Quotation to the State of West Virginia Bureau for Medical Services

for Automated Prior Authorization Services

Request for Quotation MED12003
Due November 4, 2011 at 1:30 p.m.

Submitted by:
ACS State Healthcare, LLC
8260 Willow Oaks Corporate Drive, Suite 600
Fairfax, VA 22031

1 Title Page

REQUIREMENT: RFQ Section 3.3, pg. 6

State the RFQ subject, number, Vendor's name, business address, telephone number, fax number, name of contact person, e-mail address, and Vendor signature and date.

RFQ subject	Automated Prior Authorization Services
Number	Request for Quotation MED12003
Vendor's name	ACS State Healthcare, LLC
Business address	8260 Willow Oaks Corporate Drive, Suite 600 Fairfax, VA 22031
Telephone number	239.282.1409
Fax number	770.829.4133
Name of contact person	Jeff C. Smith
E-mail address	jeff.c.smith@acs-inc.com

Vendor signature and date:

_Bryan B C_____ 10-26-2011

Bryan Christiansen, Vice President

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Jeff C. Smith
Vice President
Government Healthcare
Solutions

ACS, A Xerox Company
1916 NW 26th Place
Cape Coral, FL 33993

jeff.c.smith@acs-inc.com
tel   239.282.1409
fax   770.829.4133

November 2, 2011

Ms. Donna D. Smith
Senior Buyer
WV Department of Health and Human Resources
Office of Purchasing
One Davis Square, Suite 100
Charleston, WV 25301

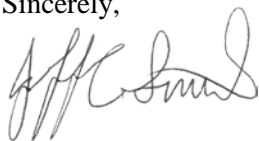RE: Automated Prior Authorization Services, Request for Quotation MED12003

Dear Ms. Smith:

With this transmittal letter, ACS State Healthcare, LLC (ACS), a wholly owned subsidiary of Affiliated Computer Services, Inc., a Xerox company, submits its response to the West Virginia Department of Health and Human Resources' Automated Prior Authorization Services Request for Quotation (MED12003). We have included exceptions to the RFQ following this letter.

ACS brings the experience, qualifications, and capability needed to enhance the current prior authorization process with leading edge applications and services. Our response specifically addresses each requirement included in the State's RFQ and further demonstrates our ability to support the State's Medicaid prior authorization requirements.

As an industry leader in clinical programs and services, our solution—SmartPA—will streamline and further automate the current prior authorization process. We look forward to working with the Bureau to develop, implement, and operate an automated prior authorization solution that meets the Bureau's program goals.

Sincerely,

Jeff C. Smith

Exceptions

ACS proposes the following modifications to the State's terms and conditions. We look forward to discussing the details of the contract during negotiations.

1. **Limitation of Liability.** Please add the following language to the contract:

    NEITHER PARTY SHALL BE LIABLE FOR INDIRECT, CONSEQUENTIAL, EXEMPLARY OR PUNITIVE DAMAGES, REGARDLESS OF THE FORM OF ACTION, WHETHER IN CONTRACT, TORT OR OTHERWISE, AND EVEN IF SUCH PARTY HAS BEEN ADVISED OF THE POSSIBILITY OF SUCH DAMAGES.

    Each party's cumulative liability to the other for any and all actions, whether in contract or in tort, will not exceed an amount equal to the total fees payable to ACS under the Contract for the nine (9) complete calendar months immediately preceding the month in which the event giving rise to the liability occurred (or, if the event giving rise to the liability occurs during the first nine (9) months after the Effective Date, the total charges estimated to be payable to ACS pursuant to the Contract for such first nine (9) months).

2. **Insurance.** Please modify the insurance language as follows:

    "5.12.2 Insurance Requirements: The Vendor as an independent contractor is solely liable for the acts and omissions of its employees ~~and agents~~. Proof of insurance**,** in the form of a standard certificate of insurance**,** shall be provided by the Vendor at the time the contract is awarded. The Vendor shall maintain and furnish proof of coverage of commercial general liability insurance for loss, damage, or injury (including death) of third parties arising from the negligent acts and omissions of the part of the Vendor~~,~~ or its ~~agents,~~ employees in the following amounts:

    ~~For~~ Commercial General Liability: with a combined single limit for bodily injury (including death)~~: Minimum of $500,000.00 per person,~~ and property damage in the amount of $1,000,000.00 per occurrence and $2,000,000.00 general aggregate.

    In addition, Professional Liability Insurance covering Vendor's negligent acts, errors, or omissions shall be provided.
    ~~For property damage and professional~~ Professional liability: Minimum of $1,000,000.00 per ~~occurrence~~ claims made basis.

3. **Indemnification.** Please modify the indemnification language as follows:

    5.4.2 Indemnification: The Vendor agrees to indemnify, defend, and hold harmless the Bureau and State of West Virginia, their officers, and employees from and against: (1) Any claims or losses for services rendered arising from the negligence or willful misconduct ~~by~~ of any subcontractor, person, or firm performing or supplying services, materials, or supplies in connection with the performance of the contract; (2) Any claims or losses resulting to any person or entity injured or damaged by the negligence or willful misconduct of Vendor, its officers, employees, or subcontractors by the publication, translation, reproduction, delivery, performance, use, or disposition of any data used

under the contract in a manner not authorized by the contract, or by Federal or State statutes or regulations; and (3) Any failure of the Vendor, its officers, employees, or subcontractors to observe Federal or State laws including, but not limited to, labor and wage laws.

4.   **Liquidated Damages.** Please modify the liquidated damages language as follows:

5.10 Liquidated Damages: The Vendor agrees that liquidated damages shall be imposed at the rate of $1,000.00 per day for failure to provide deliverables, meet milestones identified to keep the project on target, or failure to meet specified deadlines. This clause shall in no way be considered exclusive and shall not limit the Bureau or State of West Virginia's right to pursue any other additional remedy which the Bureau or State of West Virginia may have legal cause for action. Notwithstanding the above, in the event a Vendor failure causes liquidated damages to be assessed against Vendor, any liquidated damages paid by the Vendor will be applied as a credit to any actual damages that may be collected by the Bureau or State of West Virginia for the same failure.

Request for Quotation

RFQ NUMBER	PAGE
MED12003	1

State of West Virginia
Department of Health & Human Resources
Office of Purchasing
One Davis Square, Suite 100
Charleston, WV 25301

ADDRESS CORRESPONDENCE TO ATTENTION OF
DONNA D. SMITH
304-957-0218

VENDOR

ACS State Healthcare, LLC
8260 Willow Oaks Corp. Dr.
Suite 600
Fairfax, VA 22031

SHIP TO

BUREAU FOR MEDICAL SERVICES
350 CAPITOL STREET, ROOM 251
CHARLESTON, WV 25301-3706

DATE PRINTED	TERMS OF SALE	SHIP VIA	F.O.B.	FUND

BID OPENING DATE: 11/4/2011   BID OPENING TIME: 1:30 PM

LINE	QUANTITY	UOP	CAT.NO.	ITEM NUMBER	UNIT PRICE	AMOUNT
				ADDENDUM NO. 1		

1. TO ANSWER VENDORS QUESTIONS (ATTACHED).

2. ADDENDUM ACKNOWLEDGEMENT IS ATTACHED. THIS DOCUMENT SHOULD BE SIGNED AND RETURNED WITH YOUR BID. FAILURE TO SIGN AND RETURN MAY RESULT IN DISQUALIFICATION OF YOUR PROPOSAL.

REQUISITION NO.: MED12003

ADDENDUM ACKNOWLEDGEMENT

I HEREBY ACKNOWLEDGE RECEIPT OF THE FOLLOWING CHECKED ADDENDUM(S) AND HAVE MADE THE NECESSARY REVISIONS TO MY PROPOSAL, PLANS AND/OR SPECIFICATION, ETC.

ADDENDUM NO.'S"

NO. 1 ___X___
NO. 2 _____
NO. 3 _____
NO. 4 _____
NO. 5 _____

I UNDERSTAND THAT FAILURE TO CONFIRM THE RECEIPT OF THE ADDENDUM(S) MAY BE CAUSE FOR REJECTION OF PROPOSAL.

SEE REVERSE FOR TERMS AND CONDITIONS

SIGNATURE	TELEPHONE	DATE

TITLE	FEIN	
		ADDRESS CHANGES TO BE NOTED ABOVE

WHEN RESPONDING TO RFP, INSERT NAME AND ADDRESS IN SPACE ABOVE LABELED "VENDOR"

Request for Quotation

State of West Virginia
Department of Health & Human Resources
Office of Purchasing
One Davis Square, Suite 100
Charleston, WV 25301

ADDRESS CORRESPONDENCE TO ATTENTION OF
DONNA D. SMITH
304-957-0218

VENDOR	SHIP TO
ACS State Healthcare, LLC 8260 Willow Oaks Corp. Dr. Suite 600 Fairfax, VA 22031	BUREAU FOR MEDICAL SERVICES 350 CAPITOL STREET, ROOM 251 CHARLESTON, WV 25301-3706

DATE PRINTED	TERMS OF SALE	SHIP VIA	F.O.B.	FUND

BID OPENING DATE: 11/04/11   BID OPENING TIME: 1:30 PM

LINE	QUANTITY	UOP	CAT.NO.	ITEM NUMBER	UNIT PRICE	AMOUNT

VENDOR MUST CLEARLY UNDERSTAND THAT ANY VERBAL REPRESENTATION MADE OR ASSUMED TO BE MADE DURING ANY ORAL DISCUSSION HELD BETWEEN VENDOR'S REPRESENTATIVES AND ANY STATE PERSONNEL IS NOT BINDING. ONLY THE INFORMATION ISSUED IN WRITING AND ADDED TO THE SPECIFICATIONS BY AN OFFICIAL ADDENDUM IS BINDING.

