR	Total Net $	Weighted Avg Pre-rebate $/Script	Weighted Avg Post-rebate $/Script	Total Net Savings off Current
EFFEXOR XR	P	203,122	6,094	$ 4.34	$ 2.41	$ 0.23	$ 1.70	$ 880,658	$ 489,131	$ 47,095	$ 344,433	$ 169.69	$ 66.37	
PRISTIQ	N	17,585	598	$ 3.80	$ 0.83	$ -	$ 2.96	$ 66,770	$ 14,681	$ -	$ 52,088	$ 112.44	$ 87.72	
VENLAFAXINE ER	N	270	9	$ 5.30	$ 1.82	$ -	$ 3.49	$ 1,432	$ 491	$ -	$ 941	$ 159.08	$ 104.57	
CYMBALTA	NR	1,480,724	50,008	$ 4.24	$ 1.37	$ -	$ 2.72	$ 6,279,469	$ 2,033,706	$ -	$ 4,245,762	$ 125.57	$ 84.90	
SAVELLA	N	960	16	$ 1.80	$ 0.24	$ -	$ 1.55	$ 1,724	$ 233	$ -	$ 1,491	$ 107.74	$ 93.21	
EFFEXOR	P	13,216	244	$ 0.58	$ 1.55	$ -	$ (0.97)	$ 7,604	$ 20,474	$ -	$ (12,870)	$ 17.26	$ (29.22)	
VENLAFAXINE	N	5,502	94	$ 0.58	$ 0.02	$ -	$ 0.56	$ 3,166	$ 104	$ -	$ 3,062	$ 24.99	$ 24.17	
		1,721,379	**57,063**					**$ 7,240,822**	**$ 2,558,819**	**$ 47,095**	**$ 4,634,907**			**$188,379**

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

	PDL Status	# Units	# Scripts	Weighted Avg Pre-Rebate Ingr $/Unit	Weighted Avg CMS Rebate $/Unit	Weighted Avg Supp Rebate $/Unit	Weighted Avg Net $/Unit	Total Pre-rebate $	Total CMS Rebate	Total SR	Total Net $	Weighted Avg Pre-rebate $/Script	Weighted Avg Post-rebate $/Script	Total Net Savings off Current
EFFEXOR XR	N	20,042	609	$ 4.34	$ 2.41		$ 1.93	$ 86,894	$ 48,262	$ -	$ 38,632	$ 169.69	$ 75.44	
PRISTIQ	N	17,585	598	$ 3.80	$ 0.83	$ -	$ 2.96	$ 66,770	$ 14,681	$ -	$ 52,088	$ 112.44	$ 87.72	
VENLAFAXINE ER	P	183,350	6,083	$ 5.30	$ 1.82	$ 2.24	$ 1.24	$ 972,213	$ 333,129	$ 411,333	$ 227,752	$ 207.52	$ 48.61	
CYMBALTA	NR	1,480,724	50,008	$ 4.24	$ 1.37		$ 2.72	$ 6,279,469	$ 2,033,706		$ 4,245,762	$ 125.57	$ 84.90	
SAVELLA	N	960	16	$ 1.80	$ 0.24	$ -	$ 1.55	$ 1,724	$ 233	$ -	$ 1,491	$ 107.74	$ 93.21	
EFFEXOR	P	13,216	244	$ 0.58	$ 1.55	$ -	$ (0.97)	$ 7,604	$ 20,474	$ -	$ (12,870)	$ 17.26	$ (29.22)	
VENLAFAXINE	N	5,502	94	$ 0.58	$ 0.02	$ -	$ 0.56	$ 3,166	$ 104	$ -	$ 3,062	$ 24.99	$ 24.17	
		1,721,379	**57,652**					**$ 7,417,839**	**$ 2,450,589**	**$ 411,333**	**$ 4,555,917**			**$504,340**

Figure 11: SNRI Modeling

The SNRI antidepressants cost over $7 million annually or nearly 3% of the state drug budget. The Legislature's restrictions imposed on this class make it difficult to curb overly expensive chemically unique antidepressants. Since Venlafaxine ER is the same chemical as Effexor XR the State finally had an opportunity to capture some savings when significant SR offers materialized on both drugs this year. In this model, which incorporated all pre-rebate costs, CMS and potential SRs, savings were modeled out on the most recent quarter's utilization. The Excel sheet model allows us to vary assumptions concerning expected utilization changes long with different mixes of preferred and non-preferred drugs. In this model it became very clear that the Venlafaxine ER offer was superior and that a high success rate was probable. Taking the Effexor XR offer would provide $188,000 of new savings and not require any switching while accepting

the Venlafaxine ER offer would result in almost a three-fold higher annual savings of $504,000 but require a one-time massive switch. In this scenario we also examined the benefit of consolidating multiple Effexor strength scripts (150 mg and 75 mg) into one Venlafaxine ER script (225 mg). In other iterations (not included in the RFP for the sake of brevity) of the model we also examined what would happen if Savella was made preferred or preferred only with step edit criteria to encourage appropriate utilization in fibromyalgia.

GHS will continue to provide supplemental rebate negotiations and saving analyses of specific drugs/drug categories on a mutually acceptable schedule. We will present estimated savings in a manner agreeable to the Department. This will involve estimations based on both current and projected utilization. We can also apply estimated costs to anticipated prior authorizations in each class, as we did when we first assumed the role of Pharmacy Medical services vendor in 2004, so that the State can consider the net return on investment of its PDL design. Depending on the Department's preference, we can present a simple summary version of estimated savings within each class, reflecting shifts in market share utilization, average blended net cost per unit, and supplemental rebates. These summaries can accompany the more complex analysis that incorporates all the utilization, including that of minor drugs.

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

At a detailed level, the cost analyses are performed to arrive at comparisons of net costs. We take your pharmacy reimbursement rate(s), FULs, and SMACs and then subtract out CMS rebates (and eventually supplemental rebates) to arrive at net costs. We then compare drug net costs within PDL classes to help decide best values. Most drugs, especially the one unit per day drugs, are then easily compared. Other drugs require adjustments in order to arrive at fair comparisons. For example, we judge inhalers, nose sprays and eye drops by actual utilization data. We apply a net cost value to the average number of units used per day supply by the entire state Medicaid population. Another example concerns antibiotics. We determine the most frequently prescribed courses of therapy and model out net costs to arrive at net cost per course of therapy.

The last major component of the cost analysis relates to market share. The committee members need to know how many people are on (tentatively) preferred and non-preferred drugs. They also need to know if any data exists that would help predict the probability of success if drug A was made preferred and drug B non-preferred. This data assists in making sound decisions.

In the more complex analysis, we use a predictive pricing approach to estimate the final budget impact of PDL decisions after accounting for all rebates, prescribing alterations, and offsetting administrative costs. We have attached the initial step of this methodology in Figure 12. The first step involves analyzing whether a specific PDL decision will result in less or more savings than another scenario. This requires us to make market share assumptions, then examine, and quantify

the results. To do this, we use prior experiential claims data on similar drugs or drug classes that have already been incorporated within PDLs. In Figure 12, we model several assumptions on the statin class. We vary market shares and net unit costs to arrive at potential savings. We then compare the outcomes of these scenarios to projected and actual Lipitor net prices. The models are reviewed with the States to arrive at a best fit.

Exhibit IV c.
Cholesterol - HMG COA + Inhibitors
Pure Statins

		Baseline *		Scenario A	Scenario B	Scenario C	Scenario D
		No Mktshr Chg		*No Mktshr Chg*	*No Mktshr Chg*	*Mktshr Chg*	*Mktshr Chg*
Simvastatin							
	Avg Units/Script	30		30	30	30	30
	Avg Unit Cost	$2.00		$1.00	$0.50	$1.00	$0.50
	Avg Script Cost	$60.00		$30.00	$15.00	$30.00	$15.00
LIPITOR							
	Avg Units/Script	30		30	30	30	30
	Avg Unit Cost	$2.20		$2.20	$2.20	$2.20	$2.20
	Avg Script Cost	$66.00		$66.00	$66.00	$66.00	$66.00

* Baseline = Maine mktshr

	Baseline MarketShare		Baseline *		Marketshare Cost	Marketshare Cost	Marketshare Cost	Marketshare Cost
	Mktshr	Scripts						
Simvastatin	19.0%	6,974	19.0%	Mktshr %	19.0%	19.0%	66.9%	66.9%
			6,974	Scripts	6,974	6,974	24,607	24,607
			$418,440	Mktshr Cost	**$209,220**	**$104,610**	**$738,215**	**$369,107**
LIPITOR	63.0%	23,147	63.0%	Mktshr %	63.0%	63.0%	15.0%	15.0%
			23,147	Scripts	23,147	23,147	5,514	5,514
			$1,527,702	Mktshr Cost	**$1,527,702**	**$1,527,702**	**$363,914**	**$363,914**
			$1,976,264		**$1,767,044**	**$1,662,434**	**$1,132,250**	**$763,143**
				Change from Baseline	**($209,220)**	**($313,830)**	**($844,014)**	**($1,213,121)**
				% chg	**-10.59%**	**-15.88%**	**-42.71%**	**-61.38%**

Figure 12: Predictive pricing approach to estimate the final budget impact of PDL decisions

One limitation with the financial model is that it is only concerned with the choices being presented to the Committee and not what is unavailable. The model does not account for what you had last year compared to this year. It does not compare between what you could save as a single state versus participating in a pool. It is simply focused on facilitating the choice of the best savings option present within an individual drug class. We can assist the Department in performing these other levels of financial analysis while still being faithful to rebate confidentiality requirements.

c. *With the Department approval, incorporate therapeutic reviews at subsequent P&T committee meetings and respond to questions from the committee. The contractor shall provide drug monographs, supplemental rebate negotiation information, and savings information for each therapeutic class. The contractor shall provide supplemental rebate information in a format agreed to by the Department. In addition, the contractor shall perform and include documentation of benchmark analyses for financial and clinical outcomes to monitor trends and shall provide program recommendations to improve clinical and financial outcomes.*

Over the past five years GHS has created nearly one hundred (100) therapeutic class reviews. We have several pharmacists devoted to updating the reviews and staying current with recent publications. We also contract with a number of specialists to assist in their area of expertise. With Department approval, GHS will incorporate these therapeutic reviews at subsequent P&T Committee meetings and will respond to all questions from the committee. GHS will also

provide drug monographs, supplemental rebate negotiation information, and savings information for each therapeutic class. Supplemental rebate information will be provided in a format agreeable to the Department, and will be coded to protect confidentiality. We have extensive experience in creating and providing customized drug monographs to drug committees, according to each state's specifications. We have been providing this service to the State of Iowa since 2004 and will continue to strive to meet and exceed the IME's goals and expectations. The goal of the clinical monographs is to assist the P&T Committee member to arrive quickly at a rational assessment as to what unique properties (both positive and negative) each drug has relative to other agents in the same class, if any exist. The monographs concisely summarize essential data concerning safety, efficacy and cost. If a drug is recommended as preferred but with conditions, then these conditions are described along with their clinical rationales.

States vary in how they choose to employ these class reviews. Some states, Iowa among them, are very selective. They concentrate on reserving class reviews for categories that pose significant new clinical questions relating to PDL status. This is possible because the P&T Committee members are largely seasoned veterans of the drug review process. Many of them have considered and reconsidered the PDL for five years. Other States have had higher rates of turnover or only recently implemented their PDL. For several of these states we delivered a CD containing *all* the therapeutic class reviews and relevant utilization data to the committee members. In another state we are only asked to provide therapeutic class reviews for those classes where a PDL status change is being recommended. We will, of course, continue to follow the State's direction in this matter.

States also differ in how they want confidential pricing data presented to the committee. Several states prefer to have us convey this information verbally, fearing accidental transgressions by members. Other states allow us to present drug specific net cost data down to the drug strength while others only allow us to show bundled up drug name or drug category net cost data. When allowed to show cost data, we give the committee the AWP price, the state reimbursement off AWP, the CMS rebate (either actual or estimated) and the supplemental rebate, if offered. In most cases it is also appropriate to express the net cost as either per script, per month or annualized. In some cases, like those involving sprays, we need to convert the unit cost into a daily cost based on the average quantity used. As an example, in Figure 13, we have carved out an excerpt showing the average net script costs per PDL category comparing Q2-2009 to the Q4-2004 baseline. In this excerpt we have highlighted the top twenty or so PDL categories, in terms of total net costs. Of 322 categories, 288 had utilization from 2004 through 2009. Of these 288, 100 had experienced increases in net script cost compared to the 2004 baseline while 188 evidenced decreases. There were just over 20 key categories that had over $300,000 in net costs for Q2-2009. Only four of these high net dollar drug categories had trended up in cost compared to 2004 (three asthma drug classes and the stimulant methylphenidate). All of the major mental health classes had experienced significant decreases in net cost over time including anticonvulsants (-28%), antidepressants (-40%), atypicals (-0.5%) and stimulants (-56% to +3.2%). This report accurately details for us where we are doing well and where we need to reconsider our approach or augment with interventions outside the realm of preferred or non-preferred designations.

	Q2 CY2009									
Iowa PDL Category Description	Sum Pre-rebate Paid Amt	% of Total Pre-rebate Paid Amt	Sum CMS Rebate Amount	Sum SR Amount	% of Total Rebates out of Sum Pre-rebate Paid	Total Net Costs	% of Total Net Cost	N of Scripts	Avg Net Cost per Script	% Change in Avg Net Cost per Script from Baseline Q4
ANTIPSYCHOTICS - ATYPICALS	$10,953,726.29	17.26%	$4,066,235.41	$ 140,151.50	38.4%	$6,747,339.38	20.19%	38,377	$ 175.82	-0.5%
ANTICONVULSANTS	$ 5,587,559.19	8.80%	$3,067,080.36	$ 47,624.35	55.7%	$2,472,854.48	7.40%	50,909	$ 48.57	-28.4%
ANTIDEPRESSANTS - SELECTED SSRI's	$ 4,349,408.03	6.85%	$1,891,421.75	$ 194,059.87	47.9%	$2,263,926.41	6.77%	74,201	$ 30.51	-40.8%
ANTIHEMOPHILIC AGENTS	$ 1,872,303.57	2.95%	$ 120,662.72	$ -	6.4%	$1,751,640.85	5.24%	90	$19,462.68	-4.5%
ANTIASTHMATIC - LEUKOTRIENE RECEPTOR ANTAGONISTS	$ 1,692,578.31	2.67%	$ 732,622.84	$ 57,278.60	46.7%	$ 902,676.88	2.70%	15,484	$ 58.30	0.9%
STIMULANTS - METHYLPHENIDATE - LONG ACTING	$ 2,306,980.45	3.63%	$1,379,377.03	$ 90,703.80	63.7%	$ 836,899.62	2.50%	17,016	$ 49.18	-16.7%
STIMULANTS - AMPHETAMINES - LONG ACTING	$ 3,467,373.12	5.46%	$ 846,328.65	$1,815,188.18	76.8%	$ 805,856.30	2.41%	20,217	$ 39.86	-42.8%
ANTIASTHMATIC - ADRENERGIC COMBOS	$ 1,481,932.83	2.33%	$ 658,554.41	$ 116,490.64	52.3%	$ 706,887.77	2.12%	8,038	$ 87.94	8.3%
NARCOTICS - MISC.	$ 724,189.35	1.14%	$ 79,237.61	$ -	10.9%	$ 644,951.74	1.93%	49,780	$ 12.96	-28.7%
MACROLIDES / ERYTHROMYCIN'S / KETOLIDES	$ 665,830.64	1.05%	$ 36,955.01	$ -	5.6%	$ 628,875.63	1.88%	23,723	$ 26.51	-23.2%
CEPHALOSPORINS	$ 859,055.58	1.35%	$ 199,558.43	$ 83,565.32	33.0%	$ 575,931.83	1.72%	19,764	$ 29.14	-5.8%
ANTIASTHMATIC - BETA - ADRENERGICS	$ 1,059,215.94	1.67%	$ 397,429.44	$ 159,535.22	52.6%	$ 502,251.27	1.50%	28,293	$ 17.75	-12.9%
BETA-LACTAMS / CLAVULANATE COMBO'S	$ 534,737.40	0.84%	$ 56,831.93	$ 233.87	10.7%	$ 477,671.60	1.43%	37,359	$ 12.79	-44.2%
NARCOTICS-LONG ACTING	$ 884,910.32	1.39%	$ 431,207.09	$ 6,060.35	49.4%	$ 447,642.88	1.34%	4,630	$ 96.68	-26.1%
ANXIOLYTICS - BENZODIAZEPINES	$ 415,514.80	0.65%	$ 13,977.32	$ -	3.4%	$ 401,537.48	1.20%	46,589	$ 8.62	-34.0%
ANTIASTHMATIC - STEROID INHALANTS	$ 826,864.99	1.30%	$ 395,038.86	$ 42,963.65	53.0%	$ 388,862.48	1.16%	5,243	$ 74.17	1.3%
CHOLESTEROL - HMG COA + ABSORB INHIBITORS	$ 916,216.18	1.44%	$ 322,973.51	$ 207,570.84	57.9%	$ 385,671.83	1.15%	16,022	$ 24.07	-59.5%
STIMULANTS - OTHER STIMULANTS / LIKE STIMULANTS	$ 768,074.85	1.21%	$ 386,498.34	$ -	50.3%	$ 381,576.51	1.14%	4,815	$ 79.25	-13.1%
GI - PROTON PUMP INHIBITOR	$ 1,742,216.45	2.74%	$1,118,429.09	$ 271,177.78	79.8%	$ 352,609.58	1.06%	14,304	$ 24.65	-69.1%
RSV PROPHYLAXIS	$ 740,916.83	1.17%	$ 407,015.82	$ -	54.9%	$ 333,901.01	1.00%	468	$ 713.46	-28.5%
STIMULANTS - METHYLPHENIDATE	$ 910,368.76	1.43%	$ 376,756.17	$ 227,266.40	66.3%	$ 306,346.19	0.92%	10,789	$ 28.39	3.2%

Figure 13: Iowa Rebates and Net Cost by PDL Category

GHS will continue to perform and document benchmark analyses for financial and clinical outcomes, to monitor trends and provide program recommendations to improve clinical and financial outcomes. As one example consider how the diabetic drug Januvia has been handled. The initial analysis concluded that the drug was clinically less potent than existing preferred therapies (metformin, sulfonylureas and TZDs) and from two to twenty times more expensive. The State considered taking a supplemental rebate but the trending analysis concluded that doing so would seriously erode its current projected savings rate. Several other states did decide to take the SR on Januvia. After just one year Iowa had only 25 % of the Januvia use of these other states. Clinically, Iowa maintained a higher proportion of diabetics on more potent oral medications while also increasing the percentage of diabetic members using basal insulins. Since Iowa belongs to the SSDC pool we are able to provide valuable comparative state data. This allows us to benchmark Iowa not just against its own baseline but also against other state Medicaid programs.

d. When two or more drugs within a therapeutic class have equal effectiveness and therapeutic value, review the drugs on a cost basis to formulate recommendations to the Department.

GHS will review equally effective and therapeutically valuable drugs on a net cost basis in order to formulate recommendations to the Department. This has been the operating directive for the past five years. In cases where there is no historical rebate data that will allow net cost

computations we will use estimations based on our understanding of WAC and its relationship to AMP, especially for brand drugs.

e. Develop a strategy to collaborate with the supplemental drug rebate negotiation vendor to incorporate the rebate information into analyses and P&T meetings.

This is not an issue for GHS since we negotiate the supplemental rebate offers on behalf of the SSDC. When assuming responsibility for taking over PDL and SR duties in other states from other vendors we have had to work out confidentiality agreements between ourselves, the exiting vendor and the State that allowed the sharing of all historical rebate data. This has been difficult in one case where the vendor was a party to the manufacturer contracts and insisted that it, not the State, owned the SR deals and the SR pricing data. It is and always has been our position that the State owns all of the data. We hope and would assume that should GHS at some point no longer be the negotiation vendor for the SSDC pool that the State would retain its full rights to and use of the SR data. Currently, GHS is able to seamlessly provide SR pricing formulas to all of the SSDC member states, several of which either invoice manufacturers themselves (Utah, Oregon) or use another vendor (Vermont). We would expect reciprocity and no difficulties performing our analytic duties if another vendor assumes these functions. If the State was to obtain bids from outside the existing pool via a new vendor, we would then need to work out file layouts, data transfer protocols and confidentiality agreements. We currently provide this for Georgia's PDL/POS vendor so we understand exactly how this will need to work if our positions were reversed.

f. Consider expanding coverage of nonprescription drugs and including on the PDL as preferred agents when they are determined to be cost-effective. This responsibility includes establishing the reimbursement rate as set forth in state law.

The selective coverage of nonprescription drugs represents a wonderful opportunity for the PDL but it does have some well-acknowledged risks of which the State is already aware. OTC drugs can be substantially less costly than legend products but the exit of the dual eligibles into Part D has made these decisions problematic. If Medicaid elects to cover any OTCs then they must also cover them for the duals. In certain OTC drugs usage by duals could be very heavy. Although it is true that the State would receive federal match on any OTC dollars spent, it is very possible that the increased state dollars spent on dual OTC drugs could negate any savings produced. Therefore these decisions must be made very cautiously. OTC drugs primarily used by the pediatric population would be more attractive candidates. Many of the Part D plans also elect to cover cost-effective OTC medicines so to the extent this occurs then Iowa can safely extend coverage, too. After Part D was implemented in 2006 we noticed a gradual reduction in usage of Medicaid covered OTC drugs by duals as the PDPs added them to their formularies.

Years ago the P&T Committee saw the value of OTC Prilosec. It was of immense value then because any brand Prilosec or generic omeprazole users that switched over saved several dollars per patient per day. It also served as leverage in inducing superior rebates on the remaining preferred PPI choice(s). After several years the SMAC on generic omeprazole finally improved enough to remove this OTC. This reminds us of the need for constant vigilance. Presently cost-effective OTCs may not necessarily stay that way forever.

Our OTC management practice is to monitor the market and present pertinent information to the Department and the Committee and then develop a strategy for incorporating cost-effective OTC medications in the formulary. We have had very positive results through this practice. Our clinical staff continually researches and monitors the market for appropriate OTC inclusion. Assuming that consumption by dual-eligibles will not wipe out potential savings in the non-dual population, we would always recommend covering OTC's that are cost effective, thereby reducing the utilization of more expensive legend products. The math is simple. The clinical issues are just as simple in these cases. The biggest problem usually relates to covering the most cost-effective package sizes and accommodating the larger day supplies. The reimbursement rates (currently based on median AWP) will be factored in and established as according to state law.

g. Include on the PDL those preferred drugs recommended by the P&T committee and confirmed by the Department.

GHS will include preferred drugs recommended by the P&T Committee, once they have also been confirmed by the Department. This implies that the Department may at some time exercise its authority to not accept specific recommendations. This is an important right to reserve because it is essential to be able to protect the viability of the Medicaid Program. Committees are comprised of people with areas of expertise that are strong in some parts of the PDL and weak in others. Attendance may also affect key votes depending on whether the leader in that area is present. Less than ideal results can and do happen and it is important to maintain the ability to rectify the problem, or at the least, forestall it.

h. Subject to Department approval, establish written criteria and a prior authorization process for obtaining the nonpreferred drugs.

GHS understands our role in developing prior authorization criteria and processes. The Department will need to approve the criteria and the precise process for obtaining non-preferred drugs. Iowa requires the submission of PA forms primarily by fax in order to speed access to decisions and medicines. Since a successful PDL requires a higher standard of evidence for approvals, written PA forms with explicit criteria, including needed chart documentation, is the norm. Requests for additional information can be expressed by fax the same day.

Every non-preferred drug has explicit approval criteria. In many cases the PDL itself provides enough information about access to drugs without PA. Many drugs have age edits, above or below which no PA is required. The Department also maintains a PA criteria chart that is posted online. This chart contains very detailed criteria concerning PDL classes or in many cases specific individual drugs and is updated frequently during the year. Supporting data or documentation requirements are clearly listed.

As described throughout these PDL sections, GHS will continue to develop and revise written PA criteria and PA processes for obtaining non-preferred drugs. We understand that the Department must approve these processes.

i. Ensure that the PDL program includes provisions for:

1. *The dispensing of a 72-hour emergency supply and/or a 30-day supply of the prescribed drug and a dispensing fee to be paid to the pharmacy for such a supply in accordance with policies established by the Department*
2. *Responses by telephone or other telecommunications device within 24 hours of a request for prior authorization*
3. *Consumer and provider education, which shall include informational letters and web site access to information*

The Prior Authorization process, as administered by GHS under the guidance of the state, will continue to remain compliant with all of the Federal and state laws and regulations. OBRA '90 stipulates that a response to a complete PA request must occur within twenty-four hours and that, except for non-covered drugs, a seventy-two hour supply of medication must be provided in emergency situations. As noted above, GHS has and will continue to devote all resources necessary to maintain the efficient performance of its PA processing system. We will strive to maintain complete request determinations in two hours.

Iowa has, until very recently, allowed a longer "emergency" override thirty day supply to help prescribers cope with the initial burden and unfamiliarity with the PDL/PA process. As this ceases to be available we would expect the federally mandated 72 hour emergency supply scripts to increase. This 30 day override was an important compromise due to the tight implementation timeline since it allowed recipients to pick up their medicines without having to all rush in ahead of schedule to see the doctor and get their prescriptions changed over. Now that the PDL/PA processes have been operating smoothly for some time, this 30 day override is no longer necessary and has been phased out.

Federal law and State Medicaid rules require the timely consideration of all PA requests within 24 hours. GHS is aware of the paramount importance of always meeting these requirements and has demonstrated that it can do so successfully. Responses will be made by fax, phone and in writing so that determinations are conveyed in the timely manner demanded by law. GHS will perform all of the necessary monitoring in order to continually verify turnaround times.

Further details of our turnaround times and processes are given in Section 6.3.2 Prior Authorization of this proposal.

GHS will continue to satisfy the performance requirement that all determinations must be made within 24 hours of a complete PA request. GHS' PA help desk and our PADSS will be responsible for responding to these requests. They respond via telephone, fax, email, and mail.
The PDL program will provide both telephonic and web-based access to information about the ongoing efforts including recipient and provider education and more formal training opportunities.

GHS will proactively provide information to prescribers, pharmacists, and recipients, periodically communicating with them about upcoming changes to the PDL and to follow-up with past changes. GHS has proven strategies to disseminate information to targeted populations via specialized analysis; we are able to notify specific prescribers about upcoming PDL changes and patients that may be affected. This allows physicians to initiate drug regimen changes with their patients before a PDL restriction come into effect. Our PA help desk technicians and pharmacists are available via telephone and email to respond to PDL-related inquiries. We also

will have PDL information available on our website. Patient specific information (personal health information or PHI) would not be available via the web, to prevent a HIPAA PHI disclosure.

j. Ensure that Medicaid providers have accurate, timely and complete information about all drugs on the PDL. The contractor shall make this information available through various sources, such as written materials and on the web site. The minimum notification to providers is 30 days prior to implementation.

GHS fully understands that provider access to accurate, complete and timely information on the PDL is vital for success. This is our standard practice to facilitate and dampen the volume of unnecessary PAs by ill-informed providers. We are able to utilize electronic and paper newsletter, email, fax, and mail. All of this information will also be prominently posted on the website. All public disseminations will be approved by the Department and will follow the Department's minimum notification timeframe policies of thirty (30) days.

In certain situations, such as positive additions to the PDL after implementation, drugs can be become preferred with simultaneous notification. In this case, dispersed information would not meet the 30-day requirement. In cases like these, GHS would seek written approval from the Department before implementing a change that would fail to meet the information dispersion requirements. Any changes proposed to the PDL will be highlighted. PDL drugs with proposed status changes or PA criteria changes are highlighted in blue. New drugs are highlighted in pink to attract significant attention.

The PDL manages several thousand drugs. This is a high-maintenance activity. We currently post, on average, six to eight updated PDLs on the website each year. Beyond this there are many specialized PDL lists that must be periodically updated to keep providers current. These include covered OTC drugs, preferred cough and cold drugs, brands preferred over generics and Medicare Part D excluded drugs.

k. Receive claims files (on a schedule to be determined) from the appropriate IME contractors to support evaluation and management of the PDL program.

GHS is aware that claims files will need to be shared and analyzed periodically to support PDL evaluation and management. These extracts will enable us to perform the many elements of evaluation and management critical to the well-being of this program. We have developed considerable proficiency in this area. We have had no issues with receiving data from IME's other claims/data vendors. We currently receive medical claims data and SMAC data with great frequency. On the PDL side we use the SMAC data to make timely decisions on preferring brands or generic versions. The medical claims data is extremely important when PA exemptions or grandfatherings are planned based on diagnoses. We also use the diagnostic data in analyses in preparing for P&T meetings where we need to know the size of a population that will be affected by drug PDL decisions. The medical data is also crucial when trying to determine the extent that a drug is being used for specific FDA approved indications or for off-label conditions. One very important example was the anticonvulsant class where it was easily demonstrated that less than 25% of most use was directed toward seizures. This type of information also helps us to estimate the cost associated with exempting certain people (diagnoses, ages) from PDL requirements.

l. Support the management and coordination of all activities related to the maintenance of the PDL, including presentation of ongoing efforts to the Department and the P&T committee as appropriate. Activities include but are not limited to the following:

1. *Clinical review of new brand drugs for clinical safety and efficacy including a cost analysis.*
2. *Clinical review of new generic drugs or clinical safety and efficacy including a cost analysis.*
3. *Clinical review and cost analysis of existing drugs for new indications, changes to indications and/or safety issues.*
4. *Review of new products forms and strengths and associated cost analysis.*
5. *Development of and changes to PDL criteria based on new information.*

PDL maintenance is not simple. A PDL needs constant attention as it is constantly evolving. Some drugs become too expensive and must be removed. New drugs are added, previously preferred drugs are removed and as more information becomes available, some previously non-preferred drugs are moved into more advantageous positions. As time passes we must constantly assess new drugs and their variants:

- Drugs become unavailable due to shortages or discontinuation
- New products, new forms, new strengths and new package sizes enter the market incessantly and require prompt attention
- Generics become available but are often financially unattractive initially
- New FDA approved indications appear nearly weekly and necessitate revisions of existing criteria
- Warnings are released on drugs and corresponding alterations must be made in the PDL
- Prices drop and prices increase (mostly)

Over the past five years we have developed a fairly simple but thorough process to flag and rate new drugs. The weekly drug file is reviewed and new drugs/new NDCs are identified and scored using a four part key to create an initial PDL status recommendation. The key includes logic that determines if a new drug should be treated like an existing drug or if it really requires a new drug assessment. Many new drugs can be automatically rated using the key as a guide.

Truly new drugs require clinical monographs that elaborate on efficacy and safety. The drug must be rated to its closest comparators, both financially and clinically. To the extent that it is available we try to gather and include Number Needed to Treat (NNT) and Number Needed to Harm (NNH) data. When comparing side effects and only placebo controls have been used we will adjust side effect rates for brands by subtracting the placebo rates from the brand rates.

Generic drugs are somewhat easier to review since the primary clinical issue relates to AB ratings and automatic substitution concerns. If the brand remains available then the cost review is primarily concerned about which version costs less after rebates. Some brands have accumulated massive CMS rebates due to price inflation interest and best price penalties. A good general rule is that any exclusive generic will remain more expensive than the corresponding brand for the first six months.

New brand product forms and strengths are almost always uniformly more costly to the State. It is rare for these types of new drugs to be recommended as preferred on the PDL unless the cost is controlled by a SR contract. These versions of “new” drugs typically shed the large CMS rebates associated with the existing versions and become comparatively expensive.

As new indications appear prior authorization criteria must be revised on non-preferred drugs and in some cases the drug might even become preferred. When existing versions of some drugs disappear an alternate version may need to have its PDL status flipped.

In order to make these decisions easier for the committee, we have grouped new PDL drugs by type: new brands, new forms/strengths, new generics and new names (rebranding). This seems to make it easier to describe what is being proposed and speeding up decision making and voting. Proposed changes to existing drugs can also be frequently sub-grouped by type (manufacturer discontinuations, manufacturer non-participation, FDA black boxing etc…).

We assume that the new drug process will remain the same. New drugs in already reviewed drug classes will be identified and immediately coded as non-preferred-PA required until presented at the next meeting. New drug entities in therapeutic classes not yet reviewed by the committee will remain payable until the class is discussed. Exceptions can be made based on priority drug designation by the FDA or "draft preferred" designation by the State on an interim basis if a drug is clinically superior, safer and less expensive.

In summary, we will continue to provide timely reviews and recommendations to the State and the Committee regarding new drugs, new indications, new safety issues, and negative studies both for the scheduled Committee meetings and for any interim drug decisions.

m. Perform ongoing analysis and clinical reviews of Iowa Medicaid pharmacy claims and conduct a review and cost analysis of each therapeutic class at least one time per calendar year.

Every therapeutic class will be reviewed at least once per calendar year. Additional indications and off-label abuse must be considered. Trends toward or away from specific drugs must be identified. Supplemental contracts may run from one to three years but it is worthwhile for many reasons to re-analyze the PDL completely each year. CMS rebates can trend up or suddenly plummet. Expectations in each category should be reviewed. Were they met? What lessons can be learned? Is there a different approach possible this year for underperforming areas? Can successful categories be tightened further? If the category is problematic, is it due to incorrect assumptions (excessive switching failures) or faulty execution (PA criteria not being applied properly)?

n. Represent the Department in public relations matters and coordinate with other agencies, groups, boards and individuals regarding the program at the request of the Department, including but not limited to the following activities:

1. *Preparing draft written responses or assisting the Department in responding to inquiries from providers and other interested parties concerning the PDL*
2. *Orally presenting the PDL process or otherwise informing various Department personnel and designees including but not limited to the legislature, provider groups or associations, other state agencies, or any other interested parties about the PDL and supplemental rebate process*
3. *Providing education materials, communication strategies, and/or providing training for groups that may be impacted by the PDL process*

GHS is prepared to continue to represent the Department in public relations matters and to coordinate with other agencies, groups, boards and individuals regarding the program at the request of the Department. GHS has provided representatives to testify and present before the Iowa legislature and other designated parties about issues related to work performed by GHS for

the State. We perform this duty willingly and routinely for the State of Iowa now and will continue to do so upon request. GHS will prepare draft written responses and assist the Department in responding to provider and interested party inquiries, provide educational materials, communication strategies and/or provide training for any group that may be impacted by the PDL process. In the past year a substantial amount of effort was devoted to expanding the PDL to include mental health drugs determined not to be truly chemically unique. This involved assisting the State in responding to queries from medical associations and the Legislature along with cultivating the DUR Mental Health Advisory Group.

As part of these duties in the past, we have been requested to create tailored Power Point presentations and handouts. The State would typically give us specific instructions on their needs and we would then clear the materials beforehand with State personnel. We provide similar services in the States of Maine, Wyoming and West Virginia. GHS will provide all of the educational materials, trainings and communication strategies necessary to ensure that all parties affected by the PDL will be in the best form possible.

o. Provide stakeholder support and include a Department-approved method of communication for manufacturers to receive assistance with questions related to the PDL.

GHS will continue to provide all that is needed to obtain stakeholder support. In some cases this means analyzing claims data to accurately gauge how many people will be affected by potential decisions. In other cases this means providing greater detail on how drug determinations are or how exceptions are made to explicit prior authorization criteria. Most importantly this means first listening carefully to their concerns and fears.

The bulk of manufacturer communication regarding the PDL comes during the supplemental rebate negotiation process. It is during this time that manufacturers are notified of Iowa's requirements and PDL processes. Manufacturers then have an opportunity to impact whether their product(s) are designated as preferred or non-preferred. GHS will continue to engage with manufacturers in a method approved by the Department.

Other manufacturer communications often concern their drug's PDL status and PA criteria. Supplemental rebate questions (past, present and future) are funneled to GHS personnel in Maine while questions relating to the actual day to day operations of the Iowa PDL are handled by the on-site Iowa GHS and State staff as approved by the State. All GHS communications are logged and archived for posterity. If we encounter an unusual question not previously answered before we will ask the State for guidance first.

We meet in person with most manufacturers at least once each year, especially if the drug is a potential budget buster or if supplemental rebates are involved or customized prior authorization criteria are needed.

p. Provide a web site that is available to all the public. The web site must include but is not limited to the following:
1. *Preferred drug list*
2. *Prior authorization criteria and forms*
3. *P&T committee meetings, agendas and minutes*
4. *Communication and education as determined in collaboration with the IME Member Services and Provider Services contractors*
5. *Manufacturer-specific directions for the supplemental rebate process*

6. *A link to a Department-provided mailbox for submission of questions, which must be monitored regularly and responded to within a timeframe specified by the Department*
7. *A link to a Department-provided mailbox for submission of public comment which must be monitored regularly and posted to the web site within a timeframe specified by the Department*
8. *All communications to members and providers*
9. *Any other documents deemed necessary by the Department*

At the State's direction, GHS created a website containing all of the required elements listed in this section. GHS has organized and posted great numbers of documents and related materials on this site. The archives are quite substantial after five years. We understand that any additions, subtractions or other revisions must be approved by the State. Please see the developed website at www.iowamedicaidpdl.com.

