CHANGE HEALTHCARE

Request for Proposal

Clearinghouse Services

Proposal for
The CLIENT Network

Jane Doe Digital Sales Account Executive

Software and Analytics | Network Solutions | Technology-enabled Services

PROPRIETARY AND CONFIDENTIAL PROPOSAL

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

By receiving the proposal that you solicited, The CLIENT Network agrees to retain in strict confidence all information contained in it. The information shall only be reproduced and used by The CLIENT Network for 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, The CLIENT Network agrees 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.

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Executive Summary

The CLIENT Network (TMN) seeks a cost-effective clearinghouse service that can seamlessly interface with Avatar to support providers across your national network. Specifically, the vendor must be able to process at least 25,000 claims per month through your Finance Shared Service Center for 291 facilities located in 30 states. The experienced partner must provide an all-in-one revenue cycle solution that can optimize your revenue cycle from patient check-in to payment posting with:

- Secure, real-time connectivity to thousands of payers for faster payment
- End-to-end revenue cycle automation to optimize efficiency and cash flow
- Advanced analytics to improve facility and financial performance

We recommend our **Revenue Performance Advisor (RPA)** solution to automate TMN's end-to-end revenue cycle processes. Automating the revenue cycle means more time for patients and less time chasing revenue. RPA helps you expertly administer your entire revenue cycle, from patient check-in to payment posting. Real-time visibility into eligibility, claims tracking, and rejections and denials, helps simplify your workflow. Taking payments when and where it's most convenient for you and your patients—in the office, over the phone or online—helps you get paid faster, and more easily and accurately. RPA provides multiple payment options that support patient-preferred channels, including online and walk-in, combined with integrated digital and print statements to simplify patient collections. **All of these features reside in our single, end-to-end revenue cycle management software solution, Revenue Performance Advisor.**

Secure, Real-time Connectivity to Thousands of Payers for Faster Payment

Change Healthcare has more than 35 years of experience in healthcare EDI, and is at the forefront of clearinghouse services, patient access workflow, and claims management. No other vendor can offer you more connectivity. Our solutions are built on top of our Intelligent Healthcare Network™. As the nation's largest financial network, we can connect you to 1,300+ payers for eligibility and benefits verification, 2,600 payers for claims management, 800,000+ clinicians, and 5,500 health systems representing 90% of covered lives to speed reimbursement. Our clearinghouse processes up to 550 transactions per second (over 6M claims daily) through its applications. The HITRUST and EHNAC-certified network offers enterprise-scale use, enabling TMN to boost revenue cycle efficiency, improve real-time analytics, cut costs, and improve the patient experience.

No other vendor can offer TMN more connectivity to obtain real-time accurate patient data that produces 99% clean claims downstream. Prior to submission to our clearinghouse, claims are validated and scrubbed based on 40 different data fields before submission, helping to reduce errors and rejections. RPA is currently installed with 13,000 customers where it is helping more than 70,000 providers reduce their financial risk by providing clear visibility into patient financial responsibility and:

- Improving patient access and eligibility verification in real time
- Improving pre-, point of, and post-service collection of patient payments

- Minimizing denials and underpayments
- Managing daily revenue cycle effectively with strategic reporting

End-to-End Automation to Optimize Efficiency and Cash Flow

Our revenue cycle management technologies and services are designed to help TMN improve cash flow and mitigate workflow inefficiencies. A cloud-based solution, RPA offers a full suite of features that can help TMN manage your entire revenue cycle through a single interface. TMN can standardize and simplify workflows with real-time eligibility verification, patient estimation, claims submission and tracking, rejections and denials management, and comprehensive reporting for **revenue cycle visibility. Our user-friendly, digital payment approach also streamlines financial transactions for consumers, to help accelerate remittance, minimize collections, and improve patient satisfaction.** RPA is the right solution for TMN if you want to:

Spend more time with patients and less time chasing revenue. Advanced automation streamlines workflows, facilitates faster payment, and enhances patient satisfaction.

Reduce time on the phone with payers verifying eligibility and benefits coverage. Our nationwide connectivity with thousands of payers helps simplify and automate the entire process.

Decrease rejections and denials. RPA performs real-time edits on rejected claims and resubmits them within minutes. TMN staff can also streamline denials with pre-populated appeal letters.

Increase collections by providing patients with easy-to-understand estimates of their payment responsibility and multiple payment options so you get paid faster including online patient portal, pay by phone, and merchant services.

Improve Enterprise Performance with advanced reporting capabilities to help identify problematic trends before they negatively impact profitability.

Advanced Analytics to Improve Facility and Financial Performance

To be competitive in your market, your business needs to understand the drivers of performance, the impact of quality on financial outcomes, and the impact of potential efficiency gains. Pairing analytics-driven technology with our pace-setting customer service, we can help you turn complex data into visionary plans. Our goal is to help you take charge of your revenue cycle from start to finish to inspire a better health system at TMN. RPA custom reports add strategic value by helping you track performance by facility and across your enterprise to benchmark progress toward KPIs. The solution mines data from all of your facilities to help you uncover and source problematic trends, such as repeated rejections. The enhanced visibility also identifies top 10 claims rejection reason by each health plan or payer. ***You can count on Change Healthcare to deliver a solution that will drive revenue performance across your enterprise and a relationship that can evolve with your needs.***

Section A: Company Background

1. Discuss your company; include the following items:

a. Location(s)

Our corporate offices are located in Nashville, TN and in Alpharetta, GA.

The Change Healthcare corporate headquarters that would service TMN is located at:

3055 Lebanon Pike

Nashville, TN 37214

b. Contact Information

Heather Scott, Digital Sales Account Executive

Telephone: 615.932.3673

Fax: 615.238.0988

Email: hscott@changehealthcare.com

c. General information

i. Number of Direct Employees

We have over 14,000 employees based at 100 locations nationwide and 10 international locations to support our clients and partners.

ii. Number of Indirect Employees (contractors, partners, etc.)

Approximately 150 of our direct employees are RPA staff. No contractors or partners are required to fulfill the requirements of this RFP.

iii. Years in Business

Change Healthcare has been in business for 30 years and is a leading provider of software and analytics, network solutions, and technology-enabled services for the healthcare market.

iv. Core Purpose and Mission Statement

The Change Healthcare name is more than just a brand- it's a mission to help our clients extract opportunity from change. As the pioneer of the nation's largest Intelligent Healthcare Network, we are committed to being the single greatest point of connectivity in the healthcare industry. With our deep reach across the healthcare ecosystem and interconnected position at the center of healthcare, we can help you unlock the power of your data for a more comprehensive view of your patient population, network, revenue cycle, and organizational health.

We are the largest private, independent healthcare serving and technology company in the United States with 14,000 employees servicing the hospital, provider, and payer markets. Formed by the March 2017 merger of McKesson Technology Inc. (MTI) and Change Healthcare Holdings, Inc. (CHC), Change Healthcare leverages decades of experience. Our focused investments in people, service delivery models, and the ongoing advancement of core technologies position us to be an innovative and key partner in your quest to drive value-based care savings and efficiencies within the health system.

Our focus is on enabling better patient care, choice, and outcomes at scale. We achieve this by working alongside our customers and partners, and leveraging our software and analytics, imaging, workflow and extended care capabilities, network solutions, and technology-enabled services.

Our interoperable, end-to-end revenue cycle products and AI-driven automation deliver more value with less effort, allowing you to perform tasks more easily and accurately to accelerate revenue. Our strategic growth plan to help TMN remain agile in a rapidly evolving business environment includes innovation that can hand you the keys to financial security with:

- Robotic process automation
- Community customer benchmark data & support
- AI machine learning
- Single sign-on systems

d. Revenue for the last three years

Change Healthcare financials are not publicly reported by service line. However, our combined total annual revenues exceeded three billion dollars last year. We have provided the most recent annual report for Change Healthcare as Attachment A Change Healthcare 2018 Audited Financials.

2. Discuss your ability to manage our account.

a. Identify the Account Manager who will be CLIENT's single point of contact with your company

You can expect to receive proactive customer support from your trusted Account Manager, Heather Scott. She maintains an intimate knowledge of all aspects of your business, including overall strategy, IT initiatives, and any market challenges to drive optimum utilization of our technology. She is readily accessible and is responsible for the strategic and tactical ownership of your account and relationship. She regularly holds meetings and provides annual solution ROI reports to TMN and consults with our leadership team to ensure you receive the most value for our solutions and services.

b. Support Staff availability

All RPA Customer Service Support staff are located within the continental United States. Our support telephone hours are Monday through Friday from 8 a.m.- 8 p.m. ET, excluding Change Healthcare-observed holidays (Memorial Day, Independence Day, Labor Day, Thanksgiving Day, Day after Thanksgiving, and Christmas Day). TMN staff may submit service requests 24/7 via the web.

c. Staffing hours to accommodate different time zones

Our RPA support telephone hours are Monday through Friday from 8 a.m.- 8 p.m. ET, excluding Change Healthcare-observed holidays.

d. Other

We are committed to delivering customer satisfaction. Escalation may occur through a variety of channels, including standard Tier 1 escalation, technical support, and escalation from your account manager. All requests are resolved within the continental U.S. 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.

3. Describe any preferred supplier relationships with third party providers/supplier who you would utilize to support this relationship. Include any additional industry-related partners that would be meaningful for us.

