Response to:

State of Nebraska
Department of Health and Human Services
Request for Information MPDR
Medicaid Pharmacy and Drug Rebate Services

Magellan Medicaid Administration, Inc.
11013 West Broad Street, Suite 500
Glen Allen, Virginia 23060

October 16, 2019

Magellan Medicaid Administration

Magellan Rx MANAGEMENT℠

October 16, 2019

Jennifer Crouse/Holly Glasgow
State of Nebraska
Department of Health and Human Services
DHHS Procurement
301 Centennial Mall South, 5th Floor
PO Box 94926
Lincoln, Nebraska 68508

Re: *Nebraska Department of Health and Human Services Request for Information MPDR for Medicaid Pharmacy and Drug Rebate Services*

Dear Ms. Crouse and Ms. Glasgow,

Magellan Medicaid Administration, Inc. (MMA) is pleased to present our response to the Nebraska Department of Health and Human Services' Request for Information MPDR for Medicaid Pharmacy and Drug Rebate Services. MMA is an industry leader in pharmacy benefit services for government healthcare programs and is pleased to provide information about our proven pharmacy solution. MMA brings more than 35 years of pharmacy expertise and experience, including over 20 years of hands-on experience supporting the Nebraska Medicaid Pharmacy Program through our POS and PDL contracts. Our response to the Medicaid Pharmacy and Drug Rebate Services RFI provides a high-level overview of our modular, scalable, and configurable pharmacy solutions for helping DHHS provide high-quality pharmacy services to the vulnerable populations it serves.

MMA is a wholly-owned, indirect subsidiary of Magellan Health, Inc. (Magellan). Magellan Rx Management (MRx) is Magellan's pharmacy services division, and MMA is the component of MRx that focuses on delivering exceptional clinical solutions that are cost-effective and Medicaid-focused.

MMA currently contracts with 26 Medicaid agencies nationwide, including Nebraska DHHS, to provide innovative and comprehensive pharmacy benefit services, including single Preferred Drug Lists (PDLs) for 10 states. In addition, we hold pharmacy benefit management contracts for AIDS Drug Assistance Programs (ADAPs) in five states and State Prescription Assistance Programs (SPAPs) in three states. All these government programs together represent $17 billion in annual drug spend and touch more than 25.7 million lives. We processed 225 million claims in 2018 across all our government pharmacy services contracts. Since the inception of our drug rebate administration programs in 2003, we have collected more than $26 billion in total Medicaid federal and state rebates for our customers and currently provide drug rebate services for 19 Medicaid FFS programs, including CMS, supplemental, MCE, and medical supply rebate programs. We offer a full-service platform, including real-time POS Fee-for-Service (FFS)

claims adjudication/claims processing, formulary management, PDL management, prior authorization management, financial management, fiscal agent administration, rebate administration, business intelligence and predictive modeling, clinical services, call center services, post-adjudication encounter processing, retrospective and prospective DUR (RetroDUR and ProDUR), website management, MCE oversight, and reporting services.

Our solutions are built to serve state Medicaid agencies. We provide our pharmacy solution as a stand-alone pharmacy benefit manager through direct contracts with state Medicaid agencies as well as in partnership with Fiscal Agents as part of an overall MMIS solution. We provide a modular, scalable, and configurable PBM and PDL solution for our Medicaid customers, focusing on collaborative clinical support. Our SOA-enabled, MITA-compliant pharmacy solution has been certified for 13 states. Through our innovative Quarterly Business Review briefings and industry-leading publications, our customers receive the highest quality financial and clinical information to assist in managing their programs. This ensures that agency decision-makers have the information and guidance to lead their Medicaid pharmacy benefit programs, now and in the future.

I, Meredith Delk, PhD, MSW, Senior Vice President and General Manager, Government Markets am the individual authorized to represent and legally bind MMA. If you have any questions or concerns, or want any further clarification about our response, please do not hesitate to contact Valarie Simmons, MS, our Nebraska Account Operations Executive. She can be contacted via telephone at 636-751-5456, via email at vsimmons@magellanhealth.com, or via mail at 11013 West Broad Street, Suite 500, Glen Allen, Virginia 23060.

MMA looks forward to responding to DHHS' upcoming RFP as you lead your Medicaid pharmacy benefit program into the future. We hope to continue to share our Medicaid experience with Nebraska. We are ready to continue our work with you to provide best-in-class pharmacy benefit services and innovative, state-of-the-art pharmacy systems that assist DHHS in attaining the goals of better health care and lower costs.

Sincerely,

Meredith Delk, PhD, MSW
Senior Vice President and General Manager, Government Markets
Magellan Medicaid Administration, Inc.

Table of Contents

[This page has been left blank intentionally.]

State of Nebraska
State of Nebraska Department of Health and Human Services

REQUEST FOR INFORMATION

RETURN TO:
DHHS - Procurement
301 Centennial Mall South, 5th Floor
PO BOX 94926
Lincoln, NE 68508
Phone: (402) 471-6082
E-mail:
dhhs.procurement@nebraska.gov

SOLICITATION NUMBER	RELEASE DATE
RFI MPDR	
OPENING DATE AND TIME	PROCUREMENT CONTACT
2:00 p.m. Central Time	**Jennifer Crouse/Holly Glasgow**

This form is part of the specification package and must be signed in ink and returned, along with information documents, by the opening date and time specified.

PLEASE READ CAREFULLY!

SCOPE OF SERVICE

The State of Nebraska (State), Department of Health and Human Services (DHHS), is issuing this Request for Information RFI MPDR for the purpose of gathering information to request information and potential demonstrations from subject matter experts regarding Medicaid pharmacy and drug rebate services.

Written questions are due no later than September 25, 2019, and should be submitted via e-mail to dhhs.procurement@nebraska.gov.

Bidder should submit one (1) original of the entire RFI response. RFI responses should be submitted by the RFI due date and time. RFI responses should be received in DHHS Procurement by the date and time of RFI opening indicated above. RFI resonses may be mailed or emailed to the address provided in section II.A.

BIDDER MUST COMPLETE THE FOLLOWING

By signing this Request For Information form, the bidder guarantees compliance with the provisions stated in this Request for Information.

FIRM: Magellan Medicaid Administration, Inc.

COMPLETE ADDRESS: 11013 W. Broad Street, Suite 500, Glen Allen, VA 23060

TELEPHONE NUMBER: 512-659-1376 FAX NUMBER: 804-548-0015

SIGNATURE: _____ DATE: 10-9-19

TYPED NAME & TITLE OF SIGNER: Meredith Delk, Senior Vice President and General Manager, Government Markets

D. Response Instructions

DHHS is seeking information on managing pharmacy benefits including both the information technology (IT) and business operations for its Medicaid population. DHHS is also interested in exploring innovative payment and delivery models to support the shrinking fee for service populations and managing the rising costs of prescription drugs.

Having provided a full line of industry-leading pharmacy services to state Medicaid programs for 35 years, MMA has the extensive experience, operational capability, and capacity to support the State of Nebraska. We have demonstrated experience in providing Medicaid pharmacy services under stand-alone PBM carve-out models, as well as embedded within MMIS PBM support contracts. MMA currently contracts with 13 of the nation's Medicaid programs, as well as ADAP and SPAP programs, to provide our full pharmacy POS solution. ***Using our FirstRx POS adjudication system, we processed over 225 million claims across all our government pharmacy services contracts in 2018.***

D.1 Experience and Qualifications

a. For each of the areas below, please summarize the processes, technology, and services that distinguish your firm's capabilities from its competitors.

i. Pharmacy Claims Processing

FirstRx provides fully integrated capabilities for claims processing including rules and limit application, prospective drug utilization review (ProDUR), pharmacy prior authorization (PA), and Third-Party Liability (TPL) coordination of benefits (COB) and cost avoidance. We meet all state and federal privacy and security regulatory requirements for protecting data confidentiality, including those defined by the HIPAA Security Rule and HITECH Act, and all requirements for data and information processing as mandated by 42 CFR 447 for individual and batch claims. ***Our pharmacy solution is CMS-certified for all 13 of our Medicaid FFS POS customers, including seven recent MECT 2.x certifications, and is in place and operational in Nebraska today.***

FirstRx validates that each incoming claim is submitted in an NCPDP-compliant format and that it meets all applicable NCPDP Telecommunication edits/rules for fields, segments, and code sets. If the claim fails any edit(s), FirstRx returns the appropriate NCPDP reject codes on the claim response.

We have successfully configured FirstRx to accommodate each customer's complex and specific requirements. The following table provides a high-level summary of the integrated systems that comprise MMA's pharmacy solution.

Component	Purpose
FirstRx℠	Highly configurable and flexible business rules-based pharmacy claims processing application that serves the complex, ever-changing Medicaid market. Supports online benefit configuration and claims adjudication in real time, 24/7, as well as encounter claim loads/pricing. Accepts pharmacy claims via real-time and batch submission, web claims submission, and manually entered paper claims.
FirstTrax℠	Supports call center, Prior Authorization (PA) request disposition, and clinical notes. Fully integrated with FirstRx for real time bi-directional updates.
FirstCI℠	Provides a real-time, read-only view of claims and PAs for authorized external users.
FirstFinancial℠	Provider payment solution that is based on the GAAP-compliant Oracle Accounts Payable solution
MRx Assist℠	Authorized users are able to view, add, edit enrollment, and add/view PAs.

Component	Purpose
MRx Explore℠	Advanced web-based analytics and reporting tool for business intelligence and retrospective analysis. Allows authorized users interactive online access to explore pharmacy information across all domains.
eRebate℠/ eInvoice℠	For Government Rebates, produces electronic manufacturer invoices, provides accounts receivable functionality for payment reconciliation, interactive reporting, and dispute resolution management.
FirstIQ℠	Medical and pharmacy claims data are integrated to provide rules- based RetroDUR.

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

MMA's FirstRx pharmacy POS claims processing system is a flexible business rules-based application that serves the complex, ever-changing Medicaid market. It supports online benefit configuration and claims adjudication in real time, 24/7, as well as encounter claim loads/pricing. FirstRx accepts pharmacy claims via point-of-sale, batch submission, web claims submission, and manually entered paper claims. FirstRx provides DHHS with an agile, highly configurable system with 6,245 Medicaid-tailored claim checks and edits that manage care within the guidelines of Medicaid rules.

FirstRx provides fully integrated capabilities for claims processing including rules and limit application, ProDUR, PA, and TPL COB and cost avoidance. FirstRx is currently configured to apply all of DHHS' claims adjudication business logic, including COB, patient benefit evaluation and accumulations, member copays and deductibles, clinical and business edits, pricing methodologies, provider fees, PA, automated PA (AutoPA) processing, ProDUR, multi-ingredient compound processing, and lock-in alert messaging to providers.

FirstRx edits claims in accordance with all applicable 340B policies and requirements. Claims that do not meet or adhere to the 340B policies and requirements will deny. FirstRx supports using NCPDP claim indicators when possible to identify 340B claims and non-340B claims. FirstRx evaluates the claim to determine the appropriate edits, including reimbursement to apply to each transaction. We offer full custom capabilities and will tailor claim edits specific to DHHS' needs and consistent with NCPDP standards. Highly configurable, FirstRx provides the functionality to support payment of clinical services and administration fees at the POS when requested in accordance with DHHS program requirements.

FirstRx has been configured to support Nebraska Pharmacy Program requirements for 340B submitted claims. To be considered for 340B pricing, the claim must be submitted with the following NCPDP fields and values:

- 423-DN Basis of Cost Determination = 08
- 420-DK Submission Clarification Code = 20
- 409-D9 Submitted Ingredient Cost = portion of a prescription's cost attributable to the drug.

If these values are submitted on claims that do not have a 340B ceiling price on file, the values are ignored, and claims will follow the lesser of pricing algorithm. Claims will reject with NCPDP EC = 78 – Cost Exceeds Maximum when the Submitted Ingredient Cost is greater than the ceiling price and will return a supplemental transaction message Cost exceeds maximum: NDC not verified as available at 340B price. Additionally, 340B claims will only be paid for pharmacies listed on the NE provider panel. Any pharmacy on the NE 340B provider panel must also be active in the NE general panel to adjudicate claims.

During adjudication, validation occurs to ensure the format and content adheres to the NCPDP Telecommunications D.0 standard. After FirstRx has validated and verified the submitted data, FirstRx performs edits for the pharmacy provider, member, prescriber, and drug(s). FirstRx compares the data transmitted on the claim to the effective-dated reference data in the FirstRx database and by applying the configured DHHS-approved edits associated with those data sets in a hierarchical manner.

FirstRx edits for unit of measure and lesser of logic when pricing a claim, and it applies DHHS-approved DUR edits, PAs, and edits for COB. If a COB segment is present, and there are values in the "Other Payer Amount Paid" field, the amounts will be summed and deducted from the final claim payment. The pharmacy receives a confirmation identifying the cost share for the member and the remaining balance payable by DHHS. FirstRx also validates that the batch file (header, trailer, transactions included within) meets all NCPDP Batch edits/rules.

Duplicate checks and other State Plan edits are applied once FirstRx determines member coverage/eligibility. Adjudication proceeds through the applicable rules defined for the member's benefit (e.g., pricing, quantity, and day supply limits/limitations, ProDUR, member responsibility, claim messaging) using a configurable hierarchy that accounts for the business area and state or federal policy. Provisioned users have online access to view claim and encounter history, as well as status reporting. This includes detail regarding the process used to submit the encounter, as well as the detail regarding the batch sender, date processed, and the MCE providing the encounter.

FirstRx supports claim response messaging fields that provide not only the claims status, including denial and rejection error codes, but also allows for customized supplemental messaging as defined and approved by DHHS, up to the maximum length of the record. All edits are recorded on the claim record and made available for reporting purposes. In cases where multiple claims are sent on a single transaction, FirstRx is configured to ensure that only those claims that hit denial edits are returned to the provider in a non-payable state. The other claims within the transaction that do not hit any denial edits are processed.

Our staff was directly involved with the shaping and development of the D.0 standard and the next HIPAA-named Telecommunication standard (version F2 or a newer version). MMA maximizes participation at NCPDP with technical, operational, and clinical employees, who represent all aspects of our business. This all-encompassing approach means that MMA provides input on and votes on every proposed update to transactions and NCPDP code sets (i.e., the External Code List) and is aware of the changes and new guidance as they are approved, enabling us to continually update our systems, solutions, and processes accordingly.

Edit capability is virtually unlimited, enabling rapid adjustments in response to changing demands of program strategy, including benefit plan design, therapy limits, lock-ins, and other policy changes. These configuration changes are made in accordance with MMA's established Change Control Management process, which ensures that all changes are fully tested and receive DHHS signoff before being put into production. For one of our western Medicaid customers, MMA has configured over 600 edits since Go-Live to assist with broadening the PDL and automating the PA process. ***MMA has worked in conjunction with DHHS to implement customized Nebraska edits tailored specifically for the Nebraska Medicaid Pharmacy Program.*** The following table provides an overview of the POS edits MMA has implemented to improve the pharmacy benefit, as well as to control costs for this Medicaid customer.

POS Edits	Purpose
National Impact	▪ MME – Implemented Morphine-Milligram Equivalent (MME) Accumulator ▪ Standard CDC and customer-configured Equivalency tables available ▪ Unique call center calculator to help providers (POS and prescribers) anticipate unadjudicated claims impact on MME limit ▪ Member-specific MME limit tapering, e.g., movement from 300 to 250 MME or 300 to 90 MME with relatively short front-end notice ▪ SUPPORT Act – Duplicate Therapy Configuration ▪ Opioids with Benzodiazepine and Opioid and Antipsychotic Edits – Customization available by therapeutic classes or specific NDCs ▪ Edit types – DUR edit with custom severity levels, soft (messaging) edits, hard edits

POS Edits	Purpose
MMA Content	▪ AutoPAs – Automated therapy or clinical edits and approvals based on medication use, therapy duration, ICD-10 diagnosis history, automated grandfathering of non-preferred agents ▪ Examples – Stimulant therapy AutoPAs for ICD-10 diagnosis in history, 365-day Contraceptive allowance with 90-day stabilization, Non-preferred approval with preferred(s) utilization in history (reduces call center impact with PDL changes) ▪ POS Edits ▪ Maximum Quantity per day, Quantity per fill, Quantity per rolling days, accumulation quantity maximums in drug groups, etc. (cost containment) ▪ Days per fill, Days' supply, Number of fills, etc. ▪ Customizable tolerance around First Databank (FDB) or customer-provided maximum doses ▪ Examples – Maximum of 3000 mg of Acetaminophen (APAP) accumulated across all APAP-containing products, Maximum of 675 mg of Ajovy® (fremanezumab) across all dosage forms, Maximum of 2 per day of Oxycontin® (oxycodone ER)

The highly configurable FirstRx Formulary Management Tool (FMT) functionality allows for parameters to be configured within the system to tailor DHHS' pharmacy benefit plans within FirstRx, thereby eliminating the need for multiple benefit plan files. Configurable parameters within the system include minimum and/or maximum age values, OTC coverage by benefit plan, nursing home status, gender restrictions, number of refill restrictions, package size, quantity per billing unit, maximum quantity allowed, monthly script limits, auto-exemption list, and other parameters. The ability to quickly change FMT indicators is beneficial for DHHS because it eliminates the task of creating numerous lists and then manually adding drug codes to those lists. As a result, these changes occur almost instantly in FirstRx. FMT offers an infinite choice of options to DHHS to define business rules and apply claims edits. Customization of drug product coverage and pricing can be established at all hierarchy levels. If specific products are identified for alternate or manual pricing intervention or review (e.g., compound processing), claims for those products can be processed in an automated manner or denied pending further review. FMT offers easy-to-use fields for managing DHHS' drug benefit coverage management screen.

ii. Call Centers

MMA has extensive experience operating pharmacy Call Centers across the country to serve Medicaid FFS, including Nebraska, commercial (non-government), health plan/managed care, Medicare Part D, and employer-sponsored Medicare EGWP plan customers. Our Call Center staff are co-located and work collaboratively to serve members, providers, and pharmacies. Our Call Center solution is strong and scalable, and we will continue to bring the infrastructure capabilities, best practices, and suite of integrated Call Center tools to meet and/or exceed Nebraska Medicaid Pharmacy Program requirements. The customer experience is a priority, and our Call Center operations are continuously measured and improved through various feedback mechanisms. Our Call Center is the single point of contact for all pharmacy-related service requests. We provide a fully-trained Call Center staff of skilled clinicians—including pharmacists, certified pharmacy technicians (CPhTs), and customer service representatives—who respond to service requests submitted via telephone (through one established toll-free number), voicemail, fax, mail, web portal, and/or email. Call Center staff are available 24/7 to answer calls, provide support, answer emails and inquiries from members, providers, and other Nebraska Medicaid stakeholders. Our focus is to provide the best service experience for all stakeholders contacting our Call Center by providing accurate information, education, and caring service.

a) Provider Technical Assistance

MMA has the ability to provide technical assistance to providers including addressing inquiries about system processes and troubleshooting. We offer pharmacy Call Center and technical help desk customer

service to all users. MMA provides a toll-free telephone line to be used for the Call Center to respond to all claims processing questions and those policy questions for which answers can be retrieved from existing written, web, or other reference sources. Our Call Center Representatives are reachable using the Nebraska Medicaid Pharmacy Program toll-free line provided by MMA. We configure our POS solution to provide responses to providers in real-time when a claim is denied. When additional information is needed, our highly trained Call Center staff will continue to assist DHHS staff and contractors, as well as support the variety of prescriber and pharmacy provider inquiries typically seen in a pharmacy Call Center regarding DHHS-approved programs (e.g., eligibility inquiries, claim/appeal submissions, pharmacy claims processing and status, etc.); systems availability; technical support for EDI submissions; member services assistance, including clinical assistance; complaints and appeals acceptance and processing; provider payment and reimbursement guidelines; and IT help desk questions. We also provide a web knowledge base and other support services to users, including PBM and pharmacy POS, by making content accessible via the web portal, using a standard web browser. For application and software support, MMA provides a toll-free technical support telephone line to our established IT Help Desk for the life of the contract. The technical support line addresses concerns about the availability and operation of our web portal and all other systems, and the IT Help Desk provides comprehensive support to end-users.

b) Provider Clinical Call Center

MMA's highly trained clinical and administrative staff, along with our innovative, automated, and integrated Call Center solution, accurately processes, determines the appropriate disposition, and preserves all relevant history of each inquiry with the ability to see every claim and PA. These features significantly reduce unnecessary burden to members and providers. Our Call Center staff clearly understand clinical aspects and recognizes, appreciates, and respects the needs and support requirements of pharmacies, prescribers, members, and all Nebraska Medicaid Pharmacy Program stakeholders.

