CHANGE HEALTHCARE

EDI Solution for Hospital and Physician Billing

Response to Request for Proposal

Software and Analytics | Network Solutions | Technology-enabled Services

PROPRIETARY AND CONFIDENTIAL PROPOSAL

The information contained in this proposal is prepared expressly for CLIENTHealth System. Change Healthcare considers this information to be proprietary and confidential and it will remain so for 5 years from the date of this proposal.

By receiving the proposal that you solicited, CLIENTagrees to retain in strict confidence all information contained in it. The information shall only be reproduced and used by CLIENTfor evaluating the merits of a business relationship with Change Healthcare and will not be shared with other hospitals, healthcare providers or competitive vendors. If you have hired consultants to help evaluate this potential relationship, CLIENTagrees that it will require such consultants to execute a confidentiality agreement in a form acceptable to Change Healthcare, to protect the confidentiality of Change Healthcare's response.

Contents

Section 1 — Executive Summary

CLIENT seeks an automated EDI solution with clinical edits that standardizes your hospital and physician billing and establishes Epic as the single source of truth. You require eligibility, claims, and remittance technology that fully integrates with Epic to enhance performance across your enterprise. Specifically, you want:

- Technology to drive eligibility, claims accuracy, and remittance receipt with strong edits
- Epic integration and correction capabilities to reduce denials
- Flexible reporting and analytics to improve revenue cycle performance

As the nation's leading healthcare IT company, Change Healthcare is helping set the standard in innovative revenue cycle solutions and optimizing performance for CLIENTCarson City and many of Michigan's largest multi-hospital systems. We understand your market and your business and can offer CLIENTtechnology and services that expand access, improve care, and accelerate cash.

Technology to Drive Eligibility, Claims Accuracy, and Remittance Receipt

To address CLIENT's request for automated eligibility verification, claims processing, and remittance results directly in Epic, we propose **RelayClearance™Plus** and **RelayAssurance™Plus**. Our one-stop shop of solutions is built on the nation's largest Intelligent Healthcare Network™ that manages 3.3 billion financial transactions each year valued at more than $2 trillion. No other EDI solution can offer CLIENTmore connectivity to over 2,200 payers to return accurate data, so you can map the fastest route to reimbursement.

Real-time Eligibility

Healthy revenue begins at registration. **With RelayClearance Plus for eligibility and verification, CLIENTgains visibility into patients' financial responsibility to reduce denials and increase point-of-service collections**. The suite includes unlimited real-time eligibility verification (**for a flat fee**), patient ID and address validation with fraud alerts, and propensity to pay. You may also wish to consider our optional Authorization solution (including Medical Necessity and Enhanced Notice of Admission) that automates 75% of manual processes by determining if a pre-authorization is required and on file with the payer.

Munson Healthcare is performing transactions twenty times faster with RelayClearance Plus and has increased up-front collections by $1 million in only one year.

Faster Claims Acceptance and Remittance Receipt

Simplify and speed your clean claims acceptance rates with RelayAssurance Plus, the industry's most mature automated claims and remittance management solution. With direct connections to 97% of payers and a 93% same-day submission rate, our real-time claims processing reduces A/R days to accelerate cash. CLIENTis already successfully using RelayAssurance Plus to rapidly process laboratory claims for faster reimbursement. The solution automatically double checks and identifies and corrects

claims errors once within the application and again at the clearinghouse prior to submission to typically achieve a 99% acceptance rate without incident.

Only exception claims are returned to your biller's work queues for rework. Its advanced exception-based workflows and robust library of over 2M industry-leading (payer-, government-, clinical-, and client-specific) edits are embedded within the system to promote cleaner claims and faster claim adjudication. Post-service eligibility checks can also dramatically decrease denials and reduce bad debt. In addition, our Medicare Direct Entry (MDE) functionality automatically triggers Automated Secondary Billing (ASB), helping to speed resolution of claims and reduce Medicare A/R days. It can accelerate your Medicare primary payment by at least one business day and secondary billing by up to two weeks.

Epic integration and Correction Capabilities to Reduce Denials

Our proven solutions seamlessly integrate with Epic to improve your revenue cycle performance. Through a strong and lasting relationship with Epic that spans more than a decade, our Epic-certified consultants have successfully developed bi-directional interfaces for more than 400 clients. Our cloud-based solutions enhance Epic capabilities by creating user-friendly, intelligent workflows to help CLIENTprevent denials by identifying claim errors early in the process and correcting them before they are transmitted to payers. CLIENThas the option of working directly within Epic or within the proposed solutions.

Just as our technology is integrated, our people collaborate as one team to provide you with a singular, successful implementation experience. The powerful alliance includes custom project team planning, implementation management, and outlining and testing of best-practice set up and processes.

Flexible Reporting and Analytics to Improve Revenue Cycle Performance

RelayAssurance Plus provides insightful intelligence and powerful standard reporting tools for claims tracking and denial management. With more than 100 reports, containing actionable intelligence and visibility into where and why denials are happening, CLIENTcan make informed decisions to drive strategy and performance improvements.

Powerful Capabilities with Change Healthcare

McKesson and Change Healthcare recently formed a new healthcare information technology and services company to address some of the most pressing and emerging challenges in healthcare. With the breadth of our cloud-based solutions and financial strength, we can deliver CLIENTa scalable one-stop shop solution that fully integrates with Epic to accelerate cash across your enterprise.

As the revenue cycle solutions vendor for most of Michigan's largest health system organizations, we have extensive experience with multi-system integration and implementation. Better yet, we understand your market and how to work within Epic to achieve your goals. ***As your strategic partner, you can count on Change Healthcare to deliver progressive solutions and a relationship that evolves with your needs, so CLIENTcan thrive in today's healthcare market.***

Section 2 — Overview of Proposed Solutions

To address CLIENT's request for automated eligibility verification, claims processing, and remittance results directly in Epic, we propose **RelayClearance Plus** and **RelayAssurance Plus**. Our one-stop shop of solutions is built on the nation's largest Intelligent Healthcare Network™ that manages 3.3 billion financial transactions each year valued at more than $2 trillion. No other EDI can offer CLIENTmore connectivity to over 2,200 payers to return accurate data, so you can map the fastest route to reimbursement.

Eligibility Verification Solutions

We are offering RelayClearance Verifier, Address Validation with Fraud Alerts, and Propensity to Pay in this proposal to help CLIENTaccelerate reimbursement and optimize revenue from registration through point-of-service collections.

The following is a brief description of those solutions.

RelayClearance Plus integrates with Epic and drives eligibility and benefit verification in Prelude and Cadence to enhance the Epic workflow and collect cash as early in the revenue cycle as possible. It confirms coverage and manages patient expectations to reduce CLIENT's financial exposure. Tightly integrated workflow tools integrate with Epic to deliver real-time eligibility and benefit verification, notice of admission, address validation with fraud alerts, and propensity to pay.

- ***RelayClearance Verifier*** is the core component of RelayClearance Plus and offers the most innovative eligibility and benefits verification in the industry **for a flat fee**. The solution provides CLIENTstaff a quick method to verify insurance coverage in real time or through fast-batch processing. It integrates X12, 270/271 eligibility responses within your existing Epic workflow, allowing your staff to set up work queues and take advantage of alerts that help them work efficiently.

  Integration with Epic permits CLIENTto:

  - Harness the power of RelayClearance Plus 1,300 plus payer connections by going directly to payer web portals for eligibility information.
  - Leverage an Epic-normalized 271 to simplify RTE data mapping, drive alerts, and enhance workflows directly in your Epic system.
  - Effectively identify missed coverage and properly reclassify self-pay with timely fast-batch eligibility checks.

- ***RelayClearance Address Validation with Fraud Alerts*** quickly and accurately verifies all patient demographic data, spots potential fraud, flags discrepancies, and automatically alerts staff to correct errors prior to service (shown in Figure 1). Staff can easily see and address "identity issues" in real time with the patient still in front of them to improve quality assurance and increase collections.

Alternative addresses and telephone numbers are automatically indicated for any data mismatches, such as:

- Invalid SSN
- Deceased SSN
- SSN issued prior to birth
- SSN associated with a different person
- Invalid addresses
- Disconnected phones (cell and landline)

The solution integrates directly into your Epic workflow to improve CLIENT's downstream processes and reduces administrative back-office costs.

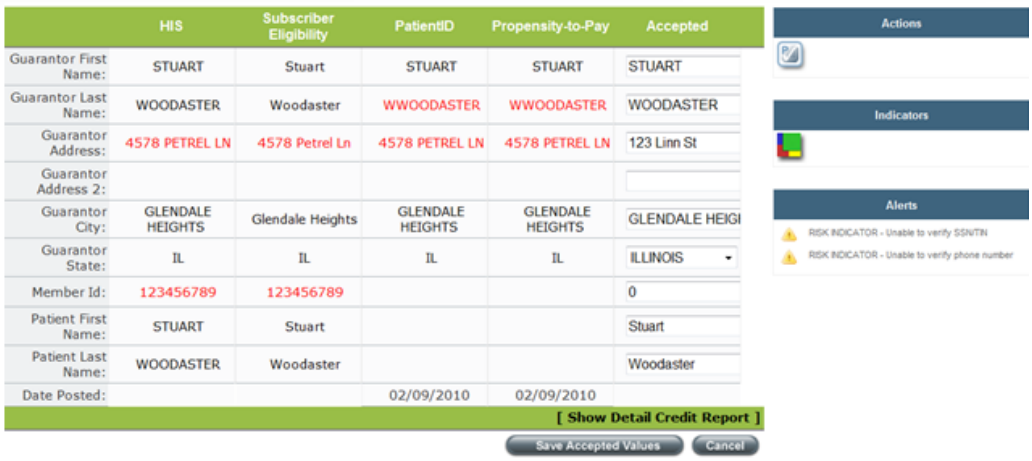

Figure 1. RelayClearance Address Validation with Fraud Alerts notifies users to potential mis-keys that are often mistaken for fraudulent data.

- **RelayClearance Propensity to Pay (P2P)** is an automated predictive modeling tool of RelayClearance Plus that integrates with your Epic workflow. It can help CLIENTdetermine a guarantor's ability and inclination to pay their bill and can offer credit scoring on all patients or just certain patient types.

  The P2P score combines reliable financial modeling of patient income that plots against the RelayClearance P2P Score "calculation matrix." One of the four color-coded (easy to understand and visible on the dashboard shown as Figure 2) P2P Scores is assigned to the patient:

  - Green is good probability/high income = collect payment
  - Blue is low probability/high income = collect payment
  - Yellow is good probability/low income = possible financial assistance needed - screening suggested if payment not possible
  - Red is low probability/low income = financial assistance screening

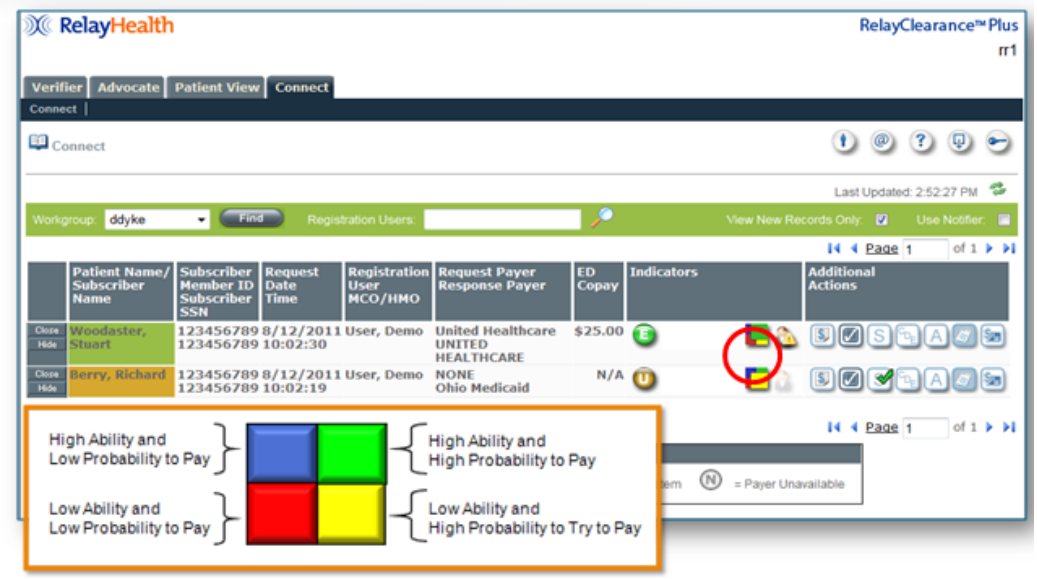

Figure 2. A color-coded screening tool helps your staff make the right collection decisions.