Change Healthcare is able to fulfill all of the requirements of this RFP without the need to engage third-party providers or suppliers.

4. Please provide an overview of your disaster recovery plan.

Our disaster recovery plan is designed to deliver a highly resilient network of redundant and geographically dispersed servers that are housed and operated in SSAE16 SOC-1 Type II Compliant IBX data centers. The data centers are designed with resilience and redundancy. The redundancy is intended to minimize the impact of common equipment failures and environmental risks. All infrastructure systems have been designed to eliminate single points of failure. Dual circuits, switches, networks, or other necessary devices are utilized to provide this redundancy. Critical facilities infrastructure at the data centers have been designed to be robust, fault tolerant, and concurrently maintainable. Preventative and corrective maintenance is performed without interruption of services.

The facilities use state-of- the-art security systems featuring 2-factor zone-based authentication, alarm monitoring/intrusion detection, video imaging, closed-circuit television (CCTV) and audio intercom subsystems. The data centers are manned 24 hours a day, seven days a week, by the Data Center team, which includes dedicated security personnel. In addition, the data centers are located in unmarked buildings to protect their identity and reduce the risk of intentional attacks.

5. Please indicate the number of clients you are servicing with volumes/requirements similar or greater than CLIENT.

RPA is currently installed with 13,000 customers where it is helping more than 70,000 providers take charge of their revenue cycle from start to finish to accelerate cash. Of those customers, we have 42 customers who rely on us to process 25K+ transactions per month. We have 15 clients who submit over 100K transactions per month, and our largest client submits over 400K per month in healthcare transactions.

Section B: Account Management/Client Communications

1. **Describe your account management approach for clients with spend and program requirements.**

   Following contract award, we customize an implementation plan to fit your business needs. This includes the assignment of senior leaders to work closely with you and provide an expeditious and effective implementation as well as ongoing value from your solution.

   We will also assign a senior account manager, Heather Scott, to serve as your single point of contact. She is accountable for ensuring your satisfaction and helping you realize the return on investment you expect. The responsibilities of this individual include:

   Relationship Manager

   - Fostering the relationship between our organizations at all levels (from end-users to executives)
   - Understanding your environment and key stakeholders
   - Understanding your objectives, issues, and business drivers and sharing our strategy to find areas for further alignment
   - Providing same-day responses to all customer-initiated communications

   Client Liaison and Advocate

   - Acting as your advocate to promote exemplary service from all Change Healthcare departments and serving as a liaison where needed
   - Managing and troubleshooting issues
   - Identifying and coordinating resources across business unit lines
   - Escalating within Change Healthcare on your behalf when necessary and providing prompt follow-through
   - Serving as a conduit for product direction information
   - Coordinating communications on newly released beta site when applicable

   Return on Investment Advisor

   - Understanding and proactively managing your business objectives and issues for best use of products
   - Maintaining awareness of implementation issues or concerns
   - Ensuring you receive the greatest degree of value from each licensed product and service
   - Ensuring you achieve your defined success metrics for each licensed product and service

- Proposing action to add value
- Fostering the use of licensed but non-installed applications

2. **List the primary individual(s) who would be responsible for managing our program. Detail roles, responsibilities, credentials and contact information and credentials.**

   To help you get the most out of your investment, Heather Scott, will serve as your trusted account executive. She is your single point of contact and facilitates communication at multiple levels between our organizations, as needed. She and the following members of the RPA will work hard to meet and exceed your expectations.

   - Eric Arnson, Senior Vice President of Product Management
   - Joanne Feeney, Operations Manager
   - Jason Strandberg, Director of Revenue Cycle Management Client Services

   To protect the confidentiality of our employees, detailed credentials and contact information are provided upon down selection.

3. **Beyond dedicated account management personnel, what other resources will be engaged to optimize our program (e.g., consulting, supplier relations support, etc.)?**

   The account management team listed above in Question 2 work together to address your needs and help TMN optimize RPA.

Section C: Quality Initiatives & Customer Service

1. **What formal quality initiatives, if any, are underway to streamline operations and deliver tangible benefits to your customers?**

   Our Quality Assurance program facilitates the realization of Change Healthcare's mission of inspiring better health systems. The purpose of the QA Program is to continually improve our products, processes, and systems to support the highest quality of care and services delivery to our members, clients, and providers.

   The QA plan promotes the monitoring of quality performance standards, product performance standards, client performance standards and client satisfaction. Change Healthcare's QA Program is defined, administered and achieved by quality and performance improvement experts that consult with internal and external clients in the development of:

   - Clinical competencies
   - Program compliance standards
   - Tools and processes to monitor administrative and clinical performance
   - Management training (monitoring, auditing and process improvement)
   - Process improvement recommendations

   The QA Program is responsible for facilitating improvement efforts as identified by Senior leadership and key stakeholders within the organization. Relying on the creativity of all members of the organization, the Change Healthcare QA Program leads empowered teams through a logical sequence of steps that encourage thorough analysis of problems, identification of potential causes, and possible solutions.

   Quality Control Definition

   Quality Control is defined as a system for maintaining desired standards in a product or process. This is accomplished through the inspection of samples of the product. Change Healthcare uses Quality Control, primarily as a methodology in operations, which relies on consistent evaluation of performance metrics to control our service delivery.

   The data collection for quality control is obtained through routine monitoring, continuous audits, special projects, and other monitoring methodologies. The data is reviewed by operations, program outcomes managers, quality committees, and the General Manager on a regular basis. Quality control provides one of the many avenues used to identify improvement and innovation opportunities.

   Quality Assurance Models for Achievement

   We are committed to providing the highest quality in the delivery of the Change Healthcare suite of revenue cycle solutions and services. We have developed a comprehensive integrated QA process to achieve our quality outcomes and fulfill our corporate mission. The QA Program for Change Healthcare is based on four primary models:

- Quality Control
- Continuous Performance Improvement (CPI)
- Six Sigma™
- The Capability Maturity Model® (CMM)

Our strategic growth plan to help our clients remain agile in a rapidly evolving industry environment includes innovation that can hand you the keys to financial security with:

- Block chain cloud security
- Robotic process automation
- Community Customer benchmark data & support
- AI Machine-learning process improvement
- Single sign-on systems

Championing innovation is one of the core Change Healthcare values. We continually identify and invest in key technologies and innovative programs to improve our customer's operational and financial performance. Following are some recent examples.

- **Blockchain Technology**: Change Healthcare has launched what we consider the first enterprise-scale blockchain network in healthcare. By using the distributed ledger technology, hospitals, physician practices and payers can longitudinally track the real-time status of claims submission and remittance using its Intelligent Healthcare Network. We use Hyperledger Fabric 1.0 – an open-source blockchain framework hosted by The Linux Foundation – as the foundation for its blockchain app design and development in the network. The emerging technology enables improved transparency and efficiency allowing for better auditability, traceability, and trust.
- **The Change Healthcare Intelligent Network:** processes up to 550 transactions per second through its blockchain applications. We will continue to explore new areas where blockchain technology can leveraged to help lower costs, improve quality and make healthcare more patient-centric. One of these areas is to put blockchain to work in the tracking and visibility of data across the complete patient healthcare encounter – from check-in for a preoperative visit, through to the procedure and on to billing and payment.

  https://www.healthcareitnews.com/news/change-healthcares-enterprise-blockchain-tech-now-available-hospitals-practices-payers
- **Patient Engagement Technology:** Change Healthcare is partnering with Adobe and Microsoft on a new platform to aggregate patient data for a more seamless and user-friendly patient experience. The platform will enable our clients to offer a better online experience to their customers, The technology can be deployed as part of revenue cycle and customer relationship management projects.

https://www.healthcareitnews.com/news/change-healthcare-joins-adobe-and-microsoft-new-patient-engagement-tech

- **AI Machine-Learning Automation:** We have invested over $4M in the last 18 months to build an internal Center of Excellence (CoE) for Intelligent Automation in Revenue Cycle. We are leveraging a complete automation platform coupled with key Artificial Intelligence investments in machine (deep) learning, natural language processing (NLP), and Intelligent Character Recognition (ICR) as the basis for structured and unstructured document ingestion in addition to other predictive and cognitive tools.

  Our Intelligent Automation platform supports and processes transactions (either in production or beta test) for 11 key revenue cycle workflows today including Denial Management (using predictive avoidance), ERA, Credit Balance, Self-Pay, Claims Status, Payment Posting, Lockbox, and Bank Statement Pulling, Payment Reconciliation, Charge, and Demographic Entry. These processes span 1,300 providers in six specialties.

  https://www.changehealthcare.com/press-room/press-releases/detail/change-healthcare-fuses-artificial-and-human-intelligence-for-medicare-advantage

- **Shared Savings.** Our mission is to be a key catalyst of a value-based healthcare system — working alongside our customers and partners to accelerate the journey toward improved lives and healthier. We partner with payers and providers to develop fresh ways to create savings for all stakeholders while improving the patient experience.

  Shared Savings: https://www.changehealthcare.com/press-room/press-releases/detail/successful-results-innovative-shared-savings-program

Lastly, we listen to our clients. Fully 70% of our product and solution enhancements come directly from customer feedback, helping us stay in lockstep with your needs.