We will continue to provide a fully-trained Call Center staff of skilled clinicians—including pharmacists and CPhTs—who will respond to clinical questions and status of PA requests. These staff provide 24/7 Call Center support, as we do for 100% of our Medicaid FFS customers, including Nebraska, which includes 24-hour coverage by a pharmacist. Our CPhT-certified Call Center staff is able to clearly understand not only clinical aspects, but also recognizes, appreciates, and respects the needs and support requirements of pharmacies, prescribers, and members. In addition, MMA has a comprehensive Call Center training program that has been established based on the needs of our customers during our 30 years of experience using best practices that result in successful implementation and operations. Our Call Center staff receives training on all systems, processes, and policies and procedures used to support the Nebraska Medicaid Pharmacy Program and will continue to be informed and prepared to respond to provider, pharmacy, and DHHS inquiries.

Our FirstTrax system is a full contact management system, in that it is the application used for calls, emails, faxes, PAs, and mail correspondence. We use FirstTrax to comprehensively support the contact tracking and PA process. Our trained Call Center staff of CPhTs responds to inquiries received by telephone, secure email, fax, and US mail. All Call Center contacts are promptly documented, time-stamped, and processed, whether received via telephone, facsimile, Internet, US mail, or encrypted email. Fully trained and credentialed personnel respond to PA requests within 24 hours of receiving all required documentation, through the same communication method channel as we receive the PA request. MMA uses FirstTrax date- and time-assigning capabilities for all PA requests to meet monitoring and reporting requirements. In addition to the Call Center-based manual PA process, integrated in FirstRx is the ability to analyze complex algorithms to automate PA transactions, reducing the need for

provider or prescriber intervention, ensuring consistent PA dispositions. FirstRx provides extensive configuration options to automatically process PAs. Provider intervention is only necessary when the AutoPA process does not find the required criteria information on file (e.g., specific drug(s) or ICD-10 code(s) are not found in patient history).

c) Drug Rebate Dispute/Inquiry Call Center

For all our rebate customers, including Nebraska, MMA pursues resolution of all unresolved drug manufacturer rebate disputes. We do this regardless of when the dispute was filed by the drug manufacturer. MMA's collections processes have been developed to resolve disputes, including the pursuit and collection of monies owed to the State not in official dispute. Our processes provide all the information necessary to document and support our claim. We meet with manufacturer representatives by telephone, video conference, or in person to assist in the resolution. In addition, we take every opportunity to educate the manufacturer representatives on best practices to minimize or prevent future disputes. MMA takes outstanding balances for our customers seriously; thus, we have established a corporate Drug Rebate Collections Department whose sole purpose is the resolution of disputes, as well as other collection of monies owed to our customers but not necessarily in dispute. In performing rebate collections, we use a transparent process that is stable and follows all state and federal guidelines and standards. Our quality processes and transparent reporting enables MMA to aggressively pursue collections, and we take pride in maximizing rebate funds returned to our customers.

In the event disputes occur, our Rebate Operations Team provides analysis and resolution for the outstanding balance in question. We follow the CMS guidelines on dispute resolution processes and Best Practices for dispute resolution and overall collections. The MMA resolution process begins with providing claim detail to manufacturers to support invoice totals and working with the manufacturers to determine if they need any adjustments to the invoice amount. We pay particular attention to the reconciliation of managed care and state-only claim activity. All communications are documented in eRebate, and actual source communication—email/electronic communications—is available through our tracking tool. Reporting on disputed invoice data is available through our eRebate reporting solution.

iii. Prior Authorization

MMA has robust systems and clinical experience to verify eligible members have access to care through therapeutically appropriate use of pharmaceuticals. MMA has 27 years of experience managing and performing pharmacy PA activities that include developing and implementing clinical PA requirements. MMA will continue to collaborate with DHHS to develop criteria that are clinically relevant, representing current treatment protocols. We draw on the clinical expertise of our staff to partner with DHHS to develop Nebraska Medicaid-specific PA criteria that meet the State's needs, using a broad range of data. Through a comprehensive review of medical references and pharmacy compendia, including peer-reviewed literature and nationally recognized treatment protocols, MMA's team of clinical pharmacists works closely with our customers to develop and recommend clinical criteria for approval of non-preferred drugs within each proposed therapeutic class.

a) Automated/"smart" Prior Authorizations

Our automated PA, AutoPA, is a robust and fully integrated feature of the FirstRx system that streamlines the PA process for the provider and prescriber using automated decision-making based on established and approved clinical rules and edits within the processing engine. AutoPA functions use stored data, as well as incoming data, to make intelligent decisions, guided by criteria approved by

DHHS. AutoPA uses information submitted on the claim and/or stored in the member profile (i.e., past drug use, etc.) to determine the appropriate disposition of the claim, all of which reduces unnecessary administrative burden on Nebraska's provider community and call volume to the Call Center, ensuring timely delivery of appropriate medication to Nebraska Medicaid Pharmacy Program members. MMA will continue to partner with DHHS to review existing criteria and provide suggestions based on clinical decisions to achieve the expected outcomes for PA automation.

Since the approval of the authorization takes place as part of the normal claim adjudication process, provider intervention is only necessary when the AutoPA process does not find the required criteria information on file (e.g., specific drug or ICD-10 codes are not found in member history). FirstRx uses pharmacy and medical claims data, including ICD-10 diagnosis codes, present in the member's history profile. Requirements can be bypassed as determined by DHHS for certain medications when specific medical conditions exist. Prescribers are encouraged to include the applicable diagnosis code on written prescriptions for inclusion on the electronic pharmacy claim. The claim is then submitted by the pharmacy, including the appropriate Diagnosis Code.

MMA is constantly looking for ways to improve our existing PA solution. We are automating more of the edits via AutoPA in the POS system and retrieving more of the data from electronic medical records to build comprehensive patient detail facilitating the clinical decision. MMA uses our FirstTrax PA and call tracking system as the repository for all automated and manual PA requests, dispositions, and clinical notes processed through the pharmacy benefit for Nebraska. The integration of the FirstTrax and FirstRx systems provides streamlined entry and updates of PA requests. We use a custom-built application programming interface (API) between FirstRx and FirstTrax to allow Call Center Representatives creating a PA, to generate rules within FirstRx. These rules ensure that the PA is correctly interpreted by the adjudication engine when the claims are submitted by the pharmacy. FirstTrax is a proprietary online, automated system, powered by our configurable, businesses rules-driven Clinical Decision Module (CDM). The CDM is a web-enabled, secure tool that is table- and parameter-driven, allowing flexible and easy configuration to support changes and updates as requested by DHHS. MMA uses the CDM to support the manual and web-based PA process. MMA's CDM is the dynamic core of our manual PA process. The CDM is a custom knowledge base, designed specifically for processing PA requests. It incorporates preferred and non-preferred drug lists, diagnostic information, age and gender considerations, and quantity limitations, along with sophisticated questions based on Nebraska's PA criteria to allow consistent processing of complex clinical PA requests. The CDM uses the same criteria as the FirstRx AutoPA rules while allowing users to enter and consider additional information pertinent to the PA request and an individual patient's situation. The CDM is incorporated seamlessly into the FirstTrax call tracking and PA management system, providing access to the member's eligibility, claims, and previous PA history necessary for adjudicating any PA request. FirstTrax also has a highly flexible IVR solution to support automation of PAs such as early refill. The architecture makes use of a common set of web services to exchange key PA data. MMA provides state-of-the art methods for PA submission processes, and these entry points are integrated to support PA requests. These include fax, IVRU, CPT codes, HCPCS codes, ICD-10 codes, internet technology, AutoPA within the FirstRx POS system, mail, telephone, email, manual PA entry, and through our electronic prior authorization (ePA) process. The entry points are integrated through MMA to efficiently support PAs submitted both at the POS and manually. Each approach utilizes the same criteria to drive consistent decisions for DHHS' PAs that are submitted through the Call Center using our CDM. We will perform a PA on any drug categorized as "non-preferred" or requiring clinical PA.

MMA understands the importance of ensuring that the PA program meets the goal of providing the right medication to the right member in the right situation to ensure effective management of tax dollars. MMA follows new edits/PA programs for a year post implementation to ensure that the pre-defined goals of the edit are met, whether that be cost savings, member outcomes, or enhanced safety. Outcomes of these evaluations are reported during Quarterly Business Reviews, which are data-driven meetings between MMA and the State designed to analyze program success through evaluation of drugs, criteria, return on investment, and recommendations for change. These Quarterly Business Reviews allow MMA to work closely with the State in designing plans to alter the program as necessary.

In addition to AutoPA, MMA offers the following methods to process PAs.

ePA Entry: MMA's overall vision looks to the cloud, technology, advanced analytics, and mobile platforms to support our customers and their future needs. MMA supports a proprietary ePA real-time, end-to-end electronic PA solution that is integrated within an Electronic Medical/Health Record (EMR/EHR) workflow. Our ePA solution is the future of PA processing. This functionality provides the following benefits:

- Prescription abandonment reduction for members
- Turnaround time from prescribing to start of a medication is shortened
- Button integration that allows automatic submission of PA request directly from the pharmacy to the prescriber from claim rejection
- Turnaround time from claim rejection to dispensing of a medication is shortened
- One portal for all drug information that reduces administrative waste
- Integration with eligibility to verify PA request
- Integration with clinical decision and preferred alternatives at time of prescribing
- Improved user experience for the provider community
- Reduced PA turnaround time.

The ePA solution allows providers to initiate and view all PA requests through their practice management software. It integrates directly with FirstTrax and the CDM to maximize automation of the PA process and apply DHHS' approved clinical criteria. It provides shorter turnaround time reducing the administration burden (i.e., lowers Call Center inquiries), allowing members to receive their prescriptions more rapidly, and MMA to better allocate time and effort on more clinically robust edits. Users also can print a list of all PAs or gain details about an individual request through this application. Providers may return to the My PA Requests screen to see if a determination has been made on a request previously pended for manual review. Once a clinical pharmacist enters a determination in FirstTrax, the Status column will automatically change from "Submitted" to the appropriate PA status for that request.

Manual PA Entry: MMA's Call Center staff is responsible for the manual PA process. We accept manual PA requests from providers and DHHS staff. When a request is submitted for an NDC that requires a manual PA request, providers or DHHS staff may contact our Call Center. During the creation of the PA request, information from a denied claim is automatically populated by FirstTrax in a template that is designed for the specific initiative associated with the PA condition. Call Center staff use the CDM in the PA decision-making process. CPhTs in our Call Center conduct an initial review of the PA. Once eligibility and program coverage rules have been reviewed, the member's history is reviewed to compare all information regarding the medication or drug class. If an alternative is available, outreach to the

physician is conducted to see if the substitution is appropriate for the member. If the prescriber elects to change the therapy, the CPhT records in the PA log that a therapy change was accepted. If the physician chooses to proceed with the PA request, the CPhT reviews the information submitted. If supporting documentation satisfies all criteria, the CPhT logs the approval and communicates the approval to the physician. If additional information is needed or criteria for PA are not met, the CPhT contacts the provider for more information and escalates the review to a pharmacist. If the pharmacist is able to approve the request, it is finalized in our system, and the decision is communicated to the physician.

iv. Rate Setting – MAC and OTC Pricing

MMA provides DHHS with more than 17 years of experience managing MAC programs for 13 of our Medicaid customers, including 12 years of Nebraska-specific MAC list development and maintenance experience. We currently manage the State's Maximum Allowable Cost (MAC) and OTC pricing programs that include MAC federal legend, blood factors, covered OTC, pharmacy supplement, medical supplies, and non-drug pharmacy products, as well as rate dispute resolution services. We provide the State unmatched Nebraska-specific experience in managing the State's MAC program and OTC drugs.

MMA manages a comprehensive MAC program that enhances accuracy in determining MAC rates for DHHS and providers. We provide a rate setting services solution that includes administration of MAC for federal legend drugs, MAC rates for covered OTC drugs, as well as pharmacy supplements, drug related medical supplies, and specified non-drug pharmacy products such as active pharmaceutical ingredients (APIs) and compounding excipients. Our MAC program is based on what provider pharmacies are paying for medications, while accounting for unique Medicaid requirements. These include OBRA rebate requirements, federal and state reimbursement regulations, and the foundation that Medicaid pricing must not compromise member access nor discourage provider participation.

Our solution uses data attributes/indicators found in a national drug database to create generic drug groupings for inclusion in the MAC program, including OTC drugs. We can, upon request, manage specialty drug pricing for biological drugs and select oral and injectable medications to help manage expenditures. ***Our comprehensive solution also offers the State management for Intravenous Immunoglobulin (IVIG) drugs, a unique MMA offering. Although this category of drugs contains few drugs, we have achieved over $100,000 in savings annually for one of our Medicaid customers.*** We can customize the MAC by the generic code numbers (GCNs), National Drug Code (NDC), and hierarchical specific Therapeutic Class 3 (HIC3).

Rate Setting Activities

MMA MAC program and OTC drug rate setting occurs through our unique automated application, FastMAC. FastMAC enhances accuracy and maintenance in determining MAC rates for customers and providers. FastMAC is based on the amount provider pharmacies are paying for medications, while accounting for unique Medicaid requirements. The MMA solution provides continuous process improvement with a proprietary algorithm that adapts to marketplace and regulatory changes, state-specific criteria, and dynamics gleaned from experience. This is combined with an advanced system that allows for rapid implementation of these changes. After FastMAC determines the MAC rate, it is passed to the POS system. The respective system determines the lessor of logic for reimbursement to the provider submitting the claim depending on customer-defined claims processing rules. MAC rates are updated and posted weekly to support initial MAC inquiries via a toll-free telephone and fax number for providers and others with questions about the MAC program. In addition, we provide a resolution tracking system and review the analysis with the State. We will also provide a monthly cost savings

report to the State comparing estimated savings with and without a MAC list. We also work with local pharmacies to identify regional and national shortages of medications through our MAC price appeal process. We use information supplied by market disruption reports and pulled from the appeals process (as submitted by providers) to identify shortages, pricing variances, and other drug availability issues to refine the list with each update. These factors are built into our model and result in a current, fair, and competitive price per unit assigned to each GCN.

We encourage providers to move utilization toward the less expensive generic alternatives in a way that is both fair to the pharmacy providers and more cost-effective for the State.

v. Pharmacy Reporting

a) Scheduled

b) Ad Hoc

For more than 20 years, MMA has been providing a pharmacy reporting solution to assist DHHS in the management of the Medicaid pharmacy benefit program.

MMA utilizes advanced analytics and an evidence based clinical approach that combine pharmacy and reference data, powered by a state-of-the-art, Medicaid-centric claims system in order to provide and support a comprehensive pharmacy reporting and business intelligence solution. MRx Explore, our complete web-based query and reporting solution provides flexible, adaptable, user-friendly, and extensive reporting capabilities, as well as ad hoc reporting features. Queries and feature-rich tools can be used to produce reports and information for further analysis for use in monitoring and making decisions in the operation of the Nebraska pharmacy program. MRx Explore provides analytical and reporting capabilities of prescription claims data, including drug usage and cost metrics for all utilizers. Our reports take advantage of a robust set of data from the various aspects comprising the program operation which are collated and curated into our central data warehouse overnight, following the conclusion of each business day. Data are available the next day for reporting and analysis purposes. Our Business Intelligence reporting solution for DHHS includes, but is not limited to, the following reports:

- PBM vendor performance reports
- Federal and State-mandated reports
- Call Center reports
- Clinical reports
- Financial reports
- Utilization and trend reports
- Board and committee reports including DUR Board reports and Pharmaceutical and Therapeutics Committee reports
- Drug utilization review reports
- PDL reports.

Other Clinical Reports

MMA is at the forefront of our competitors in the pharmacy reporting and analysis space. We have developed highly sophisticated reports designed to meet the needs of our Medicaid agency customers, including our Quarterly Business Review (QBR) and Medicaid Pharmacy Trend Report. We will continue

to provide the QBR to serve as a forum for MMA and DHHS to examine, on a routine basis, financial trends and performance, claim distribution, and clinical updates (MRx Pipeline). We report on the overall trends, and the drivers of trends. This is important because it helps to keep the State and MMA on the same page when examining trends and developing management strategies to meet DHHS' goals.

Through our innovative reports and other industry-leading publications, our customers receive the highest quality financial and clinical information in order to assist them in managing their programs. MMA provides insightful data points at various levels based on pharmacy reimbursement and net expenditure over targeted time periods. We have the ability to include data from FFS claims, as well as managed Medicaid claims in the QBR, as well as other reports if the State provides us with the MCE claims. This collaboration and partnership will be increasingly important with the addition of specialty drugs to the scope of services. Specialty drugs are high cost drivers that continue to increase and play a big role in the overall management of the PDL. Our comprehensive reports ensure that DHHS decision-makers have the information and guidance to lead their Medicaid Pharmacy Program, now and in the future.

Scheduled Standard Reporting

Through MRx Explore, MMA provides a comprehensive standard reporting suite that covers all facets of PBM operations. Our standard reporting package currently consists of more than 100 unique reports. Most recently, we developed a suite of 16 reports to support the growing need for opioid usage monitoring. Our standard reporting package consists of:

- Dashboards
- Claims reporting
- Drug reporting
- Prescriber and pharmacy reporting
- Program Integrity reporting
- Member reporting
- Utilization reporting
- Clinical and drug utilization prospective and retrospective reporting.

MMA continuously invests in expanding the capabilities and offerings of our reporting solution to meet evolving industry and customer needs. We use innovative technology combined with our in-depth knowledge, in accordance with industry standards. We also seek to enhance our MRx Explore offering so that it continues to offer more powerful data visualizations while continuing to strive for maintaining an easy to use interface. As part of our focus on ensuring the user experience is rich with benefits, we strive to maintain the following features to enable user communities to benefit from the breadth of capabilities within MRx Explore without having to endure an elongated learning curve:

- Contextualized smart search for anything available within the tool including reports, folders, and dashboards
- A highly intuitive interface that helps users quickly author content
- Single interface to create ad hoc or pixel perfect reports
- A variety of learning tools ranging from classroom instruction, to guided one-on-one tutoring to short focused videos aimed at assisting users with learning specific features available within the tools.

Ad Hoc Reporting

MMA recognizes that DHHS requires customized ad hoc reports to meet specific technical and administrative program needs. Through the online self-service query tools, designated DHHS staff have the ability to create their own ad hoc reports using the data elements and parameters available through the system. This allows DHHS the ability to create and run their own reports when needed and the flexibility to analyze Nebraska Medicaid Pharmacy Program information with individual customized queries. When, however, DHHS needs additional reporting beyond what is available through the online query tools, MMA's advanced data collection methods and tools have allowed us to produce custom and ad hoc reports that fulfill DHHS reporting needs when additional information is needed.

While the majority of information needs can be satisfied through the use of MRx Explore and our comprehensive pharmacy data warehouse (PDW), occasionally an information need will arise that requires real-time access to information that is stored in transactional systems. When these needs arise, our Business Intelligence staff and staff from our Clinical Outcomes Analytics and Research (COAR) Department leverage other tools, technologies, and data sources to ensure that needed information can be acquired for the purpose of delivering the required reports or analyses. We have provided DHHS with custom reports to help evaluate clinical initiatives, proactively identifying opportunities, conduct health economics and outcomes analyses based on the level of available data, forecasting clinical and economic impact of clinical interventions being considered by DHHS and other ad hoc advanced analytic services.