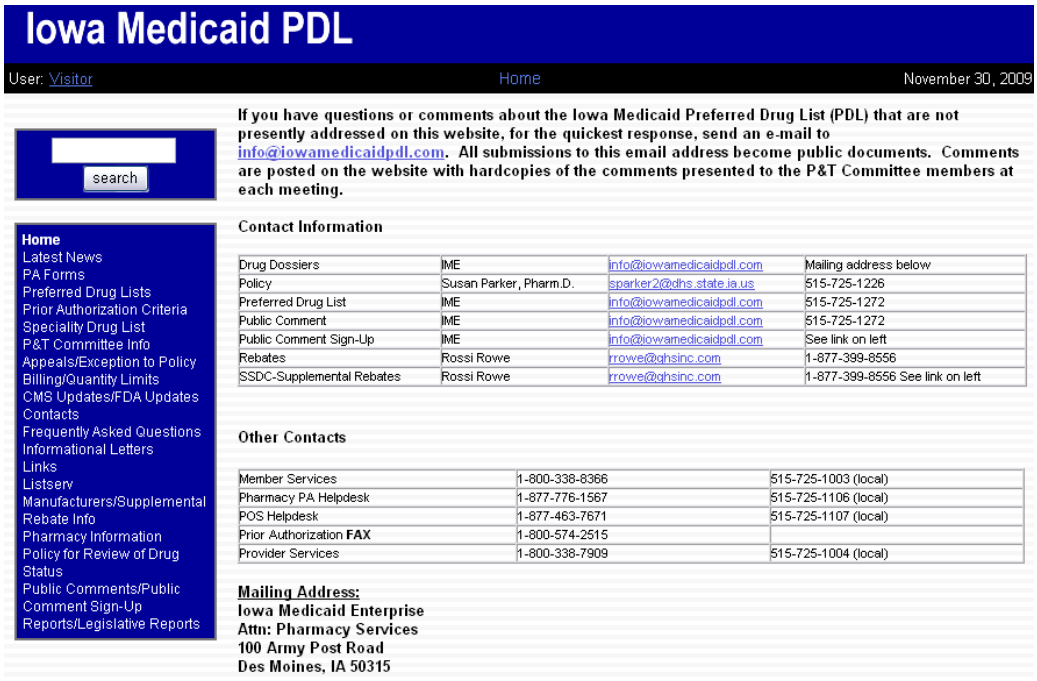


Figure 14: Iowa Medicaid PDL home page

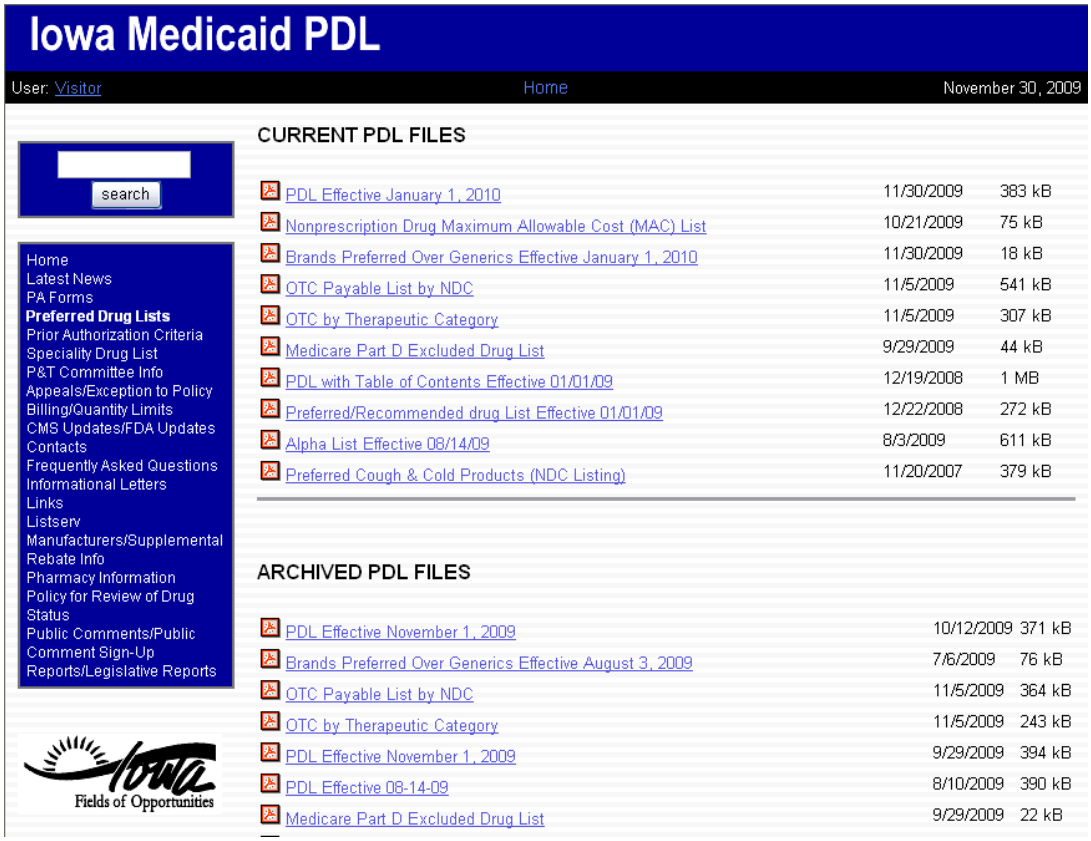


Figure 15: Screenshot of preferred drug lists posted to the Iowa Medicaid PDL website

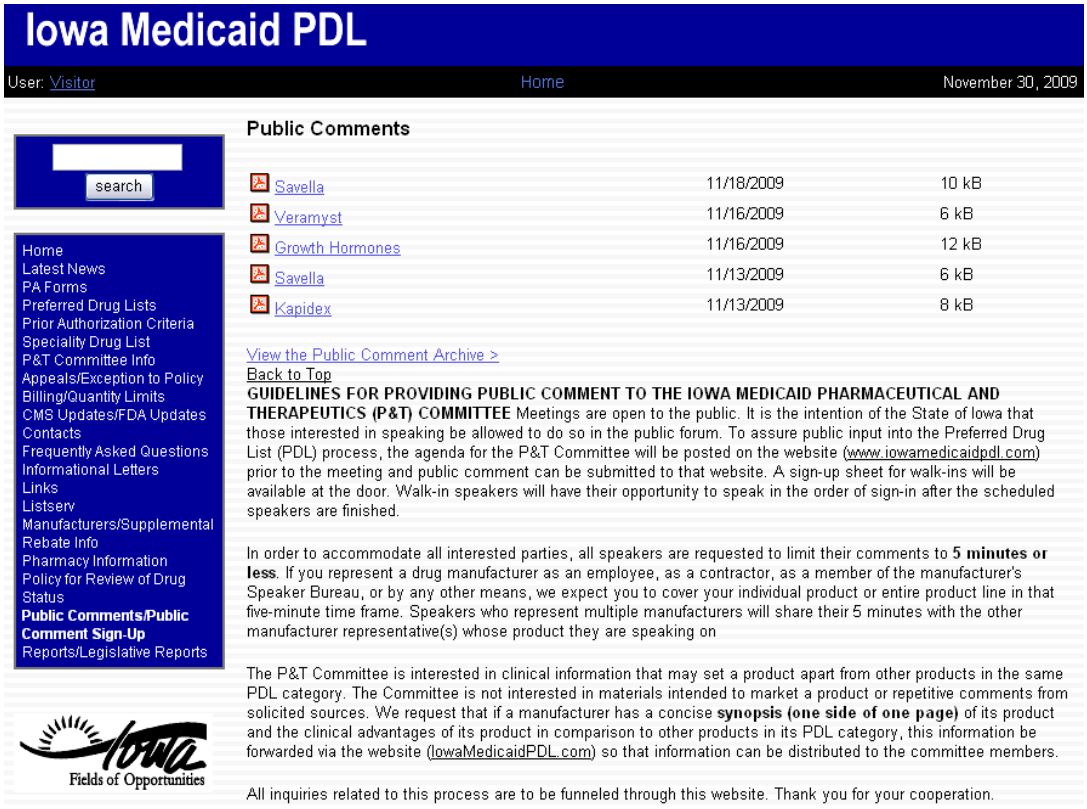


Figure 16: Screenshot of the public comment page from the Iowa Medicaid PDL website

Our experience demonstrates that maintaining an up-to-date website is an important part of a successful program. We monitor website access or "hits" and have found that these documents are viewed frequently and the information obtained contributes to users' education. We have on-staff a web master who is able to meet our design requirements. As we hopefully move into the future it may be time again to archive some of the older and less relevant materials to make the website more easily navigable.

q. Provide administrative support to the P&T committee to administer and maintain the PDL and prior authorization services.

1. Ensure that meetings of the P&T committee are conducted in accordance with Chapter 21 of the Code of Iowa (open meetings). In accordance with Chapter 21, notice shall be given of the time, date, and place of each meeting and its tentative agenda by publication in the news media and by appropriate posting of the notice. Notice shall be e-mailed on request to organizations or associations whose membership consists of persons who have an interest in the activities of the P&T committee.

The P&T Committee meetings will continue to be conducted as required by Chapter 21. Adequate notice will be given including time, place and date, along with the tentative agenda both on the website and in the news media. Interested parties such as medical and pharmacy associations will be included on the notification list.

We understand the importance of following established rules, laws, and policies, as they affect the validity of the PDL program. We fully understand our role in remaining vigilant to the Committee's obligations in these matters, most notably the requirement to confine discussions in the closed portions of these meetings to truly confidential matters.

2. Schedule the meetings, including arrangement of the meeting location. This responsibility includes scheduling and conducting orientation of new members in coordination with the Department pharmacy consultant.

GHS will take responsibility for scheduling meetings and providing public notice in coordination with and per the directions of the Department pharmacy consultant. Presentations by manufacturers and other parties will also be scheduled for an agreed-upon amount of time unless modified by the State. The Department will continue to dictate the quantity and types of presentation materials. Public notice will occur in the above-specified manner.

3. Provide and collect required forms from commission members (including but not limited to conflict of interest disclosures, confidentiality forms, travel and meeting reimbursement forms), and provide copies as required to the Department. Contractor staff is responsible for coordinating all commission member reimbursement associated with the meetings.

GHS will continue to provide and then collect the forms and other confidential documents distributed to Committee members on behalf of the State. We will also perform all the work necessary to coordinate member meeting reimbursements.

4. Convene meetings of any P&T subcommittees as necessary to perform specified function. This responsibility includes securing the professional staff to serve voluntarily on these subcommittees.

GHS understands that it will be necessary to convene and conduct subcommittee meetings for various PDL needs during the course of this contract. We recognize that enlisting the support of qualified participants is our responsibility.

5. *Provide an orderly mechanism for interested persons to speak at meetings of the P&T Committee regarding issues coming before the committee, including public comment participation by interested parties, according to the policy established by the P&T committee and provide public notice of the meetings.*

GHS will continue to provide an orderly process for interested parties to participate in P&T Committee meetings as per the Committee's established policy. We will provide the necessary public notice of these meetings. We will collect comments from parties unable to personally attend these meetings and make them available to Committee members.

6. *Maintain a web site listing the P&T committee meeting schedule, agendas, committee members, minutes of the meetings and other information deemed necessary by the Department.*

GHS will continue to maintain the website such that it includes P&T Committee meeting schedules, agendas, committee member listings, minutes, and other pertinent information approved by the Department. An example of this listing can be found on the current www.iowamedicaidpdl.com website maintained by GHS.

7. *Formulate information packets, including at a minimum the preparation of the agenda, meeting minutes for committee's review and approval, and therapeutic class reviews (including drug monographs) for Department review and approval at least 45 days prior to each meeting. Mail to the P&T committee at least 30 days prior to each meeting. At the same time, post all information to the web site for public review.*

As is our current practice in the State of Iowa, GHS will continue to provide information packets to the Department for approval at least 45 days prior to each meeting unless otherwise directed by the Department. These meeting materials will then be mailed to members at least 30 days prior to each meeting. Typically the posted materials will include a detailed agenda, draft PDL, PA reports, marketshare data, drug monographs and therapeutic class reviews if needed. A good example of a typical packet can be seen on the www.iowamedicaidpdl.com website under the P&T Committee section for the recent November 12, 2009 meeting.

8. *Record the open and closed minutes of the P&T committee meetings for approval by the committee and distribute the minutes as approved. Minutes must include a summary of the events that took place including attendees, action items and outcome, and follow-ups for subsequent meetings at a minimum.*

GHS will record the open and closed minutes of each P&T Committee meeting. We will distribute these as outlined in the RFP. We will make any corrections to the minutes and publish the approved version on the website. The minutes will include a detailed summary of all that transpired including attendee names, affiliations, action items, outcomes and follow-ups for future meetings. Approved final minutes will be posted on the website at the direction of the State. Please see the website www.iowamedicaidpdl.com for an example of these minutes.

9. *Provide information and staff support to the P&T committee as needed to ensure timely on-going maintenance of the PDL and prior authorization programs.*

GHS will devote a considerable amount of effort to keep the P&T Committee well-informed of PDL and PA activities. The Committee will be kept apprised of negotiations, upcoming opportunities and all PDL maintenance data. They will be given all of the new drug information as it becomes available. They will be given updated PA data each quarter reviewing approval

rates, determination times and PA volumes. We will continue to provide detailed marketshare data that includes

- Average script cost
- Script, unit and paid amount totals
- % script share
- % Preferred activity in each PDL category
- Average script cost changes within PDL categories

We will also do the research necessary to answer queries raised by committee members so that timely and clinically appropriate decisions can be made. Sometimes these questions relate to who is using a certain drug, or for what conditions doctors are employing drugs. Other queries relate to whether certain drugs can have ostensible benefits validated or not (like Treximet).

10. *Facilitate the review of all therapeutic classes by the P&T committee before and after implementation of the program.*

We will continue to facilitate the review of all therapeutic classes. This will occur annually and as needed whenever new drugs enter a class or new indications or new outcomes data appear. Other reviews will be triggered by quarterly financial reports that indicate the need for potential PDL modifications. In any reviews determined to be necessary we will focus the Committee's attention on the factors most germane to sound decisions.

11. *Provide P&T committee support by providing reviews of all medications in a therapeutic class for comparative efficacy, side effects, dosing, prescribing trends, and other clinical indications. The therapeutic class reviews should include at a minimum a description of products scheduled for review at the meeting and clinical, safety and cost-effectiveness information for each drug class. The information must be accurate, reflect recent cost and clinical outcomes information, and be based on acceptable clinical review protocols and nationally peer-reviewed, evidence-based research.*

GHS will provide the P&T Committee with accurate, up-to-date therapeutic class reviews that include all of the required elements listed while conforming to internationally accepted medical literature review protocols focused on distilling relevant, published, peer reviewed, evidence-based research.

Each class review will generally include a synopsis, FDA approved indications, table including dosage forms, dose and manufacturer, pharmacology, pharmacokinetics, clinical trial details including data supporting other indications, contraindications, special populations, adverse drug reactions table with placebo adjusted ADE rates, drug-drug interactions, summary and references. To the extent available, seminal clinical reviews and meta-analyses will also be incorporated. Relative costs of medications within drug categories, net of all discounts and rebates, including what has been negotiated to date with the manufacturers will also be presented to the Committee. Confidential net cost data will be presented during the closed portion of each meeting. Generally, any medication determined to be superior to all other therapeutic alternatives is initially placed in the PDL regardless of the (best value) cost. Therapeutic equivalents are then subject to ranking in order of ascending cost. The cost-effectiveness analysis often provides the rationale or framework for opening a SR discussion with a particular manufacturer. For example, in the statin (cholesterol-reducing drug) category, the surrogate healthcare outcome is the amount of LDL cholesterol reduction. The statins vary considerably in potency and even more so in cost

per unit of cholesterol reduction. It is a relatively simple and intellectually defensible strategy to request that manufacturers price their products cost-neutral to the index drug on this parameter. It is much easier to argue that the Department should not pay more for lesser clinical outcomes.

The therapeutic class review development process **must** be rigorous. Manufacturers must submit dossiers that include information on the disease in question, the product's role in therapy, clinical efficacy, safety and effectiveness data (including off-label), an economic evaluation, economic modeling, any reporting bias, outcomes modeling and the drug's cost and value. The usual drug compendia recommended in the Federal formulary regulations are also used for the development of a PDL including the AHFS and USPDI. An increasing number of reputable medical journals have formally adopted the standard of reporting only on evidence-based medicine. As such, there is no longer any shortage of evidence-based information upon which to build a solid foundation for a PDL. Although incomplete in scope, Clinical Evidence, published by the British Medical Journal, is a superior and heavily used resource for substrate data. It specifically aims to provide the raw material necessary for P&T Committees to form independent and unbiased opinions, rather than providing the specific recommendations themselves. Other information resources used include, but are not limited to, the Cochrane Library, ACP Journal Club, Evidence-Based Medicine, Evidence-Based Mental Health, and the Journal of Family Practice.

In evaluating the clinical literature pertaining to drugs under consideration for a PDL, we prefer to reference meticulously designed studies. When the effectiveness of a drug is tested, we prefer randomized, double-blinded, placebo-controlled trials. Assessing whether a substance is related to the development of an illness is best-studied using case control design. Determining the outcome of a particular disease is best served with a longitudinal cohort study. If requested by the State, GHS could assist the P&T Committee (or other drug use subcommittees) in the use of a formal clinical evaluation trial checklist to assist in reviewing relevant literature. This tool allows scoring on a number of characteristics including:

- Population studied (inclusion / exclusion criteria);
- Treatments compared (biopharmaceutics);
- Experimental design detail (controls, randomized);
- Data collection (reproducible);
- Bias control (blinding);
- Results (measures, drop outs); and
- Data analysis (statistical tests, clinically meaningful).

In as much as it is available, the pharmacoeconomic data is compared for the various treatment alternatives in order to determine the most cost-effective option. Pharmacoeconomic studies are used to identify, measure and compare the cost and consequences of various treatment alternatives. The goal of considering this data is to contain overall costs without unintentionally causing a negative effect on recipient outcomes. When a program solely focuses attention on controlling drug costs, ignoring complex therapeutic trade-offs, there is admittedly some risk of spending drug "savings" on adverse or sub-optimal medical outcomes. Therefore, it is important to either have an internal PDL decision support system capable of accepting, integrating and analyzing non-drug medical data or an independent third party that can supply this capability. When healthcare resources are limited, decisions about the treatments to fund can be complex and difficult to make, involving the careful balancing of multiple factors. The decisions made

may have far-reaching consequences affecting many people. Although everyone would agree that drug selection should be a rational process that follows the guidelines of evidence-based medicine, many other factors may play a role in decision-making. Some of these are explicit and rational, others are less clearly defined, and decision-makers may be unaware of the influence exerted by some of these factors. In order to facilitate transparent decision-making that makes rational use of health outcomes information, the System of Objectified Judgment Analysis (SOJA), combines the quality advantages of the 'top-down' approach to drug selection, based on a thorough literature review, with the compliance advantages of a 'bottom-up' approach, where the final decision is made by the individual P&T Committee and not by the authors of the review. The SOJA method, based on decision-making processes in economics, ensures that health outcomes information is given appropriate weight. Such approaches are valuable tools in discussions about product selection for formularies.

In summary, GHS will always strive to provide Iowa's P&T members with a sensible distillation of the available data that is most relevant to the decisions that the Committee needs to make.

12. *Develop and maintain a predictive pricing methodology that incorporates rebate and administration costs to estimate the net cost to the Department associated with individual PDL decisions. This information must be provided to the Department and the P&T committee for specific drugs reviewed by the P&T committee.*

GHS uses a predictive pricing methodology that incorporates rebate and administration cost algorithms to estimate potential rebate recovery and the net costs to the Department associated with individual PDL decisions on a drug.

GHS has developed its predictive pricing approach to estimate the final budget impact of PDL decisions after accounting for all rebates, prescribing alterations and offsetting administrative costs. This was first based on our experience with Maine and has now been refined after years of working for the State of Iowa and later the State of West Virginia. We went through the process of estimating savings prior to each PDL decision, then after each final PDL decision and then after implementation. This approach is not perfect; however we have improved our projection accuracy over the years due to practice and constant reassessment. Many categories can be projected extremely accurately because we have gone through several iterations of the process. Other new categories (Chantix) are much more difficult precisely because it is the first time and because there is precious little data published on PDLs in this drug area.

Based on our experience in Iowa, Maine and other states with full spectrum PDLs, we have acquired a good sense of all the factors inherently necessary to make accurate predictions. It is vital to know roughly what percent of a population can successfully be maintained on two or three specific preferred drugs. Each category is different. Prior utilization data around the PDL and prior authorizations must be mined to glean this information. It is also vital to know what percent of the population is already on the preferred and non-preferred agents. This is useful both for calculating successful switches and for estimating PA volume, a key component of administrative costs.

Although it may take more time, it is also very useful to determine who would already meet PA approval criteria by virtue of having already tried every preferred choice. This can lead to accurate savings discounts and to consideration of POS online "approvals". Any age or condition

exclusions need to be factored in as well as implementation timelines. Exceptionally tight or demanding criteria that require testing or specialty consultations must have their ancillary costs included.

A number of categories have unique considerations that require further manipulation of the projection methods. The narcotics category was complicated because many Oxycontin users became "allergic" to morphine as soon as the PDL was announced. It became necessary to insist on prior medical records to document these mostly un-witnessed allergic reactions. It also became prudent to require urine drug tests that monitored for morphine use since many recipients who developed morphine side effects were found to have negative morphine tests during the time they were allegedly on the preferred morphine product. All of this information was made available to the Department and the P&T Committee.

Administration costs including the PA and PDL contracts will be assimilated into the projections. We will also be able to provide some help in forecasting administrative fair hearing rates in the various PDL categories. The vast majority of the time there are no additional administrative costs associated with PDL drug decisions. Most new drugs generally do not create much PA volume. Even when they do there is often a corresponding offsetting decrease in PA requests in other drugs (like the Topamax generic topiramate becoming affordable enough to prefer for next year). The total PA volume was greatest in the first year, 2005, with 81,000. The exit of the dual-eligibles reduced PAs to 54,000 in 2006. The PA totals then increased to 63,000 in 2007, 75,000 in 2008 and an estimated 80,000 in 2009. The PA growth in 2007 was primarily due to a more aggressive PDL while most of the recent growth is due to eligibility increases. The biggest recent single drug addition was the decision to cover Chantix in 2008 which has averaged 700 to 800 requests per month (nicotine products average around 300) since then. We modeled out potential utilization using claims data from Maine Medicaid which began covering the drug soon after it entered the market. Our original cost projection for SFY 2008 was nearly $1 million. Fortunately the actual figure was closer to $600,000. This was due to the nature of Iowa's PA criterion requiring participation in a state designated quit line assistance program.

Figure 17 is the predictive price model used for considering the Venlafaxine ER deal. These are an extension of the net savings models where we add estimated PA volumes and pro-rated costs. The state shares are then displayed using blended annual FMAPs. There was limited Medicaid data available for actual Effexor XR to Venlafaxine ER switches so we obtained some aggregate commercial data from the manufacturer and supplemented with Medicaid data on similar (rantidine cap/tab) situations.

In summary, the best predictive models are built using the State's own historical data pertaining to drug decisions that most closely match the proposed scenario. When a good match is not available we will seek analogous examples from other State Medicaid programs, make adjustments for eligibility differences and perform regression analyses as appropriate. In cases where no good match exists from which to build a highly accurate model we will act conservatively and avoid placing the State at jeopardy of being underfunded.

Iowa Medicaid Pharmacy
SNRI ONLY Predictive Price Modeling
For Entire Year
Based on Q1 CY2009 Utilization and Supplemental Rebate Offers

Scenario A 1: Supp rebate offers are taken, VENLAFAXINE ER becomes Preferred and take 95% from EFFEXOR XR, Minimal PAs seen

	PDL Status	# Units	# Scripts	Total Net $	Total Net Drug Savings off Current	New PAs	PA Cost	Total Net Net Cost	State Share Net
EFFEXOR XR	N	75,038	335	$ 21,251		250	$ 5,000		
PRISTIQ	N	17,585	598	$ 52,088					
VENLAFAXINE ER	P	1,425,728	6,357	$ 238,011					
CYMBALTA	NR	1,480,724	50,008	$ 4,245,762					
SAVELLA	N	960	16	$ 1,491					
EFFEXOR	P	13,216	244	$ (12,870)					
VENLAFAXINE	N	5,502	94	$ 3,062					
		1,721,379	**57,063**	**$4,548,795**	**$ 511,462**		**$ 5,000**	**$ 506,462**	**$ 146,165**

Scenario A 2: Supp rebate offers are taken, VENLAFAXINE ER becomes Preferred and take 90% from EFFEXOR XR, Moderate PAs seen

	PDL Status	# Units	# Scripts	Total Net $	Total Net Drug Savings off Current	New PAs	PA Cost	Total Net Net Cost	State Share Net
EFFEXOR XR	N	20,042	609	$ 38,632		400	$ 8,000		
PRISTIQ	N	17,585	598	$ 52,088					
VENLAFAXINE ER	P	183,350	6,083	$ 227,752					
CYMBALTA	NR	1,480,724	50,008	$ 4,245,762					
SAVELLA	N	960	16	$ 1,491					
EFFEXOR	P	13,216	244	$ (12,870)					
VENLAFAXINE	N	5,502	94	$ 3,062					
		1,721,379	**57,063**	**$4,555,917**	**$ 504,340**		**$ 8,000**	**$ 496,340**	**$ 143,244**

Scenario A 3: Supp rebate offers are taken, VENLAFAXINE ER becomes Preferred and take 80% from EFFEXOR XR, heavy PAs seen

	PDL Status	# Units	# Scripts	Total Net $	Total Net Drug Savings off Current	New PAs	PA Cost	Total Net Net Cost	State Share Net
EFFEXOR XR	N	300,153	1,338	$ 84,876		650	$ 13,000		
PRISTIQ	N	17,585	598	$ 52,088					
VENLAFAXINE ER	P	183,350	5,354	$ 200,453					
CYMBALTA	NR	1,200,613	50,008	$ 4,245,762					
SAVELLA	N	960	16	$ 1,491					
EFFEXOR	P	13,216	244	$ (12,870)					
VENLAFAXINE	N	5,502	94	$ 3,062					
		1,721,379	**57,063**	**$4,574,862**	**$ 485,395**		**$ 13,000**	**$ 472,395**	**$ 136,333**

Figure 17: Predictive Pricing Model – Venlafaxine Deal

13. *Provide the Department with a written report of the P&T committee's PDL recommendations within three business days of the conclusion of the meeting for review and final approval by the Department. This report must be accompanied by a contractor analysis in cases where the P&T committee made modifications to the original recommendations.*

In addition to writing and publishing P&T Committee minutes, GHS will create a summary report that highlights the Committee's specific PDL recommendations for the Department's review and action within three business days of each meeting. In addition to this summary we will point out instances where the Committee made modifications to the original PDL recommendations. The Department's approval of this report will trigger the implementation plan for the affected class(es) of drugs. We will produce this report and any analysis within three (3) business days of the conclusion of the Committee meeting.

As per our usual practice, the report will include a synopsis, an analysis of any recommendations that ran counter to our proposed actions and whether any further analysis or follow-up will be recommended. When this occurs we will attempt to explain:

- Why we think the committee acted the way they did;
- Whether it will have negative, positive or neutral consequences;
- Whether or not DHS should approve or reject; and
- Offer alternative courses of action or strategies.

14. *Facilitate the P&T committee's use of clinical subject matter experts in reviewing various classes of drugs or individual drugs if such expertise is needed and is not represented among the P&T committee members.*

GHS realizes that the P&T Committee will not have clinical expertise that deals with every therapeutic drug class. Therefore, we will facilitate and preferably proactively seek the appropriate use of clinical subject matter experts. We provide the same service for several Medicaid programs, and find that this relieves not only the Committee from the burden of making decisions in areas beyond their capabilities, but it gives answers to recipients and manufacturers who may question a clinical PDL decision. In many cases all that is needed is to consult relevant specialists prior to any meeting addressing drugs outside the purview of Committee members and convey their impressions or concerns. In certain situations it may even make sense to enlist the input and more formal assistance of multiple members of one specialty as was the case with the DUR Mental Health Advisory Group.

15. *Develop and facilitate a process for the Department to act on or deviate from the recommendations by the P&T.*

As briefly discussed elsewhere in this proposal, the Department needs a mechanism to promptly review and approve sage recommendations while also discerning and mitigating poor advice. It has always been GHS' practice to go into committee meetings with preconceived ideas of what constitutes good or bad recommendations. It is our belief that one of our duties is to support the Committee decision making by providing them with the same data that led us to our opinions. Frequently, when the committee is given the same information, enough time to digest it and enough time for collegial discussion, consensus is reached. Unfortunately, some committee members are philosophically opposed to the goals of a financially constrained Medicaid Program. Sometimes a provider, for whatever reason, may be entrenched in their opinion on a particular issue and may have been persuasive enough to affect the entire committee vote.

Sometimes the entire Committee (including GHS) makes a decision in error and does not recognize it until after the meeting is over. When these scenarios arise, we need to replay the entire sequence of events leading up to the questionable decision. Did we omit or underemphasize the presentation of vital data? Was one member biased or extremely influential in controlling the discussion and vote? Was misinformation presented and not refuted? We then need to point out the potential negative ramifications to the Department and propose corrective actions. In some cases we might recommend that the Department not accept the decision at this time and ask for reconsideration by the Committee or a detailed explanation of their rationale. In other cases we will propose that the Department actually send back a counterproposal for consideration, especially if it becomes apparent that key data was not available or given due consideration. Finally, there may be times when a particular decision is biased due to a lack of specialty education or specialist involvement. In these cases the Committee may be directed by the Department to seek specialty input prior to a new recommendation.

On the other hand we must keep in mind that it is not in the State's best interest to have a "rubber stamp" committee. There are some drugs that are fiscally neutral and of uncertain clinical value. There is no cost when the Committee diverges from initial recommendations on these drugs. In summary, the Committee must balance the State's financial interests with those of the provider community. Most of their variations from GHS recommendations represent thoughtful modifications that professionally balance these competing concerns.

r. Provide the following supplemental drug rebate services:

1. Assist the Department during analysis and negotiation of state supplemental rebate agreements with pharmaceutical manufacturers annually and as needed.

GHS will assist the Department during the various stages of obtaining supplemental rebate agreements both annually and on an as needed basis during the year. We will analyze marketshare utilization data and whether we are losing or winning share on important preferred and non-preferred drugs. We will be fully aware of CMS rebate net costs and Iowa SMAC prices for all drugs prior to the onset of negotiations. We will be careful to ensure that the State uses proper comparators for any offered drugs. We will also do all the homework necessary to be certain that net prices for all drugs are adjusted properly for differences in doses, especially the actual average daily doses seen in the Iowa Medicaid population. GHS will critique the strategic opinions offered by other states and manufacturers. We will examine other Medicaid PDLs for parallel decisions in order to fully prepare the state for sound well-informed decision-making.

Each year and during the year as needed, we will sit down with the Department and map out the overall strategy. We will explain how much of the PDL savings is likely to occur from supplemental rebates and how much will emanate from redirection to lower net-priced drugs. We will review what needs to happen with key drugs and key categories to achieve success. We will then highlight the drugs that are popular and that will create pushback if designated non-preferred. We will point out which potential decisions are the riskiest and help the State fully explore the consequences of all possible decisions. This year the most difficult decision by far was what to do with Prevacid. The generic would appear in November 2009 but it would be exclusive and overpriced. The brand manufacturer was ending the Prevacid SR deal and instead presented a very attractive offer on a chemically related drug (Kapidex). This would involve massive switching of established users and the fact remained that the generic could become very cost-effective after six months and quickly offset the short-term gains of a Kapidex deal. We had to consider many different scenarios, such as keeping the brand preferred, going to the generic immediately, taking the Kapidex deal, taking another brand PPI and shrinking the preferred PPIs from three to two. In the end there was no simple obviously correct answer. We provided the relevant data but in the end the Department considered the pros and cons of each approach and chose the best fit based on balancing short/long-term savings and prescription switching burdens to doctors and members.

2. Establish a method for communication between the contractor and manufacturers as approved by the Department.

We will establish a method or methods of communication with the manufacturers as approved by the Department. At present we speak with them over the phone, share e-mails and written mailed materials and meet in person. Any SR offers must be officially entered through the SSDC prescribed entry way but initial tentative or exploratory offers along with conditions and contract

terms are often discussed over the phone and via emails. Most importantly we log and save records of our manufacturer interactions. We have encountered more than one ethically challenged manufacturer over the years and it has become very clear that you can never have enough documentation. We do value meeting the manufacturers periodically during the year if new clinical data surfaces on existing significant PDL drugs or when new drugs enter the market.

3. *Accept and handle all contract discussions and inquiries from manufacturers, consulting with the Department as needed.*

On behalf of the Department, GHS will accept and handle all contract discussions and inquiries from manufacturers. If GHS should no longer be the negotiating agent for the SSDC pool, we will conduct any contract discussions with manufacturers as expressly directed by the Department. There are many manufacturer inquiries over the year. They can relate to issues of coverage, PDL placement, PA criteria, verification of preferred status on the POS, pharmacy difficulties with their drugs, new indication, new studies, new safety warnings and meeting requests. As per prior instructions, when the Department needs to be consulted, we will do so. In addition, we will provide periodic updates to the Department on the status of negotiations and the projected impact that they will have on the PDL.

4. *Maintain all the original agreements and provide the Department with access to all supplemental rebate agreements and related documentation within 24 hours of request. The Contractor must maintain electronic copies of all executed supplemental rebate agreements.*

GHS will maintain all original SR agreements and provide the Department with access to copies and related documentation within 24 hours of a request. We will make certain that the original agreements are preserved safely. GHS will also create and keep electronic scanned copies in our possession as back-up. These agreements will be scanned and saved as electronic PDF files, which will facilitate prompt access and delivery to the State as needed. These electronic files facilitate quick access to the files since States occasionally require urgent access. For instance, sometimes you might need to review the terms and conditions when you are away at a meeting and your staff might be out sick, on vacation or otherwise unavailable.

5. *Ensure that supplemental rebates are over and above the federal rebates and in compliance with federal law.*

We will ensure that the supplemental rebates are in compliance with all federal and state laws as detailed in the State approved SRA agreement. We will also work closely with IME staff to ensure that the supplemental rebates are over and above the CMS/federal rebates. Given the landscape of federal health care reform and national pharmacy reimbursement issues, we may need some assistance from the Department in two areas.

The first policy area is the effect of any health care reform legislation passed this year or next concerning Health Care Reform as it relates to Medicaid/federal drug rebates. If certain proposed language passes in its present form, CMS would effectively remove a portion of drug rebates from the States. To the extent that Iowa has guaranteed net price contracts in place on drugs affected by the proposed increase, then supplemental rebates would not be over and above federal rebates but in fact under and below. We would argue that if CMS is going to manage a range of CMS rebates based on AMP then they should also bear the full upfront drug payment

for that same price range. Assuming we would lose that argument, our next advice to the Department would be to allow us to renegotiate SR contracts on such affected drugs away from guaranteed net prices toward fixed percentage WAC deals.

The second policy issue to consider also relates to the GNP (guaranteed net price) contracts. When CMS rebates increase sufficiently they can absolve the manufacturer of any additional SR obligation. If you only think of supplemental rebates as an income stream then it feels like you are getting shortchanged when this happens. If your goal is to meet a budget figure then GNP contracts remove any pricing risk during the contract period so you only have to worry about utilization/eligibility related budget effects. We will work closely with the Department to get further clarification on these issues as they evolve.

6. *Maintain the terms of the supplemental rebate agreement with each pharmaceutical manufacturer as confidential, separate from any of the contractor's other clients and undisclosed except to the Department or its designee.*

GHS assures the Department that it will keep their contracts confidential and hold their agreements separated physically from those of any other clients. We have been the vendor for the states of Maine, Iowa, and now the Sovereign States Drug Consortium (SSDC) pool and have been successful with retaining this information without violating confidentiality issues. Our performance record is sound and contains no confidentiality breaches. We have designed and built many systems that warehouse sensitive and confidential data for distribution to different audiences with no reported failures.

The agreements will be kept separate from those of our other clients. The paper copies will be stored in a separate, locked file cabinet devoted to the State of Iowa. The electronic agreement copies will be stored in a well-protected and separate electronic file.

The terms of the agreements will be preserved as confidential, undisclosed to anyone except the Department or its designee.

7. *Provide supplemental drug rebate billing data quarterly in a Department-approved format in accordance with timelines established by the Department. Ensure system interface with the IME pharmacy POS system for the receipt of data to track and invoice the supplemental rebates.*

We will provide the SR billing data quarterly in the Department approved format and as per their timelines. We currently provide this data to Iowa and other SSDC states quarterly. We will do whatever is necessary to continue interfacing successfully with the POS contractor, should GHS no longer be the vendor. We successfully interface with several state POS systems that we do not operate (West Virginia and Georgia). We can interface with a POS regardless of the type of drug file used (like Medispan in Iowa or FDB in West Virginia). We are aware of the State's contractual timelines for processing supplemental rebate invoices. The SR data provided is and will remain sufficient for tracking, invoicing and collecting supplemental rebates.

8. *Establish and operate a process for accurate reporting and monitoring of negotiated supplemental rebates.*

GHS incorporates our negotiation tracking, SR contract status, and SR contracted amounts into a common database. We use this during negotiations, for communicating status to the state, and

for computing SR's. This database is a direct extract from the SSDC web-based offer system. We track PDL saving progress via standard reporting. This is referred to during any dispute resolutions when actual SR invoicing begins to occur. All offers are currently percentages of WAC or guaranteed net prices calculated once the past quarter's CMS rebate is known. If a CMS rebate is not reported for a contracted drug then an estimated SR is invoiced using prior quarter(s) data. A new NDC report watches for related NDCs that enter the market by the same manufacturer that might be suitable for contract line extensions.