2. **How does your company monitor service level agreements?**

   Service Level Agreements related to application performance and transaction/file delivery are monitored via reports and dashboards within our CRM.

3. **How do you measure and report on customer satisfaction?**

   Change Healthcare utilizes the Net Promoter Score (NPS) system to measure customer satisfaction. Transactional NPS scores are collected for each individual issue or interaction, and surveys are sent to the end user for each customer service item. Relational NPS scores are compiled twice yearly and sent to relationship-level contacts (typically upper management) for each customer.

4. **How are user survey results tabulated and identified for action?**

   We keep our finger on the pulse of quality and client satisfaction through satisfaction surveys, customer support service level measurements, and engaging clients in conversations about their satisfaction with our products and services through user groups.

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

   - Direct, personal local relationship management through your assigned account executive who is responsible for proactive efforts to ensure satisfaction.
   - Automated and random surveys post-customer support case resolution.
   - Surveys are conducted across our client base regarding products, support, communications, and overall customer satisfaction.

5. **What is the process for resolving customer service issues?**

   The problem resolution process varies depending on the type of issue, and if the issue relates to the core application functions, daily systems processes, client-specific functions, general or client-specific edits, or network/hardware-related functions. Most issues can be resolved remotely.

   Our EDI Specialists can work directly with TMN to facilitate any action needed to resolve customers concerns related to internal teams, trading partners; or payers. There is an escalation grid that is provided to customers by the Implementation Specialist. Furthermore, technical issues may be reported by clients, recipients, or others within Change Healthcare. Regardless of their origin, issues are logged into the RPA Customer Relationship Management System by EDI Specialists. Mission or business critical production issues are handled as high priorities and customer service management is notified. Issues are tracked according to their severity and time to resolution.

6. **How will your company ensure that service standards are met or exceeded?**
   Service Level Agreements related to application performance and transaction/file delivery are monitored via reports and dashboards within our CRM.

Section D: Technology

1. **Please describe any online access available for clients to update, track, and manage claims that were submitted inclusive of electronic remittance advice downloads. Please describe any reporting or analytics capability available for claims submission and status.**

   To be competitive in your market, your business needs to understand the drivers of performance, the impact of quality on financial outcomes, and the impact of potential efficiency gains. Pairing analytics-driven technology with our pace-setting customer service, we can help you turn complex data into visionary plans.

   Our goal is to help you take charge of your revenue cycle from start to finish to inspire a better health system at TMN. RPA custom reports add strategic value by helping you track performance by facility and across your enterprise to benchmark progress toward KPIs. The solution mines data from all of your facilities to help you uncover and source problematic trends, such as repeated rejections. The enhanced visibility also identifies top 10 claims rejection reasons by each health plan or payer. RPA's custom reporting empowers TMN with in-depth insight into issues impacting your bottom line, such as:

   - Top 10 Change Healthcare-related claim rejections
   - Top 10 payer-generated rejections
   - Top 10 remittance denials
   - Zero-paid claims
   - Overview of accepted and rejected claims with associated dollar figures

   Reports can be customized to include a single site, multiple sites, or your entire book of business. Analytics include:

   - Base system reporting to look at data sets in sections of the account, accounting reports, claim processing reports, stat reports, and audit reports.
   - Report on rejections, safety net (to make sure rejected claims are not lost), top diagnosis and procedure code pairs, payer acceptance, claim file reconciliation.
   - Performance at a glance reports show claims, top rejections, remits, and denials.
   - Reports on 31 different key performance indicators, based off of remit and claim data. These reports can also be site or child-account specific.

   In addition to our Dashboard reports, Processed Claim and Processed Remittance Reports, each time a user creates a search in RPA, they have the opportunity to create a task that can be assigned to users. The ability to create lists of claims, eligibility, rejections, denials and appeals and save them as tasks is also a way to build "working reports" and a workflow in the practice. Please refer to Attachment B Revenue Performance Advisor Sample Standard Denial Reports.

2. Please describe in detail the technology solution used to transmit claims and receive information back from payers.

Revenue Performance Advisor is a cloud-based solution with a full suite of features that helps providers manage their entire revenue cycle through a single interface from patient check-in to payment posting, helping them get paid faster, and more easily and accurately (as shown in Figure 1). TMN users access RPA through the web to connect to our clearinghouse, the nation's largest and most comprehensive network offering real-time eligibility and claims processing that maps the fastest route to payment.

Today, 21 other clearinghouses rely on our in-house EHNAC-certified clearinghouse for financial processing. Our EDI Connectivity Platform has direct access to 2,600 payers, including Medicare, Medicaid, BC/BS, commercial HMOs and third-party administrators. Our solutions easily and seamlessly integrate with Avatar and nearly every HIS in the industry. Change Healthcare relies on industry standards (837, 835, 270, 271, 276, 277, 277CA, 997 and 999) Secure FTP, and web upload to connect providers across all platforms. RPA integrates X12, 270/271 and B2B Web Services allowing for supplemental workflows in your practice management system. Our combined networks processed over 3.3 billion healthcare-related transactions in fiscal year 2017 valued at more than $2 trillion in healthcare billing.

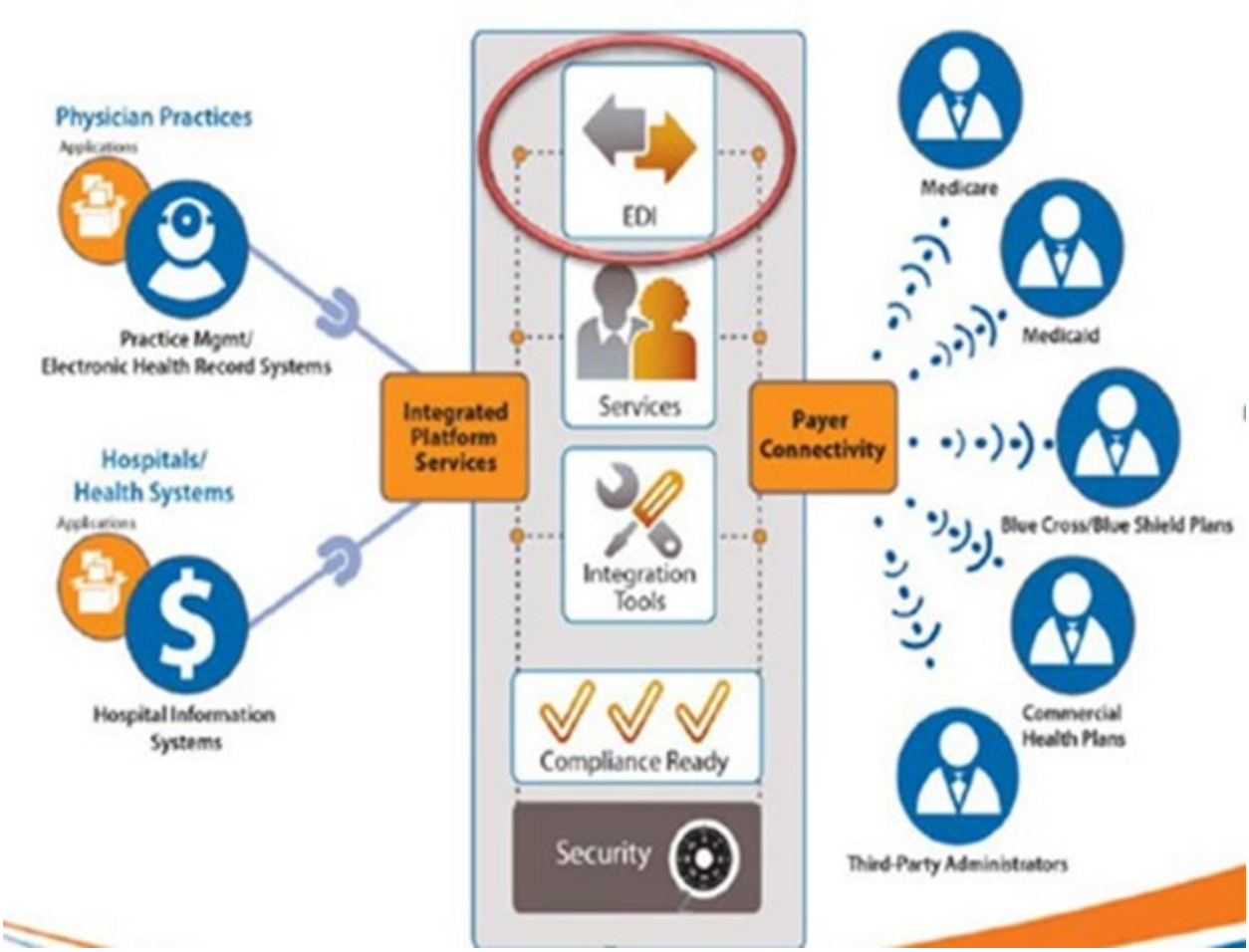


Figure 1. The RPA EDI Connectivity Platform has direct access to 2,600 payers, including Medicare and Medicaid.

3. Please describe how security is enforced during data transfer.

Change Healthcare is committed to the protection and privacy of TMN and your customer's data. We stringently comply with all federal and state regulations and guidelines relating to IT security, including HIPAA. We understand that your organization and systems need to remain 100% operational (especially in emergency situations). Change Healthcare maintains and executes a comprehensive business continuity and disaster recovery program throughout our enterprise to secure and protect your data and our internal operations and systems and client-hosted systems. All infrastructure systems have been designed to eliminate single points of failure or intrusion.