It helps your staff assess the likelihood that a patient will pay and if the payment will be timely. The solution integrates with Epic via the standard Epic HL7 for P2P and PID: Epic sends Change Healthcare a Q22 request, and we send the K22 P2P/PID response back to Epic.

Claims and Remittance Management

We propose RelayAssurance Plus, as CLIENT's claims and remittance management solution. It provides you real-time claims processing of all claims in one system.

RelayAssurance Plus is one of the most mature offerings in claims and remittance management today. It leverages analytics driven technology with advanced user-friendly workflows to improve clean claim rates, reduce errors and increase payment velocity. Using our expansive library of over 2.2 million industry-leading payer edits, it offers real-time claims processing. In fact, many of our customers experience 99.7% of their claims processes without staff intervention and a 97% first-pass adjudication rate.

No other solution provides you with greater connectivity to our EHNAC-certified clearinghouse (one of the nation's largest IT networks) of more than 2,200 payers. Unique to RelayAssurance Plus is also the ability to post remit data to a claim in the claims management database. This contributes to the full claims tracking and claims status features in the system and triggers the Automated Secondary Billing (ASB) feature for applicable claims. The solution offers transparency into the entire life cycle of your claims processes and leverages intelligence to drive exception-driven workflow. Tracking and claims status features help you address claim issues earlier in the process to speed payment velocity. Finally, RelayAssurance Plus's in-depth reporting capabilities add valuable insight into operational efficiencies and staff productivity to drive strategic and performance improvements.

RelayAssurance Plus suite of claims and remittance management tools include:

- **Claims Status** supports the receipt of claims status information from payers. It automatically solicits claims status to connected payers, posts the response information to the claim, and returns the normalized ANSI 277 (5010) to CLIENTfor use in Epic. It identifies claims that are moving through the process appropriately and those that need attention so your staff works more efficiently (shown in Figure 3).

Figure 3. A visual representation of an operational dashboard depicting claims status.

- **Reconciliation Manager** automates your claim reconciliation process so your staff does not waste time searching and monitoring claims that are moving through the process appropriately. Instead, they can focus on problem claims, ensuring prompt reimbursement and reduced labor costs for CLIENT. Data extraction posting (DEP) allows Epic clients to post "notes" back to Epic regarding claims that have been "released" from RelayAssurance Plus. We can return claim edits to Epic and drive Epic work queues through Epic CRD, if desired.
  The solution offers intelligent, exception-based follow-up workflow to reduce denials and payment delays. Your staff can gain visibility into the status of claims in real time and easily identify outlier claims that need corrective action.
  The following (shown in Figure 4) is an example of how the dashboard offers enhanced visibility and processing transparency.

Figure 4. Gain visibility into when claims are heading for trouble, so users can easily take early action to avoid delays.

The **Reconciliation Manager Claims Tracker** (Figure 5) drills down to the individual claim. The system gives billers a visual indicator of how well the claim is progressing. Color-coded alerts indicate issues or potential issues that need immediate action. High- priority denials that meet assigned criteria appear in red on the dashboard and in the tracker view. Staff members can quickly correct the claim and resubmit, helping to reduce denials and A/R days. Early and proactive identification of claim processing exceptions at a payer, either through leveraging status information provided by a payer or through threshold based alerting, reduces the follow-up cycle time and the "let me go check" workflow models that have burdened claims processing teams for decades.

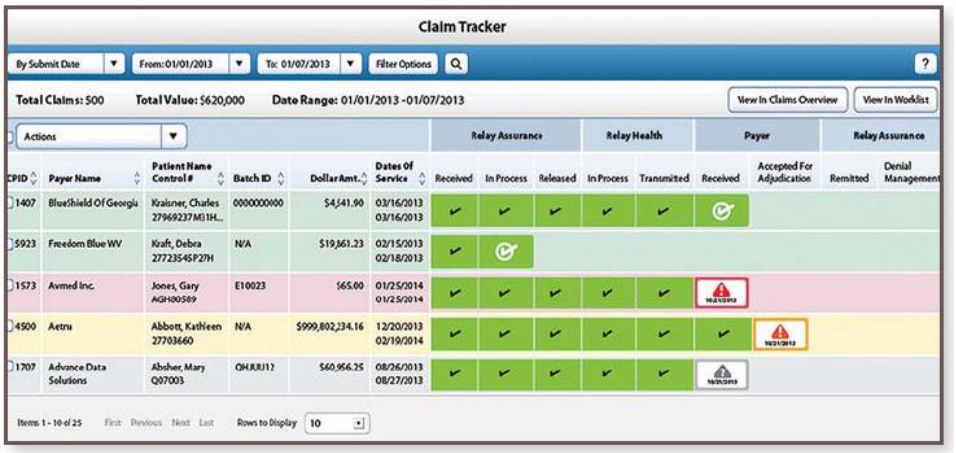

Figure 5. Claims Tracker drills down to the individual claim. The system gives billers a visual indicator of how well the claim is progressing. Color-coded alerts indicate issues or potential issues that need immediate action.

- **MDE** is the only product of its kind associated with an EHNAC-accredited clearinghouse. MDE helps manage Medicare claims and integrates with all other workflows, including integrated Return to Provider corrections to offer:
  - One-click error correction
  - Reduced RTP/rejections
  - Accelerated Medicare claims payment by at least one business day
  - Simplified and faster automated secondary billing
  - Elimination of the need for additional Medicare claims processing system

  MDE checks claims for eligibility errors and submits them directly to Medicare in real time, so CLIENTcan avoid fiscal intermediary delays. Claims with errors are corrected within the system. It expedites reimbursement and accelerates your Medicare primary claim cash flow by at least one business day and secondary billing by more than two weeks (see process flow in Figure 6.) MDE enhances productivity, accelerates cash flow, and virtually eliminates claim suspensions and rejections.

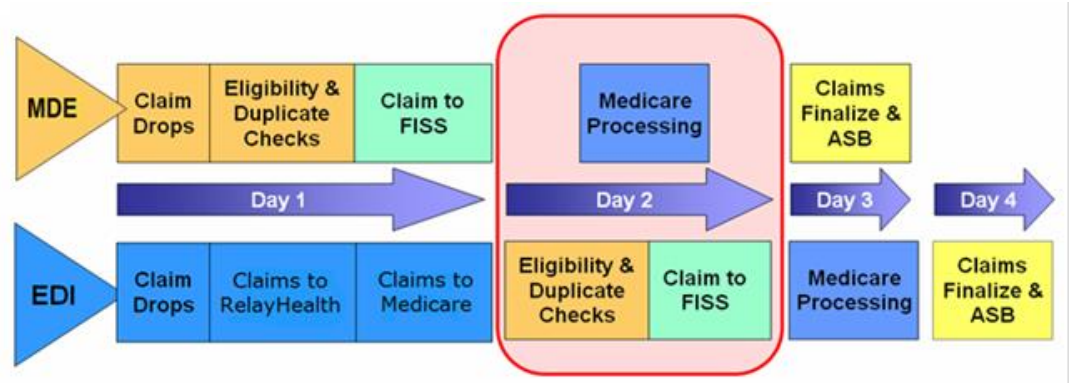

Figure 6. MDE provides a faster avenue to Medicare Reimbursement versus usual EDI processes.

- **RelayAssurance Attachments** is a feature that integrates worker's compensation and property and casualty claims attachments into the claims workflow at **no additional charge**. This promotes cash acceleration and staff productivity.
- **Remittance Management** uses normalized 5010a 835 formats (as shown in Figure 7) to process payer remittances that are delivered into your Patient Accounting System and posted to the claim in RelayAssurance Plus. Remittance data can be customized, split, or otherwise tailored to meet your specific posting needs. Unique to the solution is the ability to post remit data to the claim in the claims management database. This posting contributes to the full claims tracking and claims status features in the system and triggers the Automated Secondary Billing (ASB) feature for claims that require secondary billing. CLIENTmay configure secondary billing options at the remittance payer level (i.e., different rules for operating with a Medicare remit than a Medicaid remit or charity care remit) as well as secondary billing rules specific to the secondary payer (e.g., when secondary is BCBS, add Value Code for Deductible to the claim).

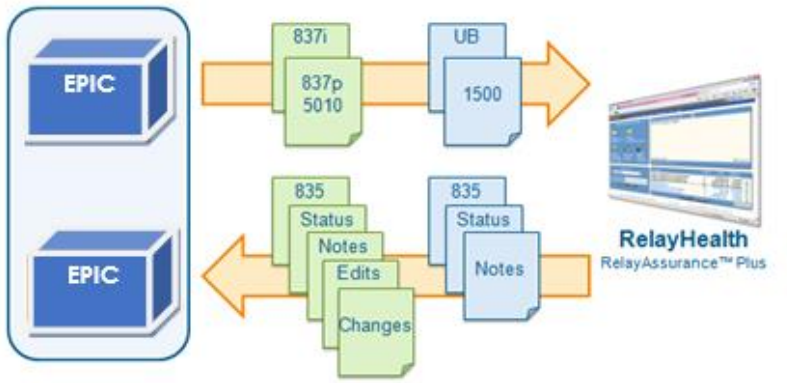

Figure 7. Epic System Integration offers one single automated billing solution with RelayAssurance Plus.

Automated Secondary Billing: We support electronic submission of secondary claims as supported by payers. The Automated Secondary Billing (ASB) feature of RelayAssurance Plus helps manage your secondary volume by automatically generating the secondary claim, including CAS segments and explanation of benefits (EOB) from the primary remittance advices. These claims/EOBs can be delivered electronically if the payer is capable or you can print and mail your claims in-house. Paper claims can be printed and mailed by CLIENTor by Change Healthcare.

- ***RelayAssurance Plus Comprehensive Reporting*** offers CLIENTover 100 standard and configurable reports to support all the solution's modules. For example, error reports provide information of all edit errors contained on a claim, including a claim error summary report, claim error detail report, field error detail, field error summary, Medical Necessity Errors, Eligibility Errors, and CCI error details, to name a few. Error reports are available in various machine-readable formats, including XML, and are generally used by Epic clients to populate Epic work queues for errors requiring correction within Epic. All the solution's reports can be produced automatically as scheduled events and returned electronically. If CLIENTchooses to use Epic reporting, RelayAssurance Plus can feed claims data to Epic dashboard via CSV.

Section 3 — Required Information

1. Company Information and Process

1. **Provide key contact names, title, email address and phone number.**

   Tina Cameron

   Regional Sales Manager

   tina.cameron@relayhealth.com

   614.636.9662

2. **What differentiates your company's primary services from your competition?**

   The following represents five differentiators that set Change Healthcare apart from our competitors.

Scalability

Few companies have the breadth of data we have gathered through our robust Intelligent Healthcare Network™, the single largest financial and administrative network in the United States. We can use our strength and scale to provide CLIENTwith flexible options that enable you to rapidly access accurate data for faster reimbursement and heightened compliance. Our unparalleled reach and proven track record of proficiency can strategically position CLIENTto effectively respond to today's changing reimbursement models for a healthy revenue and a healthy future.