MMA has worked in conjunction with DHHS for more than two decades to form an effective partnership that ensures clear lines of communication exist, as well as the flexibility to develop effective and innovative reporting solutions in the ever-changing Medicaid pharmacy environment. Benefiting from our long Medicaid history with the DHHS and with other state Medicaid programs in general, MMA understands how DHHS works and the State's specific needs. This valuable insight has helped us design a comprehensive reporting solution that meets and exceeds the goals of DHHS and other stakeholders.

Together, we have accomplished the following reporting initiatives:

- MMA provides DHHS with the CMS Annual report package, as well as other supporting reports that were customized specifically for Nebraska in support of the DUR Board. We provide a generic utilization report, as well as a customized cost avoidance report that includes or excludes certain data depending on Nebraska specifications. These reports provide an extensive amount of data that ease the administrative burden on DHHS in completing their annual CMS survey.
- MMA established customized programs to incorporate managed Medicaid claims into the quarterly PDL cost models for more visibility to drug spend.
- MMA fully supports all DUR efforts by the State with customized reporting and analysis, as needed to fulfil requests by the Nebraska DUR Board for FFS, such as an annual RetroDUR outreach report.

vi. Drug Utilization Review (ProDUR and RetroDUR)

MMA system modules are designed to be highly flexible and deployed through configuration and offer a virtually limitless capacity for customized edits. Because our prospective and retrospective Drug Utilization Review (DUR) functions are fully integrated, we are able to automate these processes, thereby obtaining better outcomes as well as furthering our customers' MITA maturity. MMA compiles both medical (received from MMIS and other entities) and pharmacy claims data into a comprehensive member profile. Retail pharmacy claims transmitted via POS and batch pharmacy claims are all

evaluated according to State-approved criteria against each member's profile. Our DUR activities include, but are not limited to, provider profiling, educational outreach, peer-to-peer education, and promote best practice compliance. Through our prospective DUR (ProDUR) and retrospective DUR (RetroDUR) functionality, MMA provides the ability to manage narcotics, drugs used for substance abuse treatment, psychotherapeutic drugs for both adults and children, drugs for treatment of chronic pain such as opioids, ADHD, diabetes, asthma, and other costly and complex chronic conditions.

Prospective DUR (ProDUR)

Using expertise gleaned from more than 35 years of pharmacy experience, that includes 29 years of ProDUR experience, MMA continuously enhances our ProDUR solution and editing capability. Based on each state's specifications, these edits are set to message or deny, which results in meaningful interventions that do not over-burden dispensing pharmacists with clinically insignificant data.

The MMA Clinical Team is responsible for monitoring utilization data and ProDUR edit/message trends and making sound recommendations to the DUR Board pertaining to potential additions, deletions, or modifications of ProDUR criteria. We design our ProDUR messaging to be clear and concise and to address only the most clinically significant circumstances so as not to create message-fatigue. We believe that the most effective ProDUR program functions as an adjunct to a pharmacist's education and professional judgment. It does not replace the human cognitive review process.

FirstRx ProDUR edit configurability provides enhanced DUR refinement functional capability, which supports further refinement of the claim disposition based on attributes of the drug, the alert, and the member's historical claim profile. As an example, the vast majority of diabetic beneficiaries require multiple agents to achieve therapeutic goals. To return only clinically relevant DUR information to the pharmacist, specific drugs used in the treatment of diabetes may be eliminated from the Therapeutic Duplication ProDUR edit (at the discretion of the State).

This enhanced functionality offers greater flexibility to meet state and population-specific needs by allowing a more focused approach to identification and control of the most clinically relevant ProDUR events. It also offers superior support to submitting providers by returning controlled messaging and requiring intervention only in specifically targeted conditions.

Retrospective DUR (RetroDUR)

MMA has been involved in RetroDUR since the program's inception. We created one of the first OBRA '90-based RetroDUR programs in the country for the Commonwealth of Virginia. We currently perform RetroDUR activities for 11 Medicaid programs, including Nebraska Medicaid, as well as seven commercial plans and a Medicare Part D plan. Our RetroDUR programs are formulated to identify, and ultimately correct, potentially dangerous prescribing, dispensing, and drug utilization patterns.

Over the years and using experience gained from decades of working with Medicaid agencies, MMA has developed sophisticated RetroDUR systems and logic to identify and profile members, pharmacy providers, prescribers, and disease states. Our sophisticated algorithms are designed to identify members with medication regimens that are outside of standard disease state management practices. DHHS-specific historical data, including pharmacy claims, medical claims and lab data if available, is used to identify trends of interest and variables that can be used as reliable predictors of subsequent outcomes.

MMA's RetroDUR programs include the standard member exception-based program, as well as pharmacy provider and prescriber focused activities. Our programs are designed to provide educational outreach and peer-to-peer education around the most costly or complex disease conditions, giving the

State the ability to better manage disease states such as chronic pain, mental health disorders, diabetes, asthma, and other costly and complex chronic conditions. Our Gaps in Care algorithm allows identification of members whose medical conditions would benefit from medications that they are not currently receiving, based on sound medical literature. For example, diabetic patients have been shown to benefit from statin medications, even if their cholesterol levels are within normal limits. Our FirstIQ RetroDUR application can identify members who are diabetics both by medical claims and inferred by pharmacy claims who are not receiving a statin medication and who do not have a concurrent medication that is contraindicated with a statin.

Recent enhancements in FirstIQ allow MMA to accept encounter claims and run activities on any subset of members who can be identified by a group or other indicator in their eligibility record, such as members who are dually eligible for Medicaid and Medicare or MCE claims if they are provided. FirstIQ can also incorporate prescriber taxonomy into our algorithms, allowing inclusion or exclusion of members based on the prescriber taxonomy. An example is an educational mailing on current annual influenza guidelines to be sent to prescribers who wrote for Tamiflu during the previous influenza season, excluding claims written by emergency or urgent care providers. Likewise, educational mailing on updated hypertension guidelines could be targeted to just prescribers of antihypertension medication who are family practice or general practice providers.

MMA supports our RetroDUR program with FirstIQ, our clinical management decision support tool that performs menu-driven RetroDUR functions and uses a proprietary polypharmacy algorithm. One can select the number of different drugs, unique prescribers and pharmacy providers to be identified in a given audit, such as 10 different drugs, three prescribers, and two pharmacies. Member medical profiles are produced that contain all paid pharmacy and medical claims during the last six months and are then reviewed by MMA clinical staff to determine the significance of the polypharmacy. Both prescribers and pharmacy providers are notified by letter of findings, as directed by the State. ***MMA sent out more than 20,000 Intervention Letters in 2018 for our customers.***

FirstIQ uses ***complex algorithms*** that help identify possible fraud, waste, and abuse for commonly abused pharmaceuticals. We have the ability to create ad hoc reports that identify potential drug addiction to controlled substances. FirstIQ identifies potential and existing members at risk whose medication profiles are reviewed by our clinical pharmacists. Potential opportunities to improve member care are sent to the member's physician and the plan for incorporation into care and case management.

vii. Preferred Drug List

a) Purchasing Pools

MMA is a recognized pharmacy benefit administrator for state Medicaid programs and is an industry leader in delivering cost savings and transparency to our customers. We have demonstrated success in the development, implementation, and maintenance of PDL and supplemental rebate programs in more states than any other vendor. ***Our PDL experience and expertise are broad and deep; we have been a national leader in this area since 2001.*** We have 26 Medicaid PDL customers today: ***Nebraska,*** Alaska, Arizona, Arkansas, Colorado, Connecticut, the District of Columbia, Florida, Georgia, Idaho, Kentucky, Louisiana, Maryland, Michigan, Minnesota, Montana, New Hampshire, New York, North Carolina, Rhode Island, South Carolina, Tennessee, Texas, Virginia, Wisconsin, and Washington.

MMA developed the first CMS-approved Medicaid purchasing pools in the country, the National Medicaid Pooling Initiative (NMPI) in 2004 and The Optimal PDL $olution℠ (TOP$) in 2005. Together, these two pools have 18 state participants, and constitute the largest number of states and Medicaid lives in the country. Additionally, we manage eight individual-state PDL programs, as well as 11 single-PDLs. The breadth of our PDL program management experience allows our customers access not only to knowledge of their own trends, but to the knowledge, trends, and solution-sharing that takes place across the country. ***Our expertise in PDL management benefits our customers because it allows us to maximize both federal and supplemental rebate opportunities overtop clinically appropriate decision making in order to pursue every opportunity to improve clinical outcomes for members and reduce Medicaid drug costs.***

Nebraska has been a member of our TOP$ multi-state drug purchasing pool since 2009 – more than 10 years. The experience, knowledge gained, program successes, and expertise in providing PDL and supplemental rebate services make MMA the best choice to support DHHS in whatever RFP type is pursued. With nearly two decades of PDL and supplemental rebate services experience, MMA demonstrates the successful and reliable experience required for the new contract.

Over the past 18 years, we have developed innovative and reliable modeling tools and expertise for both individual programs and multi-state purchasing pools. Our focus on serving Medicaid customers has led to a deep understanding of the population these programs serve, the state and federal rules under which they operate, and the benefit designs, clinical policies, and programs allowable within the constraints of regulations that have proven effective in providing and preserving access to clinically appropriate care in a cost-effective manner. ***We support multiple pricing models including pass through pricing to deliver the lowest net cost to the State, including single-PDL designs.*** MMA understands DHHS wishes to improve pharmacy transparency, efficiency, and accountability. We provide our customers with open, accurate, and timely information regarding clinical review, rebate generation, and other pharmacy benefit agreements.

MMA recommends that the State of Nebraska continues to manage its own pharmacy network, using the current pharmacy reimbursement algorithm published on the CMS website at https://www.medicaid.gov/medicaid/prescription-drugs/state-prescription-drug-resources/drug-reimbursement-information/index.html as a means to improve pharmacy transparency, efficiency, and accountability in the Medicaid program. This model removes the incentive for MCEs to steer business to a limited network of pharmacies which can limit access to pharmacy providers in rural areas. A state-sanctioned network will promote transparency that the State needs while providing access that customers want in a pharmacy benefit. We offer a collaborative partnership with a Medicaid-focused staff. ***As the Nebraska Medicaid Pharmacy Program continues to evolve, DHHS can be confident that we have the depth and breadth of experience to continue to evolve along with it.***

We negotiate contracts that deliver a clinically sound, lowest cost PDL with minimal disruption. Although we broadly define value as having clinical and financial considerations as the main components, we recognize that other market factors play a role in value determination. Provider abrasion, member disruption, and call center volumes represent the strongest of these factors. We make recommendations having considered all factors. Brand drug disruption is minimized due to MMA's broad footprint in Medicaid and our expert negotiating team as we have supplemental rebate agreements with all major manufacturers/labelers.

Manufacturers/labelers understand the Medicaid volume represented by MMA, and they have experienced first-hand our customers' collective ability to drive market share. That success translates into cost savings for our customers, evidenced by the pharmaceutical industry's desire to provide competitive proposals for the pools and the individual state contracts utilized by MMA's customers.

Single-PDL

The current era's hallmark was ***MMA's design and implementation of the country's first single PDL program in Texas.*** Recognizing that the Affordable Care Act (ACA) permitted states to collect supplemental rebates on all utilization under the state's PDL, MMA and Texas were quick to take advantage of this new opportunity. With our analysis and guidance, Texas implemented the first single-PDL program in the country in 2013. This is a successful hybrid of managed care patient care principles and FFS pharmacy pricing that became a model program for many other states to implement.

Currently, we manage the single-PDL for Nebraska for both the Medicaid FFS and the MCEs, as well as for 10 other current Medicaid customers. This arrangement allows DHHS to collect supplemental rebates for MCE utilization as they would for FFS utilization. Our guidance includes the provision of multiple financial projections to determine the best fiscal avenue for DHHS in handling their PDL program. Having successfully supported DHHS despite the additional challenges of incorporating MCE considerations (utilization, pricing) into the recommendation process, MMA is uniquely well-qualified to advise DHHS in this area. ***MMA is the market leader in assisting state Medicaid agencies with a single-PDL, no other vendor provides this type of experience.*** We are responsive and provide tremendous value while working to maximize savings opportunities through rebates and lowest net cost and supporting optimal access for the members served.

Unique MMA Strategies for PDL Management

MMA has a plan for the next stage of PDL management. With comprehensive pharmacy services under our corporate umbrella, there are multiple projects underway at MMA to expand savings initiatives and develop new strategies to combat rising prices in a time of diminished resources. We are exploring outcomes-based contracting with independent partners and manufacturers with the intent of introducing new savings opportunities to states. MMA continues our analysis of pharmacy trends throughout health care via numerous Magellan trend reports, as well as the formation of industry-leading seminars such as the annual Magellan Specialty Summit.

Sophisticated Cost Models for Savings Projections

One of the reasons that MMA's state Medicaid customer partnerships have been successful is our sophisticated cost modeling, which aids our customers in financial decision-making and projecting the impact of various PDL scenarios on a net-cost basis. Our cost models provide the information necessary to make the PDL decisions that are most appropriate and clinically defensible. Our cost models enable our state customers to intelligently assess the cost-benefits of a variety of PDL choices. We continually develop enhancements to our cost models in order to provide our customers with more sophisticated projections. MMA's in-depth clinical drug evaluations combined with our proven cost modeling enables us to recommend those drugs that represent the best value for the State's PDL. MMA conveys financial projections through our cost models to provide our state Medicaid agency customers with critical information about the expected performance of their PDL programs. However, MMA participation in program performance extends beyond drug rebate projections. Our customers regularly involve MMA in actuarial matters when monitoring our successful single-PDL program. Our projections are taken into account by the State actuaries in order to confirm that the State is operating its PDL program in the most fiscally sound manner while bringing excellent clinical care to its Medicaid members.

MMA's Cost Models Focus on Accuracy
Our cost models take into account:
- Cost and Rebate information
- Market share and utilization data
- Project market share
- Savings estimates based on various PDL scenarios.

The cycle for providing PDL/supplemental rebate services begins with the selection of supplemental rebate classes. As the experts in the Medicaid market, we advise DHHS on the most advantageous PDL classes to implement in the single-PDL program, where supplemental rebate opportunities and net-cost monitoring lead to the highest net savings potential for the State. Next, we produce a solicitation for supplemental rebates, where ongoing discussions with manufacturers evolve into offers. These offers are stored electronically in our databases with other financial metrics and are then incorporated into our proprietary cost models for financial analysis. The cost models are the vehicle for delivering PDL recommendations to DHHS. Clinical evaluation is combined with the financial analysis to determine the value of each product. PDL recommendations are discussed with the State and presented to the Pharmaceutical and Therapeutics Committee. MMA established customized programs for DHHS that incorporate managed Medicaid claims into the quarterly PDL cost model sheets for more visibility to drug spend for DHHS.

Experience is essential to intelligently predicting and reporting the fiscal impact resulting from the exclusion or inclusion of therapeutic classes on the PDL. ***Our predictive modeling is enhanced by the knowledge and expertise gained from our more than 18 years of PDL experience and through managing our 26 current Medicaid PDL customers across the country with a concentrated focus on saving healthcare dollars.***

Clinical Recommendations and Analysis

MMA develops PDL recommendations for our customers. Our expert pharmacy benefit management team vigilantly monitors and responds to market shifts with the goal of optimizing opportunities to maximize our state customers' Medicaid program dollars while supporting access to pharmacy benefits for their member populations. We have a strong commitment to stay current on industry news, which enables us to develop expert reviews of the latest pharmaceutical industry studies and provide deeper insight into trends and changes to come. With our team-based approach, we share ideas in a manner that maintains confidentiality of data. This approach has led to successful programs, processes, and increased savings. We constantly monitor the changing pharmaceutical marketplace from both clinical and financial perspectives and develop plans to proactively manage the changes and seek opportunities for our customers' PDL programs. Our ongoing monitoring of the pharmaceutical marketplace—trends, pipelines, regulatory and legal actions—and experience of our broad customer base in Medicaid enable us to make recommendations directed towards clinically appropriate and cost-effective pharmacy services. We provide clinical recommendations and pharmacoeconomic analysis for each therapeutic class that we review. In addition, MMA runs Ad Hoc analysis for state programs as needed.

viii. Website Tools

MMA has 16 years of experience in creating and managing web sites and their content for our government customers. We currently provide and maintain Medicaid pharmacy web portals for 11 of our Medicaid FFS customers, including Nebraska. Using this extensive experience, MMA has the ability to continue to maintain a provider web portal that includes support, updates, and maintenance customized to meet the needs of DHHS.

a) Pharmacy benefit content management

Through the use of our intuitive and user-friendly web sites, targeted features are made available to members, prescribers, pharmacy providers, and other key stakeholders which supports effective communication. We make available all relevant Nebraska Medicaid Pharmacy Program content electronically on the web portal. At DHHS' discretion, such content may include policy information,

program information, provider communications, provider manuals, and forms. Examples of other information we routinely post include PA clinical criteria, training material, provider bulletins, and other related communications/material. ***Site content is reviewed on a regular basis to ensure that it is current and accurate at all times.*** We provide web content according to agreed-upon schedules, and the content will be clear, accurate, easy-to-read, and up-to-date. Our content management strategy has strict procedures in place to maintain all types of program documentation, system documentation, provider manuals, operating procedures, or other documentation to ensure they remain current as program requirements or our systems or processes change. An internal documentation review process occurs that validates all revisions have been correctly made to the documentation in accordance with DHHS-specific approved criteria and standards, as well as industry professional standards. This ensures that all information (e.g., PA criteria) used by Call Center staff to assist Nebraska Medicaid Pharmacy Program stakeholders is accurate and up to date.

In addition, our web portals provide the following functionality:

- **Member Eligibility Inquiry:** Our web portal affords authorized users the ability to query member eligibility. In addition, MMA exposes secure web services so that eligibility may be verified automatically by other service-oriented applications both inside and outside of MMA's firewall. This functionality brings efficiency to our partnership, as well as furthering MITA maturity levels.
- **Prior Authorization (PA) Submission and Inquiry:** MMA has the ability to provide a direct link on the Nebraska web portal for PA submission and inquiry. This functionality allows prescribers to complete a PA request directly from their practice management software. The ability for doctors to submit a PA without having to leave their standard workflow results in greater efficiency and coordination of care for members.
- **Claim Submission and Inquiry:** Our web portals support queries for claims history. Authorized users can retrieve lists of claims including provider, drug, and claim information.

Functions, Features, Materials, and Links: Our Nebraska Medicaid Pharmacy Program web portal is a combination of services and static content and includes functions, features, materials, and links as directed by DHHS. The site is interactive and makes intelligent use of defined design features. Our current User Interface strategy is to employ responsive design in which pages are designed with the intelligence to configure themselves to best fit the form factor of the device and to provide easy access to online assistance for users by employing screen elements and using interface techniques that foster usability across applications with the use of familiar elements. Examples of functionality and features incorporated include:

- **Hypertext Links:** Hypertext links are clearly distinguished by both color and underline.
- **Drop-Down Lists and Menus:** Drop-down lists and menus are navigable by mouse and keyboard.
- **Point and Click Functionality:** Buttons, links, menus, and all other interactive areas of the screen are accessible by pointing and clicking with a mouse or another input device.
- **Forward and Back Navigation:** Native browser functionality for navigating forward and backward.
- **Section 508 Compliance:** We maintain our web site in a 508-compliant format that conforms to WCAG. MMA currently satisfies Level AA Success Criteria.
- **Cut and Paste:** Cutting and pasting both from and to the application.

Create, Maintain, and Facilitate Electronic Communication: We provide a "Contact Us" email support option for questions or concerns on the Nebraska Medicaid Pharmacy Program web portal which gives authorized users the ability to electronically submit questions, comments, and request outreach assistance. The mailbox is checked daily and a response will be provided within one business day.