As the largest IT Healthcare company in the nation, entrusted with handling PHI and PII of our clients, earning a HITRUST certification demonstrates our compliance with the required safeguards in place to protect your data. HITRUST is a comprehensive and certifiable security framework used by healthcare organizations and their business associates to efficiently approach regulatory compliance and risk management. HITRUST unifies recognized standards and regulatory requirements from NIST, HIPAA/HITECH, ISO 27001, PCI DSS, FTC, COBIT, and can be completed

according to SOC II criteria, making it the most widely-adopted security framework in the U.S. healthcare industry. We also undergo annual third-party security assessments, subsequently achieving and maintaining SSAE 16 SOC II and ISO 27001 certifications.

Change Healthcare has been continuously certified with the industry benchmark EHNAC accreditation for the past 18 years. Criteria include security, privacy and confidentiality, technical performance, business practices, physical and personnel resources, and data integrity. With a greater than 99% score on the last accreditation, we exceed the requirements for all aspects of security and privacy to deliver protection of our client's interests.

We serve as the gateway for a large segment of commercial and government payers and maintain the following industry-recognized and trusted accreditations and certifications:

- HITRUST
- CAQH CORE
- EHNAC HNAP-EHN
- EHNAC DTAAP-HISP - Privacy and Security
- MHCC
- PCI Compliance

Our web-based portal enables TMN to access patient financial information in a secured manner. Access and authentication control technologies restricts unauthorized access to internal and client systems and data. RPA adheres to HIPAA and all confidential client information is protected by encryption. This is accomplished through several encryption technologies, including PGP, SFTP and TLS, or through a direct network VPN. End users accessing the user interface are on a TLS-encrypted session at all times. As reports and invoices are posted to client-specific accounts, an email message is instantaneously sent to the client's email address to alert them that a report has been posted.

Our range of security policies and procedures safeguard our systems and client data, and include a variety of mechanisms such firewalls, anti-virus, anti-intrusion, anti-malware, VPN and encryption rules. We use redundant CISCO firewalls and perform routine vulnerability scans across all layers of the platform to protect access to the platform and its data to provide a highly secure environment.

We back up the system every day. Our data centers have redundant power and auxiliary generators. Using a combination of replicated data storage with backup tape retrieval, we can recover from a declared disaster (Recovery Time Objective – RTO) in 48 hours. The Recovery Point Objective (RPO) is 24 hours. Data center techs perform monthly tests to ensure that all security and backup components are working as designed. Some services may be performed out of different data centers that have commensurate security/disaster recovery plans and will be moving to these standards in the near future.

4. **Please describe in detail the process used to connect your technology solution to a payer's technology solution inclusive of testing. Please provide information on any annual or ongoing testing that is done.**

   Revenue Performance Advisor is a hosted cloud-based solution. The online tool is supported by Internet Explorer and Chrome browsers. TMN only requires internet access and the ability to generate ANSI files for processing. Although, our preferred transmission method is SFTP for batch processing, we also offer real-time transmissions via web services, and manual uploads into RPA.

   TMN can expect high system integrity from Change Healthcare upon implementation and throughout the life of the product. Change Healthcare mitigates the risk of introducing defects into releases by providing excellent quality assurance (QA). We have an accomplished QA team dedicated exclusively to functional and regression testing. Through proactive testing methodologies and thorough testing techniques, the team builds quality into the product. We have established processes to perform comprehensive testing of every component prior to delivery to our customers.

   Our QA group has developed repeatable processes. As new features are developed, this experienced team creates thorough test case documentation and works with developers to ensure quality and integrity throughout the product. Also, prior to each release, the QA team executes a comprehensive regression plan using regression test cases and test automation to ensure the highest levels of quality and compatibility with multiple browsers.

   Test Set Creation

   To validate any software release requirements, QA has created a complete set of manual and automated tests. These tests allow for the validation of all current and future software application requirements. In addition, they reduce project risk and identify software deficiencies and discrepancies early enough in the process to minimize schedule and budgeting conflicts.

   Test Approaches

   QA carries out the following verification activities during the software application developmental steps:

   - Envisioning and Planning:
     - Determination of verification approach
     - Determination of requirements adequacy
     - Determination of consistency with design requirements
     - Generation of functional test data
   - Developing:
     - Determination of design adequacy
     - Determination of consistency with design

  - Determination of implementation adequacy
  - Generation of structural and functional test data
  - Generation of structural and functional test data for programs
  - Testing of application system
- Stabilizing:
  - Modification and regression test
  - Placement of tested system into production

Testing Tools

QA uses a variety of testing tools to verify application requirements, including:

- Walk-through
- Requirements matrix
- Desk checking
- Data flow analysis
- Design reviews
- Inspections
- Checklists
- Fact-finding
- Peer review
- Automated test tools
- Test Factor Risks

  QA tests the following factors during software application development. Factors are arranged in order of risk contribution to the product:

- Accuracy: Assurance that the data entered, processed, and outputted is accurate and complete.
- File Integrity: Assurance that the data entered will be returned unaltered.
- Authorization: Assurance that the data is processed in accordance with Management's intent.
- Audit Trail: The capability to validate processing if problems occur.
- Processing Continuity: The ability to sustain processing if problems occur.
- Service Level: Assurance that the user's desired results occur within acceptable timeframes.

- Access Control: Assurance that application resources will be protected against accidental or intentional modifications, destruction, misuse, and disclosure.
- Compliance: Assurance that the application is designed in accordance with organizational strategy, policies, procedures, and standards.
- Reliability: Assurance that the application will perform its intended function with the required precision, over time.
- Ease of Use: The extent of effort required for learning, operating, preparing input for, and interpreting output from the application.
- Maintainability: The effort required locating and correcting a system error.
- Portability: The effort required transferring a program from one hardware configuration and/or software system to another.
- Coupling: The effort required in interconnecting components within and across applications.
- Performance: The amount of computing resources and code a system requires to perform its stated functions.
- Ease of Operation: The amount of effort required to integrate the system into the operating environment and to operate it.
- Reporting of Test Results: QA generates summary testing reports following each testing phase, and prior to final application release.

Testing Phases: After each testing phase, QA delivers the test results to the Project Management team. These reports include recommendations for proceeding to the next development phase. Once the application has passed TQA's tests, it proceeds into User Acceptance testing. User Acceptance testing is a process, managed by the Quality Management department, whereby the actual users of the software can identify problematic issues and report back to Product Management for immediate attention. While QA's tests validate specific functionality, User Acceptance testing validates that the application is valid from the user's perspective. Software releases will not occur until the User Acceptance process occurs.

Release Stage: Following the final QA and User Acceptance testing process, QA delivers a set of summary reports to the Project Management team. At this time, QA also recommends that the application be released to production. The final report set consists of:

Test Procedure Results: include test procedures executed, number of steps passed or failed, percentage of steps passed or failed specifications that were not testable and those not yet tested.

Monthly Accomplishment Reports: include internal testing activities and accomplishments of the QA group.

5. **Please describe how you address payer system changes and is there an interruption of services during such activities.**

   The RPA message center notifies TMN of any system issues or changes. You can also sign up for email notifications.

6. **Please describe integration options between electronic healthcare systems and the billing clearinghouse.**

   Revenue Performance Advisor is a hosted cloud-based solution. The online tool is supported by Internet Explorer and Chrome browsers. TMN requires the ability to generate ANSI files for processing. Although, our preferred transmission method is SFTP for batch processing, we also offer real-time transmissions via web services, and manual uploads into RPA.

7. **Please describe any automation used to minimize claim errors.**

   RPA automation eliminates delays in revenue flow associated with rejected claims, allowing TMN to work by exception, using pre-configured rejection search screens to quickly get a list of rejected claims and the reason it rejected, to resolve the rejection and subsequently re-validate instantly to ensure it passes edits successfully.

   RPA provides easy access to more transaction information than other competitors to assist users in identifying and resolving rejections and denials. Displaying Inbound data, outbound data for all RPA transactions and highlighted errors to be fixed demonstrates our commitment to transparency.

   For instance, our standard batch report provides the processing status of each submitted batch of claims. It includes the processing status from submission to adjudication. The Standard Batch Report provides the processing status of each submitted batch of claims. The payer response times and response levels vary by payer.

   Claims that are validated in RPA are submitted to the payer multiple times a day for processing.

   Rejected claims being corrected in RPA can be re-validated instantly and resubmitted to the payer within minutes. We have no limitations on the size of batches sent to Change Healthcare. Once status is received from payer claims, the status is available immediately.

   RPA technology collects and standardizes payer messaging into a normalized, clean, 277 file that is easily uploaded into your Practice Management System.

   When claims are resubmitted in RPA, a new claim number is assigned to the new claim and it is automatically associated to the original claim. The Claim History of the corrected claim will list the user that corrected the claim, the date it was corrected, the original claim number and link to the original claim, as well as the additional validation and processing events. After a rejected claim has been resubmitted in RPA, the system automatically changes the status of the original claim so that it is no longer listed as rejected and an event is added to the original claim's Claim History showing the correction and including a link to the corrected claim.