Demonstrated Competence and Industry Experience

Change Healthcare is a leader in revenue cycle solutions (shown in Figure 8) and is committed to being the single greatest point of connectivity in the U.S. for our clients and the industry. As a key catalyst to a value-based healthcare system, we can work alongside CLIENTand provide you with proactive ways to provide measurable impact as you navigate industry changes. Our comprehensive, cloud-based, high-performance revenue cycle solutions successfully integrate value-based models into Epic to reduce manual touchpoints and standardize processes across your enterprise.

We pioneered and maintain the nation's largest network of payers and providers. We are proud to have built intelligent networks and connections that are making healthcare smarter and bringing people and information closer together to expand access and accelerate cash. We offer our clients:

- Direct access to 97% of 2,200 payers through our EHNAC-certified clearinghouse, reaching nearly all United States government and commercial payers. We serve 5,500 hospitals and more than 800,000 physicians, helping health system leaders achieve strategic objectives.
- The largest footprint in the industry processing patient eligibility verification and claims in more than 60% of hospitals/health systems nationwide and reaching 90% of covered lives.

- Our Intelligent Healthcare Network processed more than 12 billion healthcare-related transactions, covering more than $2 trillion in claims, and touching one in five United States patient records in fiscal year 2016.
- Our best-in-industry library of more than 2M payer-, government-, clinical-and client-specific edits (with a 99.5% rate of updating prior to the effective) throughout the revenue cycle to prevent denials and drive clean claims.

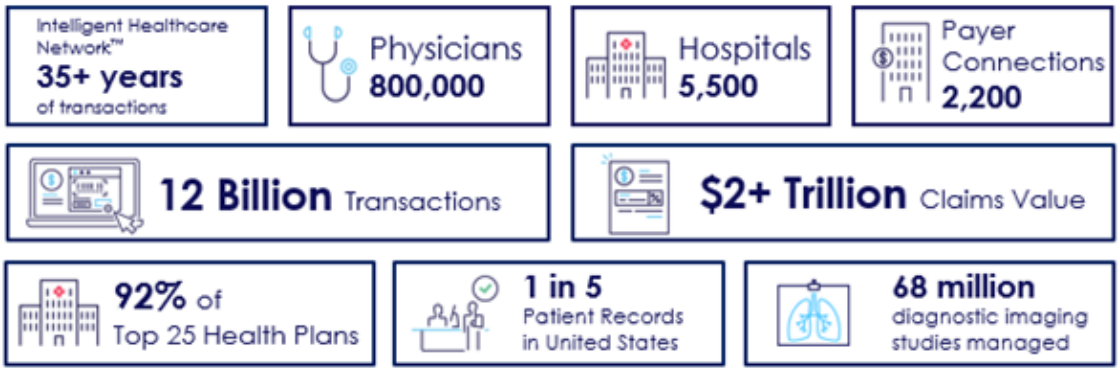

Figure 8. Change Healthcare offers our clients a breadth of revenue cycle technology and services that are unmatched by competitors.

Award-winning Customer Support

CLIENTcan expect to receive quality customer service as evidenced by our numerous industry awards and accreditations (Omega Northface, SCP Certification, EHNAC Certification) and our recent benchmarks:

- We maintain a 98% client retention rate.
- Our award-winning customer support and service is delivered by 15,000 employees at over 100 locations nationwide
- Our customer support centers have an average speed-to-answer of 20 seconds or less with a call abandonment rate less than 3%.
- Our average customer support resolution time for claims processing issues is 1.97 days.
- Our customer support team ratio is one support person to every 16 clients (1:16) and more than 60% of all issues are resolved on first call.
- More than 70% of our product enhancements come directly from client feedback.

Pricing Advantage

By choosing Change Healthcare as your vendor CLIENTcan immediately add value and ROI to your IT investment with:

- Unlimited client-specific edits at **no extra charge.**
- Unlimited business edits provided four times a week at **no extra charge.**
- Automated application updates or upgrades at **no extra charge.**
- User-friendly and intuitive workflows that minimize training needs.
- More net revenue per FTE.
- No hardware or maintenance requirements to use our system.
- No licensing requirements.

Strong End-to-End Revenue Cycle Solutions

Change Healthcare is uniquely qualified as a single revenue cycle vendor to fulfill the requirements of the RFP. The strength of our end-to-end solutions are supported by the largest EHNAC-certified clearinghouse in the industry with direct access to 1,300 payers for eligibility verification and 2,200 payers for claims transactions.

These brief descriptions highlight the powerful solutions that make up our comprehensive one-stop-shop revenue cycle that can help CLIENTbuild healthy revenue and a healthy future:

- **RelayClearance Plus** gives you clear vision into patient financial responsibility to help you collect earlier in the process, reduce denials and enhance patient satisfaction. It provides real-time eligibility and benefits verification with notice of admission for a flat fee, patient ID and address validation with fraud alerts, and propensity to pay scoring that classifies a patient's ability and willingness to pay their bill. As an option, the solution also offers you automated pre-authorization screening and verification and medical necessity with results returned to Epic within seconds.
- **RelayAssurance Plus** analytics-driven claims and remittance technology identifies and helps you flag and correct claims issues before submission to increase payment speed and productivity. Its advanced exception-based workflows and library of industry-leading edits (with 99.5% updated prior to effective date) promote cleaner claims to help assure claim acceptance and speed adjudication. Its Medicare Direct Entry functionality can reduce Medicare A/R days and accelerate your Medicare primary payment by at least one-business day and secondary billing by two weeks. The solution offers you greater visibility into claims status and advice to expedite re-transmission of exception claims. Included are real-time claims processing, automated secondary claim billing, remit management, claims status, reconciliation management, Medicare Direct Entry, attachments, and extensive reporting capabilities.

3. **Who will be the primary contact during this RFP process (name, title, phone and email address)?**

Tina Cameron, Regional Sales Manager, is your primary point of contact during this RFP process. Tina can be reached at 614.636.9662 or via email at tina.cameron@relayhealth.com.

4. **Please confirm your commitment to provide 3 references if selected as a vendor of choice (Epic preferred).**

   Confirmed.

5. **Please describe your company's overall experience and working relationship with Epic.**

   During an era of unprecedented change in healthcare, Change Healthcare has remained at the forefront of the transformation, supplying new information technology, services, and ideas that deliver improved outcomes for businesses and patients. We believe higher-quality care comes when industry leaders work together. As a result of our decade-long collaboration with Epic, we can provide our Epic clients with solutions to better manage risk and respond to health reform and regulatory changes.

   Our rich history with Epic means that our technology is integrated, and we have worked together as one team in the development of bi-directional interfaces for more than 400 clients. Our strong partnership with Epic has established best-practice processes between applications and testing and implementation protocols that are being employed nationally to help transform revenue cycle management.

   CLIENTcan expect our in-house Epic consultants to work closely with Epic to deliver a singular, successful solution and implementation experience. We support Epic's standard integration services and are working to pioneer additional joint services. Processes between our applications include: Implementation management, bi-directional interfaces, custom project team planning, coordinated involvement throughout your go-live process.

   We also engage in biweekly product management calls to discuss and plan for better integration and communication between the two applications. Many of our clients are multi-facility entities with multiple Epic systems that require staged rollouts (single region/geography, ambulatory/acute, per facility). An average implementation in an environment with one to five acute care facilities, affiliated practices, and ancillary organizations is 90 days.

   In addition, we conduct proactive reviews of new installations to ensure smooth implementation and engage in biweekly product management calls for better integration /communication between the two applications (e.g., DEP instead of Claim Error Detail III Report; fewer requirements for bridge routines.) Through our unique knowledge and interconnected technology, we can provide a visible measure of quality and value and are committed to pioneering additional services with Epic to help CLIENTmeet your business challenges.

2. Solution

1. **Briefly describe your expertise in the claims management and clearinghouse industry.**

We manage high volumes of eligibility and claims transactions through our EHNAC-certified clearinghouse connecting to 5,500 hospitals/health systems that include 800,000 clinicians. Last year, we processed 3.3 billion financial transactions valued at more than $2 trillion.

Expertise in Claims Management

RelayAssurance Plus is one of the most mature offerings in claims and remittance management today. Its analytics-driven claims and remittance technology identifies and helps you flag and correct physician-billing (PB) and hospital-billing (HB) claims issues before submission to increase payment speed and productivity. Its advanced exception-based workflows and library of industry-leading edits are integrated with Epic's Accelerated Claims Reconciliation (ACRD) to promote cleaner claims and support a 97% adjudication rate and fewer reworks. The Medicare Direct Entry (MDE) functionality can reduce Medicare A/R days and accelerate your Medicare primary payment by a least one-business day and secondary billing by two weeks. The solution integrates with Epic Claims Reconciliation (CRD) to enhance your visibility into claims status and advice to expedite re-transmission of exception claims.

No other solution provides you with greater direct connectivity to our EHNAC-certified clearinghouse of more than 2,200 payers. Please see *Attachment A* for a copy of our payers list for claims processing.

Industry-Leading Clearinghouse

Our EHNAC-certified clearinghouse leverages our industry-leading payer network of 2,200 payers to help our clients increase point-of-service collections and reduce risk. We can successfully connect CLIENTto more payers than any other healthcare business in the marketplace.

Our newly formed company has 35+ years of experience in the healthcare IT industry, and this dramatic new chapter is already transforming us into a company with fresh ideas, new technology, and services that are inspiring better healthcare systems. The new Change Healthcare provides software and analytics, network solutions, and technology-enabled services that can help CLIENTobtain actionable insights, exchange mission-critical information, control costs, optimize revenue opportunities, and increase cash flow.

Our collection of technology and services span the revenue cycle continuum (shown in Figure 9) and work to minimize manual processes, increase staff productivity, accelerate cash flow, and reduce A/R days and bad debt. Finally, we can provide CLIENTwith strategic insight where improvements might be most favorable across your enterprise.

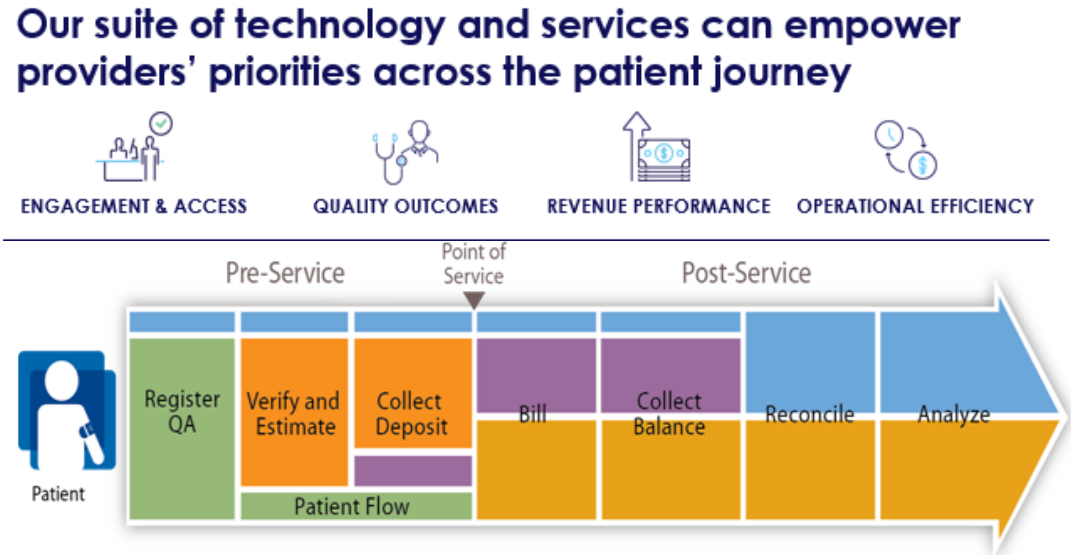

Figure 9. End-to-end suite of technology and services across the revenue cycle continuum bringing people and information closer together to expand access and accelerate cash.