Compliance with State and Federal Web Standards: MMA's web portals make content accessible for people with disabilities and we maintain our web site in a 508-compliant format that conforms to Web Content Accessibility Guidelines (WCAG). MMA currently satisfies Level AA Success Criteria. We support the goal of making web content accessible for people with disabilities and will assist DHHS with posting all web site documents in a 508-compliant format. Our web portal content provides text alternatives for non-text content, is accessible from a keyboard, contains readable/understandable text, and maximizes compatibility with user tools.

Secure Functionality Accessibility: We ensure that any data exchanged on our web portal between MMA and DHHS or providers is secure. All content on the Nebraska Medicaid Pharmacy web portal is accessible through role-based security ensuring that only authorized users are allowed to consume any data and functionality exposed by the web site. We adhere to DHHS' security requirements, routinely require password updates, and provide the option for authorized users to request password resets.

ix. Pricing and management of physician administered drugs

The MMA solution offers innovative Medical Pharmacy and Physician-Administered Drug management for our customers. We have been providing Medical Pharmacy services to our customers for over 14 years (including state Medicaid customers). Our Medical Pharmacy services encompass all physician-administered medications that are billed on the medical benefit. These are typically drugs that are bought-and-billed by the provider and administered in the physician's office or outpatient hospital settings as an intravenous (IV) infusion or injection. Many of these products are high-cost specialty drugs including IV oncology, biologics for autoimmune disorders, and drugs to treat rare diseases and are not typically managed by traditional PBMs as they do not fall under the pharmacy benefit. We manage Medical Pharmacy prior authorizations, Outpatient Hospital and Physician Fee Schedules, provide Post-Service Pre-Payment Claim Edits, and offer consultative services and advanced analytics. ***This program has been highly successful, producing more than 49% in savings in 2018 across high-cost therapeutic categories, such as oncology, oncology support, and autoimmune disease states.***

Physician Office Fee Schedule Methodology

We work in partnership with our customers to offer a variable reimbursement fee schedule that aligns the program's interests with the providers' interests and moves the medical benefit drug mix towards lower cost but equally effective agents. The approach supports physician buy and bill and office administration, which is typically the most cost-efficient distribution channel for provider-administered drugs. Through our clinical consultative recommendations, we implemented our recommended fee schedule in 2010 for a state Medicaid program and saved millions in annual savings. The program uses a proprietary multi-tiered approach including a MAC/Least Cost Alternative (LCA) tier for reimbursing physician offices for provider-administered drugs paid under the medical benefit. The method for creating MAC/LCA rates includes calculating the brand drug margin at the per claim or dosage level using actual physician acquisition costs and applying that equivalent dollar margin to the lowest cost agent's acquisition cost.

Medical Pharmacy (Management of Physician Administered Drugs)

For many years, the MMA solution has included innovative Medical Pharmacy services. Our Medical Pharmacy program encompasses all physician-administered medications that are billed on the medical benefit. These are typically medications that are bought-and-billed by the provider and administered in the physician office or outpatient hospital settings as an intravenous (IV) infusion or injection. Many of these products are high-cost specialty drugs, including IV oncology, biologics for autoimmune disorders, and drugs to treat rare diseases. These medications are not typically managed by traditional PBMs as they do not fall under the pharmacy benefit. For one of our Medicaid clients, we manage Physician Office Fee Schedules, Medical Pharmacy prior authorizations, and offer consultative services and advanced analytics. This program has been highly successful, producing millions in savings annually. ***This represents a greater than 25% savings across high-cost therapeutic categories, such as oncology, oncology support, and autoimmune disease states.***

Medical Pharmacy Prior Authorizations

The MMA Medical Pharmacy Program currently covers over 100 drugs. Savings are achieved by requiring strict enforcement of medical policy criteria for appropriate indications and dosing prior to administration. The medical policy criteria for each drug is developed by experienced clinical pharmacists using the most up-to-date compendia and vetted by a team of thought-leading physicians and pharmacists with specialties in the category of treatment. Our cost models are constantly undergoing enhancements that bring additional enhancements and further ease of use. The latest iteration incorporates a synopsis of the recommendation strategy within each PDL class. This information aids Nebraska pharmacy staff in passing on information to staff unfamiliar with PDL development and serves as a resource for future reviews to see how strategy has developed. This solution delivers immediate savings.

x. Provider and member appeals – conducting administrative reconsideration prior to having a State fair hearing, in addition to preparation for any State fair hearing that is based off of a decision relating to the PBM.

MMA currently provides member and provider appeal support for 12 of our Medicaid POS accounts. We will leverage that experience to customize a State Appeal Process to meet the unique needs and requirements of DHHS. MMA's clinical call center pharmacists provide the expertise and experience to effectively manage all PA requests according to state specified criteria and guidelines.

Our clinicians work with the providers to identify the most appropriate medication for their patients, minimizing the number of cases leading to an appeal. When a PA request is denied, MMA notifies providers and members of their appeals rights in accordance with the DHHS' policy. We coordinate closely with the State personnel who oversee the grievance and appeals process, providing the appropriate reports and documentation to support the decision that resulted in the request for an appeal. MMA provides appeals and grievance support adapted to address the unique needs of each state Medicaid program. Our Call Center staff responds to all PA requests from providers within the CMS required 24-hour turnaround time. A response is returned when the request is approved, denied or additional information is required. When there is doubt or insufficient clinical information available, the CPhT escalates the case to a clinical pharmacist. The pharmacist evaluates all available information and renders a decision, based on state specific criteria and guidelines and their clinical expertise. Physicians specializing in pediatrics, geriatrics, and psychiatry and other specialty areas are available for peer-to-peer consultation as needed in the appeals and grievance process. MMA provides CPhTs, clinical pharmacists, and physicians responsible for supporting the grievance and State Fair Hearing (SFH)

process. Emergency contact information for these clinicians is available for situations that need to be addressed emergently. The Appeals Unit staff fully understand the state's specific SFH and grievance process, which includes training on patients' and providers' rights and obligations. In certain states, MMA works with state appointed entities such as universities that have been designated to handle its State Fair Hearings. We provide a dedicated clinician in states that require that level of support. This person prepares all the documentation and coordinates with the state judiciary to schedule the hearings and provide testimony at each hearing.

xi. Provider Payment and Remittance Advice Generation

MMA uses our FirstFinancial provider payment system to pay claims. FirstFinancial is based on an online, GAAP-compliant, Oracle-based, COTS claims payment application. We maintain pharmacy provider records in FirstFinancial, with the appropriate payment mechanism and provider financial address information for remittance.

FirstFinancial interfaces with FirstRx to coordinate payment to pharmacies and can provide denied claim information on remittance advices if necessary. It handles provider payments as well as remittance advices (RAs) in various media. FirstFinancial provides automated system functionalities and business processes to handle all tasks necessary to produce payment and RA files and record any cash receipts from providers.

Our business processes focus on the cyclical (weekly, bi-weekly, monthly, bi-monthly) production of payment and RA files to various state partners. FirstFinancial meets all provider payment and remittance advice requirements needed to support Nebraska's PBM needs, including the following:

- Handle transactions such as levies, liens, or payment re-assignments at the summary level or at the claim level, if necessary
- Maintain pharmacy provider records with the appropriate payment mechanism and provider financial address information for remittance
- Track State-created provider payment information
- Create the necessary files to support provider payment
- Produce and distribute RAs to providers and/or the State
- Manage and report cash receipt information from provider refunds received
- Hold payments to providers or chains as necessary.

Balancing Processes and Appropriate Disbursement

As part of MMA's overall payment processing system, we have adopted several balancing processes so that all transactions and associated dollars are accounted for. At several points in the payment process, balancing routines validate accurate payment processing for DHHS. Our sophisticated system, effective procedures, and experienced staff enable us to appropriately disburse funds for the payment of claims and State/federal post-payment transactions.

Reflecting Claim Adjustments on Remittance Advices

The reversal is included on the remittance advice (RA), along with the reason for the reversal. When we must adjust a claim(s), FirstRx reverses the claim(s) and re-adjudicates the claim(s). Because different adjudication rules and/or records (e.g., pricing) can be in effect during the re-adjudication, an adjusted claim can have a different claim outcome, including different calculated costs for the pharmacy. The

reversal and re-adjudicated claim each receive a unique TCN and all three transactions are linked. The adjustment is reflected on the provider's RA with the appropriate reason code(s). If multiple claims must be adjusted or voided, FirstRx includes functionality that mass adjusts/voids claims automatically so that the user is not required to intervene on a claim-by-claims basis. Authorized users can search for a subset of claims based on parameters including drug product, member, pharmacy, adjudicated group, and/or specific rule ID effected during adjudication.

Mass Adjustments

Claims returned in the FirstRx Mass Claims Adjustment search are available for review and selection/de-selection prior to executing the adjustments or voids. Users may submit the mass claim adjustment job as a trial job in the FirstRx restore environment and review results before executing the job in the production environment. When requested by DHHS, FirstRx can flag claims/encounters as they are loaded and apply appropriate business rules. For example, this flag can be used to indicate that a claim was part of a higher-level adjustment as part of an audit and this flag will block the pharmacy from subsequently processing a reversal for the claim. FirstRx also can re-price claims/encounters using our adjustment processes.

xii. Supplemental Drug Rebate

Our rebate administration support enables our customers to maximize rebate collections and allocate funds as appropriate. For almost three decades, we have assisted our state partners in navigating federal regulations and oversight, as well as providing support during CMS/OIG audits and state audits. We have more than 25 years of experience in managing federal rebates. MMA currently provides drug rebate services for 26 Medicaid and other state agencies, and we currently provide state supplemental rebate administration for 21 Medicaid customers, including Nebraska.

We began drug rebate processing in 1993, when we launched our Medicaid rebate program for Oregon. MMA's rebate system, eRebate, produces manufacturer invoices, supports customers in managing dispute resolution, and provides accounts receivable functionality for payment reconciliation and reporting.

eRebate is a third-generation, web-based, rules-driven, drug rebate invoicing and payment processing system that allows for flexibility in establishing independent program needs to accommodate the federal program, supplemental programs, as well as medical/diabetic supply programs. Because the eRebate application resides in the cloud, we are able to expand based on Nebraska Medicaid future program needs without adversely affecting program speeds.

Drug rebate plays a vital and important role in offsetting overall drug cost for our customers. Its high visibility within our organization helps us to promote internal efficiencies and in turn deliver superior service for drug rebates. In addition, we have an experienced rebate team that will continue supporting supplemental drug rebate services for Nebraska Medicaid, as well as assisting with Nebraska's Federal Medicaid Drug Rebate (MDR). ***Our rebate leadership team provides DHHS with decades of drug rebate experience.***

Negotiating and Handling Supplemental Rebates to Benefit our State Customers

MMA revenues are not enhanced by supplemental review negotiations. ***One hundred percent of supplemental rebates is collected for the sole benefit of and remitted to our state customers.*** We do not enhance our own revenue by negotiating better rebates for our state customers, and our recommendations are based upon the "True Net" cost to the State, not rebates alone.

MMA's cycle for providing PDL/supplemental rebate services begins with the selection of supplemental rebate classes. As the experts in the Medicaid market, we are able to advise DHHS on the most advantageous PDL classes to implement in their partial single-PDL program, where supplemental rebate opportunities lead to the highest net savings potential for the State. Next, we produce a solicitation for supplemental rebates, where ongoing discussions with manufacturers evolve into offers. These offers are stored electronically in our databases with other financial metrics and are then incorporated into our proprietary cost models for financial analysis. The cost models are the vehicle for delivering PDL recommendations to DHHS. Clinical evaluation is combined with the financial analysis to determine the value of each product. Our databases have the capacity for comprehensive analysis and the generation of electronic and hard copy reports, both scheduled and ad hoc. PDL recommendations are discussed with the State and presented to the DUR Board.

Rebate Negotiation and Solicitation Process: Our process for rebate negotiation and solicitation encourages active and aggressive participation by pharmaceutical manufacturers. Our approach has been refined over the years and results in a process that is transparent and trusted by manufacturers and that results in maximum savings for our customers. Our solicitation and negotiation process is:

- **Open to all:** All manufacturers are given an equal opportunity to participate, giving them assurance that their rebate offers are evaluated in an equitable manner, increasing the likelihood that a maximum number of labelers will participate.
- **Consistent:** Giving manufacturers/labelers certainty on what they are bidding on increases the likelihood of more aggressive offers.
- **Credible:** Manufacturers know that with MMA they are dealing with the organization that has the longest history and most extensive experience in the negotiation and contracting of rebates for Medicaid FFS programs.

In order to provide cost-effective pharmaceuticals to our customers, MMA has developed strong relationships with well over 100 manufacturers throughout the past 18 years of supplemental rebate contracting. These relationships are valuable tools for our customers, and we put great emphasis on maintaining them. We rely on these relationships to glean information necessary to refine our processes, adjust to the pharmaceutical landscape, and provide value to DHHS through knowledge and best practices.

Negotiation Process: Supplemental rebate savings are generated through negotiation with pharmaceutical manufacturers who seek positioning for their products on the PDL. On behalf of our TOP$ pool states, our Contracting Team uses a competitive negotiation model in developing PDLs that are based on the powerful results achieved by allowing market forces to work. MMA ultimately solicits best-and-final supplemental rebate offers from manufacturers with products contained in the therapeutic classes that Nebraska has designated for solicitation. Our strategy requires manufacturers to provide their best pricing or risk having their product non-preferred for one year, until the next offer solicitation and negotiation period. Manufacturers offer Guaranteed Net Unit Prices (GNUPs) for their products and may attach positioning language. Positioning language can include:

- Limiting the number of preferred products in a class
- Defining a subclass of products
- Detailing clinical criteria for consideration allowing manufacturers the flexibility in their approach and providing maximum value to our customers.

We negotiate contracts that deliver a clinically sound, lowest cost PDL with minimal disruption. Although we broadly define value as having clinical and financial considerations as the main components, we recognize that other market factors play a role in value determination. Provider abrasion, member disruption, and call center volumes represent the strongest of these factors. We make recommendations having considered all factors. Brand drug disruption is minimized due to MMA's broad footprint in Medicaid and our expert Negotiation Team, as we have developed SRAs with all major manufacturers on behalf of our customers.

MMA maintains negotiated rebate information as confidential, separate from other customers' rebate data. We follow this practice whether the customer participates as an individual state or in a multi-state pool. The same is true for any state's utilization data. All financial analyses and supporting reports are developed using the state's utilization data. We typically acquire this directly from the state in an agreed-upon file format for the exchange. This information is frequently requested by manufacturers but denied by MMA. Both current utilization data and cost data are included in our cost models. Manufacturers understand the Medicaid volume represented by MMA, and they have experienced first-hand our customers' collective ability to drive market share. That success translates into cost savings for our customers, evidenced by the pharmaceutical industry's desire to provide competitive proposals for MMA's customers.

MMA successfully supports our customers by maximizing state purchasing power and lowering overall costs for the Nebraska taxpayer, while preserving a robust drug benefit for members. MMA's strategy for improving savings to DHHS is to continually negotiate deeper discounts on pharmaceuticals year after year. Negotiations with manufacturers are conducted over the course of the year, not during the solicitation and analysis time frames. Having established dialogues with these companies, there is no need for lengthy back-and-forth negotiations when it comes time for them to submit their supplemental rebate offers, permitting us to maintain a condensed review cycle that gives the most up-to-date data to DHHS and the DUR Board when making PDL recommendations.

It is imperative that we maintain constant contact with manufacturers and continually monitor pricing sources (such as MAC or quarterly CMS rebate files) to demonstrate to our PDL customers that they are receiving the lowest net prices available. Pharmaceuticals are reviewed on a continuous basis for changes that affect prescribing habits. New indications and changes to existing indications, as well as off-label uses, are considered as they occur. MMA advises DHHS of such changes on a weekly basis via the Clinical Update and recommends an expedited review of the product if it is deemed advantageous for the State.

Solicitation Process: MMA sends the solicitation to manufacturers for supplemental rebate offers according to DHHS' schedule. Best-and-final offers from all manufacturers that have products in the existing drug classes being reviewed are collected within the allotted time frames from MMA, along with any new single products or classes that DHHS desires to review. This solicitation process provides all manufacturers the opportunity to offer their products at competitive pricing and submit pertinent clinical information for review. After the initial analysis, MMA may contact a manufacturer for clarification of the supplemental rebate offer if it is determined to be in the best financial interest of the State. Manufacturers are not permitted, however, to submit revised offers unless requested by the MMA Negotiation Team. This prohibition ensures that the manufacturers provide their best offer initially. Our best-and-final offer strategy allows us to use the most current information available for analyses and guidance to the State, rather than using a prolonged negotiation that spans multiple quarters before finally reaching supplemental rebate contract effective dates.

In addition to the financial component, MMA's solicitation also requests relevant clinical information available from the manufacturers, related to their labeling and indications. Clinical submissions are

supplemented by frequent manufacturer presentations to the MMA Clinical Team. These presentations include clinical trial data on new and established products, DHHS-specific information, as well as pipeline drugs.

Rebate Support: MMA provides supplemental rebate support to our customers through PDL recommendations, clinical criteria development, manufacturer bid review, selection, and contracting, rebate invoicing, collections, dispute resolution, and reporting. MMA Clinical Account Managers have extensive experience in presenting data to committees and other Medicaid stakeholders. Our Clinical Account Manager will continue to provide account support to DHHS to ensure the bid review and selection process and will present background information, financial and clinical PDL recommendation processes, savings strategies, relevant and updated clinical information, and clinical and financial rationale for PDL recommendations to DHHS.

MMA supports our customers and ensures all Supplemental Rebate Agreement are reviewed and executed prior to approval of PDL statuses to ensure the pharmaceutical manufacturer agrees with all applicable terms and conditions. We guide all Supplemental Rebate Agreements through the point at which the manufacturer signs the CMS-approved template agreement. Our custom-developed eRebate solution supports the rebate services provided by MMA and is based on business rules that adhere to the requirements of the Medicaid Drug Rebate Program created by OBRA '90, and any subsequent amendments. A rebate extract is sent from the source POS system to eRebate in order to support the drug manufacturer rebate process. Claim detail is sent in conjunction with the provider reimbursement cycle, accommodating weekly or bi-weekly extracts. eRebate supports the administration (process, invoice, collection, dispute resolution, and reporting) for the rebate programs.

a) Self-service for labelers

eInvoice is MMA's online invoice and claims tool. eInvoice provides a secure site that allows pharmaceutical manufacturers to log in and retrieve rebate invoices in multiple formats. Manufacturers can download supporting claims to validate invoices.

b) Reconciliation of payment to invoice and NDC

eRebate provides accounts receivable functionality for payment reconciliation and reporting. Our supplemental rebate process starts with federally invoiced NDCs in states where we provide support for both, and MMA invoices only those that are supported by supplemental contracts on the supplemental invoices. Claims are scrubbed at the federal level, including HCPCS to NDC. Claims are also scrubbed at the federal level for 340B, whether it is based on provider or claim, and therefore, will not be identified as such (coordinating as necessary with all other sources of information to identify 340B entities) at the supplemental level as part of our standard audit processes.

c) Invoicing

MMA will continue to make certain that we adhere to all applicable state and federal laws and policies for invoicing, collection, and remittal to Nebraska's supplemental rebate funds. eRebate supports FFS, MCE, Supplemental Rebates, Medical Supply, and non-federal programs. eRebate features state-of-the-art electronic invoicing. We generate manufacturer invoices based on the manufacturer/labeler information that is provided by CMS on a quarterly basis.

For customers where we process both FFS and supplemental rebates, the system uses a subset of the FFS claims to invoice the supplemental. All scrubbing of the data is accomplished at the FFS level; so the claims that flow through to the supplemental invoice have already been scrubbed. This ensures that manufacturers will see same unit counts on both the FFS and supplemental invoices with an exception of a different phase in/ phase out date on the supplemental side. Additionally, PPA adjustments will flow

through the FFS process and find their way to the supplemental side automatically. This keeps the two programs units in sync.

d) Reporting

Using our eRebate system, MMA provides DHHS with an accounting and reconciliation of supplemental rebates monthly and in accordance with requirements and procedures as established by DHHS. The reconciliation involves amounts of drug rebates received by the PBM, amounts transferred to the State or fiscal agent bank account, and amounts reported on the CMS-64.9R form for the quarter.

