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STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF MEDICAID SERVICES

Lori A. Weaver
Commissioner

Henry D. Lipman
Director

129 PLEASANT STREET, CONCORD, NH 03301
603-271-9422 1-800-852-3345 Ext. 9422
Fax: 603-271-8431 TDD Access: 1-800-735-2964 www.dhhs.nh.gov

October 13, 2023

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
State House
Concord, New Hampshire 03301

REQUESTED ACTION

Authorize the Department of Health and Human Services, Division of Medicaid Services, to enter into a **Sole Source** amendment to an existing agreement with Magellan Medicaid Administration, LLC (VC# 175784), Eagan, MN to continue management of the Pharmacy Benefits Management system, by increasing the price limitation by $11,689,136 from $38,002,959 to $49,692,095 and by extending the completion date from December 31, 2023 to June 30, 2027, effective January 1, 2024 upon Governor and Council approval. 61% Federal Funds. 22% General Funds. 17% Other Funds (as defined in RSA 126-AA:3,I and Pharmaceutical Rebates).

The original contract was approved by Governor and Council on June 9, 2010 (Item #82), as amended on June 20, 2012 (Item #65), June 5, 2013 (Item #87), November 6, 2013 (Item #54), September 3, 2014 (Item #12), December 16, 2015 (Item #12), November 8, 2017 (Item #9) and most recently amended on December 18, 2019 (Item #22).

See attached Fiscal Details Sheet.

EXPLANATION

This request is **Sole Source** because the Department is seeking to extend the contract beyond the completion date and there are no renewal options available. This amendment is connected to the Department's Medicaid Enterprise System (MES) Re-Procurement strategy that is intended to replace existing Medicaid Management Information Systems modules consistent with the Department's procurement migration prioritization plan and the Centers for Medicare and Medicaid Services federal funding approval. The Pharmacy module procurement based on the current MES timeline is set to follow the successful implementation of the System Integrator, Provider and Enterprise Data Warehouse modules ensuring the necessary human resources are focused on those modules in a manner that supports a cost effective and operationally manageable overall timeline. By extending this contract with a sole source request the State will maintain the existing pharmacy program while completion of the initial modules are contracted and implemented. As such, the Contractor is the vendor that is able to provide the necessary Pharmacy Benefit Management services while other higher priority system modules are implemented first for the Department.

The purpose of this request is for the Contractor to continue to provide Pharmacy Benefit Management services, which include the Medicaid and AIDS Drug Assistance Pharmacy Benefit Management Systems. The Contractor will continue to manage the Medicaid preferred drug list and supplemental rebates for all Medicaid clients (Fee-for-service and Managed Care Organizations). The extension of the completion date will enable alignment with the upcoming

procurement of the Department's Medicaid Care Management contracts. Specifically, to assess whether specifications to include functionality for a single Pharmacy Benefit Manager to contract with each Managed Care Organization are compelling to include. A number of states (e.g. Kentucky and Ohio) have implemented a single Pharmacy Benefit Manager with early indications of material cost savings for their state. As more experience emerges from other states, and a specific evaluation of NH's circumstances is completed, this contract extension will enable the Department to potentially be included in the future procurement if it is economically and programmatically an opportunity.

Approximately 180,000 Medicaid and 650 AIDS Drug Assistance Pharmacy Benefit Management System (ADAP) clients will be served from January 1, 2024 through June 30, 2027.

The Contractor manages pharmacy claims, pharmacy benefits, drug rebates, drug utilization and review program, and prior authorization services. Additionally, the Contractor provides call center management and formulary management to ensure the availability of the most effective pharmaceuticals at the most efficient price. The Contractor monitors the new drugs to market and makes recommendations to the Department regarding the most suitable management strategy to assure clinically appropriate and cost efficient drug utilization. The current Medicaid Pharmacy Benefits Management system was certified by the Centers for Medicaid and Medicare Services in June 2015 as a modular Medicaid system and is managed by the Contractor.

The Department will monitor services by:

- Reviewing Quarterly Drug Rebate Invoices.
- Reviewing and approving provider payments for each payment cycle.
- Reviewing Point of Service (POS) claims.
- Meeting with the provider and Department staff bi-monthly.
- Reviewing monthly and annual performance reports.

Should the Governor and Council not authorize this request the Department will not be able to process pharmacy claims in real time, and process the monthly charges for administrative reviews, automatic prior authorizations, and clinical reviews. This would cause significant disruptions in access to critical pharmacy services for Medicaid beneficiaries and ADAP recipients.

Area served: Statewide.

Source of Federal Funds: 61% Federal Funds: Assistance Listing Number 93.778, FAIN 2305NH5ADM; 22% General Funds; and 17% Other Funds (as defined in RSA 126-AA:3,I and Pharmaceutical Rebates).

In the event that the Federal or Other Funds become no longer available, additional General Funds will not be requested to support this program.

Respectfully submitted,

Lori A. Weaver
Commissioner

DEPARTMENT OF HEALTH AND HUMAN SERVICES
FISCAL DETAILS SHEET

05-95-047-470010-79370000, HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT OF HHS: DIVISION OF MEDICAID SERVICES: OFC OF MEDICAID SERVICES, MEDICAID ADMINISTRATION

Magellan Medicaid Administration, LLC — Vendor #175784

State Fiscal Year	Class / Account	Class Title	Job Number	Current Amount	Increase (Decrease)	Revised Amount
2014	102-500731	Contracts for Prog Svc	47000075	$3,002,203	$0	$3,002,203
2015	102-500731	Contracts for Prog Svc	47000075	$2,610,300	$0	$2,610,300
2016	102-500731	Contracts for Prog Svc	47000075	$2,501,700	$0	2,501,700
2017	102-500731	Contracts for Prog Svc	47000075	$2,407,800	$0	$2,407,800
2018	102-500731	Contracts for Prog Svc	47000075	$2,369,370	$0	$2,369,370
2019	102-500731	Contracts for Prog Svc	47000075	$2,365,902	$0	$2,365,902
2020	102-500731	Contracts for Prog Svc	47000075	$2,496,882	$0	$2,496,882
2021	102-500731	Contracts for Prog Svc	47000075	$2,509,991	$0	$2,509,991
2022	102-500731	Contracts for Prog Svc	47000075	$2,585,291	$0	$2,585,291
2023	102-500731	Contracts for Prog Svc	47000075	$2,662,850	$0	$2,662,850
2024	102-500731	Contracts for Prog Svc	47000075	$1,351,102	**$946,315**	$2,297,417
2025	102-500731	Contracts for Prog Svc	47000075		**$1,921,019**	$1,921,019
2026	102-500731	Contracts for Prog Svc	47000075		**$1,978,649**	$1,978,649
2027	102-500731	Contracts for Prog Svc	47000075		**$2,038,009**	$2,038,009
			Subtotal	**$26,863,391**	**$6,883,992**	**$33,747,383**

05-95-047-470010-23580000, HEALTH AND SOCIAL SERVICES,HEALTH AND HUMAN SVCS DEPT OF HHS: DIVISION OF MEDICAID SERVICES: OFC OF MEDICAID SERVICES, NH GRANITE ADVANTAGE HEALTH CARE TRUST

Magellan Medicaid Administration, LLC — Vendor #175784

State Fiscal Year	Class / Account	Class Title	Job Number	Current Amount	Increase (Decrease)	Revised Amount
2024	102-500731	Contracts for Prog Svc	TBD	$0	**$445,325**	$445,325
2025	102-500731	Contracts for Prog Svc	TBD	$0	**$904,009**	$904,009
2026	102-500731	Contracts for Prog Svc	TBD	$0	**$931,129**	$931,129
2027	102-500731	Contracts for Prog Svc	TBD	$0	**$959,063**	$959,063
			Subtotal	**$0**	**$3,239,526**	**$3,239,526**

05-95-90-902510-2229 HEALTH AND SOCIAL SERVICES, DEPT OF HEALTH AND HUMAN SVS HHS: DIVISION OF PUBLIC HEALTH, BUREAU OF DISEASE CONTROL, PHARMACEUTICAL REBATES

Magellan Medicaid Administration, LLC — Vendor #175784

State Fiscal Year	Class / Account	Class Title	Job Number	Current Amount	Increase (Decrease)	Revised Amount
2020	103-502664	Contracts for Prog Svc	90024603	$392,761	$0	$392,761
2021	103-502664	Contracts for Prog Svc	90024603	$392,914	$0	$392,914
2022	103-502664	Contracts for Prog Svc	90024603	$402,737	$0	$402,737
2023	103-502664	Contracts for Prog Svc	90024603	$412,805	$0	$412,805
2024	103-502664	Contracts for Prog Svc	90024603	$208,951	**$215,219**	$424,170
2025	103-502664	Contracts for Prog Svc	90024603	$0	**$436,895**	$436,895
2026	103-502664	Contracts for Prog Svc	90024603	$0	**$450,002**	$450,002
2027	103-502664	Contracts for Prog Svc	90024603	$0	**$463,502**	$463,502
			Subtotal	**$1,810,168**	***$1,565,618***	***$3,375,786***

DEPARTMENT OF HEALTH AND HUMAN SERVICES
FISCAL DETAILS SHEET

05-95-95-956010-6143 HEALTH AND SOCIAL SERVICES, DEPT OF HEALTH AND HUMAN SVCS, HHS: COMMISSIONER, OFF MEDICAID & BUSINESS POLICY, PHARMACY SERVICES

Magellan Medicaid Administration, LLC — Vendor #175784

State Fiscal Year	Class / Account	Class Title	Job Number	Current Amount	Increase (Decrease)	Revised Amount
2011	102-500731	Contracts for Prog Svc	9560000175	$2,640,669	$0	$2,640,669
2012	102-500731	Contracts for Prog Svc	9560000175	$3,110,697	$0	$3,110,697
2013	102-500731	Contracts for Prog Svc	9560000175	$3,578,034	$0	$3,578,034
			Subtotal	***$9,329,400***	***$0***	***$9,329,400***
			Overall Total	**$38,002,959**	**$11,689,136**	**$49,692,095**

STATE OF NEW HAMPSHIRE
DEPARTMENT OF INFORMATION TECHNOLOGY
27 Hazen Dr., Concord, NH 03301
Fax: 603-271-1516 TDD Access: 1-800-735-2964
www.nh.gov/doit

Denis Goulet
Commissioner

September 5, 2023

Lori Weaver, Commissioner
Department of Health and Human Services
State of New Hampshire
95 Pleasant Street
Concord, NH 03301

Dear Commissioner Weaver:

This letter represents formal notification that the Department of Information Technology (DoIT) has approved your agency's request to enter into a contract amendment with Magellan Medicaid Administration, LLC, as described below and referenced as DoIT No. 2010-038H.

The purpose of this request is to provide continued management of the Pharmacy Benefits Management system.

The Total Price Limitation will increase by $11,689,136, for a New Total Price Limitation of $49,692,095, effective upon Governor and Council approval through June 30, 2027.

A copy of this letter must accompany the Department of Health and Human Services' submission to the Governor and Executive Council for approval.

Sincerely,

Denis Goulet

DG/jd
DoIT #2010-038H

cc: Mike Williams, IT Manager

State of New Hampshire
Department of Health and Human Services
Amendment #8

This Amendment to the Pharmacy Benefits Management System contract is by and between the State of New Hampshire, Department of Health and Human Services ("State" or "Department") and Magellan Medicaid Administration, LLC ("the Contractor").

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor and Executive Council on June 9, 2010 (Item #82), as amended on June 20, 2012 (Item #65), June 5, 2013 (Item #87), November 6, 2013 (Item #54), September 3, 2014 (Item #12), December 16, 2015 (Item #12), November 8, 2017 (Item #9) and most recently amended on December 18, 2019 (Item #22), the Contractor agreed to perform certain services based upon the terms and conditions specified in the Contract as amended and in consideration of certain sums specified; and

WHEREAS, pursuant to Form P-37, General Provisions, Paragraph 18, the Contract may be amended upon written agreement of the parties and approval from the Governor and Executive Council; and

WHEREAS, the parties agree to extend the term of the agreement, increase the price limitation, or modify the scope of services to support continued delivery of these services; and

NOW THEREFORE, in consideration of the foregoing and the mutual covenants and conditions contained in the Contract and set forth herein, the parties hereto agree to amend as follows:

1. Form P-37 General Provisions, Block 1.3, Contractor Name, to read:

   Magellan Medicaid Administration, LLC

2. Form P-37 General Provisions, Block 1.4, Contractor Address, to read:

   2900 Ames Crossing Road, Eagan, MN, 55121

3. Form P-37 General Provisions, Block 1.7, Completion Date, to read:

   June 30, 2027

4. Form P-37, General Provisions, Block 1.8, Price Limitation, to read:

   $49,692,095.

5. Form P-37, General Provisions, Block 1.9, Contracting Officer for State Agency, to read:

   Robert W. Moore, Director

6. Modify Exhibit B, Methods and Conditions Precedent to Payment, from Amendment #7 by replacing it in its entirety with Exhibit B – Amendment #8, Methods and Conditions Precedent to Payment, which is attached hereto and incorporated herein.

DS MD
Contractor Initials
9/29/2023
Date

All terms and conditions of the Contract and prior amendments not modified by this Amendment remain in full force and effect. This Amendment shall be effective January 1, 2024, upon Governor and Council approval

IN WITNESS WHEREOF, the parties have set their hands as of the date written below,

State of New Hampshire
Department of Health and Human Services

10/11/2023
Date

DocuSigned by:
Henry Lipman
Name: Henry Lipman
Title: Medicaid Director

Magellan Medicaid Administration, LLC

9/29/2023
Date

DocuSigned by:
Meredith Delk
Name: Meredith Delk
Title: SVP & GM State Government Solutions

The preceding Amendment, having been reviewed by this office, is approved as to form, substance, and execution.

OFFICE OF THE ATTORNEY GENERAL

10/12/2023
Date

DocuSigned by:
Robyn Guarino
74873484404411460...
Name: Robyn Guarino
Title: Attorney

I hereby certify that the foregoing Amendment was approved by the Governor and Executive Council of the State of New Hampshire at the Meeting on: _____ (date of meeting)

OFFICE OF THE SECRETARY OF STATE

_____
Date

_____
Name:
Title:

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
PHARMACY BENEFITS MANAGEMENT SYSTEM
EXHIBIT B –AMENDMENT #8
Method and Conditions Precedent to Payment

1. **Price and Payment Schedule for Pharmacy Benefits Management System for the Division of Medicaid Services.**

1.1. Firm Fixed Price

The Firm Fixed Price (FFP) for this Amendment totals $10,123,518 for the period between the effective date and 6/30/2027. The source of funds shall be 71% Federal Funds, 20% General Funds and 9% Other Funds. The Contractor shall be responsible for performing its obligations in accordance with the Contract. Subject to the Contractor's compliance with the terms and conditions of this Contract and for routine services provided, the State shall reimburse the Contractor as follows:

1.2. The Contractor shall invoice the State for the following services, Deliverables, or milestones at the fixed pricing/rates appearing in the price and payment tables below:

Pricing shall be effective for the Term of this Contract, and any extensions and amendments thereof.

Table 1: Funding Amounts by State Fiscal Year for NH Medicaid Fee-for-Service (FFS) Program shall not exceed the following amounts for each State Fiscal Year:

State Fiscal Year	SFY 2024	SFY 2025	SFY 2026	SFY 2027	TOTAL
Dates	1/1/2024-6/30/2024	7/1/2024-6/30/2025	7/1/2025-6/30/2026	7/1/2026-6/30/2027	
Fees	$1,391,640	$2,825,028	$2,909,778	$2,997,072	$10,123,518

Table 2: Reimbursement for Routine Services from January 1, 2024 through December 31, 2024

Description	Reimbursement
All Inclusive Administrative Fee	$225,969/per month
FastMAC Fee	$5,971/per month
Total Monthly Fees	**$231,940/per month**
System Modification (as needed)	$140.40/hour

Table 3: Reimbursement for Routine Services from January 1, 2025 through December 31, 2025

Description	Reimbursement
All Inclusive Administrative Fee	$232,748/per month
FastMAC Fee	$6,150/per month
Total Monthly Fees	**$238,898/per month**
System Modification (as needed)	$140.40/hour

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
PHARMACY BENEFITS MANAGEMENT SYSTEM
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Table 4: Reimbursement for Routine Services from January 1, 2026 through December 31, 2026

Description	Reimbursement
All Inclusive Administrative Fee	$239,730/per month
FastMAC Fee	$6,335/per month
Total Monthly Fees	**$246,065/per month**
System Modification (as needed)	$140.40/hour

Table 5: Reimbursement for Routine Services from January 1, 2027 through June 30, 2027

Description	Reimbursement
All Inclusive Administrative Fee	$246,922/per month
FastMAC Fee	$6,525/per month
Total Monthly Fees	**$253,447/per month**
System Modification (as needed)	$140.40/hour

1.3. Monthly Invoicing

On a monthly basis, Contractor shall send an invoice to the State. Documentation shall include: the FastMAC Fee and the All Inclusive Administrative Fee.

1.4. Pricing

Pharmaceuticals are reimbursed according to the State Plan Amendment and Administrative Rules ("Rules"). The State shall provide Contractor thirty (30) business days to implement changes to the State's rules from the date of effective rule publication; provided, however, the State shall provide more implementation time to Contractor in the event of a fundamental change in pricing Rules.
The State MAC and CMS FUL shall be modified and monitored at least monthly to ensure accurate pricing.

The Contractor shall bill the Department on a monthly basis for the services in the Contract provided during the previous month. Invoices shall calculate the service payment in detail including the units, volume and price by service for each group under the Contract as well as report the transaction volumes by month and year to date. The Contractor shall provide invoices and detailed documentation demonstrating monthly activity measurements that are subject to approval by the Department. On a monthly basis, within 30 calendar days after the final day of the month, the Contractor shall submit reports that include numbers of users, number of prescriptions and cost per user and prescription as well as total cost both per month and year to date by State Fiscal Year.

Invoices shall be sent to the New Hampshire Department of Health and Human Services at the address below in order to receive payment. All invoices shall be sent to the Department no later than 12 months of the date of service.

Name: Michele Looney
Mailing Address: NH Medicaid
New Hampshire DHHS

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
PHARMACY BENEFITS MANAGEMENT SYSTEM
EXHIBIT B –AMENDMENT #8
Method and Conditions Precedent to Payment

129 Pleasant Street
Concord, NH 03301
Telephone: 603-271-9679
Fax: 603-271-8431
Email: michele.l.looney@dhhs.nh.gov

2. Price and Payment Schedule for Pharmacy Benefits Management System for the Division of Public Health Services.

2.1. Firm Fixed Price

The Firm Fixed Price (FFP) for this Amendment totals $1,565,618 for the period between the effective date and 6/30/2027. The source of funds shall be Other Funds, primarily drug manufacturers' rebates collected under the 340B Drug Pricing Program for drugs purchased by NH ADAP. The Contractor shall be responsible for performing its obligations in accordance with the Contract. The Contractor shall invoice the State for the following activities, deliverables, or milestones at fixed pricing/rates appearing in the price and payment tables below:

Table 6: Activities/Deliverables/Milestones Pricing Worksheet

Reference Number	Activity, Deliverable, or Milestone		Deliverable Type	Price
	Ongoing Services			
1	FY 2024 System Support and Maintenance		Non-Software	Included
2	FY 2024 PBM Services		Non-Software	$215,219
3	FY 2025 System Support and Maintenance		Non-Software	Included
4	FY 2025 PBM Services		Non-Software	$436,895
5	FY 2026 System Support and Maintenance		Non-Software	Included
6	FY 2026 PBM Services		Non-Software	$450,002
7	FY 2027 System Support and Maintenance		Non-Software	Included
8	FY 2027 PBM Services		Non-Software	$463,502

Table 7: Funding Amounts by State Fiscal Year

State Fiscal Year	SFY 2024	SFY 2025	SFY 2026	SFY 2027	TOTAL
Dates	1/1/2024-6/30/2024	7/1/2024-6/30/2025	7/1/2025-6/30/2026	7/1/2026-6/30/2027	
Fees	$215,219	$436,895	$450,002	$463,502	$1,565,618

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
PHARMACY BENEFITS MANAGEMENT SYSTEM
EXHIBIT B –AMENDMENT #8
Method and Conditions Precedent to Payment

2.2. Payment

The State shall pay the Contractor on a monthly basis for PBM services and support, as shown above.

On a monthly basis, the Contractor shall send documentation to the State in support of their monthly invoice. Documentation shall include:

1. Number of claims processed and number of claims paid with amount paid for that month;
2. Number of prior authorizations completed in that month; and
3. Number of e-prescribing transactions.