2. **Briefly describe your claims management and clearinghouse workflow.**

RelayAssurance Plus offers CLIENTclaim processing in real-time. It leverages intuitive analytics-driven technology with advanced user-friendly workflows to improve clean claim rates, reduce errors and increase payment velocity and productivity. The solution provides real-time claims processing, using best-in-industry edits to facilitate clean claims transmissions to payers, resulting in 99.7% of claims processing without incident and a 97% first-pass adjudication rate.

The application uses (*embedded*) industry-leading edits to correct claims errors and CLIENT-defined edits. Our claims correcting capabilities validate codes and modifiers and ensure that claims are not denied because of missing information through the solutions comprehensive standard and configurable edit capabilities.

Claim submission files are imported to RelayAssurance Plus through a series of steps as follows:

- Client produces the claim file(s) and stores them on a network location accessible to the RelayAssurance Agent (e.g., UNC path, mapped Drive, local drive)

- RelayAssurance Agent identifies the claim file to be imported (based on location and file naming convention) and submits the file for processing. The claim file is read by RelayAssurance Plus and all claim edits, Bridge Routines (for data transformations, client-defined edits and holds); Eligibility Edits (optional) are applied during the import, and claims are saved to the database.
- Automated import balancing processes are performed, and confirmation reports are returned.
- Additional import-driven automation can occur to trigger additional reports and drive additional processes, such as MDE edit processing or release of error-free (Accepted) for delivery to the payer(s).
- Claims are available to users immediately upon being saved unless they are included in processes, such as MDE.

Clearinghouse Workflow

Our EHNAC-certified clearinghouse is embedded with our industry-leading edits and performs additional claim correcting to facilitate clean claims before being transmitted to payers. Only exception claims (needing attention) are returned to the biller's work queue for analysis, rework, and resubmission.

Edits Specific to Epic

Change Healthcare has a best-in-industry practice of updating 99.5% of edits prior to their effective date. Updates are made four times weekly to promote high compliance and first-pass acceptance rates. We work closely with our Epic clients to recognize errors that can be identified in Epic to reduce the error rate once claims are processed through RelayAssurance Plus. We co-developed with Epic, a best-practice approach to assist with more timely delivery of claims and working the errors in the most appropriate place for accelerated cash flow. As part of our joint development, we have created processes to deliver edit errors back to Epic for dissemination into Epic work queues for appropriate correction.

The co-development work that we have done with Epic produces a configurable response process for claim edits. First, the edit errors returned to Epic are detailed and delivered to the AIF crosswalk file in Epic to drive those edit errors to the appropriate work queues in Epic. Second, the edit error text is delivered, along with the edit, into Epic for more clarity on edit errors.

Although, managing workflow within RelayAssurance Plus is preferred, we can return claim edits to Epic and drive Epic work queues through CRD, if desired.

Updated Edits Help to Reduce Rejections

We continually evaluate the ever-changing state of healthcare reimbursement by identifying and developing new edits to prevent rejections and keep our clients compliant. Edits are developed using proprietary tools and are tested against previous (volume testing) and specific test scenarios. Approved edits are documented and released to clients four times a week through an automated update process (*which does not result in any system downtime*). Edit documentation is automatically updated within the solution and through the customer support system.

Client-defined edits (known as bridge routines) permit CLIENT-specific claim editing and claim data transformation during the claim import process. During implementation, our implementation project team works with CLIENTto develop custom-edits based on your specific business and operational needs.

3. Please describe the architecture and functionality of your claims management solution.

Our solutions are offered in a modern and scalable hosted Software-as-a-Service (SaaS) architecture that easily and seamlessly integrates with Epic. Our architecture uses the power of the cloud and big data to help CLIENTmake better financial decisions for your organization and patients at the point of care.

We have been providing connectivity solutions to Epic clients for more than a decade. In fact, we have over 400 clients with Epic as their HIS. Change Healthcare relies on industry standards (837, 835, 270, 271, 277, 997, HL7, and CCD) to connect providers across all platforms and can integrate with any patient accounting or EMR system. Working closely with Epic project managers, we have co-developed integration and best practices for a successful integration for our clients.

Change Healthcare EDI Connectivity Platform (shown in Figure 10.) has direct access to 2,200 payers, including Medicare, Medicaid, BC/BS, commercial HMOs, and third-party administrators.

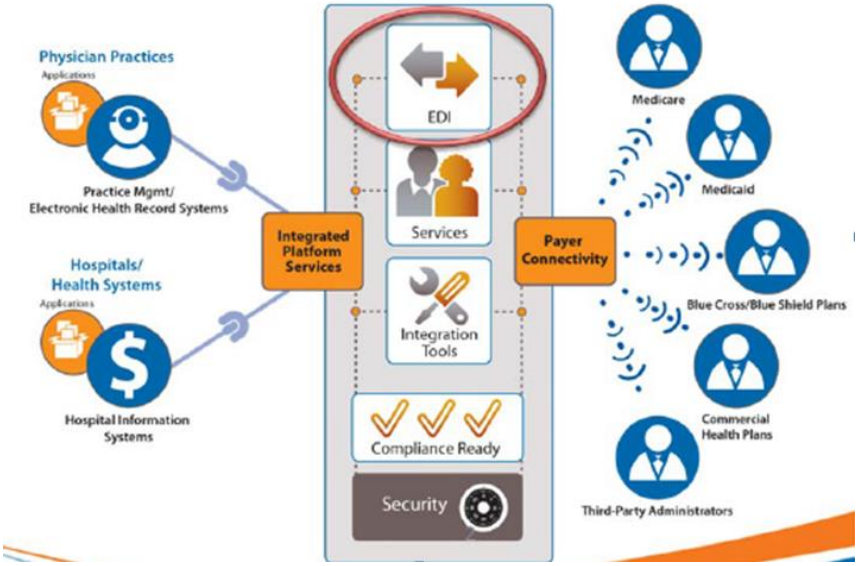

Figure 10. Epic Integration with our clearinghouse platform directly connects CLIENTto over 2,200 payers.

Epic-specific host integration provides a flexible and client-configured data extraction process. We can provide eligibility and address validation responses, claim, claim status, and claim history data through an automated extraction process that supports system information integration.

Some of the points of integration are:

- Our co-developed best practice approach allows delivery of edit errors from RelayAssurance Plus back to Epic. They *are returned into Epic work queues* for correction and delivered back to RelayAssurance Plus direct to your host system with detailed 835 data being *automatically posted back* to the individual account or line item.
- Receipt of transactions from payers, such as 277, 997, and payer response reports. Solicited 277 files *can be uploaded into Epic* and RelayAssurance Plus can provide other payer rejection data in an up-loadable file format.
- Receipt of claims status information from payers. RelayAssurance Plus automatically solicits claims status to connected payers, *posts the response information to the claim, and returns the normalized ANSI 277 (or 5010) for use in Epic*.
- Real-time and fast-batch standard eligibility responses *are returned to Epic in the normalized ANSI 271 format.* We can support additional data and HL7-based formats for Epic clients, as appropriate.

Claims Management Functionality

RelayAssurance Plus leverages intelligence driven technology with advanced user-friendly workflows to improve clean claim rates, reduce errors, and increase payment velocity and productivity. The solution provides real-time claims processing using best-in-industry edits to facilitate clean claims transmissions to payers, resulting in 99.7% of claims processing without incident and a 97% first-class adjudication rate.

In addition to real-time claims processing and claim error correcting, the solution offers CLIENTclear visibility into claims status, claims reconciliation, MDE features, attachments, denial management, and over 100 standard configurable reports. Unique to the solution is the ability to post remit data to a claim in the claims management database. This contributes to the full claims tracking and claims status features in the system and triggers the Automated Secondary Billing (ASB) feature for applicable claims.

4. **Do you have your own clearinghouse? Please describe how it works and the various gateways that would be used for Medicare, Medicare Plus Blue, Blue Cross, Medicaid, Medicaid HMO, and PHP.**

   Yes. We own and operate an EHNAC-certified clearinghouse that complements the claim and remit workflow management in RelayAssurance Plus. Our clearinghouse provides our clients with direct access to over 2,200 payers, including Medicaid, Medicare, commercial health plans, BS/BS, PHP, and other national and regional payers. It provides additional claim error correcting automation prior to claims submission to ensure clean claims processing and speed reimbursement. Together, the application and our clearinghouse processes more than 90% of remits and claims status electronically, so CLIENTspeeds payment velocity, reduces the cost to collect, and accelerates cash.

5. **Do you currently interface with Epic clients and if so, please provide a list of Epic clients?**

   Yes. We interface with over 400 Epic clients. To protect our client's confidentiality, we do not provide complete lists of our clients or their contact information. However, we are willing to provide CLIENTwith suitable references. We respect and value the relationships we have established with our clients. Out of consideration for our clients, we coordinate reference calls and site visits for you upon being named vendor of choice. Our reference clients greatly appreciate working through our account executive team in this process and CLIENTwill too.

6. **Does your solution provide responsive claim edits in a real-time environment?**

   Yes. Our claims management solution can submit claims in real time and via batch processing. We can return claims edits to Epic and drive Epic work queues through CRD, if desired.

7. **Does your solution automatically provide governmental and payer-specific edits without the client having to build? Are they easily integrated into EPIC?**

   Yes. Government and payer-specific edits are embedded in the RelayAssurance Plus solution. The solution "edits" a claim (compares the claim content with the payer-specific data required submission, CCI, Medical Necessity, OCE, 72-Hour, Duplicate, etc.) during claim import in real time. Unlimited real-time edit operations are performed within seconds to ensure clean claim submissions.

   Eligibility claim edits occur simultaneously as real-time eligibility transactions are generated by RelayAssurance Plus. Edits are applied in real time when the eligibility response is received from the payer.

   MDE edits, such as member specific, claim history, overlap, and benefit edits, are generally applied through post-claim-import processes. During this process, claims are available to staff as they complete the process.

8. **With regard to edits:**

   a. **Is there an additional cost and if so, what is the cost?**

      No. Approved edits are documented and released to clients four times weekly at **no additional charge.** During implementation, your assigned Change Healthcare project team creates CLIENT-specific edits based on your business and operational needs. CLIENTalso receives training to create and manage your edits following go-live.

   b. **Describe the source used to develop your edits, i.e. CCI, Medicare, blend, etc.?**

      RelayAssurance Plus offers unlimited payer-specific edits to promote first-pass acceptance rates. Edits are continually identified and monitored by our team of 70 analysts, **at no additional charge**. This team monitors all industry changes relating to commercial and government (including Medicaid and Medicare) to ensure that our clients have the most up-to-date edits in place to comply with payer requirements and to prevent payer rejection(s).

The following workflow (shown in Figure 11) represents how edits are harvested and reviewed. Edits are developed using proprietary tools and are tested against previous and specific test scenarios and are released to our client base without interruption to claims processing. The team updates the system four times a week. The solution also offers post-service eligibility edits.

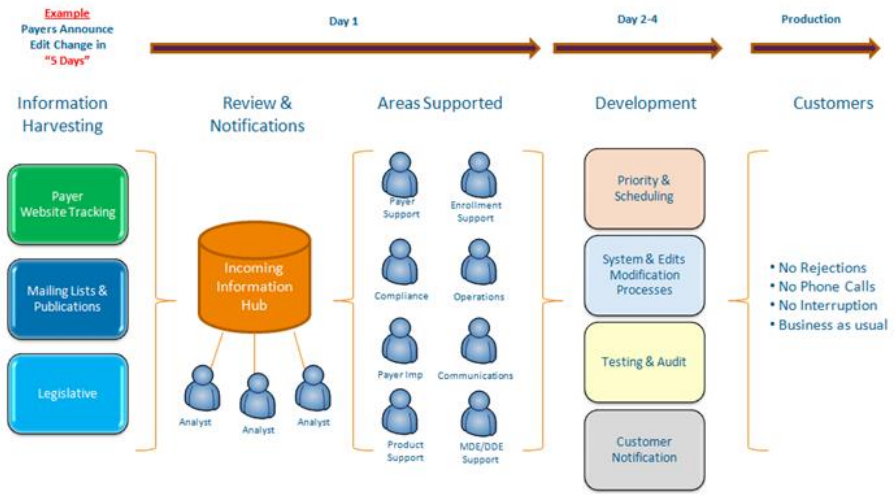

Figure 11. Our team of analysts proactively harvests, reviews, and develops edits to keep CLIENTupdated and compliant.