We submit all contractor-provided portions of the CMS-64.9R to designated State staff by the tenth of the month following the end of the quarter. The CMS-64.9R demonstrates reconciliation of all rebate system activity against rebate invoices, rebate deposits, and rebate adjustments for any given quarter. MMA's rebate processes follow CMS guidelines. MMA generates the CMS-64.9R reports quarterly for each government rebate program we support, and when required, for non-federal rebate programs. We also include QROA amounts where applicable. The supporting documentation we currently provide is comprised of subsidiary reports to support all data reported in the CMS-64.9R. The report data include:

- **Invoice List:** Invoices by Manufacturer that tie to the "Invoice" row on the CMS-64.9R for rebates Invoiced for the current quarter
- **Adjustments:** All adjustments associated with the program on the "Adjustments to Previous Rebates" row
- **Cash receipts:** Detailed listing of cash receipts for the current quarter that ties into the "Rebates Received This Quarter" row. MMA balances — at least monthly — each customer's cash receipts as part of our process. This balancing allows MMA and the customer to proactively resolve any discrepancies prior to our generation of the quarterly CMS-64.9R
- **Quarterly Labeler Account balance:** Tied to the ending Balance row and columns on the CMS-64.9R.

MMA can easily produce additional reports and/or data, as required and requested by the State.

e) Accounts Receivable and Collections processes

MMA takes outstanding balances for our customers seriously; thus, we have established a corporate Drug Rebate Collections Department whose sole purpose is the resolution of disputes, as well as other collection of monies owed to our customers but not necessarily in dispute. In performing rebate collections, we use a transparent process that is stable and follows all state and federal guidelines and standards. Our quality processes and transparent reporting enables MMA to aggressively pursue collections and we take pride in maximizing rebate funds returned to our customers.

We monitor and actively pursue accounts receivable, including manual intervention, according to State-approved processes and procedures. As part of MMA's ongoing provider payment process, we send collection letters to all providers who have outstanding pending balances. We monitor the collection process monthly and send letters on a quarterly basis for the first three quarters that a provider has an active accounts receivable balance. As part of MMA's rebate activities, we actively pursue outstanding balances and dispute resolution according to CMS best practices.

f) Dispute resolution

For all our rebate customers, including Nebraska, MMA pursues resolution of all unresolved drug manufacturer rebate disputes. We do this regardless of when the dispute was filed by the drug manufacturer. MMA's collections processes have been developed to resolve disputes, including the

pursuit and collection of monies owed to the State not in official dispute. Our processes provide all the information necessary to document and support our claim. We meet with manufacturer representatives by telephone, video conference, or in person to assist in the resolution. In addition, we take every opportunity to educate the manufacturer representatives on best practices to minimize or prevent future disputes.

In the event disputes occur, our Rebate Operations Team provides analysis and resolution for the outstanding balance in question. We follow the CMS guidelines on dispute resolution processes and Best Practices for dispute resolution and overall collections. The MMA resolution process begins with providing claim detail to manufacturers to support invoice totals and working with the manufacturers to determine if they need any adjustments to the invoice amount. We pay particular attention to the reconciliation of managed care and state-only claim activity.

All communications are documented in eRebate and actual source communication—email/electronic communications—is available through our tracking tool. Reporting on disputed invoice data is available through the eRebate report functionality within our eRebate reporting solution.

xiii. Federal Drug Rebate

MMA is ready to assist DHHS as it continues to improve its existing Federal Medicaid Drug Rebate (MDR) processes to reduce remaining manual processes, provide self-service functionality to labelers, increase the accuracy of the quarterly rebates, and potentially increase the amount of quarterly rebates collected for the State. Using eRebate, we currently perform federal rebate administration services for 14 Medicaid agency customers. For these customers, MMA administers and is responsible for the day-to-day operation and management of all aspects of each State's federal rebate program, such that at all times this program is in full compliance with applicable state and federal laws and requirements, as well as any rebate requirements present in the contract between State and its medical supply manufacturer(s), as applicable.

As a highly experienced rebate vendor, MMA serves as a technical and rebate contact with CMS on behalf of many of our Medicaid customers, regularly receiving CMS notifications, publications, and announcements regarding Medicaid. We are active in the Medicaid Drug Rebate community and attend the yearly Medicaid Drug Rebate Program (MDRP) Summit conference, where we participate in dispute resolution meetings and present in panel discussions on drug rebate topics. Our comprehensive and innovative approaches are based on the following:

- MMA has more than 25 years of experience in managing federal rebates.
- We currently provide drug rebate services for 26 Medicaid and other state agencies.
- MITA-compliant rules engine drives the main functionality of rebates.
- Work with DHHS Fiscal SMEs during implementation to ensure sub-ledger numbers agree with those reported on balance sheet.
- Currently, 97% of all manufacturers are enrolled to use MMA's web-based electronic invoice application, eInvoice.
- eInvoice allows manufacturers to log into a secure web site and retrieve their own claim detail along with the quarterly invoices. Efficiencies provided by our eInvoice capability include the following:
  - Shortens the time frame for payment.

- Providing claim detail with the invoices allows Manufacturers to review, analyze and reach resolution prior to submitting payment.
- Automatic delivery of invoice information starts the 38-day window on average about 5 to 7 days earlier than if invoices were mailed.

The eRebate operational application has four components:

- **Contract Administration** is used for setting up the customer and programs, as well as to define security.
- **Invoice Generation** is used for generating the invoices after the claims have been received, reviewed, and had any adjustments applied.
- **Rate Generation** is used in the Non-CMS OBRA related rebate programs to create the rate associated with the manufacturer contracts for that quarter.
- **Rebate Operations** includes claims review and editing, cash posting, invoice adjustments, and supports DHHS by performing dispute resolution.

Additional components of the rebate process include eInvoice (mentioned above) and reporting.

Processing the CMS Rebate Utilization Files: As part of our ongoing processes, MMA loads the quarterly drug rebate files from CMS into eRebate through an automated process. These data are cumulative and maintained within the eRebate application. The data supplied includes manufacturer contract and contact information used for invoicing and dispute resolution. We will also load claims from several sources, including our own FirstRx system, the MMIS, and any other applicable third-party data sources. MMA retrieves and loads the CMS drug product data file each quarter from the Medicaid.gov site prior to invoicing. When the CMS product data are retrieved, we use the most recent published file available. Once the CMS product file is loaded into eRebate, the data are checked for accuracy against the file contents to account for any loading errors. Any errors identified are addressed, and the file is reloaded. MMA understands that the CMS drug product files are used to identify clotting factor and pediatric drugs, which have a different percentage of Average Manufacturer Price (AMP) used when calculating the URA.

a) Self-service for labelers

MMA offers a web-based, electronic invoice application, eInvoice, which allows manufacturers to log into a secure web site and retrieve their own claim detail along with the quarterly invoices. This provides efficiencies and benefits DHHS rebate operations by eliminating most email requests for claim detail and allowing less analyst time to deliver requested files. This results in fewer disputes, thereby shortening the time frame for payment. When manufacturers do dispute the amounts filed, they are able to reach resolution prior to submitting payment.

b) Reconciliation of payment to invoice and NDC

MMA diligently monitors information provided by CMS that is used in generating rebate invoices to ensure that all information is complete and accurate. Each of our state customers allows us to monitor their feeds into the CMS communications systems. MMA monitors on their behalf and acts upon each piece of information as needed. Information gained is actioned as mandated by the State to your standards and timelines. MMA registers with CMS and the digital document repository (DDR) on behalf of, and with the agreement of the State, to receive all notifications from CMS so that DHHS may remain in compliance with all current requirements. Our rebate solution complies with all CMS-related

guidelines. MMA will work with the State to be assigned as a representative to capture policy and procedure changes as they are released.

We maintain all current and updated crosswalks between NDC and HCPCS/CPT, and we will maintain historical cross-walk data for claims/encounters processing and drug rebate within our eRebate system. This system is used with all our state Medicaid customers as required and will be used by MMA to maximize State federal rebate funding. MMA has incorporated our version of a HCPCS/NDC crosswalk file into claims processing, and our staff pharmacists update this file monthly. After several years of monitoring and updates, the file includes over 10,000 separate record crosswalks.

MMA staff pharmacists monitor the DDR site weekly to review any new drugs for rebate eligibility. The pharmacists also receive input from our customers and manufacturers about any new conversion records. After a thorough review of a proposed drug for eligibility, it is added to the conversion file if appropriate. Our regular review and update of this file ensures the most accurate outcome for the rebate process. MMA has also developed a Unit of Measure (UOM) conversion table that converts those drugs whose pharmacy quantity is different from the quantity CMS mandates to be rebated. This file ensures the most complete and accurate invoices to the manufacturers.

c) Invoicing

MMA follows established business processes, supported by eRebate, to perform all tasks necessary to produce drug rebate invoices for drug manufacturers, as well as to record payments and disputes related to these invoices. eRebate and its related systems reside in the cloud, and they therefore have full redundancy and automatic failover. MMA generates all program type rebate invoices from eRebate in the CMS R-144 layout and within the CMS-required time period, where applicable.

The system enables the MMA Rebate Operations staff to generate invoices without costly developer assistance. Claims are reviewed and analyzed for any anomalies in a two-step process after they have been received. Staff starts the invoice summary once the CMS rate file is loaded and claims have been reviewed and analyzed. MMA generates and sends invoices to drug manufacturers/labelers, within the established CMS time frame of 60 days after the end of quarter.

Using eInvoice, we will ensure issuance of accurate invoices to drug manufacturers, doing so in a timeframe in accordance with CMS requirements. eInvoice is our online invoice tool, which provides a secure site that allows pharmaceutical manufacturers to log in and retrieve rebate invoices in multiple formats, as well as supporting claims data. All programs can utilize our eInvoice delivery site making the delivery of the invoice and supporting claims data to the manufacturer possible the same day of the invoice creation, rather than multiple days if mailed. The eInvoice notification meets all CMS guidelines and its delivery meets the postmark requirement for interest calculations.

d) Reporting

MMA's system incorporates a rebate reporting module in ***our MRx Explore application that contains approximately 60 parameter-driven financial, management and invoice reports.*** These reports support multiple program types. We offer a standard reporting package of management reports pertaining to federal and supplemental rebate administration, which include Financial and Utilization Reports as well as Invoice and operational reports. These standard management reports include historical rebate data, as well as current data and include an Accounts Receivable Summary Report by Manufacturer, Dispute Amount Report, Dispute Code Report, Batch Total, Check and Claims Balancing Report. Our MRx Explore reporting tool provides data, accessibility, flexibility, customization, and user-friendliness and is

refreshed with data from transactional systems daily. Data for these reports are refreshed as frequently as every five minutes.

e) Accounts Receivable and Collections processes

For states in which MMA administers the federal MDR, we perform due diligence for collection of all federal rebate accounts receivables, dating back to the inception of the State's federal rebate program (e.g., the pursuit and collection of disputed rebate amounts and any other invoiced but uncollected federal rebate accounts receivable).

MMA's collections processes have been developed to resolve disputes, including the pursuit and collection of monies owed to the State not in official dispute. Our processes provide all the information necessary to document and support our claim. We meet with manufacturer representatives by telephone, video conference, or in person to assist in the resolution. In addition, we take every opportunity to educate the manufacturer representatives on best practices to minimize or prevent future disputes.

We will ensure that disputes or other outstanding balances that are pursued yet unresolved through the CMS dispute resolution processes and procedures will be elevated to the applicable State administrative or judicial review process. MMA will coordinate closely with the State on unresolved disputes and outstanding balances until they are resolved.

f) Dispute resolution

For all our rebate customers MMA pursues resolution of all unresolved drug manufacturer rebate disputes. We do this regardless of when the dispute was filed by the drug manufacturer. MMA's rebate system, eRebate, produces manufacturer invoices, supports DHHS by managing its dispute resolution, and provides accounts receivable functionality for payment reconciliation and reporting. eRebate functionality includes claims review and editing, cash posting, invoice adjustments, and supports dispute resolution. Use of our eInvoice application results in fewer disputes, thereby shortening the time frame for payment. When manufacturers do dispute the amounts filed, they are able to reach resolution prior to submitting payment.

b. Please provide a brief description of the systems you have implemented within the past 5 years that have required certification by CMS, including the state name and the result.

Our pharmacy solution is CMS-certified for all 13 of our Medicaid FFS POS customers including seven recent MECT 2.x certifications. MMA has the proven ability to supply the required documentation/artifacts and to actively participate in certification activities to support our State Medicaid Agency customers. ***MMA has achieved pharmacy CMS certification 100% of the time in every state where certification was requested.***

Brief Description of Systems Certification Experience within the Last 5 Years

MMA participated in the 2017 CMS Vendor Pre-Certification Pilot program for Pharmacy and Provider Screening. We met weekly with CMS and MITRE staff as we worked through the details of the MECT checklists, which offered us particular insight into CMS expectations for many of the checklist items. This provides assurance to DHHS that we are using the latest Medicaid-focused technology, standards, and advancements.

Our recent and highly relevant CMS certification experience means that MMA has proven our ability to work productively with CMS and the state staff stakeholders within a Medicaid Enterprise who are responsible for overseeing PBM services. We know how to collaborate with provider associations and member advocates to be sure we meet the needs of providers and members.

Our PBM/POS solution complies with all applicable laws and regulations. It is HIPAA-compliant and meets all requirements prescribed by CMS, as well as requirements outlined by CFR parts 42 and 45. We are aligned with CMS' strategy for modularity and interoperability to support the seven conditions and standards and MITA compliance, and we have the proven ability to supply required documentation and to actively participate in successful certification activities to support our state Medicaid customers.

Our experience with supplying documentation is extensive and current, and this expertise will be utilized to continue supporting Nebraska. Our depth of experience with CMS Certification has provided us with significant insight into the way that CMS and the MITRE reviewers approach the interpretation of the necessarily broad business checklist items. CMS and MITRE have approved MMA's standardized processes and the high quality of our artifacts. This expedites the certification process for our state Medicaid agency customers, eliminates re-work, and has resulted in no findings.

MMA's pre-existing standard products deployed across the country include FirstRx, FirstTrax, FirstIQ, FirstCI, eRebate, and MRx Explore. The following table provides CMS certification details for our current full state Medicaid PBM/POS customers that we have assisted to received CMS certification within the last five years.

Medicaid Customer	Date Certification Notification was Received from CMS	Effective (Retroactive to) Certification Date	Certification Type	MECT Version	Corrective Actions/ Findings
Alaska	September 2018	September 2018	MMIS	MECT 2007 Release	None
Arkansas	June 2018	March 2015	Pharmacy Modular	MECT 2.2	None
Colorado	September 2019	March 2017	MMIS	MECT 2.2	None
District of Columbia	December 2017	December 2015	Pharmacy Modular	MECT 2.1	None
Kentucky	August 2016	July 2014	Pharmacy Modular	MECT 2007 Release	None
New Hampshire	June 2015	March 2013	MMIS	MECT 2.1	None
South Carolina	April 2019	November 2017	Pharmacy Modular	MECT 2.2	None
Tennessee	February 2018	June 2013	Pharmacy Modular	MECT 2.2	None
Virginia	December 2018	September 2017 (Encounter Processing System) October 2017 (PBMS)	Pharmacy Modular	MECT 2.2	None
CMS certification note: MMA has also assisted the following long-time current PBM customers with achieving their CMS certifications, but these certifications were received more than five years ago: Florida (June 2010), Idaho (July 2012), Michigan (April 2011), and Nebraska (January 2012).					

c. What lessons learned, and recommendations can you provide concerning CMS system certification of pharmacy and rebate systems?

MMA has learned many best practices from our experiences with CMS system certification of pharmacy and rebate systems. For example, MMA would recommend that DHHS focus on specifying desired pharmacy services rather than technology. We suggest that DHHS focus on obtaining effective solutions through flexible, responsive and customizable technology, rather than prescribing a specific technological solution as some states do.

Lessons Learned and Recommendations

DHHS should consider asking vendors such as MMA to demonstrate modular PBM solutions. We are available to provide a demo of our modular PBM solution for DHHS if the State is interested in exploring flexible options.

Benefits of Vendor-Hosted Systems

We recommend that DHHS allow a vendor-hosted PBM system to be proposed. Our MMA-hosted Medicaid agency customers benefit from redundant disk mirroring, state-of-the-art physical and technical security measures, offsite backup procedures, and quicker recovery in the event of a disaster. This will free DHHS from dependence on a single physical location that can easily be attacked by natural disaster or malevolent forces.

Lessons Learned for Replacing an Aging Legacy MMIS and Ancillary Systems

In supporting our customers as they have worked to bring their systems into alignment with the CMS Modularity Standard, we have learned this above all else: although it may seem that a state's legacy MMIS is its knowledge base, the real value lies in the state's carefully honed business rules and the program knowledge of its people. Obtaining a more modern, modular, reliable, easy-to-use system will benefit DHHS users as well as Nebraska's providers and members. This will free up DHHS to use its expertise to direct its program and oversee the implementation of its rules.

In order for many legacy MMIS functional areas to comply with many new federal or state regulations, programmers must re-code to accommodate the changes. ***MMA's FirstRx PBM/POS system allows 98% of all required changes to be made by benefit plan administrators without coding.*** The system is highly flexible and enables DHHS to put its changes and improvements into action much more quickly and efficiently.

Modularity Investment Pays Off, Especially the Pharmacy Module

Modular certification allows for quicker certification of the carved-out PBM module. A Medicaid PBM specialist such as MMA is a nimble, responsive partner with the ability to execute DHHS' strategic program changes quickly to maximize savings in a rapidly changing environment. Our state customers have experienced a lower risk by certifying pharmacy systems independently from MMISs – and expedited access to 75% FFP.

To achieve modularity, the State will invest more in the beginning of the process, but DHHS will begin to see savings on drug spend once operations are underway. DHHS will eventually gain savings on medical spend as well, because so much specialty spend occurs on the medical side.

Building in Sufficient Requirements Validation Time

Through our work supporting our state customers as they modernize, we have learned that when a state has had a legacy MMIS in place for a very long time, its structural and functional weaknesses can be hidden by layers of creative work-arounds.

Because of this, requirements validation with such a system becomes an exercise in discovery. This is similar to renovating an old house, in that the renovator cannot know what is actually behind a wall until the remodeling is under way.

The hidden problems that aren't found and addressed during requirements definition will often come to light during user acceptance testing (UAT). Therefore, it is advisable to schedule extra time for requirements validation and UAT when replacing a legacy MMIS.

Avoiding the Big Bang Pitfall

Nebraska's RFI indicates that DHHS does not contemplate a "big bang" approach (trying to implement everything more or less simultaneously). MMA agrees that the big bang is not an advisable way to replace a legacy system, and we do not believe that such an approach is likely to be CMS-approved, following the experience of a state that MMA recently worked with.

One serious risk in the modular type of implementation is that the vendors of different modules, working in isolation, are likely to build differing and possibly incompatible standards. It is in DHHS' best interest to get consistent data governance in place before the other modules are built, thus avoiding this risk. As discussed under the next heading in this response, this is most efficiently achieved by hiring a strong central SI that is empowered to perform data governance and drive to well-defined industry standards wherever possible.

Strong Central Systems Integrator

MMA has learned that states are most successful when they design their enterprise to consist of modules with well-defined business processes, such as pharmacy, decision support system, and eligibility. This enterprise architecture requires a strong central Systems Integrator (SI) to manage the flow of information among the modules.