2.3. Pricing

All pharmacies that fill prescriptions for NH ADAP clients utilizing the Contractor's Services shall receive the same reimbursement rate and dispensing fees for prescriptions as is used by NH Medicaid. This methodology is described below.

Pharmaceuticals are reimbursed at the lesser of the following:

1. The AAC using NADAC files when available, plus the dispensing fee;
2. The WAC, when a NADAC is not available, plus the dispensing fee;
3. The usual and customary charge to the general public;
4. The NHMAC plus the dispensing fee; or
5. The FUL plus the dispensing fee

The State MAC and CMS FUL shall be modified and monitored at least monthly and modified as necessary to ensure accurate pricing.

The invoices for NH ADAP shall be sent to the New Hampshire Department of Health and Human Services at the address below in order to receive payment. All invoices shall be sent to the Department no later than twelve (12) months of the date of service.

Name:	Karen Hammond
Mailing Address:	NH CARE Program / NH ADAP New Hampshire DHHS 29 Hazen Drive Concord, NH 03301
Telephone:	603-271-7365
Fax:	603-271-4934
Email:	DHHS.DPHS.Contract@dhhs.nh.gov

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
PHARMACY BENEFITS MANAGEMENT SYSTEM
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3. Provisions Applicable to all Services provided under the Contract

3.1. Liquidated Damages

1. The State and the Contractor agree that it will be impracticable and difficult to determine actual damages that the Department will sustain in the event the Contractor fails to maintain the required performance standards identified below throughout the life of the Contract. Any breach by the Contractor will delay and disrupt the State's operations and obligations and lead to significant damages. Therefore, the parties agree that the liquidated damages as specified in all the sections below are reasonable.

2. Assessment of liquidated damages shall be in addition to, and not in lieu of, such other remedies as may be available to the Department. Except and to the extent expressly provided herein, the Department shall be entitled to recover liquidated damages under each section applicable to any given incident.

3. The Department shall make all assessments of liquidated damages. Should the Department determine that liquidated damages may, or shall be assessed, the Department shall notify The Contractor of the potential assessment in writing.

4. The Contractor agrees that as determined by the DHHS, failure to provide Services meeting the performance standards described below shall result in liquidated damages as specified in the following table. The Contractor agrees to abide by the Performance Standards and Liquidated Damages specified in the Table 3.

Table 8: Liquidated Damages

Service Category	Minimum Standard	Potential Liquidated Damages
1. Retail Point-of-Sale Claims Adjudication Accuracy	The Contractor shall agree to a financial accuracy rate of at least 99% for all prescription claims electronically processed at point-of-sale, measured monthly.	For failure to meet the standard, The Contractor shall be assessed Liquidated Damages equal to 10% of the administrative fee in the Contract month in which the incident occurred.
2. Point-of-Sale Network System Downtime	The Contractor shall agree that unscheduled system downtime shall be no greater than eight (8) hours per incident; not to exceed two times per Contract year. Contractor shall provide notice to the State as to its regularly, scheduled maintenance windows which shall not be part of this guarantee.	For failure to meet the standard, the Contractor shall be assessed Liquidated Damages equal to 10% of the administrative fee in the Contract month in which the incident occurred.

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
PHARMACY BENEFITS MANAGEMENT SYSTEM
EXHIBIT B –AMENDMENT #8
Method and Conditions Precedent to Payment

3. Drug Rebates • **This section regarding Drug Rebates pertains to Medicaid services ONLY**	All rebate reporting and payments to the State shall be posted within thirty (30) days of the receipt of the rebate information received from the drug manufacturers through the State. Reporting shall describe the source of the rebates at the item level, and the date payment was received from the manufacturer.	For failure to meet the standard, the Contractor will be assessed Liquidated Damages equal to 10% of the administrative fee in the Contract month in which the incident occurred.
4. Reporting Requirements	The Contractor shall provide all scheduled reports, ad hoc reports, and paid claims transactional history files where the Scope of Work specifies a timeframe within the stated time periods, and to provide the on-line query capability described in The Contractor's response.	For failure to meet the standard, The Contractor shall be assessed Liquidated Damages equal to 10% of the administrative fee in the Contract month in which the incident occurred.
5. Average Speed to Answer	Beneficiary and pharmacy calls received shall be answered within an average of thirty (30) seconds. Reporting shall be provided monthly by the 7th day of the month.	For failure to meet the standard, The Contractor shall be assessed Liquidated Damages equal to 10% of the administrative fee in the Contract month in which the incident occurred.
6. Call Abandonment and Call Blocking Rate	No more than 2% of all beneficiary and pharmacy calls shall be abandoned or blocked. Reporting shall be provided monthly by the 7th day of the month.	For failure to meet the standard, The Contractor shall be assessed Liquidated Damages equal to 10% of the administrative fee in the Contract month in which the incident occurred.
7. Customer Service Resolution Rate	All customer service interactions shall be logged in The Contractor's information systems with 95% of all issues resolved the same day. 99% of issues resolved within 30 days. Reporting shall be provided monthly by the 7th day of the month.	For failure to meet the standard, The Contractor shall be assessed Liquidated Damages equal to 10% of the administrative fee in the Contract month in which the incident occurred.
8. Prior Authorizations	100% of requests for PA shall be completed within twenty-four (24) hours.	For failure to meet the standard, The Contractor shall be assessed Liquidated Damages equal to 10% of the administrative fee in the Contract month in which the incident occurred.

9. Legislative Ad Hoc Report Requests	All requests for legislative ad hoc reports shall be completed within two (2) weeks of request unless otherwise negotiated at the time of the request from the State.	For failure to meet the standard, The Contractor shall be assessed Liquidated Damages equal to 10% of the administrative fee in the Contract month in which the incident occurred.

3.2. PAYMENT ADDRESS

All payments shall be sent to the following address:

Magellan Medicaid Administration, LLC
PO Box 783053
Philadelphia, PA 19178-3053

3.3. OVERPAYMENTS TO THE CONTRACTOR

The Contractor shall promptly, but no later than fifteen (15) business days, return to the State the full amount of any overpayment or erroneous payment upon discovery or notice from the State.

3.4. CREDITS

The State may apply credits due to the State arising out of this Contract, against the Contractor's invoices with appropriate information attached.

The Contractor shall keep detailed records of their activities related to State-funded programs and services and have records available for Department review, as requested.

3.5. Notwithstanding anything to the contrary herein, the Contractor agrees that funding under this agreement may be withheld, in whole or in part, in the event of non-compliance with any Federal or State law, rule or regulation applicable to the services provided, or if the services or have not been satisfactorily completed in accordance with the terms and conditions of this Contract. Payments may be withheld pending receipt of required reports or documentation.

3.6. Notwithstanding paragraph 18 of the General Provisions P-37, changes limited to adjusting amounts within the price limitation and adjusting encumbrances between State Fiscal Years may be made through the Budget Office by written agreement of both parties, without obtaining additional approval of the Governor and Executive Council, if needed and justified.

3.7. The final invoice shall be due to the State no later than forty (40) days after the contract completion date specified in Form P-37, General Provisions Block 1.7 Completion Date.

State of New Hampshire

Department of State

CERTIFICATE

I, David M. Scanlan, Secretary of State of the State of New Hampshire, do hereby certify that MAGELLAN MEDICAID ADMINISTRATION, LLC is a Virginia Limited Liability Company registered to transact business in New Hampshire on November 05, 2004. I further certify that all fees and documents required by the Secretary of State's office have been received and is in good standing as far as this office is concerned.

Business ID: **375715**

Certificate Number: **0006328896**

IN TESTIMONY WHEREOF,
I hereto set my hand and cause to be affixed
the Seal of the State of New Hampshire,
this 2nd day of October A.D. 2023.

David M. Scanlan
Secretary of State

CERTIFICATE OF AUTHORITY

I, Mike Kolar, hereby certify that:
(Name of the elected Officer of the Corporation/LLC; cannot be contract signatory)

1. I am a duly elected Clerk/Secretary/Officer of Magellan Medicaid Administration LLC.
(Corporation/LLC Name)

2. The following is a true copy of a vote taken by written resolution of the Board of Directors/shareholders, on September 27, 2023, of which a quorum of the Directors/shareholders voted.
(Date)

VOTED: That Meredith Delk, SVP and General Manager, Government Markets (may list more than one person)
(Name and Title of Contract Signatory)

is duly authorized on behalf of Magellan Medicaid Administration LLC to enter into contracts or agreements with the State
(Name of Corporation/ LLC)

of New Hampshire and any of its agencies or departments and further is authorized to execute any and all documents, agreements and other instruments, and any amendments, revisions, or modifications thereto, which may in his/her judgment be desirable or necessary to effect the purpose of this vote.

3. I hereby certify that said vote has not been amended or repealed and remains in full force and effect as of the date of the contract/contract amendment to which this certificate is attached. This authority **remains valid for thirty (30)** days from the date of this Certificate of Authority. I further certify that it is understood that the State of New Hampshire will rely on this certificate as evidence that the person(s) listed above currently occupy the position(s) indicated and that they have full authority to bind the corporation. To the extent that there are any limits on the authority of any listed individual to bind the corporation in contracts with the State of New Hampshire, all such limitations are expressly stated herein.

Dated: 9/28/2023

DocuSigned by:
Mike Kolar
A33390E19F7C4D5...
Signature of Elected Officer
Name: Michael Kolar
Title: Secretary

DocuSign Envelope ID: 4A314C1C-04E8-4DF4-B0C0-9FD98CCFDCC7

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 03/31/2023

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER MARSH USA LLC. 540 W. MADISON CHICAGO, IL 60661	CONTACT NAME: Marsh | U.S. Operations PHONE (A/C, No, Ext): 866-966-4664 FAX (A/C, No): 212-948-0770 E-MAIL ADDRESS: Chicago.CertRequest@marsh.com
CN101504588--GAWU-23-24	INSURER(S) AFFORDING COVERAGE / NAIC # INSURER A : Hartford Fire Insurance Company 19682 INSURER B : Trumbull Insurance Company 27120 INSURER C : Hartford Casualty Insurance Company 29424 INSURER D : INSURER E : INSURER F :
INSURED Prime Therapeutics LLC 2900 Ames Crossing Road Eagan, MN 55121	

COVERAGES **CERTIFICATE NUMBER:** CHI-010199360-04 **REVISION NUMBER:** 1

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	X COMMERCIAL GENERAL LIABILITY CLAIMS-MADE [X] OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: X POLICY [ ] PRO-JECT [ ] LOC OTHER:	X		83UENAU7D7K	04/01/2023	04/01/2024	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG	$ 1,000,000 $ 50,000 $ 5,000 $ 1,000,000 $ 2,000,000 $ 1,000,000
B	AUTOMOBILE LIABILITY X ANY AUTO OWNED AUTOS ONLY HIRED AUTOS ONLY SCHEDULED AUTOS NON-OWNED AUTOS ONLY	X		83UENAF1111	04/01/2023	04/01/2024	COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident)	$ 1,000,000 $ $ $
C	X UMBRELLA LIAB X OCCUR EXCESS LIAB CLAIMS-MADE DED X RETENTION $ 10,000			83XHUAV0F1A	04/01/2023	04/01/2024	EACH OCCURRENCE AGGREGATE	$ 10,000,000 $ 11,000,000
C	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N ANYPROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? N (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	N/A		83 WB AA8WJ8	01/01/2023	01/01/2024	X PER STATUTE OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	$ 1,000,000 $ 1,000,000 $ 1,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

RE: Insured: Magellan Medicaid Administration, LLC.

The holder is named as an additional insured as respects to general and automobile liability policies where required by written contract or written agreement, subject to the policy(s) terms and conditions.

CERTIFICATE HOLDER

State of NH
Department of Health and Human Services, 129 Pleasant Street
Concord, NH 03301-3857

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

Marsh USA LLC

ACORD

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 03/31/2023

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER MARSH USA LLC. 540 W. MADISON CHICAGO, IL 60661 CN101504588--E&O-23-24	**CONTACT NAME:** Marsh | U.S. Operations **PHONE (A/C, No, Ext):** 866-966-4664 **FAX (A/C, No):** 212-948-0770 **E-MAIL ADDRESS:** Chicago.CertRequest@marsh.com
INSURED Prime Therapeutics LLC 2900 Ames Crossing Road Eagan, MN 55121	**INSURER(S) AFFORDING COVERAGE** / **NAIC #** **INSURER A :** ACE American Insurance Company / 22667 **INSURER B :** **INSURER C :** **INSURER D :** **INSURER E :** **INSURER F :**

COVERAGES **CERTIFICATE NUMBER:** CHI-010199361-03 **REVISION NUMBER:** 1

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	COMMERCIAL GENERAL LIABILITY						EACH OCCURRENCE	$
	☐ CLAIMS-MADE ☐ OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$
							MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$
	☐ POLICY ☐ PRO-JECT ☐ LOC						PRODUCTS - COMP/OP AGG	$
	OTHER:							$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	ANY AUTO						BODILY INJURY (Per person)	$
	OWNED AUTOS ONLY ☐ SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	HIRED AUTOS ONLY ☐ NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	$
								$
	UMBRELLA LIAB ☐ OCCUR						EACH OCCURRENCE	$
	EXCESS LIAB ☐ CLAIMS-MADE						AGGREGATE	$
	DED ☐ RETENTION $							$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N						PER STATUTE ☐ OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) ☐ N	N/A					E.L. EACH ACCIDENT	$
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$
							E.L. DISEASE - POLICY LIMIT	$
A	MANAGED CARE E&O*			MSP G71508134 005	04/01/2023	04/01/2024	EACH CLAIM	10,000,000
	(See ACORD 101)						AGGREGATE	10,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

RE: Insured: Magellan Medicaid Administration, LLC.

*The Managed Care E&O policies evidenced above are subject to self-insured retentions for various perils covered.

CERTIFICATE HOLDER

State of NH
Department of Health and Human Services, 129 Pleasant Street
Concord, NH 03301-3857

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

Marsh USA LLC

DEC09'19 PM 1:50 DAS

22 mac

STATE OF NEW HAMPSHIRE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

DIVISION OF MEDICAID SERVICES

Jeffrey A. Meyers
Commissioner

Henry D. Lipman
Director

129 PLEASANT STREET, CONCORD, NH 03301
603-271-9422 1-800-852-3345 Ext. 9422
Fax: 603-271-8431 TDD Access: 1-800-735-2964
www.dhhs.nh.gov

November 25, 2019

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
State House
Concord, New Hampshire 03301

REQUESTED ACTION

Authorize the Department of Health and Human Services, Division of Medicaid Services to amend an existing **sole source** agreement with Magellan Medicaid Administration, Inc., 110113 West Broad Street Glen Allen, VA 23060 (Vendor # 175784), to manage the Pharmacy Benefits Management system by increasing the price limitation by $12,017,122 from $25,985,837 to $38,002,959 and by extending the completion date from December 31, 2019 to December 31, 2023, effective upon Governor and Executive Council approval or January 1, 2020, whichever is later. 67% Federal Funds, 22% General Funds for Medicaid and 11% Other Funds.

The agreement was originally approved by the Governor and Executive Council on June 9, 2010 (Item #82), and subsequently amended on June 20, 2012 (Item #65), June 5, 2013 (Item # 87), November 6, 2013 (Item #54), September 3, 2014 (Item #12), December 16, 2015 (Item #12), and November 8, 2017 (Item #23).

Funds are available in the following accounts for State Fiscal Years 2020 and 2021, and are anticipated to be available in State Fiscal Years 2022, 2023, and 2024, with authority to adjust amounts within the price limitation and adjust encumbrances between State Fiscal Years through the Budget Office, if needed and justified.

05-95-95-956010-6143 HEALTH AND SOCIAL SERVICES, DEPT OF HEALTH AND HUMAN SVCS; HHS: COMMISSIONER, OFFICE OF MEDICAID BUSINESS AND POLICY, PHARMACY SERVICES

05-095-047-470010-79370000 HEALTH AND SOCIAL SERVICES, DEPT. OF HEALTH AND HUMAN SVSC, HHS: COMMISSIONER, OFFICE OF MEDICAID BUSINESS AND POLICY, MEDICAID ADMINISTRATION

05-95-90-902510-2229 HEALTH AND SOCIAL SERVICES, DEPT OF HEALTH AND HUMAN SVS, HHS: DIVISION OF PUBLIC HEALTH, BUREAU OF INFECTIOUS DISEASE CONTROL, PHARMACEUTICAL REBATES

See attached fiscal details.

EXPLANATION

This request is **sole source** because there are no renewal options available in the current contract and there is no other system currently available to efficiently provide Pharmacy Benefit Management services to the New Hampshire Department of Health and Human Services ("Department"). The purpose of this **sole source** amendment is to extend the completion date of the agreement, increase the price limitation, and modify the scope of services. The scope of services is being modified to conform to current DOIT standards and to incorporate services currently provided by the Contractor under a separate agreement with the Department for the AIDS Drug Assistance Pharmacy Benefit Management System (ADAP), which was originally approved by the Governor and Executive Council on June 19, 2013 (Item #90) and expires on December 31, 2019.

Approximately 174,000 Medicaid and 550 ADAP clients will be served from January 1, 2020 through December 31, 2023.

The Contractor provides the Department with Pharmacy Benefit Management systems for both Medicaid and ADAP. Each of these implementations have unique as well as common requirements. The Contractor manages pharmacy claims, pharmacy benefits, drug rebates, drug utilization and review program, and prior authorization services. They also provide call center management and formulary management to ensure the availability of the most effective pharmaceuticals at the most efficient price.

The Contractor's current solutions meet the requirements of both the Division of Medicaid Services and the Division of Public Health Services and are similar in nature. In line with the Department's goals to streamline processes and build on economies of scale, through this amendment, the Department will now have a single contract that will provide the following benefits:

- A single contracting process for both programs;
- Better and consistent pricing for both programs;
- Consistent Contractor management and expectations;
- Common processes and systems planning reducing complexity and need for customization; and
- The ability to leverage the current designed, developed and implemented solutions, reducing costs of migration to a different system and associated startup costs of a new system.

The Current Medicaid Pharmacy Benefits Management system was certified by the Centers for Medicaid and Medicare Services in June 2015 as a modular Medicaid system and is managed by the Contractor. By utilizing the existing contract and associated system, the Department will not expend the estimated $8.5 million dollars, of which $1.275 million was general funds that was submitted for biennium 20/21, in accordance with contract expiration and subsequent RFP with an anticipated result in a new system for Medicaid and save 450 thousand dollars ($450,000) in estimated costs to replace the Public Health solution funded from pharmaceutical rebates.

This current system already conforms to the modular requirements from the Centers for Medicaid Services and as a result would be recommended to be staged later in the MMIS re-procurement strategy.

The Contractor will continue to provide pharmacy claims management, pharmacy benefits management, drug rebate management, a call center, drug utilization and review program, prior authorization services, and formulary management to assure the availability of the most effective pharmaceuticals at the most efficient price to New Hampshire Medicaid and ADAP clients. The services provided by the Contractor through this contract will enable the Department to continue improving the quality of beneficiary health while managing the high cost of pharmaceuticals.

The Contractor will continue to manage the Medicaid preferred drug list and supplemental rebates for all Medicaid clients Fee-for-Service (FFS) and Managed Care Organization (MCO). In State Fiscal Year 2019, the State share of the drug rebates collected was $25.1 million. These funds were used to reduce the General Fund portion for the Provider Payment expenses. The Contractor monitors the new drugs to market and makes recommendations to the Department regarding the most suitable management strategy to ensure clinically appropriate and cost efficient drug utilization.

Should the Governor and Executive Council not approve this request, the Department would not be able to process the monthly charges for Administrative reviews, Automatic Prior Authorizations, and Clinical Reviews that are related to the drug claims of the enrolled Medicaid and ADAP population. If the administrative charges are not paid in a timely manner this would cause a delay in processing drug claims for New Hampshire Medicaid and ADAP recipients.

Area served: Statewide

Source of Funds: 11% Other Funds (340B Pharamaceutical Rebates), 67% Federal Funds, and 22% General Funds

In the event that the Federal (or Other) Funds become no longer available, no additional General Funds will not be requested to support this program.