Edits are embedded in RelayAssurance Plus and are integrated with Epic's Accelerated Claims Reconciliation to facilitate clean claims transmissions to payers, resulting in 99.7% of claims processing without incident and a 97% first-pass adjudication rate.

The following edits are included in RelayAssurance Plus:

- **Payer-Specific Edits** - Built and deployed for a given payer, edits are tailored within the "Edit Master" to operate at the plan level when necessary.
- **Client-Specific Edits** – CLIENTcan confirm patient coverage, demographic, and related information for connected payers.
- **Medicare Compliance Edits (NDC, LCD, 72-Hour, CCI)** - Distributed twice monthly for both Part A and Part B services. LCD edits are managed at the MAC level. Medical Necessity edits can be applied to any other payer. Medicare CCI Edits are distributed quarterly in line with updates to the Medicare OPPS system. Medicare CCI edits can be applied to any other payer at the procedure code level.
- **Duplicate Claim Edits** – Our solution allows CLIENTto create procedure/diagnosis (clinical) edits and look for duplicate claims.
- **Medicare Recovery Audit Contractor (RAC) Edits** – With necessary RAC edits CLIENTcan identify improper payments.

MDE Edits *are optional with the solution:*

- **MDE Edits** offer pre-submission Medicare FSS/CWF edits for provider, patient, demographic, service, and claim history edits. MDE also reduces A/R days by checking claims for eligibility errors then submits them directly to Medicare in real time, so CLIENTcan avoid fiscal intermediary delays. Claims with errors are corrected within the system.

During implementation, your assigned Change Healthcare project team creates CLIENT-specific (bridge routines) edits to align with your business and organization needs. Your staff is also trained to create edits and rules for internal hold, and how to manage automated correction of claims during import to reduce manual time associated with edit corrections.

c. How often are edits updated?

Approved edits are documented and released to clients four times weekly at **no additional charge.** We have a best-in-industry practice of updating 99.5% of edits prior to the effective date. Our automated updates process does not result in any system downtime.

9. Describe how your company can return 837i and 837p files of transmitted data to payers?

As a co-developed best practice for RelayAssurance Plus and Epic implementation, we use the Epic 837I/P files as the source of truth for Facility and Physician information. We have been providing connection to Epic clients for more than a decade and have over 400 Epic clients using our solutions.

10. Is secondary billing automated? For example, if the account has both a primary and secondary payer, and there is a remittance from the primary, can we automate submission to the secondary?

Yes. The Automated Secondary Claims module of RelayAssurance Plus helps manage your secondary volume by automatically generating the secondary claim, including CAS segments and explanation of benefits (EOB) from the primary remittance advices. These claims/EOBs can be delivered electronically if the payer is capable, or you can print and mail your claims in-house.

With the solution's MDE capability, our clients can also accelerate the processing of claims secondary to Medicare as soon as the claims have been adjudicated within the Medicare system.

CLIENTmay configure secondary billing options at the remittance payer level (i.e., different rules for operating with a Medicare remit than a Medicaid remit) as well as Secondary billing rules specific to the secondary payer (i.e., when secondary is BCBS, add Value Code for Deductible to the claim). Additionally, Bridge Routine functionality is available for Secondary Claims, which allows for comprehensive configuration of secondary claims based on payer's requirements.

Paper claims can be printed and mailed by CLIENTor by Change Healthcare.

11. **Can 835s be split electronically and routed to the individual account level?**

    Yes. Remittance data can be customized, split, or otherwise tailored to meet the specific posting needs of CLIENT, working seamlessly with Epic.

12. **Does your solution directly connect to payers or use a third-party clearinghouse?**

    Yes. Change Healthcare operates its own EHNAC-certified clearinghouse, with direct connectivity to over 2,200 payers. Only 3% of our claims process through third-party vendors. As one of the largest health IT companies in the world, no other company provides greater real-time connection to payers, patients, and providers, helping transform your path to payment and journey to value-based care.

    Our modern and scalable solutions and growing network connect over 2,200 payers to 5,500 hospitals, including 800,000 clinicians. Last year, we processed 3.3 billion financial transactions, valued at more than $2 trillion.

13. **Are payer website responses integrated?**

    Yes. In both the acute and ambulatory settings, RelayAssurance Plus receives data from, and shares data back to, Epic as well as to other systems. Among the points of integration are:

    - Integration directly to Epic with detailed 835 data automatically posted back to the individual account or line item.
    - Change Healthcare retrieves the 835 files automatically from the payer, uses that data within RelayAssurance Plus and pushes the 835 to your network for use in your imaging and reporting systems where CLIENTcan take the data and post it back into Epic.
    - Receipt of transactions from payers, such as 277, 997, and payer response reports. Solicited 277 files can be uploaded into your host information system. RelayAssurance Plus can provide other payer rejection data in a normalized file format.
    - Receipt of claims status information from payers. RelayAssurance Plus automatically solicits claims status to connected payers, posts the response information to the claim, and returns the normalized ANSI 277 (5010) for use in your host system(s).
    - Files generated that include changed claim data can be provided for upload to the host patient accounting system.

14. **Does your solution have a Medicare claims status and corrections solution integrated?**

    Yes. MDE is the only product of its kind associated with an EHNAC-accredited clearinghouse.

    MDE expedites reimbursement, reduces A/R days, and accelerates your Medicare primary claim cash flow by at least one business day. MDE checks claims for eligibility errors AND submits them directly to Medicare in real time, so CLIENTcan avoid fiscal intermediary delays. Claims with errors are corrected within the system.

    The status of submitted claims is automatically checked to track adjudication and expected payment date. Returned claims are automatically routed to billers for rework and resubmission. Secondary claims are automatically generated the same day the primary claim is adjudicated.

3. Reporting

1. **Please describe the reporting in the application.**

   RelayAssurance Plus provides more than 100 standard and configurable reports that can align to CLIENT's business goals to improve performance. Our reporting capabilities can help you quickly track and report accurate reasons for non-payment on claims from hundreds of payer portals to reduce denials. CLIENTcan also use the reports to easily analyze data related to staff productivity, billing, clinical coding accuracy, and other key operational areas. The exception-based reporting within the solution can be filtered by eligibility status, specific payers, financial classes, and more. RelayAssurance Plus reports are classified into the following categories:

   - Claim Reports provide a snapshot of the information that is in the claims database at the time the report is requested.
   - Reconciliation Reports are not created by users. They are sent to your site by the clearinghouse. These reports contain information about the claims you have released to payers.
   - Remit Reports provide information about remittance advices returned by payers. Remit reports use the Remit Filter. The remit reports are empty if payers do not send remittance advices to the clearinghouse.
   - Submission Reports provide information on claims either successfully bridged or discarded from bridging by client rules.
   - System Reports reflect the contents of selected master files or other site information files at the time the report is requested.
   - Management Reports are designed to give managers insight into user activity or the system processing of claims and remits.
   - Direct Entry Reports show information returned from the Direct Entry processing of Medicare claims.
   - Miscellaneous Reports can either report on the entire claims database or do not report on claims at all. Examples of these reports include:

- 72-Hour Rule report shows all overlapping claims found by the 72-hour audit.
- Claim + 277 report generates pairs of claims plus the current 277. When printed, the pairs can be separated and used in various capacities.
- Claim + Eligibility report is part of the separately contracted Eligibility Edits service. It prints a claim along with its most recent eligibility request and response (if present).
- Claim + EOB report matches claims in the working group with their EOBs and presents them in Claim/EOB pairs. Claims and EOBs print on separate sheets of paper. Print this report for claim/EOB pairs that can be sent to a payer.
- Extract Data Reports are XML files that contain data from each claim in the working group.

2. **Is ad hoc reporting available (i.e., users can create their own reports using available data)? If not, what is the process for custom reports, and is there an additional cost for this functionality?**

   Our solutions offer exception-based reporting, known as work queues that can be run against all the records in your database. Staff can create and filter reports based on the amount of information returned in the request and returned by the payer. For example, you can use these parameters to filter by eligibility status, specific payers, specific claims status, financial classes, and more. Depending on CLIENT's need, reports can be run on a daily, weekly, or monthly basis. Exception work queue capabilities let non-technical end users easily create their own work queues, or work queues that can be shared.

4. Epic Integration

1. **Does the solution support bi-directional interface and full integration with Epic?**

   Yes. We have extensive experience in developing bi-directional interfaces with over 400 Epic clients nationally. Change Healthcare and Epic teams work closely together to deliver a successful bi-directional interface and full implementation. We support Epic's standard integration services and are working to pioneer additional joint services.

   RelayClearance Plus and Epic integration speed eligibility and benefit verification, so you can collect cash as early in the process as possible. It confirms coverage and manages patient expectations to reduce CLIENT's financial exposure. Tightly integrated workflow tools integrate with Epic to deliver eligibility and benefit verification, address validation with fraud alerts, propensity to pay, notice of admission, and more.

   It integrates X12, 270/271, HL7 eligibility responses within your existing Epic workflow (shown in Figure 12), allowing staff to set up work queues and take advantage of alerts that help them work efficiently. Sophisticated pre-service exception work listing within your Epic work queues reduces FTE hours. Staff can also effectively identify missed coverage and properly reclassify self-pay with timely fast-batch eligibility checks.

   RelayClearance Plus also integrates notification of admission data directly into your Epic workflow with direct connections to a growing list of payers. The solution also takes care of the tedious process of adding new payers for you.

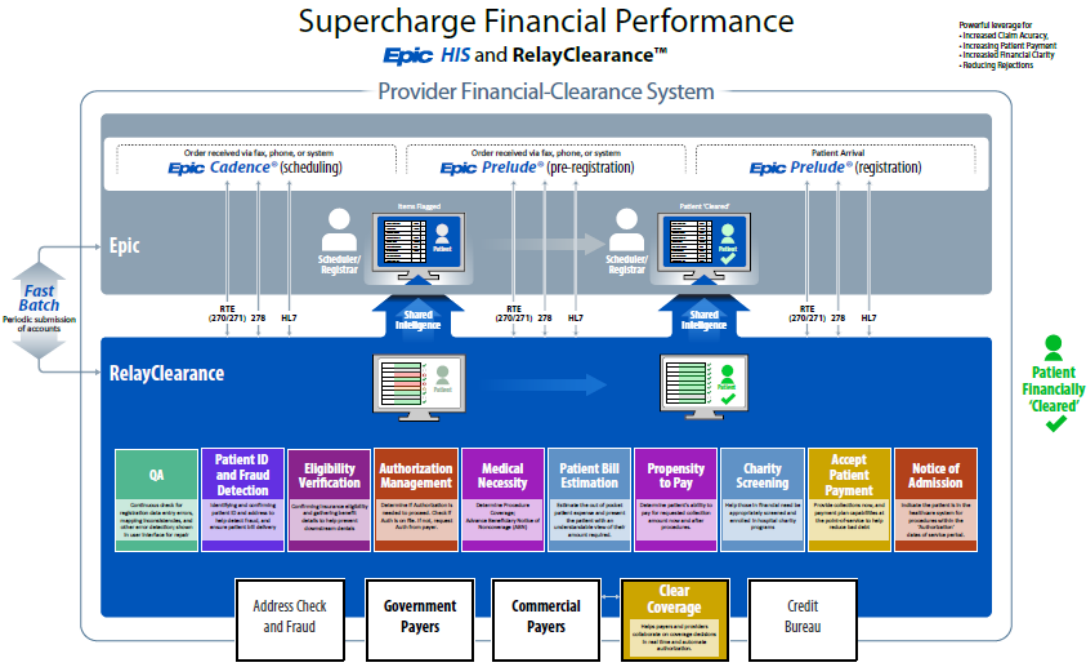

Figure 12. Epic HIS and RelayClearance Plus integration can supercharge CLIENT's financial performance.