Implement Your SI First

We strongly recommend that DHHS schedule its enterprise procurement so that its SI starts work before the vendors of the other modules that make up the enterprise, or at least concurrent with the first module implementation by any other vendor. ***This greatly increases efficiency and decreases the burden on DHHS' stakeholders by minimizing rework.***

Another state MMA recently worked with did not implement the SI first in its Medicaid Enterprise System project to replace its previous legacy MMIS with a fully modular system. This necessitated rework down the line, which required extra time and resources.

- ***Single Sign-on:*** DHHS' SI should function as the identity provider (IdP) for single sign-on (SSO), including provisioning users and monitoring use of that access.
- ***Consistency across the Enterprise:*** The SI should set out precise interface definitions and ensure that they are enforced throughout the enterprise for the vendor of every module. This small investment will pay DHHS back every time a new interface between modules needs to be made, because testing of each newly-built interface need only be performed once, rather than every time that a new module is added to the enterprise.

Consistent Data Governance

MMA has found that a hub-and-spoke architecture with a strong SI offers the opportunity to execute a single data use agreement with the vendor of each module, with the SI included as a party to each agreement. This is an advantage to DHHS, because the alternative when implementing the CMS-recommended data use agreements is to create and execute a multitude of separate data use agreements between each vendor and every other vendor.

Industry Standards

MMA advises the use of industry-standard formats and interfaces whenever they are available. States find it easier to advance technically when they strive to modify their business processes to accommodate standard interfaces. Even the industry-standard interfaces offer the flexibility required to accommodate each State's unique business rules and requirements. By driving to the industry standard, DHHS saves money and time in the long run, as well as advances its MITA maturity level.

Central Repository or Website to Track and Coordinate the Enterprise Transformation

MMA also recommends that DHHS set up a central repository or website dedicated to tracking the Nebraska re-design, with a designated primary contact person to facilitate the dissemination of information. Colorado and Virginia had websites dedicated to the re-design efforts, and the "single source of truth" was very helpful in ensuring that the states as well as their vendors were all playing from the same sheet of music.

Use of a Rebates Lockbox

As a best practice, the expert MMA Rebate Operations Team recommends the use of a lockbox, which allows the State immediate access to all rebate funds collected. All check payments go into the lockbox along with any supporting information, including Reconciliation of State Invoices (ROSIs) and Prior Quarter Adjustments (PQAs), as well as envelope postmark information.

MMA tracks these payments on a daily basis on a deposit reconciliation spreadsheet, which can be formatted to Department specifications. On a monthly basis, we send the deposit reconciliation spreadsheet to DHHS to verify that it matches the State's records. We also have the capability to run reports based on deposit dates should DHHS require that information.

d. Provide an estimate of the implementation timeline for your solution and describe the factors that might cause this timeline to become longer or shorter.

MMA is known for its track record of successful pharmacy implementations. We understand that strong and robust project management is one of the key success factors for any project. The scope, scale, and complexity of a project, such as the Nebraska Medicaid Pharmacy and Drug Rebate Services, requires detailed planning and execution, experienced resources, clear communication lines, and rigorous monitoring and adherence to quality standards. To that end, our approach is to apply effective project management processes and procedures to optimize and balance project scope, schedule, activities, tasks, deliverables, risk, and resources, while ensuring a successful implementation and operation.

We consistently deliver on schedule and with high customer, member, and provider satisfaction. We ensure a successful implementation by using our proven project management methodology (PMM) which is in place and formally describes and provides structure to our project management approach and process. ***We incorporate the concepts of agile development in our methodology,*** which is based on the concept of incremental and iterative development, in which the phases within a development life

cycle are revisited over and over again. In Agile development, rather than a single large process model that is implemented in conventional SDLC, the development life cycle is divided into smaller parts, called "increments" or "iterations," in which each of these increments touches on each of the conventional phases of development.

There are many dependencies that affect the timeline of an implementation. In order to ensure the success of the project and that it remains on track, we use a structured development process to validate all RFP requirements for new and existing functionality. Identification of MMA and State resources, as well as other stakeholders and vendors is also vital to ensure all tasks and deliverables remain on schedule and go through the appropriate review and approve cycle. Adequate testing and auditing of the system throughout the process is another component that affects the timeline schedule.

However, the most common challenges that affect the implementation timeline occur during the data mapping and data conversion processes, particularly when non-standard file layouts are required by the State and/or the MMIS vendor. MMA leverages data standards such as NCPDP to ensure that all data from the State and other vendors is provided in the proper format to remain on schedule. The success of the implementation has to do with the quality of the data provided, not only the data itself. The MMIS vendor needs to provide resources who have adequate knowledge of the data and are fully committed to participating in the mapping and testing processes that support the interface build-out and adhere to project work plan timelines. All of these factors affect the length of the implementation timeline. The typical implementation timeframe consists of the following components:

- Requirements validation occurs for one third of the implementation timeframe.
- Configuration, design, and development occurs for one third of the implementation timeframe.
- Testing occurs during one third of the implementation timeframe.

Using our experience and proven processes, MMA guides the continued operation of existing services and ensures a successful implementation without disruption of services to members within the appropriate timeframe.

i. Implementation of POS only

Our typical implementation timeline for a POS ranges from 9 – 12 months depending on the complexity of the program. This timeframe estimate includes the implementation of a call center. Some factors that affect the timeframe range involve dealing with State and vendor resources. As the incumbent, MMA has established relationships with the State, the MCEs, and other vendor resources which minimizes the risk of a delay in the implementation timeline.

ii. Implementation of PDL

Our typical implementation timeline for a PDL is four months, depending on the complexity of the program. This timeframe estimate includes the assessment of current PDL classes and supplemental rebate agreement expiration dates, identification of classes for review, solicitation for offers, data analysis and PDL recommendations, presentation of recommendations to the State and their Pharmaceutical and Therapeutics Committee, and the execution of contracts. Some factors that affect the timeframe range involve dealing with State and vendor resources. As the incumbent PDL vendor, MMA already has established relationships with the State, the MCEs, and other vendor resources.

iii. Implementation of Drug Rebate System.

a) Include timelines for delivery of the IT solution with the State continuing the operations using the vendor maintained system.

If the State chooses a delivery model where the State performs the operations using our system, the implementation of timeframe of the Drug Rebate System would increase because the State would not be familiar with the applications and processes. Extra time would need to be built for more extensive training and knowledge transfer, so the timeline would push out to nine months, instead of six months. The State staff will have to be trained on the solution, applications, and processes rather than MMA leveraging existing, trained staff and management while adding additional operations team members to handle the Nebraska programs. MMA would partner with the State Rebate Subject Matter Expert (SME) who owns the rebate services and works with CMS to ensure we are doing the operation in a timely efficient matter. A 9 to 12 month implementation timeframe would be recommended for this option.

b) Include timelines if vendor were to implement the IT solution as well provide business services to perform drug rebate operations.

If the State chooses a delivery model where MMA implements the IT solution and provides the business services to perform drug rebate services, only a six month timeframe is necessary for implementation. Typically, the standard with our current customers is that we implement the services which provides the State with the experience, staff expertise, and resources. In addition, we have established relationships with more than 100 manufacturer/labelers that facilitate the rebate process. A timeline of six to nine months would be typical. If the outgoing vendor has data conversion extracts clearly defined and test files readily available, there is the possibility to compress that timeline after a detailed review between the State, existing vendor and incoming vendor.

iv. Implementation of all services described in this RFI

MMA has an outstanding track record for successful large Medicaid pharmacy and drug rebate implementations, including implementation of all services described in this RFI. ***We provide pharmacy management services to 13 current Medicaid customers, including Nebraska. We also have more than 35 years of experience implementing successful Medicaid pharmacy systems and services, and more than 15 years of experience with our proven Project Management Methodology (PMM).*** The result of our well-honed project management methodology is a smooth implementation with minimal risk to members, providers, and other stakeholders. In the following table we demonstrate some examples of recent successful Medicaid pharmacy and drug rebate implementation experience. For each of the below transitions, we implemented one or more of our pharmacy modules.

Contract	Last Install Date	Time to Transition	Contractor At Time of Transition
State of Georgia Medicaid PDL/Drug Rebate	2018	11 months	Change Healthcare
Commonwealth of Virginia Medicaid PBM	2017	6 months	Conduent
State of Colorado Medicaid PBM *All modules were timed with a big bang MMIS transition.	2017	21 months *	Conduent

Contract	Last Install Date	Time to Transition	Contractor At Time of Transition
State of South Carolina Medicaid PBM	2017	9 months	MMA – retained contract and added services
District of Columbia Medicaid PBM	2015	6 months	Conduent
State of Arkansas Medicaid PBM	2014	14 months	DXC

e. What lessons learned, and recommendations can you provide concerning conversion of historical pharmacy data? Drug rebate data?

The Medicaid environment is complex and fast-changing, with significant challenges and hurdles. With over 35 years of experience implementing successful public and private sector pharmacy systems and services on time, including the Nebraska Medicaid Pharmacy Program, MMA brings to DHHS the benefits of our experience and staff expertise. We take our project management responsibilities seriously, and we continuously strive to improve on our project delivery capabilities by reviewing lessons learned from previous projects.

Conversion activities always pose challenges during transitions. The most common challenges occur during the data mapping and data conversion processes, particularly when non-standard file layouts are required by the State and/or the MMIS vendor. The MMIS vendor needs to provide resources who have adequate knowledge of the data and are fully committed to participating in the mapping and testing processes that support the interface build-out and adhere to project work plan timelines. MMA will be a prepared partner – we have demonstrated our ability to interface with many different vendors – we are able to overcome these challenges.

- **Data Layouts:** To ensure a successful transition, the focus should be on coming to quick agreement with the current and new vendor on the data layouts for all conversion activities. The use of Industry Standard NCPDP and X12 interfaces, whenever possible, can increase the speed of the conversion. Regardless of whether industry standard or custom layouts are used, it is critical that the incoming vendor receives the data required to load to the new operational solution. All historic reference data (e.g., member enrollment, provider, rate, etc.) must be effective dated to clearly tie back to what the data looked like at the time of claims processing.
- **Length of History Loaded (Pharmacy Data):** The amount of historic data that will be loaded into the new solution must be determined to ensure that there is a functional use for it. For example, there may be no operational benefit to loading more than two- or three-years' worth of data into the new operational solution or any new vendor's operational system. The further back in time the data goes, the more work it is for all parties involved (e.g., DHHS, prior vendor/s, incoming vendors) to accurately validate it to the new system. If DHHS needs to have access to historic data than what is needed for operations, an option would be for the vendor to stage/load data beyond a certain time period in a database accessible to DHHS.
- **Drug Rebate Data:** The incoming vendor should supply DHHS with a comprehensive data conversion plan that designates the required files/fields needed for a successfully conversion to the new system. This should include reports and summary file to which the detailed information should balance. The existing vendor needs to be able to quickly supply the required fields in a timely, and accurate fashion. As part of any transition and conversion, there will be decisions that need to be made on

what actions to take with data that are not of the required quality to be loaded or for which data transformation needs to take place. Having the prior vendor's data experts working on the transition and requiring them to provide documentation on the data being sent (e.g., data dictionaries, business rules, etc.), makes the transition much more efficient.

f. What support would you need from the State, the outgoing PBM, and any other contractors during the implementation?

MMA needs access to DHHS SMEs who are able to make decisions on pharmacy policy and programs and who have experience working with the prior vendor. DHHS SMEs need to be able to make decisions, approve requirements, review and approve test results, and approve the transition to operations. In addition to pharmacy program experts, many states have their project management office, testing group, security, information technology, contracting and various other department experts involved during implementation. It is important to identify at the beginning of the transition the specific SMEs who are responsible for reviewing and approving artifacts for accurate and efficient scheduling. The identification of all vendors and their role must also be determined in order to create an accurate timeline, including review of various artifacts (e.g., project plans, meeting minutes, status updates, requirements documents, test results, etc.). During the transition, in addition to having DHHS and vendor SMEs who know the clinical, policy, benefit and other rules available, there is a large emphasis on having the experts who will be supplying data for the conversions, as well as ongoing operational interfaces, involved throughout the implementation process. For operational data interfaces, thorough and complete files must be available and ready for testing in a timely manner. The sooner the file layouts and corresponding test files (including large, production like files) are available, the more complete and accurate the interface development and testing process will be.

g. What information do you need from the State to submit a responsive proposal?

With more than three decades of Medicaid pharmacy experience, MMA understands the impact that an RFP can have on a prospective bidder when developing a responsive proposal or bid. We recommend that the State determine all the details of the procurement prior to RFP Requirements, and the following information should be included:

- Detailed proposal instructions that include the requirements for proposal conference information, required proposal format, quantity of proposals, electronic and/or paper submission, wet or electronic signatures, evaluation criteria and scoring elements, subcontractors, program background information, contract terms, corporate experience including CMS certification experience, etc.
- Required staffing and the location where the work will be performed is key. Will work be performed from state provided offices, in-state, or remotely so that the vendor can leverage established shared service to deliver the most efficient use of State dollars, i.e. a Call Center like Glen Allen.
- Detailed scope of work (SOW) requirements must be provided such as whether eligibility and financial payment services are included in the SOW.
- Adequate timeline to allow for a thorough development of the proposal response. An ideal proposal response time is 60 days.
- Detailed timeline provided for Implementation and Go-Live dates.
- Adequate timeframe for vendors to submit questions and for the State to provide responses within a timeline that provides prospective bidders ample time to incorporate the responses.
- Detailed metrics and historical volumes on PAs that are handled by the call center broken out by fax and phone, non-PA related calls, claims (paid only is best), rebate statistics, and membership levels over the previous twelve months are vital for a prospective bidder. This ensures the best "apples to apples" comparison for pricing purposes for all bidders.

- Identification of State responsibilities and vendor responsibility within the scope of work. For example, in the rebate space, sometimes the State handles the federal component and a vendor handles the state supplemental and vice versa.
- Identification of all the data structures, libraries, and sources, so an interface map can be built and costed.
- Detailed requirements regarding communication with members and providers including physicians and pharmacies.
- Information regarding the trading partners the vendor will need to interact with and in what capacity.
- Detailed information regarding the State's intent to maximize 90/10 federal match on the Design, Development, and Implementation costs.

h. Please describe the considerations you would weigh in deciding whether to respond to a state RFP for Pharmacy and Drug Rebate Services?

The major factor when making a bid/no bid decision is the scope of work requirements and other RFP opportunities in the pipeline. Additional decision-making factors include recently won new business that is already in the implementation pipeline. Additionally, the goals of the procurement need to align with Magellan's core values of assisting sensitive populations and leading humanity to healthy, vibrant lives.

D.2 Technology and Service Innovation

MMA leverages our best-of-breed processes, technology, and services to create long-term collaborations with our State Medicaid Agency customers. Our systems, applications, and workflows are built specifically to support Medicaid agencies, the members they serve, and the providers they work with.

Our approach is to partner with our customers to manage the fastest-growing high-cost drivers of pharmacy program spend, while successfully navigating the complex Medicaid regulatory environment using the latest technology and service innovations.

a. DHHS is considering utilizing FedRAMP-authorized cloud services for hosting MMIS modules with the MMIS module vendors responsible for operating and maintaining the modules. DHHS may contract directly with a cloud services broker for purchase of the cloud services.

i. Are you willing to implement, maintain, and operate your solution within this environment?

Cloud environments are complex and rapidly evolving, which led the Federal Government to develop Federal Risk and Authorization Management Program, or FedRAMP. MMA currently deploys workloads in Amazon Web Services (AWS) FedRAMP Moderate US-East West across four availability zones, and we have nine availability zones to choose from.

This gives us the ability to build more fault-tolerant systems, with much more scalability while meeting security and compliance requirements. MMA would be happy to have our staff of AWS-certified Cloud Architects and Security professionals meet with DHHS to discuss the FedRAMP Moderate East/West Environment.

ii. What challenges, risks, or concerns do you see with this approach?

The concerns that are generally raised regarding cloud services hosting center around the ability to safeguard the security of cloud-hosted data, the ability to authorize and track access to the data, and the ability to continuously monitor cloud products and services. This approach is generally a more expensive option than if we deployed the program in our existing shared services.

The FedRAMP certification framework delivers a standard approach to the security assessment, authorization, and continuous monitoring of cloud products and services. According to guidance provided on FedRAMP.gov:

- Moderate Impact systems accounts for nearly 80% of Cloud Service Provider (CSP) applications that receive FedRAMP authorization and is most appropriate for CSPs where the loss of confidentiality, integrity, and availability would result in serious adverse effects on an agency's operations, assets, or individuals.
- FedRAMP introduced their High Baseline to account for the government's most sensitive, unclassified data in cloud computing environments, including data that involves the protection of life and financial ruin.
- High Impact data are usually housed in Law Enforcement and Emergency Services systems and Financial systems, where loss of confidentiality or integrity could be expected to have a severe or catastrophic adverse effect on organizational operations, organizational assets, or individuals.

Our process to determine the best cloud environment for our solutions began with a thorough analysis of our customers' needs. This included a review of not only the relevant security frameworks such as HIPAA and the NIST 800-53 control set, but also the functionality required such as high availability, interoperability, and auditing. We determined that the FedRAMP Moderate East/West environment offered us the ability to best serve our customers. Some of the factors that weighed into that decision were:

- **FedRAMP East/West is more mature and includes more services than many other available cloud environments.** The FedRAMP East/West environment offers a greater number of services than those offered in the GovCloud, for example. Additionally, when AWS offers new services, they appear in the FedRAMP East/West environment first and take longer to appear, and some will never appear, in the GovCloud.
- **FedRAMP East/West meets security requirements.** Our adoption of the FedRAMP Moderate environment combined with our focus on the MARS-E and HITRUST security auditing frameworks and the usage of only HIPAA-eligible services, positions us and our state partners to take advantage of the security, auditability, and compliance of cloud-native solutions while maintaining or exceeding industry best practices for security and privacy.

Given the maturity of the FedRAMP East/West environment, its availability of key services, and its compliance with the appropriate security frameworks for healthcare data, we have determined that the only way for us to provide a solution that meets all of our customers' security and functional requirements is to host our solution in the FedRAMP East/West environment.

The ongoing FedRAMP Certification is obtained by our Cloud Infrastructure Service Provider, which is Amazon Web Services (AWS). AWS is required to submit security monitoring data on a monthly basis and perform an annual reassessment in order to maintain their FedRAMP certification. MMA supplements our regular contact with AWS by monitoring FedRAMP.gov in order to validate that their certification is current.

DHHS, as a government agency, would be in a position to access FedRAMP security packages directly through the FedRAMP Secure Repository, located on OMB MAX. Registration for OMB MAX can be completed at https://omb.max.gov. Agency employees and contractors must use their .gov or .mil email address when registering for access. Once registered, agency employees and contractors must request access to CSP-specific FedRAMP security packages using the FedRAMP Package Access Request Form.

Once completed, this form should be submitted directly to the FedRAMP Program Management Office (PMO) at info@fedramp.gov. The FedRAMP PMO will then review the accuracy and completeness of the submitted form and upon approval will notify the agency when access to the FedRAMP secure repository is granted. We would welcome the opportunity to have our staff of AWS-certified Cloud Architects and Security professionals join DHHS in a call or an in-person meeting to further discuss these details.

b. Does your pharmacy and drug rebate system integrate with other vendors for eligibility, claim editing, third party information, etc.?

i. Please describe the data exchanged, how it is used, and if it is stored or maintained.

Data Exchange

MMA's FirstRx POS system uses current and historical eligibility data provided by the MMIS/MCOs and provided by the MMIS eligibility database and stored in the member enrollment file to support eligibility verification and claims processing. It maintains current and historical eligibility data for basic program

eligibility, special program eligibility, and other member data required to support claims processing, eligibility verification, and reporting, according to each state's Medicaid Manual. On a regular basis, pharmacy claims that have been processed according to the eligibility data in FirstRx are sent to our rebate system.

FirstRx validates eligibility, benefit restrictions or limitations, TPL or other coverage information, and program-specific drug product coverage. MMA checks eligibility information and ensures that members are not enrolled in multiple PBM-governed programs simultaneously. MMA checks eligibility on a daily basis and dis-enrolls members from Medicaid MCEs if they have Medicaid FFS coverage.