Respectfully submitted,

Jeffrey A. Meyers
Commissioner

05-95-95-956010-6143 HEALTH AND SOCIAL SERVICES, DEPT OF HEALTH AND HUMAN SVCS, HHS: COMMISSIONER, OFF MEDICAID & BUSINESS POLICY, PHARMACY SERVICES

State Fiscal Year	Class/ Account	Class Title	Job Number	Current Modified Budget	Increase/ (Decrease)	Revised Modified Budget
2011	102-500731	Contracts for Program Services	9560000175	$2,640,669	$0	$2,640,669
2012	102-500731	Contracts for Program Services	9560000175	$3,110,697	$0	$3,110,697
2013	102-500731	Contracts for Program Services	9560000175	$3,578,034	$0	$3,578,034
		SFY 2011 through SFY 2013 Subtotal:		*$9,329,400*	*$0*	*$9,329,400*

05-095-047-470010-79370000 HEALTH AND SOCIAL SERVICES, DEPT. OF HEALTH AND HUMAN SVSC, HHS: COMMISSIONER, OFF MEDICAID & BUSINESS POLICY, MEDICAID ADMINISTRATION

State Fiscal Year	Class-Account	Class Title	Job Number	Current Modified Budget	Increase-(Decrease)	Revised Modified Budget
2014	102-500731	Contracts for Program Services	47000075	$3,002,203	$0	$3,002,203
2015	102-500731	Contracts for Program Services	47000075	$2,610,300	$0	$2,610,300
2016	102-500731	Contracts for Program Services	47000075	$2,501,700	$0	$2,501,700
2017	102-500731	Contracts for Program Services	47000075	$2,407,800	$0	$2,407,800
2018	102-500731	Contracts for Program Services	47000075	$2,369,370	$0	$2,369,370
2019	102-500731	Contracts for Program Services	47000075	$2,365,902	$0	$2,365,902
2020	102-500731	Contracts for Program Services	47000075	$1,200,432	$1,296,450	$2,496,882
2021	102-500731	Contracts for Program Services	47000075	$0	$2,509,991	$2,509,991
2022	102-500731	Contracts for Program Services	47000075	$0	$2,585,291	$2,585,291
2023	102-500731	Contracts for Program Services	47000075	$0	$2,662,850	$2,662,850
2024	102-500731	Contracts for Program Services	47000075	$0	$1,351,102	$1,351,102
		SFY 2014 through 2024 Subtotal:		*$16,457,707*	*$10,405,684*	*$26,863,391*

05-95-90-902510-2229 HEALTH AND SOCIAL SERVICES, DEPT OF HEALTH AND HUMAN SVS HHS: DIVISION OF PUBLIC HEALTH, BUREAU OF INFECTIONS DISEASE CONTRACT PHARMACEUTICAL REBATES.

State Fiscal Year	Class/ Account	Class Title	Job Number	Current Modified Budget	Increase/ (Decrease)	Revised Modified Budget
2020	103-502664	Contracts for Program Services	90024603	$198,730	$194,031	$392,761
2021	103-502664	Contracts for Program Services	90024603	$0	$392,914	$392,914
2022	103-502664	Contracts for Program Services	90024603	$0	$402,737	$402,737
2023	103-502664	Contracts for Program Services	90024603	$0	$412,805	$412,805
2024	103-502664	Contracts for Program Services	90024603	$0	$208,951	$208,951
		SFY 2014 through 2024 Subtotal:		*$198,730*	*$1,611,438*	*$1,810,168*
		Contract Total:		*$25,985,837*	*$12,017,122*	*$38,002,959*

STATE OF NEW HAMPSHIRE
DEPARTMENT OF INFORMATION TECHNOLOGY
27 Hazen Dr., Concord, NH 03301
Fax: 603-271-1516 TDD Access: 1-800-735-2964
www.nh.gov/doit

Denis Goulet
Commissioner

December 6, 2019

Jeffrey A. Meyers, Commissioner
Department of Health and Human Services
State of New Hampshire
129 Pleasant Street
Concord, NH 03301

Dear Commissioner Meyers:

This letter represents formal notification that the Department of Information Technology (DoIT) has approved your agency's request to enter into a **sole source** contract amendment with Magellan Medicaid Administration, Inc., of Glen Allen, VA as described below and referenced as DoIT No. 2010-038G.

The purpose of this request is to enter into a **sole source** contract amendment with Magellan Medicaid Administration, Inc. to continue to manage pharmacy benefits for the Medicaid Program. The PBM System provides automated capabilities needed to support the clinical drug program management objectives of DHHS (processing drug/medical equipment claims), ensure uninterrupted service to members and providers, support program operational needs, and maximize cost savings potential. Pharmacy management services include claims management, benefits management, drug rebate management, prior authorization services, and manage the Medicaid preferred drug list.

The funding amount for this amendment is $12,017,122.00, increasing the current contract from $25,985,837.00 to $38,002,959.00, and extends the completion date from December 31, 2019 to December 31, 2023. The amendment shall become effective upon Governor and Council approval, or January 1, 2020, whichever is later, through December 31, 2023.

A copy of this letter should accompany the Department of Health and Human Services' submission to the Governor and Executive Council for approval.

Sincerely,

Kenneth Dunn FOR
Denis Goulet

DG/kaf
DoIT #2010-038G

cc: Bruce Smith, IT Manager, DoIT

State of New Hampshire
Department of Health and Human Services
Amendment #7 to the Magellan Medicaid Administration, Inc. Contract

This 7th Amendment to the Magellan Medicaid Administration, Inc. contract (hereinafter referred to as "Amendment #7") is by and between the State of New Hampshire, Department of Health and Human Services (hereinafter referred to as the "State" or "Department") and Magellan Medicaid Administration, Inc., (hereinafter referred to as "the Contractor"), a Virginia corporation with a place of business at 11013 West Broad Street, Glen Allen, VA 23060.

WHEREAS, pursuant to the "Magellan Medicaid Administration, Inc. Contract" (the "Contract") approved by the Governor and Executive Council on June 9, 2010 (Item #82), and amended by an agreement (Amendment #1 to the Contract) approved on June 20, 2012 (Item # 65), and amended by an agreement (Amendment #2 to the Contract) approved on June 5, 2013 (Item # 87), and amended by an agreement (Amendment #3 to the Contract) approved on November 6, 2013 (Item #54), and amended by an agreement (Amendment #4 to the Contract) approved on September 3, 2014 (Item #12), and amended by an agreement (Amendment #5 to the Contract) approved on December 16, 2015 (Item #12), and amended by an agreement (Amendment #6 to the Contract) approved on November 8, 2017 (Item #9), the Contractor agreed to perform certain services based upon the terms and conditions specified in the Contract as amended and in consideration of certain sums specified; and

WHEREAS, pursuant to Form P-37, General Provisions, Paragraph 18, the Contract may be amended upon written agreement of the parties and approval from the Governor and Executive Council; and

WHEREAS, the parties agree to extend the term of the Contract, increase the price limitation, and modify the scope of services to support continued delivery of services; and

NOW THEREFORE, in consideration of the foregoing and the mutual covenants and conditions contained in the Contract and set forth herein, the parties hereto agree to amend the Contract as follows:

1. Form P-37 General Provisions, Block 1.7, Completion Date, to read:

   December 31, 2023.

2. Form P-37, General Provisions, Block 1.8, Price Limitation, to read:

   $38,002,959.

3. Modify Exhibit A, Scope of Services, by replacing it in its entirety with Exhibit A – Amendment #7, Scope of Services, which is attached hereto and incorporated by reference herein.

4. Modify Exhibit B, Methods and Conditions Precedent to Payment, from Amendment #6 by replacing it in its entirety with Exhibit B – Amendment #7, Methods and Conditions Precedent to Payment, which is attached hereto and incorporated herein.

5. Modify Standard Exhibit C-1, Additional Special Provisions, by replacing it in its entirety with Exhibit C-1 – Amendment #7, Revisions to Standard Contract Language, which is attached hereto and incorporated by reference herein.

6. Modify Exhibit D, Certification Regarding Drug Free Workplace, by replacing it in its entirety with Exhibit D – Amendment #7, Certification Regarding Drug Free Workplace, which is attached hereto and incorporated by reference herein.

7. Modify Exhibit E, Certification Regarding Lobbying, by replacing it in its entirety with Exhibit E – Amendment #7, Certification Regarding Lobbying, which is attached hereto and incorporated by reference herein.

8. Modify Standard Exhibit I, Health Insurance Portability and Accountability Act Business Associate Agreement, by replacing it in its entirety with the attached Exhibit I – Amendment # 7,

Health Insurance Portability and Accountability Business Associate Agreement, which is attached hereto and incorporated by reference herein.

9. Modify Exhibit J, Certification Regarding the Federal Funding Accountability and Transparency Act (FFATA) Compliance, by replacing it in its entirety with the attached Exhibit J- Amendment # 7, which is attached hereto and incorporated by reference herein.

10. Add Exhibit K, DHHS Information Security Requirements.

11. All terms and conditions of the Contract and prior amendments not inconsistent with this Amendment #7 remain in full force and effect.

This Amendment #7 shall be effective upon the date of Governor and Executive Council approval or January 1, 2020, whichever is later.

IN WITNESS WHEREOF, the parties have set their hands as of the date written below,

State of New Hampshire
Department of Health and Human Services

12/6/19
Date

Henry Lipman
Director

Magellan Medicaid Administration, Inc.

12/4/19
Date

Name: Meredith Delk
Title: GM & SVP Government Markets

Acknowledgement of Contractor's signature:

State of Texas, County of Travis on December 4th, 2019, before the undersigned officer, personally appeared the person identified directly above, or satisfactorily proven to be the person whose name is signed above, and acknowledged that s/he executed this document in the capacity indicated above.

Signature of Notary Public or Justice of the Peace

Kelly Dougherty - Notary Public
Name and Title of Notary or Justice of the Peace

My Commission Expires: May 31, 2023

KELLY DOUGHERTY
Notary ID #130235413
My Commission Expires
May 31, 2023

The preceding Amendment, having been reviewed by this office, is approved as to form, substance, and execution.

OFFICE OF THE ATTORNEY GENERAL

12/5/19
Date

Name: CATHERINE PINOS
Title: Attorney

I hereby certify that the foregoing Amendment was approved by the Governor and Executive Council of the State of New Hampshire at the Meeting on: _____ (date of meeting)

OFFICE OF THE SECRETARY OF STATE

Date

Name:
Title:

1. Provisions Applicable to All Services

1.1. The Contractor agrees that, to the extent future legislative action by the New Hampshire General Court or federal or state court orders may have an impact on the Services described herein, the State Agency has the right to modify Service priorities and expenditure requirements under this Agreement so as to achieve compliance therewith.

1.2. For the purposes of this Agreement, the Department has identified Magellan Medicaid Administration, Inc. as a Contractor in accordance with 2 CFR 200.300.

Contract Definitions

I. The term "Adjudicated Claim" means a transaction, as defined by the then current NCPDP Transaction Code, that is received, processed, and responded to by The Contractor. A transaction can be received in multiple media as: (1) Point of Service (POS) - a transaction received electronically via telephone lines from the Providers' Point of Service (2) Electronic Media - A batch of transactions received by The Contractor in electronic media (tape, diskette or electronic bulletin board) and submitted to The Contractor System for processing, and (3) Paper - a transaction received on paper and data entered by The Contractor and submitted to The Contractor System for processing, but does not include a rejected claim.

II. The term "Administrative Fees" means all fees and reimbursements paid or payable to The Contractor for Services provided pursuant to this contract, except for the actual costs of the drugs prescribed and dispensing fees paid to network pharmacies.

III. The term "Contractor" means The Contractor Magellan Medicaid Administration, Inc.

IV. The terms "Department", "DHHS", "DPHS" or "State" means The State of New Hampshire, Department of Health and Human Services, Office of Medicaid Business and Policy and the Department of Information Technology (DOIT).

V. The term "Federal Upper Limit" means the maximum amount that Medicaid can reimburse for a drug product as established by CMS.

VI. The term "Fiscal Pend" means adjudicated claims and financial transactions, based on user-defined parameters for exclusion from payment during selected future financial cycles.

VII. The term "Lock In" means to identify clients who are restricted, when obtaining drugs, medical Services or supplies, to one or more specified Providers.

VIII. The term "Maximum Allowable Cost" means the maximum amount NH Medicaid shall reimburse for a drug product as established by the Contractor in accordance with Centers for Medicare and Medicaid Services (CMS) guidelines.

IX. "Paid Adjudicated claim" is claim for which a check or payment has actually been sent to the Provider or state approved payees.

X. The term "Preferred Drug List" or "PDL" means is a list of preferred drugs and non-preferred drugs. The preferred drugs have been reviewed and are

Medicaid's recommended first choice drugs. Doctors and pharmacists have reviewed preferred drugs. Preferred drugs are as safe and effective as non-preferred drugs but can cost the Medicaid program less. The term "Prior Authorization" or "PA" means the pre-claim submission approval that shall be given to Providers by the Contractor's clinical call center for a specified client for any drug that is subject to PA restrictions.

XI. The term "Provider" means an enrolled NH Medicaid Provider.

XII. The term "Payee" means a State authorized Medicaid Recipient (or designated agent) or Medicaid Provider that is issued a check paid through the NH Medicaid Drug Payment Custodial Bank Account.

XIII. The term "Prescriber" means the individual writing the prescription for the recipient and who is authorized to do so.

XIV. The term "Recipient" or "client" or "beneficiary" or "member" means a person or persons eligible for New Hampshire Medicaid.

XV. The term "Third Party Liability" or "TPL" means any source of payment or potential source of payment for prescription drugs, other than Medicaid.

Scope of Services for Pharmacy Benefits Management System for Medicaid Services

I. OVERVIEW

The Contractor shall be responsible for the design, development, and implementation of the State's Pharmacy Benefits Management (PBM) system and shall act as the State's Fiscal Agent for these services. The Contractor shall provide for all of the systems functional components and requirements, including services and deliverables, outlined within this contract.

1. The Contractor shall provide the State with secure, on-line access to any and all components that comprise the NH PBM system solution. Additionally, the Contractor shall provide secure, restricted access to NH Medicaid Providers and Recipients to selected information as described in the RFP and such other information as Contractor and the State mutually agree in writing.
2. The Contractor shall work collaboratively with the Department, its MMIS fiscal agent, and other interfacing entities to implement effectively the requisite exchanges of data necessary to support the requirements of the RFP.
3. The Contractor is responsible for hosting the NH PBM solution at the Contractor's data center and providing for adequate redundancy, disaster recovery, and business continuity such that in the event of any catastrophic incident, stem availability is restored to the State within 24 hours of incident onset in the event of a catastrophic incident and eight (8) hours in the event of an unscheduled downtime incident

involving the POS functionality.

4. The Contractor shall ensure that the hardware and software supporting the State's solution, and the State's data, data processing and data repositories are securely segregated from any other PBM account or project, and are under configuration management and change management governed through and in support of the State project.

5. The Contractor shall implement the necessary telecommunication infrastructure to support the State's PBM solution and shall provide the State with a network diagram depicting the communications infrastructure, including but not limited to, connectivity between the State and Contractor, including any contractor and subcontractor locations supporting the State's PBM project.

6. The Contractor shall utilize data extract, transformation, and load (ETL) methods for data conversion and data interface handling, that, to the maximum extent possible, automate the extract, transformation and load processes, and that provide for source to target or source to specification mappings, all business rules and transformations where applied, summary and detailed counts, and any, data that cannot be loaded.

7. The Contractor shall provide for a common, centralized electronic project repository, providing for secure access to authorized Contractor and State staff to project plans, documentation, issues tracking, deliverables, and other project related artifacts, that shall be turned over to the State after certification.

A. Systems Capability and Performance Standards

1. The Contractor shall ensure the following system availability and access:

   a. Twenty-four hours per day, seven days a week, three hundred and sixty five days per year, except for scheduled maintenance;
   b. Provider network connectivity;
   c. Documented scheduled down time and maintenance windows;
   d. DHHS on-line access to all components of the system;
   e. DHHS access to user acceptance environment;
   f. Documented instructions and user manuals for each component;
   g. Secure access.

2. The Contractor shall ensure the following systems operations support:

   a. Twenty-four hours per day, seven days a week, three hundred and sixty five days per year, except for scheduled

maintenance;

b. On-call procedures and contacts;
c. Job scheduling and failure notification documentation;
d. Secure data transmission methodology;
e. Interface acknowledgements and error reporting;
f. Technical issue escalation procedures;
g. Business and customer notification;
h. Change control management;
i. Assistance with user acceptance testing and implementation coordination;
j. Documented interface specifications-data imported and extracts exported; and
k. Disaster recovery plan.

3. Automated data files and interfaces. The State will send to the Contractor all of the files (with periodicity noted) below (except those noted with a *) that the Contractor will send to the State:

a. Third party liability (TPL) extract to the Contractor (Daily);
b. Provider extract to the Contractor-Pharmacy Only (Daily);
c. Recipient Eligibility Extract to the Contractor (Daily);
d. Recipient Refresh Data Extract to the Contractor (Monthly);
e. Paid, voided, denied drug claims processed from the contractor (biweekly or as scheduled following the financial cycle)-(from Contractor to State)*
f. Medical claims to the Contractor-claims types medical, outpatient, nursing home and inpatient (Monthly);
g. Provider, all EXCEPT pharmacy (Monthly);
h. Fee-for-Service and managed care medical claims for physician-administered drugs processed by the MMIS and the managed care organizations to the Contractor- "J" and "S" Codes only (Quarterly) for quarterly rebate processing.
i. A copy of the First Data Bank file, including a clear designation of brand vs. generic drugs and incorporating State Maximum Allowable Cost (SMAC) pricing (from the Contractor to the Medicaid Management Information System (MMIS)); and
j. HIPAA compliant Electronic Data Interchange (EDI) transaction files-incoming and outgoing to providers and trading partners.
k. Managed care pharmacy data to the Contractor for quarterly rebate processing.

4. Provider and Patient Pharmacy Web Access. The Contractor will create secure web access for Medicaid providers and Medicaid recipients to access case-specific pharmacy information. The Contractor shall manage provider and beneficiary access to the system, providing for the applicable secure access management, password and Personal

Identification Number (PIN) communication, and operational services necessary to assist the providers and beneficiaries with gaining access and utilizing the web portal.

5. Provider access shall be made available through a secure provider website and shall include, but not be limited to: the ability to electronically submit prior authorization requests and access and utilize other utilization management tools; the ability to download and print any needed Medicaid program forms and other information; to e-prescribe as an option for providers without electronic medical records or hand held devices; provider support to request and receive general program information with contact information for phone numbers, mailing and e-mail address(es); provide drug information appropriate to providers; and to access drug history through paid patient claims.

6. Recipient access should include patient relevant pharmacy program information, access to appropriate drug information, access to available pharmacy locations within a specified radius of a given location and access to their pharmacy claims information.

7. The Contractor shall provide a real-time web based formulary search tool to view formulary information. This tool shall identify drug (generic or brand) availability by strength, formulation, co-payment, formulary status, quantity limits, formulary alternatives, other utilization management tools agreed upon by the parties, and requirement for prior authorization. The tool shall also provide links to prior authorization or other necessary prescriber forms.

8. All costs associated with the development and maintenance of these websites shall be borne by the Contractor and must be incorporated in the transaction fee.

9. The website shall provide an e-mail link to the Contractor to allow Medicaid recipients or other interested parties to e-mail inquiries or comments. This website shall also provide a link to the State's Medicaid website and these services shall be provided at no cost to the provider or recipients.

   a. Performance standards shall include but not be limited to: e-mail inquiries responded to within two (2) business days; new information posted within, one (1) business day of receipt of that information from the State; and routine website maintenance to ensure that all website content remains accurate no less than once per month.

10. The Contractor will provide reports to include but not be limited to: number of "hits' per month by provider/recipient; number and type of provider and recipient e-mail inquiries and requests; the turnaround time for all responses to e-mail inquiries: and website maintenance report to include a summary of any updates or other changes made and the date completed. The website and any associated electronic transmissions shall be secure and HIPAA compliant in order to protect Medicaid

recipient confidentiality and to protect against the exposure of protected health information. Access shall be limited to authorized and authenticated users via secure user logins and passwords. The Contractor is responsible for ensuring that the website and any component of the Contractor's solution meets the applicable privacy and security standards required for a component of the MMIS under Chapter 11 of the Centers for Medicare and Medicaid Services' (CMS) State Medicaid Manual, the Health Insurance Portability and Accountability Act (HIPAA), the American Recovery and Reinvestment Act (ARRA), and any other applicable State or Federal required standard for data security.

11. Contractor shall be responsible for all of the duties of program implementation and maintenance including any duties that may be the responsibility of any subcontractor.