_____
SIGNATURE

ACS State Healthcare, LLC
COMPANY

10-25-2011
DATE

END OF ADDENDUM NO. 1

SEE REVERSE FOR TERMS AND CONDITIONS

SIGNATURE	TELEPHONE	DATE
TITLE	FEIN	ADDRESS CHANGES TO BE NOTED ABOVE

WHEN RESPONDING TO RFP, INSERT NAME AND ADDRESS IN SAPCE ABOVE LABELED "VENDOR"

4   Attachment A: Cost Sheet

REQUIREMENT: RFQ Section 3.3, pg. 6
Complete Attachment A: Cost Sheet included in this RFQ.

The information in this section has been redacted

Attachment A: Cost Sheet

Cost information below as detailed in the RFQ and submitted.

Cost Proposal Format/Bid Sheet

	Year 1	Year 2 Optional Renewal	Year 3 Optional Renewal
Start Up Cost	$17,489		
Yearly Operating Cost	$94,690	$163,949	$165,589
Total Yearly Cost	$112,179	$163,949	$165,589
Grand Total For Three (3) Year Contract Period			$441,717

Vendor will invoice all costs in arrears in twelve (12) equal monthly installments.

The cost proposal will be evaluated based on the total three (3) year period grand total amount.

Optional Services:

Optional Services as specified in Section 2.3.7 shall be bid as an all-inclusive hourly rate and shall require Bureau approval of a Statement of Work and submission of a related Cost Estimate.

Hourly Rate: Year 1	$125
Hourly Rate: Option Year 2	$125
Hourly Rate: Option Year 2	$125

ACS State Healthcare, LLC
(Company)

Bryan Christiansen, Vice President
(Representative Name, Title)

801-567-5006/801-567-5457
(Contact Phone/Fax Number)

November 2, 2011
(Date)

(Signature)

5 Attachment B: Special Terms and Conditions

REQUIREMENT: RFQ Section 3.3, pg. 6

Complete Attachment B: Special Terms and Conditions included in this RFQ. By signing and dating this attachment, the Vendor acknowledges that they agree to meet or exceed each of the specifications as outlined in this Attachment.

ACS has signed Attachment B: Special Terms and Conditions and includes it following this page.

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5.1 Mandatory Requirements

ACS provides innovative technology and applications for automated prior authorization (PA) services. Providers and members benefit from streamlined business processes, advanced automation, and a Web-based rules engine for real-time pharmacy authorization determinations.

Automated prior authorization serves as a powerful reinforcement of preferred prescribing patterns leading to greater compliance by West Virginia providers with the Bureau's clinical criteria and PDL. An evidence-based, automated PA solution leads to greater long-term savings for West Virginia. Providers will prescribe the right drug at the right time, as opposed to learning the proper behavior to bypass a simple administrative hurdle. SmartPA's automated technology will provide the Bureau with the most effective prior authorization program in the nation.

SmartPA Features
- Real-time PA decisions made at the point of service
- Easily updatable, table-driven rules engine
- User friendly web-based interface

As a leader in designing and implementing innovative prior authorization functionality for state Medicaid programs across the country, ACS has the experience and necessary qualifications to meet and exceed the RFQ's automated prior authorization service requirements. In the following sections, we further substantiate our qualifications and demonstrate how we are uniquely positioned to help the Bureau meet its goals for its pharmacy PA review services and advance the program to the next higher level of achievement.

5.1.1 Attachment B Requirements

ACS provides a line-by-line description of our solution in the following sections, which fully comply with the Bureau's requirements listed in Attachment B.

5.1.2 Technical Requirements

The Bureau is seeking a qualified partner to provide pharmacy prior authorization services. Our current working relationship with the Bureau combines with the depth of our expertise and innovative solution to provide the foundation for a rewarding partnership.

SmartPA, implemented or in design for 13 pharmacy or MMIS point of service (POS) systems, was the first automated pharmacy prior authorization (PA) solution available to the Medicaid market. Developed

in 2002, SmartPA uses a table-driven rules engine that examines at least 24 months of patient-specific drug and medical claims information and applies evidence-based guidelines to determine prescribing appropriateness. This process was historic—for the first time an authorization could be approved automatically during the point of service (POS) transaction—with no human intervention required. This creative approach significantly improved the PA process for all stakeholders.

REQUIREMENT: RFQ Section 2.3.2.1, pg. 3
Have the ability to query Medicaid claims data, including, but not limited to, diagnoses codes, procedure codes and pharmacy claims data extracted from the existing MMIS and MCO encounter data files to determine if pre-established criteria, e.g. rules for approval based on evidence based guidelines, criteria developed by the West Virginia Medicaid Drug Utilization Review Board, and recommendations of the Bureau for the prior authorization of drugs has been met. The Vendor must have a portfolio of suggested clinical prior authorization criteria and integrate criteria requested by the Bureau.

SmartPA uses a clinical rules engine that allows the Bureau to establish prescription drug criteria for numerous drug classes, enabling improved clinical efficacy and reduction of costs. SmartPA executes real-time PA decisions at the POS by employing high-performance, table-driven clinical rules fueled by recipient specific drug and medical claims history that are extracted from the existing MMIS and MCO encounter data files. Should the servicing provider or prescriber call with a clinical override request, a Bureau PA specialist has immediate access to the PA request, prescription claim content, patient demographics, and patient pharmacy/medical claim history to help guide the override review workflow. The same rule logic built into the SmartPA automated rules engine is engaged in the SmartPA Web interface application, providing the PA specialist with clear clinical guidance.

At the pharmacy, the pharmacist submits the patient's prescription to the claim processor, which checks the claim for eligibility and then transmits each authorization request to the SmartPA system. SmartPA automatically queries at least 24 months of administrative data (basic patient demographic data, pharmacy claims data, medical claims data, MCO encounter claims data, diagnosis code data, procedure code data, and PA history) and determines if pre-determined screening criteria are met. If the criteria are met, SmartPA sends an "approved" message to the claim processor, indicating the prescription meets criteria. If the criteria are not met, SmartPA sends a message to the claims processor stating that the provider must provide mitigating clinical evidence to the Bureau PA team for approval of the claim. This entire process takes less than a second to complete. ACS monitors the system to ensure that 95 percent of electronic PA transactions complete in less than one second, thereby ensuring the pharmacy transactions are adjudicated well within NCPDP-mandated response times. SmartPA maintains PA requests submitted electronically in HIPAA-compliant transaction formats and the NCPDP D.0 format.

With our automated authorization solution being utilized by state programs around the country, we can tap our significant knowledge base to ensure that the Bureau effectively accomplishes program goals without sacrificing its autonomy with respect to managing the prior authorization program. We maintain an ACS SmartPA Library that contains more than two thousand SmartPA clinical algorithms that can be provided to Bureau leadership for review and approval. Our flexible rules engine allows us to quickly and efficiently customize the existing criteria and/or add new rules.

REQUIREMENT: RFQ Section 2.3.2.2, pg. 3-4
Have the capability of sending the claims processor a National Council Prescription Drug Program (NCPDP) standard formatted transaction compliant with current standards (available at http://www.ncpdp.org/pdf/Standards_Matrix.pdf) to indicate that the claims should be paid when the criteria has been met and an electronic message to call the Prior Authorization Help Desk when they have not.

SmartPA maintains PA requests submitted electronically in HIPAA-compliant transaction formats and the NCPDP D.0 format. In cases where the PA criteria are met, ACS sends the claims processor's system a

NCPDP D.0 formatted transaction indicating the prescription should be paid and dispensed. If the criteria are not met, ACS sends the claims processor a NCPDP D.0 formatted transaction indicating that the claim should be denied and the pharmacist is sent a message indicating the provider must call the Bureau PA specialist to review the claim.

REQUIREMENT: RFQ Section 2.3.2.3, pg. 4
Have the capability of working with the MMIS system, directly or with file extracts, without significantly affecting its performance by increasing the time required for claims adjudication or causing timeouts.

SmartPA is used by Medicaid programs across the country. As such, we bring the capabilities needed to establish a direct interface or establish file extract protocols. SmartPA is set up to interface directly with the MMIS system to access the information required to relay automated prior authorization determinations.

During POS adjudication, if the criteria are met, SmartPA sends an "approved" message to the MMIS system indicating the prescription should be dispensed. If the criteria are not met, SmartPA sends a message to the MMIS system stating that the provider must provide mitigating clinical evidence to the Bureau PA team for approval of the claim. This entire process takes less than a second to complete and does not significantly affect the MMIS system performance. This ensures that the Bureau's claims processing vendor can adjudicate pharmacy transactions well within NCPDP-mandated response times.

REQUIREMENT: RFQ Section 2.3.2.4, pg. 4
Have the ability to search at least twenty four (24) months of fee-for service medical claims, MCO encounter data and pharmacy claims for the total Medicaid population.

SmartPA automatically queries at least 24 months of fee-for service medical claims, MCO encounter data, and pharmacy claims data in making PA decisions. This data includes basic patient demographic data, pharmacy claims data, medical claims data, MCO encounter claims data, diagnosis data, procedure code data, and PA history.

REQUIREMENT: RFQ Section 2.3.2.5, pg. 4
Have the ability to hold once-in-a lifetime medical procedure codes (hysterectomy, organ transplants, etc.) for criteria searches.

Within SmartPA, medical procedure code data is stored with date ranges that indicate both the first and most recent appearance of that code in the claims data. These codes can be held in the database indefinitely and provide the ability to hold and reference once-in-a-lifetime medical procedures for criteria searches. The rules engine also allows criteria to be entered with no look-back period limit. These two features combine to provide the capability required to perform criteria searches for once-in-a-lifetime medical procedure codes.

REQUIREMENT: RFQ Section 2.3.2.6, pg. 4
THIS NUMBER SKIPPED IN RFQ

This requirement number was skipped in the RFQ.

REQUIREMENT: RFQ Section 2.3.2.7, pg. 4
Have a secure web-based interface that meets all Health Insurance Portability and Accountability Act (HIPAA) privacy regulations and allows the Bureau's prior authorization help desk staff to access criteria and view the steps performed in the automated prior authorization process

Via the SmartPA Web interface, all of the Bureau's PA information is accessible to designated Bureau and ACS employees via a secure Web-based interface. Through this single Web portal, authorized users are able to access approved and denied pharmacy prior authorizations, can access criteria, and view the steps performed in the automated prior authorization process. Real-time and historical PA information can

be accessed from any computer meeting the minimum workstation requirements, including Internet access. The SmartPA Web portal is fully HIPAA compliant.