MMA has extensive experience in accepting eligibility data from state MMISs. Our systems are fully capable of interfacing with state MMISs and uploading Medicaid 834 eligibility files. Eligibility loads are an enrollee level refresh, so historic data are sent with each update. Because we do an enrollee level refresh, additions, changes, and deletions are automatically handled by the load process.

MMA has processes in place to ensure timely delivery of this daily file through a state's SFTP server. Automated processes notify all stakeholders of any delay in file delivery or receipt, so that we can work with Medicaid agency technical contacts to immediately identify and correct file delivery delays.

MMA has a robust jobs execution and tracking mechanism which captures execution details along with interface static information. In the last three years we have moved from dedicated client script code to reusable Informatica jobs in order to reduce maintenance and streamline support. MMA built the Informatica infrastructure and the JETS system to store schedules, contact information, server information, and the type of interface for operational supports and reporting.

Once eligibility has been updated within the core system files, it becomes immediately available to all other applications using that data. We can support eligibility updates (add, change, and deletes) as frequently as every 15 minutes.

We have built the capability to support real time web services for eligibility, and upon request we can work with an MMIS to start the process for implementation. We have also built other data exchanges supporting real-time needs for both PA and claims data needed to support state call center integration requirements.

ii. Please also describe the integration methods supported (e.g. APIs, SFTP, etc.)

MMA integrates with external entities using both batch interfaces and real time application programming interfaces (APIs). All our interfaces comply with HIPAA privacy and security rules and guidelines and use industry standards such as XML, NCPDP, HIPAA, and HL7 for interoperability and data integration needs. We support the use of industry-standard data exchange in bulk file transfer using industry-leading tools, including Oracle Fusion, EDIFECS, and Informatica.

We currently receive and process through near real- time processing or with daily processing. We are able to support several methods of data exchange, including SFTP (secure file transfer protocols), NDM (network data mover), EDI (electronic data interchange), and real-time REST based or SOAP/XML exchanges. MMA uses Oauth2 to secure our APIs.

We have more than 3,500 interfaces established to transmit data to our customers. We have established APIs with outside vendors for electronic prior authorization, as well as an established e-prescribing API with that outside vendor. We are also in the process of implementing APIs with a State Medicaid client through their integration services vendor.

With SOA and interoperability as key drivers, MMA supports the necessary security standards and practices to deliver functionality securely. Our SOA-enabled systems can support single sign-on (SSO), transport level, and message level security models. Additionally, we have developed an enterprise user

provisioning system that facilitates provisioning of users who work on behalf of providers, state offices, or other stakeholders, in order to provide secure role-based access to web applications.

This facilitates HIPAA guidance and supports non-repudiation and role-based access to ensure delivery of correct information to the users on a need-to-know basis. The other benefit of service-oriented architecture (SOA) style of software design, where services are provided to the other components by application components, is that it allows us to support modularity in key domains.

Service-oriented architecture allows us to compose an application by integration of distributed, separately maintained and deployed software components. Our components are loosely coupled, enabling us to replace one technology with another in order to meet the operational need or technology driver.

We have built our applications in a modular design so that they can be combined to meet the specific needs of each state. Please see below for examples of our services that have been built for current application support and for future support:

- **Pharmacy Lookup Service** – retrieve pharmacy location via geocoding information
- **Eligibility Service** – retrieve and update member eligibility information within the POS
- **Identity Service** – retrieve information about user account attributes and roles.

MMA has adopted the open source tool Swagger to support our services documentation and to support the building of our services. We have also moved from XML to REST standards.

The services are based upon REST standard to ensure they are technology neutral. Representational state transfer (REST) or RESTful web services facilitates interoperability between computer systems on the Internet. REST-compliant web services allow requesting systems to access and manipulate textual representations of web resources using a uniform and predefined set of stateless operations.

By making use of a stateless protocol and standard operations, REST systems promote fast performance, reliability, and the ability to grow by re-using components that can be managed and updated without affecting the system as a whole, even while it is running. This also allows for technology-neutral interfaces that allow for minimizing the impact when accessing or supplying a new technology or system.

c. DHHS is interested in learning more about how other States maintain logic to select claims and NDCs for drug rebate, including State specific rule sets. Please provide information on how the information is maintained in your solution and the process for updating the information.

eRebate accomplishes this four ways:

1. Through internal code associated with our data transfer protocols we can exclude include claims based on format issue
2. We have a rules functionality that allows us to appropriately include/exclude claims based on an agreeable set of criteria
3. Through the use of proprietary files such as the UOM or HCPC/NDC crosswalk, we can adjust units according to CMS guidelines
4. We have a two-step manual process that ensures all three of the previous sets of logic performed the steps appropriately. This ensures completeness and accuracy of the data.

d. What technical innovation or business operations improvement recommendations do you have for increasing the percentage of drug rebates for the supplemental and federal drug rebate program?

Our eInvoice site supplies both the current invoice and claims associated with it as well as PPA invoices. The manufacturers have the claims at their disposal to analyze before making payments. This availability occurs minutes after the invoice process is completed thereby cutting down the timeframe to review from days, if mailed, to minutes through the Web portal.

Operationally, we have added a collections area to our rebate department to focus solely on collection of outstanding balances both in dispute and non-disputed as well. The main focus of this group is to recommend/ follow up with old balances in order to "clean" them up.

e. Summarize the cost-related and non-cost advantages or disadvantages of a state-owned MDR system relative to a vendor-owned system? Over a 5 year and 10-year time horizon?

Cost Related Advantages: In evaluating its return on investment (ROI), the State could offset the rebate administration fee with the savings in direct and indirect costs associated with the IT labor and hardware, which the state-owned MDR system would incur in order to maintain and enhance the system as requirements change. Additionally, there would also be a direct savings of operational costs that would also be used to offset current realized expenses.

Non-Cost Related Advantages: By choosing MMA's MDR system, Nebraska would be supported by a proven system that has achieved CMS certification 100% of the time in states where certification was required. Our dedicated Rebate Operations staff offers decades of Medicaid-specific experience in working with manufacturers, auditors and CMS.

f. Please describe any relevant technology innovations that have occurred within the past 5 years which you feel may be of interest to the State.

Technology Innovation

MMA uses innovative technology to ensure we offer business solutions that meet the functionality required, in accordance with latest industry standards and systems. MMA has been a driver for business-configurable, secure, and scalable systems; and we have taken advantage of various technologies to drive increased quality, agility, and lower overall support cost for the clients we serve.

We continue this overall technology vision as we look to the cloud, advanced analytics, and mobile platforms to support our customers. In this section of MMA's response to Nebraska's RFI, we describe relevant technology innovations we have employed within the past five years as well as those that MMA plans to implement within the next five years.

MITA-compliant, Service-oriented Architecture (SOA): MMA continuously drives to enhance innovation and operational efficiency in our current businesses. MMA uses a SOA approach to transform existing enterprise solutions to web services. SOA components use web services to improve system interoperability based on key business drivers and on guidance from CMS through its MITA initiatives. We leverage these technologies along with the guidance of our internal Enterprise Architecture and Solutions Group and IT Leadership Team. ***MMA's Medicaid Pharmacy Module has been certified 13 times by CMS.***

Innovative Pharmacy Data Warehouse and Reporting: Over the past five years, MMA has expanded its capabilities in the area of business intelligence (BI) and analytics through the introduction of new technologies and techniques for improving the quality and breadth of our suite of BI and analytical offerings. Introducing a comprehensive pharmacy data warehouse (PDW) that brings information

together from various subject areas and for various programs has enabled our pharmacy programs to be more effectively managed using techniques such as benchmarking and comparison analysis.

Our PDW contains not only the key characteristics of a pharmacy claim, including clinical and financial characteristics, but also broad sets of information on membership, prior authorization, pharmacy and prescriber demographics. The PDW also houses extensive characteristics of pharmacy products, enabling us to perform deep analyses for targeted financial and quality improvements.

MMA has also begun expanding the breadth of our data footprint and data delivery mechanism to include cloud hosting and accessibility. This expansion positions us to have a versatile mechanism in which business intelligence and analytics information can quickly be shared securely, while enabling processing power to be adjusted during peak utilization periods without any significant investment in effort and without needing the same amount of time that might be needed when adding capacity through in premise solutions.

MMA has developed a broad set of reporting packages and dashboards that focus on key aspects of the pharmacy program. In addition to financial and clinical reporting, MMA's management dashboards provide a 13-month rolling view of key facets of the program, including representations of key cost categories such as specialty spend and utilization as well as other key categories of utilization such as for populations with behavioral health product utilization.

Expanded suites of reports have been or are being created for Cost Avoidance, Coordination of Benefits, Medicaid Adherence and Refill Management, Manufacturers Rebates and Maximum Allowable Cost (MAC) solutions. To support these expanded offerings, the design of our data architecture using dimensional models that integrate facts from across the pharmacy enterprise has been implemented and is continuously undergoing refinements as either new facts are added to the data model or performance tuning changes are made.

Enhanced TPL (eTPL): MMA has built an enhanced TPL capability into our FirstRx POS system, which provides access to the most comprehensive nationwide database available. Differentiating enhanced TPL from all competitors, any identified OHI discovered by this process is validated in real time with the primary payers' PBM. The key distinction is that the information we are using to determine coverage does not lead to false positives and potential access issues (it is not suspected OHI).

Our solution allows us to deliver fast, accurate, and actionable information. Immediate benefit and cost savings are realized by providing the pharmacist with accurate claim processing information and alleviating unnecessary patient delays. FirstRx can also use information received from the MMIS on the eligibility file and combine it with the enhanced TPL data in accordance with Medicaid's status as the payer of last resort. Additionally, product lists specific to supplemental programs or coverage such as Medicare, LTC, or Nursing Home per-diem coverage can be incorporated in the system to further ensure that unnecessary costs are not payable under the member's Medicaid benefit.

e-Prescribing: MMA has partnered with Surescripts, the industry leader in e-Prescribing, to support the industry standard transactions for e-Prescribing. MMA has built a strong relationship with the industry's largest e-Prescribing vendor serving the provider, prescriber, and pharmacy marketplace through health information exchange (HIE). Surescripts is the leader in providing Accredited Standards Committee (ASC) X12 270/271 (Eligibility Request/Response) and NCPDP compliant electronic prescription transactions (version 10.6 XML), and their presence in the market gives MMA customers and ASC's members access to over 60,000 pharmacy providers and most of the industry practice management vendors that have been actively involved in electronic prescribing. MMA supports millions of transactions a year for e-Prescribing within the Medicaid space.

Call Center: FirstTrax has built a highly flexible Interactive Voice Response (IVR) solution to support automation of PAs such as early refill. The IVR automates the data gathering for the information needed to approve and PA. For example, through use of menu items we can collect early refill reasons such as a vacation or a medical procedure. We have also built the capability to automate letter generation when triggered by a system event. In the case of a PA denial, the system automatically triggers a letter event by systematically handing the data over to our letter generation system CorrPub, which auto-populates the template with the PA denial information. The information is then mailed to the respective parties. FirstTrax can retrieve this letter and records the mailing events to support any follow-up contacts or audits.

MRx Assist: MRx Assist is a recent product that incorporates the SOA design pattern and modern UI design to support key functionality around eligibility, claims, and PA needs. We continue to expand its capabilities as needed. MRx Assist reflects our future vision for our applications. This application incorporates responsive design so that it can be viewed and easily used within all platforms (desktop, mobile, and tablet). The MRx Assist application allows authorized users to perform simple administrative, but necessary (and timely) tasks such as add a member, update a member, and enter administrative PAs. With appropriate authorization, users can perform a multitude of tasks, designed to empower the user. Members added are instantly written to the database, and are available in our FirstRx POS system as eligible. All changes are time/date/user stamped for auditing and tracking purposes.

ePA: MMA built the FirstTrax call tracking system as the repository for all automated and manual PA requests, dispositions, and clinical notes. MMA tightly integrates FirstTrax with the FirstRx system to provide streamlined entry and update of PA requests to support claims processing. The architecture makes use of a common set of web services to exchange key PA data. FirstTrax also has a highly flexible Interactive Voice Response (IVR) solution to support automation of PAs such as early refill. MMA uses our innovative Clinical Decision Module (CDM) to support the manual and web-based PA process. This CDM also supports our ePA solution, ensuring high inter-rater reliability.

FirstTrax, a proprietary online, automated system, is also powered by our configurable, business rule driven CDM. CDM is the dynamic heart of the manual PA process and is a custom knowledgebase designed specifically for processing PA requests. It incorporates preferred and non-preferred drug lists, diagnostic information, age and gender considerations, and quantity limitations, along with sophisticated questions based on the State's PA criteria to allow consistent processing of complex clinical PA requests.

The CDM uses the same criteria as the FirstRx AutoPA rules, while allowing users to enter and consider additional information pertinent to the PA request and an individual patient's situation. The CDM is incorporated seamlessly into the FirstTrax call tracking and PA management system, which provides access to the patient's eligibility, claims, and previous PA history necessary for adjudicating any PA request. ePA uses several key services including 270/271 eligibility check service, ePA NCPDP standard transaction service, and we are currently integrated with two ePA vendors. We are working with states to implement these capabilities for improved PA services through ePA.

Multi-factor Authentication: This security enhancement requires a second factor of authentication, such as a code sent via a text message for users when accessing our corporate network from untrusted environments (e.g., a home network), which will be coupled with an employee's username and password for full authentication.

MARS-E Security Assessments: In order to support our state customers' CMS certification efforts, MMA has performed both and internal and external security assessment based on the MARS-E 2.0 templates and guidance. The documents and artifacts produced by these efforts are used to fulfill the

MECT checklist requirements and assist in the CMS certification process that is so critical to the funding of our customers' programs.

Morphine Milligram Equivalent (MME) Edit: In order to combat the national opioid crisis and in partnership with DHHS, MMA determined specific MME edits and thresholds to implement for the Nebraska Medicaid Pharmacy Program. We recommend the management of opioid utilization through a variety of methodologies, including quantity limits (number of tablets or days' supply), dose limits (total mg/mcg per day), comprehensive authorization criteria, and enhanced member and provider support interventions. This approach provides the prescriber with ongoing support and enables members to receive optimal care.

MMA has a number of interventions and strategies for promoting the appropriate prescribing and utilization of opioid medications and medication-assisted treatment (MAT) for substance abuse that include system capabilities through our FirstRx POS claims processing system and our FirstIQ RetroDUR decision support tool. We also have system capabilities and interventions for promoting the appropriate prescribing and utilization of opioid medications and other CNS depressants and stimulants.

MMA operates FirstRx, our POS system, and performs RetroDUR activities using our proprietary FirstIQ tool, which performs menu-driven inquiries into program data to manage opioid overuse and overuse of opioids in combination with other CNS depressants and stimulants. The results of these queries are used to produce reports, files, and graphs for further analysis for monitoring clinical and economic trends for the various Medicaid agency pharmacy programs.

Through FirstRx, MMA ensures the right members are receiving the right drugs at the right doses, through enhanced edits and utilization management criteria. MMA provides configurable benefit management and pharmacy claims processing, system edits, ProDUR, and RetroDUR that can be customized for opioid management, as well as other substance abuse. MMA uses current system capabilities to manage opioid and other CNS depressants and stimulant utilization, including ProDUR edits, quantity limits (number of tablets or days' supply), dose limits (total mg/mcg per day), and total daily Morphine Milligram Equivalent (MME) (Morphine Daily Equivalents).

Application Security Code Review: MMA has implemented auditing of source code of an application to verify that proper security controls are present, that they work as intended, and that they have been invoked in all the right places. This has become a standard part of the software-development lifecycle (SDLC) within our application development teams, significantly improving the security standards within the software we are producing. We are currently evaluating a product that facilitates agile development and meets both contractual and Information Security requirements.

Training Innovation: MMA has consistently offered instructor-led training both in person and virtually. If a customer requests, we can deliver all of their training virtually through our online Learning Management System (LMS). Within the last five years, we have updated our LMS to Saba. With Saba, we transferred the tracking of internal instructor-led and virtual instructor led trainings from paper attendance and evaluations to online records stored within Saba.

Within the past year, we transferred updates to the Contact Center on procedures and plan changes from e-mail attachments to documents stored in Saba that require attestation from the learner. This applies for all clients, but has specifically been used for updates to Colorado Medicaid, MCC Florida and CCP, Alaska Medicaid, MCC Virginia, and Michigan Medicaid. This allows us to track all training in one location.

We continued to use our LMS for computer-based trainings (CBTs), and we have expanded our offerings for our internal audience. On our web portals, we have added CBTs for our provider applications. These are available for all contracts that use these applications. For contracts that use a web portal without

these applications, we now record the Introduction to Providers that is facilitated prior to implementation. This recording is available on the web portal and allows providers who were unable to attend a live session to still receive the necessary information.

Member Portal: MMA has built external portal capability for web access to the member Medicaid pharmacy portal. Using a modern web-based architecture, we have expanded the capability for members to perform self-service on a number of functions. This allows members to take action and get information needed quickly and easily via modern web tools. Using the portal, members will be able to view important information and announcements and perform the following self-service functions:

- **Pharmacy Locator:** This look-up function allows an individual to find an in-network and/or out-of-network pharmacy based on name, geographical location, or specialization (e.g., 24-hour, drive-through, compound pharmacy, specialized pharmacy, etc.), which enables the member to easily find the pharmacy of their choosing. Once a pharmacy is selected, a link will be provided to show its precise location using Google Maps.
- **Member Profile:** Members have access to view their demographics information (date of birth, address, etc.), current and historic eligibility, and medication history.
- **Medicaid Covered Drugs Inquiry:** This functionality affords users the ability to perform a search of the state-specific formulary via the web by individual National Drug Code (NDC) number or drug name (brand or generic) (full or partial name) for the purpose of ascertaining formulary status or other plan limitations associated with a drug. Also, they have Access to Preferred Drug List (PDL) documentation. This functionality will allow users easy access to view and print the most current Preferred Drug List (PDL) documentation published by the state for which this is implemented.

i. Please identify the State contract(s) where these technology innovations are employed.

MMA identifies the State contracts where we provide the technology innovations described in this section of our proposal in the following table.

Technology Innovations (state contracts listed are Medicaid PBMs unless indicated)	
ESB, SOA, MITA-compliant Architecture and Mobile-enabled GUI	MMA supports these innovations for the following Medicaid PBM/POS customers: Alaska, Arkansas, Colorado, the District of Columbia, Florida, Kentucky, Idaho, Michigan, Nebraska, New Hampshire, South Carolina, Tennessee, and Virginia. We also support these innovations for the following publicly funded PBM/POS programs using the same technology: California ADAP/DGS, Florida MCO, Idaho ADAP, New Hampshire ADAP, New York Elderly Pharmaceutical Insurance Coverage (EPIC) SPAP, and Pennsylvania Pharmaceutical Assistance Contract for the Elderly (PACE) SPAP and ADAP.
Web Claims Submission	Arkansas, Kentucky, Michigan, Nebraska, New Hampshire, Pennsylvania PACE, and South Carolina.
Innovative Pharmacy Data Warehouse and Reporting	Medicaid PBM/POS customers: Alaska, Arkansas, Colorado, the District of Columbia, Florida, Kentucky, Idaho, Michigan, Nebraska, New Hampshire, South Carolina, Tennessee, and Virginia. Other publicly funded PBM/POS programs using the same technology: California ADAP/DGS, MCCVA, MCCFL, MCCAZ, Connecticut ADAP, Idaho ADAP, New Hampshire ADAP, New York EPIC SPAP, and Pennsylvania PACE SPAP and ADAP.
eTPL	Tennessee, Idaho, Virginia, Connecticut ADAP, Community Care Plan Medicaid MCO.