B. Claims Requirements

Contractor shall be responsible for meeting the following claims requirements:

1. Accept and process POS, batch and paper claims;
2. Accept and process member submitted, home infusion and long-term care pharmacy claims;
3. Claims edits and audits consistent with State business logic including editing for PA's and Lock-in;
4. Prospective drug utilization review (ProDUR) edits;
5. Pricing consistent with State pricing, methodologies and any CMS updates;
6. Paid, denied, reversals and adjustments;
7. Coordination of benefits (TPL cost avoidance) including Medicare Parts A, B, C and D
8. Timely management of the Contractor's MAC list.
9. Timely and accurate claims processing that meets the requirements of the CMS State Medicaid Manual and the' Prompt Payment timely processing and reporting of clean claim requirements of the American Reinvestment and Recovery Act (ARRA) of 2009 throughout its timeframe and including any extensions.

C. Financial Processing and Provider Payment

Contractor shall meet the following standards and conditions:

1. Flexible financial and check cycle processing to support a biweekly financial cycle initially, but at the State's discretion, change to weekly processing, including warrant processing and fund code reporting;

2. Non-claim specific financial transactions capability including recoupments, payouts, voids, refunds and returned checks;
3. Flexible maintenance capability in support of assigning claims and financial transactions to State fund codes and associated appropriation account numbers; being able to add new fund codes at no additional cost to the State;
4. Transactions assigned to appropriate fund codes at the claim and financial transaction level based on State business logic, provide the Department with manual invoice within two (2) business days after last adjudicated date for the biweekly check cycle;
5. Complete funds transfer request based on invoice amount;
6. Reconciliation to assure data integrity claim and financial transaction levels;
7. Bank account management and provisions of monthly bank reconciliation statements;

a. The Contractor shall use Wells Fargo, or a mutually agreed upon successor, for the custodial bank account. The Contractor shall obtain approval from the Department prior to using any other bank or other financial institution for this purpose.

b. The Contractor shall be responsible for producing checks, printing remittance advices and mailing these documents to State approved payees.

c. The Contractor shall monitor the daily activities of the New Hampshire Medicaid Drug Payment Custodial Account to ensure that transactions are completed accurately and in compliance with generally accepted accounting principles (GAAP).

d. The Contractor shall monitor outstanding checks and contact payees to resolve issues regarding outstanding checks. At the direction of the Department, the Contractor shall stop payments and re-issue checks to payees.

e. Subject to the Department's review and approval of the manual invoice, the State shall make an Electronic Funds Transfer deposit into the New Hampshire Medicaid Drug Payment Custodial Account.

f. The Contractor shall prepare documentation and transfer funds to the State of New Hampshire, Department of Health and Human Services, Division of Medicaid Services so it may provide restitution of the federal share, through the CMS 64 filing, that is compliant with federal 42 C.F.R & 433.40, Treatment of uncashed, or cancelled (voided) Medicaid checks.

g. The Contractor shall provide monthly bank account management reports that meet GAAP. The reports shall include

bank statements for the custodial account and a bank reconciliation statement and a comprehensive listing of outstanding checks to date. In addition, the Contractor shall provide a monthly stale dated check report that includes check number, check amount, amount invoiced, batch date, date issued, payee identification number, payee name and payee address.

h. Generation of HIPAA compliant electronic remittance advice (RA);

i. Generation of checks or Electronic Funds Transfer (EFT) and mail checks with paper RA to providers;

j. Negative balance tracking and collection according to State policies;

k. Allocation of drug rebate collections across fund codes and counties based on claims paid;

l. Support electronic funds transfer (EFT), allowing providers to elect EFT or check payment; and

m. The capability to fiscally pend both administrative fees and claim payments at the request of the State.

D. Member Claims

The Contractor shall accept and process Member Claims submitted by the Department to reimburse individual recipients or other entities in cases of retroactive eligibility and administrative appeal. Member claims shall be submitted to the Contractor in a format mutually acceptable to the Contractor and the Department. The Contractor shall enter these claims into the processing system. Member claims shall be exempt from all system edits and audits except recipient eligibility; product coverage, and third party liability. Payment for Member Claims shall be made to the payee indicated on the claim form submitted by the Department at the Medicaid rate.

E. Fiscal Pend

The Contractor's PBM solution for the State shall include these components:

1. Provide the capability to select adjudicated claims and financial transactions, based on user-defined parameters for exclusion from payment during selected future financial cycles. This functionality is referred to as "fiscal pend", and is primarily used to delay disbursement of funds until a future date when funding becomes available or is used on a more limited basis for withholding payment to targeted providers pending further investigation;
2. Provide the capability for authorized users to set specific pend

criteria or combinations of parameters for a selected financial cycle, including at a minimum: provider number(s); provider type(s), fund code(s); number of days pended (to select older pended claims); and dollar limit(s), including zero (0) and unlimited dollars;

3. Provide the capability to define and set multiple combinations of parameters, to set the dollar cap for each combination including zero (0) and unlimited dollars, and to define the priority order of the various combinations for fiscal pend during the financial cycle. The dollar cap represents the maximum total payable limit allowed for transactions meeting the pend criteria for that financial cycle;

4. Provide the capability to include or exclude financial transactions from the pend for a particular financial cycle;

5. Perform a check for the existence of applicable fiscal pend criteria during each financial cycle and complete financial cycle processing accordingly, restricting payment processing to any pend limits established;

6. Provide the capability to report pended claims on a provider RA and include the capability to suppress reporting of pended transactions at the discretion of the State;

7. Maintain a complete date-sensitive audit trail of fiscal pend activity, including the pend criteria identified, the authorized user identification for each combination, and all reports run in support of fiscal pend;

8. Provide the requisite support and capability to run iterative preview reports, in advance of a financial cycle; to inform the State's contract manager regarding the need to fiscal pend and to inform the State of the final financial impact of the fiscal pend criteria on the financial cycle. These review reports mimic the financial cycle reports but are run during the pend process; and

9. Provide and maintain reporting and requisite operations support to validate the results of fiscal pend processing, to verify that pend and financial cycle processes have been completed with the integrity of the payment intact, and all inputs and outputs are accounted for and balance.

F. Custodial New Hampshire Medicaid Bank Account and Check Processing

Contractor shall provide cash management services for the Custodial New Hampshire Bank Account used for payment of drug claims. Check processing services include: creation of remittance advices (RA); printing of checks or creation of debits, mailing the RA with the check or transmitting an Electronic Remittance Advice (835) and resolution of outstanding checks including reporting and remitting to the State Treasury escheated funds. Financial reporting of bank account and check processing activity is required

that meets Generally Acceptable Accounting Principles (GAAP) and is approved by the State. The Contractor is responsible for responding to and resolving auditor inquiries and funding relative to the Contractor's custodial bank account and check processing activities. The State reserves the right to change its check processing services pending the implementation of the State's new MMIS claims processing system.

G. Financial Reconciliation

Contractor's efforts to support financial cycle reconciliation activities must be thorough and detailed. Such activities include the reconciliation and handling of errored transactions from the flow of claim and non-claim transaction processing through various control points, including claims entry, extract handling between components of the system, fund code assignment, financial processing, fund transfer invoicing, check generation, provider payment and provider remittance advice. The Contractor is required to conduct monthly bank account reconciliations and report to the State's contract manager.

H. Third Party Liability

1. The Contractor shall comply with the Department's stipulations for coordination of benefits. Through the POS system, Contractor shall ensure that the pharmacy shall pursue payment through other available coverage. Contractor shall capture any payment or denial of payment by the carrier of other coverage, along with any provided reason codes. The Contractor shall identify the carrier and the Department's carrier code, if known.
2. The Contractor must itemize at the claim level and report instances where the following occurred: third party insurers denied coverage for a person identified by the State as having third party coverage; third party insurers denied coverage for a person because the coverage allegedly was not in effect on the date of service; third party insurers paid a portion of a claim and Medicaid paid the balance; third party insurers denied coverage for a pharmaceutical because it is not a covered drug; and third party insurers denied coverage because the pharmacy/pharmaceutical provider is outside of the carrier's network.
    a. Reports shall be provided electronically. The specific content, format and file layout of each report will include, at a minimum, the recipient's name, Medicaid Identification Number (MID), Contractor's transaction number, date of service, reason for denial (if any), drug name, NDC#, prescription number, pharmacy name, pharmacy location, and pharmacy National Provider Identifier (NPI) number and any paid amount (if any).

The information must be provided in a format compatible with Microsoft Excel and Microsoft Access.

I. Auditing

1. General: The State reserves the right to audit any elements of the Contractor's program including claims processing and rebates and any function performed by subcontractors, including but not limited to the TPL subcontractor. The Contractor shall provide the Department with information sufficient for the Department to conduct its own independent audit of the pharmacy program.

a. SSAE-16, Statement on Standards for Attestation Engagements: The Contractor shall provide and bear the cost of an independent auditor (service auditor) to perform procedures that will supply the auditors for the State and/or the DHHS (user auditors) with information needed to obtain a sufficient understanding of the Contractor (service organization), internal controls over services provided to DHHS, to plan their audit for DHHS and the State. Contractor's selection of the independent auditors shall be subject to the prior written approval of DHHS. The audit procedures and reports are to be completed in accordance with guidance provided in the SSAE-16, as issued by the American Institute of Certificate Public Accountants. The independent auditor is required to complete a SSAE-16 (SOC-1) Audit that includes the service organization's description of controls, and detailed testing of the service organization's controls over a minimum of six (6) month period. The SSAE-16 audit much be completed for each year of the Contract period. The SSAE-16 Audit shall be provided to the State's Contract Manager. The minimum contents of the SSAE-16 Audit are as follows: The independent auditor will perform on-site fieldwork to test system controls each quarter during the audit period.

b. The service organization's description of the controls that may be relevant to DHHS internal control as it relates to the audit of the State's financial statements.

c. The service auditor's opinion on whether the description presents fairly, in all material respects, the relevant aspects of the service organization's controls that had been placed in operation during the fiscal year.

d. The service auditor's opinion on whether such controls were suitably designed to provide reasonable assurance that the specified control objective would be achieved if those controls were complied with satisfactorily.

e. A description of the service auditor's tests of controls and its opinion on whether the controls that were tested were operating with sufficient effectiveness to provide reasonable assurance that the related control objectives were achieved during the fiscal year.

f. The service auditor's procedures shall include, but are not necessarily limited to the following:

i. Information on the description of controls for the report through discussions with appropriate service organization's personnel, through reference to various forms of documentation, such as system flow charts and narratives and through the performance of tests of controls;
ii. A determination of whether the description provides sufficient information for auditors to obtain an understanding of those aspects of the service organization's controls that may be relevant to DHHS internal control;
iii. The control environment, such as hiring practices, key areas of authority, etc.;
iv. Risk assessment, such as those associated with processing specific transactions;
v. Control activities, such as procedures on modifications to software;
vi. Communications, such as the way user transactions are initiated;
vii. Control monitoring, such as involvement of internal auditors;
viii. Evidence of whether controls have been placed in operation;
ix. Inquiry of appropriate service organization management and staff;
x. Inspection of service organization documents and records;
xi. Observation of service organization activities and operations;
xii. Testing controls to determine that the service organization is operating with sufficient effectiveness to provide reasonable assurance that the related control objectives were achieved during the fiscal year; and
xiii. Determine that significant changes in the service organization's controls that may have occurred before the beginning of fieldwork are included in the service organization's description of the controls.

J. Medicaid Omnibus Budget Reconciliation Act 1990 (OBRA 90) Rebates, and Supplemental Rebates

1. All Medicaid drug rebates processed by the Contractor shall be paid to the State. The Contractor shall not retain any portion of the

rebates. The Contractor shall abide by three separate sets of requirements. Medicaid (OBRA '90) Rebate requirements, PDL requirements and State Supplemental Rebate requirements for all Medicaid pharmacy claims inclusive of both fee-for-services and managed care.

2. Medicaid (OBRA '90) Requirements:

a. Contractor shall implement all accounting functions that are part of the drug rebate program including, but not limited to, preparing and submitting manufacturer invoices quarterly. Financial reporting of drug rebate activities that complies with GAAP is required. These reports are to include but not be limited to: accounts receivable aging reports; dunning letters and reports; prior period adjustment reports; and outstanding accounts receivable.

b. The Contractor is responsible for establishing audit trails and internal controls for all drug rebate activities. Invoices shall include the following data as required by CMS guidelines: National Drug Code (NDC), drug name; CMS unit, unit rebate amount, total units reimbursed; total amount claimed; number of prescriptions; total reimbursed amount; correction record flag; TPL prescriptions and TPL payment amount.

c. The Contractor shall invoice based on the date of payment. The State's invoices shall be issued within sixty (60) calendar days after the close of each rebate period for Medicaid beneficiaries.

d. Dunning letters shall be mailed for accounts in arrears ninety (90) calendar days or greater.

e. Contractor shall maintain quarterly unit rebate amount data supplied by CMS from 1991 forward.

f. Contractor shall maintain an accounting procedure for prior period adjustments for manufacturers.

g. Contractor shall be capable of and shall calculate interest due on overdue payments per CMS guidelines.

h. The pharmacies shall be allowed to submit claims for obsolete NDC's for two (2) years post obsolete data to allow for its shelf life. After two (2) years from the obsolete date have passed, pharmacies shall receive an on-line message indicating denial is due to "NDC obsolete".

i. If a claim is reversed after invoicing a manufacturer for the rebate, the State staff shall be able to see all transactions, including but not limited to: the initial payment, the reversal, and the possible subsequent re-bill.

j. Contractor shall perform quarterly posting of the reconciliation of the State's invoice from manufacturers and transmit reports of payment receipts.

k. Contractor shall perform posting of the prior quarter adjustment statement.

l. Contractor shall provide all appropriate quarterly and annual reporting to CMS, in both electronic and paper form.

m. Contractor shall implement all dispute resolution functions that are part of the drug rebate program, including but not limited to researching and resolving discrepancies between the State and manufacturer records.

n. Contractor shall respond to any CMS change in requirements in a reasonable time frame.

o. Contractor shall maintain claims paid and rebates collected and shall report the distribution across counties by fund code on a quarterly basis.

3. Medicaid Supplemental Manufacturer Rebate Requirements:

a. The Contractor shall be required to: report the rebate recovery per NDC; conduct monthly reconciliation of rebates collected by the State and will allocate all rebate monies to the correct NDC and labeler. The State shall report to the Contractor the rebate amounts collected. One hundred percent (100%) of the rebates collected belong to the State.

b. Contractor shall invoice for rebates based on the date of payment. The State's invoices shall be issued within sixty (60) calendar days after the close of each rebate period for Medicaid beneficiaries.

K. NMPI:

1. At the option of the Department, which may be exercised no less often than annually, the Contractor shall negotiate Medicaid Supplemental rebates with pharmaceutical manufactures on behalf of fee for service and Medicaid managed care populations, conduct supplemental rebate analysis and, at the direction of the Department submit PDL classes to DUR Board for review and approval.

L. Analysis and Reporting

1. The Contractor shall provide a Reporting Specialist dedicated 70% to DMS who shall be located within 120 minutes of Concord, NH.

2. The Contractor shall provide standard reports monthly, which shall include:

a. Accounts payable;

b. Claim payment reports;

c. RA Reports in both hard copy and electronic formats;

d. Rebate reports including, at a minimum, the Federal 64.9R and County Rebate Reimbursement Report and Supplemental Rebate Reports;

e. Management and utilization reports. Reports shall

compare utilization and other trends between and among the various Medicaid programs and private sector organizations;

f. Notification of System Disruption Reports to be e-mailed to designated state and Contractor employees. Each report shall identify: issue; status (problem identified, resolution being developed, resolution being implemented, problem resolved); person responsible for resolution; date and time; description; impact; resolution; use of contingency plan; date and time contingency plan invoked; comments;

g. Cost savings reports;

h. Claims history reports;

3. Additional reporting requirements: Contractor shall provide electronically a complete package of management and utilization reports that shall be mutually agreed upon by the State and the Contractor. The State shall work with the Contractor to develop subpopulation categories, including but not limited to, long term care (LTC) and TPL, for reporting.

a. Monthly reporting requirements are as follows:

i. Total number of approved or denied claims;
ii. Total number of claims and associated dollars by eligibility type;
iii. Total number of PA requests;
iv. Total number of PA approved;
v. Total number of PA denied;
vi. Total number of PA renewal requests;
vii. By each initiative (i.e. PA, Quantity Limits, State MAC, etc.);
viii. Benchmark relative to industry;
ix. Annualized savings per drug category;
x. Total dollar amount of claims by eligibility type;
xi. Top ten reasons for denial;
xii. Generic substitution rate;
xiii. Generic dispensing rate;
xiv. Average time and range for adjudication of claims by mode of processing;
xv. Average time and range for PA approvals and denials;
xvi. Number of seventy-two (72) hour overrides;
xvii. Number of PA not resolved within 24 hours;
xviii. Reasons for PA resolved in greater than 24 hours;
xix. Cost savings for each PBM initiative;
xx. Administrative cost by initiative for PBM program;
xxi. Analysis of cost shifting;
xxii. Volume of claims paid for preferred drugs vs. non-preferred drugs;
xxiii. PA as a percent of total claims;

xxiv. Lock in program;
xxv. MCO Compliance with State PDL; and
xxvi. Any other reports referred through the RFP.

b. Annual reporting requirements:
i. Report indicating State expenditures are, in aggregate, at or below the FUL prices annually as required by federal regulations;
ii. Summary data including but not limited to, an overview of clinical impact including an analysis of any unintended or adverse clinical consequences that occurred as a result of any pharmacy initiatives, annualized savings and basis for savings, performance standards experience, a recitation of the prior year's accomplishments and recommendations for new opportunities to improve pharmacy management, save money, or improve beneficiary clinical care. This report shall be due no later than thirty (30) calendar days after the end of each State Fiscal Year.

c. Contractor shall provide access to Contractor's operational data store, for on-line, ad hoc and administrative reporting and tracking, no later than three (3) months prior to program launch. Training and support throughout the contract period shall be provided for up to five (5) employees, designated by the State, in the use of this software. The software shall be compatible with the State's internal system requirements and shall afford State employees the opportunity to query Contractor claim files through the use of parameter values such as, but not limited to, Medicaid Identification (MID), date span, provider identification number, and NDC. Any costs for establishing connectivity between the Department and the Contractor and Contractor's Department-authorized sub-contractors, if any, shall be borne by the Contractor.

d. The Contractor shall provide ad hoc reports needed for legislative compliance, as required.

e. The Contractor shall provide up to three (3) reports per quarter or twelve (12) reports per year that require advanced technical assistance ad hoc reporting for which modification cost shall not be assessed.

f. The Contractor's system shall provide data and reports that shall comply with all Federal and State Medicaid reporting requirements as requested by the State.

M. Medicaid Drug Coverage Management

1. Contractor shall administer the drug coverage program with the

approval of the Department and in accordance with the statutes and administrative rules of the State of New Hampshire. The pharmaceutical services rule includes provisions for covered and non-covered drugs, prior authorization requirements, the pharmacy lock-in program, certification of prescriptions and dispensing limitations. Contractor shall do the following:

a. Implement the drug coverage parameters established by DHHS with input from the Contractor;

b. Assign a Clinical Manager who shall be responsible for daily oversight of drug coverage parameters, all clinical programs and the provider network and interfaces with the Drug Use Review (DUR) Board;

c. The Clinical Manager shall attend each DUR Board meeting and present the Board with a written report containing the following information:

d. Recommendations for additions or changes in drug coverage and PA, dispensing limitations, generic substitution protocols, and other relevant or innovative suggestions to improve the clinical use of medications for Medicaid recipients.

e. Provide supportive evidence-based clinical research, documentation, financial impact analysis, and recommendations for newly approved therapies and indications to the Committee for consideration.

f. Contractor shall update its drug prices and other supporting drug data on a weekly basis using a recognized Contractor. Current coverage is keyed by FDB's generic sequence number (GSN) and the NDC.

g. The Contractor shall provide the State the ability to review and approve changes in NDC's or GSN's supporting data on a weekly basis, including: changes to Specific Therapeutic Drug Class, GSN or Drug Form, which is an exception report now generated by FDB to assure valid drug coverage; and reports of new generic sequence numbers added to FDB file, which is generated weekly and taken to Pharmacy Services for consideration and inclusion into the Medicaid Drug List.

N. Drug Utilization Review (DUR)

1. The Contractor shall perform Drug Utilization Review as defined by the RFP, to include ProDUR, Concurrent DUR, RetroDUR, and educational programs.