9. *Provide to the Department reports on the performance and savings associated with the PDL and supplemental rebates. Deliver reports to the Department in a format and on a schedule approved by the Department.*

We will continue to provide savings and performance reports at the frequency and in the formats requested by the Department. Since supplemental rebates must be calculated at the same time as CMS rebates in order to establish net costs most savings reports are quarterly. We run the savings reports within one to two weeks of the CMS tape arriving. At the same time we recalculate prior quarters/years savings based on any reversals or disputes settled over the interim. The best example is the extensive "Iowa Pre-rebate PDL, Rebate and Total Net Savings Report." This savings report shows the methodology, the complete tabulation of accumulated savings since the PDL inception and many detail reports such as the breakdown between PA/PDL savings, CMS rebates and supplemental rebates. Snapshots and brief summaries of some of the contents are included below:

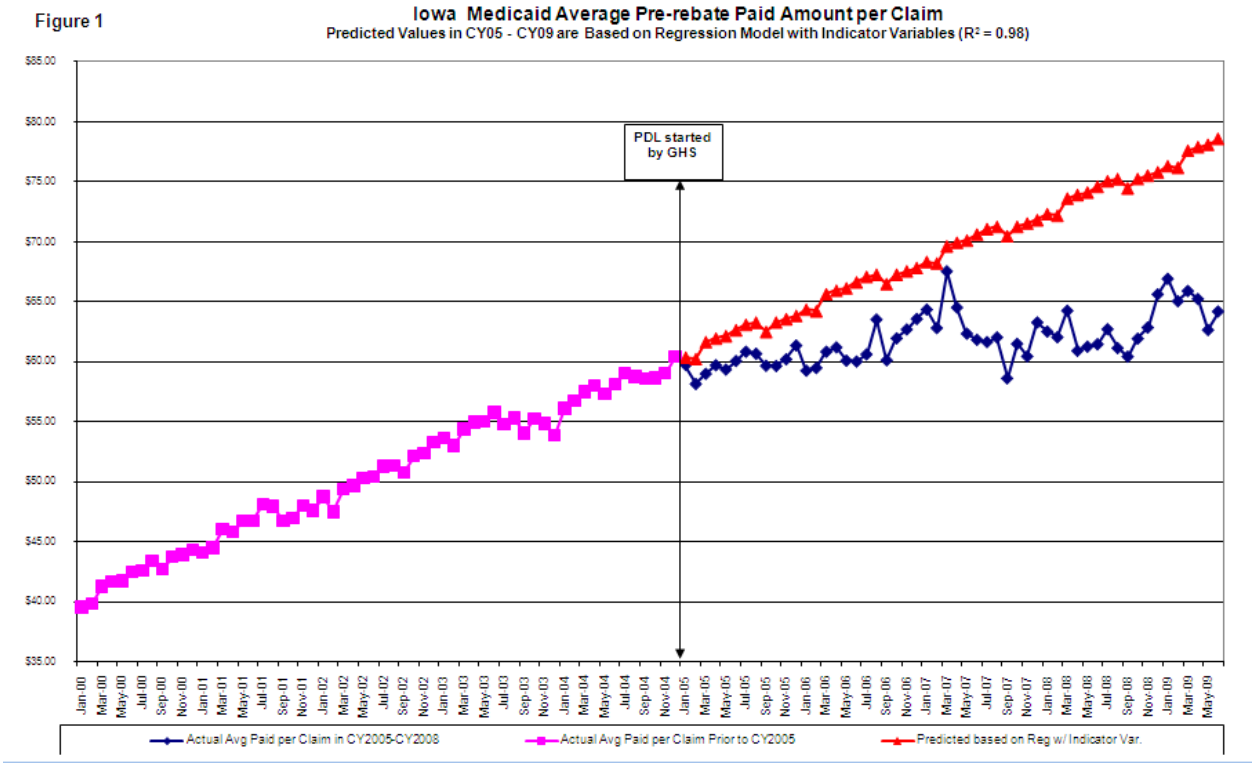


Figure 18: Report Figure 1a – Average Monthly Paid Amount per Claim

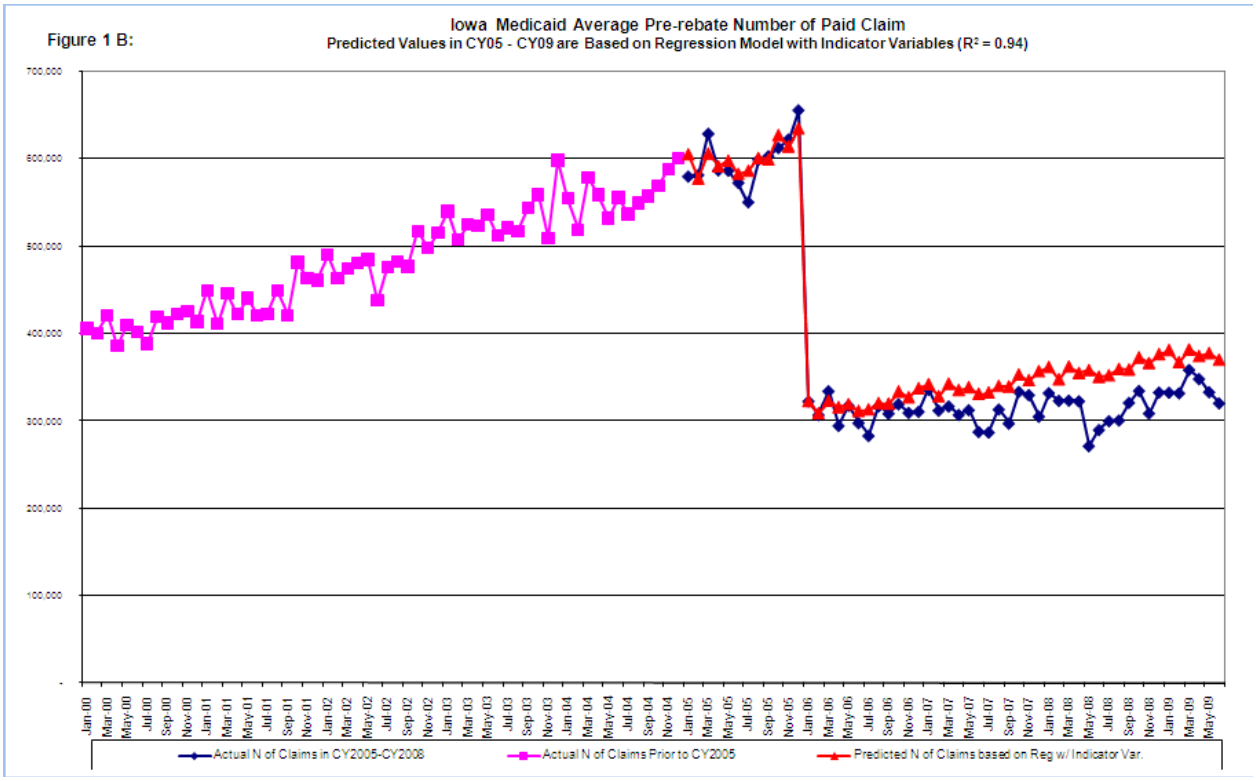


Figure 19: Report Figure 1b – Average Monthly Number of Paid Cliams

- Figure 1a and 1b Average Monthly $ claim and claims- These line graphs are the end results of the regression analyses that enables the calculation of actual net savings from what would have occurred if there were no PDL.

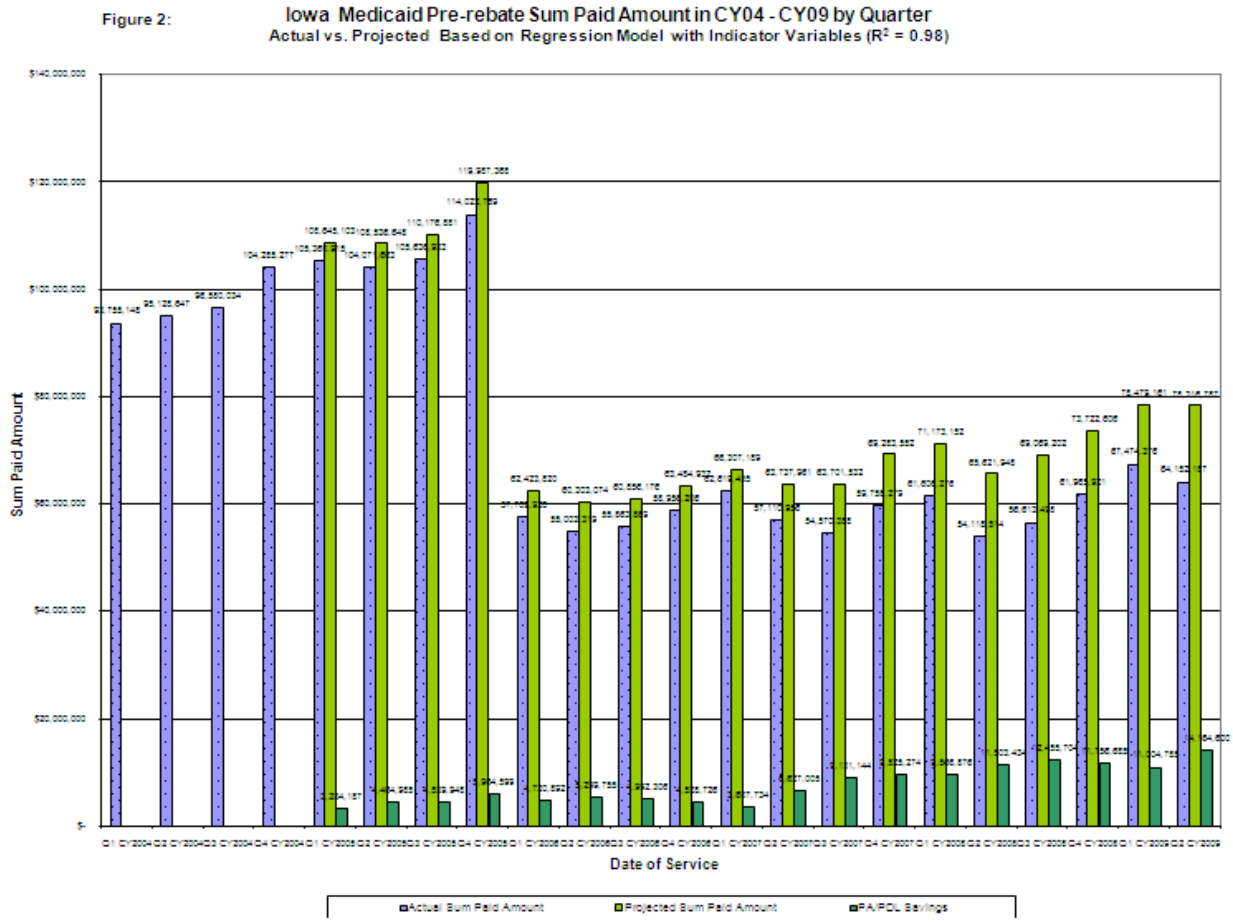


Figure 20: Report Figure 2 – Pre-rebate Sum Paid Amount

- Figure 2 Quarterly Net Cost- This bar graph is another version of the same data from Figure 1.

Iowa Medicaid PDL Pre-Rebate Savings Estimation

Actual vs. Projected Based on Regression Model with Indicator Variables (R^2 = 0.98)

Pre-rebate Savings are Difference between Projected and Actual

Quarter	Month	Actual # of Claims	Actual Avg Paid per Claim	Actual Sum Paid	Total Actual Paid for Quarter:	Projected Avg Paid per Claim	Projected Sum Paid	Total Projected Paid for Quarter:	Difference between Projected and Actual Paid	Total Savings for Quarter
	Jan-05	579,049	$ 59.72	$ 34,580,472		$ 60.37	$ 34,957,279		$ 376,808	
	Feb-05	580,649	$ 58.13	$ 33,753,325		$ 60.24	$ 34,980,001		$ 1,226,677	
Q1 CY2005	Mar-05	627,734	$ 58.99	$ 37,027,119	$ 105,360,915	$ 61.66	$ 38,707,822	$ 108,645,103	$ 1,680,703	$ 3,284,187
	Apr-05	586,017	$ 59.70	$ 34,983,246		$ 61.96	$ 36,310,397		$ 1,327,151	
	May-05	585,724	$ 59.34	$ 34,755,249		$ 62.16	$ 36,406,927		$ 1,651,678	
Q2 CY2005	Jun-05	571,754	$ 60.05	$ 34,333,168	$ 104,071,663	$ 62.65	$ 35,819,323	$ 108,536,648	$ 1,486,155	$ 4,464,985
	Jul-05	549,694	$ 60.83	$ 33,436,860		$ 63.10	$ 34,687,559		$ 1,250,699	
	Aug-05	598,091	$ 60.66	$ 36,279,875		$ 63.29	$ 37,851,503		$ 1,571,629	
Q3 CY2005	Sep-05	602,103	$ 59.66	$ 35,920,198	$ 105,636,933	$ 62.51	$ 37,637,818	$ 110,176,881	$ 1,717,620	$ 4,539,948
	Oct-05	611,626	$ 59.64	$ 36,474,732		$ 63.29	$ 38,710,273		$ 2,235,541	
	Nov-05	621,188	$ 60.20	$ 37,394,375		$ 63.57	$ 39,487,565		$ 2,093,190	
Q4 CY2005	Dec-05	654,536	$ 61.35	$ 40,153,662	$ 114,022,769	$ 63.85	$ 41,789,530	$ 119,987,368	$ 1,635,868	$ 5,964,599
	Jan-06	322,709	$ 59.24	$ 19,117,741		$ 64.35	$ 20,767,382		$ 1,649,640	
	Feb-06	307,012	$ 59.47	$ 18,256,956		$ 64.23	$ 19,718,170		$ 1,461,214	
Q1 CY2006	Mar-06	334,191	$ 60.83	$ 20,328,230	$ 57,702,928	$ 65.65	$ 21,938,268	$ 62,423,820	$ 1,610,037	$ 4,720,892
	Apr-06	294,682	$ 61.19	$ 18,032,137		$ 65.94	$ 19,432,644		$ 1,400,508	
	May-06	317,788	$ 60.08	$ 19,093,405		$ 66.14	$ 21,018,580		$ 1,925,175	
Q2 CY2006	Jun-06	297,936	$ 60.01	$ 17,877,778	$ 55,003,319	$ 66.63	$ 19,851,850	$ 60,303,074	$ 1,974,072	$ 5,299,755
	Jul-06	283,293	$ 60.61	$ 17,168,998		$ 67.09	$ 19,005,141		$ 1,836,142	
	Aug-06	317,086	$ 63.52	$ 20,141,929		$ 67.27	$ 21,330,476		$ 1,188,547	
Q3 CY2006	Sep-06	308,609	$ 60.12	$ 18,552,942	$ 55,863,869	$ 66.49	$ 20,520,559	$ 60,856,176	$ 1,967,617	$ 4,992,306
	Oct-06	319,379	$ 61.95	$ 19,785,201		$ 67.27	$ 21,485,863		$ 1,700,663	
	Nov-06	309,620	$ 62.69	$ 19,410,448		$ 67.55	$ 20,915,121		$ 1,504,673	
Q4 CY2006	Dec-06	310,839	$ 63.57	$ 19,760,557	$ 58,956,206	$ 67.83	$ 21,083,947	$ 63,484,932	$ 1,323,390	$ 4,528,726
	Jan-07	335,891	$ 64.35	$ 21,613,635		$ 68.34	$ 22,953,580		$ 1,339,946	
	Feb-07	312,135	$ 62.80	$ 19,602,802		$ 68.21	$ 21,290,471		$ 1,687,669	
Q1 CY2007	Mar-07	316,867	$ 67.55	$ 21,403,018	$ 62,619,455	$ 69.63	$ 22,063,137	$ 66,307,189	$ 660,119	$ 3,687,734
	Apr-07	307,243	$ 64.52	$ 19,823,298		$ 69.93	$ 21,484,758		$ 1,661,461	
	May-07	312,738	$ 62.34	$ 19,495,288		$ 70.12	$ 21,930,244		$ 2,434,957	
Q2 CY2007	Jun-07	287,802	$ 61.82	$ 17,792,371	$ 57,110,956	$ 70.61	$ 20,322,959	$ 63,737,961	$ 2,530,588	$ 6,627,005
	Jul-07	287,158	$ 61.64	$ 17,699,294		$ 71.07	$ 20,408,214		$ 2,708,920	
	Aug-07	313,402	$ 62.03	$ 19,439,779		$ 71.25	$ 22,330,969		$ 2,891,191	
Q3 CY2007	Sep-07	297,436	$ 58.61	$ 17,431,315	$ 54,570,388	$ 70.48	$ 20,962,348	$ 63,701,532	$ 3,531,033	$ 9,131,144
	Oct-07	333,534	$ 61.49	$ 20,507,428		$ 71.26	$ 23,766,631		$ 3,259,203	
	Nov-07	329,858	$ 60.44	$ 19,936,624		$ 71.53	$ 23,596,081		$ 3,659,456	
Q4 CY2007	Dec-07	305,252	$ 63.27	$ 19,314,227	$ 59,758,279	$ 71.81	$ 21,920,841	$ 69,283,552	$ 2,606,614	$ 9,525,274
	Jan-08	332,041	$ 62.51	$ 20,755,664		$ 72.32	$ 24,013,044		$ 3,257,380	
	Feb-08	323,323	$ 62.04	$ 20,060,239		$ 72.19	$ 23,341,429		$ 3,281,190	
Q1 CY2008	Mar-08	323,570	$ 64.25	$ 20,790,373	$ 61,606,276	$ 73.61	$ 23,818,679	$ 71,173,152	$ 3,028,306	$ 9,566,876
	Apr-08	322,788	$ 60.90	$ 19,658,976		$ 73.91	$ 23,857,485		$ 4,198,509	
	May-08	271,629	$ 61.25	$ 16,637,598		$ 74.11	$ 20,129,473		$ 3,491,875	
Q2 CY2008	Jun-08	290,023	$ 61.45	$ 17,821,940	$ 54,118,514	$ 74.60	$ 21,634,989	$ 65,621,948	$ 3,813,050	$ 11,503,434
	Jul-08	300,147	$ 62.71	$ 18,822,008		$ 75.05	$ 22,526,859		$ 3,704,851	
	Aug-08	300,910	$ 61.13	$ 18,395,877		$ 75.24	$ 22,639,432		$ 4,243,555	
Q3 CY2008	Sep-08	321,017	$ 60.42	$ 19,395,612	$ 56,613,498	$ 74.46	$ 23,902,911	$ 69,069,202	$ 4,507,299	$ 12,455,704
	Oct-08	334,627	$ 61.92	$ 20,718,769		$ 75.24	$ 25,177,374		$ 4,458,605	
	Nov-08	308,845	$ 62.85	$ 19,409,766		$ 75.52	$ 23,323,102		$ 3,913,336	
Q4 CY2008	Dec-08	332,766	$ 65.62	$ 21,837,386	$ 61,965,921	$ 75.80	$ 25,222,130	$ 73,722,606	$ 3,384,744	$ 11,756,685
	Jan-09	332,552	$ 66.92	$ 22,254,783		$ 76.30	$ 25,374,594		$ 3,119,811	
	Feb-09	331,945	$ 65.05	$ 21,591,621		$ 76.18	$ 25,286,048		$ 3,694,427	
Q1 CY2009	Mar-09	358,508	$ 65.91	$ 23,627,972	$ 67,474,376	$ 77.60	$ 27,818,519	$ 78,479,161	$ 4,190,547	$ 11,004,785
	Apr-09	348,089	$ 65.24	$ 22,708,653		$ 77.89	$ 27,113,980		$ 4,405,327	
	May-09	333,221	$ 62.64	$ 20,874,281		$ 78.09	$ 26,021,099		$ 5,146,818	
Q2 CY2009	Jun-09	320,457	$ 64.19	$ 20,569,253	$ 64,152,187	$ 78.58	$ 25,181,708	$ 78,316,787	$ 4,612,455	$ 14,164,600

Figure 21: PDL Pre-Rebate Savings Estimation

- PDL Net Savings- This table shows the monthly line item detail savings on net that is rolled up to the quarterly level in Report Figures 1 and 2 above.

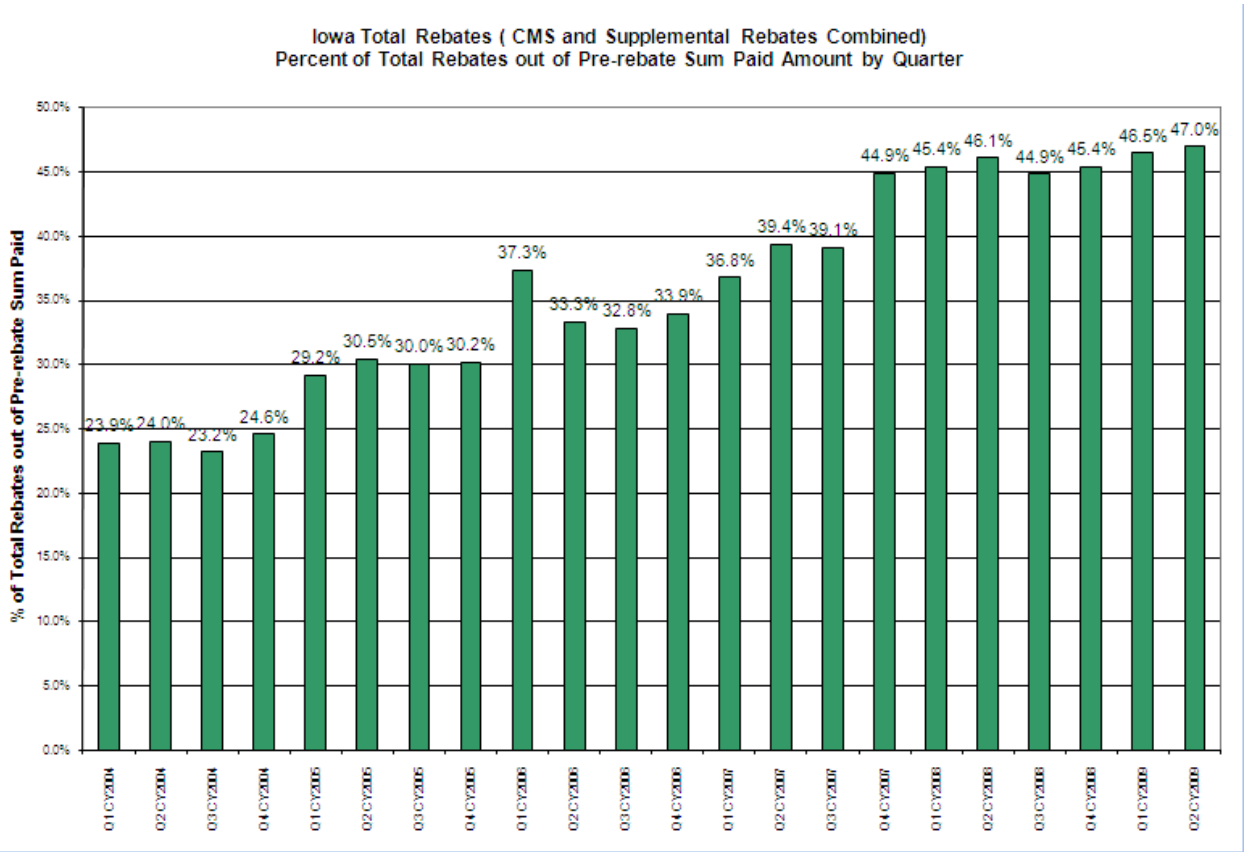
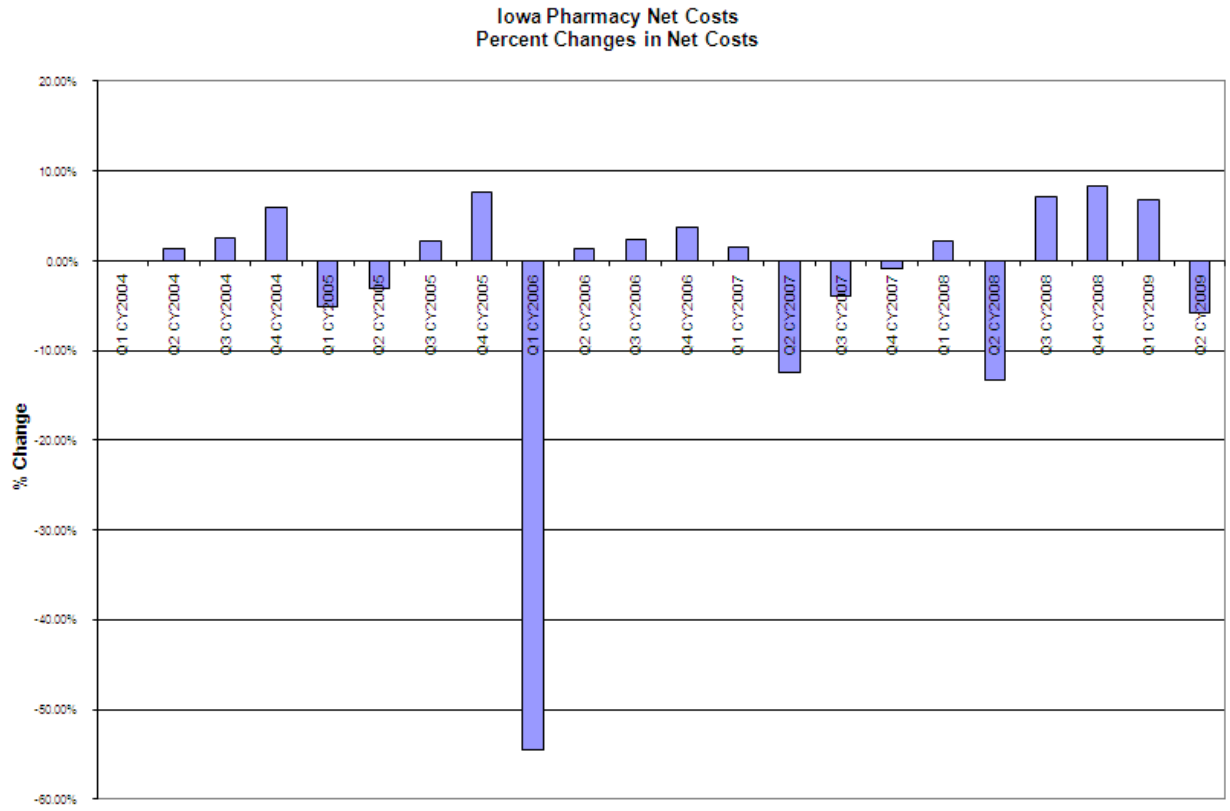


Figure 22: Percent of Total Rebates out of Pre-rebate Sum Paid Amount

- Chart % Total Rebate- This bar graph shows the quarterly total rebates due back to the State expressed as a percent of what the State paid initially paid the pharmacies. Note that the State is averaging over 45% rebates back.



- Chart % Change Average Net $ Script – This demonstrates the percent change in net cost per script per quarter relative to the baseline quarter, Q4-2004.

GHS creates a number of SR related performance reports including number of offered drugs, contracted drugs and NDCs, participating manufacturers and PDL category breakdowns. GHS also provides performance reports across various metrics such as PA volumes, determination times, and approval rates, each of which is done in summary by category or available by drug.

10. *Provide supplemental rebate projection reports. Deliver reports to the Department in a format and on a schedule approved by the Department.*

Supplemental rebate projection reports will be generated and delivered to the Department in a format and on a schedule determined by the Department. This occurs most importantly towards the end of the annual PDL negotiation. We have provided an example based on the most recent round of negotiations for CY 2009.

The reports include a summary PDL category version and a detailed drug-specific analysis. If you compare these SR reports to the savings report bundle already previously discussed you will note that a big reduction in supplemental rebates is being predicted for CY 2010. On average $3.5 million in SR was invoiced quarterly the past several years. At present we are forecasting a reduction in SR to about $2.8 million per quarter. What accounts for the big drop and is it as bad as one would immediately think?

There are two factors responsible for 90% of the decline. First, the Prevacid SR deal disappears as we wait for the generic costs to decrease significantly. This costs the State over $200,000 per quarter in SR for six months but we should recoup this on the front end in lower net costs due to SMACs during the latter half of 2010. The second major factor is the TZD strategy. We are forgoing over $400,000 in SR annually on the TZD drugs in favor of only allowing Actos 15 mg to be preferred, which should create increased CMS rebates resulting in a net $1.1 million of combined rebates to Iowa.

After all is said and done, the SR dollar amount decreases but CMS rebates increase and the generic share increases by the end of the year resulting in a lower net cost to the State. This is acceptable since the ultimate measure of financial success is net cost, not supplemental rebate dollars.

11. *Provide rebate analysis and suggestions for enhancing rebates and/or lowering net pharmacy costs. This responsibility includes review and analysis of utilization data for performance under PDL drug classes and areas for improvement for both clinical impact and cost effectiveness of PDL classes. Deliver reports to the Department in a format and on a schedule approved by the Department.*

GHS will provide quarterly rebate and utilization analysis and suggestions for improving rebates and/or lowering net costs. We will include utilization data and the effects the PDL has had or failed to have on utilization. We will deliver these reports in a format and on a schedule approved by the Department.

We monitor for savings opportunities with a wide variety of reports. Most importantly we closely follow each drug's net cost and CMS rebate trend each quarter. If it is favorable the drug will often become preferred. This is the primary reason why the blended average CMS rebate in the drug benefit has increased from about 23% in 2004 to nearly 40% in 2009. It isn't just the drug itself that we care about but also the most cost-effective strengths, forms and even package sizes. Rebate disparities make dose consolidation more important in the Medicaid world than in the commercial side.

Another reason for tracking rebates and net costs carefully is to guide us in making preferred decisions between brand and generic versions of the same drug. Heavily rebated brands can stay less expensive in net cost than their generic counterparts, especially if any exclusivity is involved. This often adds up to over a million dollars of savings annually. Knowing when to flip a preferred brand over to non-preferred is integral to optimizing savings each year. Whenever the State updates its SMAC/FUL prices we must carefully reevaluate the corresponding brand drug's net cost and make PDL recommendations to the State. This work is not intellectually intricate but it requires attention to detail and must be done promptly upon every generic pricing update.

As mentioned already, ongoing quarterly rebate and utilization analysis is a useful method to keep abreast of both positive and negative trends. Inadvertent effects need to be kept in mind. When you drive recipients away from specific drugs, they are sometimes unintentionally redirected into an unforeseen alley. For example, in Maine, when recipients were steered away from the off-label use of an atypical antipsychotic, some doctors prescribed expensive anticonvulsants that were just as off-label and nearly as expensive. On the other hand, some unintentional effects are fortuitous. When Oxycontin was made non-preferred in Maine,

hundreds of users began to pay cash without bothering to try using preferred long acting narcotics.

The PDL Compliance Report is our most valuable tool for monitoring the success of the PDL. In Figure 23 we have provided a snapshot of this report showing several categories, taken from a sample Iowa PDL Compliance Report for the 3rd Quarter of 2009. Underperforming categories are easily detected by virtue of their lower preferred prescribing percentages. We also use a generic percentage report to easily ascertain the generic composition and direction within each PDL class. These reports provide the data to differentiate between and diagnose the healthy and ill sections of the PDL.

Iowa

PDL Compliance Report

3rd Qtr 2009

CATEGORY GROUP DESCR	SCRIPTS	QUANTITY	PAID AMT	PREFFERED	PRIOR QTR
ACE AND THIAZIDE COMBO'S	1,832	60,077	$12,354	99.7%	99.8%
ACE INHIBITORS	11,296	386,756	$69,477	99.9%	99.8%
ACE INHIBITORS AND CA CHANNEL BLOCKERS	720	23,335	$84,719	98.2%	97.4%
ACNE PRODUCTS: ISOTRETINOIN	121	6,070	$90,733	98.2%	86.2%
ALCOHOL DETERRENTS	223	23,424	$27,654	100.0%	100.0%
ALS DRUG	8	480	$7,814	100.0%	100.0%
ALZHEIMER - Cholinomimetics	653	44,379	$85,561	33.8%	27.0%
AMINO GLYCOSIDES	161	19,289	$218,456	100.0%	100.0%
ANALGESICS - MISC.	42,172	2,933,607	$226,493	99.9%	99.9%
ANAPHYLAXIS THERAPY	980	1,650	$89,846	99.8%	99.9%
ANDROGENS / ANABOLICS	170	12,130	$30,702	98.5%	98.7%
ANGIOTENSIN RECEPTOR BLOCKER	2,124	66,013	$163,604	99.9%	99.7%
ANORECTAL - MISC.	269	13,360	$4,923	97.5%	97.0%
ANTHELMINTICS	736	2,318	$14,478	100.0%	100.0%
ANTI INFECTIVE COMBO'S - MISC.	9,284	703,694	$61,319	100.0%	100.0%
ANTIANGINALS--ISOSORBIDE NITRATE	1,040	42,157	$13,304	100.0%	100.0%
ANTIARRHYTHMICS	256	11,713	$9,007	95.4%	98.0%
ANTIASTHMATIC - 5-Lipoxygenase Inhibitors	2	180	$449	0.0%	0.0%
ANTIASTHMATIC - ADRENERGIC COMBOS	8,329	510,575	$1,573,935	96.9%	96.9%
ANTIASTHMATIC - ALPHA-PROTEINASE INHIBITOR	15	246,174	$105,225	72.5%	73.8%
ANTIASTHMATIC - ANTI-CHOLINERGICS	2,062	125,662	$278,192	100.0%	100.0%
ANTIASTHMATIC - ANTIINFLAMMATORY AGENTS	51	574	$73,739	79.3%	80.9%
ANTIASTHMATIC - BETA - ADRENERGICS	28,771	1,494,751	$1,097,450	96.7%	94.5%
ANTIASTHMATIC - HYDRO-LYTIC ENZYMES	102	9,205	$178,274	100.0%	100.0%
ANTIASTHMATIC - LEUKOTRIENE RECEPTOR ANTAGONISTS	15,630	470,174	$1,806,676	99.6%	99.7%

Figure 23: 3rd Quarter 2009 Iowa PDL Compliance Report

The Legislative restrictions imposed on selected drug categories including mental health drugs have certainly hindered the Department in its attempts to manage the drug budget. We have done our best to work within these confines including establishing the RDL (Recommended Drug List) which significantly increased supplemental rebates on many mental health drugs and working with the Department to establish a protocol for subjecting chemically non-unique mental health drugs to the PDL.

In this next year further incremental savings will occur now that the 30 day PDL override has been dismantled. Dose consolidation and even splitting strategies might be worthy of expanding. Therapy duration limits, especially during initiation are worth exploring. More drugs need clinical PAs to confirm appropriate indications. Finally, the long term continuation of many drugs can be made contingent upon meeting certain minimum outcomes (like diabetic hgbA1c targets).

The good news is that in addition to negotiating SRs, there are other synergistic cost-controlling strategies:

- Contain off-label prescribing on new drugs lacking sufficient evidence
- Selective utilization of disease management initiatives that complement the PDL
- Increase efforts to promote fewer prescribers with poly-pharmacy efforts.

12. *Provide by December 15 of each calendar year a list by therapeutic category of all drugs for which a supplemental rebate has been accepted, including but not limited to the drugs, NDCs, types of offer, tiers of drugs, manufacturers or labelers and durations of contracts. This report must be continually updated and provided quarterly and one month prior to the annual SSDC pool meeting.*

GHS will provide a complete listing of all drugs by Iowa PDL category for which a Supplemental Rebate contract has been accepted by December 15 of each calendar year. This listing will include NDCs, manufacturer/labeler, drug name, strength and form description, offer type, offer tier, offer pricing and length of contract term. This report will be updated on a quarterly basis and a completely current version will be generated and provided at least one prior to the annual SSDC pool meeting. We acknowledge the importance and timely access to all contractual pricing data so that new offers may be comprehended and processed as quickly and efficiently as possible.

13. *Ensure 100 percent of supplemental rebate contracts are sent to the manufacturer or labeler following Department confirmation within 30 days following the annual P&T meeting.*

GHS will ensure that 100% of supplemental rebate contracts are sent to the manufacturer/labeler within thirty days of the annual P&T meeting contingent, of course, upon the Department's confirmation. We will begin preparing the SRA contracts as soon as we know the outcomes of the annual meeting but we will not send the contracts out until the Department confirms the PDL drug voting results. This requirement should probably be broken into three parts. We should be required to deliver all tentative supplemental rebate deals as recommended or modified by the P&T Committee to the Department for review and confirmation within ten days of the annual P&T meeting, The Department should then have ten days for internal review and sign off followed by the vendor then having another ten days to finalize and send all contracts to the manufacturer/labeler for execution. Ideally we want all contracts signed and returned by the manufacturers prior to the January 1 contract effective date. Certainly most manufacturer legal departments desire or even insist upon receiving SR deals prior to the contract effective date.

14. *Ensure 100 percent of all supplemental rebate contracts are returned from the manufacturer or labeler by the end of the first quarter of the calendar year and sent to the Department for signature.*

We will ensure that 100% of all supplemental rebate contracts are returned from the manufacturer/labeler by the end of the first quarter of the calendar year and delivered to the

Department for signature. Any contracts at risk of not being fully executed in a timely manner will be brought to the Department's attention. The most notable problem we have with manufacturers in this matter relates to the acquisition of one manufacturer by another between the time the offer is initially made and the contract finally consummated. A variation of this occurs when the bidding manufacturer must divest itself of the drug being offered before the contract is successfully signed. In this case we must change horses midstream and work towards reassigning the contract to the manufacturer assuming ownership of or responsibility for the drug.

15. *Provide access to the Department of tracking on status of all supplemental rebate agreements within 24 hours of request.*

GHS will provide Department access to tracking reports and related records regarding all supplemental rebate agreements within 24 hours of request.

s. *Provide the following education services:*
   1. *Subject to Department approval, design, develop and implement an ongoing, broad-based education effort to ensure that providers and members are provided with timely and accurate information regarding the PDL and prior authorization.*

GHS will, with Department approval, continue our current, on-going, education effort aimed at providing members and providers with timely and accurate information regarding the PDL and PA program. Our education efforts include, at a minimum, Provider Manual changes, updates, mailings and web-based information. GHS offers and delivers on-site educational PDL programs in order to facilitate an understanding of the program goals and to acquire the cooperation necessary to ensure success.

Attendance at on-site presentations is actively encouraged and quite successful. It has been our experience that incorporating the audience's prescribing data into the presentation is extremely engaging and effective. Being able to show the provider their own volume of prescriptions, their detailed prescribing irregularities and the many opportunities for improvement is of paramount importance. Sending provocative provider-specific data will often open the door for an invitation to explore the matter further.

In the framework of a PDL program, the most important prescribers to concentrate on educating are the ones who have a similar alignment of interests. These prescribers are philosophically, intellectually or financially motivated to both give and accept assistance in the matter of keeping health care affordable. Several hundred prescribers are responsible for an inordinately high percentage of the drug budget and are crucial to the success of the PDL.

A further consideration is the division of the Medicaid drug benefit into two broad categories. The essential areas of the Medicaid drug benefit for PDL education efforts to focus on are the drugs that are commonly prescribed by most physicians and that:

- Have less expensive therapeutically equivalent alternatives and
- Form a large fraction of the drug budget and in some cases can be
- Can be consolidated or
- Can be stopped or
- Can be curbed with limits

2. *Begin the education effort immediately upon contract award and continue on an ongoing basis.*

With Department approval, GHS will continue to seamlessly provide educational services as we do presently. The current educational program will continue without interruption or the need for transitional period. GHS will maintain and update the educational efforts we conduct on behalf of the Department whenever required by changes to policy, procedures or at the request of the Department.

3. *At a minimum, include provider manual changes and updates, direct mailings of written materials and web-based information.*

GHS' current efforts include the components listed above. We will continue to ensure that these services are provided for all Iowa Medicaid providers and members.

4. *Ensure that the web site is accessible upon contract award and continue on an ongoing basis.*

As discussed earlier, with State guidance and approval, GHS created a website containing all of the required elements outlined in this RFP. This website is currently accessible and is available for review at www.iowamedicaidpdl.com. GHS has organized and posted great numbers of documents and related materials on this site in the five years that we've been providing these services to the State of Iowa and should we be selected to continue providing these services, this website will remain accessible and up-to-date throughout the transition from one contract period to the next.

5. *Obtain Department approval for the web site information and keep the web site accurate with regular updates as determined necessary by the Department.*

GHS will continue to obtain Department approval for any information posted to the web site. The site will be updated regularly as required and requested by the Department.

6. *Include the following topics at a minimum:*
   - i. *Program Intent*
   - ii. *Process to develop PDL*
   - iii. *Prior authorization criteria and process*
   - iv. *Appeal process*
   - v. *Informational Letters and Updates*
   - vi. *FAQ*

GHS' educational services will continue to cover all of the topics listed in this requirement. These topics are included on the www.iowamedicaidpdl.com website and are covered in pertinent mailings and newsletters created in support of the PA and PDL programs.

t. *Assist the Department in developing communication strategies for Medicaid members, Medicaid providers, pharmaceutical manufacturers, advocacy groups, Department staff, IME staff and others with an interest in the PDL and prior authorization programs. No program materials may be distributed unless approved by the Department. The communication strategies include, but are not limited to:*

GHS will continue to assist the Department in the development and maintenance of communication strategies and will collaborate with other IME contractors to ensure that

communications are seamlessly integrated. GHS understand that no program materials are to be distributed unless prior approval is obtained from the Department.

1. *Assist the Provider Services unit in training of providers to educate them.*

GHS will coordinate all provider trainings with the IME Provider Services contractor. In addition, GHS will forward all pertinent training materials to the contractor to keep them up-to-date with current PDL and PA practices.

2. *Assist the Members Services unit in providing information to the members*

GHS will work with the Member Services unit to assist in providing timely and accurate information to the members. In addition, GHS will forward all pertinent training materials to the contractor to keep them up-to-date with current PDL and PA practices.

3. *Maintain direct involvement with constituent groups to facilitate their understanding of the program and the processes that will be followed.*

GHS will maintain our current direct involvement with provider groups, hospitals, professional associations and other constituent groups to facilitate their understanding of the programs we administer and their associated processes. Having provided these services to the State of Iowa since 2005, GHS has been able to develop strong relationships with these constituent groups and ensure that all stakeholders and constituents are up-to-date and current on program processes and procedures that may affect them. Should we be selected to continue providing these services, we will build on these existing relationships and provide on-going updates whenever changes are made to the programs or processes.

4. *Provide a combination of telephone support and web-based information.*

We will continue to provide a combination of telephone support and web-based information through our help desk, the GHS website and the www.iowamedicaidpdl.com website.