When secondary claims are necessary, we simplify the process by identifying primary paid claims and automatically creating secondary claims electronically. Although, RPA allows a user to generate a secondary claim in which the ERA details are added, the user must initiate this function.

Advanced search tools are available for more detailed reporting and tasking. When secondary claims are necessary, we simplify the process by identifying primary paid claims and automatically creating secondary claims electronically.

Using pre-configured Denial and '"Zero Paid, No Patient Responsibility"' search screens, you can quickly get a list of denied claims, the EOB details with reasons why they were not paid, to resolve and appeal denied claims. TMN can create tasks to enhance the denial workflow in their offices.

RPA uses our ability to link the ERA back to claims to join payment information on each of the claims tracking, rejection, and denial screens, as well as reporting. Having access to claims and payment details on the same screens and reports keeps users from going to multiple places to find the information they need. Our advanced process automation also streamlines denials with pre-populated appeal letters to reduce A/R days and accelerate revenue at TMN.

8. **Please describe any technical support options that are available.**

   TMN will be assigned an onboarding specialist during implementation that will provide all of your technical support needs.

9. **Please provide a copy of your SOC1 or SOC2.**

   We understand that your organization and systems need to remain 100% operational (especially in emergency situations). We have a comprehensive business continuity and disaster recovery program that is tested annually and evaluated by independent third-party assessments (SSAE 16 SOC II Report). Some services may be performed out of different data centers that have commensurate security/disaster recovery plans and will be moving to these standards in the near future. See Attachment C and Attachment D for our SSAE 16 SOC II Report and Bridge Letter. A copy of our SSAE 16 SOC I Report can be provided but requires TMN execute an NDA with Change Healthcare.

10. **Please describe how access control is managed for your clients and describe any separation of duty configuration available for users.**

    Our solutions deliver robust authentication and access security controls. TMN's IS Administrator configures all roles (groups) to restrict or allow access within the application. Security can be configured to TMN's ID level (differentiating corporate and facility users). Users are assigned to security groups with specific rights and permissions. If users are assigned to more than one group, the permissions are least restrictive. Your IS or Business Office staff can disable or remove user accounts. All security information for disabled and removed accounts is retained. RPA also offers a selection of audit reports of user accounts and activities. The controls offer flexible implementation so TMN can customize the level of security necessary to meet business needs.

11. **Please describe your user authentication strategy.**

    TMN's IS Administrator configures all roles (groups) to restrict or allow access within the application. Security can be configured to TMN's ID level (differentiating corporate and facility users). Users are assigned to security groups with specific rights and permissions. If users are assigned to more than one group, the permissions are least restrictive. Your IS or Business Office staff can disable or remove user accounts. All security information for disabled and removed accounts is retained.

12. **Please provide a list of supported browsers and other device requirements.**

    Revenue Performance Advisor is a hosted cloud-based solution. The online tool is supported by Internet Explorer and Chrome browsers. No third-party hardware or software is required to be purchased or installed on client systems.

13. **Do you have the ability to edit the 837 file based on required information we would provide to you? (i.e., removing a value code that our billing software puts on the claim; Re-ordering the service codes on the claims to a specific order that the payer has requested)**

    Yes. RPA users have the ability to edit 837 claims. All edits are done at the claim level, not the file level. For claims that have rejected, TMN users can open the claim to remove a code or re-order the service lines before submitting the claim to the payer to improve acceptance rates.

14. **Is there a test environment available to clients?**

    Yes. We perform testing (using a test file from your system) to ensure seamless onboarding and ongoing success. Please see the answer to Question 4 for more detail with regard to our test environment capabilities.

15. **Please provide a list of billing systems you currently integrate with.**

    Our solutions easily and seamlessly integrate with nearly every practice management systems in the industry. Change Healthcare relies on industry standards (837, 835, 277, 277CA 997, 999) to connect providers across all platforms and can integrate with most practice management systems.

    We have one of the world's largest EHNAC-certified clearinghouses, connecting more than 2,600 payers to 800,000 clinicians to speed eligibility and claims processes. RPA is built around the X12 EDI transaction flow. We have the largest footprint in the industry processing patient eligibility verification and claims reaching 90% of covered lives.

16. **Are there limitations to the number of billing/EHR systems we can connect to your solution at one time?**

    There are no limitations to the number of billing/EHR system you can connect to RPA.

17. **Of your clients, what is the largest number of 837/835 that you manage on a daily basis for a single client?**

    Our largest client submits over 400,000 837/835s per month in healthcare transactions. **Last year, our Intelligent Healthcare Network processed over 3.3 billion healthcare-related transactions valued at more than $2 trillion in healthcare billing.**

18. **What is your typical up time?**

    Our operations are configured for high availability, redundancy and resilience resulting in a 99.83% uptime percentage.

19. **Please provide your SLAs to address production issues.**

    Mutually agreed upon service performance expectations are discussed upon down selection. However, status updates related to production issues, application downtime, or specific functionality within the application are provided at a minimum of once per business day to TMN.

20. **Please provide your disaster recovery strategy.**

    Change Healthcare maintains and executes a comprehensive business continuity and disaster recovery program throughout our enterprise to secure and protect client data and our internal operations and systems and client-hosted systems. All infrastructure systems have been designed to eliminate single points of failure or intrusion.

    As the largest IT Healthcare company in the nation, entrusted with handling PHI and PII of our clients, earning a HITRUST certification demonstrates our compliance with the required safeguards in place to protect your data. HITRUST is a comprehensive and certifiable security framework used by healthcare organizations and their business associates to efficiently approach regulatory compliance and risk management. HITRUST unifies recognized standards and regulatory requirements from NIST, HIPAA/HITECH, ISO 27001, PCI DSS, FTC, COBIT, and can be completed according to SOC II criteria, making it the most widely-adopted security framework in the U.S. healthcare industry. We also undergo annual third-party security assessments, subsequently achieving and maintaining SSAE 16 SOC II and ISO 27001 certifications.

    Our disaster recovery plan is designed to support a network of redundant and geographically dispersed servers that are housed and operated in SSAE16 SOC-1 Type II Compliant IBX data centers. The facilities use state-of- the-art security systems featuring 2-factor zone-based authentication, alarm monitoring/intrusion detection, video imaging, closed-circuit television (CCTV) and audio intercom subsystems. The environment is designed for high availability and to also provide the necessary redundancy should a circumstance dictate relocation of print/mail production.

    The data centers are manned 24 hours a day, seven days a week, by the Data Center team, which includes dedicated security personnel. In addition, the data centers are located in unmarked buildings to protect their identity and reduce the risk of intentional attacks. The data center is designed with resilience and redundancy. The redundancy is intended to minimize the impact of common equipment failures and environmental risks. All infrastructure systems have

been designed to eliminate single points of failure. Dual circuits, switches, networks, or other necessary devices are utilized to provide this redundancy. Critical facilities infrastructure at the data centers have been designed to be robust, fault tolerant, and concurrently maintainable. Preventative and corrective maintenance is performed without interruption of services. Some services may be performed out of different data centers that have commensurate security/disaster recovery plans and will be moving to these standards in the near future.

Section E: Specific Services and Service Levels Requested

TMN requires the following requirements be addressed in your proposal:

1. **Please describe the services available through your clearinghouse (billing/claims, eligibility check, claims adjudication follow up, manual paper billing/portal billing submission, collections, etc.)**

   We have one of the world's largest EHNAC-certified clearinghouses, connecting more than 2,600 payers to 800,000 clinicians to speed eligibility and claims processes. RPA is built around the X12 EDI transaction flow. We have the largest footprint in the industry processing patient eligibility verification and claims reaching 90% of covered lives.

   We serve as the gateway for a large segment of commercial and government payers and maintain the following industry-recognized and trusted accreditations and certifications:

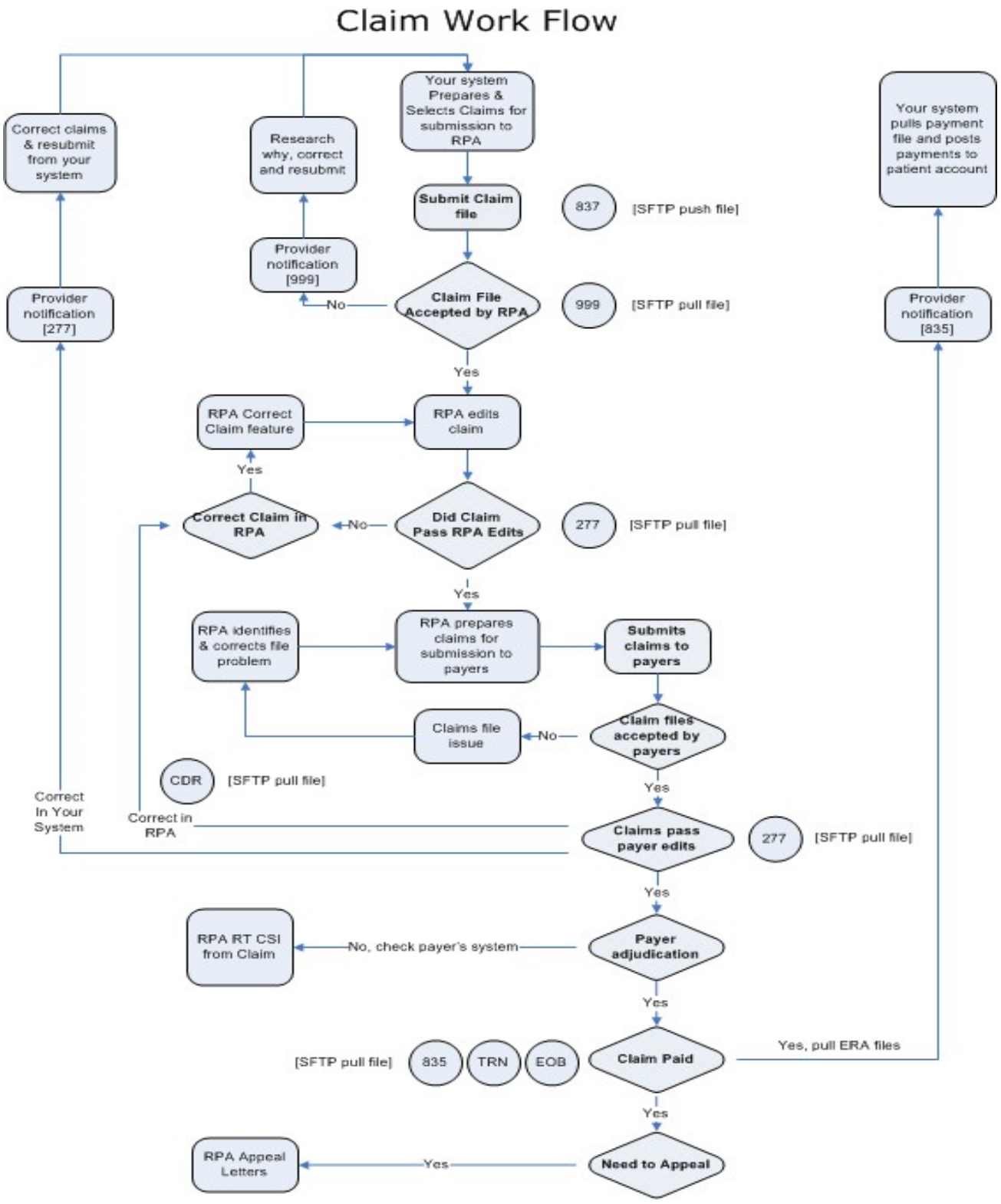
   - HITRUST
   - CAQH CORE
   - EHNAC HNAP-EHN
   - EHNAC DTAAP-HISP - Privacy and Security
   - MHCC
   - PCI Compliance

   Revenue Performance Advisor is a cloud-based solution with a full suite of features that helps providers manage their entire revenue cycle through a single interface from patient check-in to payment posting, helping them get paid faster, and more easily and accurately. Providers can simplify their workflows with real-time eligibility verification, patient estimation, claims submission and tracking, rejections and denials management, and reporting and analytics.

   Revenue Performance Advisor offers the following modules:

Module	Function	Features
Patient Access and Eligibility	Improve upfront collections and reduce bad debt risk.	• Connects to thousands of payers nationwide • Verifies patient eligibility prior to, during, or even after rendering service • Submits batch requests for the next day's roster, or saves rosters for patients with recurring visits • Provides patients with accurate, easy-to-understand estimates of their payment responsibility before they leave the office • Improves efficiencies through seamless integration with existing workflows

Module	Function	Features
		• Reduces cost of collections and the risk of bad debt from bills that go unpaid
Claims Management	Get paid faster by submitting cleaner claims.	• Submits, tracks, and manages claims faster with advanced search functionality • Offers work queues to update groups of claims (or one claim at a time) and assigns tasks to others • Prints EOBs and views ERA matched to claims • Proactively identifies gaps between submission and payments
Rejections and Denials Management	Reduce loss or delay in cash flow.	• Enables real-time edits and corrections on rejections, denials, and resubmissions Links original claims to adjudications using standardized formats • Simplifies appeals with a full library of pre-populated appeals letters • Prepares secondary claims based on initial file and primary ERA
Receivables: Payments and Billing	Collect payments faster and at a lower cost: Integrated point-of-service collections enable you to collect patient payments before, during, and after patient visits.	Get paid faster by taking payments when and where it's most convenient for your patients: **Point of Service Collections:** We enable you to accept virtually all payment types during the patient visit, by phone, or by mail, all of which can improve the likelihood of getting paid. **Patient-Friendly Billing Statements:** We offer clear, concise patient statements to create effective patient communications. Revenue Performance Advisor delivers easy-to-read statements that educate patients on their financial responsibilities, resulting in a higher payment and fewer customer service calls. **Patient Pay Online:** Directly linking from a provider's existing website, the self-service patient pay application provides comprehensive and secure online billing and payment management. Patients gain direct access to their account information to view and pay their accounts online, to set up payment schedules and auto-payments, and to receive provider-based prompt pay discounts. **Patient Pay Voice:** An integrated, cloud-based, and PCI-compliant solution for taking consumer credit, debit, and checking account payments over the phone in English and Spanish. **Merchant Services:** This feature combines our multi-channel payment applications with processing for credit cards, debit cards, physicals check, and electronic checks. TMN can benefit through streamlined merchant onboarding, simplified pricing, and consolidated billing to support patient-preferred channels and payment methods.



Patient Bill Estimation Can Help Reduce Risk at TMN and Increase Collections

Estimate your patient's share of the total cost of the bill to reduce risk and set realistic patient expectations. Patients appreciate the cost transparency, and estimates enable you to request both the co-pay and out-of-pocket deductible at the point of service to increase collections.

RPA's Patient Estimation is calculated using 2 tiers -

- Tier 1 uses historical ERA stored in Change Healthcare's system. The estimate is specific to the procedure code, payer and provider ID.
- Tier 2 uses the Medicare fee schedule + 10% to return an estimate.

Because the Patient Responsibility Estimation feature is tied to our Eligibility service, the accumulators are automatically pulled from the eligibility response and do not need to be manually entered by the user, saving time, reduces errors and increasing the accuracy of the estimate.

Robust Library of Edits Helps Keep TMN Compliant

Our real-time transaction network uses a sophisticated claims-scrubbing engine to validate nearly every aspect of a claim and is managed by a dedicated payer services team who continually monitor and update our edits based on payer rules. That means payers receive the cleanest, most accurate claims possible, resulting in faster payment times.

Advanced front-end validation tools provide Correct Coding Initiative and Medical Necessity edits. Medical Necessity and CCI are part of the edits/business rules within the RPA solution. They can be turned on upon request at no additional charge. We can configure the edits to create a warning or stop a transaction if it errors out. It is also configurable by payer and provider ID.

The CCI and Medical Necessity rules are CMS based.

When a payer returns an '"'additional coverage'"' indicator in the eligibility response, RPA presents the additional insurance information in a way that users can build reports for a secondary workflow.

Change Healthcare does not support searching non-contracted payer portals for additional benefits or coverage that patients may have.

Claims Batching

Our standard batch report provides the processing status of each submitted batch of claims. It includes the processing status from submission to adjudication. The Standard Batch Report provides the processing status of each submitted batch of claims. The payer response times and response levels vary by payer. Claims that are validated in RPA are submitted to the payer multiple times a day for processing.

Rejected claims being corrected in RPA can be re-validated instantly and resubmitted to the payer within minutes. We have no limitations on the size of batches sent to Change Healthcare. Once status is received from payer claims status is available immediately.

RPA technology collects and standardizes payer messaging into a normalized, clean, 277 file that is easily uploaded into your Practice Management System.

When claims are resubmitted in RPA, a new claim number is assigned to the new claim and it is automatically associated to the original claim. The Claim History of the corrected claim will list the user that corrected the claim, the date it was corrected, the original claim number and link to the original claim, as well as the additional validation and processing events. After a rejected claim has been resubmitted in RPA, the system automatically changes the status of the original claim so that it is no longer listed as rejected and an event is added to the original claim's Claim History showing the correction and including a link to the corrected claim.

When secondary claims are necessary, we simplify the process by identifying primary paid claims and automatically creating secondary claims electronically. Although, RPA allows a user to generate a secondary claim in which the ERA details are added, the user must initiate this function.

RPA eliminates delays in revenue flow associated with rejected claims, allowing TMN to work by exception, using pre-configured rejection search screens to quickly get a list of rejected claims and the reason it rejected, to resolve the rejection and subsequently re-validate instantly to ensure it will pass edits successfully.

RPA provides easy access to more transaction information than other competitors to assist users identify and resolve rejections and denials. Displaying Inbound data, outbound data for all RPA transactions and highlighted errors to be fixed demonstrates our commitment to transparency.

Advanced search tools are available for more detailed reporting and tasking. When secondary claims are necessary, we simplify the process by identifying primary paid claims and automatically creating secondary claims electronically.

RPA Provides Built-In Denial Management

RPA eliminates delays in revenue flow associated with denied claims, allowing your staff to work by exception, using pre-configured Denial and '"Zero Paid, No Patient Responsibility"' search screens to quickly get a list of denied claims, the EOB details with reasons why they were not paid, to resolve and appeal denied claims. Clients create tasks to enhance the denial workflow in their offices.

RPA uses our ability to link the ERA back to claims to join payment information on each of the claims tracking, rejection, and denial screens, as well as reporting. Having access to claims and payment details on the same screens and reports keeps users from going to multiple places to find the information they need.