RelayAssurance Plus and Epic integration offers CLIENTfull claims management capabilities (Figure 13) to supercharge your financial performance. No other solution provides you with greater connectivity to our EHNAC-certified clearinghouse (one of the nation's largest IT networks) of more than 2,200 payers. Claims are transmitted to a web service endpoint in either an 837 or XML format in real time or via batch processing.

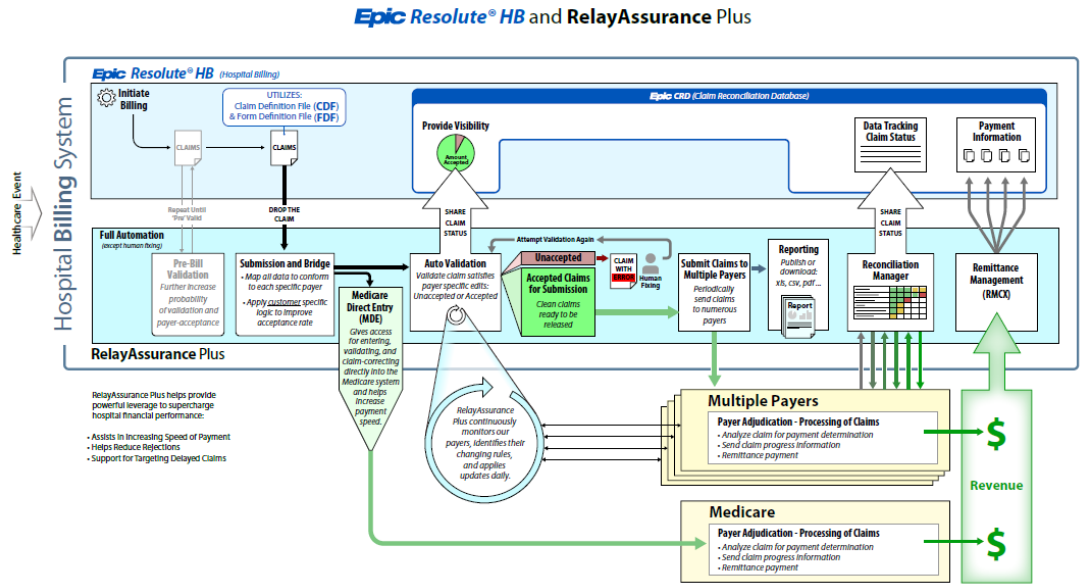

Figure 13. Epic and RelayAssurance Plus offers CLIENTpowerful integration for cleaner claims, reduced denials and reworks.

2. **Does the solution automatically update verified information in Epic?**

   Yes. RelayAssurance Plus receives data from, and shares data back to Epic. Among the points of integration are:

   - Integration directly to Epic with detailed 835 data automatically posted back to the individual account or line item.
   - Change Healthcare retrieves the 835 files automatically from the payer, uses that data within RelayAssurance Plus, and pushes the 835 to your network for use in your imaging and reporting systems where CLIENTcan take the data and post it back into Epic.
   - Receipt of transactions from payers, such as 277, 997, and payer response reports. Solicited 277 files can be uploaded into your host information system. RelayAssurance Plus can provide other payer rejection data in a normalized file format.
   - Receipt of claims status information from payers. RelayAssurance Plus automatically solicits claims status to connected payers, posts the response information to the claim, and returns the normalized ANSI 277 (5010) for use in your host system(s).
   - Files generated that include changed claim data that can be provided for upload to the host patient accounting system.

3. **Does it receive and store responses in Epic?**

   Yes.

4. **Can users access and review responses directly in Epic?**

   Yes. Our solutions permit users to work directly in Epic or within the application.

5. **Can batch inquiries be processed in Epic? Retroactive batch inquiries?**
   Yes. RelayAssurance Plus can process claims in real time and via batch processing (including retroactive batch transmissions). We recommend CLIENTprocess batch claims multiple times per day to accommodate same-day delivery to payers. During implementation, our solutions can be configured to accommodate CLIENT's preferred workflow.

6. **Using your solution, how much time is staff working outside of Epic?**
   The amount of time CLIENTstaff works outside of Epic depends on the unique business and operational needs of CLIENT. Our solutions permit users to work directly in Epic or within the application.

7. **WhenthesolutionupdatesEpicwiththetransaction,canitindicatetheEpicuser'sname insteadof "batchjob"or"integrateduser"?**
   Yes. The solution is configurable to accommodate the user's name in the work queue.

5. Hardware Considerations

1. **What hardware is required to run the software?**

   Hardware is not required. Our solutions are offered in a hosted Software-as-a-Service (SaaS) delivery model, and clients only require internet access.

2. **Describe the standard system requirements (memory, processor, disk space) for each user workstation and/or server.**

   Our solutions are cloud-based and do not require hardware. Epic is compatible with all our solutions.

   However, we recommend CLIENTuser workstations meet the following minimum requirements:

   - CPU: Intel dual core or equivalent; Minimum: Pentium® IV 2.0ghz or faster processor
   - Operating Systems Windows® 10, x64 (64-bit); Windows® Server 2012 R2; Windows® Server 2008 R2 SP1 (64 bit)
   - RAM: Windows® 7, Service Pack 1 (64-bit) operating system: 8 GB, for 5.0 Reconciliation Manager Dashboard user workstations 4 GB, for other user workstations
   - Business Class Broadband (T-1, etc.)
   - IE 11 in Enterprise Mode or Compatibility View

3. **Describe vendor-supplied software to be installed on each PC.**

   Not applicable. Our solutions are provided in a hosted cloud-based model and are internet-accessible to end users via standard browsers. Change Healthcare applications are not installed on client network, servers, or PCs.

4. **If system requires vendor software to be installed on each user workstation, describe the installation and maintenance process for the software.**

   Not applicable. Our solutions are offered in a modern and scalable hosted SaaS delivery model, and clients only require internet access.

5. **List all Microsoft or other third-party software required for use of the application on the PC.**

   Not applicable.

6. **Does the system require a certain version of Windows operation system or web browser?**

   No. Our solutions are provided in a hosted cloud-based model and are internet-accessible to end users via standard browsers. Change Healthcare applications are not installed on client networks, servers, or PCs. However, we recommend CLIENTuser workstations use web browser Internet Explorer® version 7; or optimally, Web browser OS version Windows XP, Vista, and 7 at a minimum.

7. **Do you have a test system?**

   Yes. Testing is a standard component of our implementation processes. Each implementation plan is dependent on the scope of the project, including the specific modules and number of users to be deployed.

   Moreover, our systems are tested thoroughly through Quality Assurance and again through Operations in the form of staging and mock testing. Load and stress testing are components of both the QA and Staging environments. Tests are executed specific to what's being implemented and overall in regression on full system releases.

6. Implementation Overview

1. **Discuss your proposed implementation approach and methodology, including roles and responsibilities.**

   Together with Epic, we customize CLIENT's implementation project plan to meet your unique needs and per the scope of work, specific modules being installed, and the number of users being deployed.

   CLIENTis assigned a designated Change Healthcare project manager to ensure a successful implementation. In addition to product configuration, the project implementation scope includes an assigned project team, project planning, and tracking. Regularly scheduled conference calls occur throughout implementation. Tasks from the project plan are reviewed weekly by the implementation teams to measure progress and to evaluate and resolve any project completion risks.

There are three core phases used to complete the implementation— Readiness, Implementation, and Introduction Support. CLIENTand Change Healthcare are jointly responsible for completing a set of tasks outlined by your assigned project manager. Following the Readiness phase, your assigned project manager and analyst work with CLIENTto build and validate portions of the installation.

Roles and Responsibilities

The following table defines the responsibilities of the CLIENTproject teams:

CLIENT	Change Healthcare
Establish client project team	Establish Change Healthcare project team
Participate in established status calls and complete enrollment process as needed	Facilitate and coordinate routine conference calls to address project status, problem resolution, and other issues impacting the success of the project
Execute implementation tasks assigned to the client in the project plan	Execute implementation tasks assigned to Change Healthcare in the project plan
Provide test data, file customization requirements and verify test and claim results	Perform product testing and verify claim results
Participate in end-user training	Provide training and documentation

Please see *Attachment B* for a copy of our Epic Implementation Guide.

2. **What is the average implementation timeline for this system?**

Each implementation plan depends on the scope of the project and specific modules and number of users to be deployed. On average, implementation takes approximately 90 days. A customized project plan for CLIENTis developed during pre-implementation.

Please see *Attachment C* for a sample of our implementation project plan.

7. Training

1. **Describe your training approach (e.g., train-the-trainer, web-based).**

We understand that education is a critical component to CLIENT's success. Our mission is to help equip our clients with the knowledge and skills necessary to build competency and proficiency with our industry-leading solutions and to maximize your ROI.

Your Success is Our Success

We use a blended learning approach that delivers education and documentation at appropriate intervals during implementation and beyond. Our implementation team works with CLIENTto determine your specific needs then designs a training schedule (either at our training center or on-site) and assembles the appropriate documents (training manuals and guides) accordingly.

Hands-on, Instructor-led Education

The foundation of our education programs are instructor-led classes, providing hands-on activities designed to facilitate knowledge transfer. We encourage CLIENTto take advantage of our instructor-led classes that are taught at our Education Center, located in Alpharetta, GA, for any of your staff desiring to engage in hands-on training.

Specifically, we offer a suite of classes to instruct your staff on how to integrate our revenue cycle solutions into your processes and workflows.

Education for Key Team Members

We encourage key members of your hospital revenue cycle team, including trainers, business system analysts, patient access and registration managers, business office managers, lead billers to attend training sessions as well as those that are directly involved with implementation. It is also highly recommended that someone with experience in the registration/patient access area or business office workflows attend the training. You are not limited on the number of people you can send to training sessions.

CLIENT's project team can attend education sessions as early in the implementation process as you would like. If your staff can attend training shortly after the project kickoff, they can learn the advantages of the solution and contribute information relating to CLIENTprocesses and workflows that could be impacted. This permits your staff to be an educated partner during implementation and allows your trainers the time needed to adapt their training approach to meet your business-specific workflow needs.

Moreover, training at our Education Center allows CLIENTto take advantage of in-person training for all our products, interact directly with our product subject-matter experts, and connect with other like clients in a hands-on collaborative manner.

2. Is training offered on-site or at your facility?

The foundation of our education programs are instructor-led classes that are offered at our Georgia Education Center, providing hands-on learning designed to facilitate knowledge transfer. Training includes Train-the-Trainer sessions and provides the guidance and tools to help your organization execute in-house training.

During implementation, your project team receives on-site training. However, on-site training for users is available for an additional fee.

3. **Describe ongoing training.**

Our solutions promote ongoing training to help staff gain rapid proficiency. We offer user-friendly workflows, dashboards, and productivity reporting that identifies remedial training opportunities for employees and provides staff with continuous training in real time. Alerts and quality assurance feedback train CLIENTstaff directly on the dashboard as they work their way through each step of the solutions workflow. Productivity reports help managers and staff easily identify deficiencies and encourage training to enhance skill sets and to attain performance goals.

Additionally, we offer ongoing training through a variety of mechanisms. Your staff can access several ongoing self-support training options and tools, such as:

- Help button on each dashboard
- User documentation
- Training guides
- Training videos
- 24/7 access to RelayLearn™, a catalog of in-depth, self-guided, online training offerings
- Web-based training (recorded or instructor-led)

RelayLearn online training offering complements our instructor-led courses. Your staff can self-register on RelayLearn to access a wide variety of online topics that provide in-depth, self-guided lessons to follow up on learning from our instructor-led courses. RelayLearn also provides a convenient way to register for ongoing webinars and RelayHealth Education Center classes.