5. *Monitor and report on outcomes of the educational efforts.*

GHS will continue to monitor and report on outcomes of the educational efforts as we do presently for the State of Iowa. GHS utilizes reporting mechanisms to monitor our performance. We have analysts available to create any type of monitoring report we need. For example, in our PA process, we use a PA Process Report that monitors approvals, referrals, denials and determination times. We can query different subtypes to monitor eligibility groups and providers.

6. *Recommend to the Department education and notification processes and methods that minimize transition disruptions.*

As the incumbent vendor, there will be no transition disruption should we re-secure this work. We do have in place many processes and methods to ensure that communications proceed smoothly. One component that is carefully maintained and updated is the provider address file. No amount of notification is going to help if it does not get to the right place.

In addition, we contact provider groups, hospitals and professional associations, as often times they will agree to either post educational material on their sites or provide web links to the PDL. Many advocacy and society newsletters are also more than willing to provide space. In addition, our mailings have extensive checklists to remind us who gets what notices and whether they receive part or all of scheduled quarterly mailings.

7. *Design and implement targeted educational efforts approved by the Department to improve compliance among outlier providers in order to maximize the effectiveness of the PDL.*

Inevitably there will be providers that adversely affect the success of the PDL. These outliers, and they are few in number, will cause disruptions far out of proportion to their size. They may be philosophically opposed to the restraints imposed on their professional autonomy. They may be uneducated as to the rationale behind PDL choices. Regardless of the reason, they can affect the success of the PDL and their concerns and issues must be addressed. With some doctors it is not possible to reach mutual agreement on what the best drug is. If you want to change their minds or at least their behavior, you will need to be persistent and prove repeatedly that the PDL choices are helpful or not harmful. This means showing them population and practice level data that PDL choices result in good health care outcomes. Finally, there may be some providers so recalcitrant that extraordinary measures like individually restricted prescribing privileges, across the board prior authorizations and Medicaid provider expulsion may have to be considered.

Efforts directed at improving the understanding of and compliance with PDLs and PA are vital to the long-term success of the PDL.

The P&T Committee must be extensively involved in any strategy developed aimed at educating influencing physicians. The three essential elements of any specific strategy are physician leadership, effective incentives, and tools for improving performance. In the near future forging relationships with E-prescribing vendors and EMHR systems represent wise investments.

The clinical literature also suggests that different types of interventions may work better for different types of clinicians. Pragmatic doctors are best aided by concise, bottom-line information from reputable sources, removing obstacles and strong incentives. The knowledge-seeker must be handled with journal articles, professional meetings, guidelines and the removal of major impediments. The traditionalist benefits from academic counter-detailing, minimal obstacles, reminders, feedback, rewards, penalties and reinforcement. The receptive physician can be reached with continuing medical education, sound guidelines, and obstacle removal and are minimally affected by rewards and penalties.

Profiling involves providing physicians with data showing how their performance compares to their peers. Currently GHS can perform a wide variety and high volume of provider profiles each quarter for the State of Iowa, such as we currently do for the State of Maine. There are many reasons why profiling is employed so frequently. First of all, profiling is an excellent source of performance data to feed back to physicians. Most doctors are firmly committed to the tenet of self-improvement. Better performing providers appreciate the confirmation of their quality work. Others respond to the challenge of further improvement.

Profiles are tools for changing undesirable behaviors. A provider may agree with a guideline and assert that they always follow the guideline. However, it takes a profile to either refute or corroborate the claim.

Profiles are also instruments for increasing the frequency of desirable events. For example, congestive heart failure patients should almost always be on an ACE inhibitor. A provider profile exhibiting a low score in this measure coupled with a panel profile containing recipients potentially benefiting from the initiation of an ACE inhibitor is a simple but proven strategy.

Profiling can improve the coordination of care. GHS, for example, creates profiles of providers with excessive numbers of difficult narcotics patients. Providers can see what other doctors are doing with similar patients. If their patients are obtaining narcotics from other providers then they are made aware of this fact.

Although profiles are mirrors, they can be subject to distortion. Depending on the profile measure, case-risk adjustment may be necessary to eliminate clinically significant distortions. Typically adjustments are made for differences in age and gender. In certain situations case-mix adjustments are made for varying levels and severity of co-morbid medical conditions. This requires either integrating non-drug claims or inferring diagnoses from drug profiles.

Unfortunately, age, gender and disease case-mix adjustments alone probably explain only 4% of the variation seen in outpatient doctor data. There are many other profiling methodologies to consider. The accuracy of the claims data is hindered by the increasing tendency to submit creative or “power” bills aimed at maximizing reimbursement. Sample sizes are crucial. Many experts point out that the patient’s prior utilization or experience is a much stronger predictor of variation than known case-mix variables. One way to obtain a good profile is to mimic the HMO practice of purposefully selecting healthy recipients. Another alternative to this process is to form fairer comparators. This might only involve comparing a pediatrician to other pediatricians. Intra-specialty profiling demand extra care and mitigate the need for complicated risk adjustments.

Depending on the situation, GHS can employ different physician profiling methodologies. A guideline-based system (ETG's) looks at what a physician does about disease episodes relative to a set of predetermined practice standards. Practice based methodologies (ACG's and CCI) approach profiling from a population-based perspective. The community determines the normative standard. Physicians are compared to their peers in the community, not to a remote, prescriptive guideline. Regardless of the importance of physician profiling systems, there is a slow transition to outcomes profiling that enhance the quality of care for recipients.

GHS also utilizes pharmacy data to generate PDL/formulary compliance reports on a quarterly basis. The compliance report provides data on scripts, recipients, dollars paid and $PMPM for preferred and non-preferred drugs across a large number of drug categories. In any given category prescribers may view their scores with respect to what percent of their prescribing was preferred. Compliance scores provide valuable information. They monitor the success or failure of the PDL. They identify problematic drug categories and nettlesome individual providers.

Regional groupings occasionally reveal pockets of like-thinkers. This may be helpful when considering interventions. Strategically located counter-detailing is often rewarding.

Compliance scores can also be used as incentives. Physicians with exemplary scores can be granted privileges such as exemption from specific prior authorization requirements. Many physicians appear to value relief from administrative processes as much as they do monetary rewards. When it is clear that providers understand and comply with the PDL most of the time, it is reasonable to allow those same providers greater autonomy as long as we maintain vigilant monitoring.

The quarterly PDL compliance report is a vital element to the success of the PDL. This report is versatile and meets multiple needs for both PDL and Prior Authorization. For PDL purposes, it provides essential feedback to physicians as to how cost-effectively they are prescribing compared to their peers. For PA, it allows doctors to gauge their performance in drug categories for the purpose of earning an exemption from prior authorization. The report specifies the individual prescribing thresholds that must be reached in order to qualify for an exemption for the next three months. Performance must be maintained for an exemption to be retained. Depending on how many clinical alternatives are available the threshold can vary from 90-95%. In the past quarter 905 providers earned one or more PA exemptions. This attached report identifies the number of providers earning PA exemptions and provides details within the PA categories. In the future, if compliance becomes consistently high, the PDL may only need to be enforced by prior authorizing the choices of outliers.

u. Develop and implement a Department-approved procedure for communicating system changes to all affected IME contractors and State agencies.

Generally, we recommend and follow a very simple, straightforward procedure for communicating system changes to affected IME contractors and State agencies. Presently, we have in place several email groups that contain the email addresses of all necessary stakeholders. This method is practical, thorough, and done in such a way that it meets both administrative and technical needs.

v. No later than 10 business days after Department approval of the PDL, transmit the PDL and PA criteria to the IME POS contractor. The contractor will design, develop, test and implement an electronic interface with the IME pharmacy POS system to assure timely transmission and uploading. The contractor must ensure computer system capability and interface between the contractor and the IME pharmacy POS system for accurate acceptance of the information that the contractor provides.

1. The contractor shall electronically transmit to the IME pharmacy POS contractor the list of drugs requiring prior authorization due to the level of participation on the PDL in a format approved by the Department.

2. The contractor's project work plan should include detailed data integration requirements and the steps the contractor will take to ensure successful integration.

Presently, GHS is IME pharmacy POS contractor. As such, we will maintain our current systems and interfaces. If we are selected to continue providing Pharmacy Medical Services, there will be no new integrations requirements or transition period that could potentially disrupt the provision of these important services.

Should we be replaced as the pharmacy POS contractor in the future, we will leverage our experienced Data Processing staff and IT departments to assist in establishing this required

connectivity. GHS will provide the assistance to ensure appropriate connectivity of PDL/PA data to the POS. GHS has experience in integrating with POS vendors in several states, most notably the States of West Virginia and Georgia.

The first step in designing an electronic interface to deliver the PDL to the IME POS contractor is do establish business rules of how the PDL will operate in the POS. From these rules, a file format, data content, and programming can be developed and tested. Sign off would be based upon whether the developed systems meet the business rules. As we have discussed throughout our proposal, there are PDL tools such as "automated prior authorizations" (grandfathering, step therapy, etc.) that, if selected by the Department as an appropriate tool, will need to be programmed on the POS.

Transfer and transmittal of data should be done via a secure electronic exchange. For example, we would recommend secure email exchange using PGP, sFTP (secure ftp), or normal FTP with encrypted files utilizing PGP. GHS will verify that transfers and transmittals of data are received. We will incorporate quality control measures to ensure that the entire transmission was sent and received. GHS will retain archived electronic copies of all transmissions. This transfer will be performed as described above after receiving Department (written) approval of the PDL, thus giving GHS permission to transmit the data.

Connecting to POS data is of vital importance for a successful running PA program; therefore, we will dedicate the staff and resources to assist in this connection. GHS will work with the Department and the POS contractor to determine the best means of communicating the drugs that will require prior authorization based upon the PDL rating and rules. Once the format is established and approved by the Department, the PDL will be transmitted in the approved format and on a Department approved schedule.

GHS will assist the POS contractor in understanding the data and the requirements being placed upon the claims processor to accommodate the Department's PDL driven PA program. The actual implementation of the necessary claims processor edits to accept the PDL based rules reside solely on the POS contractor.

Our PA system would need access to the following information:

- Client eligibility
- PDL
- PA rules
- Client profiles (pharmacy claims history)
- Pharmacy providers (NABP numbers, addresses, fax numbers, etc.)
- Member doctors (DEA numbers, addresses, fax numbers, etc.)

In addition to the information necessary to administer a PA system, GHS would desire to establish a positive working relationship with any future POS contractors. In running both the claims processing system and PA systems in several states, we realize how frequently the two processes rely upon each for providing the efficient services to the Medicaid recipient and provider populations. There are times when PA pharmacists need to access real-time information off the claims system or when the adjudication claims help desk needs to find out

PA information from the PA help desk. There are also times where we need to make programming changes to our claims processing system. Our system is able to accommodate these changes, and we expect any future vendor's system to do the same.

There are various ways to form data connections to the PA system. For example, we could utilize a T1 line, a VPN connection, or a FTP server. Whatever the method, it would need to be mutually agreed upon by the connecting parties. We would expect the participating parties to be in compliance with HIPAA, by either following HIPAA formats or developing a trading partner agreement for "flat file" exchanges.

The GHS PA system is a robust system, with the ability to send to the claims adjudication system on-line, real time data. The recipient pharmacy claims data we receive does not have to be real time. It is acceptable for the claims history data accessible to the PA program to be sent in regular cycles. However, the PA pharmacist occasionally needs real time access. It would be helpful to have an account set up and accessible on the adjudicator's system especially for this instance (again, another reason to have a strong working relationship established).

GHS' standard practice for establishing working relationships for data exchanges is as follows:

1. Define and agree upon rules of engagement.
2. Decide upon and set up data formats.
3. Create a trading partner agreement.
4. Become familiar with the data to be exchanged.
5. Discern what business rules and algorithms are needed to plug into the PA system.
6. Research if more data is necessary.
7. Present and exchange technical design documents.
8. Have Iowa and the vendor sign off on the plan.
9. Write code to interface with the PA system.
10. Test.
11. Implement.
12. Evaluate.
13. Report on progress.

w. Complete required reports accurately and timely. Unless otherwise indicated, monthly reports are due five business days following the end of the month, quarterly reports are due five business days following the end of the quarter, and annual reports are due the tenth business day following the end of the federal fiscal year, state fiscal year or other annual reporting period.

GHS will continue to provide the Department with robust, accurate and timely reporting services. GHS will continue to meet the reporting deadlines outlined in this requirement. All GHS reports are currently set up to meet the layout, frequency and delivery methods presently required by the Department. We are happy to discuss any potential changes to these reports that may be desired by the Department.

6.3.3.3 Performance Standards

a. Be able to demonstrate annual savings in the total outlay for prescription drugs (including an explanation of the Department-approved methodology for calculating savings). The Pharmacy Medical Services contractor will provide state savings as follows:

1. *$12.5 million in state savings in SFY 2011 (2009 number increased by 7 percent for 2010 and again for 2011)*

The best method we have found for estimating net overall savings is a regression model using the historical pre-rebate trend augmented by an analysis of the change in CMS and supplemental rebates. The main problem with just counting savings in PDL classes is that they are unadjusted for any costs that they indirectly or intentionally cause. If you block a particular drug in one class, a doctor may prescribe a drug from another class rather than one of the desired preferred drugs in the same class. A regression model based on the entire drug budget adjusts for the inflationary trends and ongoing cost-saving measures implemented by the State. It is certainly not perfect but it avoids overestimating savings inherent in methods that simply add up savings in every PDL class.

The following displays the original savings methodology that was accepted by Iowa several years ago. The essence of this complex regression model involves incorporating CMS rebates, SR and net costs over many monthly data points in order to increase its accuracy and predictive power. To evaluate the impact of the new PDL on Iowa Medicaid pharmacy post-rebate (net) costs, the model applied interrupted time series (ITS), the strongest quasi-experimental design in assessing longitudinal effects of time-delimited interventions. To assess the significance of changes in pharmacy expenditures, the study used a regression analysis, the powerful statistical method for estimating intervention effects in interrupted time series studies.

A detailed data analysis was initially performed to evaluate the structure of the time series. A visual inspection of the series over time was conducted in exploring patterns and trends in pharmacy expenditures. The time series patterns before the interventions were compared with the patterns after the interventions to assess if the time series patterns significantly changed after the interventions in relation to the pre-intervention patterns. The following three major outcomes of the ITS analysis were evaluated: (1) change in level immediately after the interventions; (2) difference between slopes before and after the interventions; and (3) the estimation of monthly effects after the interventions.

A regression analysis based on the monthly average post-rebate (net) paid amount per claim was conducted to see if changes in level and trend could be the result of the intervention alone or factors other than the intervention. The regression model with indicator variables of interrupted time series was structured as a multiple linear regression model, where the dependent outcome variable (e.g., the monthly average net cost per claim) was examined over time. The model introduced intervention points as explanatory variables that were evaluated in terms of breaks and changes in both intercept and slope in a manner that cannot be explained by random variation.

The regression model showed what could have happened if the new PDL program had not been implemented. The difference between the predicted and the actual net costs was the basis for estimating the program savings for the past 5 years.

In the tables and figures included below, we have also provided an example of intra-class PDL savings after rebate considerations (Post-rebate Drug Savings by PDL Category). This shows which categories had statistically significant changes in cost.

Iowa Medicaid Savings Estimation

The first step in estimating PDL pre-rebate savings was creating a predictive model on Average Paid per Claim for January – June 2005. For this, the actual monthly data with paid non-reversed claims and with dates of service since January 2000 were taken, and a regression model using indicator variables was built. The model was based on a multiple regression model including both the trend and seasonal components. The trend component was modeled as a linear time trend using the actual monthly data. The seasonal component was described using 11 seasonal indicator variables.

As it is well known, a regression equation allows us to express the relationship between two (or more) variables algebraically. It indicates the nature of the relationship between two (or more) variables. In particular, it indicates the extent to which you can predict some variables by knowing others, or the extent to which some are associated with others. R squared is the relative predictive power of a model. R squared is a descriptive measure between 0 and 1. The closer it is to one, the more accurate your model is.

With a high predictive power, the created regression model allowed for the explanation and prediction of the average paid per claim for January – June 2005. As Figure 24 below shows, R Square indicates that approximately 98.98% of the variable in the average paid amount can be explained using linear time trend and seasonal indicators.

SUMMARY OUTPUT

Regression Statistics	
Multiple R	0.994933601
R Square	0.98989287
Adjusted R Square	0.987312326
Standard Error	0.664917504
Observations	60

ANOVA

	Df	*SS*	*MS*	*F*	*Significance F*
Regression	12	2035.137436	169.5947864	383.5985577	1.32297E-42
Residual	47	20.77941848	0.442115287		
Total	59	2055.916855			

	Coefficients	*Standard*	*t Stat*	*P-value*	*Lower 95%*	*Upper 95%*

		Error				
Intercept	39.8218025	0.348685681	114.2054426	4.07981E-59	39.12033805	40.52326695
Time	0.336327153	0.005058199	66.49148524	3.82081E-48	0.326151379	0.346502927
Jan	0.109378681	0.424195645	0.257849608	0.797648676	-0.743992079	0.96274944
Feb	-0.331388472	0.423561864	0.782385056	0.437912507	-1.183484229	0.520707285
Mar	0.772264375	0.422987624	1.825737518	0.074246883	-0.078676162	1.623204912
Apr	0.715717222	0.422473169	1.694112844	0.096861657	-0.134188366	1.565622811
May	0.566490069	0.422018718	1.342333991	0.185935961	-0.282501282	1.41548142
Jun	0.727902917	0.421624464	1.726424768	0.090839678	-0.120295298	1.576101131
Jul	0.861255764	0.421290576	2.044327155	0.046545888	0.013729244	1.708782283
Aug	0.738208611	0.421017198	1.753393009	0.086054581	-0.108767943	1.585185166
Sep	0.353698542	0.420804448	0.840529476	0.404867413	-1.200247099	0.492850015
Oct	0.152254306	0.420652417	0.36194801	0.71901319	-0.693988406	0.998497017
Nov	0.063587153	0.420561173	0.151195966	0.880468229	-0.782471999	0.909646304

Figure 24: Regression Model with Indicator Variables and its Statistics.

Figure 25, Figure 26 and Figure 27, included on the following pages, show the monthly actual savings data since January 2000. Applying the created regression model the average paid amount per claim was first forecasted for January – June 2005 (in red) and then compared with the actual averages for these months. Over time we have updated the model quarterly through Q2-2009. We also provide total savings by quarter in other formats as requested by the states.

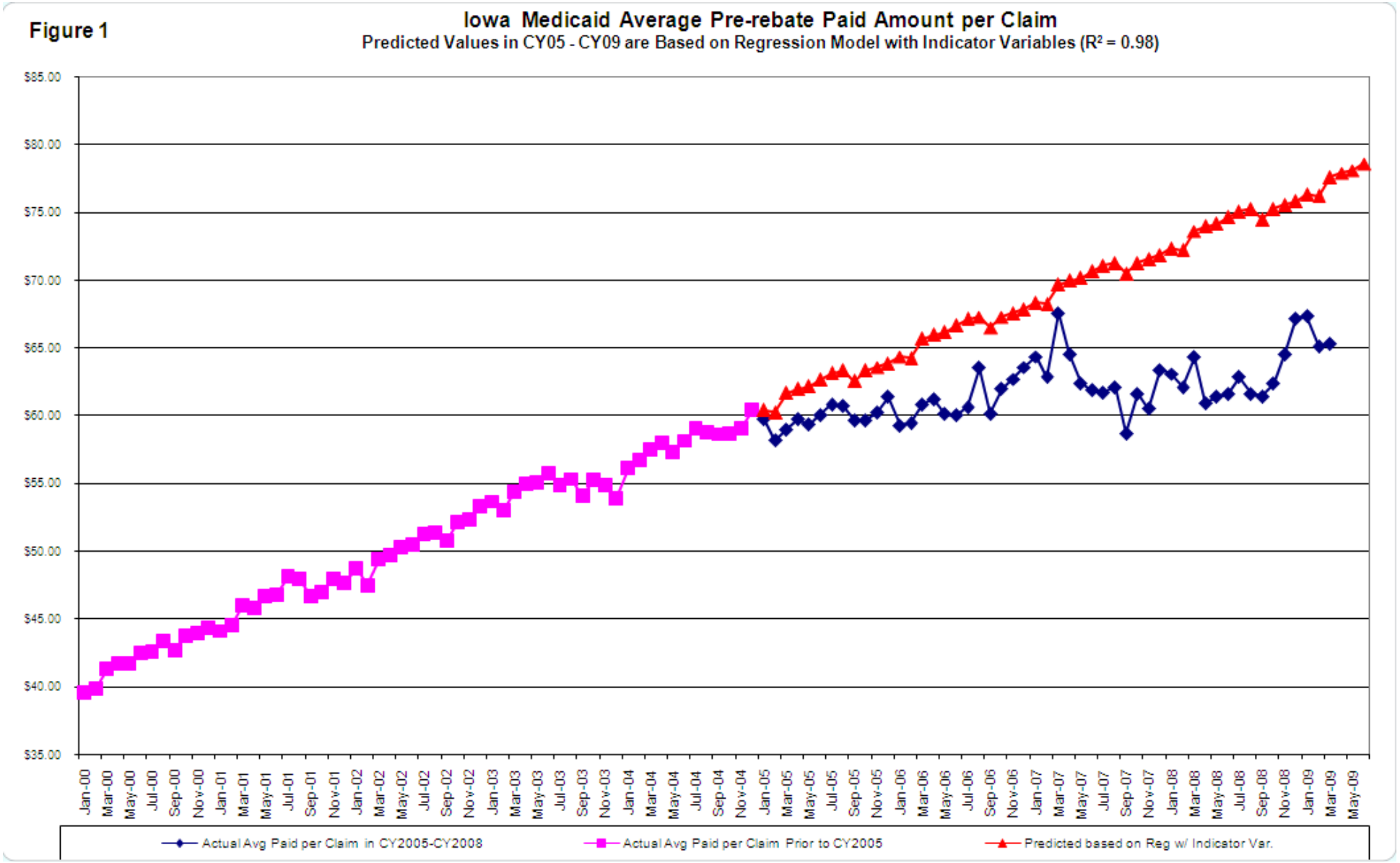


Figure 25: Iowa Medicaid Average Pre-rebate paid Amount per Claim

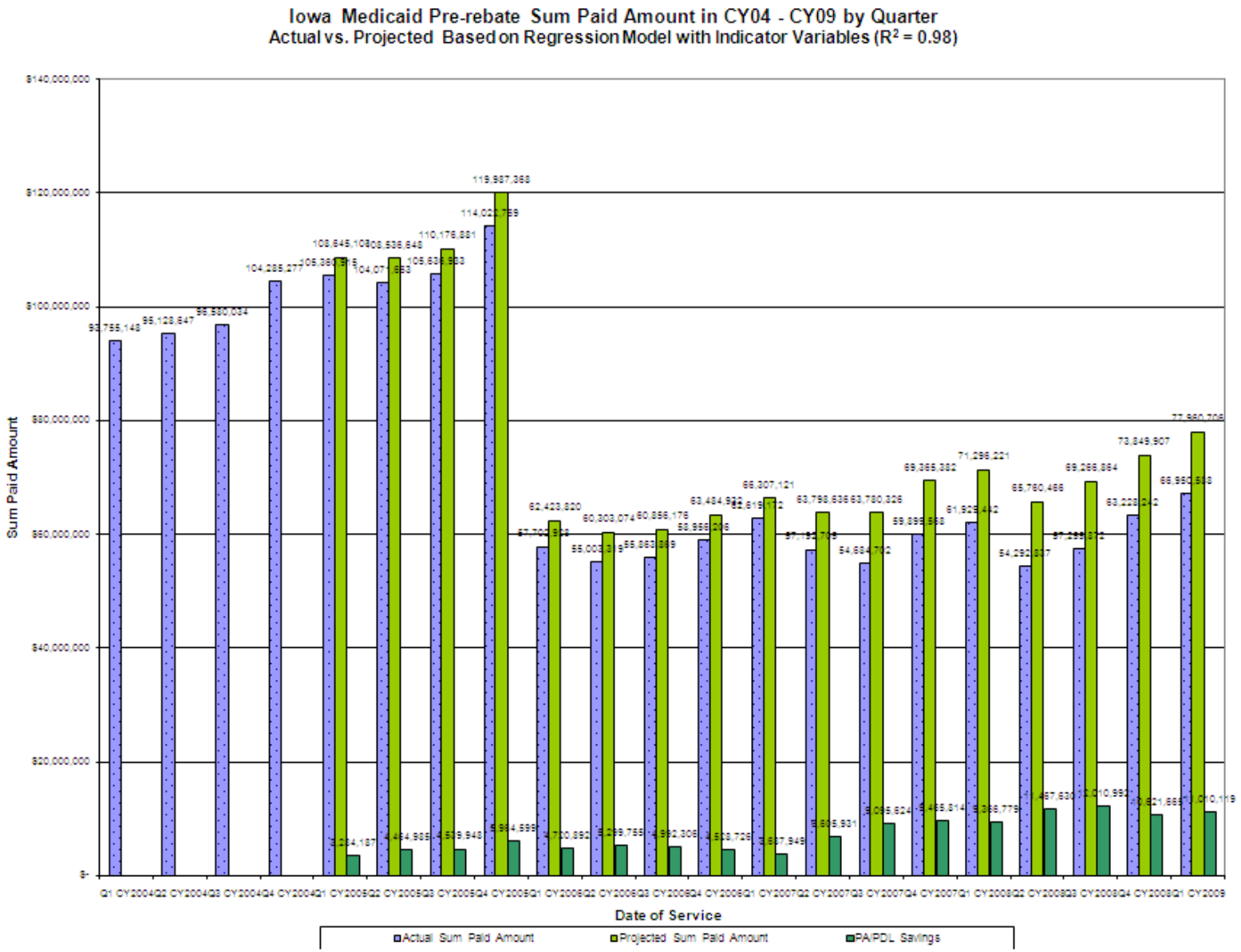


Figure 26: Iowa Medicaid Pre-rebate Sum paid Amount since CY2004 by Quarter

Iowa Medicaid PDL Pre-Rebate Savings Estimation

Actual vs. Projected Based on Regression Model with Indicator Variables (R^2 = 0.98)

Pre-rebate Savings are Difference between Projected and Actual

Quarter	Month	Actual # of Claims	Actual Avg Paid per Claim	Actual Sum Paid	Total Actual Paid for Quarter:	Projected Avg Paid per Claim	Projected Sum Paid	Total Projected Paid for Quarter:	Difference between Projected and Actual Paid	Total Savings for Quarter
	Jan-05	579,049	$ 59.72	$ 34,580,472		$ 60.37	$ 34,957,279		$ 376,808	
	Feb-05	580,649	$ 58.13	$ 33,753,325		$ 60.24	$ 34,980,001		$ 1,226,677	
Q1 CY2005	Mar-05	627,734	$ 58.99	$ 37,027,119	**$ 105,360,915**	$ 61.66	$ 38,707,822	**$ 108,645,103**	$ 1,680,703	**$ 3,284,187**
	Apr-05	586,017	$ 59.70	$ 34,983,246		$ 61.96	$ 36,310,397		$ 1,327,151	
	May-05	585,724	$ 59.34	$ 34,755,249		$ 62.16	$ 36,406,927		$ 1,651,678	
Q2 CY2005	Jun-05	571,754	$ 60.05	$ 34,333,168	**$ 104,071,663**	$ 62.65	$ 35,819,323	**$ 108,536,648**	$ 1,486,155	**$ 4,464,985**
	Jul-05	549,694	$ 60.83	$ 33,436,860		$ 63.10	$ 34,687,559		$ 1,250,699	
	Aug-05	598,091	$ 60.66	$ 36,279,875		$ 63.29	$ 37,851,503		$ 1,571,629	
Q3 CY2005	Sep-05	602,103	$ 59.66	$ 35,920,198	**$ 105,636,933**	$ 62.51	$ 37,637,818	**$ 110,176,881**	$ 1,717,620	**$ 4,539,948**
	Oct-05	611,626	$ 59.64	$ 36,474,732		$ 63.29	$ 38,710,273		$ 2,235,541	
	Nov-05	621,188	$ 60.20	$ 37,394,375		$ 63.57	$ 39,487,565		$ 2,093,190	
Q4 CY2005	Dec-05	654,536	$ 61.35	$ 40,153,662	**$ 114,022,769**	$ 63.85	$ 41,789,530	**$ 119,987,368**	$ 1,635,868	**$ 5,964,599**
	Jan-06	322,709	$ 59.24	$ 19,117,741		$ 64.35	$ 20,767,382		$ 1,649,640	
	Feb-06	307,012	$ 59.47	$ 18,256,956		$ 64.23	$ 19,718,170		$ 1,461,214	
Q1 CY2006	Mar-06	334,191	$ 60.83	$ 20,328,230	**$ 57,702,928**	$ 65.65	$ 21,938,268	**$ 62,423,820**	$ 1,610,037	**$ 4,720,892**
	Apr-06	294,682	$ 61.19	$ 18,032,137		$ 65.94	$ 19,432,644		$ 1,400,508	
	May-06	317,788	$ 60.08	$ 19,093,405		$ 66.14	$ 21,018,580		$ 1,925,175	
Q2 CY2006	Jun-06	297,936	$ 60.01	$ 17,877,778	**$ 55,003,319**	$ 66.63	$ 19,851,850	**$ 60,303,074**	$ 1,974,072	**$ 5,299,755**
	Jul-06	283,293	$ 60.61	$ 17,168,998		$ 67.09	$ 19,005,141		$ 1,836,142	
	Aug-06	317,086	$ 63.52	$ 20,141,929		$ 67.27	$ 21,330,476		$ 1,188,547	
Q3 CY2006	Sep-06	308,609	$ 60.12	$ 18,552,942	**$ 55,863,869**	$ 66.49	$ 20,520,559	**$ 60,856,176**	$ 1,967,617	**$ 4,992,306**
	Oct-06	319,379	$ 61.95	$ 19,785,201		$ 67.27	$ 21,485,863		$ 1,700,663	
	Nov-06	309,620	$ 62.69	$ 19,410,448		$ 67.55	$ 20,915,121		$ 1,504,673	
Q4 CY2006	Dec-06	310,839	$ 63.57	$ 19,760,557	**$ 58,956,206**	$ 67.83	$ 21,083,947	**$ 63,484,932**	$ 1,323,390	**$ 4,528,726**
	Jan-07	335,891	$ 64.35	$ 21,613,635		$ 68.34	$ 22,953,580		$ 1,339,946	
	Feb-07	312,134	$ 62.80	$ 19,602,519		$ 68.21	$ 21,290,403		$ 1,687,884	
Q1 CY2007	Mar-07	316,867	$ 67.55	$ 21,403,018	**$ 62,619,172**	$ 69.63	$ 22,063,137	**$ 66,307,121**	$ 660,119	**$ 3,687,949**
	Apr-07	307,497	$ 64.53	$ 19,843,608		$ 69.93	$ 21,502,520		$ 1,658,912	
	May-07	313,067	$ 62.37	$ 19,526,979		$ 70.12	$ 21,953,315		$ 2,426,336	
Q2 CY2007	Jun-07	288,083	$ 61.86	$ 17,822,118	**$ 57,192,705**	$ 70.61	$ 20,342,801	**$ 63,798,636**	$ 2,520,683	**$ 6,605,931**
	Jul-07	287,499	$ 61.68	$ 17,734,008		$ 71.07	$ 20,432,449		$ 2,698,441	
	Aug-07	313,778	$ 62.08	$ 19,479,907		$ 71.25	$ 22,357,761		$ 2,877,853	
Q3 CY2007	Sep-07	297,830	$ 58.66	$ 17,470,787	**$ 54,684,702**	$ 70.48	$ 20,990,116	**$ 63,780,326**	$ 3,519,329	**$ 9,095,624**
	Oct-07	333,933	$ 61.58	$ 20,564,694		$ 71.26	$ 23,795,062		$ 3,230,368	
	Nov-07	330,223	$ 60.49	$ 19,976,350		$ 71.53	$ 23,622,191		$ 3,645,841	
Q4 CY2007	Dec-07	305,632	$ 63.34	$ 19,358,524	**$ 59,899,568**	$ 71.81	$ 21,948,129	**$ 69,365,382**	$ 2,589,605	**$ 9,465,814**
	Jan-08	332,478	$ 63.08	$ 20,972,487		$ 72.32	$ 24,044,648		$ 3,072,161	
	Feb-08	323,814	$ 62.08	$ 20,102,910		$ 72.19	$ 23,376,876		$ 3,273,965	
Q1 CY2008	Mar-08	324,331	$ 64.30	$ 20,854,044	**$ 61,929,442**	$ 73.61	$ 23,874,697	**$ 71,296,221**	$ 3,020,653	**$ 9,366,779**
	Apr-08	324,694	$ 60.92	$ 19,779,564		$ 73.91	$ 23,998,359		$ 4,218,795	
	May-08	271,564	$ 61.34	$ 16,658,764		$ 74.11	$ 20,124,656		$ 3,465,892	
Q2 CY2008	Jun-08	290,056	$ 61.56	$ 17,854,508	**$ 54,292,837**	$ 74.60	$ 21,637,451	**$ 65,760,466**	$ 3,782,943	**$ 11,467,630**
	Jul-08	300,579	$ 62.80	$ 18,876,715		$ 75.05	$ 22,559,282		$ 3,682,567	
	Aug-08	302,268	$ 61.60	$ 18,620,579		$ 75.24	$ 22,741,603		$ 4,121,024	
Q3 CY2008	Sep-08	321,864	$ 61.39	$ 19,758,578	**$ 57,255,872**	$ 74.46	$ 23,965,979	**$ 69,266,864**	$ 4,207,401	**$ 12,010,992**
	Oct-08	336,385	$ 62.36	$ 20,976,035		$ 75.24	$ 25,309,646		$ 4,333,611	
	Nov-08	309,006	$ 64.46	$ 19,919,983		$ 75.52	$ 23,335,260		$ 3,415,278	
Q4 CY2008	Dec-08	332,540	$ 67.16	$ 22,332,225	**$ 63,228,242**	$ 75.80	$ 25,205,001	**$ 73,849,907**	$ 2,872,776	**$ 10,621,665**
	Jan-09	331,528	$ 67.30	$ 22,312,241		$ 76.30	$ 25,296,460		$ 2,984,219	
	Feb-09	330,064	$ 65.11	$ 21,491,273		$ 76.18	$ 25,142,762		$ 3,651,489	
Q1 CY2009	Mar-09	354,680	$ 65.26	$ 23,147,074	**$ 66,950,588**	$ 77.60	$ 27,521,485	**$ 77,960,706**	$ 4,374,410	**$ 11,010,119**

Figure 27: Iowa Medicaid PDL Pre-Rebate Savings Estimations since CY2005

2. *In every subsequent base and option year, an increase of 7 percent more than theSFY 2011 state savings or an increase of 7 percent more than the highest overall state savings in any year after SFY 2011, whichever is higher*

GHS agrees to meet the performance standards, as outline in the RFP. Our approach to obtaining and measuring these savings is more fully described in our response to requirement a.1, above, and in our response to 6.1.3.4.3.2 Pharmacy Medical Services in section 7.2.5 of this proposal.

7.2.7 PROJECT PLAN

The Department requires that bidders produce a project plan for each phase of the contract: transition phase, operations phase, and turnover phase. If bidding on multiple components, bidders must include a project plan for each contract phase in each individual component proposal.

Bidders should include their proposed approach for communication management, quality management, risk management, and time management as part of their overall project plan. The Department will need to consider this approach in determining the overall master project plan for the IME.

In addition to task lists and corresponding start and end dates, the project plans for each phase will include a calendar-year-based schedule for all tasks (including operational tasks), specify the allocation of resources by job for those tasks, and identify the timeframes in which the tasks will occur (expressed in weeks during transition and turnover and in quarters during operations). The bidder must be capable of updating and maintaining this information systematically throughout the contract.

GHS Management Philosophy

GHS has a sound understanding of this industry and brings over 13 years experience in processing online, real time claims adjudication in a POS environment, and over 30 years experience processing pharmacy claims and working with State Government. During this time period GHS has utilized our wealth of knowledge and experience in the industry to accomplish outstanding objectives for our clients; achievements that have been recognized nationwide as leading edge and extremely cost effective in this ever growing business. GHS recognizes that the success to any endeavor is close communication with the client, the ability and willingness to think outside the box and provide comprehensive, cost savings solutions that meet the needs of the client. Identifying the customer's needs and accommodating them is an area where GHS excels and we are prepared to continue providing the Department these services so they may continue to enjoy leading edge technology with the ability to interface with all of their existing systems, and to benefit from an experienced industry leader.

In addition, we pride ourselves on our ability to build flexible, cooperative working relationships with a State's other Medicaid vendors. GHS is experienced in working with other MMIS vendors in support of the transition to new services and in the ongoing operation of PBM services as part of a complete MMIS solution. We will work diligently to continue providing the same level of service to the Department that you presently receive.

GHS has developed its management approach to leverage GHS's relevant experience and incorporate the proven strengths of our project team. We believe that this formula provides the highest level of service to our clients. GHS blends the following four proven strategies into our operations:

- Our management team is empowered to make rapid and deliberate operational decisions in the field that are in your best interest. To manage this engagement successfully, it is mandatory that our IME Managers be empowered with the capability to make timely decisions;
- We utilize "clinical-data" teams that are comprised of our doctors and pharmacists working with our data analysts, data administrators and developers. They are available for "on-call" assistance with any clinical, operational, organizational, and developmental

function throughout the life of the contract. Our Technical Advisors are among the most experienced individuals in the state in their designated specialties.

- At the foundation of our management approach is a commitment to transparency, flexibility and responsiveness that ensures "seamless" operations and project administration. Our work plan is a "living document" designed for any changes as the project unfolds. Our management team understands this concept and will rely on experience with similar projects to manage this effort efficiently.
- GHS has made strong operational and philosophical commitments to a process of internal and external continuous quality improvement programs. GHS will ensure that these standards are maintained throughout all our Iowa operations.

Communication Management

Communication that takes place early and often, in both formal and informal processes, will be critical in ensuring the on-going timely and effective operation of the IME Pharmacy Medical Services project. GHS envisions strong monitoring by the Department of the diverse contract elements that make up the program.

GHS considers our regularly-scheduled status meetings with the Department as the most appropriate time to review project operations and discuss problems, accomplishments, and planning issues. We also invite additional representatives from other vendors to attend the status meetings to discuss relevant issues when they arise. For each status meeting, we create and distribute a status report document containing "action items" identified at the previous meeting with assigned responsibilities and a summary report of project accomplishments, issues and next steps.

It is critical to the success of the program that an informal exchange of ideas and communication of potentials barriers exist between GHS and the Department. Our management team is in daily contact with, and has responsibility for overseeing the teams that will be working during the stated phases of our engagement. They coordinate the efforts of the teams we use in our engagement to make sure they are achieving results and providing high quality services to the State of Iowa.

Quality Management

The guiding principal at GHS is to maintain standardization, documentation, adherence to processes, creating and maintaining audit trails and open communication. GHS has been audited previously by the State of Maine, and has also been audited by CMS with glowing results in regards to our documentation standards, audit trails, and performance. GHS has the ability to bring on new staff, provide them with the documentation and resources available, assign a mentor to them from their internal team and provide open door access to anyone to ensure they are successful.