RPA provides easy access to more transaction information than other competitors to assist users identify and resolve denials. Displaying Inbound data, outbound data for all RPA transactions and highlighted errors to be fixed demonstrates our commitment to transparency.

Advanced Denial Management pre-configured search screens based on denial categories (example Find Coding Errors), advanced reporting, appeal letter library, and workflow tasking is available for an additional charge.

RPA' s advanced denial management features offer:

- Simplified visibility into specific denial reasons enables more efficient user assignment and reduced appeal turnaround times.
- Visibility into service line level denial information provides additional opportunity for appeal and revenue recovery.

RPA's Advanced Denial Management reporting features empower TMN with in-depth insight into issues impacting your bottom line, including root cause analysis. Some of the reports we offer include:

- Top 10 Reason Codes for Zero Paid Claims.
- Top 10 Payers for Zero Paid Claims.
- Top 5 reports for: NPI, Billing Tax ID, Payer, and Procedure Codes - identifying the top 5 positive revenue impacts and negative impacts of reworking claims for each category.

The automated Advanced Denial Management functionality provides you with the comprehensive visibility, ease of use, and reporting tools needed to simplify appeals and maximize payer revenue. Custom appeal letters provide an unlimited number of letters and workflow tools enable efficient follow-up with payers, resulting in fewer manual touch points and faster appeal turnaround times.

When generating a letter, the ERA information is auto-populated in the letter. Advanced Denial Management users also can automatically attach the associated claim, EOB, and claim history to the appeal letter. This saves a large amount of time for users that otherwise need to hunt this information in the office to include with the appeal.

In addition to our Dashboard reports, Processed Claim and Processed Remittance Reports, each time a user creates a search in RPA, they have the opportunity to create a task that can be assigned to users. The ability to create lists of claims, eligibility, rejections, denials and appeals and save them as tasks is also a way to build “working reports” and a workflow in the practice. RPA's denial search screens offer filtered searches to identify specific issues, and create tasks to monitor those errors until they have been resolved.

The advanced performance dashboards provide additional visibility for trending the rejection and denial reasons helping to drive process improvements. Please see Attachment E RPA Advanced Denial Reporting for an example of the Submission and Prompt Pay report shows that the claims that take the longest for the office to submit are sent to the payer that pays the fastest. An educational opportunity is highlighted here showing that if this office can focus on getting those claims to the payer faster it will reduce their Days in A/R.)

Root Cause Analysis

Root Cause Analysis for rejections and denials can be completed in various places within the RPA workflow.

- Repeated Same Rejections and Denials
  - Processed Claims Report can be sorted and filtered to identify patterns with duplicates, where users are resubmitting claims without correcting first. Also, monitors first-pass rates and the effectiveness of your claim scrubbers.
  - Performance Dashboard Reports can identify top reasons claims are rejected, denied, or received a zero-dollar payment, by claim count and financial impact.
  - For an additional charge, the Advanced Denial Management Payment Summary Reports identify the top NPI or Tax IDs impacting your revenue, both positively and negatively with rework of denials.
  - Using our Reporting Service, you can schedule the processed claim and remittance reporting, as well as dashboard reports to be emailed, making prep for staff meetings easy.
- Staff Repeating same mistake
  - RPA provides workflow where each rejection or denial can be assigned to a user. Then, reports can be pulled by user to determine what claims/eras are being managed/worked by user.
  - RPA provides workflow where a status can be assigned to each rejection or denial. Then, reports can be pulled by status and/or user to determine what claims/eras are being worked and closed by status. An example would be stat using a denial as 'Appeal' when it's in the appeal process to track open appeals.
  - Performance Dashboard Report for Submission and Prompt Pay Chart can identify how long it takes for the payer to pay which is a drill down report where root cause analysis can be done to determine why payments are not being paid in a timely fashion.

Remittance Management

We offer real-time remittance management technology that collects and standardizes remittance files into a normalized, clean, single-file (837 and 835 ANSI format) that is easily uploaded into your practice management system, which means accelerated cash flow for you.

From pre-service collections to final patient billing, RPA helps TMN:

- Collect patient payments quickly through RPA at check-in and check-out with credit card swipe technology
- Accept and post checks received in the mail using ACH check conversion, eliminating trips to the bank
- Offer the option of extended payment plans or recurring payments to patients as necessary
- Establish a protocol around collecting past and current patient account balances at the time of service to reduce days in Accounts Receivable (A/R)

RPA permits authorized users to accept patient payments via credit card, e-checks, and cash. Users can use a swipe card device, eliminating keying errors. Checks can be converted into ACH transactions, simplifying the paper check workflow.

Payments can be accepted quickly over the phone and taken from patient statement payments received in the mail. Payment receipts are generated at the time of payment and archived within the system for later retrieval. Summary and detailed reports are available to help the office reconcile and post payments back into the physician management system.

Patients can also make payments on the web using a credit card or ACH and can set up payment plans through the web portal. "

Reporting

RPA uses data dynamic data, processed in real time, where the actual data is retrieved upon demand for reporting. We keep 24 months of history before it is archived in one of our data centers. We are required by federal law to maintain claims data for seven years. We do not source our data from other 3rd parties.

Hardware/Software

No hardware is required to be purchased or hosted on client premises. Revenue Performance Advisor is a hosted web-based solution accessed through the most common internet browsers. No third-party software is required to be purchased or installed on client systems. Revenue Performance Advisor is a hosted web-based solution accessed through the most common internet browsers.

2. **Please provide a list of payers with which you already have an established relationship and you routinely exchange data on behalf of your clients. Please also include the frequency that you exchange data with the payers and the average turn-around time for reimbursement.**

   Our Intelligent Healthcare Network has direct access to 2,600 payers, including Medicare, Medicaid, BC/BS, commercial HMOs and third-party administrators. RPA integrates X12, 270/271 and B2B Web Services allowing for supplemental workflows in their practice management system.

   You may view the RPA-specific payer list here http://www.caparIo.com/resource-center/payer-list-rp

3. **Please provide any volume minimums required to use the various services offered.**

   No volume minimum is required. Change Healthcare has customized a service pack for you based on your reported volumes.

4. **Please describe your knowledge and experience working with Medicaid Billing. Please indicate the states in which you have experience with Medicaid Billing.**

   Our EDI Connectivity Platform has direct access to 2,600 payers, including Medicare, Medicaid (all states), BC/BS, commercial HMOs and third-party administrators. Our combined networks processed over 3.3 billion healthcare-related transactions in fiscal year 2017 valued at more than $2 trillion in healthcare billing. As such, we perform thousands of transactions with Medicaid and Managed Medicaid payers daily. Our enrollment specialists and onboarding staff are knowledgeable in 837, 835, and eligibility transactions for all payers, including Medicaid. Please see Attachment F for a complete list of Medicaid billing connectivity by state.

5. **Please describe your experience with claims management for Human Services, Behavioral Healthcare, and Traumatic Brain Injury rehabilitative services.**

   More than 13,000 customers have installed RPA, and we have many behavioral health customers. The revenue cycle management workflows in RPA are designed to meet the needs of providers in the ambulatory market. Our clients range from traditional practices, ambulatory surgery centers, behavioral health, labs, radiology centers, and rehab centers, to ambulance services. Our flexible search features make it easy for our users to configure their reports and workflow to align with their individual business needs.

6. **Please describe the process for onboarding a new Payer and your willingness to develop a relationship with a Payer that we bring to you.**

   Change Healthcare has the largest payer network in the healthcare industry. In the rare event that we don't connect to a payer, we will work with TMN to prioritize a new buildout, depending on volume.

Section F: Implementation

1. **Do you have a documented new account transition/implementation plan? If so, please include along with a timeline.**

   Yes. RPA can be rapidly implemented within just 30-45 days. Following contract execution, we create an implementation plan that is customized to meet TMN's goals.

   Our Implementation plan usually follows a five-step implementation process:

   - Setup—configures RPA according to your business needs and preferences
   - Training—instructs staff how to integrate RPA into their daily office workflow
   - Provider Enrollment—helps TMN select providers, payers, and transactions, as appropriate
   - Testing—performs testing (using a test file from your system) to ensure a seamless onboarding experience
   - Go-Live—following Go-Live, we monitor your processes to ensure a successful implementation.

   TMN is assigned a dedicated Implementation Specialist who performs some of the following key implementation steps:

   - Set up a kickoff call to review our Getting Started Guide and set firm expectations
   - Set up client profiles
   - Establish connectivity and reporting types
   - Set up staff training

   TMN staff work directly with our dedicated implementation specialist throughout the implementation. Once your staff is fully trained and successfully submitting claims, they will be provided with an escalation matrix that provides them with a clear path for problem resolution, should an issue occur.

2. **Describe what is required of TMN during the implementation process.**

   TMN needs to submit a test file to Change Healthcare before going live. Testing ensures that our systems are able to properly process files created in your systems, and helps us avoid any surprises down the road.