Prior Authorization Process via SmartPA

The following is a brief synopsis of the PA review process used via the SmartPA Web interface at the help desk. When a call is answered, the clinical customer service center agent enters the recipient information into the SmartPA help desk application to begin the decision process. The agent can search for a recipient by the recipient ID number or name. The application also gives agents the ability to search for a specific denied PA request. A unique ticket number is automatically assigned by the SmartPA application for each incoming call. For each new ticket, the agent captures and records the caller's contact information, source, and reason for call.

In order to verify recipient eligibility, when the agent double clicks on the recipient's name, another screen is presented to verify eligibility before further processing of the PA request can occur. The agent verifies that the recipient is eligible by looking at the eligibility start date and end date. If the recipient is ineligible, the agent alerts the caller and places a PA denial into the system. If the recipient is eligible, the agent is able to continue the PA process. An example of the Eligibility screen check is shown in Exhibit 5.1.2-1, Eligibility Verification.

The information in this section has been redacted

Exhibit 5.1.2-1. Eligibility Verification
Recipient eligibility is verified prior to proceeding with a PA request.

After recipient eligibility has been verified, the agent continues the process by searching for the medication being prescribed. Medications can be searched by NDC or by drug name. The agent selects the desired medication and strength from a drug listing table by double clicking the drug name. If the medication is on the preferred drug list (PDL), the SmartPA application displays the PDL status and effective dates for the agent to review. If the medication has a status or class showing "NPD," this is a non-preferred drug. NPD medications require prior authorization.

At this time, the agent clicks a button within the SmartPA application to invoke SmartPA's clinical rules engine. The clinical rules engine automatically applies the clinical rules against the recipient's pharmacy and medical claims data to make a final determination. To ensure consistency and full compliance, the same clinical rules within the SmartPA call center application are used at the POS. There is no need for manual intervention or manual walkthroughs of criteria. The entire process is performed by the clinical rules engine within the SmartPA application.

The clinical rules engine assesses the recipient's known prescription history, age/demographic information, and any available medical history before returning an approval or denial of the PA request for the agent to view. An example of a SmartPA approval is shown in Exhibit 5.1.2-2, Clinical Rules Engine Returns Approval. If the request is approved, the agent gives the PA information to the caller, documents the call in SmartPA, and closes the ticket; no further action is required. The PA is active as soon as the ticket is closed, and the medication may be dispensed immediately at the pharmacy. There is no delay between when the PA is created and when it is accessible by the POS system. PA transactions transmit to the POS system in less than one second.

The information in this section has been redacted

Exhibit 5.1.2-2. Clinical Rules Engine Returns Approval
SmartPA's clinical rules engine has verified the recipient's history is appropriate for the medication and clinical criteria has been satisfied.

Exhibit 5.1.2-3, Clinical Rules Engine Returns Denial, provides an example of information received when a denial decision is rendered by SmartPA.

The information in this section has been redacted

Exhibit 5.1.2-3. Clinical Rules Engine Returns Denial

When the SmartPA's rules engine denies a request, the caller has the option to submit additional documentation or request a reconsideration.

If the request is denied by SmartPA, the agent informs the caller that an approval cannot be granted based on the preliminary information available, and the agent asks for additional information which could lead to an approval decision. SmartPA presents a checklist of clinical criteria ("Indicator") for the agent to confirm with the caller. SmartPA presents the clinical criteria in a user-friendly and conversational format which greatly simplifies and accelerates the review process. The agent asks the caller if the recipient has met each of the indicators listed and then resubmits the case to the SmartPA rules engine to determine if the additional information may lead to an approval.

The clinical rules engine reprocesses the medication with the new information. The agent reads the result of the new findings and continues gathering all clinical information from the caller until the request is approved or the criteria for approval is simply not met. If the criteria is not met, a denied PA is saved in the SmartPA system.

REQUIREMENT: RFQ Section 2.3.2.8, pg. 4
Have the ability to process prior authorization requests based on the generic sequence designation, National Drug Code (NDC), or segment of the NDC of the drugs to be prior authorized.

The SmartPA rules engine has the flexibility to identify subsets of drugs that require restriction at various hierarchical levels. Users may create defined lists at the AHFS, GTC, STC, HICL, GCN, GSN, and NDC segment levels.

REQUIREMENT: RFQ Section 2.3.2.9, pg. 4
Assign a staff member to work with the Bureau on criteria changes and to make the changes within three (3) business days of the Bureau's request.

An ACS clinical pharmacist will be assigned to work with the Bureau on any changes to criteria and make the criteria changes. In automating authorization requests during the POS transaction with the MMIS vendor's POS system, SmartPA has the speed to adjudicate the clinical decisions quickly and offers the flexibility needed to perform Bureau-specific comprehensive clinical reviews. ACS relies on an advanced electronic clinical support application to accomplish these goals.

The backbone of our SmartPA solution, our clinical rules engine, is a table-driven platform that enables authorized users to make changes to existing criteria easily and accurately in response to program modifications, changes to the PDL, new therapeutic indications, and results obtained from previous analyses. Since the criteria are table-driven as opposed to hard coded, our applications themselves do not need to be updated to accommodate such changes. Therefore, a non-programmer (i.e., a clinician) can easily make immediate changes to the existing criteria to meet the changing needs of the Bureau. This powerful tool is flexible and responsive to the changing nature of pharmacotherapy guidelines and is able to accommodate the needs of the Bureau's pharmacy program as it evolves. Changes to criteria will be made within three business days.

We follow established protocols for integration of rules integration with DUR rules and authorization criteria into the production environment after review and approval of the criteria by the Bureau's pharmacy program personnel. Although all SmartPA rules are parameter driven and do not require programming, in order to assure quality, we follow a strict implementation process for new rules and changes to existing rules. The rule implementation process ensures that: 1) changes requested on behalf of our customers are thoroughly tested, tracked, and documented to ensure that quality assurance is conducted; and 2) all clinical criteria are fully tested with the Bureau's claims prior to implementation.

5.1.3 Vendor Requirements

REQUIREMENT: RFQ Section 2.3.3, pg. 4
The Vendor must provide the following:

The Bureau is seeking a qualified vendor for this important initiative. ACS' SmartPA solution meets and exceeds the required services and provides the Bureau with a proven solution that operationally provides an average return on investment in excess of 10:1.

Over the past decade, ACS has focused on pharmacy prior authorization innovation. Our clinical and technical experts have worked to identify process inefficiencies and develop alternative solutions to reduce the administrative burden on program staff, simplify the process for prescribers and pharmacists, and most importantly improve the level of service provided to the Medicaid recipient community. SmartPA and its clinical rules engine have been proven to automate up to 90 percent of pharmacy PA requests while improving the efficiency of the process for all stakeholders and generating significant savings for pharmacy programs.

SmartPA is a standalone hardware and software solution that contains the ACS clinical rules engine. SmartPA contains a set of hardware, software, reference files, and clinical rules specifically designed to be integrated with the claims processing system and adjudicate claims that require PA. ACS uses MOVEit DMZ to support secure file transfer protocol (S-FTP) for moving data files. Through this connection, ACS can receive data daily or weekly from the MMIS. We also support electronic data interchanges to support building health records for Bureau clients. We have integrated or are in the process of integrating these solutions with 13 different pharmacy or MMIS programs.

Through the West Virginia RetroDUR contract awarded to ACS, we currently receive the recipient, pharmacy claims, medical claims, and encounter claims files needed for making PA determinations. Providing these services under the WV Retro-DUR contract serves as confirmation that ACS has the protocols in place to meet this requirement. The following sections provide additional information about our experience in this area.

Electronic Data Interchanges

We offer over 40 years of experience integrating pharmacy and medical claims history. ACS currently houses approximately three billion Medicaid and non-Medicaid healthcare claims for more than 87 million lives. Our team of experts has created integrated databases using multiple MMIS file formats and implemented similar solutions in numerous Medicaid programs. We also receive provider, recipient, claims, and clinical criteria files for multiple clients from multiple sources on differing frequencies (e.g., real-time, daily, weekly, monthly). Our prior experience ensures the continuation of existing services and smooth implementation of new applications. ACS will partner with the Bureau and its vendors to ensure proper formatting of data used in the transfer of data from the Bureau's current MMIS vendor to ACS.

In addition to the pharmacy and medical claims data that we integrate into a single repository, we subscribe and have established interfaces to the following reference files with updates as defined below:

- First Data Bank (FDB) – weekly updates
- Drug Enforcement Agency (DEA) – annual updates. We match DEA numbers on the respective claim to the DEA number in the reference file
- ICD-9 codes – annual and quarterly updates (we will also receive ICD-10 once they are available)
- CPT codes – annual and quarterly updates
- HCPCS codes – annual and quarterly updates

The Bureau's Medicaid Data

ACS will establish data connections with all Bureau partners and vendor organizations as required. Examples of required data feeds to ACS may include:

- A real time socket interface with the Bureau MMIS vendor's POS system to screen claims during the point of service process
- A regularly scheduled feed of all medical claims adjudicated by the Bureau's MMIS vendor (already in place under RetroDUR contract)

- A regularly scheduled feed of the Bureau's enrollment data from the Bureau's MMIS vendor (already in place under RetroDUR contract)
- A regularly scheduled feed of the Bureau's recipient data from the Bureau's MMIS vendor (already in place under RetroDUR contract)
- A regularly scheduled feed of paid pharmacy claims by the Bureau's MMIS vendor (already in place under RetroDUR contract)
- A regularly scheduled feed of pharmacy and prescriber data from the Bureau's MMIS vendor (already in place under RetroDUR contract)
- A regularly scheduled feed of formulary and PDL drug data from the Bureau's MMIS or PDL vendor

SmartPA incorporates FFS data and MCO data into one database, so that all Medicaid recipients' claims are analyzed for appropriateness using the same criteria.