Our internal structure also allows for accommodating new growth. Each team is grouped together by their specialty areas, which promotes each subject matter expert the opportunity to pool their resources and team leaders, operate under a shared knowledge approach to working. Our teams realize that by sharing their wealth of knowledge with each other, the team (and company) gets stronger. Sharing knowledge and duties becomes a win-win situation for

everybody, our clients benefit from access to staff that are knowledgeable and our staff is able to expand and grow.

GHS account managers understand the work that we do with other states via our regularly-scheduled manager meetings, discussions, etc. so they can gain lessons learned from other states. Our SSDC role also allows GHS and states to collaborate on issues such as strategies, PDL design, savings targets, best practices, etc.

GHS is proud of its consistent high quality work produced by both our highly skilled and experienced employees and our smart state-of-the-art technology investments. For every contract GHS maintains operations and administrative staff have collaborated to develop quality control and assurance strategies to provide monitoring of all operations related to a given contract. This ensures that all contractual obligations are being met to the satisfaction of the contracting entity. These strategies are documented and available for reference or for use in training new staff. Current documents will serve as a baseline and be modified to meet the specific needs of the Department

GHS is committed to continuous quality improvement; it is a major component of the work we do with Medicaid pharmacy providers. We apply this same philosophy and improvement focus to our internal activities and the services we provide to our customers. Our goal is to continuously measure our performance, identify opportunities for improvement based on analysis of the performance data, and then implement changes in our activities designed to achieve improved performance. This is not a new concept for GHS. It is ingrained in everything we do and part of our organizational culture. This dedication to ongoing performance monitoring and improvement will be rigorously applied to the work completed for the IME.

Risk Management

With the potential rewards so considerable and wide-ranging, GHS recognizes that significant risks are inherent in an undertaking such as the IME. Effective management and mitigation of risks are vital, and are an important piece of the strategy that has been, and must continue to be, integrated in the work of GHS, the Department and other contractors participating in the project.

Continued success will depend, in part, on the identification and management of risks that could have an adverse effect on IME activities. Our overall approach to the operations phase of any project is to remain flexible and responsive to our clients needs. Our business model with our State Medicaid Agencies is built upon establishing quality, transparent partnerships. We work diligently to create a positive, reciprocal relationship with the Department's Pharmacy staff and your other IME vendors to ensure the requested Pharmacy services are properly implemented and operated. GHS has proven our ability to be flexible and responsive to requests. In addition we have been proactive in identifying risk factors and interventions for successful implementation and for on-going maintenance of programs.

GHS' policy experts, clinicians, analysts and project managers strive to stay abreast of any developments within the industry that could affect the programs we administer. They also stay up-to-date on developments within each client state to ensure that management and Department staff are well-informed and prepared for any potential changes or risks to the programs. Our

policy experts, clinicians, and management staff will be available to work collaboratively with the Department and the Department's other vendors to address and mitigate these potential risks to the program.

Our existing relationship with the Department, combined with our long history of working with Medicaid healthcare providers, will enable GHS to move forward quickly. No time will be needed to learn about the state or build relationships with important constituencies. This will help reduce the administrative and logistical problems that might otherwise occur and reduce the risks posed by the transitioning of responsibilities.

Time and Resource Management

Throughout this project, GHS will seek to maximize the use of the time and resources required by bringing in an experienced senior level team that has hands-on expertise in the programmatic and financial aspects of your current service delivery system, and is well versed in the goals and objectives of the IME project. Our project management approach includes the following:

- We have retained our current account manager with extensive Iowa Medicaid experience who will ensure that our professional teams remain on task and on focus;
- We will work closely with the State staff and other IME contractors to ensure on-going smooth operations;
- We produce management reports, conduct regular status meetings and convene periodic workgroup sessions for all groups involved.

Transition

As the incumbent vendor, there will be no real transition of duties should we re-secure this work. Our systems, policies and procedures are in place. Based on our current understanding of the RFP requirements, we are not proposing any significant changes to our current systems or procedures. We will continue to use our established methods and maintain our current policies, unless otherwise requested by the Department. As a result, our main goal during the "transition phase" will be to ensure that our systems interfaces and the current policies and procedures transfer smoothly between the incumbent contractors and any new contractors that begin providing services to the IME under other components included in this procurement process. A major component of this will be to provide operations training for new vendors that require access to our systems.

This will be an intensive hands-on experience, where users are paired up and supervised by actual users of the systems. We will follow the same approach used during the initial implementation of our IME services where we trained new employees on the system. GHS Technical Writing and Training staff developed desk manuals and training materials under the guidance of the State and collaboration of the new users. Once the material was established and approved, we scheduled training with new staff. For the IME project, experienced GHS PA managers traveled to the operation site and provided hands-on system training, walking through typical scenarios and actual day-to-day job functions using the actual systems and referencing the desk manuals where appropriate. This support staff then remained on-site for the operations start-up. Additionally, they were supported by development staff located at the home office in Augusta. We will model any new staff training on this method.

GHS has experienced staff dedicated to the operation and support of this project. This staff is responsible for tracking and implementing changes to support the client. Support functions include but are not limited to system maintenance, enhancement coding, testing, quality control, file maintenance, upgrades, issue resolution and providing this information for reporting on the data warehouse. Staff monitors for inconsistencies and reports them. GHS will research and interact with the source of the data to resolve any issues in a timely manner.

Operations Phase – Tasks and Resources
A project plan for the on-going operations phase of this project has been included, beginning on the next page of this section. It shows the schedule of operational tasks with the requested allocation of resources and timeframes.

Turnover Plan
GHS will prepare a preliminary transition plan as needed and submit to the Department for approval. The approved transition plan will be a living document allowing for updates as needed. This plan will be a comprehensive, customized plan detailing the proposed schedule, activities and resource requirements associated with all turnover tasks. A draft plan is included at the end of this section.

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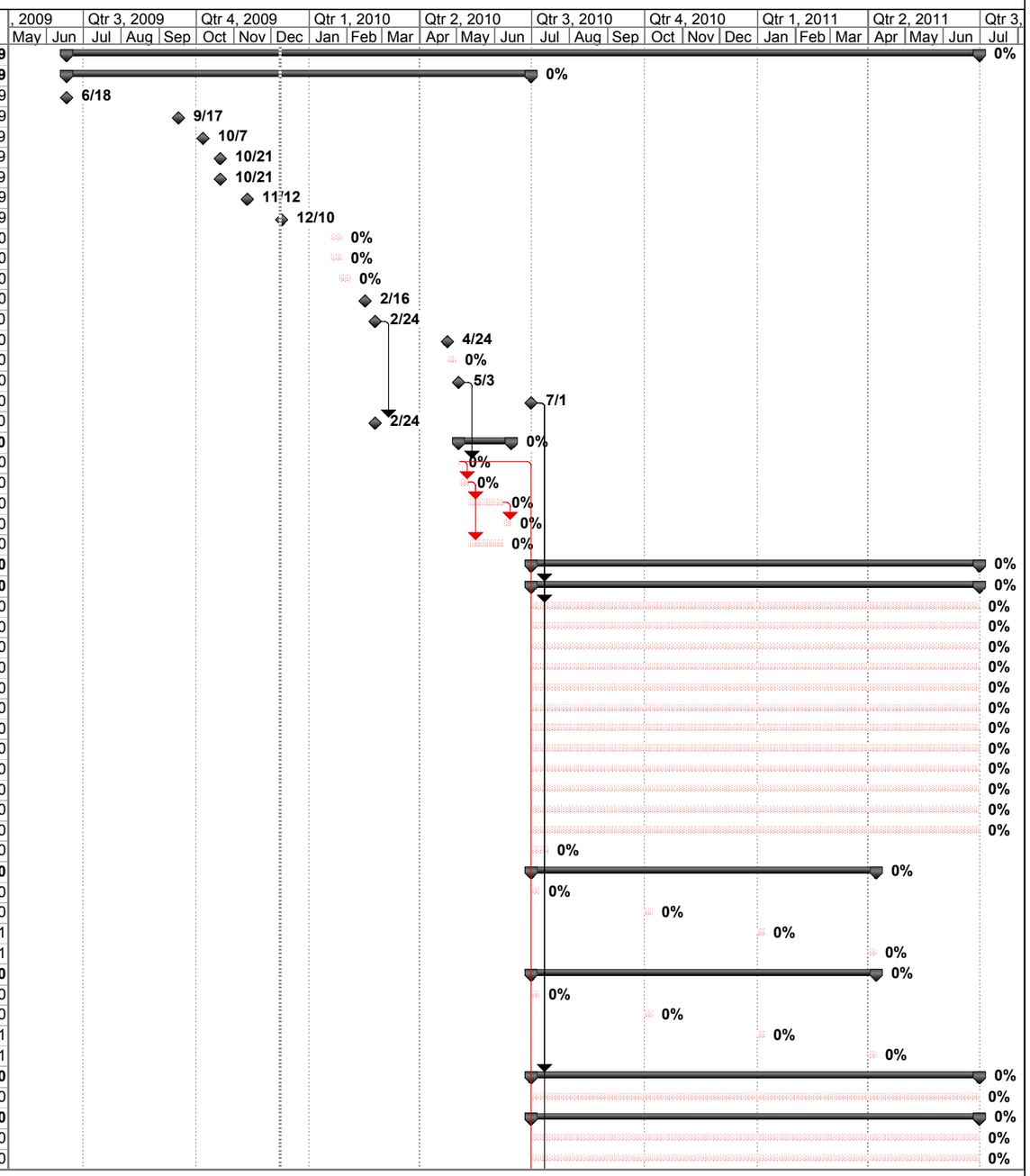
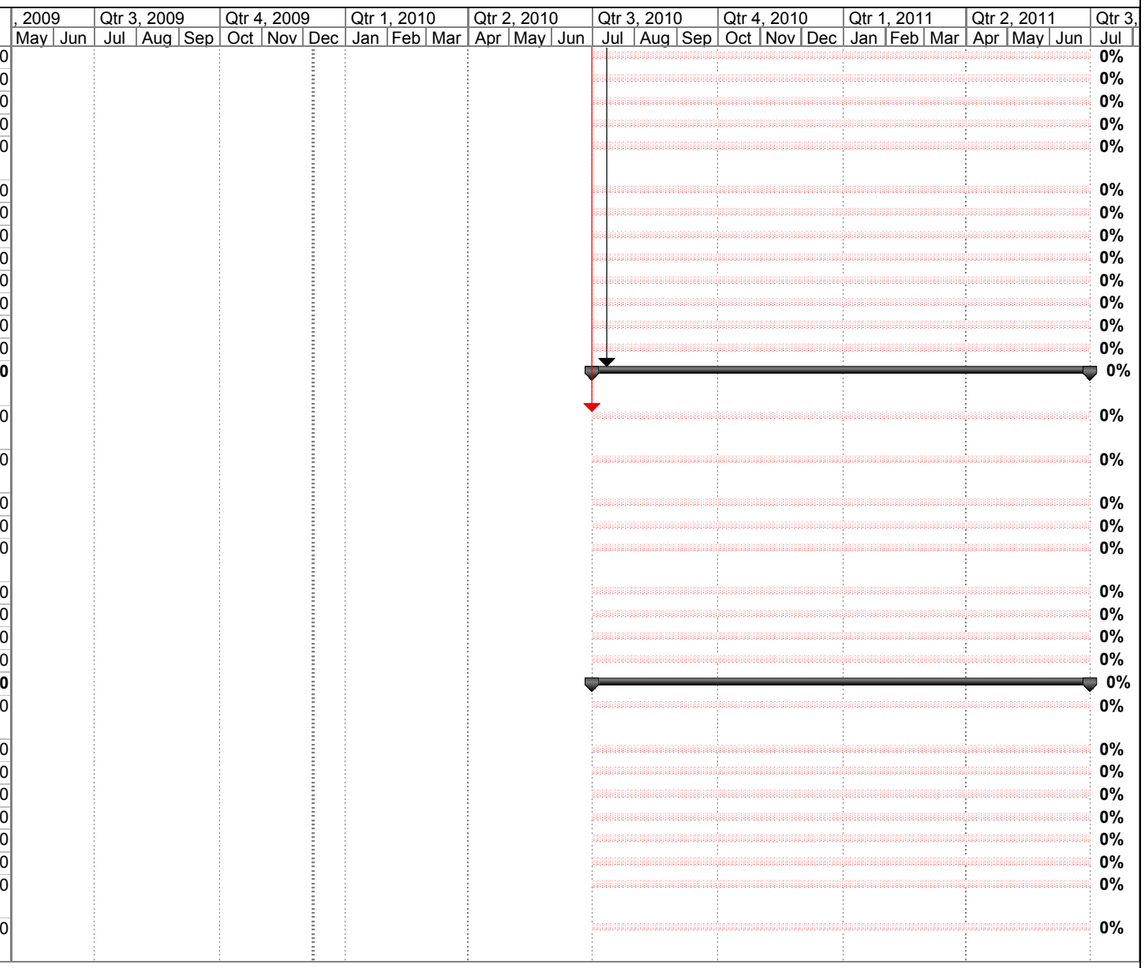
ID	WBS	Task Name	Duration	Start
1	**1**	**IME Pharmacy Medical Services Project Plan 2009 2010**	**533 days**	**Thu 6/18/09**
2	**1.1**	**RFP and Contractual**	**271 days**	**Thu 6/18/09**
3	1.1.1	Notice of intent to issue RFP June 18, 2009	0 days	Thu 6/18/09
4	1.1.2	RFP issue September 17, 2009	0 days	Thu 9/17/09
5	1.1.3	Bidders' conference October 7, 2009	0 days	Wed 10/7/09
6	1.1.4	Bidders' questions due October 21, 2009	0 days	Wed 10/21/09
7	1.1.5	Letters of intent to bid requested October 21, 2009	0 days	Wed 10/21/09
8	1.1.6	Written responses to bidders' questions November 12, 2009	0 days	Thu 11/12/09
9	1.1.7	Closing date for receipt of bid proposals and amendments December 10, 2009	0 days	Thu 12/10/09
10	1.1.8	Oral presentations January 19 through 27, 2010	7 days	Tue 1/19/10
11	1.1.9	Request for best and final offers (if any) January 19 through 27, 2010	7 days	Tue 1/19/10
12	1.1.10	Best and final offers due (as requested) January 26 through February 3, 2010	7 days	Tue 1/26/10
13	1.1.11	Notice of intent to award to successful bidders February 16, 2010	0 days	Tue 2/16/10
14	1.1.12	Completion of contract negotiations and execution of the contract February 24, 2010	0 days	Wed 2/24/10
15	1.1.13	CMS contract approval April 24, 2010	0 days	Sat 4/24/10
16	1.1.14	Execution of contracts April 24 through 30, 2010	6 days	Sat 4/24/10
17	1.1.15	Transition phase of contracts May 3, 2010	0 days	Mon 5/3/10
18	1.1.16	Operations phase of contracts July 1, 2010	0 days	Thu 7/1/10
19	1.2	M: Contract Signing Complete	0 days	Wed 2/24/10
20	**1.3**	**Transition Phase**	**31 days**	**Mon 5/3/10**
21	1.3.1	Convene kick-off Joint Application Design (JAD) with Department	1 day	Mon 5/3/10
22	1.3.2	Review affected reports and operational controls based on new requirements	5 days	Tue 5/4/10
23	1.3.3	Create new reports and submit to Department for review and approval	20 days	Tue 5/11/10
24	1.3.4	Update automated reports (as needed)	5 days	Tue 6/8/10
25	1.3.5	Update documents affected by any new contractual requirements (as needed)	20 days	Tue 5/11/10
26	**1.4**	**Operations Phase**	**262 days**	**Thu 7/1/10**
27	**1.4.1**	**Pharmacy Prior Authorization (PA)**	**262 days**	**Thu 7/1/10**
28	1.4.1.1	Host and maintain pharmacy PA software system	262 days	Thu 7/1/10
29	1.4.1.2	Maintain fax-based PA entry system	262 days	Thu 7/1/10
30	1.4.1.3	Maintain POS interface and file transfer	262 days	Thu 7/1/10
31	1.4.1.4	Network and data warehouse 24/7/365 support	262 days	Thu 7/1/10
32	1.4.1.5	Recruit and train staff (as needed)	262 days	Thu 7/1/10
33	1.4.1.6	Support PA criteria development with appropriate clinical and technical guidance	262 days	Thu 7/1/10
34	1.4.1.7	Create training and materials regarding PA criteria that is appropriate to target auc	262 days	Thu 7/1/10
35	1.4.1.8	Administration of pharmacy PA services	262 days	Thu 7/1/10
36	1.4.1.9	Revise current and develop new PA forms (as needed)	262 days	Thu 7/1/10
37	1.4.1.10	Pharmacy PA Manual updates (as needed)	262 days	Thu 7/1/10
38	1.4.1.11	Create PA monthly operational reports	262 days	Thu 7/1/10
39	1.4.1.12	Create annual SFY report	262 days	Thu 7/1/10
40	1.4.1.13	Submit annual report for review and approval	10 days	Thu 7/1/10
41	**1.4.1.14**	**Create quarterly staff performance QA reports**	**202 days**	**Thu 7/1/10**
42	1.4.1.14.1	Staff performance Report Q1	5 days	Thu 7/1/10
43	1.4.1.14.2	Staff performance Report Q2	5 days	Fri 10/1/10
44	1.4.1.14.3	Staff performance Report Q3	5 days	Sat 1/1/11
45	1.4.1.14.4	Staff performance Report Q4	5 days	Fri 4/1/11
46	**1.4.1.15**	**Create quarterly policy and appeal exception requests**	**202 days**	**Thu 7/1/10**
47	1.4.1.15.1	Policy and appeal exception report Q1	5 days	Thu 7/1/10
48	1.4.1.15.2	Policy and appeal exception report Q2	5 days	Fri 10/1/10
49	1.4.1.15.3	Policy and appeal exception report Q3	5 days	Sat 1/1/11
50	1.4.1.15.4	Policy and appeal exception report Q4	5 days	Fri 4/1/11
51	**1.4.2**	**RetroDUR**	**262 days**	**Thu 7/1/10**
52	1.4.2.1	Professional staff management	262 days	Thu 7/1/10
53	**1.4.2.2**	**P&T Meeting coordination (6 per year)**	**262 days**	**Thu 7/1/10**
54	1.4.2.2.1	Prepare meeting materials and related packets	262 days	Thu 7/1/10
55	1.4.2.2.2	Meeting facilitation	262 days	Thu 7/1/10



Gould Health Systems

Critical, Critical Split, Critical Progress, Task, Split, Task Progress, Baseline, Baseline Split, Baseline Milestone, Milestone, Summary Progress, Summary, Project Summary, Critical Split, Task Progress, Critical Progress, Baseline, Task, Split, Baseline Milestone, Milestone, Summary Progress, Summary

ID	WBS	Task Name	Duration	Start
56	1.4.2.2.3	Website maintenance and updates	262 days	Thu 7/1/10
57	1.4.2.2.4	Initiative presentations	262 days	Thu 7/1/10
58	1.4.2.2.5	Generate profiles based on selection criteria (6 times per year)	262 days	Thu 7/1/10
59	1.4.2.2.6	Letter generation resulting from patient-focused profile reviews	262 days	Thu 7/1/10
60	1.4.2.2.7	Provide the Department written reports of the DUR commission's recommendations	262 days	Thu 7/1/10
61	1.4.2.3	External / Internal communication coordination with professional associations	262 days	Thu 7/1/10
62	1.4.2.4	Monthly report creation and review	262 days	Thu 7/1/10
63	1.4.2.5	Annual report creation and review (90d before fiscal end)	262 days	Thu 7/1/10
64	1.4.2.6	Maintain data warehouse and access to data	262 days	Thu 7/1/10
65	1.4.2.7	Research and data analytic support	262 days	Thu 7/1/10
66	1.4.2.8	Manage patient-specific profile generation and related selection parameters	262 days	Thu 7/1/10
67	1.4.2.9	Create prevalence reports (6 times per year)	262 days	Thu 7/1/10
68	1.4.2.10	Produce post and distribute newsletter (3 time per year min)	262 days	Thu 7/1/10
69	**1.4.3**	**Preferred Drug List (PDL) & Supplemental Rebate (SR)**	**262 days**	**Thu 7/1/10**
70	1.4.3.1	Review current PDL with the Department and discuss any potential changes or recommendations	262 days	Thu 7/1/10
71	1.4.3.2	Incorporation therapeutic reviews for P&T committee meetings (drug monographs, SR data and savings by therapeutic class)	262 days	Thu 7/1/10
72	1.4.3.3	Maintain existing PDL program provisions	262 days	Thu 7/1/10
73	1.4.3.4	PDL management and activity coordination	262 days	Thu 7/1/10
74	1.4.3.5	Conduct ongoing analysis and clinical reviews of Iowa Medicaid pharmacy claims (once per year min)	262 days	Thu 7/1/10
75	1.4.3.6	Communicate with providers and other interested parties	262 days	Thu 7/1/10
76	1.4.3.7	Support manufacturers regarding PDL questions and concerns	262 days	Thu 7/1/10
77	1.4.3.8	Host and maintain public website and document repository	262 days	Thu 7/1/10
78	1.4.3.9	Provide administrative support to the P&T committee	262 days	Thu 7/1/10
79	**1.4.3.10**	**Supplemental Drug Rebate Services**	**262 days**	**Thu 7/1/10**
80	1.4.3.10.1	Provide assistance to the Department during analysis and negotiation (as needed)	262 days	Thu 7/1/10
81	1.4.3.10.2	Facilitate SR communications with Department and manufacturers	262 days	Thu 7/1/10
82	1.4.3.10.3	Manage SR contracts and related processes	262 days	Thu 7/1/10
83	1.4.3.10.4	Provider SR rebate billing data quarterly	262 days	Thu 7/1/10
84	1.4.3.10.5	Prepare negotiate SR rates for review by the Department	262 days	Thu 7/1/10
85	1.4.3.10.6	Prepare SR monitoring / controlling reports	262 days	Thu 7/1/10
86	1.4.3.10.7	Analytic and reporting SR support	262 days	Thu 7/1/10
87	1.4.3.10.8	Provide education and outreach and communication strategy assistance (as needed)	262 days	Thu 7/1/10
88	1.4.3.10.9	Discuss / refine existing Department-approved procedure for communicating system changes to all affected IME contractors and State agencies	262 days	Thu 7/1/10



Goold Health Systems

Critical	Split	Baseline Milestone	Project Summary	Split	Baseline Milestone
Critical Split	Task Progress	Milestone	Critical Split	Task Progress	Milestone
Critical Progress	Baseline	Summary Progress	Critical Progress	Baseline	Summary Progress
Task	Baseline Split	Summary	Task	Baseline Split	Summary

IME Pharmacy Medical Services Work and Task Estimates Rev 4

ID	Task Name	Work	Duration	Details	Qtr 2, 2010			Qtr 3, 2010			Qtr 4, 2010			Qtr 1, 2011			Qtr 2, 2011			Qtr 3, 2011		
					Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
1	**IME Pharmacy Medical Services Project Plan 2009 2010**	**3,121.85 days**	**533 days**	Work		83.85d	24.25d	256.31d	253.01d	252.33d	243.06d	251.91d	263.36d	254.51d	229.01d	263.36d	243.06d	251.91d	251.91d			
2	**RFP and Contractual**	**0 days**	**271 days**	Work																		
3	Notice of intent to issue RFP June 18, 2009	0 days	0 days	Work																		
4	RFP issue September 17, 2009	0 days	0 days	Work																		
5	Bidders' conference October 7, 2009	0 days	0 days	Work																		
6	Bidders' questions due October 21, 2009	0 days	0 days	Work																		
7	Letters of intent to bid requested October 21, 2009	0 days	0 days	Work																		
8	Written responses to bidders' questions November 12, 2009	0 days	0 days	Work																		
9	Closing date for receipt of bid proposals and amendments December 10, 2009	0 days	0 days	Work																		
10	Oral presentations January 19 through 27, 2010	0 days	7 days	Work																		
11	Request for best and final offers (if any) January 19 through 27, 2010	0 days	7 days	Work																		
12	Best and final offers due (as requested) January 26 through February 3, 2010	0 days	7 days	Work																		
13	Notice of intent to award to successful bidders February 16, 2010	0 days	0 days	Work																		
14	Completion of contract negotiations and execution of the contract February 24, 2010	0 days	0 days	Work																		
15	CMS contract approval April 24, 2010	0 days	0 days	Work																		
16	Execution of contracts April 24 through 30, 2010	0 days	6 days	Work																		
17	Transition phase of contracts May 3, 2010	0 days	0 days	Work																		
18	Operations phase of contracts July 1, 2010	0 days	0 days	Work																		
19	M: Contract Signing Complete	0 days	0 days	Work																		
20	**Transition Phase**	**108.1 days**	**31 days**	Work		83.85d	24.25d															
21	Convene kick-off Joint Application Design (JAD) with Department	2.35 days	1 day	Work		2.35d																
	Account Manager	*0.05 days*		Work		0.05d																
	Clinical Pharmacy Mgr/DUR Dir	*1 day*		Work		1d																
	Physician	*0.25 days*		Work		0.25d																
	DUR Coordinator	*1 day*		Work		1d																
	Project Manager	*0.05 days*		Work		0.05d																
22	Review affected reports and operational controls based on new requirements	11.75 days	5 days	Work		11.75d																
	Account Manager	*0.25 days*		Work		0.25d																
	Clinical Pharmacy Mgr/DUR Dir	*5 days*		Work		5d																
	Physician	*1.25 days*		Work		1.25d																
	DUR Coordinator	*5 days*		Work		5d																
	Project Manager	*0.25 days*		Work		0.25d																
23	Create new reports and submit to Department for review and approval	51 days	20 days	Work		38.25d	12.75d															
	Account Manager	*1 day*		Work		0.75d	0.25d															
	Clinical Pharmacy Mgr/DUR Dir	*20 days*		Work		15d	5d															
	Physician	*5 days*		Work		3.75d	1.25d															
	DUR Coordinator	*20 days*		Work		15d	5d															
	Project Manager	*1 day*		Work		0.75d	0.25d															
	Analysts	*4 days*		Work		3d	1d															
24	Update automated reports (as needed)	1 day	5 days	Work			1d															
	Analysts	*1 day*		Work			1d															
25	Update documents affected by any new contractual requirements (as needed)	42 days	20 days	Work		31.5d	10.5d															
	Account Manager	*1 day*		Work		0.75d	0.25d															
	Clinical Pharmacy Mgr/DUR Dir	*20 days*		Work		15d	5d															
	DUR Coordinator	*20 days*		Work		15d	5d															
	Project Manager	*1 day*		Work		0.75d	0.25d															
26	**Operations Phase**	**3,013.75 days**	**262 days**	Work				256.31d	253.01d	252.33d	243.06d	251.91d	263.36d	254.51d	229.01d	263.36d	243.06d	251.91d	251.91d			
27	**Pharmacy Prior Authorization (PA)**	**1,454.72 days**	**262 days**	Work				124.52d	121.22d	121.22d	118.31d	121.22d	126.73d	123.82d	110.2d	126.73d	118.31d	121.22d	121.22d			
28	Host and maintain pharmacy PA software system	47.16 days	262 days	Work				3.96d	3.96d	3.96d	3.78d	3.96d	4.14d	3.96d	3.6d	4.14d	3.78d	3.96d	3.96d			
	Database Architects	*2.62 days*		Work				0.22d	0.22d	0.22d	0.21d	0.22d	0.23d	0.22d	0.2d	0.23d	0.21d	0.22d	0.22d			
	Data Warehouse	*13.1 days*		Work				1.1d	1.1d	1.1d	1.05d	1.1d	1.15d	1.1d	1d	1.15d	1.05d	1.1d	1.1d			
	DEV	*13.1 days*		Work				1.1d	1.1d	1.1d	1.05d	1.1d	1.15d	1.1d	1d	1.15d	1.05d	1.1d	1.1d			
	Network	*13.1 days*		Work				1.1d	1.1d	1.1d	1.05d	1.1d	1.15d	1.1d	1d	1.15d	1.05d	1.1d	1.1d			
	Pick Programmer	*5.24 days*		Work				0.44d	0.44d	0.44d	0.42d	0.44d	0.46d	0.44d	0.4d	0.46d	0.42d	0.44d	0.44d			
29	Maintain fax-based PA entry system	52.4 days	262 days	Work				4.4d	4.4d	4.4d	4.2d	4.4d	4.6d	4.4d	4d	4.6d	4.2d	4.4d	4.4d			
	Account Manager	*5.24 days*		Work				0.44d	0.44d	0.44d	0.42d	0.44d	0.46d	0.44d	0.4d	0.46d	0.42d	0.44d	0.44d			
	Database Architects	*2.62 days*		Work				0.22d	0.22d	0.22d	0.21d	0.22d	0.23d	0.22d	0.2d	0.23d	0.21d	0.22d	0.22d			
	Data Warehouse	*13.1 days*		Work				1.1d	1.1d	1.1d	1.05d	1.1d	1.15d	1.1d	1d	1.15d	1.05d	1.1d	1.1d			
	DEV	*13.1 days*		Work				1.1d	1.1d	1.1d	1.05d	1.1d	1.15d	1.1d	1d	1.15d	1.05d	1.1d	1.1d			
	Network	*13.1 days*		Work				1.1d	1.1d	1.1d	1.05d	1.1d	1.15d	1.1d	1d	1.15d	1.05d	1.1d	1.1d			
	Pick Programmer	*5.24 days*		Work				0.44d	0.44d	0.44d	0.42d	0.44d	0.46d	0.44d	0.4d	0.46d	0.42d	0.44d	0.44d			
30	Maintain POS interface and file transfer	47.16 days	262 days	Work				3.96d	3.96d	3.96d	3.78d	3.96d	4.14d	3.96d	3.6d	4.14d	3.78d	3.96d	3.96d			
	Database Architects	*2.62 days*		Work				0.22d	0.22d	0.22d	0.21d	0.22d	0.23d	0.22d	0.2d	0.23d	0.21d	0.22d	0.22d			
	Data Warehouse	*13.1 days*		Work				1.1d	1.1d	1.1d	1.05d	1.1d	1.15d	1.1d	1d	1.15d	1.05d	1.1d	1.1d			
	DEV	*13.1 days*		Work				1.1d	1.1d	1.1d	1.05d	1.1d	1.15d	1.1d	1d	1.15d	1.05d	1.1d	1.1d			
	Network	*13.1 days*		Work				1.1d	1.1d	1.1d	1.05d	1.1d	1.15d	1.1d	1d	1.15d	1.05d	1.1d	1.1d			
	Pick Programmer	*5.24 days*		Work				0.44d	0.44d	0.44d	0.42d	0.44d	0.46d	0.44d	0.4d	0.46d	0.42d	0.44d	0.44d			

IME Pharmacy Medical Services Work and Task Estimates Rev 4

ID	Task Name	Work	Duration	Details	Qtr 2, 2010			Qtr 3, 2010			Qtr 4, 2010			Qtr 1, 2011			Qtr 2, 2011			Qtr 3, 2011		
					Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
31	Network and data warehouse 24/7/365 support	47.16 days	262 days	Work				3.96d	3.96d	3.96d	3.78d	3.96d	4.14d	3.96d	3.6d	4.14d	3.78d	3.96d	3.96d			
	Database Architects	*2.62 days*		Work				0.22d	0.22d	0.22d	0.21d	0.22d	0.23d	0.22d	0.2d	0.23d	0.21d	0.22d	0.22d			
	Data Warehouse	*13.1 days*		Work				1.1d	1.1d	1.1d	1.05d	1.1d	1.15d	1.1d	1d	1.15d	1.05d	1.1d	1.1d			
	DEV	*13.1 days*		Work				1.1d	1.1d	1.1d	1.05d	1.1d	1.15d	1.1d	1d	1.15d	1.05d	1.1d	1.1d			
	Network	*13.1 days*		Work				1.1d	1.1d	1.1d	1.05d	1.1d	1.15d	1.1d	1d	1.15d	1.05d	1.1d	1.1d			
	Pick Programmer	*5.24 days*		Work				0.44d	0.44d	0.44d	0.42d	0.44d	0.46d	0.44d	0.4d	0.46d	0.42d	0.44d	0.44d			
32	Recruit and train staff (as needed)	5.24 days	262 days	Work				0.44d	0.44d	0.44d	0.42d	0.44d	0.46d	0.44d	0.4d	0.46d	0.42d	0.44d	0.44d			
	Clinical Pharmacy Mgr/DUR Dir	*5.24 days*		Work				0.44d	0.44d	0.44d	0.42d	0.44d	0.46d	0.44d	0.4d	0.46d	0.42d	0.44d	0.44d			
33	Support PA criteria development with appropriate clinical and technical guidance	52.4 days	262 days	Work				4.4d	4.4d	4.4d	4.2d	4.4d	4.6d	4.4d	4d	4.6d	4.2d	4.4d	4.4d			
	Clinical Pharmacy Mgr/DUR Dir	*39.3 days*		Work				3.3d	3.3d	3.3d	3.15d	3.3d	3.45d	3.3d	3d	3.45d	3.15d	3.3d	3.3d			
	Physician	*13.1 days*		Work				1.1d	1.1d	1.1d	1.05d	1.1d	1.15d	1.1d	1d	1.15d	1.05d	1.1d	1.1d			
34	Create training and materials regarding PA criteria that is appropriate to target audience	34.06 days	262 days	Work				2.86d	2.86d	2.86d	2.73d	2.86d	2.99d	2.86d	2.6d	2.99d	2.73d	2.86d	2.86d			
	Clinical Pharmacy Mgr/DUR Dir	*5.24 days*		Work				0.44d	0.44d	0.44d	0.42d	0.44d	0.46d	0.44d	0.4d	0.46d	0.42d	0.44d	0.44d			
	Pharmacist	*13.1 days*		Work				1.1d	1.1d	1.1d	1.05d	1.1d	1.15d	1.1d	1d	1.15d	1.05d	1.1d	1.1d			
	Project Manager	*2.62 days*		Work				0.22d	0.22d	0.22d	0.21d	0.22d	0.23d	0.22d	0.2d	0.23d	0.21d	0.22d	0.22d			
	Administrative Assistants	*13.1 days*		Work				1.1d	1.1d	1.1d	1.05d	1.1d	1.15d	1.1d	1d	1.15d	1.05d	1.1d	1.1d			
35	Administration of pharmacy PA services	1,095.16 days	262 days	Work				91.96d	91.96d	91.96d	87.78d	91.96d	96.14d	91.96d	83.6d	96.14d	87.78d	91.96d	91.96d			
	Physician	*5.24 days*		Work				0.44d	0.44d	0.44d	0.42d	0.44d	0.46d	0.44d	0.4d	0.46d	0.42d	0.44d	0.44d			
	Pharmacist	*589.5 days*		Work				49.5d	49.5d	49.5d	47.25d	49.5d	51.75d	49.5d	45d	51.75d	47.25d	49.5d	49.5d			
	Pharmacy Technician	*497.8 days*		Work				41.8d	41.8d	41.8d	39.9d	41.8d	43.7d	41.8d	38d	43.7d	39.9d	41.8d	41.8d			
	Project Manager	*2.62 days*		Work				0.22d	0.22d	0.22d	0.21d	0.22d	0.23d	0.22d	0.2d	0.23d	0.21d	0.22d	0.22d			
36	Revise current and develop new PA forms (as needed)	13.1 days	262 days	Work				1.1d	1.1d	1.1d	1.05d	1.1d	1.15d	1.1d	1d	1.15d	1.05d	1.1d	1.1d			
	Pharmacist	*13.1 days*		Work				1.1d	1.1d	1.1d	1.05d	1.1d	1.15d	1.1d	1d	1.15d	1.05d	1.1d	1.1d			
37	Pharmacy PA Manual updates (as needed)	13.1 days	262 days	Work				1.1d	1.1d	1.1d	1.05d	1.1d	1.15d	1.1d	1d	1.15d	1.05d	1.1d	1.1d			
	Pharmacist	*13.1 days*		Work				1.1d	1.1d	1.1d	1.05d	1.1d	1.15d	1.1d	1d	1.15d	1.05d	1.1d	1.1d			
38	Create PA monthly operational reports	18.34 days	262 days	Work				1.54d	1.54d	1.54d	1.47d	1.54d	1.61d	1.54d	1.4d	1.61d	1.47d	1.54d	1.54d			
	Pharmacist	*5.24 days*		Work				0.44d	0.44d	0.44d	0.42d	0.44d	0.46d	0.44d	0.4d	0.46d	0.42d	0.44d	0.44d			
	Pharmacy Technician	*5.24 days*		Work				0.44d	0.44d	0.44d	0.42d	0.44d	0.46d	0.44d	0.4d	0.46d	0.42d	0.44d	0.44d			
	Project Manager	*2.62 days*		Work				0.22d	0.22d	0.22d	0.21d	0.22d	0.23d	0.22d	0.2d	0.23d	0.21d	0.22d	0.22d			
	Administrative Assistants	*5.24 days*		Work				0.44d	0.44d	0.44d	0.42d	0.44d	0.46d	0.44d	0.4d	0.46d	0.42d	0.44d	0.44d			
39	Create annual SFY report	18.34 days	262 days	Work				1.54d	1.54d	1.54d	1.47d	1.54d	1.61d	1.54d	1.4d	1.61d	1.47d	1.54d	1.54d			
	Pharmacist	*5.24 days*		Work				0.44d	0.44d	0.44d	0.42d	0.44d	0.46d	0.44d	0.4d	0.46d	0.42d	0.44d	0.44d			
	Pharmacy Technician	*5.24 days*		Work				0.44d	0.44d	0.44d	0.42d	0.44d	0.46d	0.44d	0.4d	0.46d	0.42d	0.44d	0.44d			
	Project Manager	*2.62 days*		Work				0.22d	0.22d	0.22d	0.21d	0.22d	0.23d	0.22d	0.2d	0.23d	0.21d	0.22d	0.22d			
	Administrative Assistants	*5.24 days*		Work				0.44d	0.44d	0.44d	0.42d	0.44d	0.46d	0.44d	0.4d	0.46d	0.42d	0.44d	0.44d			
40	Submit annual report for review and approval	0.7 days	10 days	Work				0.7d														
	Pharmacist	*0.2 days*		Work				0.2d														
	Pharmacy Technician	*0.2 days*		Work				0.2d														
	Project Manager	*0.1 days*		Work				0.1d														
	Administrative Assistants	*0.2 days*		Work				0.2d														
41	**Create quarterly staff performance QA reports**	**5.2 days**	**202 days**	Work				1.3d			1.3d			1.3d			1.3d					
42	Staff performance Report Q1	1.3 days	5 days	Work				1.3d														
	Account Manager	*0.05 days*		Work				0.05d														
	Analysts	*0.5 days*		Work				0.5d														
	Administrative Coordinator	*0.75 days*		Work				0.75d														
43	Staff performance Report Q2	1.3 days	5 days	Work							1.3d											
	Account Manager	*0.05 days*		Work							0.05d											
	Analysts	*0.5 days*		Work							0.5d											
	Administrative Coordinator	*0.75 days*		Work							0.75d											
44	Staff performance Report Q3	1.3 days	5 days	Work										1.3d								
	Account Manager	*0.05 days*		Work										0.05d								
	Analysts	*0.5 days*		Work										0.5d								
	Administrative Coordinator	*0.75 days*		Work										0.75d								
45	Staff performance Report Q4	1.3 days	5 days	Work													1.3d					
	Account Manager	*0.05 days*		Work													0.05d					
	Analysts	*0.5 days*		Work													0.5d					
	Administrative Coordinator	*0.75 days*		Work													0.75d					
46	**Create quarterly policy and appeal exception requests**	**5.2 days**	**202 days**	Work				1.3d			1.3d			1.3d			1.3d					
47	Policy and appeal exception report Q1	1.3 days	5 days	Work				1.3d														
	Account Manager	*0.05 days*		Work				0.05d														
	Analysts	*0.5 days*		Work				0.5d														
	Administrative Coordinator	*0.75 days*		Work				0.75d														
48	Policy and appeal exception report Q2	1.3 days	5 days	Work							1.3d											
	Account Manager	*0.05 days*		Work							0.05d											
	Analysts	*0.5 days*		Work							0.5d											
	Administrative Coordinator	*0.75 days*		Work							0.75d											
49	Policy and appeal exception report Q3	1.3 days	5 days	Work										1.3d								
	Account Manager	*0.05 days*		Work										0.05d								
	Analysts	*0.5 days*		Work										0.5d								
	Administrative Coordinator	*0.75 days*		Work										0.75d								
50	Policy and appeal exception report Q4	1.3 days	5 days	Work													1.3d					
	Account Manager	*0.05 days*		Work													0.05d					