Section G: Reasons for Selecting Your Program

1. **List the five most compelling reasons why TMN should select your clearinghouse solution.**

   RPA seamlessly integrates with Avatar to provide TMN with an all-in-one revenue cycle solution that can optimize your revenue cycle from patient check-in to payment posting reducing risk and cost to collect. Our solution offers:

   - **Single Interface to Consolidate Billing** – Revenue Performance Advisor can help TMN consolidate billing by providing **a single point of entry for all billing activities**. You can save time and increase efficiency by eliminating the need for multiple software systems to manage different revenue cycle activities.
   - **Complete, Simplified Visibility into the Entire Revenue Cycle** – Our solution provides a summary and detailed claim history views, allowing complete visibility into all processing events throughout the revenue cycle—claim status messages, payer claim status messages, and payer remittance processing messages. Claim history also includes all portal user/workflow status events.
   - **Advanced Nationwide Payer Connectivity** – Change Healthcare has the greatest payer connectivity in the healthcare industry through our EHNAC and HITRUST certified clearinghouse, we connect more 5,500 hospitals/health systems with over 800,000 clinicians to more than 2,600 government and commercial payers. This maximizes availability of electronic transactions and offers among the most accurate and comprehensive content. Our clearinghouse has existing connectivity to all of TMN's major payers, reducing the amount of time for payer enrollment.
   - **Flexible, Web-based Solution for Seamless User Experience** – Our solution is easily accessible through a web browser. TMN users will enjoy a seamless experience by accessing a single, common solution with data shared across all provider locations.
   - **Centralized, Advanced Reporting Provides Performance at a Glance**– RPA offers in-depth insight into trends affecting your bottom line. TMN can uncover potential issues within the claims workflow across all users and facilities. **Custom reports offer visibility from an enterprise view to group NPI, physician, practice location, sites. RPA offers 31 different key performance indicators, based off of remit and claim data to** help you establish new processes, reduce denied claims, and ultimately increase the speed of reimbursement.

2. **Please attach a list of three (3) corporate references to include contact name, title, address, phone number and years serviced. Please include one company that you have recently (within one year) added to your client base. In addition, please provide one company that no longer uses you as their supplier.**

   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 Change Healthcare account executive team in this process and TMN will too.

Section H: Additional Services

1. **Describe your capability to provide additional/ancillary services to the clearinghouse services requested. Please include all associated costs.**

   SmartPay™ with Paper Statements complements RPA by providing patients every payment channel available and working seamlessly within TMN's operations to collect on any outstanding patient payments. TMN benefits from improvements in revenue, cost reduction, and patient satisfaction. Because this solution leads the way with innovation and technology that focuses on the patient experience, TMN can be well-positioned to accelerate patient payment, while lowering costs and increasing patient satisfaction and loyalty.

   SmartPay offers a variety of patient-centric solutions and easy ways to pay to speed reimbursement, including personalized communications,

   - **Personalized Communications** reduces costs and increases patient engagement with trackable provider communications and reporting that helps TMN evaluate your delivery performance. Driven by analytics, personalized communications provide TMN a cost-effective way to communicate with your patients based on a patient's communication preference and track their engagement. The solution offers a comprehensive multi-channel communication solution, based on a patient's preferred medium to expedite and promote positive payment behavior. It distributes communications across diverse channels (print, email, and text messaging) including integrated flexible payment alternatives and directs patients to pay their bill online, leading to quicker payment for TMN.
   - **Patient Pay Online (PPOL)** is an online bill payment solution, hosted and managed by Change Healthcare and delivered through TMN's existing website. The solution is Health Insurance Portability and Accountability Act of 1996 (HIPAA) and PCI compliant, and offers 24/7 mobile optimized and user-friendly features to allow your patients to easily view, manage, and pay their accounts online, including the ability to make a one-time payment without enrollment. Patients can elect to receive email notification when each statement or account update is available, linking them directly to the online billing center for account management and payment. It offers easy-to-use customer service support and reporting. Recurring payment, prompt-pay discounting, payment plan, and auto-payment options are available to consumers, using parameters set by TMN, including automatic debits from patients' bank and/or credit card account of choice.

     Moreover, API is available to permit TMN to connect MYCHART with Change Healthcare to accept and post patient payments, request account balances, and retrieve PDF documents.
   - **Point of Service (POS) collections (eCashiering)** solution helps TMN staff accept any form of payment directly from the patient from any location throughout your enterprise. Payments can be processed for pre-service, POS, or for outstanding A/R balances. Patients can establish recurring or auto-payment plans. Choose from real-time processing of electronic transactions through TMN's existing bundled merchant-processing relationships or our bundled

merchant option for credit card and debit card transactions. We can handle transactions from consumer checking accounts on your behalf. Physical payments, including cash, physical checks, and money orders are captured through the system's virtual cash drawer.

Standard and custom reporting of consumer payment activity supports the entire cash management process, including real-time receipting, tracking, auditing, and performance reporting. Cash Drawer reporting printouts are used at end of shift to detail users' payment activity for bank deposit aggregation. TMN may elect to use our bundled merchant services option.

- **Phone Pay (IVR)** is an automated, interactive phone service (in English and Spanish) that allows patients to make payments towards their outstanding balance from virtually anywhere, anytime over the phone. It provides a customizable script messaging that accepts in-bound checking account, credit card, and debit card payments and uses payment information captured through phone keypad responses. The solutions offer your staff the ability to transfer calls relating to payment to our phone pay IVR system; freeing up your staff for other calls.
- **Patient Lockbox** automates the process of depositing, posting, and managing patient payments to help TMN get paid faster, reduce the costs of correcting errors. This healthcare-specific lockbox eliminates errors because the lockbox process works in concert with the print statement creation on your behalf. Based in Texas., our lockbox service facility is bank and merchant agnostic and can customize and automate payment posting of files for any system. The solution offers automated exception-handling and return item processing, web-based decision tools, image archiving (eliminating physical storage needs), and robust reconciliation and reporting.
- **Print Services/Paper Statements** provides scalable patient statements and remittance solutions that produce patient-friendly statements, expedited USPS mail entry, and uninterrupted statement mailing/processing and disaster recovery. The solution provides custom programming that improves the effectiveness of existing patient statements, letters, and other financial communications. As a result, patients are able to better understand their financial obligations. Print Services provides a comprehensive, single-source for printing and mailing of these improved documents, including postal address cleansing, print mail processing, and postal pre-sorting and USPS delivery.

  Change Healthcare was the first in the transactional print space to implement the Pitney Bowes® IntelliJet™ 30 Printing System. The IntelliJet™ printing system produces full-vibrant color patient correspondences in a high resolution (1200 x 600 dpi resolution) which produces sharp logos and imagery with crisp text. It also produces four-color printing, inclusive of black, and/or front/back of the statement and letter; no forms management. Benefits and features include expedited insertion into the mail system, advanced presorting technology and reduction in the time between each run.

  Other included print features: Print Address Cleansing Services incorporates NCOAlink™, CASS-certified Standardization and proprietary logic to optimize mail deliverability. We own and operate multiple state-of-the-art print mail production facilities. Vendor partnerships with

leading print, inserting and pre-sorting equipment providers guarantee responsive service levels that support rapid delivery of each day's mailings.

Print Services also provides a customer portal that enables our customers to: (a) view documents stored in our electronic archive (Document Archive), (b) reprint and re-mail selected documents, (c) access and download reporting, and (d) perform self-service administration. It also provides additional custom reporting available for delivery via email, secure ftp, message queue, or other secure file delivery methods. Reporting is available in multiple formats including HTML, CSV, and XML.

2. Describe your application training programs

We understand that training is critical to TMN's ongoing success and work with you to determine your specific training needs and custom design a training plan and schedule accordingly. Our multi-channel learning platforms help equip TMN with the knowledge and skills necessary to build competency with our industry-leading solutions and maximize your ROI.

We offer a blended approach to training that helps you integrate our revenue cycle solutions into your processes and workflows. Resources include a synergy of educational tools for quickly establishing proficiency and maintaining knowledge through a combination of online training and classroom instruction, 24/7 self-service five-minute video vignettes. portals, real-time dashboards, skills assessment portals, and computer-based tutorials, and policy and process manuals.

Training is delivered by a dedicated EDI Specialist throughout the implementation process. Our goal is to provide the right training at the right time and is based on an individual's role and job functions, e.g.:

- Administrator
- Enrollment
- Billing
- Finance
- Management

In addition to the individualized role-based training, unlimited training is also available 24/7 through Revenue Performance Advisor. Our web-based training offers a full curriculum of on-demand videos, making it easy for your trainers to design custom training programs for current and new staff, alike, as needed. Videos offer instruction relating to workflows, best practices and Revenue Performance Advisor features, allowing your trainers to decide which training works best for each member of your staff based on their specific job responsibilities.

3. Please describe any consulting services your company provides.

Heather Scott is your trusted account manager and consultant. She maintains an intimate knowledge of all aspects of your business, including overall strategy, IT initiatives, and any market challenges to drive optimum utilization of our technology. She is readily accessible and is responsible for the strategic and tactical ownership of your account and relationship. She regularly holds meetings and provides annual solution ROI reports to TMN and consults with our leadership team to ensure you receive the most value for our solutions and services.

We do offer revenue cycle consulting and other site optimization services for an additional fee.

Section J: List of Attachments

Attachment	Description
Attachment A	Change Healthcare 2018 Audited Financials
Attachment B	RPA Sample Denial Reports
Attachment C	SSAE 16 SOC II Report
Attachment D	Bridge Letter
Attachment E	RPA Submission Prompt Pay Report
Attachment F	Medicaid Billing by State