ACS stores at least two years of active data to support the POS process (e.g., pharmacy, hospitalizations, length of stay, emergency department utilization, eligibility, paid/denied claims, provider, etc.) in a single data repository for our SmartPA clients. The data is used at the POS to verify if the drug is clinically appropriate for the recipient via clinical and therapeutic rules, the defined brand/generic status of the drug, and the PDL status of the drug.

REQUIREMENT: RFQ Section 2.3.3.2, pg. 4
A portfolio of suggested drugs for prior authorization with appropriate prior authorization criteria and ongoing suggestions for drug categories that could be prior authorized automatically, based on utilization, the Preferred Drug List and the cost of the drugs to BMS.

Since our automated authorization solutions are in use in many state programs around the country, we can tap our significant knowledge base to ensure that the Bureau effectively accomplishes program goals without sacrificing its autonomy with respect to managing the prior authorization program. We maintain an ACS SmartPA library that contains over two thousand SmartPA clinical algorithms that can be provided to Bureau leadership for review and approval. Our flexible rules engine allows us to customize the existing criteria and/or add new rules quickly and efficiently.

Our team of business and clinical analysts will work with the Bureau to identify state-specific issues (e.g., utilization, PDL, cost of drugs to the Bureau) and propose recommendations to the Bureau and/or DUR Committee. To identify other pertinent issues, ACS' team of clinical pharmacists conduct daily reviews of biomedical literature, clinical practice guidelines, and other drug information resources such as MedLine, DrugDex, American Hospital Formulary Services, and The Formulary Services. We will leverage our team of experts and work closely with the Bureau to develop recommendations and/or rules that support the Bureau's program goals.

REQUIREMENT: RFQ Section 2.3.3.3, pg. 4
Automated prior authorization services must be operational twenty four (24) hours a day seven (7) days a week, including holidays, in order to operate in conjunction with the MMIS system.

Through SmartPA, we accept and process electronic PA requests on a 24/7 basis at the POS. Additionally, the SmartPA call center application also has 24 hour/7 days a week availability.

REQUIREMENT: RFQ Section 2.3.3.4, pg. 4
Technical assistance to insure that the application is fully integrated and operates effectively and efficiently and clinical and technical
staff to implement changes to prior authorization criteria within five (5) business days.

In automating authorization requests during the POS transaction with the MMIS vendor's POS system, SmartPA has the speed to adjudicate the clinical decisions quickly and the flexibility to perform Bureau-specific comprehensive clinical reviews. ACS relies on a fully integrated, advanced electronic clinical support application to accomplish these goals. The backbone of our SmartPA solution—our clinical rules engine—is a table-driven platform that enables authorized users to make changes to existing criteria easily and accurately in response to program modifications, changes to the PDL, new therapeutic indications, and results obtained from previous analyses. Since the criteria are table-driven as opposed to hard coded, our applications themselves do not need to be updated to accommodate such changes. Therefore, a non-programmer (i.e., a clinician) can easily make immediate changes to the existing criteria to meet the Bureau's changing needs. This powerful tool is flexible and responsive to the changing nature of pharmacotherapy guidelines and is able to accommodate the needs of the Bureau's pharmacy program as it evolves. Changes to prior authorization criteria will be made by clinical and technical staff within five business days. BMC TMART is used to monitor the applications by simulating a user performing a specified function at a set interval. Nimbus is also used to remotely monitor the application servers.

REQUIREMENT: RFQ Section 2.3.3.5, pg. 4
All necessary hardware, software, and dedicated clinical and technical staff, to support the day-to-day operation of the system.

ACS assumes full responsibility for the purchase, stand-up, and ownership of the hardware and software that will be used for SmartPA as offered in our proposal. Additionally, ACS will provide the clinical and technical staff necessary to support day-to-day operation of the system as well as any changes or additions needed for the PA clinical criteria.

5.1.4 Implementation

REQUIREMENT: RFQ Section 2.3.4, pg. 4
The Vendor must :

Our current Clinical Retrospective DUR project in West Virginia, combined with our support of other state healthcare programs across the country, provide the Bureau with the high-quality resources necessary to successfully perform each phase of the Automated Prior Authorization Services project.

Over the past decade, ACS has focused on pharmacy prior authorization innovation. Our clinical and technical experts have worked to identify process inefficiencies and develop alternative solutions to reduce the administrative burden on program staff, simplify the process for prescribers and pharmacists, and most importantly improve the level of service provided to the Medicaid recipient community.

Today, the combination of our sophisticated automated prior authorization tools and our state-of-the-art pharmacy prior authorization review application yield significant, proven savings for our Medicaid clients while increasing the overall efficacy and efficiency of their pharmacy programs. Our proposed implementation timeline of five months provides a realistic and cost effective path to transition the current prior authorization process to our SmartPA platform. This expedited timeline positions the Bureau and other program stakeholders to reap the benefits of our solution in less than one year.

The project consists of the design, configuration, testing, and implementation of our SmartPA automated pharmacy PA system. SmartPA and its clinical rules engine have been proven to automate up to 90

percent of pharmacy PA requests while improving the efficiency of the process for all stakeholders and generating significant savings for pharmacy programs.

REQUIREMENT: RFQ Section 2.3.4.1, pg. 4
Provide a system implementation team including, at a minimum, a project manager, system's analyst and database coordinator to coordinate development and implementation activities with BMS.

We agree to provide a qualified team to coordinate each development and implementation activity. ACS' organizational structure and the placement of the West Virginia project within ACS underscores our commitment to provide an experienced project manager, systems analyst, and database coordinator to oversee all of the implementation activities with the Bureau. Robert Berringer, PharmD, Senior Director Clinical Services, directs ACS' team of clinicians in the development of West Virginia-specific PA criteria and also brings four years of experience as account manager for West Virginia RetroDUR. He holds accountability for ACS' performance under the contract related to all scope of work services. Chasity Williams, our proposed implementation project manager, recently completed the Colorado SmartPA implementation—on time and within budget. Our proposed systems analyst, Adam Lowman, was instrumental in the development of a new component for SmartPA called SmartPA for Travel. The component extends our automated prior authorization capabilities to include non-emergency medial travel. Adam's background and in-depth understanding of our SmartPA solution offers the Bureau the expertise and experience required for this project. John Palmieri, proposed as the database coordinator, has provided both systems and database support to many of current clients. Our proposed account manager, Larry Dent, PharmD, serves as the State's single point of contact and will monitor ACS' performance under the contract related to all scope of work services including RFQ-defined objectives for the:

- Configuration and installation of the solution
- Smooth transition from the current system to the new solution
- Ongoing, timely updates to system functionality and technology required to keep the solution current
- Continuing professional support services required to maximize the use and effectiveness of the solution by the BMS pharmacy program staff

The organization chart provided in this section offers a graphical depiction of the staffing resources deployed for the West Virginia project. Based on our experience in similar implementations, we have determined that it is extremely advantageous to maintain, as much as possible, a dedicated team throughout the entire implementation period. As a result, we propose to dedicate a core team throughout the implementation and operations (continuing support) phases.

> **Experienced, consistent staff during all implementation phases:**
> - Staff selected for systems implementation experience
> - Core group provides consistency throughout implementation phases

The organization chart, Exhibit 5.1.4-1, presents the reporting relationships of the named and non-named staff, names of the named staff, and locations of all positions engaged during the implementation phase.

The information in this section has been redacted

Exhibit 5.1.4-1. Automated Prior Authorization Services Organizational Chart
ACS organizational structure used to support the Automated Prior Authorization Services project.

REQUIREMENT: RFQ Section 2.3.4.2, pg. 4
Begin detailed planning for conversion activities and data interfaces within one (1) month of the start of the contract.

During the implementation of the ACS RetroDUR application, CyberFormance, we worked with West Virginia and third party vendors to obtain much of the data necessary to support an automated prior authorization program. With that said, we recognize that an important step to the successful implementation of a system is the evaluation of the data that will flow through the entire system.

Any new data elements will go through extensive evaluation and testing to ensure compatibility with the required system functionality. Detailed data planning for conversion activities begin immediately after the initial kick-off meeting, which will occur within one month of the contract start date.

More specifically, our proven conversion processes include the production of conversion reports that specify record counts of converted data. Error reports are produced specifying records that would not convert or problems converting specific pieces of data within specified records. These reports vary by file and types of errors encountered during the conversion process. With Bureau approval, we will coordinate timing and testing of conversion activities and add these dates to the work plan for proper tracking and scheduling.

REQUIREMENT: RFQ Section 2.3.4.3, pg. 5
Conduct and conclude all data interfaces at least forty eight (48) hours prior to the system installation.

During the implementation of the ACS RetroDUR application, CyberFormance, we worked with West Virginia and third party vendors to obtain much of the data that is necessary to support an automated prior authorization program. However, during this project, requirements and design phases of the project will ensure all tasks related to interfaces, real-time or batch synchronizations, and updates will be finalized at least 48 hours prior to system installation, if they are not already in place.

REQUIREMENT: RFQ Section 2.3.4.4, pg. 5
Plan for and provide all hardware and software necessary for implementation.

ACS places high importance on the successful implementation of our projects. For the Automated Prior Authorization Services project to be effectively implemented, ACS will plan for and provide all equipment and infrastructure including hardware, software, and telecommunications systems prior to project implementation.

ACS assumes full responsibility for the purchase, stand-up, and ownership of the hardware that will be used to develop and test the proposed prior authorization systems offered in our proposal.

REQUIREMENT: RFQ Section 2.3.4.5, pg. 5
Provide system modifications, training materials and documentation at least two (2) weeks prior to system testing and implementation.

ACS will provide up-to-date training materials and related documentation including system documentation, workflow training materials, and other related materials at least two weeks prior to system testing and implementation. A successful training program requires not only quality training staff and up-to-date materials, but also a technology-enabled environment that will support blended curricula consisting of classroom and virtual classroom via WebEx. The training environment also supports staff training, performance testing, and operations readiness testing.

REQUIREMENT: RFQ Section 2.3.4.6, pg. 5
Provide a timeline within ten (10) days of the contract award detailing plans for testing and implementation of the system.