ID	Task Name	Work	Duration	Details	Qtr 2, 2010			Qtr 3, 2010			Qtr 4, 2010			Qtr 1, 2011			Qtr 2, 2011			Qtr 3, 2011		
					Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	Analysts	*0.5 days*		Work													0.5d					
	Administrative Coordinator	*0.75 days*		Work													0.75d					
51	**RetroDUR**	**589.63 days**	**262 days**	Work				50.39d	50.39d	49.71d	47.05d	49.29d	51.53d	49.29d	44.81d	51.53d	47.05d	49.29d	49.29d			
52	Professional staff management	13.1 days	262 days	Work				1.1d	1.1d	1.1d	1.05d	1.1d	1.15d	1.1d	1d	1.15d	1.05d	1.1d	1.1d			
	Clinical Pharmacy Mgr/DUR Dir	*13.1 days*		Work				1.1d	1.1d	1.1d	1.05d	1.1d	1.15d	1.1d	1d	1.15d	1.05d	1.1d	1.1d			
53	**P&T Meeting coordination (6 per year)**	**254.14 days**	**262 days**	Work				21.34d	21.34d	21.34d	20.37d	21.34d	22.31d	21.34d	19.4d	22.31d	20.37d	21.34d	21.34d			
54	Prepare meeting materials and related packets	78.6 days	262 days	Work				6.6d	6.6d	6.6d	6.3d	6.6d	6.9d	6.6d	6d	6.9d	6.3d	6.6d	6.6d			
	Clinical Pharmacy Mgr/DUR Dir	*26.2 days*		Work				2.2d	2.2d	2.2d	2.1d	2.2d	2.3d	2.2d	2d	2.3d	2.1d	2.2d	2.2d			
	Administrative Coordinator	*52.4 days*		Work				4.4d	4.4d	4.4d	4.2d	4.4d	4.6d	4.4d	4d	4.6d	4.2d	4.4d	4.4d			
55	Meeting facilitation	26.2 days	262 days	Work				2.2d	2.2d	2.2d	2.1d	2.2d	2.3d	2.2d	2d	2.3d	2.1d	2.2d	2.2d			
	Clinical Pharmacy Mgr/DUR Dir	*13.1 days*		Work				1.1d	1.1d	1.1d	1.05d	1.1d	1.15d	1.1d	1d	1.15d	1.05d	1.1d	1.1d			
	Administrative Assistants	*13.1 days*		Work				1.1d	1.1d	1.1d	1.05d	1.1d	1.15d	1.1d	1d	1.15d	1.05d	1.1d	1.1d			
56	Website maintenance and updates	47.16 days	262 days	Work				3.96d	3.96d	3.96d	3.78d	3.96d	4.14d	3.96d	3.6d	4.14d	3.78d	3.96d	3.96d			
	Database Architects	*2.62 days*		Work				0.22d	0.22d	0.22d	0.21d	0.22d	0.23d	0.22d	0.2d	0.23d	0.21d	0.22d	0.22d			
	Data Warehouse	*13.1 days*		Work				1.1d	1.1d	1.1d	1.05d	1.1d	1.15d	1.1d	1d	1.15d	1.05d	1.1d	1.1d			
	DEV	*13.1 days*		Work				1.1d	1.1d	1.1d	1.05d	1.1d	1.15d	1.1d	1d	1.15d	1.05d	1.1d	1.1d			
	Network	*13.1 days*		Work				1.1d	1.1d	1.1d	1.05d	1.1d	1.15d	1.1d	1d	1.15d	1.05d	1.1d	1.1d			
	Pick Programmer	*5.24 days*		Work				0.44d	0.44d	0.44d	0.42d	0.44d	0.46d	0.44d	0.4d	0.46d	0.42d	0.44d	0.44d			
57	Initiative presentations	7.86 days	262 days	Work				0.66d	0.66d	0.66d	0.63d	0.66d	0.69d	0.66d	0.6d	0.69d	0.63d	0.66d	0.66d			
	Clinical Pharmacy Mgr/DUR Dir	*5.24 days*		Work				0.44d	0.44d	0.44d	0.42d	0.44d	0.46d	0.44d	0.4d	0.46d	0.42d	0.44d	0.44d			
	Physician	*2.62 days*		Work				0.22d	0.22d	0.22d	0.21d	0.22d	0.23d	0.22d	0.2d	0.23d	0.21d	0.22d	0.22d			
58	Generate profiles based on selection criteria (6 times per year)	44.54 days	262 days	Work				3.74d	3.74d	3.74d	3.57d	3.74d	3.91d	3.74d	3.4d	3.91d	3.57d	3.74d	3.74d			
	Clinical Pharmacy Mgr/DUR Dir	*13.1 days*		Work				1.1d	1.1d	1.1d	1.05d	1.1d	1.15d	1.1d	1d	1.15d	1.05d	1.1d	1.1d			
	DUR Coordinator	*13.1 days*		Work				1.1d	1.1d	1.1d	1.05d	1.1d	1.15d	1.1d	1d	1.15d	1.05d	1.1d	1.1d			
	Administrative Assistants	*13.1 days*		Work				1.1d	1.1d	1.1d	1.05d	1.1d	1.15d	1.1d	1d	1.15d	1.05d	1.1d	1.1d			
	Analysts	*5.24 days*		Work				0.44d	0.44d	0.44d	0.42d	0.44d	0.46d	0.44d	0.4d	0.46d	0.42d	0.44d	0.44d			
59	Letter generation resulting from patient-focused profile reviews	44.54 days	262 days	Work				3.74d	3.74d	3.74d	3.57d	3.74d	3.91d	3.74d	3.4d	3.91d	3.57d	3.74d	3.74d			
	Clinical Pharmacy Mgr/DUR Dir	*13.1 days*		Work				1.1d	1.1d	1.1d	1.05d	1.1d	1.15d	1.1d	1d	1.15d	1.05d	1.1d	1.1d			
	DUR Coordinator	*13.1 days*		Work				1.1d	1.1d	1.1d	1.05d	1.1d	1.15d	1.1d	1d	1.15d	1.05d	1.1d	1.1d			
	Administrative Assistants	*13.1 days*		Work				1.1d	1.1d	1.1d	1.05d	1.1d	1.15d	1.1d	1d	1.15d	1.05d	1.1d	1.1d			
	Analysts	*5.24 days*		Work				0.44d	0.44d	0.44d	0.42d	0.44d	0.46d	0.44d	0.4d	0.46d	0.42d	0.44d	0.44d			
60	Provide the Department written reports of the DUR commission's recommendations	5.24 days	262 days	Work				0.44d	0.44d	0.44d	0.42d	0.44d	0.46d	0.44d	0.4d	0.46d	0.42d	0.44d	0.44d			
	Clinical Pharmacy Mgr/DUR Dir	*2.62 days*		Work				0.22d	0.22d	0.22d	0.21d	0.22d	0.23d	0.22d	0.2d	0.23d	0.21d	0.22d	0.22d			
	Administrative Assistants	*2.62 days*		Work				0.22d	0.22d	0.22d	0.21d	0.22d	0.23d	0.22d	0.2d	0.23d	0.21d	0.22d	0.22d			
61	External / Internal communication coordination with professional associations	28.82 days	262 days	Work				3.3d	3.3d	2.62d	2.1d	2.2d	2.3d	2.2d	2d	2.3d	2.1d	2.2d	2.2d			
	Clinical Pharmacy Mgr/DUR Dir	*2.62 days*		Work				1.1d	1.1d	0.42d												
	DUR Coordinator	*26.2 days*		Work				2.2d	2.2d	2.2d	2.1d	2.2d	2.3d	2.2d	2d	2.3d	2.1d	2.2d	2.2d			
62	Monthly report creation and review	42.05 days	262 days	Work				3.53d	3.53d	3.53d	3.37d	3.53d	3.69d	3.53d	3.21d	3.69d	3.37d	3.53d	3.53d			
	Account Manager	*0.13 days*		Work				0.01d	0.01d	0.01d	0.01d	0.01d	0.01d	0.01d	0.01d	0.01d	0.01d	0.01d	0.01d			
	Clinical Pharmacy Mgr/DUR Dir	*13.1 days*		Work				1.1d	1.1d	1.1d	1.05d	1.1d	1.15d	1.1d	1d	1.15d	1.05d	1.1d	1.1d			
	DUR Coordinator	*26.2 days*		Work				2.2d	2.2d	2.2d	2.1d	2.2d	2.3d	2.2d	2d	2.3d	2.1d	2.2d	2.2d			
	Analysts	*2.62 days*		Work				0.22d	0.22d	0.22d	0.21d	0.22d	0.23d	0.22d	0.2d	0.23d	0.21d	0.22d	0.22d			
63	Annual report creation and review (90d before fiscal end)	41.92 days	262 days	Work				3.52d	3.52d	3.52d	3.36d	3.52d	3.68d	3.52d	3.2d	3.68d	3.36d	3.52d	3.52d			
	Clinical Pharmacy Mgr/DUR Dir	*13.1 days*		Work				1.1d	1.1d	1.1d	1.05d	1.1d	1.15d	1.1d	1d	1.15d	1.05d	1.1d	1.1d			
	DUR Coordinator	*26.2 days*		Work				2.2d	2.2d	2.2d	2.1d	2.2d	2.3d	2.2d	2d	2.3d	2.1d	2.2d	2.2d			
	Analysts	*2.62 days*		Work				0.22d	0.22d	0.22d	0.21d	0.22d	0.23d	0.22d	0.2d	0.23d	0.21d	0.22d	0.22d			
64	Maintain data warehouse and access to data	41.92 days	262 days	Work				3.52d	3.52d	3.52d	3.36d	3.52d	3.68d	3.52d	3.2d	3.68d	3.36d	3.52d	3.52d			
	Clinical Pharmacy Mgr/DUR Dir	*13.1 days*		Work				1.1d	1.1d	1.1d	1.05d	1.1d	1.15d	1.1d	1d	1.15d	1.05d	1.1d	1.1d			
	DUR Coordinator	*26.2 days*		Work				2.2d	2.2d	2.2d	2.1d	2.2d	2.3d	2.2d	2d	2.3d	2.1d	2.2d	2.2d			
	Analysts	*2.62 days*		Work				0.22d	0.22d	0.22d	0.21d	0.22d	0.23d	0.22d	0.2d	0.23d	0.21d	0.22d	0.22d			
65	Research and data analytic support	41.92 days	262 days	Work				3.52d	3.52d	3.52d	3.36d	3.52d	3.68d	3.52d	3.2d	3.68d	3.36d	3.52d	3.52d			
	Clinical Pharmacy Mgr/DUR Dir	*13.1 days*		Work				1.1d	1.1d	1.1d	1.05d	1.1d	1.15d	1.1d	1d	1.15d	1.05d	1.1d	1.1d			
	DUR Coordinator	*26.2 days*		Work				2.2d	2.2d	2.2d	2.1d	2.2d	2.3d	2.2d	2d	2.3d	2.1d	2.2d	2.2d			
	Analysts	*2.62 days*		Work				0.22d	0.22d	0.22d	0.21d	0.22d	0.23d	0.22d	0.2d	0.23d	0.21d	0.22d	0.22d			
66	Manage patient-specific profile generation and related selection parameters	41.92 days	262 days	Work				3.52d	3.52d	3.52d	3.36d	3.52d	3.68d	3.52d	3.2d	3.68d	3.36d	3.52d	3.52d			
	Clinical Pharmacy Mgr/DUR Dir	*13.1 days*		Work				1.1d	1.1d	1.1d	1.05d	1.1d	1.15d	1.1d	1d	1.15d	1.05d	1.1d	1.1d			
	DUR Coordinator	*26.2 days*		Work				2.2d	2.2d	2.2d	2.1d	2.2d	2.3d	2.2d	2d	2.3d	2.1d	2.2d	2.2d			
	Analysts	*2.62 days*		Work				0.22d	0.22d	0.22d	0.21d	0.22d	0.23d	0.22d	0.2d	0.23d	0.21d	0.22d	0.22d			
67	Create prevalence reports (6 times per year)	41.92 days	262 days	Work				3.52d	3.52d	3.52d	3.36d	3.52d	3.68d	3.52d	3.2d	3.68d	3.36d	3.52d	3.52d			
	Clinical Pharmacy Mgr/DUR Dir	*13.1 days*		Work				1.1d	1.1d	1.1d	1.05d	1.1d	1.15d	1.1d	1d	1.15d	1.05d	1.1d	1.1d			
	DUR Coordinator	*26.2 days*		Work				2.2d	2.2d	2.2d	2.1d	2.2d	2.3d	2.2d	2d	2.3d	2.1d	2.2d	2.2d			
	Analysts	*2.62 days*		Work				0.22d	0.22d	0.22d	0.21d	0.22d	0.23d	0.22d	0.2d	0.23d	0.21d	0.22d	0.22d			
68	Produce post and distribute newsletter (3 time per year min)	41.92 days	262 days	Work				3.52d	3.52d	3.52d	3.36d	3.52d	3.68d	3.52d	3.2d	3.68d	3.36d	3.52d	3.52d			
	Clinical Pharmacy Mgr/DUR Dir	*13.1 days*		Work				1.1d	1.1d	1.1d	1.05d	1.1d	1.15d	1.1d	1d	1.15d	1.05d	1.1d	1.1d			
	DUR Coordinator	*26.2 days*		Work				2.2d	2.2d	2.2d	2.1d	2.2d	2.3d	2.2d	2d	2.3d	2.1d	2.2d	2.2d			
	Analysts	*2.62 days*		Work				0.22d	0.22d	0.22d	0.21d	0.22d	0.23d	0.22d	0.2d	0.23d	0.21d	0.22d	0.22d			
69	**Preferred Drug List (PDL) & Supplemental Rebate (SR)**	**969.4 days**	**262 days**	Work				81.4d	81.4d	81.4d	77.7d	81.4d	85.1d	81.4d	74d	85.1d	77.7d	81.4d	81.4d			
70	Review current PDL with the Department and discuss any potential changes or recommendations	41.92 days	262 days	Work				3.52d	3.52d	3.52d	3.36d	3.52d	3.68d	3.52d	3.2d	3.68d	3.36d	3.52d	3.52d			

ID	Task Name	Work	Duration	Details	Qtr 2, 2010			Qtr 3, 2010			Qtr 4, 2010			Qtr 1, 2011			Qtr 2, 2011			Qtr 3, 2011		
					Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	Account Manager	*2.62 days*		Work				0.22d	0.22d	0.22d	0.21d	0.22d	0.23d	0.22d	0.2d	0.23d	0.21d	0.22d	0.22d			
	Clinical Pharmacy Mgr/DUR Dir	*13.1 days*		Work				1.1d	1.1d	1.1d	1.05d	1.1d	1.15d	1.1d	1d	1.15d	1.05d	1.1d	1.1d			
	Pharmacist	*13.1 days*		Work				1.1d	1.1d	1.1d	1.05d	1.1d	1.15d	1.1d	1d	1.15d	1.05d	1.1d	1.1d			
	Administrative Coordinator	*13.1 days*		Work				1.1d	1.1d	1.1d	1.05d	1.1d	1.15d	1.1d	1d	1.15d	1.05d	1.1d	1.1d			
71	Incorporation therapeutic reviews for P&T committee meetings (drug monographs, SR data and savings by therapeutic class)	39.3 days	262 days	Work				3.3d	3.3d	3.3d	3.15d	3.3d	3.45d	3.3d	3d	3.45d	3.15d	3.3d	3.3d			
	Clinical Pharmacy Mgr/DUR Dir	*13.1 days*		Work				1.1d	1.1d	1.1d	1.05d	1.1d	1.15d	1.1d	1d	1.15d	1.05d	1.1d	1.1d			
	Pharmacist	*13.1 days*		Work				1.1d	1.1d	1.1d	1.05d	1.1d	1.15d	1.1d	1d	1.15d	1.05d	1.1d	1.1d			
	Administrative Coordinator	*13.1 days*		Work				1.1d	1.1d	1.1d	1.05d	1.1d	1.15d	1.1d	1d	1.15d	1.05d	1.1d	1.1d			
72	Maintain existing PDL program provisions	39.3 days	262 days	Work				3.3d	3.3d	3.3d	3.15d	3.3d	3.45d	3.3d	3d	3.45d	3.15d	3.3d	3.3d			
	Clinical Pharmacy Mgr/DUR Dir	*13.1 days*		Work				1.1d	1.1d	1.1d	1.05d	1.1d	1.15d	1.1d	1d	1.15d	1.05d	1.1d	1.1d			
	Pharmacist	*13.1 days*		Work				1.1d	1.1d	1.1d	1.05d	1.1d	1.15d	1.1d	1d	1.15d	1.05d	1.1d	1.1d			
	Administrative Coordinator	*13.1 days*		Work				1.1d	1.1d	1.1d	1.05d	1.1d	1.15d	1.1d	1d	1.15d	1.05d	1.1d	1.1d			
73	PDL management and activity coordination	41.92 days	262 days	Work				3.52d	3.52d	3.52d	3.36d	3.52d	3.68d	3.52d	3.2d	3.68d	3.36d	3.52d	3.52d			
	Account Manager	*2.62 days*		Work				0.22d	0.22d	0.22d	0.21d	0.22d	0.23d	0.22d	0.2d	0.23d	0.21d	0.22d	0.22d			
	Clinical Pharmacy Mgr/DUR Dir	*13.1 days*		Work				1.1d	1.1d	1.1d	1.05d	1.1d	1.15d	1.1d	1d	1.15d	1.05d	1.1d	1.1d			
	Pharmacist	*13.1 days*		Work				1.1d	1.1d	1.1d	1.05d	1.1d	1.15d	1.1d	1d	1.15d	1.05d	1.1d	1.1d			
	Administrative Coordinator	*13.1 days*		Work				1.1d	1.1d	1.1d	1.05d	1.1d	1.15d	1.1d	1d	1.15d	1.05d	1.1d	1.1d			
74	Conduct ongoing analysis and clinical reviews of Iowa Medicaid pharmacy claims (once per year min)	39.3 days	262 days	Work				3.3d	3.3d	3.3d	3.15d	3.3d	3.45d	3.3d	3d	3.45d	3.15d	3.3d	3.3d			
	Clinical Pharmacy Mgr/DUR Dir	*13.1 days*		Work				1.1d	1.1d	1.1d	1.05d	1.1d	1.15d	1.1d	1d	1.15d	1.05d	1.1d	1.1d			
	Pharmacist	*13.1 days*		Work				1.1d	1.1d	1.1d	1.05d	1.1d	1.15d	1.1d	1d	1.15d	1.05d	1.1d	1.1d			
	Administrative Coordinator	*13.1 days*		Work				1.1d	1.1d	1.1d	1.05d	1.1d	1.15d	1.1d	1d	1.15d	1.05d	1.1d	1.1d			
75	Communicate with providers and other interested parties	39.3 days	262 days	Work				3.3d	3.3d	3.3d	3.15d	3.3d	3.45d	3.3d	3d	3.45d	3.15d	3.3d	3.3d			
	Clinical Pharmacy Mgr/DUR Dir	*13.1 days*		Work				1.1d	1.1d	1.1d	1.05d	1.1d	1.15d	1.1d	1d	1.15d	1.05d	1.1d	1.1d			
	Pharmacist	*13.1 days*		Work				1.1d	1.1d	1.1d	1.05d	1.1d	1.15d	1.1d	1d	1.15d	1.05d	1.1d	1.1d			
	Administrative Coordinator	*13.1 days*		Work				1.1d	1.1d	1.1d	1.05d	1.1d	1.15d	1.1d	1d	1.15d	1.05d	1.1d	1.1d			
76	Support manufacturers regarding PDL questions and concerns	39.3 days	262 days	Work				3.3d	3.3d	3.3d	3.15d	3.3d	3.45d	3.3d	3d	3.45d	3.15d	3.3d	3.3d			
	Clinical Pharmacy Mgr/DUR Dir	*13.1 days*		Work				1.1d	1.1d	1.1d	1.05d	1.1d	1.15d	1.1d	1d	1.15d	1.05d	1.1d	1.1d			
	Pharmacist	*13.1 days*		Work				1.1d	1.1d	1.1d	1.05d	1.1d	1.15d	1.1d	1d	1.15d	1.05d	1.1d	1.1d			
	Administrative Coordinator	*13.1 days*		Work				1.1d	1.1d	1.1d	1.05d	1.1d	1.15d	1.1d	1d	1.15d	1.05d	1.1d	1.1d			
77	Host and maintain public website and document repository	39.3 days	262 days	Work				3.3d	3.3d	3.3d	3.15d	3.3d	3.45d	3.3d	3d	3.45d	3.15d	3.3d	3.3d			
	Clinical Pharmacy Mgr/DUR Dir	*13.1 days*		Work				1.1d	1.1d	1.1d	1.05d	1.1d	1.15d	1.1d	1d	1.15d	1.05d	1.1d	1.1d			
	Pharmacist	*13.1 days*		Work				1.1d	1.1d	1.1d	1.05d	1.1d	1.15d	1.1d	1d	1.15d	1.05d	1.1d	1.1d			
	Administrative Coordinator	*13.1 days*		Work				1.1d	1.1d	1.1d	1.05d	1.1d	1.15d	1.1d	1d	1.15d	1.05d	1.1d	1.1d			
78	Provide administrative support to the P&T committee	39.3 days	262 days	Work				3.3d	3.3d	3.3d	3.15d	3.3d	3.45d	3.3d	3d	3.45d	3.15d	3.3d	3.3d			
	Clinical Pharmacy Mgr/DUR Dir	*13.1 days*		Work				1.1d	1.1d	1.1d	1.05d	1.1d	1.15d	1.1d	1d	1.15d	1.05d	1.1d	1.1d			
	Pharmacist	*13.1 days*		Work				1.1d	1.1d	1.1d	1.05d	1.1d	1.15d	1.1d	1d	1.15d	1.05d	1.1d	1.1d			
	Administrative Coordinator	*13.1 days*		Work				1.1d	1.1d	1.1d	1.05d	1.1d	1.15d	1.1d	1d	1.15d	1.05d	1.1d	1.1d			
79	**Supplemental Drug Rebate Services**	**610.46 days**	**262 days**	Work				51.26d	51.26d	51.26d	48.93d	51.26d	53.59d	51.26d	46.6d	53.59d	48.93d	51.26d	51.26d			
80	Provide assistance to the Department during analysis and negotiation (as needed)	94.32 days	262 days	Work				7.92d	7.92d	7.92d	7.56d	7.92d	8.28d	7.92d	7.2d	8.28d	7.56d	7.92d	7.92d			
	Clinical Pharmacy Mgr/DUR Dir	*13.1 days*		Work				1.1d	1.1d	1.1d	1.05d	1.1d	1.15d	1.1d	1d	1.15d	1.05d	1.1d	1.1d			
	Physician	*2.62 days*		Work				0.22d	0.22d	0.22d	0.21d	0.22d	0.23d	0.22d	0.2d	0.23d	0.21d	0.22d	0.22d			
	Analysts	*13.1 days*		Work				1.1d	1.1d	1.1d	1.05d	1.1d	1.15d	1.1d	1d	1.15d	1.05d	1.1d	1.1d			
	Supplemental rebates	*65.5 days*		Work				5.5d	5.5d	5.5d	5.25d	5.5d	5.75d	5.5d	5d	5.75d	5.25d	5.5d	5.5d			
81	Facilitate SR communications with Department and manufacturers	65.5 days	262 days	Work				5.5d	5.5d	5.5d	5.25d	5.5d	5.75d	5.5d	5d	5.75d	5.25d	5.5d	5.5d			
	Clinical Pharmacy Mgr/DUR Dir	*7.86 days*		Work				0.66d	0.66d	0.66d	0.63d	0.66d	0.69d	0.66d	0.6d	0.69d	0.63d	0.66d	0.66d			
	Physician	*2.62 days*		Work				0.22d	0.22d	0.22d	0.21d	0.22d	0.23d	0.22d	0.2d	0.23d	0.21d	0.22d	0.22d			
	Analysts	*2.62 days*		Work				0.22d	0.22d	0.22d	0.21d	0.22d	0.23d	0.22d	0.2d	0.23d	0.21d	0.22d	0.22d			
	Supplemental rebates	*52.4 days*		Work				4.4d	4.4d	4.4d	4.2d	4.4d	4.6d	4.4d	4d	4.6d	4.2d	4.4d	4.4d			
82	Manage SR contracts and related processes	65.5 days	262 days	Work				5.5d	5.5d	5.5d	5.25d	5.5d	5.75d	5.5d	5d	5.75d	5.25d	5.5d	5.5d			
	Clinical Pharmacy Mgr/DUR Dir	*7.86 days*		Work				0.66d	0.66d	0.66d	0.63d	0.66d	0.69d	0.66d	0.6d	0.69d	0.63d	0.66d	0.66d			
	Physician	*2.62 days*		Work				0.22d	0.22d	0.22d	0.21d	0.22d	0.23d	0.22d	0.2d	0.23d	0.21d	0.22d	0.22d			
	Analysts	*2.62 days*		Work				0.22d	0.22d	0.22d	0.21d	0.22d	0.23d	0.22d	0.2d	0.23d	0.21d	0.22d	0.22d			
	Supplemental rebates	*52.4 days*		Work				4.4d	4.4d	4.4d	4.2d	4.4d	4.6d	4.4d	4d	4.6d	4.2d	4.4d	4.4d			
83	Provider SR rebate billing data quarterly	65.5 days	262 days	Work				5.5d	5.5d	5.5d	5.25d	5.5d	5.75d	5.5d	5d	5.75d	5.25d	5.5d	5.5d			
	Clinical Pharmacy Mgr/DUR Dir	*7.86 days*		Work				0.66d	0.66d	0.66d	0.63d	0.66d	0.69d	0.66d	0.6d	0.69d	0.63d	0.66d	0.66d			
	Physician	*2.62 days*		Work				0.22d	0.22d	0.22d	0.21d	0.22d	0.23d	0.22d	0.2d	0.23d	0.21d	0.22d	0.22d			
	Analysts	*2.62 days*		Work				0.22d	0.22d	0.22d	0.21d	0.22d	0.23d	0.22d	0.2d	0.23d	0.21d	0.22d	0.22d			
	Supplemental rebates	*52.4 days*		Work				4.4d	4.4d	4.4d	4.2d	4.4d	4.6d	4.4d	4d	4.6d	4.2d	4.4d	4.4d			
84	Prepare negotiate SR rates for review by the Department	65.5 days	262 days	Work				5.5d	5.5d	5.5d	5.25d	5.5d	5.75d	5.5d	5d	5.75d	5.25d	5.5d	5.5d			
	Clinical Pharmacy Mgr/DUR Dir	*7.86 days*		Work				0.66d	0.66d	0.66d	0.63d	0.66d	0.69d	0.66d	0.6d	0.69d	0.63d	0.66d	0.66d			
	Physician	*2.62 days*		Work				0.22d	0.22d	0.22d	0.21d	0.22d	0.23d	0.22d	0.2d	0.23d	0.21d	0.22d	0.22d			
	Analysts	*2.62 days*		Work				0.22d	0.22d	0.22d	0.21d	0.22d	0.23d	0.22d	0.2d	0.23d	0.21d	0.22d	0.22d			
	Supplemental rebates	*52.4 days*		Work				4.4d	4.4d	4.4d	4.2d	4.4d	4.6d	4.4d	4d	4.6d	4.2d	4.4d	4.4d			
85	Prepare SR monitoring / controlling reports	65.5 days	262 days	Work				5.5d	5.5d	5.5d	5.25d	5.5d	5.75d	5.5d	5d	5.75d	5.25d	5.5d	5.5d			
	Clinical Pharmacy Mgr/DUR Dir	*7.86 days*		Work				0.66d	0.66d	0.66d	0.63d	0.66d	0.69d	0.66d	0.6d	0.69d	0.63d	0.66d	0.66d			
	Physician	*2.62 days*		Work				0.22d	0.22d	0.22d	0.21d	0.22d	0.23d	0.22d	0.2d	0.23d	0.21d	0.22d	0.22d			
	Analysts	*2.62 days*		Work				0.22d	0.22d	0.22d	0.21d	0.22d	0.23d	0.22d	0.2d	0.23d	0.21d	0.22d	0.22d			
	Supplemental rebates	*52.4 days*		Work				4.4d	4.4d	4.4d	4.2d	4.4d	4.6d	4.4d	4d	4.6d	4.2d	4.4d	4.4d			
86	Analytic and reporting SR support	65.5 days	262 days	Work				5.5d	5.5d	5.5d	5.25d	5.5d	5.75d	5.5d	5d	5.75d	5.25d	5.5d	5.5d			
	Clinical Pharmacy Mgr/DUR Dir	*7.86 days*		Work				0.66d	0.66d	0.66d	0.63d	0.66d	0.69d	0.66d	0.6d	0.69d	0.63d	0.66d	0.66d			

IME Pharmacy Medical Services Work and Task Estimates Rev 4

ID	Task Name	Work	Duration	Details	Qtr 2, 2010			Qtr 3, 2010			Qtr 4, 2010			Qtr 1, 2011			Qtr 2, 2011			Qtr 3, 2011		
					Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	Physician	*2.62 days*		Work				0.22d	0.22d	0.22d	0.21d	0.22d	0.23d	0.22d	0.2d	0.23d	0.21d	0.22d	0.22d			
	Analysts	*2.62 days*		Work				0.22d	0.22d	0.22d	0.21d	0.22d	0.23d	0.22d	0.2d	0.23d	0.21d	0.22d	0.22d			
	Supplemental rebates	*52.4 days*		Work				4.4d	4.4d	4.4d	4.2d	4.4d	4.6d	4.4d	4d	4.6d	4.2d	4.4d	4.4d			
87	Provide education and outreach and communication strategy assistance (as needed)	68.12 days	262 days	Work				5.72d	5.72d	5.72d	5.46d	5.72d	5.98d	5.72d	5.2d	5.98d	5.46d	5.72d	5.72d			
	Clinical Pharmacy Mgr/DUR Dir	*13.1 days*		Work				1.1d	1.1d	1.1d	1.05d	1.1d	1.15d	1.1d	1d	1.15d	1.05d	1.1d	1.1d			
	Physician	*2.62 days*		Work				0.22d	0.22d	0.22d	0.21d	0.22d	0.23d	0.22d	0.2d	0.23d	0.21d	0.22d	0.22d			
	Analysts	*13.1 days*		Work				1.1d	1.1d	1.1d	1.05d	1.1d	1.15d	1.1d	1d	1.15d	1.05d	1.1d	1.1d			
	Supplemental rebates	*39.3 days*		Work				3.3d	3.3d	3.3d	3.15d	3.3d	3.45d	3.3d	3d	3.45d	3.15d	3.3d	3.3d			
88	Discuss / refine existing Department-approved procedure for communicating system changes to all affected IME contractors	55.02 days	262 days	Work				4.62d	4.62d	4.62d	4.41d	4.62d	4.83d	4.62d	4.2d	4.83d	4.41d	4.62d	4.62d			
	Clinical Pharmacy Mgr/DUR Dir	*13.1 days*		Work				1.1d	1.1d	1.1d	1.05d	1.1d	1.15d	1.1d	1d	1.15d	1.05d	1.1d	1.1d			
	Physician	*2.62 days*		Work				0.22d	0.22d	0.22d	0.21d	0.22d	0.23d	0.22d	0.2d	0.23d	0.21d	0.22d	0.22d			
	Analysts	*13.1 days*		Work				1.1d	1.1d	1.1d	1.05d	1.1d	1.15d	1.1d	1d	1.15d	1.05d	1.1d	1.1d			
	Supplemental rebates	*26.2 days*		Work				2.2d	2.2d	2.2d	2.1d	2.2d	2.3d	2.2d	2d	2.3d	2.1d	2.2d	2.2d			

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Iowa Turnover Plan

Contract Termination Transition of Services

Version 1
11/30/2009

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Date	Version	Author(s)	Description	Approved By

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1 Introduction

Goold Health Systems will work with Iowa Medicaid Enterprise, Iowa's Department of Human Services to provide an orderly, complete, and controlled transition to another vendor. The purpose of this Turnover Plan is to document the:

- Data, documentation, reports, and other operational artifacts that will be transferred to IME and / or their subsequent pharmacy medical services vendor;
- Roles and responsibilities of all of all affected parties;
- Timeline for turnover; and
- Services which will be terminated by GHS after the termination date.

The Turnover Plan will be revised and delivered to IME as directed. The initial Plan will be a general, high-level outline of activities, and be refined as instructed by IME staff.

When a decision to terminate services with GHS is made by IME, this document will be supplied to IME, the subsequent services vendor, and any other affected parties. We understand that some revision may be required at that time. The Turnover Plan will serve as a basis for developing a project plan for new / transitioning services.

2 Scheduling and Timeline

All activities will be scheduled assuming a 6-month transition timeframe.

A detailed project plan will be included in the last year of the GHS contract.

3 Delivery Method

A 'secure file transfer' method will be established with the subsequent vendor. Transfer of files and documents will be limited to a number of acceptable methods – sftp, dvd, and portable hard drive.

4 Resources and Responsibilities

4.1 GHS

At the time of transition, GHS will update the turnover plan to provide named staff members to serve in the following roles:

- Account Manager
- Transition Project Manager
- Clinical Pharmacy Services Manager

Other members of GHS's technical and administrative teams will also play roles in the contract transition. These team members include programmers, data warehouse, and other SMEs.

Presently, high-level responsibilities of GHS will include:

- Supply all items outlined in the Deliverables section of this plan
- Terminate all services outlined in the RFP, contract, and any additional amendments agreed upon during the contract duration.
- Provide IME and subsequent vendor with a project plan for the transition.
- Prepare a Transition Risk and Risk Mitigation Strategy document

4.2 IME

GHS understands that IME will coordinate the appropriate resources from the subsequent vendor and from within IME to facilitate transition. We anticipate that IME / Subsequent vendor will provide named staff in the following roles

- Vendor Account Manager
- Project Manager

Resources required of IME and the subsequent vendor include, but are not limited to:

- Data center space sufficient to store and process historic data and electronic file supplied by GHS.
- Secure transfer method for electronic data.
- Technical and administrative support contracts

5 Deliverables

Within the scope of performing Pharmacy Medical Services for IME, GHS is responsible for the creation and / or maintenance of the following deliverables, which will be transferred to the IME or their designee.

5.1 Business Rules

GHS will work with IME to explain GHS' **Iowa-specific Business Rules** to the subsequent vendor.

5.2 Pharmacy Prior Authorization (PA)

GHS will provide electronic copies of all member specific prior authorization claims history. In addition GHS will supply copies of all PA forms including criteria for each drug class where PA's are utilized. GHS will also provide the PA fax number to the subsequent vendor so no disruption in services will occur. All historical reports, manuals and other training materials developed by GHS in support of the PA process will also be provided. .

5.3 RetroDUR

GHS will provide IME with copies all materials utilized for RetroDUR activities. This includes the website domain name, presentations materials, all member/provider profiles, letters generated on behalf of IME copies of reports to support RetroDUR activities and the newsletter template.

5.4 Preferred Drug List (PDL) and Supplemental Rebate (SR)

GHS will provide an electronic copy of the most current Iowa PDL, GHS will provide copies of all drug monographs used for PDL activities, transfer of the domain name for the PDL website that would include the document repository. All Supplemental Rebate contracts would be turned over to the IME as well as copies of all SR reports.

5.5 Operational Documentation

GHS will transfer documentation providing details of operational procedures specific to the IME Pharmacy Medical Services scope of work, such as Standard Operating Procedures (SOPs).

Other documentation may be transferred as identified during the turnover phase.
Artifacts and specific details will be provided to the IME during the turnover phase.

5.6 Reports

GHS will also transfer to IME an archive of all scheduled external production reports produced during the duration of the contract agreement.

5.7 Paper Files

GHS will transition all paper files to the next vendor. An inventory of the files will be provided. GHS will discuss with IME the option of scanning and imaging the files after GHS has performed a full inventory and analysis of the existing documentation.

Transfer of the paper files will be the responsibility of GHS and will be coordinated with the subsequent vendor.

5.8 Archived Historic Data

GHS also maintains historic data sets to support Pharmacy Medical Services operations for IME. After contract termination, GHS will securely archive these data sets.

GHS will maintain these historic data in our data center until written confirmation is received from IME that GHS is to purge these records.

6 Data Record Layouts

GHS will work with the subsequent vendor to define and agree on industry standard layouts for data to be transitioned. Current layouts as of the publication of this document are attached in Attachments 1 and 2. Specific details of these layouts will be included in the final transition plan.

6.1 Data Feed Formats

GHS will provide all data to the subsequent vendor in a standard ASCII flat file. GHS will work with the subsequent vendor to define and agree on industry formats for data to be transmitted out of GHS's data center. Specific details of these layouts and delivery method will be included in the final transition plan.

7 Summary

Goold Health Systems presents this Turnover Plan in compliance with our RFP response to the IME Pharmacy Medical Services. GHS will update this document annually and will work with IME to transition all supporting documentation to a subsequent vendor should we be awarded a contract as the result of this RFP.

7.2.8 PROJECT ORGANIZATION

The proposed organization and staffing must meet the requirements of RFP Section 6.1.1 Staffing. Bidders respond to the project organization requirements for the Professional Services contractors supporting the IME in this section. This section of the proposal is the bidder's opportunity to describe the merits of its planned approach to the following topics:

- *7.2.8.1 Organization Charts*
- *7.2.8.2 Staffing*
- *7.2.8.3 Key Personnel*
- *7.2.8.4 Subcontractors*

7.2.8.1 ORGANIZATION CHARTS

For each phase of the project, the bidder will provide a narrative description of the proposed organization, roles and responsibilities of key personnel, and representative job descriptions for all positions within the organization for all phases of the contract. Bidders will include an organization chart of proposed key personnel and counts of fulltime equivalent (FTE) workers in each staff position in each organizational unit during each project phase.

Organization charts must identify the percentage of allocation of key personnel to the IME. Bidders may include separate charts for the transition phase to reflect staff loading in the individual tasks but must provide the FTE counts on each one for each organizational unit.