2. The Contractor shall provide a clinical manager (RPh or PharmD 70% dedicated to the NH Medicaid program) to coordinate with State DUR Board. The Contractor shall present an annual DUR plan to the Department and DUR Board including a profile of all

proposed DUR programs and dates for execution, as well as expert advice regarding standards for pharmacist counseling of beneficiaries or other means of improved clinical utilization review.

3. The Contractor shall prepare and provide the documentation for the annual DUR report for both the Department and CMS as mandated by CMS. The annual report shall include a description of the DUR activities (part of annual clinical plan), scope and nature of the ProDUR and RetroDUR programs, a summary of the interventions used, and an assessment of the impact of the interventions used, and an assessment of the impact of these interventions on the quality of care and an estimate of the cost savings generated as a result. The report shall also compare the current Medicaid results to the industry benchmarks including other Medicaid or private sector programs.

4. The Contractor shall attend each DUR Board meeting and present a written report to the DUR board, including meeting minutes and additionally containing the following information: based on pharmacy claims, present at least one (1) top therapeutic class and top five (5) high growth therapeutic classes, their current DUR protocol and recommendations for additions or changes in the DUR program; provide educational materials including supportive clinical research, protocols and financial analysis for newly approved therapies and indications to the DUR Board for consideration. Upon approval, this information shall be included as part of the ProDUR and RetroDUR program to targeted physicians.

5. The Contractor's DUR programs must evaluate drug use patterns among physicians, pharmacists and beneficiaries, and those associated with specific drugs or groups of drugs. DUR accesses data on drug use by comparing it to predetermined standards, consistent with evidence-based and peer-reviewed literature and the recommendations of the State DUR Board. Contractor is responsible for all costs involving travel for meeting attendance and provider education The Contractor's assessment shall include, but shall not be limited to:

a. Monitoring for therapeutic appropriateness;
b. Over-utilization and under-utilization;
c. Appropriate use of generic products;
d. Therapeutic duplication;
e. Drug-disease contraindications;
f. Drug-drug interactions;
g. Drug-age contraindications;
h. Drug-pregnancy contraindications;
i. Incorrect drug dosage or duration of drug treatment;
j. Clinical abuse/misuse.

O. ProDUR

1. The Contractor shall provide a ProDUR process that is linked to the electronic claims management network, so as to furnish medical and drug history information for each beneficiary. This process shall be subject to the review and recommendation of the DUR Board. This process shall have the flexibility to adjust to changes in criteria or procedures as recommended by the DUR Board.
2. Concurrent DUR the Concurrent DUR system shall have the following minimum capabilities: a table with days' supply limits by drug; quantity limits by drug; a dual-tracking system for early refills that tracks both current and cumulative usage; age and gender edits; and triggers for intervention regarding compliance and persistency gaps.
3. RetroDUR
   a. The Contractor shall analyze pharmacy and non-pharmacy claims on an ongoing basis and present recommendations quarterly for additions or changes to the RetroDUR programs and interventions. The State shall provide non-pharmacy claims data from its MMIS application. The proposed DUR programs shall address high risk, high cost and high utilization drug therapies and shall tie to the top drugs or disease states.
   b. The program shall routinely assess data on drug use against explicit predetermined standards including but not limited to monitoring for therapeutic appropriateness, over-utilization and under-utilization, incorrect drug dosage, or duration of drug treatment and clinical abuse, misuse and introduce remedial strategies to improve the quality of care and to assure the appropriate utilization of program funds.
   c. The RetroDUR program shall provide ongoing interventions for physicians and pharmacists targeted toward therapy problems or beneficiaries identified in the course of RetroDUR activities.
   d. The RetroDUR program shall include written, oral or electronic reminders containing beneficiary-specific or drug-specific information and suggested changes in prescribing or dispensing practices, communicated in a manner designed to ensure the privacy of beneficiary-related information.
   e. The Contractor's process shall include an evaluation of interventions to determine if the interventions improved the quality of drug therapy or improve appropriate utilization. The Contractor shall evaluate the success of interventions and make modifications as necessary. The criteria used to evaluate the success of the interventions shall include: changes in utilization patterns; decrease or elimination of opportunities to continue to

perform a given intervention; impact on costs, either to the Medicaid program or beneficiaries; and any unexpected or adverse clinical outcomes.

4. Additional DUR Activities

a. The Contractor shall provide educational materials including supportive evidence based and peer reviewed clinical research, protocols and financial analyses for newly approved therapies and indications to the DUR Board for consideration.

b. The DUR Program shall integrate with edits (POS, batch or paper claims processing) and provide communications and education to pharmacies that are not appropriately complying with these edits.

P. Utilization Management

1. The Contractor shall provide a dedicated Clinical Manager who shall be responsible for daily oversight of the PDL program and provide clinical review and analysis of beneficiaries, physicians and pharmacists, with guidance and recommendations to DMS. The Clinical Manager shall maintain the clinical integrity of the POL so that recommended therapeutic classes and preferred drugs accurately reflect evidence-based drug use.

2. The Clinical Manager shall educate and support providers on the efficient and accurate use of the Medicaid pharmacy benefits program to promote appropriate drug utilization by Medicaid providers. The Clinical Manger will also conduct periodic utilization management provider contact as needed. All travel costs associated with provider education shall be Contractor's responsibility. The Contractor's Clinical Manager shall coordinate with the Department, which shall be responsible for approving all UM programs.

3. The Contractor shall analyze claims and present recommendations for utilization management programs to the Department on a monthly basis. The proposed UM program shall include review of both high risk and high cost/utilization therapies for integration with PA, POS edits, and DUR programs or other UM strategies.

4. The Contractor shall consider UM strategies that are the least administratively burdensome to prescribers, in accordance with federal law 42USC1396a(a)(19).

5. The Contractor shall, to the fullest extent possible, use evidence based and peer reviewed literature to support discussions regarding rational drug therapy and the decision to focus on the selected prescribers and pharmacies that have been targeted for UM.

6. UM shall include written, oral or electronic (fax, e-mail, or web-based) reminders and other interventions containing information to improve UM and suggest changes in prescribing or dispensing

practices, communicated in a manner designed to ensure the privacy of recipient-related information.

Q. Prior Authorization

1. The Contractor shall have a prior authorization (PA) program.
2. The Contractor shall provide a secure Internet based physician access to recipient drug history.
3. Contractor shall allow providers the ability to submit PA information via the secure Internet portal.
4. The Contractor shall allow for automated approval of all PA requests submitted via the secure Internet portal.
5. The Contractor shall provide a secure Internet portal for the application of full electronic prescribing and the ability to auto adjudicate PA against clinical criteria and/or other UM tools in real time. Any transaction fees associated with electronic submissions must be included in the cost per transaction.
6. The Contractor shall provide regular reporting to the Department to summarize PA activity on a monthly basis.

R. Specialty Pharmacy

1. Contractor shall establish a specialty pharmacy program that ensures that Medicaid beneficiaries have access to specialty pharmaceuticals. The Specialty Pharmacy Services program shall address the use of high-cost injectable, infused, oral or inhaled drugs that are generally more complex to distribute, administer and monitor than traditional drugs.
2. The Contractor may provide specialty pharmaceuticals through a specialty pharmacy, either owned or subcontracted.
3. The Contractor shall operate the Specialty Pharmacy program in a way that maximizes the extent to which Medicaid beneficiaries obtain specialty pharmaceuticals from the specialty pharmacy rather than from retail pharmacies or physician offices.
4. The Contractor shall provide a dedicated toll free number for Medicaid beneficiaries and providers to call for assistance relating to specialty pharmaceuticals and services.
5. The Contractor shall provide specialty pharmacy services in conjunction with the specialty pharmaceuticals it provides through the specialty pharmacy for Medicaid beneficiaries who have agreed to receive specialty pharmacy services.
6. The Contractor shall document and report to the State no less than quarterly the specialty pharmacy services provided.
7. Specialty Pharmacy services shall include, but not be limited to, the following:
    a. Consultations and communications with prescribing

providers and educating beneficiaries regarding specialty pharmaceuticals in a manner that optimizes therapeutic outcomes;

b. Minimizes unnecessary and/or inappropriate use;

c. Maximizes beneficiary compliance with prescribed drug regimens;

d. Minimizes waste;

e. Minimizes adverse clinical events; and

f. Achieves a high level of Medicaid beneficiaries' satisfaction.

g. Maximizes the state and federal fiscal resources.

8. The following is a list of conditions with pharmaceuticals subject to the Specialty Pharmacy Services:

a. Self-administered;
   i. Rheumatoid arthritis;
   ii. Psoriasis;
   iii. Multiple Sclerosis;
   iv. Growth disorders;
   v. Hepatitis C;
   vi. Hematopoietics;
   vii. HIV wasting;
   viii. Other as mutually agreed upon.

b. Office-Administered:
   i. Muscular sclerosis;
   ii. Rheumatoid arthritis;
   iii. Psoriasis;
   iv. Respiratory syncytial virus;
   v. Primary pulmonary hypertension;
   vi. Hemophilia;
   vii. Immune disorders;
   viii. Miscellaneous such as: interferon, botulinum toxin, imiglucerase, levprolide, amalizumab and goserlin;
   ix. Other as mutually agreed upon.

S. E-Prescribing

1. The State requires that the Contractor participate fully in e-prescribing and enable the prescriber to participate fully as well in a system that shall be fully automated and an integral part of the POS and ProDUR.

2. Contractor shall ensure that all electronically submitted prescriptions are compliant with any existing pharmacy service utilization management programs, including but not limited to PA, PDL and quantity limits.

3. The Contractor shall ensure that the e-prescribing program has

the ability to support and perform real time eligibility verifications.

T. Recipient and Provider Telephone Support

1. The Contractor shall provide toll-free telephone support for providers, recipients, state employees, and representatives.
2. Contractor shall provide all required information systems, telecommunications, and personnel to perform these operations. The telephone system shall be appropriately staffed with positions such as a manager, team leaders, and hotline representatives, all of whom shall be extensively trained.
3. At a minimum, customer service activities shall include:
   a. A toll free number(s) for beneficiaries, prescribers, and pharmacists with touch-tone routing to respond to requests for pharmacy locations, inquiries on claims, assistance with accessing the web site including password/PIN management, and complaints about prescriber or pharmacist practices or services. Voice response unit use is allowed, however, immediate one touch access to a live operator is required during normal business hours; and
   b. For prescribers, access to an on-call pharmacist consultant and technical assistance twenty-four (24) hours per day x 7 days x 365 days.
4. Contractor's telephone staff shall have complete on-line access to all computer files and databases that support the system for applicable pharmacy programs.
5. The Contractor's telephone staff shall log and categorize all incoming and outgoing telephone calls with clients, prescribers, other providers and pharmacists. This data shall be made available routinely in an aggregated format to the State on a monthly, quarterly and annual basis and daily or weekly (if needed) after a sensitive addition or change to the Medicaid pharmacy program. The Contractor's telephone services shall provide sufficient telecommunications capacity to meet the State's needs with acceptable call completion and abandonment rates. It shall be scalable to future demand. It shall also possess an advanced telephone system that provides the State with an extensive management tracking and reporting capabilities. A quality assurance program shall be in place that samples calls and follows up to confirm efficient handling and caller satisfaction.
6. For PA purposes, the Contractor shall maintain toll-free telephone access (available for in-state and out of state providers). Contractor must have telephone services staffed no less than from 8:00 AM through 9:00 PM, Eastern Time.
7. Contractor shall have professional (licensed) medical and

pharmacological advisory staff and other resources necessary to provide pharmacists at the POS, and prescribers during the prescribing process, with advice pertaining to the proper use of prescription drugs, consistent with ProDUR and other medical standards, as they apply to each recipient's unique needs and medical conditions.

8. Contractor shall produce reports on usage of the telephone service(s), including number of inquiries, types of inquiries, average speed to answer, abandonment rates, blocked call rates and timeliness of responses.

9. The Contractor's process shall allow beneficiaries to locate nearby pharmacies for special situations, such as twenty-four (24) hour pharmacies or those dispensing compounded drugs, etc.

10. Contractor shall provide additional, secured web-based communications in accordance with the specifications set forth in Systems Capability and Performance Standards set forth above.

U. Provider Network and External Stakeholders

1. The State shall continue to enroll and credential its Medicaid pharmacy provider network. The Contractor shall provide the following services in support of the State's efforts:

a. Provider eligibility verification;

b. Maintaining a history of eligible providers;

c. Communicating with the network via US mail, e-mail, fax or other modes of communication regarding State approved operating manuals, routine updates and special memos; and

d. Provider outreach and education to include provider profiling, education visits and other communications and provider customer service.

e. The Contractor shall maintain working and contractual relations with pharmaceutical manufacturers.

f. The Contractor shall assist the Department in maintaining strong working relations with professional pharmacy association such as New Hampshire Pharmacists Association (NHPA) and the National Association of Chain Drug Stores (NACDS) in order to achieve an effective and efficient PBM program.

g. The Contractor shall cooperate with the Department's Fiscal Agent in order to achieve an effective and efficient PBM program.

h. The Contractor shall respond to provider billing questions/problems received by telephone within twenty-four (24) hours and use reasonable efforts to resolve them within twenty (20) business days.

i. The Contractor shall respond to all written inquiries within five (5) days of receipt and use reasonable efforts to resolve them within twenty (20) business days.

V. Staffing Requirements

1. The Contractor shall, provide two (2) staff members located within 120 minutes of Concord, New Hampshire; one 70% FTE Clinical Manager and one 70% FTE Reporting Specialist. The Contractor shall provide a Clinical Manager (Registered Pharmacist or Doctor of Pharmacy) with at least five (5) years clinical experience, prior public sector experience with a preference for Medicaid experience and, at a minimum, two (2) years of clinical pharmacy management experience.
2. The Contractor shall provide a Reporting Specialist familiar with pharmacy data management and reporting and with a minimum of two (2) years' experience in the pharmacy industry.
3. The Contractor shall solicit feedback from the Department on candidates for Clinical Manager and Reporting Specialist and obtain approval prior to hiring or deploying these individuals.
4. The Contractor shall provide an Account Manager, through its central office, who will be available five (5) days per week, and dedicated to the State at minimum, 25% of a full time equivalent. The Account Manager must have the ability to travel to Concord, NH, when necessary. The Account Manager shall have a pharmacy degree, either Bachelor of Pharmacy or Doctor of Pharmacy; or a Master of Business Administration degree, five (5) years of pharmacy related experience, is knowledgeable in state government affairs, and have prior Medicaid experience working with a Medicaid program.

W. MMIS Federal Certification

1. The Contractor's PBM system including all of its components delivered to satisfy the requirements of this contract shall meet all applicable requirements to achieve federal MMIS certification from the Centers for Medicare and Medicaid Services. The Contractor shall assist the State with preparing for and achieving timely federal certification and shall make system modifications or corrections requisite for achieving timely certification.

X. Innovation

1. Contractor shall provide the following program innovations which are described in detail in Exhibit A2, at section 3.25, page 74 and in Addendum 7:
   a. Enhanced MAC Program to include specialty pharmacy

products/specialty MAC;
b. Use of interactive voice response (IVR) PA;
c. Denied PA follow-up;
d. Web claim submission/web-based remittance advices;
e. Diabetic supply procurement program; and
f. Distribution Services surrounding hemophilia factor (part of proposal, section 3.19, page 67).

Y. Performance Bond and Insurance

The Contractor shall furnish a performance bond satisfactory to the State in an amount of one million dollars ($1,000,000) as security for the faithful performance of the Contract. The bond furnished by the Contractor shall incorporate by reference the terms of the Contract as fully as though they were set forth verbatim in such bonds. In the event the Contract is amended, the penal sum of the performance bond shall be increased by like amount.

Z. Department Contract Officer

The DMS shall designate a Contract Officer who shall be the State's representative with regard to contract administration and who will have authority to act on behalf of the DMS in regard to authorizing modifications, maintenance requests, resolving staffing issues, or other contractual responsibilities. This person shall be:

Name: Margaret Clifford, R.Ph.
Title: Medicaid Pharmacy Director
Mailing Address: Division of Medicaid Services
Department of Health and Human Services
129 Pleasant Street, Concord, NH 03301-3857
Telephone: (603) 271-9098
Fax: (603) 271-8431
Email: margaret.clifford@dhhs.nh.gov or a designated successor.

Scope of Services for for Pharmacy Benefits Management System for AIDS Drug Assistance Program (ADAP)

I. OVERVIEW

The Contractor shall be responsible for the maintenance of the NH AIDS Drug Assistance Program (ADAP) Pharmacy Benefits Management (PBM) system and shall act as the State's Fiscal Agent for these Services. The Contractor shall provide all of the system's functional components and requirements, including Services and deliverables, outlined within this contract.

The NH AIDS Drug Assistance Program (ADAP) is funded primarily by the federal Ryan White Program, administered by the Health Resources and Services Administration. The Ryan White Treatment Extension Act of 2009 allocates funding to states to provide core medical and support Services to persons living with HIV within their state, titled Ryan White Part B (RWPB). The largest funded service category is ADAP, which provides lifesaving medications to eligible HIV+ NH residents.

AA. Claims Requirements

The Contractor shall be responsible for meeting the following claims requirements:

1. Accept and process Point Of Sale, batched and paper claims;
2. Accept and process member submitted, home infusion and long-term care pharmacy claims;
3. Perform claims edits and audits consistent with NH ADAP business logic including editing for PA's;
4. Perform Prospective Drug Utilization Review (ProDUR) edits; The Contractor shall conduct claims edits in the POS system to support ADAP in the detection of fraud and abuse. ProDUR shall include edits such early refill, duplicate therapy, incorrect days supply, patient's gender incorrect, and incorrect date of birth;
5. Implement pricing consistent with State pricing methodologies and any CMS updates;
6. Coordinate with all other benefits (TPL cost avoidance) including NH Medicaid, Medicare Parts A, B, and D and any other private insurance coverage applicable;
7. Deliver timely management of the Contractor's MAC list;
8. Reimburse mail order pharmacies;

The Contractor must provide a description, including applicable screen shots, as to how the PBM System solution meets or exceeds the technical and system processing requirements and capabilities as listed below. The Contractor shall describe their capability for maintaining all items and sub-items listed below.

1. Management of Recipient Eligibility and Enrollment History and maintenance of eligibility data
2. Data Maintenance and Updates for eligible Providers
3. Eligibility Verification
4. Weekly Reference File Updates, e.g. First Data Bank (FDB)
5. Prior Authorization Tracking, Support and Management
6. Claims and Financial Requirements
7. Management of other third party insurance data

BB. Systems Capability and Performance Standards

1. System Availability and Access

The Contractor shall ensure the following system availability and access:

- Twenty four hours per day, seven days per week, r three hundred and sixty five days per year, except for scheduled maintenance
- Provider Network Connectivity
- Documented scheduled down time and maintenance windows
- ADAP on-line access to all components of the system
- Documented instructions and user manuals for each component
- Secure Access

2. Systems Operations Support

- Twenty four hours per day, seven days per week, three hundred and sixty five days per year operating support, except for scheduled maintenance
- User Acceptance Testing (UAT)
- On-Call procedures and contacts
- Job Scheduling and failure notification documentation
- Secure data transmission methodology
- Error reporting
- Technical Issue Escalation Procedures
- Business and Customer Notification
- Change Control Management
- Assistance with User Acceptance Testing and implementation coordination
- Documented interface specifications – data imported and extracts exported
- Disaster Recovery Plan

3. Automated Data Files and Interfaces

The NH ADAP shall send to the Contractor all of the files (with periodicity noted) below.

- Third Party Liability (TPL) Extract to the Contractor (Daily)
- Provider Extract to the Contractor – Pharmacy Only (Daily)
- Recipient Eligibility Extract to The Contractor (Daily)
- Recipient Refresh Data Extract to the Contractor (Monthly) Contractor must be able to receive periodic updates to the entire client file. ADAP shall provide to the Contractor an entire updated client data file in the format described earlier. Each update shall replace the previous file and Contractor shall accomplish installation of the updated file within 72 hours of its receipt
- Processing and exchange of files with CMS and ADAP per Data Sharing Agreement (DSA).

The Contractor shall send to the NH ADAP all of the files (with periodicity noted) below.

- Paid, Voided, Denied Drug Claims Processed (Biweekly or as scheduled following the financial cycle) the Contractor must provide to ADAP drug purchase transaction data via a secure electronic medium monthly. The timing of this shall be: data from the 1st day to the last day of the month is due by the 15th day of the following month. The Contractor must provide all the transactions for the invoice electronically and must be received within the same period as previously listed above.
- HIPAA compliant EDI transaction files- incoming and outgoing
- CMS data files for reconciliation of Medicare eligibility data.