To ensure the timely submission of the procedural documentation, the ACS implementation project manager develops a project plan to schedule deliverables and milestones for compliance and tracking purposes at the West Virginia Automated Prior Authorization Services project kick-off meeting, which is the first meeting of the project, or within 10 days of the contract award. ACS has already created a tentative timeline for the project based on the requirements defined in the RFQ and will use the tentative timeline as the starting point for our kick-off meeting. The major milestones contained in our tentative timeline are shown in Table 5.1.4-1:

Table 5.1.4-1. Tentative Project Work Plan Timeline		
Project Phase	**Start Date**	**End Date**
Initiation Phase	1/2/12	1/11/12
Planning Phase	1/10/12	1/18/12
Clinical Rules Requirements Set 1 SmartPA	1/12/12	2/6/12
Requirements Phase	1/10/12	2/28/12
Construction Phase	1/27/12	5/23/12

Table 5.1.4-1. Tentative Project Work Plan Timeline		
Project Phase	Start Date	End Date
Documentation/Training Phase	4/23/12	5/30/12
Testing Phase	1/23/12	5/21/12
UAT Phase	2/29/12	5/25/12
Implementation Phase	4/9/12	5/31/12
Post Implementation Support	1/2/12	7/5/12

We will collaborate with the Bureau to finalize our timeline during the kick-off meeting. This approach positions us for success by analyzing baseline processes, procedures, templates, and tools, and tailoring them to the specific needs of the project. The primary goal is to prepare the project for long-term success by ensuring processes are documented in detail, expectations are set, resources are prepared, and a foundation is established for on-time, within-budget, and high-quality delivery.

5.1.5 Reporting Requirements

REQUIREMENT: RFQ Section 2.3.5, pg. 5
The Vendor shall provide monthly reports within ten (10) business days of the month's end that contain, at a minimum, the following elements:

The Web-based SmartPA reporting tool provides the Bureau with extensive, robust reporting capabilities. Reports are generated by user-defined reporting parameters and include the elements required by the Bureau. From the SmartPA Report Selection screen, system users are able to generate, view, and export PA and other information summary and activity reports from the Report Selection window. All of the monthly reports generated by SmartPA will be available within 10 business days of the end of the ending month. In addition to the required reports, the reporting tool within SmartPA also includes the following reports:

- Call Center Activity Summary By Category
- Call Center Activity Summary By Period
- Call Center Activity Summary for Pending Tickets
- Call Center Activity Summary for Supervisor/Pharmacist Tickets
- Call Center Activity Summary Report By Clerk
- Call Center Approved By Period Report
- Call Center Approved By Program Area Report
- Call Center Detailed Pending Ticket Worksheet
- Edit Override Activity Log
- PA Activity Worksheet
- PA By Reason Code Detail
- PA By Reason Code Summary
- PA Drugs by PA Classification
- PA Issued Cross Tab Report
- PA Override Activity Detail by Class
- PA Pending Aged Activity By Reviewer
- PA Pending Inventory Detail

- PA Pending Inventory Summary
- PA Pharmacy Ranking
- PA POS Daily Activity Report
- PA POS Day and Time Period Report
- PA POS Time Period Report
- PA Posted Activity Summary by Reviewer
- PA Posted Aged Activity By Reviewer
- PA Posted Detailed Activity Report
- PA Prior Authorizations by Review Status Summary
- PA Resolution Time Tracking Detail
- PA Summary By Drug

REQUIREMENT: RFQ Section 2.3.5.1, pg. 5
The number of prior authorization requests by therapeutic drug class, processed each month.

A report showing the number of prior authorization requests by therapeutic drug class, processed for each month, will be provided within 10 business days of the month's end.

REQUIREMENT: RFQ Section 2.3.5.2, pg. 5
The number of routine prior authorizations, by therapeutic class processed each month.

ACS provides, through the SmartPA Web interface, reporting on the number of routine prior authorizations, by therapeutic class, processed each month. This report will be provided within 10 business days of the month's end.

REQUIREMENT: RFQ Section 2.3.5.3, pg. 5
The number of prior authorization requests denied, by therapeutic class, and routed to the help desk for manual prior authorizations each month.

Within the SmartPA Web interface, ACS provides a report showing the number of prior authorization requests, by therapeutic class, denied and routed to the help desk for manual prior authorizations each month. This report will be provided within 10 business days of the month's end.

REQUIREMENT: RFQ Section 2.3.5.4, pg. 5
Savings generated by reduced administrative costs for routine prior authorizations each month.

A report showing savings generated by reduced administrative costs for routine prior authorizations for each month will be provided within 10 business days of the month's end.

REQUIREMENT: RFQ Section 2.3.5.5, pg. 5
The percentage of approved requests and denied requests, by therapeutic drug class, each month.

ACS provides, through the SmartPA Web interface, reporting on the percentage of approved requests and denied requests, by therapeutic drug class, each month. This report will be provided within 10 business days of the month's end.

REQUIREMENT: RFQ Section 2.3.5.6, pg. 5
A tracking report logging the amount of time required for processing automated requests each month.

Within the SmartPA Web interface, ACS provides a tracking report logging the amount of time required for processing automated requests each month. This report will be provided within 10 business days of the month's end.

5.1.6 Experience

REQUIREMENT: RFQ Section 2.3.6, pg. 5
The Vendor must:

By selecting ACS, the Bureau gains the services of a proven full-service healthcare innovator with the relevant experience and a proven PA solution that supports West Virginia's goal to promote appropriate prescription drug utilization and reduce program expenditures.

In this procurement, the Bureau seeks to better serve and improve the healthcare of Medicaid clients by obtaining an automated prior authorization system, allowing pharmacists to submit claims through the point-of-sale system and obtain routine prior authorizations without interrupting the workflow or clinical practices of prescribers or pharmacy providers. Ultimately, a sophisticated automated prior authorization tool will result in:

- A reduction in unnecessary Medicaid expenditures
- Less waiting time for Medicaid clients to obtain prescriptions
- Better therapeutic outcomes for Medicaid clients
- Reduced workload for pharmacy providers
- Increased prescriber satisfaction
- Administrative savings for the Bureau

- 13 SmartPA implementations with pharmacies and MMIS POS systems since 2002
- Reduced Missouri's program expenditures by $83 million
- In 2006, the solution was expanded to include radiology, DME, and optical
- Automate 76% of radiology and 73% of DME requests
- Active involvement with the National Council for Prescription Drug Programs

It will further benefit the Bureau to contract with a vendor that has extensive experience, a proven low-risk solution with state-of-the-art technology, and a history of innovation and success in the field, including providing its state government clients with cost savings and significant returns on their investment.

ACS State Healthcare, LLC (ACS) has the qualifications and experience to serve as that vendor. In this section we will describe the extensive background and experience that makes us the right vendor for BMS. We describe our qualifications according to this roadmap:

- Summary of Qualifications
- Experience on the Ground in West Virginia
- Size of the Company
- Location of the Company
- ACS State Healthcare, LLC: an Established Firm Recognized for Our Capacity to Perform
- Xerox Acquisition of Affiliated Computer Services, Inc.
- SmartPA, Our Automated PA Solution
- Qualifications and Experience Providing Prior Authorization Services
- Client References

Summary of Qualifications

ACS is a stable and experienced provider of Medicaid and related healthcare services nationwide. We have the experience, capabilities, and resources the Bureau is seeking in this procurement, including current and past operational experience in the State.

Experience on the Ground in West Virginia

In addition to our extensive experience in Medicaid programs all across the country, ACS has had the honor of serving BMS in two healthcare-related Medicaid contracts.

West Virginia Medicaid RetroDUR

ACS served as the West Virginia RetroDUR vendor from 2000 to 2007. During that contract period, we provided services that resulted in $6.7 million in savings for the State. In 2010, ACS was awarded a new contract to provide RetroDUR services to improve pharmaceutical care delivered to Medicaid members. As the state's contractor, we review drug claims data to identify members at risk for drug-related events or suboptimal treatment and provide educational interventions to prescribers and pharmacists that improve patient outcomes. We also manage the pharmacy lock-in program to address over-utilization. Our RetroDUR and accompanying programs reduce suboptimal drug utilization, leading to better therapeutic outcomes for members and a reduction in unnecessary Medicaid expenditures.

West Virginia MMIS and Fiscal Agent Services

We served the State in this capacity from 1992 to 2005. In 1992, the Department of Health and Human Resources (DHHR) awarded ACS a contract to take over and enhance the existing MMIS and to provide full service fiscal agent operations and MMIS maintenance and modification support. We processed and adjudicated more than 15.7 million claims annually. ACS' contract was extended one time and expired in 2005. Fiscal agent responsibilities included:

- Ad hoc reporting
- Automated voice response
- Claims adjustment
- Claims entry
- Claims inventory control for receipt, sorting, imaging, batching, entry, and resolution
- Claims receipt via tape, diskette, hardcopy, direct transmission or PC-based, including Point-of-sale pharmacy claims and long-term care claims
- Coding of claim attachments
- Hardcopy claims retrieval for State
- Mailroom services

- Medicaid eligibility verification
- Online parameter, text, and exception changes
- Problem claim resolution
- Provider relations
- Quality control
- Recipient relations
- Report card monitoring
- System entry of sterilization/hysterectomy consent form information
- Technical liaison support
- Technical support for operations, maintenance, modifications, and system enhancements

Size of the Company

ACS State Healthcare LLC, the bidding entity for this procurement, has approximately 4,300 employees who specialize in Medicaid and other state healthcare programs. We are a leader in providing a wide spectrum of Medicaid solutions and services. Table 5.6.1-1 includes highlight the history of our experience.

Table 5.1.6-1. ACS State Healthcare, LLC at a Glance
• Over 40 years of Medicaid healthcare systems design, development, and implementation experience
• Healthcare projects supporting more than half the states and the District of Columbia
• Medicaid contracts in 30 states
• More than 20 million recipients covered through our Medicaid and CHIP programs annually
• More than 885,000 applications and renewals processed annually
• Approximately 30 million calls handled annually at our 27 call centers nationwide
• Over 13 million live calls answered annually

ACS is a wholly owned subsidiary of Affiliated Computer Services, Inc., which is a wholly owned subsidiary of Xerox Corporation. Our longtime parent company, Affiliated Computer Services, Inc., provides business process outsourcing and information technology services to commercial and government clients worldwide, with approximately 78,000 employees in approximately 500 global locations. Table 5.1.6-2 describes Affiliated Computer Services, Inc.