Technology Innovations (state contracts listed are Medicaid PBMs unless indicated)	
e-Prescribing	Arkansas, Florida, Idaho, Michigan, Virginia, and Pennsylvania PACE.
Real time Data Exchange with MMIS	New York and Virginia.
Call Center Letter Automation	Medicaid PBM/POS customers: Alaska, Arkansas, Colorado, the District of Columbia, Florida, Kentucky, Idaho, Michigan, Nebraska, New Hampshire, South Carolina, Tennessee, and Virginia. Other publicly funded PBM/POS programs using the same technology: California ADAP/DGS, Florida MCO, Idaho ADAP, New Hampshire ADAP, New York EPIC SPAP, and Pennsylvania PACE SPAP and ADAP.
Call Center IVR	Medicaid: Alaska, Arkansas, Colorado, the District of Columbia, Florida, Kentucky, Idaho, Michigan, Nebraska, New Hampshire, South Carolina, Tennessee, and Virginia. California ADAP/DGS, Florida MCO, Idaho ADAP, New Hampshire ADAP, New York Elderly Pharmaceutical Insurance Coverage (EPIC) SPAP, and Pennsylvania Pharmaceutical Assistance Contract for the Elderly (PACE) SPAP and ADAP
MRx Assist	Currently supporting Colorado, South Carolina, and Virginia. Other publicly funded PBM/POS programs using the same technology: California ADAP/DGS, LA County, and MCC of Arizona.
ePA	Alaska, the District of Columbia, Florida, Michigan, Tennessee, and Virginia.
Morphine Milligram Equivalent (MME) Edit	Currently supporting Arkansas, Colorado, Idaho, Nebraska, Tennessee, Virginia, and the District of Columbia.
Multi-factor, Application Security Code Review, and MARS-E Security Assessments tools within the MMA infrastructure	Medicaid PBM/POS customers: Alaska, Arkansas, Colorado, the District of Columbia, Florida, Kentucky, Idaho, Michigan, Nebraska, New Hampshire, South Carolina, Tennessee, and Virginia. Other publicly funded PBM/POS programs using the same technology: California ADAP/DGS, Florida MCO, Idaho ADAP, New Hampshire ADAP, New York EPIC SPAP, and Pennsylvania PACE SPAP and ADAP.
All initial training delivered virtually at the customers' request	California ADAP/DGS, New Hampshire TB, CT ADAP, VA Medallion
Initial training was a combination of classes offered virtually and in person at the customer's request	Medicaid: Alaska, Arkansas, Colorado, the District of Columbia, Florida, Kentucky, Idaho, Michigan, Nebraska, New Hampshire, South Carolina, Tennessee, and Virginia. Government Agencies: California ADAP/DGS, Florida MCO, Idaho ADAP, New Hampshire ADAP, New York Elderly Pharmaceutical Insurance Coverage (EPIC) SPAP, and Pennsylvania Pharmaceutical Assistance Contract for the Elderly (PACE) SPAP and ADAP.
Provider applications training is available as CBTs through the Saba LMS via our web portal	Currently supporting all our PBM customers that use CBT applications.
Recorded training introduction is offered to providers via the web portal	Currently supporting all our PBM customers that use a web portal without CBTs.

g. Please describe any relevant technology innovations you plan to implement within the next 5 years.

MMA's vision is to architect and design systems and build functionality, always with the paramount goal of serving our customers' needs for the next five years and beyond.

340B Interface Development: Recent developments and changes to the 340B Program, including the establishment of contract pharmacy relationships with covered entities as well as growth in virtual inventory management vendors, has significantly altered the covered entity, pharmacy provider, and payer dynamic.

In the current 340B management models deployed by other PBMs who own or otherwise have dependent relationships with virtual inventory management and 340B vendor contracts, there exists the potential for misaligned incentives or creation of opportunities where per claim administrative or management fees provide potentially non-disclosed augmented PBM income at the state's expense.

MMA has closely monitored these changes in the industry and developed an understanding of the virtual inventory management model while maintaining distance from any potential misaligned incentives. To that end, MMA is poised to provide analytics, guidance, and support for the multiple transactions associated with this business model and the resultant changes to OBRA rebate eligibility for claims dispensed by HRSA-enrolled providers in the event a dispensing event does not ultimately result in a 340B eligible transaction.

Cloud Computing: Healthcare service providers around the world are using Cloud (e.g., Software as a Service - SaaS, Platform as a Service - PaaS, Infrastructure as a Service - IaaS) to deliver improved service to their clients. Our Medicaid agency customers will benefit from a faster turnaround time, quicker disaster recovery, and enhanced rebate reporting once we go to the cloud.

Cloud services reduce the time and effort required to run existing workloads, provide access to powerful new analytical capabilities; include robust recovery capabilities; and meet security and privacy requirements, including: SSAE16 Type II, HITECH, NIST SP800-53 and 66, and HIPAA.

Magellan has selected Amazon Web Services (AWS) as our Cloud vendor and has signed a Business Associate Agreement (BAA) based on their security management practices, organizational security maturity, and the security capabilities of their platform and systems. AWS enables covered entities and their business associates subject to HIPAA to securely process, store, and transmit PHI.

AWS has effective security management practices that have been audited against the service organization controls - SOC1, SOC2, SOC3 and International Organization for Standards ISO-27001 security frameworks. Additionally, a security architecture review was conducted to ensure that all tenant level controls and operations are implemented and operated in compliance with MMA information technology security policies.

Dedicated instances will be used when processing PHI data on EC2. All PHI will be encrypted from end-to-end within a VPC. All PHI will be encrypted at rest. Encryption at rest will be achieved by encrypting the underlying EBS disk volumes.

Connection between the application and Oracle database instance is encrypted using Secure Sockets Layer (SSL) encryption protocol. Application URL are SSL encrypted using https protocol to access the application. Maximum level of logging will be enabled within each AWS environment. Logging services such as AWS Cloud Trail will be used to collect and persist logging from each AWS service in a centralized location for ease of monitoring and audit.

User Interfaces (UI): MMA is continuing to modernize our graphical user interfaces to reflect the best-in-class digital experiences that we are all accustomed to receiving as consumers in our everyday internet interactions. We apply design thinking to create user-centered experiences, which will deliver easy-to-use applications focused on our member and customer needs.

Our innovative information architecture is designed to deliver the right information at the right time through the right channel on any mobile device. This seamless integration with mobile capabilities includes mobile wallet, various communication channels and push notifications.

MMA is making investments in digital transformation to implement products for a customer-centric experience, adapted to a mobile-first mindset. This includes timely and context-driven video and audio content delivered through industry-leading, cloud-based content delivery networks.

MMA's web enablement strategy also includes a consideration of all mobile devices in the design and development of our UI. The web enablement activities in our MITA Roadmap work in concert with our service enablement activities to decouple the UI from the service layer. The benefit of this architecture is that as new end-user technology becomes available (new tablets, more capable smart phones, and devices that have not yet been imagined) the changes required to make use of them are all in the UI, thereby increasing the speed and decreasing the risk of enabling support for emerging technology.

Text Messaging: MMA has developed a new and cost-effective way to interact with your membership through mobile messaging. We are supporting an outbound texting program to allow state programs to proactively communicate with members. Using targeted and customized text messages, we can send short, concise, and actionable messages to your population to improve healthcare awareness, interaction, and ultimately contribute to better outcomes. For example, these messages can focus on refill reminders, or notices that it is time to get your flu shot. We will work with the state to evaluate your membership, assess the number of members who have viable cell phone numbers, and to create actionable messages that are customized to meet your specific business and clinical needs.

HITRUST: MMA has chosen to adopt the HITRUST Common Security Framework (CSF) and ultimately become HITRUST certified. As a part of this effort, we're evaluating using the SOC 2 for HITRUST converged reporting model (achieve a HITRUST certification and obtain a SOC 2 Type 2 report simultaneously). Our HITRUST partnership effort will have four iterations. The first will focus on scope, which will identify the systems and applications we'll assess under the CSF and SOC 2 report. The second will focus on mapping business, system, and security controls from our existing NIST based controls documentation to the converged CSF and SOC 2 requirements. The third is identifying, mitigating and remediating any gaps required before the final iteration, which is certification.

D.3 Delivery Model

a. The State of Nebraska contracts for a variety of support services under multiple contract as described above. Please describe any service delivery models you use that differ substantially from the approach described above.

MMA provides PBM services via a number of carved-out models (PBM modularity models) to meet the specific needs of each state that we support. Our service delivery models equate to the existing delivery models described in the State of Nebraska RFI. We have the capability to provide the following models:

- Carved-out clinical programs, including PDL management, rebate contracting, and DUR, to states who operate transactional processing using either their state-owned system or using a system built and/or owned by another vendor.
- Software as a Service (SaaS) models, in which states choose to use MMA-developed/owned software, but states choose to run their own PBM operations, such as benefit management configurations, prior authorizations, and/or call centers. In this model, MMA provides business/technical expertise and SME points of contact to support state resources who perform these functions on the MMA systems.
- MMA provides full PBM systems and services for states, including a full suite of unified PBM applications supporting POS claims processing.

i. Please identify the State contract(s) where these model(s) are employed.

MMA identifies the service delivery models employed in our State contracts in the following table.

Service Delivery Models	
Carved Out Clinical Programs	Arizona, Connecticut, Louisiana, Minnesota, Maryland, Montana, New York, North Carolina, Rhode Island, Texas, Virginia, and Wisconsin
SaaS Model	Idaho
Full PBM (COTS)	Alaska, Arkansas, Colorado, District of Columbia, Florida, Kentucky, Idaho, Michigan, Nebraska, New Hampshire, South Carolina, and Tennessee

b. As part of the MMIS Replacement project, DHHS is exploring the option of moving pharmacy claims payment and management to a fiscal agent model, removing the reliance on the MMIS for payment and remittance advice generation for these claim types. Does your pharmacy system complete the claim adjudication/finalize the claims for payment, including all responses to the provider and reimbursement? Please describe.

MMA has experience with delivery models that move pharmacy claims payment and management to a fiscal agent model, removing the reliance on the MMIS for payment and remittance advice generation for these claim types. This modular approach is used for our current contracts with Virginia and Colorado. Our sophisticated system, effective procedures, and experienced staff enable us to appropriately disburse funds for the payment of claims and State/federal post-payment transactions.

Our FirstRx claims processing system and FirstFinancial provider payment system support point-of-sale (POS) claims adjudication and provider payments. MMA's FirstFinancial provider payment solution is based on the GAAP-compliant Oracle Accounts Payable solution. FirstFinancial provides automated system functionalities and business processes to handle all tasks necessary to produce payment and RA files and record any cash receipts for providers. FirstRx completes the claim adjudication process and finalizes the claims for payment, including all responses to the provider and reimbursement. FirstFinancial uses FirstRx as the source system for all pharmacy claims transactions associated with

provider reimbursements. After the claims are adjudicated in FirstRx, including pricing, audits and edits, the resulting file of adjudicated claims is loaded into FirstFinancial and categorized by provider payee, tagged with a payment number and date, and the RA is produced. FirstFinancial manages all aspects of provider payment—the setup and management of provider credentials and preferences; the receipt of the claim; the routing of the payment to the provider and the acceptance of the payment by the provider. FirstFinancial prepares and pays providers through their preferred method (EFT or paper checks) and provides Remittance Advices (835) via their designated preference—paper, WebRA, or electronic.

c. The State's shift from traditional fee for service to a managed care model has left a very small volume of fee for service claims. The State is seeking innovative and cost-effective model to manage the drug benefits of this small population, including partnering with one or more states with similar Medicaid Pharmacy program requirements. What recommendations do you have for the State?

MMA has direct experience in delivery models that are based on a collective partnership between states with similar Medicaid Pharmacy program requirements. In 2000, MMA was selected as the pharmacy benefit manager for the Tri-State Pharmacy Initiative. The Tri-State Pharmacy Initiative was the result of a coalition between Maine, New Hampshire, and Vermont to control rising prescription drug use and expense in their Medicaid programs. Ultimately, the State of Maine did not join the coalition and MMA was awarded separate contracts with New Hampshire and Vermont to provide PBM services and assist the states in enhancing quality of care, controlling pharmacy expenditures, and reducing state administrative costs.

Nebraska has been a member of our TOP$ multi-state drug purchasing pool since 2009 – more than 10 years. The experience, knowledge gained, program successes, and expertise in providing PDL and supplemental rebate services make MMA the best choice to support DHHS in whatever RFP type is pursued. With nearly two decades of PDL and supplemental rebate services experience, MMA demonstrates the successful and reliable experience required for the new contract.

Over the past 18 years, we have developed innovative and reliable modeling tools and expertise for both individual programs and multi-state purchasing pools. Our focus on serving Medicaid customers has led to a deep understanding of the population these programs serve, the state and Federal rules under which they operate, and the benefit designs, clinical policies, and programs allowable within the constraints of regulations that have proven effective in providing and preserving access to clinically appropriate care in a cost-effective manner. We support multiple pricing models including pass through pricing to deliver the lowest net cost to the State, including single-PDL designs. MMA understands DHHS wishes to improve pharmacy transparency, efficiency, and accountability. We provide our customers with open, accurate, and timely information regarding clinical review, rebate generation, and other pharmacy benefit agreements.

MMA recommends that the State of Nebraska continues to manage its own pharmacy network, using the current pharmacy reimbursement algorithm published on the CMS website at https://www.medicaid.gov/medicaid/prescription-drugs/state-prescription-drug-resources/drug-reimbursement-information/index.html as a means to improve pharmacy transparency, efficiency, and accountability in the Medicaid program. This model removes the incentive for MCEs to steer business to a limited network of pharmacies which can limit access to pharmacy providers in rural areas. A state-sanctioned network will promote transparency that the State needs while providing access that customers want in a pharmacy benefit. We offer a collaborative partnership with a Medicaid-focused staff. As the Nebraska Medicaid Pharmacy Program continues to evolve, DHHS can be confident that we have the depth and breadth of experience to continue to evolve along with it.

Based on this experience, as well as our extensive experience with other service delivery models, MMA commits to supporting any delivery model and strategy chosen by Nebraska to manage the Medicaid FFS population.

D.4 Payment Model

a. The State is considering segmenting the major operations services in the contract and require separate pricing or issuing separate contracts for groups of related services. For certain services the pricing is also likely to be further segmented by the cost of delivering/maintaining the IT solution and the cost of the vendor performing the business operations. The list below shows a theoretical segmentation approach that is under consideration by the State:

i. **Claims adjudication for fee for service claims (including prior authorization management and MAC rate setting)**

ii. **Preferred Drug List**

iii. **Drug Rebate – Federal and Supplemental**

iv. **Provider Support Functions (Communications, call center, web support functions)**

v. **Drug Utilization Review**

vi. **Clinical and Consultation Services**

MMA has the ability to price for separate contracts if DHHS determines they will segment the major operations services in the contract and if certain services are further segmented by the cost of delivering and/or maintaining the IT solution and the cost of the vendor performing the operations. We are able to price separately for all the categories identified above, but because of the low claims and member volume, an all-inclusive bid price would be the most advantageous to the State. We leverage pooled resources such as staffing and other overhead costs, e.g., call center resources that can be spread across the enterprise in order to provide the State with the most competitive price.

b. The State is seeking information on whether the savings from the economies of scale would be enough to combine the services into a single RFP. What feedback do you have on a separate pricing, potential concerns and unintended consequences related to this approach?

We have more than 35 years of pharmacy benefit administration experience and provide services to 26 Medicaid programs across the country. Because we have a national footprint, we can bring this knowledge and experience of working with multiple state agencies to DHHS. In order to gain economies of scale, we recommend rolling all scope into one RFP so we can leverage all costs across a broad range of services. However, the State may want to consider the following potential concerns that occur with a separate pricing model:

- Fixed corporate resources are unable to be leveraged across multiple services.
- Separate pricing model results in a higher total cost.
- Bigger administrative burden on the State to manage multiple vendors.

c. Do you offer models where components of the IT solution and accompanying business operations are available separately or as a full service? For example, if the State were to choose use the POS claims processing solution and services offered by the PBM, but only utilize the PBM software for federal drug rebate and continue to utilize State staff to perform the operations.

MMA has the ability to price the solution in any manner to meet DHHS needs. Based on our experience, our recommendation is to include all services within a single RFP in order to ensure the best price.

With more than three decades of experience in Medicaid pharmacy, we have learned that providing services such as rebate administration allows the State to fully reap the benefits of our highly experienced drug rebate staff, ***who have more than 180 years of collective rebate experience.***

d. For the POS system, the State of Nebraska paid for work done in its implementation phase, and the ongoing operations and maintenance work consists of a tiered monthly fixed amount based on covered lives. Please describe any payment models you use that differ substantially from this approach.

As the incumbent vendor, MMA will have minimal or no implementation activities or expense, except for new scope. We can continue our existing tiered-pricing structure, or structure our price using alternative methodologies defined by the State.

As evidenced in the following table, we provide a sampling of MMA current POS contracts and the utilized payment model. It has been our experience that the most advantageous pricing model for DHHS is a Fixed Tiered-Pricing rolled into one contract.

Contract	Payment Model Type
Alaska POS	Fixed Monthly Fee
Arkansas POS	Fixed Monthly Fee
Colorado POS	Fixed Monthly Fee
District of Columbia POS	Fixed Monthly Fee, plus Variable Rate per Claims
Florida POS	Fixed Monthly Fee
Idaho POS	Fixed Monthly Fee plus Hourly Rate for Enhancements
Kentucky POS	Per Member/Per Month plus Pass-Through Postage
Michigan POS	Fixed Monthly Fee
Nebraska POS	Fixed Tiered-Pricing
New Hampshire POS	Fixed Monthly Fee
New York PDP	Fixed Monthly Fee, plus Fixed Rate per PA, plus Pass-Through Postage
Pennsylvania PACE POS	Fixed Monthly Fee, plus Fixed Amendments (SOUs), plus Various Pass-Through
South Carolina POS	Fixed Monthly Fee
TennCare POS	Fixed Monthly Fee, plus Pass-Through Postage, plus Percentage of TPL Cost Avoidance

e. For the management of the PDL, participation in the multi-state purchasing pool and the supplemental rebate program, the State of Nebraska paid for the initial implementation and pays a monthly fixed fee for ongoing operations. Please describe any payment models you use that differ substantially from this approach.

As the incumbent vendor, no implementation fees will occur for the continued management of the PDL and participation in the TOP$ or NMPI multi-state purchasing pools. All of our PDL contracts, including the existing Nebraska PDL contract are Fixed Monthly Fee contracts. We have the ability to use alternative pricing methodologies if the State chooses, but we have found that a Fixed Monthly Fee is the most advantageous for a PDL contract.

f. What payment models do you use for administration of the federal drug rebate services?

MMA currently provides supplemental drug rebate services for DHHS. Federal drug rebate services involve new scope and depending on the final requirements may result in an implementation fee.

[This page has been left blank intentionally.]

Form A

Vendor Contact Sheet

Request for Information Number MPDR

Form A should be completed and submitted with each response to this solicitation document. This is intended to provide the State with information on the vendor's name and address, and the specific persons who are responsible for preparation of the vendor's response.

Preparation of Response Contact Information	
Vendor Name:	Magellan Medicaid Administration, Inc.
Vendor Address:	11013 W. Broad Street Suite 500 Glen Allen, VA 23060
Contact Person & Title:	Valarie Simmons, Account Operations Executive
E-mail Address:	VSimmons@magellanhealth.com
Telephone Number (Office):	636-751-5456
Telephone Number (Cellular):	636-751-5456
Fax Number:	804-548-0015

Each vendor shall also designate a specific contact person who will be responsible for responding to the State if any clarifications of the vendor's response should become necessary. This will also be the person who the State contacts to set up a presentation/demonstration, if required.

Communication with the State Contact Information	
Vendor Name:	Magellan Medicaid Administration, Inc.
Vendor Address:	11013 W. Broad Street Suite 500 Glen Allen, VA 23060
Contact Person & Title:	Valarie Simmons, Account Operations Executive
E-mail Address:	VSimmons@magellanhealth.com
Telephone Number (Office):	636-751-5456
Telephone Number (Cellular):	636-751-5456
Fax Number:	804-548-0015