4. Pharmacy Web Access

- The Contractor shall create web access for NH ADAP to access general program information with contact information as defined by NH ADAP program.
- An e-mail link that shall allow NH ADAP clients or other interested parties to e-mail inquiries or comments. This website shall also provide a link to the State's ADAP website and these Services shall be provided at no cost to the Provider or recipients.

The website and any associated electronic transmissions shall be secure and HIPAA compliant in order to protect ADAP client confidentiality and to protect against the exposure of protected health information. The Contractor is responsible for ensuring that the website and any component of the Contractor's solution meets the applicable privacy and security standards required by the Health Insurance Portability and

Accountability Act (HIPAA) and any other applicable State or Federal required standard for data security.

CC. Financial Processing and Provider Payment

The Contractor shall meet the following requirements for:

1. Flexible maintenance capability in support of assigning claims and financial transactions to State fund codes and associated appropriation account numbers; being able to add new fund codes at no additional cost to the NH ADAP;
2. Flexible financial and check cycle processing to support a biweekly financial cycle initially, but at the State's discretion change to weekly processing, including warrant processing and fund code reporting.
3. Transactions assigned to appropriate fund codes at the claim and financial transaction level based on State business logic, provide the NH ADAP with manual invoice within two (2) business days after last adjudicated date for the biweekly check cycle; Non-claim specific financial transactions capability including recoupments, payouts, voids, refunds, returned checks
4. Complete funds transfer request based on invoice amount;
5. Reconciliation to assure data integrity claim and financial transaction levels;
6. Bank account management and provisions of monthly bank reconciliation statements;
7. Generation of HIPAA compliant electronic RA and also a paper RA for Providers
8. The Contractor shall use a designated custodial bank account. The Contractor shall obtain approval from the NH ADAP prior to using any other bank or other financial institution for this purpose.
    a. The Contractor shall be responsible for producing checks, printing remittance advices and mailing these documents to State approved payees.
    b. The Contractor shall monitor the daily activities of the New Hampshire ADAP Drug Payment Custodial Account to ensure that transactions are completed accurately and in compliance with generally accepted accounting principles (GAAP).
    c. The Contractor shall monitor outstanding checks and contact payees to resolve issues regarding outstanding checks. At the direction of the NH ADAP, The Contractor shall stop payments and re-issue checks to payees.
    d. The Contractor shall provide the NH ADAP with a manual invoice for the bi-weekly check cycle. Subject to NH ADAP review and approval of the manual invoice, the State shall make an Electronic Funds Transfer deposit into the New Hampshire ADAP Drug Payment Custodial Account or any subsequent accounts as approved by the NH ADAP.
    e. The Contractor shall provide monthly bank account management

reports that meet GAAP. The reports shall include bank statements for the custodial account and a bank reconciliation statement and a comprehensive listing of outstanding checks to date. In addition, The Contractor shall provide a monthly stale dated check report that includes check number, check amount, amount invoiced, batch date, date issued, payee identification number, payee name and payee address.

9. Negative balance tracking and collection according to State policies
10. Support Electronic Funds Transfer (EFT), allowing Providers to elect EFT or check payment
11. The capability to fiscally pend both administrative fees and claim payment at the request of ADAP.

DD. Fiscal Pend

The Contractor's PBM solution for NH ADAP shall include these components:

1. Provide the capability to select adjudicated claims and financial transactions, based on user-defined parameters for exclusion from payment during selected future financial cycles. This functionality is referred to as "fiscal pend", and is primarily used to delay disbursement of funds until a future date when funding becomes available or is used on a more limited basis for withholding payment to targeted Providers pending further investigation;

2. Provide the capability for authorized users to set specific pend criteria or combinations of parameters for a selected financial cycle, including at a minimum: Provider number; Provider type, fund code; number of days pended (to select older pended claims); and dollar limit, including zero (0) and unlimited dollars;
3. Provide the capability to define and set multiple combinations of parameters, to set the dollar cap for each combination including zero (0) and unlimited dollars, and to define the priority order of the various combinations for fiscal pend during the financial cycle. The dollar cap represents the maximum total payable limit allowed for transactions meeting the pend criteria for that financial cycle;
4. Provide the capability to include or exclude financial transactions from the pend for a particular financial cycle;
5. Perform a check for the existence of applicable fiscal pend criteria during each financial cycle and complete financial cycle processing accordingly, restricting payment processing to any pend limits established;
6. Provide the capability to report pended claims on a Provider RA and include the capability to suppress reporting of pended transactions at the discretion of the State;
7. Maintain a complete date-sensitive audit trail of fiscal pend activity,

including the pend criteria identified, the authorized user identification for each combination, and all reports run in support of fiscal pend;

8. Provide the requisite support and capability to run iterative preview reports, in advance of a financial cycle; to inform the NH ADAP contract manager regarding the need to fiscal pend and to inform the NH ADAP of the final financial impact of the fiscal pend criteria on the financial cycle. These review reports mimic the financial cycle reports but are run during the pend process; and

9. Provide and maintain reporting and requisite operations support to validate the results of fiscal pend processing, to verify that pend and financial cycle processes have been completed with the integrity of the payment intact, and all inputs and outputs are accounted for and balance.

EE. Custodial New Hampshire ADAP Bank Account and Check Processing

Services are requested from the Contractor for cash management of the Custodial New Hampshire Bank Account used for payment of drug claims. Check processing Services are requested that include:

1. Creation of remittance advices (RA)
2. Printing of checks or creation of debits
3. Mailing the RA with the check or transmitting an Electronic RA and check
   i. Resolution of outstanding checks including reporting and remitting to State of New Hampshire Treasury escheated funds.

Financial reporting of bank account and check processing activity is required that meets Generally Acceptable Accounting Principles (GAAP) and is approved by the NH ADAP. Contractor shall be responsible for responding to and resolving auditor inquires and funding relative to the ADAP custodial bank account and check processing activities.

FF. Financial Reconciliation

Reporting to support financial cycle reconciliation activities must be thorough and detailed, and include the reconciling and handling of erroneous transactions from the flow of claim and non-claim transaction processing through various control points, including claims entry, extract handling between components of the system, fund code assignment, financial processing, fund transfer invoicing, check generation, Provider payment and Provider remittance advice. The Contractor is required to

conduct monthly bank account reconciliations and report to the NH ADAP.

GG. Third Party Liability (TPL)

By law, NH ADAP is the payer of last resort for Services provided to its members. Accordingly, the Contractor shall meet the following conditions and comply fully with the Department's stipulations for Coordination of Benefits:

The Contractor shall comply with NH ADAP stipulations for coordination of benefits. Through the POS system, Contractor shall ensure that the pharmacy shall pursue payment through other available coverage. Contractor shall capture any payment or denial of payment by the carrier of other coverage, along with any provided reason codes. The Contractor shall identify the carrier, if known.

1. The Contractor shall process claims for NH ADAP as the payer of last resort. The Contractor shall configure COB adjudication logic in the POS system and cost avoid in real time. The Contractor POS system shall require the pharmacy provider to bill the member's other insurance carrier(s) before billing a claim to the NH ADAP program. The Contractor shall accept unverified TPL (TPL information is not on member's enrollment record at the time of adjudication) for cost avoidance in the POS system. When the member has other insurance coverage on file, and the incoming claim does not contain the COB segment; or, the data submitted on the incoming claim does not match the member's enrollment record; and/or, is not all inclusive of the information existing on the member's enrollment record, the POS system shall deny the claim and return the appropriate NCPDP Error Code and Message to the submitter. The POS system shall return third party carrier name, carrier code, BIN, and policy number information from the members' enrollment record in the standard message field to the submitter.

2 OTHER COVERAGE CODE (NCPDP Field # 3Ø8-C8) = "1" No other coverage identified. The POS system shall deny claims submitted with an OCC = "1" and the member has an active TPL segment on file. If the member does not have other coverage on file, the claim shall continue the adjudication process.

3 OTHER COVERAGE CODE (NCPDP Field # 3Ø8-C8) = "2" Other coverage exists. This value shall be required when payment from the primary insurance carrier(s) has been collected. The provider shall enter the payment amount received from the member's other primary/secondary etc., insurance carrier(s), in the Other Payer Amount Paid (NCPDP Field # 431-DV).

4 OTHER COVERAGE CODE (NCPDP Field # 3Ø8-C8) = "3" Other coverage exists - claim not covered. This value shall be required when the

member's primary insurance carrier returns a valid NCPDP denial code. The POS system shall require submission of the OTHER PAYER REJECT CODE (NCPDP Field # 472-6E) for the claim to adjudicate successfully. In addition, if the other payer requires a prior authorization for payment, the other payer's prior authorization procedures must be followed prior to submitting the claim to NH ADAP for payment.

5 OTHER COVERAGE CODE (NCPDP Field # 3Ø8-C8) = "4" Other coverage exists - payment not collected. This value shall be required when the primary insurance pays zero.

The Contractor shall provide solutions-based standard reporting package of clinical and utilization reports that serve to meet the programs operational reporting needs.

HH. Auditing

SSAE 16 SOC 1 (formerly the SAS 70) Audit: the Contractor shall provide and bear the cost of an independent auditor (service auditor) to perform procedures that shall supply the auditors for the State and the DHHS (user auditors) with information needed to obtain a sufficient understanding of The Contractor (service organization), internal controls over Services provided to DHHS to plan their audit for DHHS and the State. Contractor's selection of the independent auditors shall be subject to the prior written approval of DHHS. The audit procedures and reports are to be completed in accordance with guidance provided in the SSAE 16 SOC 1, as issued by the American Institute of Certified Public Accountants. The independent auditor is required to complete a SSAE 16 SOC 1 Audit that includes the service organization's description of controls, and detailed testing of the service organization's controls over a minimum six (6) month period. The SSAE 16 SOC 1 must be completed for each year of the Contract period. The SSAE 16 SOC 1 Audit shall be provided to the State's contract manager.

The minimum contents of the SSAE 16 SOC 1 Audit are as follows: The independent auditor shall perform on-site fieldwork to test system controls each quarter during the audit period.

a. The service organization's description of the controls that may be relevant to DHHS internal control as it relates to the audit of the State's financial statements.
b. The service auditor's opinion on whether the description presents fairly, in all material respects, the relevant aspects of the service organization's controls that had been placed in operation during the fiscal year.
c. The service auditor's opinion on whether such controls were suitably designed to provide reasonable assurance that the specified control objective

would be achieved if those controls were complied with satisfactorily.
d. A description of the service auditor's tests of controls and its opinion on whether the controls that were tested were operating with sufficient effectiveness to provide reasonable assurance that the related control objectives were achieved during the fiscal year.
e. The service auditor's procedures shall include, but are not necessarily limited to the following:

i. Information on the description of controls for the report through discussions with appropriate service organization's personnel, through reference to various forms of documentation, such as system flow charts and narratives and through the performance of tests of controls;
ii. A determination of whether the description provides sufficient information for auditors to obtain an understanding of those aspects of the service organization's controls that may be relevant to DHHS internal control;
iii. The control environment, such as hiring practices, key areas of authority, etc;
iv. Risk assessment, such as those associated with processing specific transactions;
v. Control activities, such as procedures on modifications to software;
vi. Communications, such as the way user transactions are initiated;
vii. Control monitoring, such as involvement of internal auditors;
viii. Evidence of whether controls have been placed in operation;
ix. Inquiry of appropriate service organization management and staff;
x. Inspection of service organization documents and records;
xi. Observation of service organization activities and operations;
xii. Testing controls to determine that the service organization is operating with sufficient effectiveness to provide reasonable assurance that the related control objectives were achieved during the fiscal year
xiii. Determine that significant changes in the service organization's controls that may have occurred before the beginning of fieldwork are included in the service organization's description of the controls.

II. Utilization Management (UM)

1. The requirements for the Contractor's UM program shall include the following, at a minimum:

a) Ensure correct payment.
b) In a Third Party Liability situation, maintain a process for rectifying an incorrect

payment.
c) Maintain documentation required for reversing or adjusting a claim.
d) Demonstrate the ability for a customer representative or help-desk staff person to correctly and fully answer questions and resolve problems of ADAP clients regarding their prescription fills and refills, by telephone, at a minimum: 8am to 4:30pm Eastern Standard Time.
e) Be able to give the specifics of their mail order program, including order turnaround and carrier(s) used for delivery, and how ADAP clients would use the service. Mail order pharmacies shall need to be registered with the NH Board of Pharmacy.
f) Additional Providers may be enrolled as necessary.

2. The Contractor shall provide a dedicated Clinical Manager who shall be responsible for daily oversight of the PDL program and provide clinical review and analysis of beneficiaries, physicians and pharmacists, with guidance and recommendations to NH ADAP. The Clinical Manager shall maintain the clinical integrity of the PDL so that recommended therapeutic classes and preferred drugs accurately reflect evidence-based drug use.

1. The Clinical Manager shall conduct periodic utilization management visits as needed. All travel costs associated with Provider education shall be the Contractor's responsibility.
2. The Contractor's Clinical Manager shall coordinate with ADAP, which shall be responsible for approving all UM programs.
3. The Contractor shall analyze claims and present recommendations for utilization management programs to NH ADAP on a monthly basis. The proposed UM program shall include review of both high risk and high cost/utilization therapies for integration with PA, POS edits, and DUR programs or other UM strategies.
4. The Contractor shall make recommendations for additions or changes in drug coverage and PA, dispensing limitations, generic substitution protocols, and other relevant or innovative suggestions to improve the clinical use of medications.
5. On a quarterly basis, the Contractor shall provide a written report profiling the top one hundred (100) utilizing beneficiaries, Prescribers and pharmacies for NH ADAP. The report shall highlight the percentage of cost (to total) attributed to the top utilizers, the actions taken (including DUR and detailing programs) and future action to be taken.
6. The Contractor shall consider UM strategies that are the least administratively burdensome to Prescribers, in accordance with federal law 42USC1396a(a)(19).
7. UM shall include written, electronic (fax, e-mail, or web-based) reminders

and other interventions containing information to improve UM and suggest changes in prescribing or dispensing practices, communicated in a manner designed to ensure the privacy of client-related information.

8. The Contractor shall provide supportive evidence-based clinical research, documentation, financial impact analysis, and recommendations for newly approved therapies and indications to the MAB for consideration.

9. Contractor shall administer the drug coverage program with the approval of NH ADAP and in accordance with the statutes and administrative rules of the State of New Hampshire. The pharmaceutical Services rule includes provisions for covered and non-covered drugs, Prior Authorization requirements, certification of prescriptions and dispensing limitations.

10. Drug Utilization Review (DUR):

a) The Contractor shall provide a clinical manager (RPh or PharmD to coordinate with the State DUR Board.

b) The Contractor shall prepare an annual DUR report for NH ADAP, a summary of the interventions used, and an assessment of the impact of the interventions used, and an assessment of the impact of these interventions on the quality of care and an estimate of the cost savings generated as a result. The report shall also compare the current NH ADAP results to the industry benchmarks including other ADAP or private sector programs.

12. The Contractor's clinical manager shall:

- Recommend drugs for Prior Authorization and step therapy to NH ADAP's Medical Advisory Board (MAB) at regularly scheduled meetings.
- Provide a quarterly written report to the MAB.
- Attend all MAB meetings.
- Be available to ADAP for consultation and oversight activities related to the management of the ADAP formulary(s) on a daily basis.
- Gather and review information as requested by the MAB in order to facilitate and support formulary management and to assist NH ADAP in determining a course of action with newly introduced drugs into the market.
- The Clinical Manager shall provide recommendations for additions or changes in the programs and provide educational materials including supportive clinical research, protocols, and financial analysis for newly approved therapies and indications.

Prior Authorizations (PA) Requirements for PA Program

a. The Contractor shall establish a Prior Authorization (PA) program, which shall be fully automated and an integral part of the UM system.

b. The Contractor shall ensure that all medications requiring PA shall be rejected, if rejection is appropriate, by an on-line adjudication process.

c. All rejections shall include messaging describing the reason for the denial

and The Contractor's toll-free telephone number for the pharmacist or the Prescriber.

d. The Contractor shall, subject to the NH ADAP's approval, provide a process by which the Pharmacist may initiate a PA request, which process shall:

- Allow the prescriber or his/her agent to call the Clinical Support Center to request the PA.
- Allow the prescriber or his/her agent to first speak to a certified pharmacy technician who collects the information based on the criteria for that medication or class of medications.
- Allow the technician to grant a PA, if the information furnished by the prescriber satisfies the criteria.
- Provide that, the retail pharmacist can facilitate the process to call the prescriber and collect the information from him/her based on the PA criteria for that particular medication or class of medications.
- Provide that, if the information furnished by the prescriber satisfies the criteria, the technician may grant an approval.
- Provide that, if there is any doubt that the criteria have been met, the telephone call shall be referred to a licensed clinical pharmacist who shall discuss the patient specifics with the prescriber, and:
  1. Approve the request after verifying criteria has been met.
  2. Provide assistance to the prescriber in changing to a more appropriate therapy without denying the initial request.
  3. Provide that, if the prescriber is unwilling to switch the patient to an acceptable therapy, the pharmacist shall issue a denial.

e. The Contractor shall recommend drugs for PA to NH ADAP and to the MAB.

f. The Contractor shall develop clinical guidelines, subject to approval by the Department, prior to implementation.

g. The Contractor shall provide a PA tracking process so that Providers have the ability to submit claims without a PA number.

h. The Contractor shall provide regular reporting to the Department to summarize PA activity on a monthly basis.

i. The Contractor shall provide a certified pharmacy technician ~~and~~ or a pharmacist to review medical necessity on all PA requests.

j. The Contractor shall enable an administrative override for utilization management, for example, a hard edit for an early refill.

k. The Contractor shall use a clinical review for utilization management, to include Prior Authorization review.

l. The Contractor shall provide samples of standard operating procedures for PA, including any system capabilities such as step therapy protocols or automated

Prior Authorization.

JJ. Client and Provider Telephone Support

1. The Contractor shall provide toll-free telephone support for providers, recipients, state employees, and representatives.
2. Contractor shall provide all required information systems, telecommunications, and personnel to perform these operations. The telephone system shall be appropriately staffed with positions such as a manager, team leaders, and hotline representatives, all of whom shall be extensively trained.
3. At a minimum, customer service activities shall include:

   a. A toll free number(s) for beneficiaries and pharmacists to respond to requests for pharmacy locations, inquiries on claims, assistance with accessing the web site including password/PIN management, and complaints about prescriber or pharmacist practices or Services. Voice response unit users are allowed, however, immediate access to a live operator and is required during Normal Business Hours.
   b. For prescribers and pharmacists, access to an on-call pharmacist consultant and technical assistance twenty-four (24) hours per day x 7 days per week x 365 days per year.

4. Contractor's telephone staff shall have complete on-line access to all computer files and databases that support the system for applicable pharmacy programs.
5. The Contractor's telephone staff shall log and categorize all incoming and outgoing telephone calls with clients, prescribers, other Providers and pharmacists. This data shall be made available routinely in an aggregated format to the NH ADAP on a monthly, quarterly and annual basis and daily or weekly if needed.
6. The Contractor shall produce reports on usage of the telephone line(s), including number of inquiries, types of inquiries, complaints received, and timeliness of responses.
7. The Contractor's telephone Services shall provide sufficient telecommunications capacity to meet the State's needs with acceptable call completion and abandonment rates. It shall be scalable to future demand. It shall also possess an advanced telephone system that provides the NH ADAP with an extensive management tracking and reporting capabilities. A quality assurance program shall be in place that samples calls and follows up to confirm efficient handling and caller satisfaction.
8. For PA purposes, the Contractor shall maintain toll-free telephone access (available for in-state and out of state Providers). Contractor must have telephone Services staffed no less than from 8:00 AM through 9:00 PM, Eastern Time.
9. Contractor shall have professional licensed medical and pharmacological

advisory staff and other resources necessary to provide pharmacists at the POS, and prescribers during the prescribing process, with advice pertaining to the proper use of prescription drugs, consistent with ProDUR and other medical standards, as they apply to each Client's unique needs and medical conditions.

10. Contractor shall produce reports on usage of the telephone service(s), including number of inquiries, types of inquiries, average speed to answer, abandonment rates, blocked call rates and timeliness of responses.

11. The Contractor's process shall allow beneficiaries to locate nearby pharmacies for special situations, such as twenty-four (24) hour pharmacies or those dispensing compounded drugs, etc. (phone only)

12. Contractor shall provide additional, secured web-based communications in accordance with the specifications set forth in Systems Capability and Performance Standards set forth above. Contractor shall provide toll-free telephone support for both Providers and recipients that include interpreter Services.