Table 5.1.6-2. Affiliated Computer Services, Inc. at a Glance
• Founded in Dallas, Texas, and incorporated in the state of Delaware in 1988
• Acquired by Xerox in 2010
• 18 major customer care centers
• 16 mega IT data centers
• 14 major finance and accounting centers
• 15 major human resource centers
• 18,000 customer care agents for the communications industry
• 3,500 technical customer support agents
• Provides services to over 500 colleges and universities
• Services over $200 billion in federal and private loans
• Provides services to more than 1,700 federal, state, county, and local governments, making the company one of the largest providers of services to governments across the U.S.

Xerox Corporation, which acquired Affiliated Computer Services, Inc. in 2010, has 136,000 employees in 160 countries worldwide, which includes Affiliated Computer Services, Inc. employees. Since acquiring Affiliated Computer Services, Inc., Xerox earns approximately $22 billion annually in revenues.

Table 5.1.6-3 provides an overview of our parent company, Xerox Corporation.

Table 5.1.6-3. Xerox Corporation. at a Glance
• Founded in 1906 as the Haloid Company
• Named Haloid Xerox in 1958 and Xerox Corporation in 1961
• Acquired Affiliated Computer Services in 2010.
• NYSE Symbol: XRX
• Chairman and CEO: Ursula M. Burns
• Headquarters: 45 Glover Avenue, Norwalk, CT 06856-4505

Location of the Company

The Bureau benefits from selecting an experienced contractor that can provide work locations well suited to providing the services described in the RFQ. ACS has successfully and securely supported Medicaid and other government healthcare programs for 40 years. We have administrative offices, data centers, and operational accounts at state capital cities and other venues nationwide that operate at the highest industry standards for technology and security. For example, our data centers host projects ranging from small data repositories to large transactional systems. For West Virginia SmartPA, we propose to use proven, existing locations where similar PA services are already being performed for other state government customers every day. These locations are identified in Table 5.1.6-4.

Table 5.1.6-4. Locations Where Services Are To Be Performed	
Facility	**Location**
ACS Project Headquarters	ACS Government Healthcare Solutions 2810 North Parham Road, Suite 210 Richmond, Virginia 23294 (804) 965-8264
ACS Production Data Center	ACS Tarrytown Data Center 777 Old Saw Mill River Road Tarrytown, New York 10591 (914) 347-3122
ACS Disaster Recovery Data Center	ACS Government Healthcare Solutions 2810 North Parham Road, Suite 210 Richmond, Virginia 23294 (804) 965-8264

ACS State Healthcare, LLC:
An Established Firm Recognized for Our Capacity to Perform

ACS State Healthcare, LLC has four decades of direct, relevant experience in Medicaid and offers our customers the widest range and array of Medicaid technology and services of any competitor. Our history reflects our mission as healthcare administrators to improve the administration of publicly funded health programs by working in collaboration with customers to solve the challenges state governments face in today's Medicaid environment. Our dedication to innovative technology, our continuing expansion of operational and clinical services, our strategic acquisitions, and our proactive emphasis on cost

containment and improved health outcomes represent the practical demonstration of our commitment to collaborating with our customers to meet their objectives and make the greatest positive impact on how state healthcare programs are delivered.

Equally important, because we are often the "face of Medicaid" to our customers' Medicaid constituency, we consider beneficiaries, providers, community-based organizations, advocacy groups, and other stakeholders as part of our own "customer base" when serving our state government customers. This commitment to service is particularly apparent in the caliber of staff we develop and employ—from former Medicaid directors, technical and operational subject matter experts, and policy experts, to call center agents, systems engineers, clerical staff, and all other positions.

Company History. ACS State Healthcare, LLC is the bidding entity and is wholly accountable for performance of the full scope of work and service level agreements on this contract. Our business history dates back to 1970 as Consultec, Inc., a Georgia corporation and one of the two oldest firms in the Medicaid marketplace. ACS was established as a limited liability company in the State of Delaware under the name Consultec, LLC on March 25, 1999. The name was changed to ACS State Healthcare, LLC on May 29, 2001, based on the company's acquisition by ACS.

In 1971, we established the federal government standard for MMIS when we developed the General Systems Design (GSD) of a prototype MMIS for the United States Department of Health, Education, and Welfare. Since that time, we have enjoyed a historic partnership with the Centers for Medicare and Medicaid Services (CMS). We continue to work closely with state and federal government entities to improve Medicaid services across the country. ACS was the first enrollment broker in the nation both for Medicaid and Medicare, pioneered efforts in managed care program design and development dating back to the 1970s, and developed the first Medicaid Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program in the nation.

We currently assist our customers with implementing, operating, and enhancing their public sector healthcare programs through the service offerings listed in Table 5.1.6-5:

Table 5.1.6-5. ACS State Healthcare, LLC Service Offerings		
Service Offering	**Details**	**ACS Advantage**
Pharmacy Benefits Management (PBM)	• Full range of PBM services, including: – Claims adjudication and payment processing – Prospective and retrospective drug utilization review (DUR) – Prescribing patterns – Prescriber and patient education – Preferred drug list development/maintenance – Prior authorization – Drug rebate administration – Pharmacy/desk auditing – Clinical consulting	Nationally recognized for flexibility, efficiency, and performance, our online, real-time pharmacy cost management solutions are among the best in the industry. This includes SmartPA, our automated prior authorization solution.

Table 5.1.6-5. ACS State Healthcare, LLC Service Offerings		
Service Offering	**Details**	**ACS Advantage**
MMIS	• MMIS design, development, and implementation (DDI), including the following components: – Claims processing – Financial services – Prior authorization – Provider – Recipient – SURS and MARS support – Third party liability (TPL) – EPSDT – Level of care – Reference • MMIS takeover, operation, and maintenance • Clinical claims editing • Web portal design and maintenance • MITA framework	ACS has a history of successful experience developing and implementing new MMIS solutions and taking over competitor-developed MMIS solutions and fiscal agent operations. Our legacy of innovation continues with our powerful self-service Web portal for providers, payers, and patients, providing better data access, streamlined patient information, and outstanding customer service. A guiding principle for the future of ACS-developed MMIS solutions is a system design that is focused on aligning with advanced MITA features in each business area. Our next-generation MMIS solution, ACS Health Enterprise, is currently being installed in New Hampshire, North Dakota, Alaska, and California.
Fiscal Agent Services	• Full Medicaid fiscal agent services • Claims processing and suspense resolution • Provider services • Finance, including accounts payable • Recipient ID card production • Electronic data interchange (EDI) • Web portal support services • Call center and contact management • TPL services • Data entry and mail room services • Printing and postage • Prior authorization • Utilization management • EPSDT support services	Clients can focus their energies on program development, management, and optimization with confidence that MMIS operations effectively support business needs. ACS delivers unprecedented transparency and access to all contract operations and data. All of our automated and manual processes fully comply with state and federal provisions governing confidentiality of data, including reporting requirements.
Call Center Services	• Call center services for the following programs: – Medicaid and Medicare – SCHIP – Enrollment broker – Workers' compensation – HMO – Pharmacy benefits management	ACS operates nearly 30 healthcare call centers nationally. Recognized by the Call Center Industry Advisory Council with its PaceSetter award, given only to the leading call center provider in individual industries, our parent, Affiliated Computer Services, Inc. operates call centers that answer approximately 30 million calls annually from recipients, providers, and stakeholders.

Table 5.1.6-5. ACS State Healthcare, LLC Service Offerings		
Service Offering	**Details**	**ACS Advantage**
Health Benefits Management/ Eligibility and Enrollment	• SCHIP administration • Medicaid and SCHIP EB services • Medicaid and SCHIP eligibility determination • Managed care program design, development, roll-out, and administration • Primary care case management (PCCM) • Long term care • EPSDT • Managed care enrollment	ACS has more than 25 years of eligibility and enrollment services expertise. Annually, we enroll hundreds of thousands of applicants into Medicaid managed care programs and SCHIP. We offer a single integrated solution for choice counseling and enrollment services.
HIE/EHR	• Actionable point-of-care information • Alerts, notifications, and gaps-in-care identifications • E-prescribing • Real-time clinical algorithms	ACS HIE and EHR solutions use our proprietary Patient Data Hub, allowing for the integration of administrative claims data, as well as data from labs, pharmacy switch vendors, EMR, health risk assessments, immunization systems, vital statistics, predictive models, and other disparate healthcare data sources.
Health Information Analysis	• Consulting • Disease and care management support • Clinical tools • Predictive modeling • Decision support/data warehouse	ACS combines healthcare program knowledge with systems integration and data warehousing expertise to provide powerful solutions that turn patient-specific claims, lab, and health risk appraisal into actionable information.
Care Management/ Care Coordination/ Disease Management	• Suite of modeling, profiling, benchmarking, reporting, and health risk prediction tools • Identification of recipients • Assessment of levels of care • Clinical quality outcomes reports • Utilization and case management • Wellness and preventative care program support • Targeted interventions and messaging • Workers' compensation program case management	ACS is one of few companies that hold URAC certifications for utilization management, case management, disease management, and workers' compensation case management. ACS secured designation as a Quality Improvement Organization (QIO)-like entity under 1902(a)(30)(A) of the Social Security Act. We use clinical expertise and a portfolio of technology tools to improve healthcare delivery and quality, promote medical best practices, and reduce costs.
Fraud & Abuse Protection	• Prevention and retrospective detection • Prepayment identification and denial • Claims analysis and auditing; network provider audits • Data warehouse-based surveillance • Peer group analysis • Recipient characteristics comparisons	ACS provides comprehensive waste, fraud, and abuse management services to combat healthcare abuse. Integrated advanced tools and experts provide results-oriented support to clients in identifying, detecting, and preventing waste, abuse, and fraud in Medicaid and other special healthcare programs.