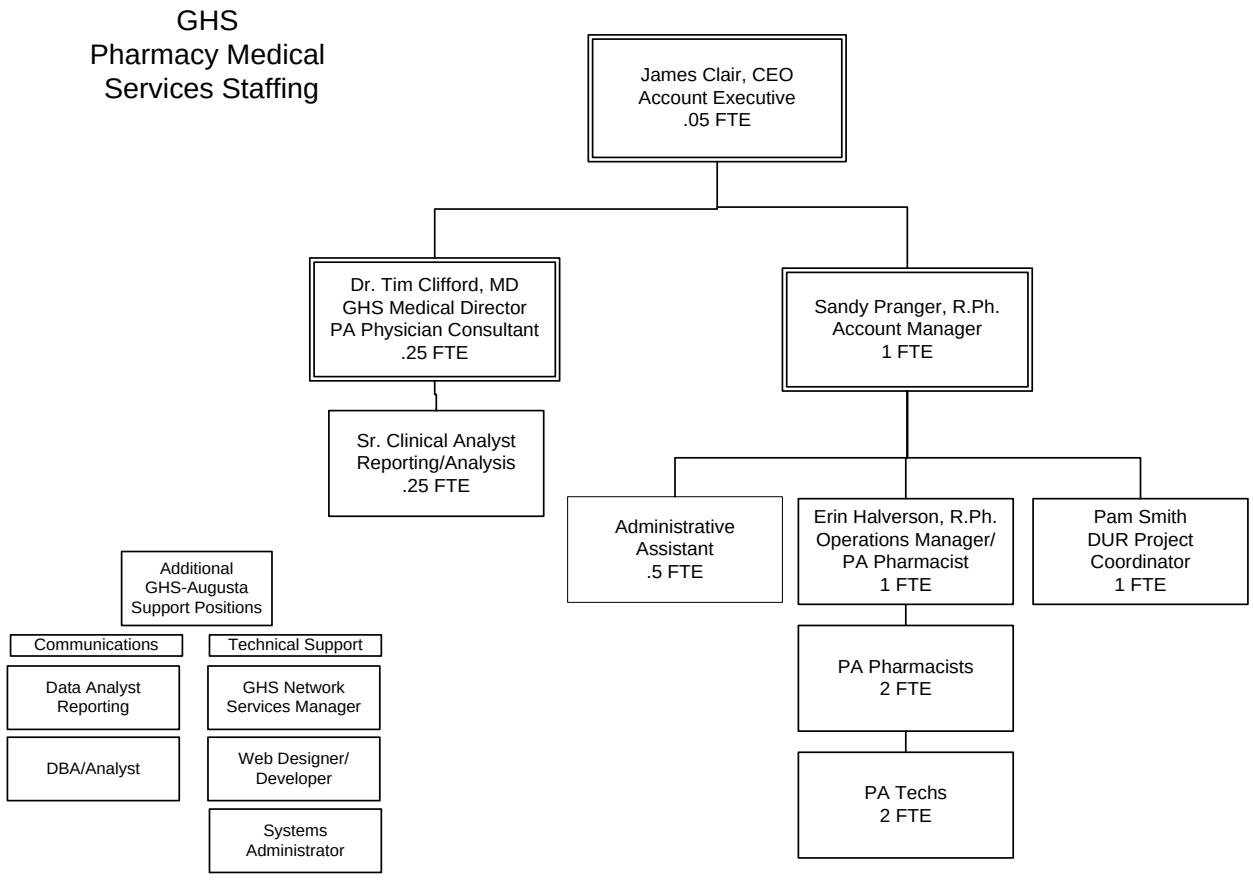


Figure 28: GHS Pharmacy Medical Services Organization Chart

The organization chart above reflects GHS current staffing for the Pharmacy Medical Services contract. This staffing configuration reflects both any transition period and the on-going operations under this contract. GHS is not proposing to make any changes to the staff currently in place. Currently, there are 7.5 FTE staff located at the IME facility and dedicated to providing the services contained in this bid proposal. GHS has some additional staff located at the Augusta, ME headquarters that also provide technical and analytical support to this project.

Further information on the named staff positions required in the RFP can be found in section 6.1.1 Staffing of this proposal. Detailed job descriptions for each of the Iowa Medicaid positions outlined above are included, below.

GOOLD HEALTH SYSTEMS JOB DESCRIPTION

POSITION: **Account Manager**
DEPARTMENT: **Iowa Medicaid Program**
FLSA STATUS: **Exempt**

General Description of Responsibilities
Serves as the primary point of contact for the GHS staff and coordinates communications between GHS, the Department and other IME vendors. Responsibilities also include development and maintenance of the Iowa Medicaid PDL as well as coordinating and attending the quarterly P&T Committee meetings. Additional responsibilities for this project include:

- Ensure contract compliance for the Iowa Pharmacy Medical Services account
- Present of reports and analyses to the P&T Committee
- Enforce business rules and policies, including timeline requirements
- Other responsibilities include:
    - Medicaid claims analysis,
    - Analyzing and forecasting drug trends,
    - Analyzing and summarizing data
    - Pharmacy benefit management,
    - Strategic planning, and
    - Report preparation.

Experience
Required: Three years of account management or major supervisory role for government or private sector healthcare payer or provider; bachelor's degree or equivalent relevant experience to the account manager position. Desired: Previous management experience with Medicaid and MMIS operations; knowledge of HIPAA rules and requirements

Education
Master’s Degree in Business Administration, Healthcare Delivery Systems, Computer Science, or related field or equivalent experience in lieu thereof.

GOOLD HEALTH SYSTEMS **JOB DESCRIPTION**

POSITION: **Operations Manager**
DEPARTMENT: **Iowa Medicaid Program**
FLSA STATUS: **Exempt**

General Description of Responsibilities
Responsibilities include supervising the Iowa Medicaid Enterprise Pharmacy Prior Authorization staff; ensuring all contract performance criteria are met; providing policy and technical assistance to the IME. Additionally responsible for updating the prior authorization criteria chart, prior authorization forms and Preferred Drug List (PDL) and maintaining the PDL website at www.iowamedicaidpdl.com. Responds to calls from clients, providers and technicians regarding the processing of prior authorizations or pharmacy claims, as well as oversight of the PA process, including enforcement of business rules and policies, including timeline requirements.

Experience
Minimum of four years experience managing a major component of a public or private health care claims processing operation in an environment similar in scope and volume to the Iowa Medicaid Program. Relevant experience includes claims management, eligibility, financial controls, utilization review, managed care enrollment and/or provider services.

Education
Bachelor's Degree in related field required or equivalent experience in lieu thereof.

GOOLD HEALTH SYSTEMS **JOB DESCRIPTION**

POSITION: **DUR Project Coordinator**
DEPARTMENT: **IME**
FLSA STATUS: **Salaried Non-Exempt**

General Description of Responsibilities
Serve as the primary point of contact for the Department, providers and other vendors for all DUR-related questions and issues. Responds in writing to questions submitted by providers regarding provider correspondence, communicating by telephone with providers to answer questions and address concerns and coordinating face-to-face interventions as determined necessary by the DUR commission. Coordinate and conduct the DUR commission meetings in cooperation with the chair and vice chair of the commission.

Experience
Minimum of two years experience in a pharmacy environment as a Licensed Pharmacist; excellent organizational skills and phone etiquette, ability to multi-task, and proven customer services skills. Minimum of one year of experience with Medicaid drug programs; pharmacy benefit management; generic, single source and multi-source drugs in all therapeutic categories;

clinical indications for drug therapies; contraindications of therapies, and indications of abuse, overuse, and medical necessity of therapies. Additionally, will have relevant experience in best drug therapy practices; trends in drug use and prescribing behaviors; and manufacturer and pharmacy practices.

Education
Licensed Registered Pharmacist in the State of Iowa or license eligible.

GOOLD HEALTH SYSTEMS **JOB DESCRIPTION**

POSITION: **Medical Director**
DEPARTMENT: **Data Services**
FLSA STATUS: **Exempt**

General Description of Responsibilities
Serves as the senior clinical director for GHS programs/contracts, oversees the processes for and makes final determinations as to the clinical appropriateness of all aspects of GHS' client services including PDL design, P & T Committee support, SR negotiation, individual case review, retro and pro-DUR criteria, State Maximum Allowable Cost determination, report design and PA criteria and decisions. Provides research and testimony for fair hearings and administrative appeals, assures that all clinical activities are guided by the State-specific needs while adhering to the highest standards of clinical and professional ethics. Directly negotiates with drug manufacturers to obtain supplemental rebates with skillful, experienced use of both clinical and fiscal information and attends and leads the annual SSDC drug rebate negotiations and meetings. Attends and presents for GHS or the State at the State P&T, DUR or other meetings, develops and maintains a working knowledge of the clinical and budgetary issues that are unique to every client state and provides subject matter support for clinical, coding and billing, drug file and other areas of technical/clinical expertise.

Experience
Must have 6 years of experience as a Medicaid Medical Director or similar with extensive experience in all aspects of Medicaid including technical, provider, member and policy issues, at least 15 years of active practice experience. Must have knowledge of pharmacy benefit management and SMAC price generation; generic, single source and multi-source drugs in all therapeutic categories; clinical indications for drug therapies; contraindications of therapies, and indications of abuse, overuse, and medical necessity of therapies, knowledge of analytic methods and relaying information via reports and relevant experience in best drug therapy practices; trends in drug use and prescribing behaviors; and manufacturer and pharmacy practices.

Education
MD or DO required. Must have active Board Certification in at least one field and active license to practice medicine.

GOOLD HEALTH SYSTEMS **JOB DESCRIPTION**

POSITION: **Prior Authorization Pharmacist**
DEPARTMENT: **IME**
FLSA STATUS: **Salaried Non-Exempt**

General Description of Responsibilities
Will be responsible for responding to calls from clients, providers; including physicians, pharmacists, and technicians regarding the processing of prior authorizations or pharmacy claims. Responsible for the PA process, including enforcement of business rules and policies, including timeline requirements. Must be able to adhere to schedule, as process is time sensitive. Ultimately responsible for all PA requests which includes utilizing the software package and manual interventions as necessary. Additionally, will be available as a resource for data processing personnel, responsible for general office duties, maintaining media libraries, equipment maintenance, creating mailings, and coordinating shipments with the mailroom as necessary. Other responsibilities as assigned.

Experience
Minimum of two years experience in a retail pharmacy environment as a Licensed Iowa Pharmacist; experience in an office environment, excellent organizational skills and phone etiquette; ability to multi-task, and proven customer services skills.

Education
Licensed Pharmacist in the State of Iowa.

GOOLD HEALTH SYSTEMS **JOB DESCRIPTION**

POSITION: **Prior Authorization Technician**
JOB TITLES SUPERVISED: **None**
FLSA STATUS: **Non-Exempt**

General Description of Responsibilities
Will be responsible for responding to calls from providers, including physicians, pharmacists, and technicians regarding the processing of prior authorizations or pharmacy claims. Responsible for processing PA requests which includes utilizing the software package and manual interventions as necessary. Must be able to adhere to schedule, as process is time sensitive. Must have a working knowledge of pharmaceutical drug names and be able to apply policies and business rules relative to this process. Additionally, will be responsible for general office duties, maintaining media libraries, equipment maintenance, creating mailings, and coordinating shipments with the mailroom. Other responsibilities as assigned.

Experience

Minimum of two years experience in a pharmacy environment as a pharmacy technician; experience in an office environment, excellent organizational skills and phone etiquette; ability to multi-task, and proven customer services skills.

Education
High school diploma or equivalent required; Pharmacy Technician coursework a plus; computer coursework a plus.

Additional support will be provided as needed by GHS' technical staff, located at GHS' main office in Augusta, ME. With the Pharmacy Medical Services project currently in place and operating, this support will be minimal to ensure the continued smooth, efficient operations of the GHS IME project. The support positions are highlighted below.

TECHNICAL SUPPORT STAFF
Technical staff consists of network services staff, website developers and systems administrators. GHS' Technical staff is available during regular business hours. A staff member is available 24/7 to troubleshoot GHS systems. The technical staff also supports development and upgrades. Development responsibilities include:

- Develop and Maintain websites and Graphic User Interfaces
- Modify / configure backend database rule sets
- Establish user authentication protocols
- Establish web interface and related links
- Work with network to provide full interface and data security

Network responsibilities include:

- Establish secure ftp process
- Create automated subroutines to drive file processes
- File transfer QC
- New version software updates
- Software patches
- Help resolve technical or programmatic issues
- Oversee policy and technical compliance

COMMUNICATIONS SUPPORT STAFF
The communications support staff consist of GHS' Senior Clinical Analyst, a Data Analyst to support reporting and Database Architects (DBA).

Senior Clinical Analyst
GHS Senior Clinical Analyst must be a clinician – a licensed doctor or pharmacist – with strong quantitative and analytical skills. Responsibilities include:

- Develop clinical data analysis, studies, reports, and presentations.
- Fulfill clinical analysis and report requests, and reporting strategies per direction of Medical Director
- Interact with Data Development Team and Data Analysts on analysis strategies

Data Analyst - Reporting
Data Analyst Responsibilities include:

- Report generation / customization
- Data QC
- SQL queries, reports, data extracts, models, and databases.
- Fulfill data requests and strategies per business needs/requirements

Database Architects
Responsibilities include:

- Designs and builds relational databases
- Designs, implements and supports data warehousing
- Implements data models and database designs.
- Reviews, evaluates, designs, implements and maintains company databases. Maintains database, identifies data sources, constructs data decomposition, diagrams, provides data flow diagrams and documents the process.
- Handles aspects of the warehouses such as data sourcing, migration, quality, design, and implementation.
- Resolves database performance issues, database capacity issues, replication, and other distributed data issues

7.2.8.2 STAFFING

Bidders are expected to propose sufficient staff who have the requisite skills to meet all requirements in this RFP and who can attain a satisfactory rating on all Performance Standards. Unless otherwise specified by the bidder and approved in advance by the Department, staff positions are effective for the entire duration of the project phase. The Department encourages bidders to describe their approaches to acquiring qualified staff with experience in the IME. Special attention should be paid to retaining expertise that exists within the IME today.

The proposed staff members are all current employees of GHS who presently perform the required job duties as described in this proposal. Because the proposed staff are currently working as part of the IME, they have extensive knowledge of and experience with this "best of breed" model that will enable us to continue providing seamless, efficient services. GHS staff currently attains satisfactory ratings on all Performance Standards in effect and will continue to ensure that our systems, policies and procedures meet all Performance Standards set by the Department.

GHS is not proposing to make any changes to our current staffing configurations, which are described in detail in this section and in section 6.1.1 Staffing of this proposal. All staff members will remain in place and will be effective for the entire duration of the project.

GHS has been very successful in recruiting and retaining qualified staff for GHS and our Iowa contracts. To mitigate staff turn-over, GHS offers competitive wages and benefits, opportunities for professional development, and regularly surveys our employees. We participate in an annual wage and benefits survey to make sure that we stay ahead of our competition. Our success is evidenced, in part, by our 34 year track record and the stability of our company. Our management style is participative, we hire experienced leaders with proven track records, and we

offer and encourage upward internal mobility. We provide a work environment that allows employees to do their best.

The turn-over of our Iowa staff has been very low. We have found that these pharmacy jobs are attractive to qualified personnel who are accustomed to working in a retail or hospital environment. The predictable hours with minimal nights and weekends, the working environment, and working conditions make it a favorable place for professionals to practice. GHS also relies on the relationships that we have built with local Iowa professional associations and other IME stakeholders when seeking qualified candidates to fill positions. Working with these organizations, we are able to ensure that we can draw from a wide, qualified pool of candidates who have a working knowledge of the Iowa Medicaid landscape.

7.2.8.3 KEY PERSONNEL

The bidder must provide resumes and references for all identified key personnel, including the bidder's account manager who will be involved in providing the services contemplated by this RFP. Resumes and references must meet the requirements of section 6.1.1 Staffing. All staff identified as key personnel must be employees of the bidder, unless specified otherwise by the key personnel subsections of the RFP.

Resumes and references for the key, named personnel positions required in the RFP can be found in Section 6.1.1.1.1 Key Personnel Requirements on page 39. All key personnel, resumes and references meet the requirements of the RFP and are current employees of GHS.

7.2.8.4 SUBCONTRACTORS

The bidder shall disclose the planned use of another company or individual staff member with which the bidder will contract to perform the services described in this RFP. The information that the bidder must provide includes:

- *Subcontractor name and address*
- *Subcontractor qualifications*
- *Work that the subcontractor will perform*
- *The estimated percentage of total contract dollars for each subcontract.*

Special services project staff members that are hired on a retainer or as-needed basis (such as physicians, attorneys, and similar professional staff) are excluded from subcontractor percentage calculations.

GHS does not plan to use any subcontractors in the fulfillment of the duties described in this proposal.

7.2.9 CORPORATE QUALIFICATIONS

7.2.9.1 CORPORATE ORGANIZATION

The bidder must provide an organization chart for the firm that is submitting the proposal. If the firm is a subsidiary of a parent company, the organization chart should be that of the subsidiary firm. The chart should display the firm's structure and the organizational placement of the oversight for the IME project. The bidder must identify the name of the person who will be responsible for signing the contract and indicate the signing person's relationship with the firm. The bidder must include the following information in the proposal:

a. History of the organization

Founded in 1974, Goold Health Systems (GHS) is a privately held corporation affiliated with the Waldron Group of companies. The Waldron Group is owned by William G. Waldron, Jr. and Victoria Waldron Mulkern. GHS is incorporated in the State of Maine and employs 192 people at four locations. We maintain headquarters in Augusta, Maine, with additional satellite offices located in Falmouth, Maine, Des Moines, Iowa and Cheyenne, Wyoming. James A. Clair was named Chief Executive Officer of GHS in February 2007 and is authorized to sign any contract with respect to the IME Pharmacy Medical Services project. Additionally, Mr. Clair shall be responsible for the overall management of any resulting contract.

GHS is a leader in Medicaid Pharmacy Benefits Services Administration (PBSA). GHS brings 35 years of pharmacy experience to our clients and business partners. This includes 17 years of electronic Point of Sale (POS) claims processing, 12 years of drug rebate management, 7 years of PDL maintenance, and 7 years of PA experience. Our major clients include the States of Alabama, Colorado, Georgia, Illinois, Iowa, Maine, Oregon, Utah, Vermont, West Virginia, and Wyoming. GHS has a full understanding of the commitment needed to fulfill our obligations to new clients, PBSA systems in general and the Missouri Preferred Drug List contract in particular.

GHS is a leader in Medicaid healthcare management. The major service components that GHS provides include:

- On-line real-time pharmacy Point of Sale (POS) claims adjudication;
- Pharmacy Prior Authorization (PA);
- Prospective Drug Utilization Review (ProDUR) rules, algorithms, and profiling;
- Retrospective Drug Utilization Review (RetroDUR);
- Medicaid Program Integrity
- Pharmacy / Physician help desks (to support PA and POS systems);
- Cost containment consultation and implementation;
- Robust reporting to our clients; and
- Medical Prior Authorization Services (Beginning in 2010 for the Maine Medicaid Program).

GHS has assisted the State of Maine in its electronic administration of pharmacy programs since

1996, accepting claims data for on-line adjudication for Maine's Low Cost Drugs for the Elderly and Disabled (DEL) program. In the earliest years of the DEL contract, starting in 1974, the system relied exclusively on paper claims. In 1996, GHS migrated to a fully electronic system, resulting in significant cost savings for the State at the time.

In December of 1995, GHS implemented an electronic pharmacy POS claims adjudication system (MEPOP) for Maine's Medicaid pharmacy program. While not without its challenges, the development, implementation, refinement, and on-going administration of the system proceeded with few difficulties. The services we now provide as part of the MEPOP contract include Pharmacy POS claims adjudication, PA, PDL maintenance, drug rebate management, a pharmacy/provider help desk, and other related services.

Most recently in Maine GHS entered into a subcontract with Unisys to provide five services in support of their Maine MMIS duties. GHS and Unisys are also working on integrating our respective PBM and MMIS systems in Maine.

In the State of Iowa, we have successfully developed and implemented PDL, PA, Supplemental Rebate, and pharmacy POS claims adjudication services. In July 2004, GHS began work on designing and developing a PDL and pharmacy PA system for the State's Iowa Medicaid Enterprise (IME) project. We are a subcontractor to the Iowa Foundation for Medical Care (IFMC) for the Medical Services portion of the project. Immediately after contract initiation, GHS commenced working with Iowa's Pharmaceutical and Therapeutics Committee, developing the PDL and negotiating supplemental rebates with drug manufacturers. By the fourth quarter of 2004, a partial PDL was in place with its accompanying supplemental rebate contracts and PAs. On January 15, 2005, GHS implemented a full PDL and took over all pharmacy PA determination responsibilities from the incumbent contractor. This included the deployment of our redesigned PA determination application, PADSS 3.0. The PA implementation was almost six months ahead of schedule, as these responsibilities were not supposed to be transferred to GHS until June 30, 2005.

The second portion of GHS' work for the IME began in December 2004 when we were awarded the pharmacy POS contract. As with the PA system, we upgraded our POS claims adjudication system (to our version 5.1) to meet the IME requirements. We also started claims processing ahead of schedule on June 25, 2005, so as to ensure a smooth transition between POS vendors. All other vendors at the IME project became operational on June 30, 2005.

We are proud that the IME supplemental rebate, PDL, PA, and POS systems were implemented ahead of schedule. We designed, developed, upgraded, and implemented both systems within six-month timeframes. This is an example of the commitment GHS and its employees provide to our clients. Through proper resource allocation, communication, and follow-through, we will continue to meet or exceed the expectations of our public-sector clients.

In the State of Iowa GHS adjudicates approximately 5 million pharmacy claims per year on-line in real-time, performs ProDUR activities, handles about 45,000 POS helpdesk calls per year, conducts drug rebate invoicing and dispute resolution duties, and interfaces with the rest of the IME vendors and state staff.

As the Pharmacy Medical services vendor, GHS provides clinical staff assistance to the P&T Committee, negotiates the Supplemental Rebate agreements on Iowa's behalf, provides clinical analyses, determines over 70,000 pharmacy prior authorizations per year, and handles nearly 20,000 PA help desk calls per year.

GHS' PBM systems were included in CMS' certification of the Iowa Medicaid Enterprise MMIS in 2005-06.

GHS began providing the State of Wyoming with Supplemental Rebate and Preferred Drug List services in October 2007. We have also taken over as Wyoming's PBM vendor as of January 1, 2009. Full rebate functionality has been seamlessly integrated into the overall Pharmacy Benefits Management program for Wyoming.

In 2008 GHS was contracted to design West Virginia's Preferred Drug List (PDL), perform supplemental rebate negotiations, and to perform State Maximum Allowable Cost services. In June of 2009 GHS began providing Medicaid and Supplemental Rebate services to the State of Georgia and are currently working to implement a State Maximum Allowable Cost (SMAC) program for the State of Illinois.

b. Description of the executive, management and any other staff assigned to oversight of this project, their roles on this project, their expertise and experience in providing the services described in the RFP, and their tenure with the organization

James A. Clair, Chief Executive Officer
Jim will continue to serve as the Account Executive overseeing the overall contract management for this project. Jim's responsibilities for this project include:

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

As CEO, he oversees day-to-day operations at GHS and is responsible for guiding the company's future. Jim joined the GHS team in 2001 to work on strategic planning, finances, operations and business development initiatives. He brings nearly two decades of policy analysis, budgeting and operations experience from a number of non-partisan staff positions at the Maine State House. Jim holds an MPA from Syracuse University and an MS concentration in planning from the State University of New York.

Sandy Pranger, R.Ph.
Ms. Pranger will continue to serve as the Account Manager for this project. She has been with GHS since 2004 and has served as GHS' Iowa Account Manager throughout her tenure here. She brings with her fifteen years of prior experience in the pharmaceutical industry. Including her time at GHS, she has almost 10 years of experience in Medicaid pharmacy operations. Ms. Pranger is a registered pharmacist in two states, including the State of Iowa.

Ms. Pranger is the primary point of contact for the GHS staff and coordinates communications between GHS, the Department and other IME vendors. Her responsibilities also include

development and maintenance of the Iowa Medicaid PDL as well as coordinating and attending the quarterly P&T Committee meetings. Additional responsibilities for this project include:

- Ensure contract compliance for the Iowa Pharmacy Medical Services account
- Present of reports and analyses to the P&T Committee
- Enforce business rules and policies, including timeline requirements
- Other responsibilities include:
    - Medicaid claims analysis,
    - Analyzing and forecasting drug trends,
    - Analyzing and summarizing data
    - Pharmacy benefit management,
    - Strategic planning, and
    - Report preparation.

c. Legal structure of the organization, names and credentials of the owners and executives, and state in which the organization is registered

Goold Health Systems	
Legal Structure	Corporation
State of Incorporation	Maine
Status	In good standing
Parent Organization	Independent company affiliated with the Waldron Group of companies
Authorized Signatory	James Clair, CEO

Principal Officers/Board of Directors	
President/Treasurer	Victoria Waldron Mulkern P.O. Box 1090 Augusta, ME 04332-1090 T: 800-832-9672 Organizational Affiliation: Owner, Waldron Group
Chairperson of the Board of Directors	William G. Waldron, Jr. P.O. Box 1090 Augusta, ME 04332-1090 T: 800-832-9672 Organizational Affiliation: Owner, Waldron Group
Chief Executive Officer	James A. Clair P.O. Box 1090 Augusta, ME 04332-1090 T: 800-832-9672 Organizational Affiliation: Chief Executive Officer, Goold Health Systems
Executive Vice President, Pharmacy	John H. Grotton, R.Ph. P.O. Box 1090 Augusta, ME 04332-1090 T: 800-832-9672 Organizational Affiliation: Executive Officer, Goold Health Systems

d. Evidence of an Iowa business license and any necessary applicable professional license required by law

A copy of GHS' Certificate of Authorization issued by the Iowa Secretary of State can be found can be found at the end of this section, along with copies of the professional licenses for the applicable GHS staff members.

e. Any established partnership relationships with the community

As the incumbent vendor, GHS has established positive, reciprocal relationships not only with Department staff, but also with the other IME vendors and Iowa Medicaid providers. This successful partnership with the IME, the IME's other Medicaid vendors, and the provider community allows Iowa's pharmacy clients to achieve improved health outcomes while the State of Iowa's taxpayers enjoy pharmacy cost savings.

In addition, GHS has developed relationships with many local Iowa professional associations and boards. These relationships enable us to keep abreast of developments in the provider community and to disseminate vital information to key Medicaid stakeholders.

GHS also has a local staff presence at the IME facility in Des Moines. The core values of all GHS team members comprise accountability, integrity, innovation, and commitment to community. Our employees have honed these values with years of providing excellent service to clients and witnessing the outcomes of these services on the economy, communities, and citizens.

f. Other projects in which the bidder is currently providing or has provided services similar to the services described in this RFP with names and contact information for the clients' contract administrators

State	Services GHS Provides	Contract Administrator
Iowa	PA/PDL/DUR/POS/ Rebates	Eileen M. Creager IME Pharmacy Services Unit Manager Iowa Medicaid Enterprise 100 Army Post Road Des Moines, IA 50315 Phone: (515) 725-1273 ecreage@dhs.state.ia.us
Wyoming	Full PBM services	Antoinette Brown, R.Ph. Pharmacy Program Manager 6101 Yellowstone Road, Ste 259 A Cheyenne, WY 82002 Phone: (307) 777.6016 antoinette.brown@health.wyo.gov
Maine	Full PBM services	Tony Marple Director, Office of MaineCare Services Maine Office of Medical Services 11 SHS, 442 Civic Center Drive Augusta, Maine 04333 Phone: (207) 287-8477 Tony.marple@maine.gov

West Virginia	PDL, SR, SMAC	Peggy King, R.Ph. Director, Pharmacy Services Bureau for Medical Services 350 Capitol St., Rm 251 Charleston, WV 25301 Phone: (304) 558-5976 pking@wvdhhr.org
Alabama	Clinical Pharmacy Support	Bakeba Raines Thomas Associate Director Alabama Medicaid Agency Pharmacy Clinical Support 501 Dexter Avenue P.O. Box 5624 Montgomery, AL 36103-5624 Phone: (334) 353-4582 bakeba.thomas@medicaid.alabama.gov
Georgia	Medicaid and Supplemental Rebate	Adrian Washington Pharm.D., MBA Director of Pharmacy Services Department of Community Health 2 Peachtree Street NW, 37th Floor Atlanta, GA 30303 Phone: (404) 657-9092 awashington@dch.ga.gov

g. Other contracts or projects currently undertaken by the bidder with names and contact information for the clients' contract administrators

State	Services GHS Provides	Contract Administrator
Illinois	SMAC	Brian Brinker Division of Medical Programs Illinois Department of Healthcare and Family Services 607 East Adams, 4th Floor Springfield, Illinois Phone: (217) 557-0982 Brian.Brinker@Illinois.gov
Maine	Prescription Drug Monitoring Program (PDMP)	Daniel Eccher, PMP Coordinator Maine Office of Substance Abuse 11 SHS, Marquardt Bldg, 3rd Fl Augusta, Maine 04333-0011 Daniel.Eccher@maine.gov Phone: (207) 287-3363
Colorado	Prescription Drug Monitoring Program (PDMP)	Wendy Anderson, Program Director Colorado Department of Regulatory Agencies

		1560 Broadway, Suite 1310 Denver, CO 80202 wendy.anderson@dora.state.co.us Phone: (303) 894-7754
Sovereign States Drug Consortium (SSDC) Member states: Iowa, Maine Oregon, Utah, Vermont, West Virginia and Wyoming	SR Negotiations	Ann Rugg Contract Administrator Office of Vermont Health Access 312 Hurricane Lane, Ste 201 Williston, VT 05495 Phone: (802) 879-5901

7.2.9.2 CORPORATE EXPERIENCE

Bidders will describe all relevant experience within the last five years, including all Medicaid contracts. As appropriate, bidders also will specify their participation as primary contractor or subcontractor on each project. Bidders will include projects that demonstrate at a minimum:

a. Relevant governmental experience with the functional areas and proposed requirements of the RFP component considered by the bid proposal
b. Relevant commercial experience with the functional areas and proposed requirements of the RFP component considered by the bid proposal
c. Other experience with governmental healthcare programs
d. For up to five projects in each category, the bidder shall provide the following items in the project summaries:
    1. Project title
    2. Client organization name
    3. Client reference contact name, title, and current telephone number
    4. Original contract start and end dates
    5. Total contract value to the bidder's organization
    6. Average staff hours in FTEs during operations
    7. Workload statistics
    8. Brief description of scope of work that demonstrates relevance to this contract

Project summaries are limited to one project per page. The state reserves the right to contact other references on the project.

GHS sets the bar for excellence when it comes to providing Pharmacy Benefit Services Administration (PBSA) and related services to state Medicaid programs. We offer states a unique combination of clinical and technical expertise, in depth knowledge, and decades of experience to help manage their drug programs. GHS has been providing these services for over 35 years. The requested project summaries describing this experience begin on the next page.

Relevant Governmental Experience

1. IOWA MEDICAID ENTERPRISE (IME)

This project includes PDL, Supplemental Drug Rebate Agreement, P&T Committee support, and PA program as well as a POS electronic information system and related pharmacy and administrative services. GHS is the prime contractor for the POS contract and is a subcontractor to the Iowa Foundation for Medical Care (IFMC) for the PDL/SR and PA contract.

Customer Name / Contracting Organization:
Iowa Department of Human Services (DHS)/Iowa Medicaid Enterprise (IME)

Description of Project:
The IME project was divided into two contracts, each with six month DDI timeframes, with implementation dates six months apart. The IME PA / PDL contract was awarded to GHS in July of 2004, with DDI commencing by the third week of that month. In this timeframe, we configured our Prior Authorization Decision Support System (PADSS) to meet the specific needs of the contract, developed a Reference Drug List (RDL) by November of 2004, and finished the full PDL on January 15, 2005. We also implemented all hardware, software, and network updates needed to meet performance requirements of the PA/PDL contract. The IME POS contact was awarded to GHS in December of 2004, and design and development began immediately thereafter. We made significant updates to our POS pharmacy claims adjudication to meet specific IME standards and requirements, and also to prepare for future federal, state, and NCPDP mandates. The POS system was implemented on June 25, 2005. In addition to the services described in this RFP, GHS is also responsible for negotiating supplemental rebates with pharmaceutical manufacturers, as part of a multi-state pool, providing CMS and supplemental rebate services, operating the pharmacy POS system and other supporting activities.

Time Period of the Project/ Scheduled and Actual Completion Dates:
July 2004 to present
PDL completion: January 15, 2005. Project completed on time.
POS completion: June 25, 2005. Project completed ahead of schedule.

Current Value of the Project/ Average Staff Hours During Operations:
$3,300,000 (1 year combined value of both contracts)
We have an average of approximately 20 FTEs working on these two contracts, combined.

Workload Statistics:
We oversee the benefit and develop PDL, negotiate SR and provide clinical pharmacy services for approximately 366,500 covered lives. The PDL encompasses 139 PDL categories. Last year we processed approximately 68,200 PAs with an average determination time of 1 hour and 53 minutes and paid 3.6 million claims with total payments of $233 million.

Customer Reference Contact Information:

Eileen M. Creager
IME Pharmacy Services Unit Manager
Iowa Medicaid Enterprise
100 Army Post Road
Des Moines, IA 50315
Phone: (515) 725-1273
ecreage@dhs.state.ia.us

2. MAINE POINT OF PURCHASE SYSTEM (MEPOPS)

This is a Pharmacy Benefit Services Administration project and GHS is the prime contractor.

Customer Name / Contracting Organization:
Maine Department of Health and Human Services (DHHS)

Description of Project:
GHS provides all hardware and software necessary to operate an on-line, pharmacy Point of Purchase electronic information system (i.e., MEPOP). The scope of work includes eligibility verification, electronic claims management, RetroDUR, ProDUR and help desk services. Among other related administrative tasks, GHS is also responsible for Point of Sale (POS) claims processing, file exchanges, formulary maintenance, reporting and on-going provider training. GHS implemented the Physician Directed Drug Initiative (PDDI) in December of 1999 to control costs through an educational effort designed to target physicians' prescribing practices. In March of 2003, GHS commenced work on implementing a full PDL for the State of Maine. This work included:

- Soliciting and analyzing Supplemental Rebate (SR) offers.
- Developing a preliminary PDL to present to Maine's P&T Committee
- Supporting the P&T Committee.
- Creating a database to support the PDL.
- Making programming changes in the POS claims processor to handle new PDL data.
- Scaling-up the PA system to handle the increased volume caused by the PDL.
- Educating providers in regards to the expanded PDL and new PA criteria.

The bulk of the full PDL was successfully implemented starting on July 1, 2003; by November 1, 2003, implementation was entirely complete. The PDL initially increased our PA volume from approximately 200 PAs per day, to 700 – 800 PAs per day. We designed the PA system in-house and created a data driven PDL process, allowing us to easily accommodate the increased volume.

Time Period of the Project/Scheduled and Actual Completion Dates:
April 1995 to present / project completed on time in January 1996.

Current Value of the Project/ Average Staff Hours during Operations:
Current value is $7,054,350 (1 year contract period). An average of approximately 42 FTEs work on this project during normal operations.

Workload Statistics:
In Maine in State Fiscal Year 2009 GHS administered a SMAC program encompassing 1,920 drugs. GHS negotiated SR and Special Rebates (diabetic monitors, test strips & related supplies) for approximately 260,000 covered lives. GHS processed approximately 89,200 PAs and 5.7 million claims with total payments of $205 million.

Customer Reference Contact Information:

Tony Marple, Director
Maine Office of Medical Services
11 SHS, 442 Civic Center Drive
Augusta, Maine 04333-0011
Phone: (207) 287-8477
tony.marple@maine.gov

3. West Virginia State Maximum Allowable Cost (SMAC), Supplemental Rebate (SR), and Preferred Drug List (PDL) Services

This is a Pharmacy Benefit Services project, including a PDL, Supplemental Drug Rebate negotiations, State Maximum Allowable Cost program, P&T Committee support, as well as related pharmacy and administrative services.

Customer Name:
West Virginia Department of Health and Human Services (DHHS), Bureau of Medical Services (BMS)

Description of Project:
GHS provides West Virginia's BMS with clinical and administrative support to develop and manage their Preferred Drug List and to negotiate and administer their Supplemental Rebate and SMAC programs. GHS supports the BMS in the design, development, implementation, administration and maintenance of the PDL and associated PA process. GHS provides complete support for West Virginia's Pharmaceutical and Therapeutics (P&T) Committee. In 2007 GHS negotiated Supplemental Rebates on behalf of West Virginia as a single state. In 2008 West Virginia joined the Sovereign States Drug Consortium (SSDC). This pooling service is a consortium of States created to fund and direct a cooperative effort aimed at controlling the cost of pharmaceuticals. GHS manages the SSDC; however, the program is ultimately "owned" by the States within the Consortium and operated on a nonprofit basis. All rebate savings are returned in a transparent manner to members of the SSDC.

Time Period of the Project
October 2007 to present

Scheduled and Actual Completion Dates:
March 2008 for initial project. Project completed on time.

Current Value of the Project:
$1,456,792 for a 3 year contract period.

Average Staff Hours During Operations:
An average of approximately 3 FTEs work on this project.

Workload Statistics:
We oversee the benefit and develop PDL, negotiate SR and provide clinical pharmacy services for approximately 322,000 covered lives entailing approx 6 million claims/year for total payments of about $384 million/year. Their PDL encompasses 68 major therapeutic categories and a larger number of subcategories.

Customer Reference Contact Information:
Peggy King, R.Ph.
Director, Pharmacy Services
350 Bureau for Medical Services
Capitol Street, Room 251
Charleston, WV 25301
Phone: (304) 558-5976
pking@wvdhhr.org

4. GEORGIA MEDICAID AND SUPPLEMENTAL REBATE PROGRAM

This is a Pharmacy Benefits Services project to provide Medicaid and Supplemental Rebate services.

Customer Name / Contracting Organization:
Georgia Department of Community Health

Description of the Project:
GHS provides Medicaid, Supplemental and J-code rebate services consisting of rebate negotiations, invoicing and accounting reconciliation. GHS negotiates directly on behalf of the State of Georgia as a stand-alone state.

Time Period of the Project:
March 2009 to present

Scheduled and Actual Completion Dates:
June 2009. Project completed on time.

Current value of the Contract:
$4,872,744 over a 5 year contract period.

Average Staff Hours During Operations:
Approximately 6.5 FTEs work on this project, on average.

Workload Statistics:
In SFY2009 the Georgia Medicaid FFS program covered 430,000 eligible lives, with over $492,000,000 in claims paid and $199,000,000 in rebate collections.

Customer Reference Contact Information:
Adrian Washington, PharmD, MBA
Director of Pharmacy Services
Georgia Department of Community Health
2 Peachtree Street NW, 37th Floor
Atlanta, GA 30303
Phone: (404) 657-9092
awashington@dch.ga.gov

5. STATE OF WYOMING, DEPARTMENT OF HEALTH, PHARMACY BENEFITS SERVICES ADMINISTRATION

This is a full Pharmacy Benefits Services Administration project, including PDL, SR, SMAC and fiscal agent responsibilities.