KK. Contractor Capacity

Contractor must submit a copy of its organizational chart within 120 days of the contract. Contractor will identify the Key Person(s) and departments who support the ADAP program, Contractor shall ensure staff are trained to meet the unique needs of the ADAP program and clients. The Contractor's network pharmacies shall include all those in the New Hampshire Medicaid network. These shall be pharmacies with whom the Contractor is on-line and from whom it can accept and process electronic claims.

The Contractor's network pharmacies shall include all those in the New Hampshire Medicaid network. These shall be pharmacies with whom the Contractor is on-line and from whom it can accept and process electronic claims. The Contractor shall agrees to maintain during the term of the contract association with any other pharmacies designated by NH ADAP.

The Contractor shall demonstrate the ability for a customer representative or a help-desk staff person to fully perform duties for ADAP staff and participating pharmacies, by telephone and fax machine, email at a minimum: 8am to 4:30 pm Eastern Standard Time. Duties include adding and removing covered clients, answering any questions and problems that might arise from participating pharmacies and ADAP staff about specific or general electronic transmissions, error messages, overrides, invoices, pharmacy payments, Prior Authorizations, and other similar duties required by ADAP.

The State reserves the right to change the timing of the delivery of the data. ADAP shall notify all parties at least thirty (30) days before any such change

takes effect.

LL. Analysis and Reporting:

The Contractor shall provide solutions-based standard reporting package of clinical and utilization reports that serve to meet the programs operational reporting needs. The table below summarizes the contents of the various reports provided that support day to operations of the New Hampshire ADAP program.

Functional Area	Report Description
Prior Authorization (PA)	The Contractor PA Reports provide summarization metrics on the disposition of processed authorization requests in order to show the counts and quickly determine percentages of requests that involved changes to existing authorization or new requests that were approved or denied. In addition, the reports provide information on the various clinical decision rules that both our Pharmacist and Pharmacy Technicians use in the process of adjudicating and arriving at a decision for the requests that we receive. The Contractor shall categorize PAs and report on them based on the basis for the PA requirement, such as the product not being on a preferred drug list.
Clinical Utilization	The Contractor Clinical Utilization Reports identify key performance metrics related to drug utilization, utilization within a particular therapeutic class, top drugs and therapeutic classes by utilization and expenditures. These reports shall provide valuable insight into how the pharmacy program is performing.
Call Center	MMA shall utilizes the IP-based version of Avaya Call Management System (CMS) which provides real-time monitoring and historical reporting, including custom reporting, task scheduling, exception notification, threshold warning, administration and configuration, and long term ACD data storage. Reports in CMS shall be distributed via printing the report directly, exporting the reports into a Microsoft Word, Microsoft Excel, HTML or text file. Real-time reports give supervisors snapshots of the call center's performance and status. Standard real-time reports show the current status of Automatic Call Distribution (ACD) activity and data for the current interval for agent, split/skill, trunk/trunk group, vector, and Vector Directory Number (VDN) activities, for example number of ACD calls, abandoned calls, and average talk time.

The Contractor's reporting solutions, coupled with technical, operational and clinical subject matter expertise, shall provide the most accurate and timely reporting services to the New Hampshire ADAP program for effective and efficient management of the pharmacy program. Reports may be generated daily, weekly, monthly, and/or quarterly based on the program's requirements and shall be distributed via a web-based reports library, where they shall be made available to

only users with secured credentials and authorized access.

In addition to the comprehensive solution-based standard reporting package, the Contractor shall offer report development services for any newly identified or initiative specific reporting needs. Requests for newly developed routine or ad hoc reports shall be submitted through the NH ADAP the Contractor Account Support representatives and forwarded to the Business Intelligence team for an impact analysis, effort level estimate and for development work to commence in the creation of new reports upon request.

Clinical and Utilization Reporting Package

The below is an overview and samples of the Contractor's Standard POS Reporting Package which includes clinical and utilization reports directly from the Contractor's point-of-sale operational system.

Daily Reports

Daily Claims Summary
This report shows the daily claims volume and total paid for claims processed through the system. This report is based on adjudication date.

Daily Claims Denial
This report shows the NCPDP error codes, the corresponding internal error codes, and the total number of denied claims associated with each error code grouping. This report is based on adjudication date.

Daily Denial Report
This report shows the NCPDP error codes and the total number of denied claims associated with each NCPDP error code. This report is based on adjudication date.

Monthly Reports

Twelve Month Summary
This report shows by calendar month a summary of claims processed. This report is based on only paid claims by adjudication date.

Gender Utilization (Male, Female, and Combined)
This report shows the claim distribution by age group and gender. This report is based on only paid claims by adjudication date. The report is generated for male,

female, and combined.

Generic Analysis
This report shows the claim distribution by drug type classification. This report is based on only paid claims by adjudication date.

Therapeutic Class Analysis by Amount Paid or Claim Volume
This report shows the claim distribution by drug therapeutic class from highest to lowest. This report can be retrieved based on the total amount paid per therapeutic class or total number of claims by therapeutic class. This report is based on only paid claims by adjudication date.

Most Utilized Pharmacies by Amount Paid or Claim Volume
This report ranks the top pharmacies from highest to lowest. This report can be retrieved by total amount paid or total number of claims. This report is based on only paid claims by adjudication date.
Top Members Ranking by Amount Paid or Claim Volume
This report ranks the top members from highest to lowest. This report can be retrieved by total amount paid or total number of claims. This report is based on only paid claims by adjudication date.

Most Prescribed NDCs by Amount Paid or Claim Volume
This report ranks the top NDCs from highest to lowest. This report can be retrieved by total amount paid or total number of claims. This report is based on only paid claims by adjudication date.

On Request Reports

Claim Balancing for Payment Date or Service Date
This is a management report that provides a summary of claims by claim status and type for a selected period of time based on either service date or payment date.

Cost and Utilization Analysis by Drug Type
This is a management report that provides summary of claims by selected service date period showing summary by single source, multisource or generic status of drugs in paid claims.

Cost and Utilization Analysis by Claim Type
This is a management report that provides summary of claims by selected service

date period showing summary by retail or mail order status.

Denied Claims Analysis
This is a management report that provides summary of claims by selected service date period showing summary of denied claims per NCPDP error code.

Therapeutic Class Summary
This is a management report that provides summary of claims by selected service date period showing summary of paid claims summarized at the specific therapeutic class level.

Top X Drug Ranking
This is a management report that provides summary of claims by selected service date period showing summary of claims at the drug name level. User selects ranking by payment or claim count and number of drugs to be returned in report.

Top X Pharmacy/Prescriber Ranking
This is a management report that provides summary of claims by selected service date period showing summary of claims ranked by a variable selected by user. User can select the number of providers returned and either prescriber or pharmacy.

Top X Recipient Ranking
This is a management report that provides summary of claims by selected service date period showing summary of top recipients. User can select method of ranking. Report can be drilled through to the individual recipient profile report for each recipient listed.

Top 10 Therapeutic Classes by Total Paid, Claim Volume, or Ingredient Cost
This is a management report that provides summary of claims by selected service date periods showing summary at the specific therapeutic class level. Ranking is by total paid, claim volume, or ingredient cost and includes only the top ten classes.

Twelve Month Summary
This is a management report that provides summary of claims by selected service date year showing summary by month of claim utilization data.

CMS Data Sharing Report
This report will show the number of clients for whom the data on Medicare

eligibility and enrollment did not match that of the CARE Program

Standard Prospective DUR Reporting Package

The below is an overview and samples of the Contractor's Standard Prospective DUR Reporting Package which includes denials, encounters, interventions and messages to appropriately manage processing of pharmacy claims both clinically and fiscally.

Daily Reports

Daily ProDUR Denial Report
This report shows the ProDUR conflict codes and the corresponding number of denied claims associated with each code. This report is based on adjudication date.

Daily ProDUR by HIC3 Denial Report
This report shows the ProDUR conflict codes, HIC3, and the total number of denied claims associated with each grouping of conflict code and HIC3. This report is based on adjudication date.

Monthly/Annual Reports

ProDUR Top Encounters by Problem Type
This report shows the encounter and claim distribution by ProDUR problem type. This report is based on only paid claims by adjudication date.

ProDUR Payment Report
This report shows the ProDUR payments by claim history errors vs. non-history errors as well as DUR error code. The data is broken down into month to date and year to date.

ProDUR Message Report
This report shows the ProDUR encounter messages by severity code. This is based on adjudication date for the claims.

ProDUR Encounters Report
This report lists the ProDUR encounters by type and provides the number of claims associated with each type. This is based on adjudication date.

ProDUR Denied Claims Savings Report
This report shows by provider the number of denied claims due to ProDUR encounters and the subsequent resubmission claims. These claims are then

calculated to determine a savings amount by provider.

ProDUR Paid Claims Savings Report
This report shows by provider the number of paid claims due to ProDUR encounters and the subsequent reversal and resubmission claims. These claims are then calculated to determine a savings amount by provider.

ProDUR Encounter – Outcomes by Problem Type
This report shows by ProDUR encounter the pharmacy submitted ProDUR outcome codes and number of claims associated with each.

ProDUR Encounter – Interventions by Problem Type
This report shows by ProDUR encounter the pharmacy submitted ProDUR intervention codes and number of claims associated with each.

Active Pharmacy Provider Report
This report shows all active pharmacy providers and their effective and termination dates.

Denied Claims Analysis
This report shows the NCPDP error codes, descriptions, and the number of claims associated with each.

Cost Sharing Savings Report
This report shows the cost sharing breakdown of claims by month. The data is based on adjudication date and a month is a calendar month.

Adjudication Demographics Report
The purpose of this report is show the breakdown of the paid claims and some important metrics associated with these. Some of the metric breakdowns include brand, generic, ingredient cost, gross cost, etc. The data is pulled according to adjudication date and broken down into current month, this month last year, and year-to-date.
Prescriber Ranking Report by Amount Paid or Claim Volume
This report ranks all prescribers based on total amount paid or total number of claims to the prescriber. The data within the report gives an overview of each physician's prescribing habit. The data is based on paid claims by adjudication date.

MM. ADAP Client Eligibility

- The ease and speed of updating individual eligibility information for ADAP clients in The Contractor electronic system is critical. Individuals categorized as "enrolled"

shall be those who have completed the ADAP enrollment process as required semiannually.

- The Contractor shall update ADAP client eligibility information in its own system within 24 hours of notification by mutually agreed upon method, preferably an electronic file transfer. The Contractor shall notify ADAP to confirm client eligibility updates are received and any changes are processed.

- The Contractor shall terminate ADAP coverage for ineligible clients within 24 hours of notification. Termination of coverage is defined as the removal of an ADAP client from network access, wherein a claim that a pharmacy attempts to electronically transmit for that non-covered client would be rejected.

- A change in ADAP client coverage and/or legibility mid ADAP enrollment period shall be updated in The Contractor's system within 24 hours of receipt of the eligibility notification.

NN. Performance Measures

To measure and improve the quality of public health Services, the Department employs a performance management model. This model, comprised of four components, provides a common language and framework for the Department and its community partners. These four components are:

1) Performance standards;
2) Performance measurement;
3) Reporting of progress; and,
4) Quality improvement.

The Department shall apply the following performance measures to the services provided by the Contractor:

Performance Measure #1

Goal: To ensure that NH ADAP Funds are utilized only when all other insurance options have been exhausted.

Target: Annually, 95% of claims are correctly applied to NH ADAP (no other insurance or coverage was available at the prescription fill date).

Numerator: On an annual basis, number of claims applied to NH ADAP correctly.

Denominator: On an annual basis, number of claims applied to NH ADAP.

Data Source: Random sample review of claims applied to NH ADAP collected via

CAREWare, conducted quarterly.

Performance Measure #2

Goal: To ensure that NH ADAP covers the full price of medications (with exception to items on the NH CARE Program exclusion list) when an item is not covered by Medicare Part D, Medicaid or other insurance.

Target: Annually, 95% of medication insurance denials are correctly paid by NH ADAP at the NH Medicaid rate (includes all medications except for those on the NH CARE Program exclusion list).

Numerator: Annually, number of medication insurance denials correctly paid at NH Medicaid rate.

Denominator: Annually, number of medication insurance denials paid at NH Medicaid rate.

Data Source: Random sample review of claims applied to NH ADAP collected via CAREWare, conducted quarterly.

General Provisions

1. STATE MEETINGS AND REPORTS

The State believes that effective communication and reporting are essential to the program's success. The Contractor key staff shall participate in meetings as requested by the State, in accordance with the requirements and terms of this Contract. The Contractor will conduct Status meetings at least monthly to address overall program status. Participants shall include, at a minimum, the Pharmacist Account Executive, Reporting Analyst, and benefit configuration plan administrator. The Pharmacist Account Executive shall submit monthly status reports and meeting minutes in accordance with the schedule and terms of this Contract which shall serve as the basis for discussion.

2. STATE-OWNED DOCUMENTS AND DATA

The Contractor shall provide the State access to all documents, state data, materials, reports, and other work in progress relating to the Contract ("State-owned Documents"). Upon expiration or termination of the Contract with the State, the Contractor shall turn over all State-owned documents, material, reports, and work in progress relating to the Contract to the State at no additional cost to the State. State-owned Documents must be provided in both printed and electronic format.

3. RECORDS RETENTION AND ACCESS REQUIREMENTS

The Contractor shall comply with all applicable State and federal laws and regulations, which are incorporated herein by reference, regarding retention and access requirements, including without limitation, retention policies consistent with the Federal Acquisition Regulations (FAR) Subpart 4.7 *Contractor Records Retention*.

The Contractor and its Subcontractors shall maintain books, records, documents, and other evidence of accounting procedures and practices, which properly and sufficiently reflect all direct and indirect costs invoiced in the performance of their respective obligations under the Contract. The Contractor and its Subcontractors shall retain all such records for three (3) years following termination of the Contract, including any extensions. Records relating to any litigation matters regarding the Contract shall be kept for one (1) year following the termination of all litigation, including the termination of all appeals or the expiration of the appeal period.

Upon prior notice and subject to reasonable time frames, all such records shall be subject to inspection, examination, audit and copying by personnel so authorized by the State and federal officials so authorized by law, rule, regulation or Contract, as applicable. Access to these items shall be provided within Merrimack County of the State of New Hampshire, unless otherwise agreed by the State. Delivery of and access to such records shall be at no cost to the State during the three (3) year period following termination of the Contract and one (1) year term following litigation relating to the Contract, including all appeals or the expiration of the appeal period. The Contractor shall include the record retention and review requirements of this section in any of its subcontracts.

The State agrees that books, records, documents, and other evidence of accounting procedures and practices related to the Contractor's cost structure and profit factors shall be excluded from the State's review unless the cost of any other Services or Deliverables provided under the Contract is calculated or derived from the cost structure or profit factors.

4. ACCOUNTING REQUIREMENTS

The Contractor shall maintain an accounting system in accordance with generally accepted accounting principles. The costs applicable to the Contract shall be ascertainable from the accounting system and the Contractor shall maintain records pertaining to the services and all other costs and expenditures. **SYSTEM MAINTENANCE**
The Contractor shall maintain and support the Pharmacy Benefits Management System in all material respects as described in the applicable program Documentation for 3 years of maintenance after delivery and the Warranty Period of 3 year(s).

4.1 The Contractor's Responsibility

The Contractor shall maintain the application system in accordance with the Contract. The Contractor shall not be responsible for maintenance or support for Software developed or modified by the State.

4.1.1 Maintenance Releases

The Contractor shall make available to the State the latest program updates, general maintenance releases, selected functionality releases, patches, and documentation that are generally offered to its customers, at no additional cost.

4.1.2 SECURITY

The Contractor shall ensure that appropriate levels of security are implemented and maintained in order to protect the integrity and reliability of the State's Information Technology resources, information, and Services. The Contractor shall provide the State resources, information, and Services on an ongoing basis, with the appropriate infrastructure and security controls to ensure business continuity and to safeguard the confidentiality and integrity of State networks, Systems and Data.

5. SYSTEM SUPPORT

5.1 Contractor's Responsibility

Contractor shall be responsible for performing on-site or remote technical support in accordance with the contract , including without limitation the requirements, terms, and conditions contained herein.

As part of the Software maintenance agreement, ongoing Software maintenance and support levels, including all new Software releases, shall be responded to according to the following:

5.1.1. Class A Deficiencies - The Contractor shall have available to the users and the State on-call telephone assistance, with issue tracking available to the State, **twenty four (24) hours per day and seven (7) days a week with an email/telephone response within two (2) hours of request;** or the Contractor shall provide support on-site or with remote diagnostic Services, within four (4) business hours of a request;

5.1.2. Class B & C Deficiencies –The users or the State shall notify the Contractor of such Deficiencies during regular business hours and the Contractor shall respond back within 24 hours of notification of planned corrective action;

6. SUPPORT OBLIGATIONS AND TERM

6.1 The Contractor shall repair or replace Software, and provide maintenance of the Software in accordance with the Specifications and terms and requirements of the Contract;

6.2 The Contractor shall maintain a record of the activities related to warranty repair or maintenance activities performed for the State;

6.3 The Contractor must work with the State to identify and troubleshoot potentially large-scale System failures or Deficiencies by collecting the following information: 1) mean time between reported Deficiencies with the Software; 2) diagnosis of the root cause of the problem; and 3) identification of repeat calls or repeat Software problems.

6.4 If The Contractor fails to correct a deficiency within the allotted period of time stated above, The Contractor shall be deemed to have committed an Event of Default, and the State shall have the right, at its option, to pursue the remedies in the General Provisions, Form P-37, as well as to return the Contractor's product and receive a refund for all amounts paid to the Contractor, including but not limited to, applicable license fees, within ninety (90) days of notification to the Contractor of the State's refund request

6.5 If the Contractor fails to correct a deficiency within the allotted period of time stated above, the Contractor shall be deemed to have committed an Event of Default, and the State shall have the right, at its option, to pursue the remedies in the General Provisions, Form P-37.

The Contractor shall provide all of the system's functional components and requirements, including services and deliverables, outlined within this contract. The ADAP PBM system shall be consistent with the Pharmacy Benefits Management System. The Contractor shall be responsible for the maintenance of the NH AIDS Drug Assistance Program (ADAP) Pharmacy Benefits Management (PBM) system and shall act as the State's Fiscal Agent for these Services.

The NH AIDS Drug Assistance Program (ADAP) is funded primarily by the federal Ryan White Program, administered by the Health Resources and Services Administration. The Ryan White Treatment Extension Act of 2009 allocates funding to states to provide core medical and support Services to persons living with HIV within their state, titled Ryan White Part B (RWPB). The largest funded service category is ADAP, which provides lifesaving medications to eligible positive Human Immunodeficiency Virus (HIV) NH residents.

7. Minimum Required Services

The Contractor shall provide:

- Maintenance and support of a statewide Pharmacy Benefit Management (PBM) program for NH AIDS Drug Assistance Program (ADAP) clients based upon best practice models;
- The accurate and efficient automated systematic adjudication and payment of pharmacy claims indicated by this Contract;
- Specialty pharmacy management for other public health programs, including the Tuberculosis Financial Assistance (TBFA) program to address sub-populations ensuring appropriate clinical utilization and cost savings among all clients;
- Mail order pharmacy strategies where appropriate;
- Coordination of benefits with Medicare plans, Medicaid and other private payers;
- Secure exchange of eligibility and claims data via Secure FTP or other agreed upon method;
- Integrated reporting systems (between financial and claims data systems, among others), Internet based functionality as applicable, which enables The Contractor to proactively initiate program changes, refinements or enhancements and to ensure successful program management. Key ADAP staff should have ready electronic access to all reporting (both standard and ad hoc) and PBM company materials;
- The application of standardized, streamlined and efficacious administrative processes to enhance service delivery, cost containment and program integrity;
- Internet based functionality, including access to NH ADAP program information.
- Systems On-line Access, Implementation, Maintenance, and Modification of an automated PBM system to support claims processing and payment, data management, call center tracking, and ad hoc reporting providing on-line access to all components;
- Serve as the NH ADAP's liaison to pharmaceutical manufacturers and other industry representatives.
- Maintain and perform all required data processing and data exchange per the Data Sharing Agreement (DSA) with the Centers for Medicare and Medicaid Services (CMS).