As shown in the table, ACS brings a history of innovation to the Medicaid arena, developing products and services that have assisted our customers meet the challenges of an ever-changing state and federal regulatory landscape and improve the administration of their programs. Exhibit 5.1.6-1 depicts the breadth and depth of our support for various healthcare programs throughout the United States.
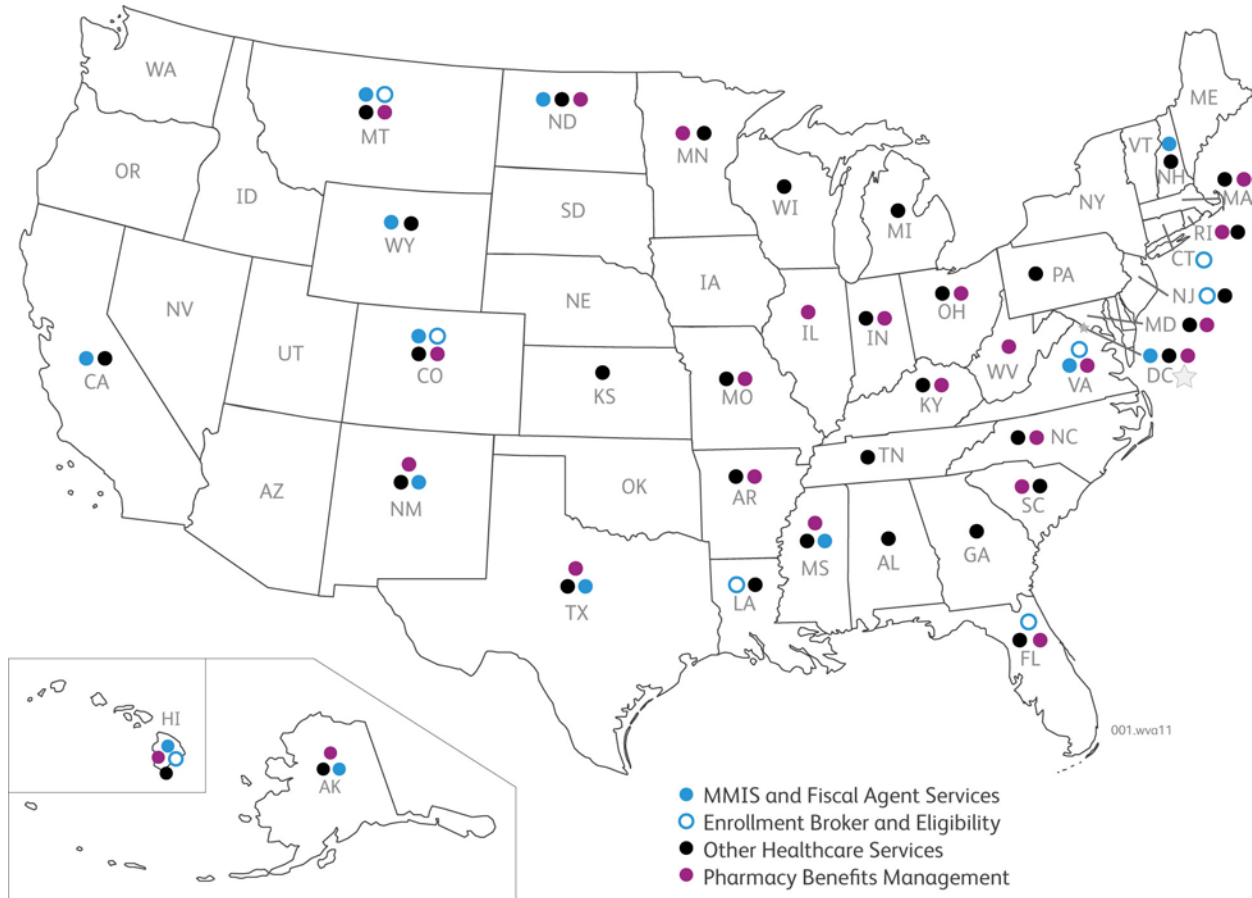

Exhibit 5.1.6-1. National Healthcare Experience
The Bureau benefits from the broad understanding and practical knowledge ACS gains from providing prior authorization services and a wide range of healthcare systems and services to state customers nationwide, including our current RetroDUR project in West Virginia.

Xerox Acquisition of Affiliated Computer Services, Inc.

Our longtime parent organization, Affiliated Computer Services, Inc., is the largest provider of diversified information technology (IT) and business process outsourcing (BPO) solutions to government and commercial customers in more than 100 countries worldwide. In 2009, Affiliated Computer Services, Inc. and Xerox Corporation (Xerox) announced that they had entered into an Agreement and Plan of Merger providing for the acquisition of Affiliated Computer Services, Inc. by Xerox. Closing on this acquisition took place on February 8, 2010, and Affiliated Computer Services, Inc. is now a subsidiary of Xerox. As a result of this acquisition, Affiliated Computer Services, Inc. is now known as "ACS, a Xerox company" even though the formal entity name is still the same, Affiliated Computer Services, Inc. ACS' CEO, Lynn Blodgett, became the President of the ACS division of Xerox. Mr. Blodgett reports to Ursula Burns, the

CEO of Xerox. Organizationally, Affiliated Computer Services, Inc. will remain intact within Xerox and serve as the BPO arm of Xerox.

ACS' commitment to providing quality-driven technology solutions and services originates from—and is reinforced by—Xerox's commitment to its clients and ability to develop creative, flexible solutions to address real-world business challenges. The "client-first" environment of our parent company allows us to provide the responsive, flexible, and reliable solutions our healthcare customers seek to address unique and complex challenges. The combination of Affiliated Computer Services, Inc. and Xerox is powerful for many reasons, but especially for the shared spirit of innovation. Both companies have a strong reputation for innovation, whether that means perfecting new technologies or transforming government operations.

SmartPA, Our Automated PA Solution

ACS is the leader in the automation of pharmacy PAs. In addition, our pharmacy PA solution possesses the proven ability to generate savings for our customers while promoting appropriate prescription drug utilization. Our clients have found that our automated SmartPA solution minimizes the delays typically associated with the PA process. As such, providers are actually incentivized to prescribe appropriately. For the Bureau, this will lead to greater overall compliance with State-preferred prescribing patterns. SmartPA uses automation to the fullest extent and automates up to 90 percent of PA requests while still providing any necessary manual pharmacy PA services.

The capabilities of the SmartPA solution enable ACS to meet all of the Bureau's needs as requested in the RFP, including such vital services as:

- Quantity limits
- Maximum allowable cost price for dispense-as-written overrides
- Maximum and minimum age edits
- Retroactive 72-hour supply
- Clinical edits
- Monthly prescriptions limits
- Preferred drug lists (PDL)
- Therapeutic edits

> **Recent Successful SmartPA Implementations**
>
> On October 10, 2011, our Colorado MMIS account implemented SmartPA. The total implementation time was under six months and was successfully completed on time and on budget.
>
> Earlier in 2011, we also implemented SmartPA in Kansas, which has a bigger program than Colorado, completing the project under budget in six months.

Qualifications and Experience Providing Prior Authorization Services

ACS is the leader in the automation of pharmacy prior authorizations and has experience with, and proven savings capability, automating non-pharmacy prior authorizations.

In 2002, ACS introduced the first fully integrated automated drug Smart Pharmacy Authorization (SmartPA[SM]) solution to the Medicaid market. At the core of the solution is a table-driven rules engine that examines at least 24 months of recipient-specific drug and medical claims information, and applies evidence-based guidelines, to determine prescribing appropriateness. For the first time, an authorization could be approved automatically, during the point-of-service (POS) transaction, with no human intervention required. This creative approach significantly improved the PA process for all stakeholders.

The SmartPA application is currently operational or in the design, development, and implementation phase for the following 13 government-sponsored programs:

- Arkansas Medicaid
- California Medicaid
- Colorado Medicaid
- Hawaii Medicaid
- Indiana Medicaid
- Kansas Medicaid
- Maryland Medicaid
- Massachusetts Medicaid
- Mississippi Medicaid
- Missouri Medicaid
- Montana Medicaid
- North Carolina Medicaid
- Ohio Medicaid

> **A Leader in Prior Authorization Services**
> - Support more than 2,000 drug and professional authorization algorithms
> - Extensive call center experience with 19 current pharmacy help desk clients
> - Call center focused solely on pharmacy benefit management programs
> - Nearly four decades of Medicaid technology innovation

Case Study: Our Solution's Success for the State of Missouri

In 2002, Missouri Medicaid selected ACS to implement a cutting-edge screening application to support the State's PA program. Prior to the installation of SmartPA, Missouri resisted requiring every COX-2 prescription (a drug that targets the inflammation- and pain-causing COX-2 enzyme) to receive an authorization from an administrative call center, due to patient access issues, concern from patient advocacy groups, and the associated authorization administrative costs. In fact, there was concern that requiring prior approval for COX-2 medications would overburden the call center, which was already operating at full capacity. Realizing the power of our technology's automation, Missouri initiated the real-time rules engine to screen individual patients with prescription claims for COX-2s. The following impressive results were achieved:

- Decreased prescription claim counts for COX-2s by 33 percent – from approximately 30,000 claims per month to 20,000 claims per month

- Decreased the benefit cost associated with COX-2 Inhibitors by approximately $900,000 per month, net the cost of substitute therapy for other analgesics

- Screening criteria produce only 450 call center requests per month – a fraction of the 20,000 claims paid per month by Missouri Medicaid

- Successfully changed physician-prescribing patterns for COX 2s and significantly reduced program expenditures with minimal administrative disruption and burden

> **Proven Savings in Missouri**
> Missouri Medicaid uses the benefits of our enhanced PA technology to automate authorization decisions at the point of service, generating savings of more than $83 million annually.

It is important to note that the typical industry approach would require 100 percent of requests—all 30,000 claim requests—to be processed by a manual authorization processing center, versus 450 requests generated with the SmartPA solution. For Missouri, SmartPA eliminated over 95 percent of the paper PA requests that would have been produced by the typical industry process, and saved the program over $10 million per year in reduced COX-2 utilization.