Customer Name / Contracting Organization:
State of Wyoming, Department of Health

Description of Project:
In the State of Wyoming, GHS provides full PBM services including PDL, SR, and SMAC services. In 2008 GHS began negotiating Supplemental Rebate Agreements for Wyoming as part of the Sovereign States Drug Consortium (SSDC). GHS took over the entire chain of rebate services for the state of Wyoming in the second quarter of 2009, including invoicing processing, accounting, reporting and dispute resolution. As of January 2009 GHS is responsible for the State Maximum Allowable Cost program. We recently implemented the full set of PBM services for the State of Wyoming, including PDL management, Prior Authorization (PA) services, help desk and Drug Utilization Review (DUR). GHS has successfully met a series of aggressive deadlines for this project and has successfully integrated with ACS' existing MMIS and POS systems.

Time Period of the Project
October 2007 to present.

Scheduled and Actual Completion Dates:
Full set of PBM services went live May 2009. Project completed on time.

Current value of the Contract:
This project is a combination of three separate contracts. The PBM contract value is $6,224,504 over a 5 year contract period. The SR and SMAC combined contract value is $477,450 over 2 years.

Average Staff Hours During Operations:
GHS devotes, on average, approximately 10 FTEs to this project.

Workload Statistics:
For the period of 05/28/09 through11/30/09, GHS paid a total of 287,132 claims with total expenditures of approximately $20,410,516. In that time GHS also processed approximately 4095 PAs and administered a SMAC program for over 1100 drugs. As of November 30, 2009 the Wyoming Medicaid Program covered 71,871 eligible lives.

Customer Reference Contact Information:
Antoinette Brown, R.Ph.
Pharmacy Program Manager
6101 Yellowstone Road, Suite 259 A
Cheyenne, WY 82002
(307) 777.6016
antoinette.brown@health.wyo.gov

Relevant Commercial Experience

GHS does not currently hold any commercial contracts relevant to the functional areas and proposed requirements of the Pharmacy Medical Services component of the RFP.

Other Experience with Governmental Healthcare Programs

1. Alabama Medicaid Agency Clinical Pharmacy Support

This is a clinical Pharmacy Benefits Administration project providing clinical and administrative support for the Alabama Medicaid Pharmacy Program.

Customer Name / Contracting Organization:
Alabama Medicaid Agency

Description of the Project:
We assist the State of Alabama with the clinical aspects of PDL decisions by conducting clinical research and providing analysis and recommendations. GHS creates Therapeutic Class Reviews, provides administrative support for the quarterly P&T Committee meetings and assists with the administration of the Hemophilia Audit Program.

Time Period of the Project:
2008 to present

Scheduled and Actual Completion Dates:
July 2008. Project completed on time

Current value of the Contract/ Average Staff Hours During Operations:
Current contract value is $270,000 for a 1 year contract period. GHS devotes, on average, approximately 1.75 FTEs to this project.

Workload Statistics:
The PDL is comprised of approximately 100 therapeutic classes and affects the benefits of:

- Approximately 930,000 eligibles
- Over 7 million prescriptions per year
- The Alabama Medicaid Pharmacy budget of $409,000,000 in SFY2007

Customer Reference Contact Information:
Bakeba Raines Thomas
Associate Director
Alabama Medicaid Agency
Pharmacy Clinical Support
501 Dexter Avenue
P.O. Box 5624
Montgomery, AL 36103-5624
Phone: (334) 353-4582
bakeba.thomas@medicaid.alabama.gov

2. ILLINOIS STATE MAXIMUM ALLOWABLE COST (SMAC) PROGRAM

This is a Pharmacy Benefits Services program providing SMAC services for the Illinois Medicaid Program.

Customer Name / Contracting Organization:
Illinois Department of Healthcare and Family Services

Description of the Project:
The Illinois Department of Healthcare and Family Services (Agency) is the single state Medicaid agency in the state and operates the Medicaid Program, the State Children's Health Insurance Program, the Illinois Cares Rx State Pharmaceutical Assistance Program, and other programs that provide prescription drug benefits. GHS is currently implementing a program to review, develop and maintain a comprehensive set of MAC prices for multi-source prescription drugs, select single-source prescription drugs and over-the-counter drugs.

Time Period of the Project:
August 2009 to present.

Scheduled and Actual Completion Dates:
Project is currently in the DDI phase. All deliverables are on-time to date.

Current value of the Contract:
This is currently a 3 year contract valued at $300,000.

Average Staff Hours During Operations:
N/A. Project is currently in the DDI phase.

Workload Statistics:
N/A. Project is currently in the DDI phase.

Customer Reference Contact Information:
Brian Brinker
Division of Medical Programs
Illinois Department of Healthcare and Family Services
607 East Adams, 4th Floor
Springfield, Illinois
Phone: (217) 557-0982
Brian.Brinker@Illinois.gov

7.2.9.3 Corporate References

The bidder shall provide letters of reference from three existing or previous clients knowledgeable of the bidder's performance in providing services similar to the services described in this RFP and a contact person and telephone number for each reference

Letters of reference have been included at the end of this section of this RFP. The contact person and telephone number for each of these references are listed below.

References for Goold Health Systems	
State of Maine, Office of Medical Services	Tony Marple Director, Office of MaineCare Services Maine Office of Medical Services 11 SHS, 442 Civic Center Drive Augusta, Maine 04333 Phone: (207) 287-8477
State of West Virginia, Bureau for Medical Services	Peggy King, R.Ph. Director, Pharmacy Services Bureau for Medical Services 350 Capitol St., Rm 251 Charleston, WV 25301 Phone: (304) 558-5976
State of Georgia, Department of Community Health	Adrian Washington Pharm.D., MBA Director of Pharmacy Services Department of Community Health 2 Peachtree Street NW 37th Floor Atlanta, Georgia 30303 Phone: (404) 657-9092

7.2.9.4 Felony Disclosures

The bidder must state whether it or any owners, officers, or primary partners have ever been convicted of a felony. Failure to disclose such matters may result in rejection of the bid proposal or in termination of any subsequent contract. This disclosure must continue for the life of the contract. Any such matter commencing after submission of a bid proposal, and with respect to the successful bidder after the execution of a contract, must be disclosed in a timely manner in a written statement to the Department.

Goold Health Systems affirms that the company and its owners, officers and primary partners, have never been convicted of a felony. GHS understands that failure to disclose such matters may result in rejection of the bid proposal or termination of any subsequent contract. Should this change at some point in the future, GHS will disclose the matter in a timely manner in a written statement to the Department.

7.2.9.5 Certifications and Guarantees

The bidder must include signed copies of Attachments B through J. Signature must be from an individual authorized to bind the company.

Signed copies of the required certifications and guarantees are included, beginning on the next page.

This page intentionally left blank.

ATTACHMENT B: PROPOSAL CERTIFICATION

PROPOSAL CERTIFICATION

BIDDERS – SIGN AND SUBMIT CERTIFICATION WITH PROPOSAL.

I certify that I have the authority to bind the bidder indicated below to the specific terms, conditions and technical specifications required in the Department's Request for Proposal (RFP) and offered in the bidder's proposal. I understand that by submitting this bid proposal, the bidder indicated below agrees to provide services described in the Iowa Medicaid Enterprise Program Integrity Procurement RFP which meet or exceed the requirements of the Department's RFP unless noted in the bid proposal and at the prices quoted by the bidder.

I certify that the contents of the bid proposal are true and accurate and that the bidder has not made any knowingly false statements in the bid proposal.

James A. Clair 12/08/09

Signature Date

James A. Clair, Chief Executive Officer

Name and Title

Goold Health Systems

Name of Bidder Organization

ATTACHMENT C: CERTIFICATION OF INDEPENDENCE AND NO CONFLICT OF INTEREST

CERTIFICATION OF INDEPENDENCE AND NO CONFLICT OF INTEREST

By submission of a bid proposal, the bidder certifies (and in the case of a joint proposal, each party thereto certifies) that:

a. the bid proposal has been developed independently, without consultation, communication or agreement with any employee or consultant of the Department who has worked on the development of this RFP, or with any person serving as a member of the evaluation committee;

b. the bid proposal has been developed independently, without consultation, communication or agreement with any other bidder or parties for the purpose of restricting competition;

c. unless otherwise required by law, the information in the bid proposal has not been knowingly disclosed by the bidder and will not knowingly be disclosed prior to the award of the contract, directly or indirectly, to any other bidder;

d. no attempt has been made or will be made by the bidder to induce any other bidder to submit or not to submit a bid proposal for the purpose of restricting competition;

e. no relationship exists or will exist during the contract period between the bidder and the Department that interferes with fair competition or is a conflict of interest.

James A. Clair 12/08/09

Signature Date

James A. Clair, Chief Executive Officer

Name and Title

Goold Health Systems

Name of Bidder Organization

ATTACHMENT D: CERTIFICATION REGARDING DEBARMENT SUSPENSION INELIGIBILITY AND VOLUNTARY EXCLUSION

CERTIFICATION REGARDING DEBARMENT, SUSPENSION, INELIGIBILITY AND VOLUNTARY EXCLUSION -- LOWER TIER COVERED TRANSACTIONS

By signing and submitting this Proposal, the bidder is providing the certification set out below:

1. The certification in this clause is a material representation of fact upon which reliance was placed when this transaction was entered into. If it is later determined that the bidder knowingly rendered an erroneous certification, in addition to other remedies available to the federal government the Department or agency with which this transaction originated may pursue available remedies, including suspension and/or debarment.
2. The bidder shall provide immediate written notice to the person to whom this Proposal is submitted if at any time the bidder learns that its certification was erroneous when submitted or had become erroneous by reason of changed circumstances.
3. The terms covered transaction, debarred, suspended, ineligible, lower tier covered transaction, participant, person, primary covered transaction, principle, proposal, and voluntarily excluded, as used in this clause, have the meaning set out in the Definitions and Coverage sections of rules implementing Executive Order 12549. You may contact the person to which this Proposal is submitted for assistance in obtaining a copy of those regulations.
4. The bidder agrees by submitting this Proposal that, should the proposed covered transaction be entered into, it shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under 48 CFR part 9, subpart 9.4, debarred, suspended, declared ineligible, or voluntarily excluded from participation in this covered transaction, unless authorized by the Department or agency with which this transaction originated.
5. The bidder further agrees by submitting this Proposal that it will include this clause titled "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion--Lower Tier Covered Transaction," without modification, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.
6. A participant in a covered transaction may rely upon a certification of a prospective participant in a lower tier covered transaction that it is not proposed for debarment under 48 CFR part 9, subpart 9.4, debarred, suspended, ineligible, or voluntarily excluded from covered transactions, unless it knows that the certification is erroneous. A participant may decide the method and frequency by which it determines the eligibility of its principals. A participant may, but is not required to, check the List of Parties Excluded from Federal Procurement and Nonprocurement Programs.
7. Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render in good faith the certification required by this clause. The knowledge and information of a participant is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.
8. Except for transactions authorized under paragraph 4 of these instructions, if a participant in a covered transaction knowingly enters into a lower tier covered transaction with a person who is proposed for debarment under 48 CFR part 9, subpart 9.4, suspended, debarred,

ineligible, or voluntarily excluded from participation in this transaction, in addition to other remedies available to the federal government, the Department or agency with which this transaction originated may pursue available remedies, including suspension and/or debarment.

CERTIFICATION REGARDING DEBARMENT, SUSPENSION, INELIGIBILITY AND/OR VOLUNTARY EXCLUSION--LOWER TIER COVERED TRANSACTIONS

(1) The bidder certifies, by submission of this Proposal, that neither it nor its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any federal department or agency.

(2) Where the bidder is unable to certify to any of the statements in this certification, such bidder shall attach an explanation to this Proposal.

James A. Clair 12/08/09

Signature Date

James A. Clair, Chief Executive Officer

Name and Title

Goold Health Systems

Name of Bidder Organization

ATTACHMENT E: AUTHORIZATION TO RELEASE INFORMATION

AUTHORIZATION TO RELEASE INFORMATION

Goold Health Systems (name of bidder) hereby authorizes any person or entity, public or private, having any information concerning the bidder's background, including but not limited to its performance history regarding its prior rendering of services similar to those detailed in this RFP, to release such information to the Department. The bidder acknowledges that it may not agree with the information and opinions given by such person or entity in response to a reference request. The bidder acknowledges that the information and opinions given by such person or entity may hurt its chances to receive contract awards from the Department or may otherwise hurt its reputation or operations. The bidder is willing to take that risk. The bidder agrees to release all persons, entities, the Department, and the Department of Iowa from any liability whatsoever that may be incurred in releasing this information or using this information.

James A. Clair 12/08/09

Signature Date

James A. Clair, Chief Executive Officer

Name and Title

Goold Health Systems

Name of Bidder Organization

ATTACHMENT F: CERTIFICATION REGARDING REGISTRATION, COLLECTION AND REMISSION OF STATE SALES AND USE TAXES

CERTIFICATION REGARDING REGISTRATION, COLLECTION, AND REMISSION OF STATE SALES AND USE TAX

By submitting a proposal in response to this Request for Proposal (RFP), the undersigned certifies the following: (check the applicable box):

☒ Goold Health Systems [name of vendor] is registered ~~or agrees to become registered if awarded the contract,~~ with the Iowa Department of Revenue, and will collect and remit Iowa Sales and use taxes as required by Iowa Code chapter 423; or

☐ _____ [name of vendor] is not a "retailer" or a "retailer maintaining a place of business in the state" as those terms are defined in Iowa Code §§ 423.1(42) & (43) (2005).

Goold Health Systems [name of vendor] also acknowledges that the Department may declare the Vendor's bid or resulting contract void if the above certification is false. The Vendor also understands that fraudulent certification may result in the Department or its representative filing for damages for breach of contract.

James A. Clair 12/08/09

Signature Date

James A. Clair, Chief Executive Officer

Name and Title

Goold Health Systems

Name of Bidder Organization

ATTACHMENT G: CERTIFICATION OF COMPLIANCE WITH PRO-CHILDREN ACT OF 1994

CERTIFICATION OF COMPLIANCE WITH PRO-CHILDREN ACT OF 1994

The Contractor must comply with Public Law 103-227, Part C Environmental Tobacco Smoke, also known as the Pro-Children Act of 1994 (Act). This Act requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted by an entity and used routinely or regularly for the provision of health, day care, education, or library services to children under the age of 18, if the services are funded by federal programs either directly or through State or local governments. Federal programs include grants, cooperative agreements, loans or loan guarantees, and contracts. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable federal funds is Medicare or Medicaid; or facilities (other than clinics) where WIC coupons are redeemed.

The Contractor further agrees that the above language will be included in any subawards that contain provisions for children's services and that all subgrantees shall certify compliance accordingly. Failure to comply with the provisions of this law may result in the imposition of a civil monetary penalty of up to $1000 per day.

James A. Clair 12/08/09

Signature Date

James A. Clair, Chief Executive Officer

Name and Title

Goold Health Systems

Name of Bidder Organization

ATTACHMENT H: CERTIFICATION REGARDING LOBBYING

CERTIFICATION REGARDING LOBBYING

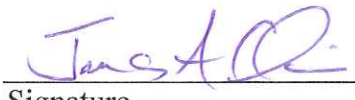
The undersigned certifies, to the best of his or her knowledge and belief, that:

a. No federal appropriated funds have been paid or will be paid on behalf of the Sub-Grantee to any person for influencing or attempting to influence an officer or employee of any federal agency, a Member of the Congress, an officer or employee of the Congress, or an employee of a Member of Congress in connection with the awarding of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant loan or cooperative agreement.

b. If any funds other than federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any federal agency, a Member of the Congress, or an employee of a Member of Congress in connection with this Contract, grant, loan, or cooperative agreement, the applicant shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

c. The Contractor shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S.C.A. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.



12/08/09

Signature Date

James A. Clair, Chief Executive Officer

Name and Title

Goold Health Systems

Name of Bidder Organization

ATTACHMENT I: BUSINESS ASSOCIATE AGREEMENT

BUSINESS ASSOCIATE AGREEMENT

THIS Attachment supplements and is made a part of the Iowa Department of Human Services ("Department") Contract (hereinafter, the "Underlying Agreement") between the Department and the Contractor ("the Business Associate"). This Attachment, when accepted by the Department, establishes the terms of the relationship between the Department and the Business Associate.
Whereas, the Department and the Business Associate are parties to the Underlying Agreement pursuant to which the Business Associate provides or performs certain services on behalf of or for the Department. The Department discloses to the Business Associate certain Protected Health Information ("PHI") (as defined in 45 C.F. R. § 164.501), related to the services performed by the Business Associate for the relationship and, in connection with the provision of those services. This PHI is subject to protection under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA");
Whereas, the Department is a "Covered Entity" as that term is defined in the HIPAA implementing regulations, 45 C.F.R. Part 160 and Part 164, Subparts A and E, the Standards for Privacy of Individually Identifiable Health Information ("Privacy Rule");
Whereas, the Contractor, provides or performs certain services on behalf of or for the Department which require the disclosure of PHI from the Department, and is, therefore a "Business Associate" as that term is defined in the Privacy Rule; Whereas, pursuant to the Privacy Rule and the Security Rule, all Business Associates of Covered Entities must agree in writing to certain mandatory provisions regarding the use and disclosure of PHI; and
Whereas, the purpose of this Attachment is to comply with the requirements of the Privacy Rule and the Security Rule, including, but not limited to, the Business Associate's contract requirements at 45 C.F.R. §164.504(e) and 45 C.F.R. §164.314.
NOW, THEREFORE in consideration of the mutual promises and covenants contained herein, the parties agree as follows:

1. **Definitions**. Unless otherwise provided in this Attachment, capitalized terms have the same meanings as set forth in the Privacy Rule and the Security Rule.
2. **Scope of Use and Disclosure by Business Associate of Protected Health Information**.
   A. The Business Associate shall be permitted to use and disclose PHI that is disclosed to it by the Department as necessary to perform its obligations under the Underlying Agreement.
   B. Unless otherwise limited herein, in addition to any other uses and/or disclosures permitted or authorized by this Attachment or required by law, the Business Associate may:
      (a) Use the PHI in its possession for its proper management and administration and to fulfill any legal responsibilities of DHS;
      (b) Disclose the PHI in its possession to a third party for the purpose of proper management and administration or to fulfill any legal responsibilities of DHS; provided, however, that the disclosures are required by law or Business Associate has received from the third party written assurances that:

(i) The information will be held confidentially and used or further disclosed only as required by law or for the purposes for which it was disclosed to the third party; and

(ii) The third party will notify the Business Associate of any instances of which it becomes aware in which the confidentiality of the information has been breached;

and

(c) Disclose or use any PHI created or received by DHS under this Attachment, for other purposes, so long as it has been de-identified and the de-identification conforms to the requirements of the Privacy Rule.

3. **Obligations of Business Associate**. In connection with its use and disclosure of PHI, the Business Associate agrees that it will:

A. Use or further disclose PHI only as permitted or required by this Attachment or as required by law.

B. Use reasonable and appropriate safeguards to prevent use or disclosure of PHI other than as provided for by this Attachment;

C. To the extent practicable, mitigate any harmful effect that is known to the Business Associate of a use or disclosure of PHI in violation of this Attachment.

D. Promptly report to the Department any use or disclosure of PHI not provided for by this Attachment of which the Business Associate becomes aware.

E. Require contractors or agents to whom the Business Associate provides PHI to agree to the same restrictions and conditions that apply to the Business Associate pursuant to this Attachment.

F. Make available to the Secretary of Health and Human Services the Business Associate's internal practices, books and records relating to the use and disclosure of PHI for purposes of determining the Business Associate's compliance with the Privacy Rule, subject to any applicable legal privileges.

G. Obtain consents, authorizations and other permissions from all individuals necessary or required by laws applicable to the Business Associate to fulfill its obligations under the Underlying Agreement and this Attachment.

H. Promptly comply with any changes in, or revocation of, permission by an Individual for the Business Associate or the Department to use or disclose PHI, after receiving written notice by the Department.

I. Promptly comply with any restrictions on the use and disclosure of PHI about Individuals that the Department has agreed to, after written notice by the Department.

J. Within 15 days of receiving a request from the Department, make available the information necessary for the Department to make an accounting of disclosures of PHI about an individual.

K. Within 10 days of receiving a written notice from the Department about a request from the Individual, make available PHI necessary for the response to individuals' requests for access to PHI about them in the Business Associate's possession which constitutes part of the Department's Designated Record Set.

L. Within 15 days of receiving a written notice from the Department to amend or correct an Individual's PHI in accordance with the Privacy Rule, make the amendments or corrections to PHI in Business Associate's possession which constitutes part of the Department's Designated Record Set.

M. Implement administrative, physical, and technical safeguards that protect the confidentiality, integrity, and availability of the electronic PHI that it creates, maintains, or transmits on behalf of the Department. This security requirement is effective April 20, 2005.

N. Promptly report to the Department any security incident of which the Business Associate becomes aware. This security requirement is effective April 20, 2005.

4. **Obligations of the Department**. The Department agrees that it:

A. Has included, and will include, in the Department's required Notice of Privacy Practices that the Business Associate may disclose PHI for health care operations purposes.

B. Has obtained, and will obtain, from Individuals authorizations and other permissions necessary or required by laws applicable to the Department and the Business Associate to fulfill their obligations under the Underlying Agreement and this Attachment.

C. Will promptly notify Business Associate in writing of any restrictions on the use and disclosure of PHI about Individuals that the Department has agreed to that may affect Business Associate's ability to perform its obligations under the Underlying Agreement or this Attachment.

D. Will promptly notify the Business Associate in writing of any changes in, or revocation of, authorization by an Individual to use or disclose PHI, if such changes or revocation may affect the Business Associate's ability to perform its obligations under the Underlying Agreement or this Attachment.

5. **Termination**.

A. Termination for Cause. The Department may terminate this Attachment for cause if the Department determines that the Business Associate, or any of its subcontractors, etc. has breached a material term of this Attachment. The Department will allow the Business Associate an opportunity to cure the breach. The Department shall provide written notice to the Business Associate requesting that the breach be remedied within the period of time specified in the notice. If the breach is not remedied by the date specified to the satisfaction of the Department, the Department may immediately terminate this Attachment and the Underlying Agreement.

B. Automatic Termination. This Attachment will automatically terminate upon the termination or expiration of the Underlying Agreement.

C. Effect of Termination.

(a) Termination of this Attachment will result in termination of the Underlying Agreement.

(b) Upon termination of this Attachment or the Underlying Agreement, unless specially required by the Department for the business associate to retain the protected health information, the Business Associate will return or destroy all PHI received from the Department, or created or received by the Business Associate on behalf of the Department, that the Business Associate still maintains and retain no copies of such PHI. If such return or destruction is not feasible, the Business Associate will extend the protections of this Attachment to the PHI and limit any further uses and

disclosures. The Business Associate will provide the Department in writing the reason that will make the return or destruction of the information infeasible.

6. **Amendment**. The Department and the Business Associate agree to take such action as is necessary to amend this Attachment from time to time as is necessary for the Business Associate to comply with the requirements of the Privacy Rule and/or the Security Rule.
7. **Survival**. The obligations of the Business Associate under section 5.C. (b) of this Attachment shall survive any termination of this Attachment.
8. **No Third Party Beneficiaries**. Nothing express or implied in this Attachment is intended to confer, nor shall anything herein confer, upon a person other than the parties and their respective successors or assigns, an rights, remedies, obligations or liabilities whatsoever.
9. **Effective Date**. This Attachment shall be effective on _____ .

Goold Health Systems Contractor	**Department of Human Services**
By: James A Clair	By: _____
Name: James A. Clair	Name: _____
Title: Chief Executive Officer	Title: _____
Date: 12/08/09	Date: _____

ATTACHMENT J: PROPOSAL CERTIFICATION OF AVAILABLE RESOURCES

PROPOSAL CERTIFICATION OF AVAILABLE RESOURCES
BIDDERS – SIGN AND SUBMIT CERTIFICATION WITH PROPOSAL.

I certify that the bidder organization indicated below has sufficient personnel resources available to provide all services proposed by this Bid Proposal. I duly certify that these personnel resources for the contract awarded will be available on and after July 1, 2010.
In the event that we, the bidder, have bid more than one component contract specified by this RFP, my signature below also certifies that the personnel bid for this component Bid Proposal are not personnel for any other component Bid Proposal. If my organization is awarded more than one component, I understand that the State may agree to shared resource allocation if the bidder can prove feasibility of shared resource.

James A. Clair 12/08/09

Signature Date

James A. Clair, Chief Executive Officer
Name and Title

Goold Health Systems
Name of Bidder Organization

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IOWA

SECRETARY OF STATE

No. W00352592
Date: 07/16/2003

490 FP-000281415
GOOLD HEALTH SYSTEMS

ACKNOWLEDGEMENT OF DOCUMENT FILED

The Secretary of State acknowledges receipt of the following document:

Certificate of Authority

The document was filed on June 24, 2003, at 10:11 AM, to be effective as of June 24, 2003, at 10:11 AM.

The amount of $100.00 was received in full payment of the filing fee.

STATE OF IOWA 1838 1846 SECRETARY OF STATE SEAL

CHESTER J. CULVER SECRETARY OF STATE

Printed on Recycled Paper

CHESTER J. CULVER
Secretary of State
State of Iowa

APPLICATION FOR CERTIFICATE OF AUTHORITY

TO THE SECRETARY OF STATE OF THE STATE OF IOWA:

Pursuant to section 1503 of the Iowa Business Corporation Act, the undersigned corporation applies for a certificate of authority to transact business in Iowa, and states:

1. The name of the corporation is Goold Health Systems

1A. [*See note 5*] The name the corporation will use in Iowa, if different than the legal name of the corporation is GOOLD HEALTH SYSTEMS, INC.

2. The corporation is incorporated under the laws of the state [or foreign country] of Maine

3. The date of incorporation of the corporation was May 27, 1992

4. The duration of the corporation is indefinite

5. The street address of its principal office is

Address 5 Community Drive PO Box 1090

City, State, Zip Augusta, Maine 04332-1090

6. The street address of its registered office in Iowa and the name of its registered agent at that office:

Name Search Network LTD

Address 2 Corporate Place 1501 42nd Street Ste 210

City, State. Zip West Des Moines IA 50266

7. The names and business addresses of its current directors and officers:

Name Joseph Bruno, President

Address 5 Community Drive PO Box 1090

City, State, Zip Augusta, Maine 04332-1090

Name John Grotton, Vice President

Address 5 Community Drive PO Box 1090

City, State, Zip Augusta, Maine 04332-1090

Name Jim Clair, Vice President

Address 5 Community Drive PO Box 1090

City, State, Zip Augusta, Maine 04332-1090

03 JUN 24 AM 10:11
RECEIVED
SECRETARY OF STATE
IOWA

635_0110A
06/01

0862

3

Name Deb Whitworth, Vice President

Address 5 Community Drive PO Box 1090

City, State, Zip Augusta, Maine 04332-1090

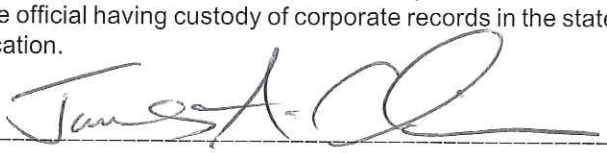
Name Enter the name here

Address Enter the address here

City, State, Zip Enter the city, state and zip here

[Please attach additional pages as necessary]

8. A certificate of existence, or a document of similar import, duly authenticated within 90 days prior to the date of this application, by the official having custody of corporate records in the state or country of incorporation, accompanies this application.

9. Signature 

Type or print name and title Jim Clair, Vice President

NOTES:

1. The filing fee is $100.00. Make checks payable to SECRETARY OF STATE.

2. The document is to be signed by the chairperson of the board, the president, or other officer of the corporation. If directors have not been selected, the document is to be signed by an incorporator. If the corporation is in the hands of a court appointed fiduciary, the document is to be signed by the fiduciary. A copy of a signature is acceptable for filing. Verification is not required.

3. One copy of the document is to be delivered to the Secretary of State for filing.

4. The effective time and date of the document is the later of the following:
   a. the time of filing on the date it is filed;
   b. the time specified in the document on the date it is filed;
   c. the time and date specified in the document, not later than 90 days after the date it is filed.

5. If the name of the corporation does not satisfy the requirements of section 401 of the Iowa Business Corporation Act, the corporation may do either of the following in applying for a certificate of authority:
   a. add one of the following words or abbreviations to its corporate name for use in Iowa: corporation, incorporated, company, limited, corp., inc., co., ltd.;

   or

   b. use a fictitious name to transact business in Iowa if the corporation's real name is unavailable and the corporation delivers to the secretary of state for filing a copy of the resolution of its board of directors, certified by its secretary , adopting the fictitious name.

SECRETARY OF STATE
Corporations Division
Lucas Building, 1st Floor
Des Moines, Iowa 50319

Phone: 515/281-5204
FAX: 515/242-5953

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06/01

0863

State of Maine

Department of the Secretary of State

I, the Secretary of State of Maine, certify *that according to the provisions of the Constitution and Laws of the State of Maine, the Department of the Secretary of State is the legal custodian of the Great Seal of the State of Maine which is hereunto affixed and of the records of organization, amendment, and dissolution of corporations and annual reports filed by the same.*

I further certify *that GOOLD HEALTH SYSTEMS, formerly GHS DATA PROCESSING SERVICES, INC., formerly GHS II is a duly organized business corporation under the laws of the State of Maine and that the date of incorporation is May 27, 1992.*

I further certify *that said business corporation has filed annual reports due to this Department, and that no action is now pending by or on behalf of the State of Maine to forfeit the charter and that according to the records in the Department of the Secretary of State, said corporation is a legally existing business corporation in good standing under the laws of the State of Maine at the present time.*

In testimony whereof, *I have caused the Great Seal of the State of Maine to be hereunto affixed, given under my hand at Augusta, Maine, this twenty-third day of June 2003.*

DAN GWADOSKY
Secretary of State

FILED
IOWA
SECRETARY OF STATE
6-24-2003
10:11 AM
W352592

0864

Mail this document to:
TIMOTHY S CLIFFORD
23 SUNRISE STREET
AUGUSTA ME 04330
USA

We are pleased to provide you with this certificate of renewal of registration of your Maine medical doctor license, which is to be displayed in your primary place of practice with your Maine license certificate. We are also providing you with a wallet card evidencing the continuing validity of your Maine license.

Please write to the Board at 137 State House Station, Augusta, ME 04333-0137 if your address changes, if your professional activities alter the basis upon which your Maine license has been renewed and classified in registration, or if you have any question about your Maine license record.

Maine Board of Licensure in Medicine
Medical Doctor License

Licensee Name:
Timothy S Clifford, MD
Maine License #: 011490
Expiration Date: April 30, 2010

Maine Board of Licensure in Medicine
Medical Doctor License

This is to certify that the physician named below is licensed for the practice of medicine and surgery in the State of Maine and that the license is validly registered for the period March 05, 2008 through April 30, 2010 pursuant to Title 32, Maine Revised Statues of 1964, Chapter 48, as amended. If this registration certificate is marked "Inactive", the licensee may not lawfully provide professional services within the borders of the State of Maine without having first satisfied the Board of his/her Continuing Medical Education qualification in compliance with Board Rules, Chapter 1, Section 13.

LICENSEE NAME: Clifford, Timothy S, MD
MAINE LICENSE No. 011490

Issue Date: March 05, 2008 **Expiration Date: April 30, 2010**

Gary R. Hatfield, M.D. Secretary
Maine Board of Licensure in Medicine

IOWA LICENSED PHARMACIST

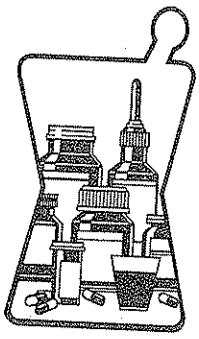
05/20/2008 TO 06/30/2010

This is to certify the person whose name appears on this card is empowered to practice pharmacy for the period above.

Halverson Erin R
19106

Executive Director
Iowa Board of Pharmacy

IOWA PHARMACIST LICENSE



Halverson Erin R
19106

Renewal for Period

May 20, 2008
TO
June 30, 2010

Executive Director
Iowa Board of Pharmacy

Board Members

L. Olson
V. Benjamin
S. Frey
M. Whitworth
E. Maier
D. Wedemeyer-Oleson
A. Diehl

HALVERSON ERIN R
29302 560TH AVE
CAMBRIDGE IA 50046-

This evidence of renewal must be displayed in connection with the original certificate.

REMINDER:
Iowa law requires a pharmacist to report in writing to the Board, within 10 days, a change of name, address, or employment.

You may submit your change via fax, via regular mail, or via E-mail to charity.harman@iowa.gov

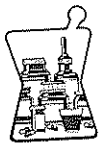
-8093 REV.10/07

Iowa Board of Pharmacy, 400 S.W. Eighth St., Ste. E, Des Moines, IA 50309-4688
Telephone 515/281-5944 **Fax 515/281-4609**

IOWA LICENSED PHARMACIST

06/18/2008 TO 06/30/2010

This is to certify the person whose name appears on this card is empowered to practice pharmacy for the period above.



Smith Pamela Ann

18696

Executive Director
Iowa Board of Pharmacy

IOWA LICENSED PHARMACIST

05/07/2008 TO 06/30/2010

This is to certify the person whose name appears on this card is empowered to practice pharmacy for the period above.

Pranger Sandra K
18720

Executive Secretary/Director
Iowa Board of Pharmacy Examiners

MaineCare Services
An Office of the
Department of Health and Human Services

John E. Baldacci, Governor Brenda M. Harvey, Commissioner

Department of Health and Human Services
MaineCare Services
11 State House Station
Augusta, Maine 04333-0011
Tel: (207) 287-2674; Fax: (207) 287-2675
TTY: 1-800-423-4331

December 3, 2009

Mary Tavegia
Issuing Officer
Iowa Department of Human Services
Iowa Medicaid Enterprise
200 Army Post Road, Suite 2
Des Moines, Iowa 50315

Dear Ms. Tavegia:

Thank you for the opportunity to recommend Goold Health Systems as the Pharmacy Medical Services vendor to the Iowa Medicaid Enterprise (IME). As the division director at Maine's Office of Medical Services, I am responsible for the State's Medicaid drug benefit programs, including the MaineCare and Drug for the Elderly Programs, and for oversight of GHS' work. These combined drug programs provide services to nearly 300,000 people and now cost approximately $300 million annually. Accordingly, the oversight of the complex pharmacy contract with GHS has been very intensive, requiring a daily "hands-on" (and frequently on-site) approach. Due to significant expansions and modifications in these programs of the past several years, I have acquired detailed knowledge of GHS.

Many of the capacities and skills required in our current contract with GHS are pertinent to your program. GHS possesses diverse technical and clinical skills. In Maine GHS performs the following services:

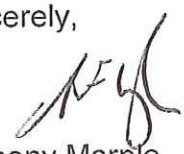
- Serves a population of 2,000 physicians and process approximately 400 prior authorizations per day
- Invoices, reports and accounts for pharmacy and supplemental rebates
- Designs and operates an extensive preferred drug list that saves the State tens of millions of dollars annually
- Creates customized reporting tools that allow required querying functionality

As you are already aware, Maine has the reputation for being an innovative state when it comes to pharmacy benefit issues. Within GHS, this necessitated the development of an exceptionally strong and versatile pharmacy data management capacity.

I highly recommend GHS because they have repeatedly demonstrated themselves to be knowledgeable, responsive and reliable. GHS is able to deliver the full range of required

services. It is worth mentioning that although a number of states have similar systems, very few to date have successfully translated their data and reports into measurable actions and outcomes. I am confident in GHS' ability to deliver.

Sincerely,



Anthony Marple
Director, Office of MaineCare Services

GEORGIA DEPARTMENT OF
COMMUNITY HEALTH

Rhonda M. Medows, MD, Commissioner

Sonny Perdue, Governor

2 Peachtree Street, NW
Atlanta, GA 30303-3159
www.dch.georgia.gov

December 3, 2009

Mary Tavegia
Issuing Officer
Iowa Department of Human Services
Iowa Medicaid Enterprise
200 Army Post Road, Suite 2
Des Moines, Iowa 50315

Dear Ms. Tavegia:

Thank you for the opportunity to recommend Goold Health Systems (GHS) as the Pharmacy Medicaid Services vendor to the Iowa Medicaid Enterprise (IME). In June of this year, GHS began providing Medicaid Pharmacy Rebate and Supplemental Rebate Services for the State of Georgia.

GHS has been successful in implementing CMS and Supplemental Rebate services for the Department. These services consist of rebate negotiations, invoicing, and accounting reconciliation for both rebate programs. In FY09 our FFS program covered 430,000 eligible lives, with over $492M in claims paid, and $199M in rebate collections.

I highly recommend GHS because they have demonstrated themselves to be knowledgeable, responsive and reliable. GHS is able to deliver the full range of required services and I am confident that they will fulfill all of their contract requirements in a timely and professional manner.

Sincerely,

Adrian Washington, Pharm D. MBA
Director of Pharmacy Services
Georgia Department of Community Health
Medicaid Assistance Plans

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STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
Bureau for Medical Services
Office of Pharmacy Services
350 Capitol Street - Room 251
Charleston, West Virginia 25301-3706
Phone: (304) 558-1700 - Fax: (304) 558-1452

Joe Manchin III
Governor

Patsy A. Hardy, FACHE, MSN, MBA
Cabinet Secretary

December 7, 2009

Mary Tavegia, Issuing Officer
Iowa Department of Human Services
Iowa Medicaid Enterprise
200 Army Post Road, Suite 2
Des Moines, Iowa 50315

Dear Ms. Tavegia:

Thank you for the opportunity to recommend Goold Health Systems (GHS) as the Pharmacy Medical Services vendor to the Iowa Medicaid Enterprise (IME). I am responsible for the oversight of GHS' work for the State of West Virginia for the Preferred Drug List, Supplemental Rebate negotiation, Pharmacy and Therapeutics Committee support, and State Maximum Allowable Cost administration (SMAC).

Through my direct interactions with them, I can assert that GHS possesses the technical and clinical skills to:

- Successfully develop and support the management of a complex Preferred Drug List (PDL) that is both fiscally prudent and clinically effective with full Pharmacy and Therapeutics (P & T) Committee support;
- Engage in successful ongoing interactions and data exchange with our MMIS and "Automated Electronic Authorization" vendors;
- Manage a "Multi-State Pool" approach to Supplemental Rebates that provides West Virginia with the benefit of pooled lives while allowing us to maintain flexibility in the design and management of our PDL;
- Provide clinically relevant therapeutic class reviews to enable appropriate deliberation by the P & T Committee;
- Successfully develop, maintain, and update pharmacy claims databases for use in the regular and ad hoc reporting needs relating to the PDL and SMAC program performance, P & T reporting, and drug utilization reports in general;
- Provide a comprehensive State Maximum Allowable Cost program that includes invoice collection and help desk services; and
- Provide ongoing consultation in all aspects of the management of the West Virginia Medicaid Pharmacy Program.

I highly recommend GHS because they have repeatedly demonstrated themselves to be knowledgeable, responsive and reliable. I am confident that GHS will provide excellent pharmacy services for the State of Iowa and your Medicaid population.

Sincerely,

Peggy King

Peggy King, R.Ph.
Director, Pharmacy Services

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