We also provide super-user training through user group meetings. User group meetings are offered as a forum for CLIENTand our other clients to present product questions, concerns, and suggestions to our product managers to ensure best-practice utilization. Members of the product management, service, and support teams attend the user group meetings to receive user input into product direction, to inform users about topics of specific interest, to give status reports, and updates on development of the various product lines, and to conduct product demonstrations.

8. Support Services

1. **Describe the ongoing support services offered to your customers.**

Our Product Support Center has received the prestigious Service Capability & Performance (SCP) certification as a world-class support center for the past 15 years. We have a dedicated team of implementation and support personnel who pass the rigorous SCP Call Center Certification each year. We were the first to achieve this designation and are still one of only a handful of healthcare organizations to complete the certification.

CLIENTcan receive customer support through one of four locations (Atlanta, GA; Columbus, OH; Dubuque, IA; and Tulsa, OK) that ensures availability and redundancy in case of a natural disaster. Customer support is available through a toll-free number 24/7 for critical issues. Other issues are handled during our normal operating hours (7 a.m. to 7 p.m. CT, Monday through Friday). CLIENTcan access our 24/7 online customer support system to create new or view and update already existing support requests directly through the customer portal at https://customerportal.mckesson.com/portal.

When reporting an issue, your first point of contact is our customer support analyst. The customer support analyst provides the first tier of support to all our clients by documenting and researching the reported issue. The customer support analyst provides an immediate resolution, if possible.

Service orders are worked based on priority (Critical, High, and Standard) to deliver the most appropriate response and to ensure your request meets the service level standards criteria.

Proactive Customer Support

Proactive customer support is delivered through the relationship management activities of an assigned Change Healthcare account executive. Your assigned account executive serves as your trusted advisor and is readily available to assist as a single point of contact for issues, escalations, strategic planning, process improvements, or any other business-related needs. He/she meets with your management to review our performance as a business partner. An important part of these sessions is a discussion of any opportunities or business changes you may be experiencing, so we may assess how to best add value as a business partner.

2. **Describe the procedure customers follow to report problems. Include a discussion of methods of contacting the support center, the escalation process and location of support resources. Indicate the availability of support resources after normal business hours.**

Customer support is available through a toll-free number 24/7 for critical issues. Other issues are handled during our normal operating hours (7 a.m. to 7 p.m. CT, Monday through Friday).

CLIENTalso has access to our 24/7 online customer support portal at https://customerportal.mckesson.com/portal. Here you can create new requests or view and update already existing ones.

When reporting an issue, CLIENT's first point of contact is your customer support analyst. The customer support analyst provides the first tier of support to all Change Healthcare clients by documenting and researching the reported issue. He/she provides immediate resolution if possible.

Our customer support team tracks all service orders for CLIENTand measures both response and resolution time against operational service level goals. By closely monitoring service level metrics, we consistently work to meet and exceed your expectations.

Service orders are worked based on priority (Critical, High, and Standard) to ensure the most appropriate response.

The standards criteria and response times are:

- Critical Priority Issues: Major disruption to client operations or cash flow
- High: Follow-up within four hours and case resolution time criteria less than 24 hours
- Standard Priority issues: Follow-up within three business days and case resolution time criteria is less than 10 business days (average is currently six business days)

Our product support analysts can also raise the priority of a service order.

CLIENTis assigned an account executive for the length of the contract that serves as your trusted advisor and is readily available to assist as a single point of contact for issues, escalations, strategic planning, process improvements, or any other business-related needs.

Escalation Process

Escalation of issues may occur through a variety of other channels, including standard Tier 1 escalation, technical support, and escalation from pulse surveys or Sales/Account management contact. All Tier 2 requests are resolved within the continental United States and may involve escalation to a product architect/manager, Operations Managers, VPs of Sales, and Account Management, depending on the severity of the issue. Change Healthcare can ensure that Tier 2 support is available during CLIENTstated business hours.

3. Describe the methods you used to measure customer satisfaction and actions taken based on customer feedback.

We actively and continuously engage with our clients, using a multi-disciplinary approach, including a combination of:

- Direct, personal local relationship management through your assigned account executive who is responsible for proactive efforts to ensure satisfaction.
- Feedback is solicited by our customer support team who solicits upon resolution of customer support activities through automated and random surveys.
- Quarterly surveys are conducted across our client base regarding products, support, communications, and overall customer satisfaction.
- Third-party comprehensive satisfaction survey interviews are performed across a section of clients.
- Outside survey and research resources to evaluate aggregated and anonymous feedback, including Black Book Survey and KLAS Research.
- User groups are regularly scheduled to attain user feedback and suggestions.

4. **Please describe the processes used for software maintenance post-implementation. In your answer, please indicate how federal and state regulatory changes are made. Indicate what is included during normal business hours, off hours, and weekends/holidays. Describe the committed response time and escalation process.**

Our solutions are provided in a modern and scalable hosted, SaaS delivery model. We effectively manage the application environment and implement software upgrades on behalf of our entire client base at **no additional cost**, ensuring that all clients operate on the most current version of the software.

Monitoring Healthcare Industry Changes

We continually monitor evolving healthcare industry changes affecting our solutions, systems, and clients. We have a large team of 70 analysts who monitor federal and state requirements and make appropriate organizational changes, so we can remain compliant. We have stringent measures to address the privacy and security implications and the transaction and code set standards promulgated under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). We strictly adhere to HIPAA Privacy and Security and Transaction Processing regulations and comply with federal, state, and local laws and business policies relating to IT security and the protection of our client's data.

Maintenance and Upgrades Schedule

Scheduled software releases ensure that CLIENToperates on the most current version of the software.

Maintenance and upgrades are usually performed quarterly, depending on the features enhanced and patches required. To minimize downtime, maintenance is performed during off-peak hours (usually less than one hour). Downtime is not always required and is driven by the scope of the upgrade. We maintain an average uptime of 99.9%. Scheduled outages can consist of software upgrades (both production application or as required for operating system, security, or compliance), hardware updates (bios, new devices) and network enhancements and maintenance.

During maintenance windows or pre-arranged client upgrade windows, our staff is available in the office to serve your needs. Notification for system upgrades is provided to our clients with generous lead times.

Response Time and Escalation Process

We closely monitor mutually agreed-upon service level criteria in your Service Level Agreement contract.

Our customer support team logs and tracks all service orders for CLIENTand measures both response and resolution times against service level goals. By closely monitoring service level metrics, we consistently work to meet and exceed your expectations.

Service orders are worked based on priority (Critical, High, and Standard) to ensure the most appropriate response. The standards criteria and response times are:

- Critical Priority Issues: Major disruption to client operations or cash flow
- High: Follow-up within four hours and case resolution time criteria less than 24 hours
- Standard Priority issues: Follow-up within three business days and case resolution time criteria is less than 10 business days (average is currently six business days)

CLIENTis assigned an account executive for the length of the contract that serves as your trusted advisor and is readily available to assist as a single point of contact for issues, escalations, strategic planning, process improvements, or any other business-related needs.

We check 100% of all service orders daily to affirm that we adhere to our process compliance. We also manually review three service orders per employee daily on each team against non-automated metrics. This ensures that inquiries and issues are addressed immediately or within the timeframe stated in our service level agreements and do not escalate unnecessarily.

Escalation of issues may occur through a variety of other channels, including standard Tier 1 escalation, technical support, and escalation from pulse surveys or sales and account management contact. All Tier 2 requests are resolved within the continental United States and may involve escalation to a solution architect/product manager, Operations Managers, VPs of Sales, and Account Management depending on the severity of the issue. Change Healthcare can ensure that Tier 2 support is available during CLIENT-stated business hours.

Our goal is to achieve high customer satisfaction and to avoid unnecessary escalations, and we can proudly confirm that less than 0.1% of issues reach a point of escalation.

Customer Support Performance and Achievements

For the last several years, our award-winning customer support centers have achieved:

- An average speed to answer support calls of 20 seconds or less, with a call abandonment rate of less than 3%.
- An average resolution time for eligibility transaction issues of under four days (dependent upon payer response time).
- A rate of 60% of all issues resolved on first call.

5. Describe how updates, enhancements, and new releases are delivered to customers. Indicate how federal and state regulatory changes are made.

We effectively manage the application environment and implement software upgrades, enhancements, and new releases on behalf of our entire client base at **no additional cost**. Scheduled software releases ensure that CLIENToperates on the most current version of the software. We notify clients of product updates and upgrades at least four weeks in advance of the scheduled update and upgrade.

Federal and State Regulatory Changes

We continually monitor evolving healthcare industry changes affecting our solutions, systems, and clients. We have a large team of 70 analysts who monitor federal and state changes and requirements and make appropriate organizational changes, so we can remain compliant.

6. **What is the frequency of software versions and releases?**

   Frequency of software versions and releases depends on the type of upgrade and enhancements being launched. We upgrade payer edits continually and release changes four times a week to keep our clients up-to-date. Healthcare industry changes affecting our solutions and systems are released immediately as appropriate. Otherwise, version and enhancement releases could be released as often at quarterly.

7. **Describe how you engage the user community for input to product development. Indicate the types of user groups and how they interact with your company.**

   User group meetings offer a forum for CLIENTand our other clients to present product questions, concerns, and suggestions to our product managers. Members of the product management, service, and support teams attend the user group meetings to do the following: receive user feedback regarding product direction, inform users about topics of specific interest, give status reports and updates on product development, and conduct product demonstrations. We constantly monitor our performance through client feedback. CLIENTis always welcome to offer feedback by participating in user groups, responding to annual customer satisfaction surveys, and contacting your assigned account executive.

8. **Detail how the customer can submit product enhancement requests.**

   We solicit feedback from our clients through a variety of avenues, including through user group meeting/activities, annual client conferences, customer satisfaction surveys, and by contacting your assigned account executive or customer support representative. In fact, 70% of our enhancements are a direct result of client feedback and suggestions.

9. **Is the Internet-based support portal available to the customer?**

   Yes. CLIENTstaff have direct access to our online customer support system 24/7 through the customer portal at https://customerportal.mckesson.com/portal.

10. **Is a knowledge base available for customers to self-service their support requirement?**

    Yes. Although, not necessarily referred to as a knowledge base, our online customer support system is available for CLIENTstaff 24/7 to create new, or to view and update already existing support requests directly through the customer portal at https://customerportal.mckesson.com/portal.

    Additionally, users can access the "Help" button on their dashboard where they can find "how to" information relating to the solution's functionality.

11. **Detail any support or maintenance for the system that is provided by other companies.**

    Not applicable. We manage all support, maintenance, and upgrades internally.

Section 4 — Pricing Proposal

Assumptions

Pricing is based on the following assumptions:

- Pricing is valid for 120 days or until January 15, 2018.
- Pricing is based on a three-year contract.
- The services offered are based on Epic integration.
- Pricing for RelayAssurance Plus is based on an estimated claims volume of 185,000 per month.
- Pricing for MDE is based on an estimated 5,000 claims transactions per month.
- Customer license fees are not applicable to our hosted SaaS delivery model.
- Support and maintenance is included at no additional charge.
- The proposed pricing is not considered Best and Final Offer.

THE PRICING SET FORTH BELOW IS COMMERCIAL AND/OR FINANCIAL INFORMATION THAT, IF DISCLOSED, WOULD CAUSE SUBSTANTIAL COMPETITIVE HARM TO CHANGE HEALTHCARE.

The following pages contain our detailed pricing.