Client References

REQUIREMENT: RFQ Section 2.3.6.2, pg. 5
Provide at least three (3) references, not including West Virginia from clients who have experience with the Vendor's prior authorization application.

The information in this section has been redacted

5.1.7 Optional Services

ACS is committed to providing the Bureau with additional services to comply with externally driven changes to BMS programs and requirements, including any state or federal laws, rules, and regulations. We understand that these services could include assistance with policy development, impact analysis, requirements definition, and testing activities that require substantial subject matter expertise derived from experience in other states, other healthcare organizations, or participation in federal activities. ACS will provide implementation support as requested.

ACS offers broad experience with the design, implementation, and ongoing administration of PA programs. We apply best practices garnered from our other pharmacy PA clients and constantly develop new PA criteria. We also modify existing criteria to ensure all PAs are based on up-to-date, evidence-based literature. We stand ready to suggest enhancements to the Bureau's PA program by evaluating current criteria and utilization patterns. ACS understands that the Bureau's PA criteria are "living" lists and will closely monitor areas such as new drugs, new generics, policy changes, market shifts, and utilization trends and proactively make recommendations to maximize savings and improve quality of care.

Clinical Support and Expertise

ACS provides clinical support and expertise in collaboration with the Bureau's staff and consultants to develop new or modify existing PA criteria. These PA recommendations include assessments of projected therapeutic benefits, impact to clients, and associated cost savings.

Evidence-based Approach

The process for developing new PA criteria is systematic and scientifically sound. All new criteria and criteria modifications go through a rigorous internal ACS peer-review process before being placed into production. ACS' clinical staff reviews medical literature resources such as those listed below and identifies new PA opportunities or changes to existing PA criteria daily. ACS also collaborates with the Bureau and researches requests from staff and consultants on potential PA areas.

Evidence-based/medical literature resources examples:

- American Hospital Formulary Service Drug Information

- United States Pharmacopoeia-Drug Information

- DrugDex/Micromedex

- Drug Effectiveness Review Project

- Intergovernmental Agreement for Evidence-Based Policy Research

- Peer reviewed clinical and scientific literature

- Official product labeling

- Relevant guidelines obtained from professional groups through a consensus-derived process

- Experiences of practitioners with expertise in drug therapy

- Drug therapy information supplied by pharmaceutical manufacturers

- Subscriptions to journals and newsletters (pharmacy and medical)

- E-mail list with Center for Drug Evaluation and Research at the FDA (daily)

- E-mail list with Medwatch at the FDA

- Medscape e-mail notifications (weekly) and journal scan on Medscape site

- Weekly First Databank (FDB) updates

- New drugs

- Traditional literature searches

- Online access to Virginia Commonwealth University medical library

ACS also applies and shares PA best practice from other clients to identify new opportunities. We maintain an ACS SmartPA library that contains over 2,000 SmartPA clinical algorithms that can be provided to Bureau leadership for review and approval. Our flexible rules engine allows us to customize the existing criteria and/or add new rules quickly and efficiently.

If any changes need to be made or new criteria developed, clinicians that have expertise or specialization in a particular area are assigned the PA protocol development. What follows is an overview of the components we use in the clinical criteria development process when evaluating proposed clinical criteria.

Literature Search. Our clinical pharmacists continuously review clinical resources to generate ideas for new clinical criteria or to identify how literature impacts current criteria and also collaborate with the Bureau to develop prior authorization requirements. The clinical pharmacists identify the specific medical criteria necessary to comprehensively address the prior authorization criteria in question. Depending on the clinical topic, clinical pharmacists or physicians that have expertise or specialization in a particular area are assigned the protocol development.

Internal Peer-Review. Clinical algorithms are presented by the respective clinical pharmacist at the weekly clinical management services meetings. These meetings occur weekly to review existing and new clinical criteria and are chaired by ACS' clinical operations director. ACS' representatives from account management, rules administration, and clinical teams are available. All clinicians review the algorithm and provide feedback/comments. Based on this review, the criteria may require additional research and an update of the algorithm.

Rule Writing. After the clinical algorithm has been finalized, it is then used to write the clinical rule.

Data Modeling. The written rule is modeled against the Bureau's data to identify specific clinical/business opportunities.

Clinical Rule Validation. Based on the data modeling step, patient profiles are generated that include profiles of patients who would approve or deny on the respective clinical criteria. These profiles are then reviewed by the clinical pharmacist who developed the algorithm to validate the clinical rule. Based on this review, the clinical pharmacist may identify clinical rule changes that are required. If necessary, the clinical pharmacist may request additional profiles for review until the clinician is ensured the rule is correctly identifying issues and is validated.

External Peer Review. For all criteria sets, clinical proposals are provided to the Bureau that define the criteria and include components such as specific clinical criteria, drug lists, ICD-9 codes, and CPT/HCPCS codes. These proposals are typically presented to the Bureau's boards/committees (e.g., drug utilization review boards, pharmacy and therapeutics committees, pharmacy staff, etc.) for review and approval. After this review the customer may request changes to the criteria that are then communicated back to the respective clinical pharmacist to create Bureau-specific criteria. These changes would then be tested and validated before placed into production.

Production. After each algorithm has been reviewed and validated, it is placed into the Bureau-specific set of clinical rules.

The information in this section has been redacted

Attachment B: Special Terms and Conditions

If a vendor's Quotation includes proprietary language, an electronic copy omitting any proprietary language for publishing to the DHHR web-site should be submitted.

Agree that BMS retains ownership of all data, procedures, programs, work papers and all materials gathered or developed under the contract with West Virginia.

Vendor Debrief: As the evaluation and award process has been described and documented, unsuccessful vendors have the opportunity to request a Debrief. That Debrief will be conducted at BMS facilities, privately, with the requesting vendor, the buyer and appropriate members of the evaluation committee. The vendor's proposal will be discussed, and the evaluation committee scoring and contract award will be explained. This will help vendors understand the process, be more competitive by improving their proposals, and will increase their potential for winning bids.

I certify that I have acknowledged the additional contract provisions contained in Attachment B and that the Quotation meets or exceeds all additional requirements as listed.

ACS State Healthcare, LLC
_____
(Company)
Bryan Christiansen, Vice President
_____
(Representative Name, Title)
801-567-5006/801-567-5457
_____
(Contact Phone/Fax Number)
November 2, 2011
_____
(Date)
_____
(Signature)

6 Required Forms

REQUIREMENT: RFQ Section 3.5, pg. 7

Purchasing Affidavit: In accordance with Medicaid Services Contracts Purchasing Methodology and Manual, all bidders must submit an affidavit regarding any debt owed to the State of West Virginia. The affidavit must be signed and submitted prior to award. It is preferred that the affidavit be submitted with the quotation.

ACS has completed this form and includes it following this page.

REQUIREMENT: RFQ Section 3.6, pg. 7

Resident Vendor Preference: DHHR Office of Purchasing will make the determination of the Resident Vendor Preference, if applicable. Resident Vendor Preference provides an opportunity for qualifying Vendors to request at the time of bid preference for their residency status. Such preference is an evaluation method only and will be applied in accordance with Medicaid Services Contracts Purchasing Methodology and Manual. A certificate of application is used to request this preference. A West Virginia Vendor may be eligible for two (2) 2.5% preferences in the evaluation process.

ACS does not qualify for a residency status credit and has, therefore, not included an application with this quotation.

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BUREAU FOR MEDICAL SERVICES

MED PURCHASING AFFIDAVIT

West Virginia Code §5A-3-10a states: No contract or renewal of any contract may be awarded by the state or any of its political subdivisions to any vendor or prospective vendor when the vendor or prospective vendor or a related party to the vendor or prospective vendor is a debtor and the debt owned is an amount greater than one thousand dollars in the aggregate

DEFINITIONS:
"Debt" means any assessment, premium, penalty, fine, tax or other amount of money owed to the state or any of its political subdivisions because of a judgment, fine, permit violation, license assessment, defaulted workers' compensation premium, penalty or other assessment presently delinquent or due and required to be paid to the state or any of its political subdivisions, including any interest or additional penalties accrued thereon.

"Debtor" means any individual, corporation, partnership, association, Limited Liability Company or any other form or business association owing a debt to the state or any of its political subdivisions. "Political subdivision" means any county commission; municipality; county board of education; any instrumentality established by a county or municipality; any separate corporation or instrumentality established by one or more counties or municipalities, as permitted by law; or any public body charged by law with the performance of a government function or whose jurisdiction is coextensive with one or more counties or municipalities. "Related party" means a party, whether an individual, corporation, partnership, association, limited liability company or any other form or business association or other entity whatsoever, related to any vendor by blood, marriage, ownership or contract through which the party has a relationship of ownership or other interest with the vendor so that the party will actually or by effect receive or control a portion of the benefit, profit or other consideration from performance of a vendor contract with the party receiving an amount that meets or exceed five percent of the total contract amount.

EXCEPTION: The prohibition of this section does not apply where a vendor has contested any tax administered pursuant to chapter eleven of this code, workers' compensation premium, permit fee or environmental fee or assessment and the matter has not become final or where the vendor has entered into a payment plan or agreement and the vendor is not in default of any of the provisions of such plan or agreement.

Under penalty of law for false swearing *(West Virginia Code* §61-5-3), it is hereby certified that the vendor affirms and acknowledges the information in this affidavit and is in compliance with the requirements as stated.

WITNESS THE FOLLOWING SIGNATURE

Vendor's Name: __ACS State Healthcare, LLC__

Authorized Signature:. _____ Date: __10-27-2011__

State of __UTAH__

County of __SALT LAKE__, to-wit:

Taken, subscribed, and sworn to before me this __27__ day of __OcTOBER__, 20 __11__.

My Commission expires __AUGUST 3__, 20__13__.

AFFIX SEAL HERE   NOTARY PUBLIC _____

MATTHEW GARN RISENMAY
Notary Public
State of Utah
Comm. No. 579713
My Comm. Expires Aug 3, 2013

Purchasing Affidavit (Revised 12/15/09)