A. Pricing Detail

RelayAssurance Plus					
CLAIMS MANAGEMENT	**MONTHLY** Usage Fees (Three-year Contract Term)	**ONE-TIME** IMPLEMENTATION COST	**TRAINING COST** On-Site Training, T&E Billed at Cost	ONE-TIME LICENSE COST	ANNUAL SUPPORT & MAINTENANCE COST
RelayAssurance Plus Claims & Remittance Processing	185,000 claims per Month $45,695.00	$23,600.00	Included*	$0.00	$0.00
Medicare Direct Entry (MDE)	$0.208 Per Trans. Estimate 5,000 claims per Month $1,040.00	$5,920.00	Included	$0.00	$0.00
Host Integration (DEP)	$0.0455 Per Trans. Estimate 185,000 claims per Month $8,417.50	$5,920.00	Included	$0.00	$0.00
Claims Test System	$288.00	$1,200.00	Included	$0.00	$0.00
Hard Copy Direct (HCD) – Secondary Claims Print and Mail	$0.286 Per Trans. Plus Postage	0.00	Included	$0.00	$0.00
Paper Claims Print and Mail	$0.23040 Per Trans. Plus Postage	0.00	Included	$0.00	$0.00
Total	**$55,440.50**	**$36,640.00**	**Included**	**$0.00**	**$0.00**

**Standard Training is delivered in Corporate Training Center in Atlanta. If training is required on-site at CLIENTfacilities a $1,600 per day fee (plus travel and per diem) apply.*

RelayClearance Plus					
ELIGIBILITY	**MONTHLY** Usage Fees (Three-year Contract Term)	**ONE-TIME** IMPLEMENTATION COST	**TRAINING COST** On-Site Training, T&E Billed at Cost	ONE-TIME LICENSE COST	ANNUAL SUPPORT & MAINTENANCE COST
RelayClearance Plus Eligibility Verification (Hospital)	45,000 encounters per Month $17,167.15 (unlimited usage)	$18,593.60	Included	$0.00	$0.00
RelayClearance Plus Eligibility Verification (Physician)	50,000 visits per Month $6,339.00 (unlimited usage)	17,393.60	Included	$0.00	$0.00
Address Validation w/ Fraud	$0.273 Per Trans.	0.00	Included	$0.00	$0.00
Propensity to Pay	$0.6045 Per Trans.	0.00	Included	$0.00	$0.00
Total	**$28,656.10**	**$42,387.20**	**Included**	**$0.00**	**$0.00**

B. Optional Pricing

RelayClearance Authorization					
ELIGIBILITY	**MONTHLY** Usage Fees (Three-year Contract Term)	**ONE-TIME** IMPLEMENTATION COST	**TRAINING COST** On-Site Training, T&E Billed at Cost	ONE-TIME LICENSE COST	ANNUAL SUPPORT & MAINTENANCE COST
Authorization (with Medical Necessity)	$5,149.95	$6,400.00	Included	$0.00	$0.00
Total	**$5,149.95**	**$6,400.00**	**Included**	**$0.00**	**$0.00**

Section 5 — Optional Solution

To further optimize your revenue cycle, we suggest the following OPTIONAL solutions:

RelayClearance Authorization

RelayClearance Authorization (*which includes Medical Necessity and enhanced NOA free of charge*) effectively works with Epic to enhance revenue cycle performance and decrease denials and delays in reimbursement. It can help CLIENTmanage pre-authorization for commercial payers and medical necessity for Medicare by automating the process within the Epic-based referral workflow and performing clinical code audits on Medicare outpatient services. It minimizes manual touch points and time-consuming phone calls to help CLIENTsave time and money.

We understand that manual pre-authorization processes are costly in terms of time, resources, and potential financial risk. On average, manual transactions cost providers and plans $2 more each than automated electronic transactions. With RelayClearance Authorization, CLIENTgains the consistent automated workflow for managing authorization processes, facilitating reduced labor costs and claim denials. Our solution automates 75% of cumbersome authorization processes to ensure authorization before services are rendered, preventing downstream denials. The automated screening functionality enables systematic determination of whether an authorization is required for a given procedure and payer combination and on file. The solution houses a library of over 2M industry-leading edits and accesses rules from over 600 payers, representing 90%+ of covered lives. The authorization database is routinely updated to ensure actions are taken on the most up-to-date set of payer rules.

RelayClearance Authorization also automatically monitors and tracks pending authorization/medical necessity decisions and updates Epic with the authorization decisions (see Figure 14), creating an audit trail for appeals.

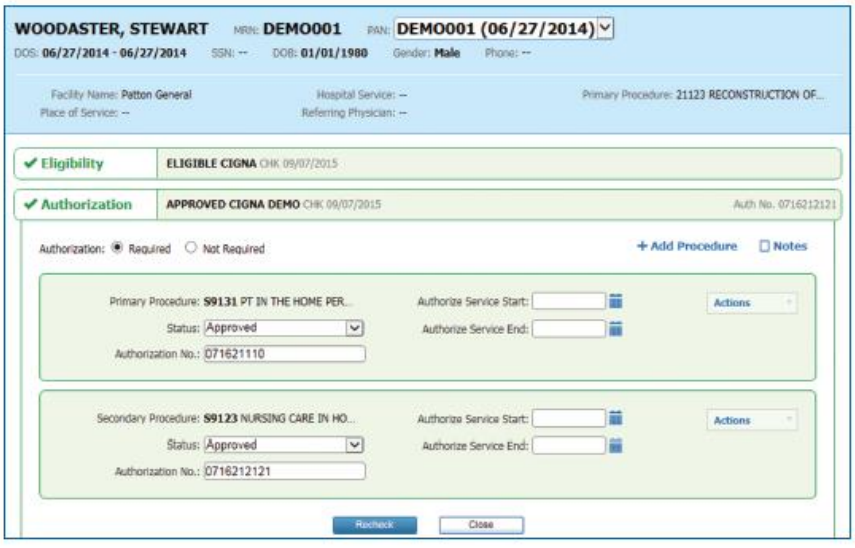

Figure 14. RelayClearance Authorization determines if pre-authorization is required and on file with the payer.

The solution offers additional value to CLIENTwith embedded Medical Necessity and enhanced Notice of Admission functionality **at no additional charge.**

Medical Necessity, a no-cost feature of RelayClearance Authorization, simplifies time-consuming manual medical necessity checking processes. It automatically checks medical necessity as part of the upfront financial clearance process thus reducing denials, improving reimbursements, and ensuring CLIENTcompliance with CMS guidelines. With RelayClearance Medical Necessity, CLIENTcan be better equipped to manage the ever-evolving medical necessity definitions and Medicare guidelines because we proactively monitor and update the software with regulatory and policy changes from multiple sources for you, including National Coverage Decisions (NCDs) and Local Medical Review Policy (LMRP) content.

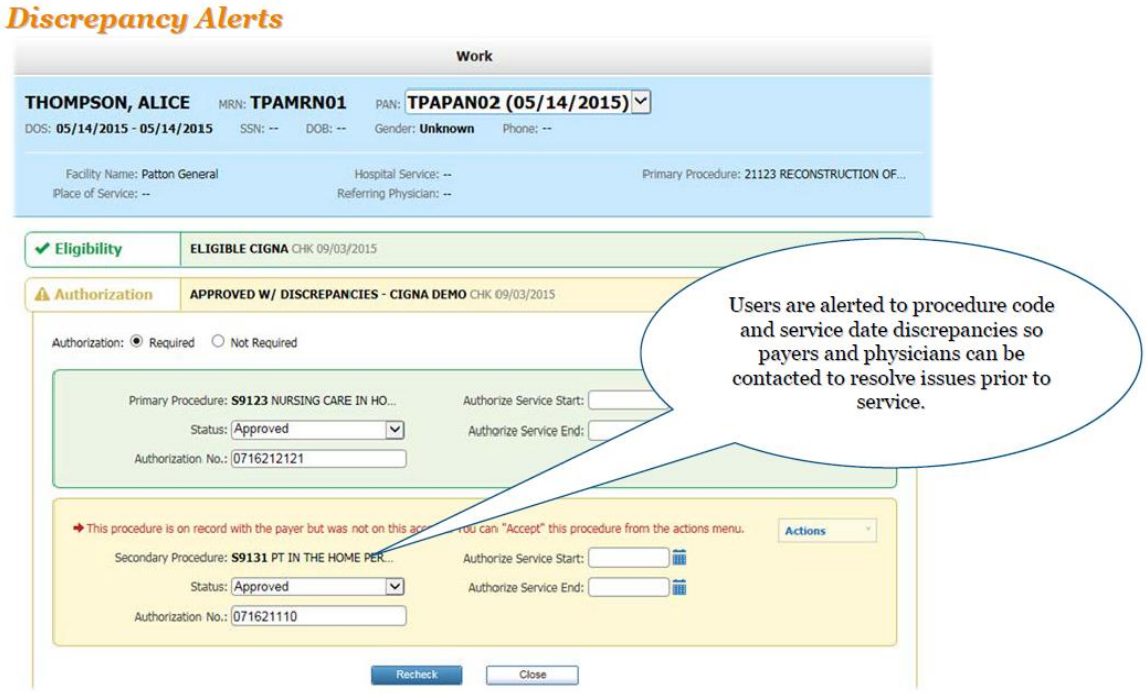

Figure 15. RelayClearance Authorization determines if pre-authorization is required and on file with the payer.

If a medical necessity request is declined, the solution immediately generates an Advanced Beneficiary Notification (see Figure 16) to secure a patient's acknowledgement of their financial responsibility.

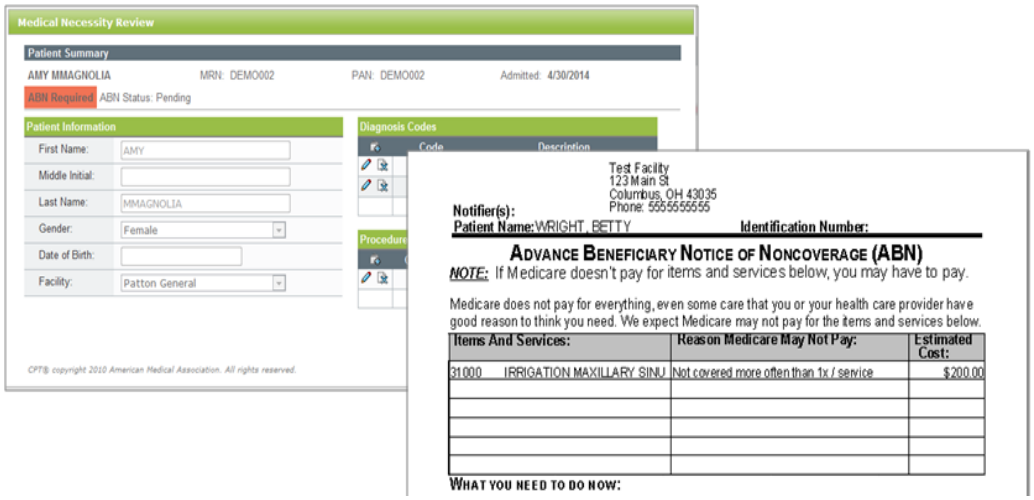

Figure 16. The solution generates a "red" alert identifying that an ABN is required and automatically generates the ABN Form for the user.

Please see *Attachment D* for more information regarding RelayClearance Authorization.

Enhanced Notice of Admission (NOA) is a valuable (*embedded*) feature of RelayClearance Authorization and integrates directly into your Epic workflow. It transmits NOA to payers like UnitedHealthcare, BC/BS, Aetna, and Molina (and others as required and available) within 24 hours to keep you compliant. Payers are informed that a patient has been admitted to an acute care, skilled nursing, or acute rehabilitation facility, using a modified X12 278 transaction in RelayClearance Plus.

Section 6 — Signature Page

RFP submitted by:

Signature:	
Printed Name and Title:	Marcy Tatsch, VP and GM, Revenue Cycle Management
Company Name:	Change Healthcare
Date:	9.15.2017

Section 7 — Attachments

A.	RelayAssurance Payers List
B.	Epic Implementation Guide
C.	Sample Implementation Project Plan
D.	RelayClearance Authorization Brochure and White Paper