The Contractor shall provide the NH ADAP with on-line access to any and all components that comprise the NH ADAP PBM system solution. Additionally, the Contractor shall provide access to NH ADAP Pharmacies and Recipients to selected information and such other information as Contractor and the NH ADAP mutually agreed upon in writing. The Contractor shall work collaboratively with the NH ADAP and other interfacing entities to implement effectively the requisite exchanges of data necessary to support the requirements of the Scope of Services.

The Contractor is responsible for hosting the NH ADAP PBM solution at the Contractor's data

center and providing for adequate redundancy, disaster recovery, and business continuity such that in the event of any catastrophic incident, system availability is restored to the NH ADAP within 24 hours of incident onset and eight (8) hours in the event of an unscheduled downtime incident involving the POS functionality.

The Contractor shall ensure that the NH ADAP data are securely segregated, using role based security, from other PBM accounts or Projects, and are under configuration management and change management in support of NH ADAP.

The Contractor shall implement the necessary telecommunication infrastructure to support the NH ADAP's PBM solution and shall provide the NH ADAP with a network diagram depicting the communications infrastructure, including but not limited to, connectivity between ADAP and The Contractor, including any contractor and subcontractor locations supporting the ADAP PBM Project.

The Contractor shall utilize methods for data conversion and data interface handling, that, to the maximum extent possible, automate the process, and that provide for source to target or source to specification mappings, all business rules and transformations where applied, summary and detailed counts, and any data that cannot be loaded.

The Contractor shall provide for a common, centralized electronic Project repository, providing for secure access to authorized Contractor and ADAP staff to project plans, documentation, issues tracking, deliverables, and other project related artifacts.

8. TECHNICAL REQUIREMENTS

Information Technology (IT) Systems Requirements

The Contractor shall be responsible for the maintenance of the State's Pharmacy Benefits Management system, providing for all of the system functional components and requirements, including but not limited to:

1. Point of Sale (POS) Pharmacy Claims Adjudication (Paid, Denied, Reversed, Adjusted, Voids);
2. Prior Authorization Management;
3. Interface Management;
4. Third Party Coverage and Cost Avoidance Management;
5. Financial Management (Financial Transactions, Fund Codes, Fiscal Pend);
6. Payment Management;
7. Reference Data Management (Drug Codes, Rates, Edits, Audits);
8. Reporting (Ad hoc and Pre-Defined/Scheduled and On-Demand);
9. Call Center Management;
10. Other components as necessary to meet requirements.

The Contractor shall provide the State with secure, on-line access to any and all components that comprise the NH PBM system solution. Additionally, the Contractor shall provide access to NH Medicaid Providers and Recipients to selected information as the Contractor and the State

mutually agree in writing.

The Contractor shall work collaboratively with the Department, its MMIS fiscal agent, and other interfacing entities to implement effectively the requisite exchanges of data necessary to support the requirements of the Contract.

The Contractor is responsible for hosting the NH PBM solution at the Contractor's data center and providing for adequate redundancy, disaster recovery, and business continuity such that in the event of any catastrophic incident, system availability is restored to the State within 24 hours of incident onset in the event of a catastrophic incident and eight (8) hours in the event of an unscheduled downtime incident involving the POS functionality.

The Contractor shall ensure that the hardware and software supporting the State's solution, and the State's data, data processing, and data repositories are securely segregated from any other PBM account or project, and are under configuration management and change management governed through and in support of the State project.

The Contractor shall implement the necessary telecommunication infrastructure to support the State's PBM solution and shall provide the State with a network diagram depicting the communications infrastructure, including but not limited to, connectivity between the State and The Contractor, including any contractor and subcontractor locations supporting the State's PBM project.

The Contractor shall utilize data extract, transformation, and load (ETL) methods for data conversion and data interface handling, that, to the maximum extent possible, automate the extract, transformation and load processes, and that provide for source to target or source to specification mappings, all business rules and transformations where applied, summary and detailed counts, and any data that cannot be loaded.

9. ASSUMPTIONS

A. Logistics

- The Contractor Team shall honor all holidays observed by the Contractor or the State, although with permission, may choose to work on holidays and weekends.

B. Reporting

The Contractor shall conduct monthly status meetings, and provide reports that include, but are not limited to, minutes, action items, test results and documentation.

C. User Training and Change Management

- The Contractor Team shall lead the development of the end-user training plan.
- A train the trainer approach shall be used for the delivery of end-user training.
- The State is responsible for the delivery of end-user training.
- The State shall schedule and track attendance on all end-user training classes.

D. Performance and Security Testing

The Contractor shall monitor the systems constantly to maintain uptime and performance. System capacity shall be forecasted regularly to ensure adequate system resources are available to support current and future business. Metrics shall be systematically collected and evaluated to ensure that all service level agreements and key performance indicators are met or exceeded. Testing and monitoring results shall be made available the State upon request.

10. DOCUMENTATION COPIES

The Contractor shall provide the State with a sufficient number of hard copy versions of the Software's associated Documentation and one (1) electronic version in Microsoft WORD and PDF format. The State shall have the right to copy the Software and its associated Documentation for its internal business needs. The State agrees to include copyright and proprietary notices provided to the State by the Contractor on such copies.

11. RESTRICTIONS

Except as otherwise permitted under the Contract, the State agrees not to:

a. Remove or modify any program markings or any notice of The Contractor's proprietary rights;
b. Make the programs or materials available in any manner to any third party for use in the third party's business operations, except as permitted herein; or
c. Cause or permit reverse engineering, disassembly or recompilation of the programs.

12. TITLE

Title, right, and interest (including all ownership and intellectual property rights) in the Software, and its associated Documentation, shall remain with the Contractor.

13. VIRUSES

The Contractor shall provide Software that shall not contain any viruses, destructive programming, or mechanisms designed to disrupt the performance of the Software in accordance with the Specifications.

As a part of its internal development process, the Contractor shall use reasonable efforts to test the Software for viruses. The Contractor shall also maintain a master copy of the appropriate versions of the Software, free of viruses. If the State believes a virus may be present in the Software, then upon its request, the Contractor shall provide a master copy for comparison with and correction of the State's copy of the Software.

14. AUDIT

Upon forty-five (45) days written notice, the Contractor may audit the State's use of the programs at the Contractor's sole expense. The State agrees to cooperate with The Contractor's audit and provide reasonable assistance and access to information. The State agrees that the Contractor shall not be responsible for any of the State's reasonable costs incurred in cooperating with the audit. Notwithstanding the foregoing, the Contractor's audit rights are subject to applicable State and federal laws and regulations.

15. SOFTWARE NON-INFRINGEMENT

The Contractor warrants that it has good title to, or the right to allow the State to use all Services, equipment, and Software ("Material") provided under this Contract, and that such Services, equipment, and Software do not violate or infringe any patent, trademark, copyright, trade name or other intellectual property rights or misappropriate a trade secret of any third party.

The warranty of non-infringement shall be an on-going and perpetual obligation that shall survive termination of the Contract. In the event that someone makes a claim against the State that any Material infringe their intellectual property rights, the Contractor shall defend and indemnify the State against the claim provided that the State:

a. Promptly notifies the Contractor in writing, not later than 30 days after the State receives actual written notice of such claim;
b. Gives the Contractor control of the defense and any settlement negotiations; and
c. Gives the Contractor the information, authority, and assistance reasonably needed to defend against or settle the claim.

Notwithstanding the foregoing, the State's counsel may participate in any claim to the extent the State seeks to assert any immunities or defenses applicable to the State.

If the Contractor believes or it is determined that any of the material may have violated someone else's intellectual property rights, the Contractor may choose to either modify the material to be non-infringing or obtain a license to allow for continued use, or if these alternatives are not commercially reasonable, the Contractor may end the license, and require return of the applicable Material and refund all fees the State has paid the Contractor under the Contract. The Contractor shall not indemnify the State if the State alters the Material without the Contractor's consent or uses it outside the scope of use identified in the Contractor's user documentation or if the State uses a version of the material which has been superseded, if the infringement claim could have been avoided by using an unaltered current version of the material which was provided to the State at no additional cost. The Contractor shall not indemnify the State to the extent that an infringement claim is based upon any information design, specification, instruction, software, data, or material not furnished by the Contractor. The Contractor shall not indemnify the State to the extent that an infringement claim is based upon the combination of any Material with any products or Services not provided by the Contractor without the Contractor's consent.

16. WARRANTIES

16.1 Services

The Contractor warrants that the System and the Contractor PBM Services shall operate to conform to the Specifications, terms, and requirements of the Contract.

16.2 Software

The Contractor warrants that the Software, including but not limited to the individual modules or functions furnished under the Contract, is properly functioning within the System, compliant with the requirements of the Contract, and shall operate in accordance with the specifications and terms of the Contract.

For any breach of the above Support and Maintenance warranty, the State's remedy, and the Contractor's entire liability, shall be: (a) the correction of program errors that cause breach of the warranty, or if the Contractor cannot substantially correct such breach in a commercially reasonable manner, the State may (b) require the re-performance of the Deficient Services, or (c) if the Contractor cannot substantially correct a breach in a commercially reasonable manner, the State may end the relevant Services and recover the fees paid to the Contractor for the Deficient Services.

16.3 Non-Infringement

The Contractor warrants that it has good title to, or the right to allow the State to use, all Services, equipment, and Software ("Material") provided under this Contract, and that such Services, equipment, and Software do not violate or infringe any patent, trademark, copyright, trade name or other intellectual property rights or misappropriate a trade secret of any third party.

16.4 Viruses; Destructive Programming

The Contractor warrants that the Software shall not contain any viruses, destructive programming, or mechanisms designed to disrupt the performance of the Software in accordance with the Specifications.

16.5 Compatibility

The Contractor warrants that all System components, including but not limited to the components provided, including any replacement or upgraded System Software components provided by the Contractor to correct Deficiencies or as an Enhancement, shall operate with the rest of the System without loss of any functionality.

16.6 Services

The Contractor warrants that all services to be provided under the Contract shall be provided expediently, in a professional manner, in accordance with industry standards and that Services shall comply with performance standards, Specifications, and terms of the Contract.

16.7 Personnel

The Contractor warrants that all personnel engaged in the Services shall be qualified to perform the Services, and shall be properly licensed and otherwise authorized to do so under all applicable laws.

16.8 Breach of Data

The Contractor shall be solely liable for costs associated with any breach of State

Data housed at their location(s) including but not limited to notification and any damages assessed by the courts.

17. WARRANTY SERVICES

The Contractor agrees to maintain, repair, and correct Deficiencies in the System Software, including but not limited to the individual modules or functions, during the Warranty Period, at no additional cost to the State, in accordance with the Specifications, Terms and requirements of the Agreement, including, without limitation, correcting all errors, and Defects and Deficiencies; eliminating viruses or destructive programming; and replacing incorrect, Defective or Deficient Software and Documentation. The Warranty Period shall commence upon approval of the contract by the Governor and Executive Council and shall remain in effect for the duration of the Agreement.

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
PHARMACY BENEFITS MANAGEMENT SYSTEM
EXHIBIT B
Method and Conditions Precedent to Payment

Price and Payment Schedule for Pharmacy Benefits Management System for the Division of Medicaid Services.

1.1 Firm Fixed Price

The Firm Fixed Price (FFP) for this Amendment totals $10,405,685 for the period between the effective date and 12/31/2023. The source of funds shall be 75% Federal Funds, and 25% General Funds. The Contractor shall be responsible for performing its obligations in accordance with the Contract. Subject to the Contractor's compliance with the terms and conditions of this Contract and for routine services provided, the State shall reimburse the Contractor as follows:

The Contractor shall invoice the State for the following services, Deliverables, or milestones at the fixed pricing/rates appearing in the price and payment tables below:

Pricing shall be effective for the Term of this Contract, and any extensions and amendments thereof.

Table 1: Funding Amounts by State Fiscal Year for NH Medicaid Fee-for-Service (FFS) Program shall not exceed the following amounts for each State Fiscal Year:

State Fiscal Year	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	TOTAL
Dates	1/1/2020-6/30/2020	7/1/2020-6/30/2021	7/1/202-6/30/2022	7/1/202-6/30/203	7/1/2023-12/31/2023	
Fees	$1,296,450	$2,509,991	$2,585,291	$2,662,850	$1,351,102	$10,405,685

Table 2: Reimbursement for Routine Services from January 1, 2020 through December 31, 2020

Description	Reimbursement
All Inclusive Administrative Fee	$200,770/per month
FastMAC Fee	$5,305/per month
Total Monthly Fees	**$206,075/per month**
System Modification (as needed)	$140.40/hour
Setup of Single PDL (up to 3 MCOs) –compliance monitoring	$60,000 One Time Fee

Table 3: Reimbursement for Routine Services from January 1, 2021 through December 31, 2021

Description	Reimbursement
All Inclusive Administrative Fee	$206,793/per month
FastMAC Fee	$5,464/per month
Total Monthly Fees	**$212,257/per month**
System Modification (as needed)	$140.40/hour

Table 4: Reimbursement for Routine Services from January 1, 2022 through December 31, 2022

Description	Reimbursement
All Inclusive Administrative Fee	$212,997/per month
FastMAC Fee	$5,628/per month
Total Monthly Fees	**$218,625/per month**
System Modification (as needed)	$140.40/hour

Table 5:. Reimbursement for Routine Services from January 1, 2023 through December 31, 2023

Description	Reimbursement
All Inclusive Administrative Fee	$219,387/per month
FastMAC Fee	$5,797/per month
Total Monthly Fees	**$225,184/per month**
System Modification (as needed)	$140.40/hour

Monthly Invoicing
On a monthly basis, Contractor shall send an invoice to the State. Documentation shall include: the FastMAC Fee and the All Inclusive Administrative Fee.

Pricing
Pharmaceuticals are reimbursed according to the State Plan Amendment and Administrative Rules ("Rules"). The State shall provide Contractor thirty (30) business days to implement changes to the State's rules from the date of effective rule publication; provided, however, the State shall provide more implementation time to Contractor in the event of a fundamental change in pricing Rules.
The State MAC and CMS FUL shall be modified and monitored at least monthly to ensure accurate pricing.

The Contractor shall bill the Department on a monthly basis for the services in the Contract provided during the previous month. Invoices shall calculate the service payment in detail including the units, volume and price by service for each group under the Contract as well as report the transaction volumes by month and year to date. The Contractor shall provide invoices and detailed documentation demonstrating monthly activity measurements that are subject to approval by the Department. On a monthly basis, within 30 calendar days after the final day of the month, the Contractor shall submit reports that include numbers of users, number of prescriptions and cost per user and prescription as well as total cost both per month and year to date by State Fiscal Year.

Invoices shall be sent to the New Hampshire Department of Health and Human Services at the address below in order to receive payment. All invoices shall be sent to the Department no later than 12 months of the date of service.

Name: Jeffrey Whitney
Mailing Address: NH Medicaid
New Hampshire DHHS

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
PHARMACY BENEFITS MANAGEMENT SYSTEM
EXHIBIT B
Method and Conditions Precedent to Payment

129 Pleasant Street
Concord, NH 03301
Telephone: 603-271-9435
Fax: 603-271-8431
Email: jeffrey.whitney@dhhs.nh.gov

Price and Payment Schedule for Pharmacy Benefits Management System for the Division of Public Health Services.

2.1 Firm Fixed Price $1,611,438 MB 12-10-19

The Firm Fixed Price (FFP) for this Amendment totals ~~$4,663,610~~ for the period between the effective date and 12/31/2023. The source of funds shall be Other Funds, primarily drug manufacturers' rebates collected under the 340B Drug Pricing Program for drugs purchased by NH ADAP. The Contractor shall be responsible for performing its obligations in accordance with the Contract. The Contractor shall invoice the State for the following activities, deliverables, or milestones at fixed pricing/rates appearing in the price and payment tables below:

Table 6: Activities/Deliverables/Milestones Pricing Worksheet

Reference Number	Activity, Deliverable, or Milestone		Deliverable Type	Price
	Ongoing Services			
1	FY 2020 System Support and Maintenance		Non-Software	Included
2	FY 2020 PBM Services		Non-Software	$194,031
3	FY 2021 System Support and Maintenance		Non-Software	Included
4	FY 2021 PBM Services		Non-Software	$392,914
5	FY 2022 System Support and Maintenance		Non-Software	Included
6	FY 2022 PBM Services		Non-Software	$402,737
7	FY 2023 System Support and Maintenance		Non-Software	Included
8	FY 2023 PBM Services		Non-Software	$412,805
9	FY 2024 System Support and Maintenance		Non-Software	Included
10	FY 2024 PBM Services		Non-Software	$208,851

Table 7: Funding Amounts by State Fiscal Year

State Fiscal Year	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	TOTAL
Dates	1/1/2020-6/30/2020	7/1/2020-6/30/2021	7/1/2021-6/30/2022	7/1/2022-6/30/2023	7/1/2023-12/31/2023	
Fees	$194,031.48	$392,913.78	$402,736.62	$412,805.04	$208,950.72	$1,611,438

2.2 Terms of Payment

The State shall pay the Contractor on a monthly basis for PBM services and support, as shown above.

On a monthly basis, the Contractor shall send documentation to the State in support of their monthly invoice. Documentation shall include:

1. Number of claims processed and number of claims paid with amount paid for that month;
2. Number of prior authorizations completed in that month; and
3. Number of e-prescribing transactions.

A. Pricing

All pharmacies that fill prescriptions for NH ADAP clients utilizing the Contractor's Services shall receive the same reimbursement rate and dispensing fees for prescriptions as is used by NH Medicaid. This methodology is described below.

Pharmaceuticals are reimbursed at the lesser of the following:

1. The AAC using NADAC files when available, plus the dispensing fee;
2. The WAC, when a NADAC is not available, plus the dispensing fee;
3. The usual and customary charge to the general public;
4. The NHMAC plus the dispensing fee; or
5. The FUL plus the dispensing fee

The State MAC and CMS FUL shall be modified and monitored at least monthly and modified as necessary to ensure accurate pricing.

The invoices for NH ADAP shall be sent to the New Hampshire Department of Health and Human Services at the address below in order to receive payment. All invoices shall be sent to the Department no later than twelve (12) months of the date of service.

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
PHARMACY BENEFITS MANAGEMENT SYSTEM
EXHIBIT B
Method and Conditions Precedent to Payment

Name:	Karen Hammond
Mailing Address:	NH CARE Program / NH ADAP New Hampshire DHHS 29 Hazen Drive Concord, NH 03301
Telephone:	603-271-7365
Fax:	603-271-4934
Email:	karen.hammond@dhhs.nh.gov

3 Provisions Applicable to all Services provided under the Contract

Liquidated Damages

1. The State and the Contractor agree that it will be impracticable and difficult to determine actual damages that the Department will sustain in the event the Contractor fails to maintain the required performance standards identified below throughout the life of the Contract. Any breach by the Contractor will delay and disrupt the State's operations and obligations and lead to significant damages. Therefore, the parties agree that the liquidated damages as specified in all the sections below are reasonable.

2. Assessment of liquidated damages shall be in addition to, and not in lieu of, such other remedies as may be available to the Department. Except and to the extent expressly provided herein, the Department shall be entitled to recover liquidated damages under each section applicable to any given incident.

3. The Department shall make all assessments of liquidated damages. Should the Department determine that liquidated damages may, or shall be assessed, the Department shall notify The Contractor of the potential assessment in writing.

4. The Contractor agrees that as determined by the DHHS, failure to provide Services meeting the performance standards described below shall result in liquidated damages as specified in the following table. The Contractor agrees to abide by the Performance Standards and Liquidated Damages specified in the Table 3.

Table 8: Liquidated Damages

Service Category	Minimum Standard	Potential Liquidated Damages
1. Retail Point-of-Sale Claims Adjudication Accuracy	The Contractor shall agree to a financial accuracy rate of at least 99% for all prescription claims electronically processed at point-of-sale, measured monthly.	For failure to meet the standard, The Contractor shall be assessed Liquidated Damages equal to 10% of the administrative fee in the Contract month in which the incident occurred.

2. Point-of-Sale Network System Downtime	The Contractor shall agree that unscheduled system downtime shall be no greater than eight (8) hours per incident; not to exceed two times per Contract year. Contractor shall provide notice to the State as to its regularly, scheduled maintenance windows which shall not be part of this guarantee.	For failure to meet the standard, the Contractor shall be assessed Liquidated Damages equal to 10% of the administrative fee in the Contract month in which the incident occurred.
3. Drug Rebates • **This section regarding Drug Rebates pertains to Medicaid services ONLY**	All rebate reporting and payments to the State shall be posted within thirty (30) days of the receipt of the rebate information received from the drug manufacturers through the State. Reporting shall describe the source of the rebates at the item level, and the date payment was received from the manufacturer.	For failure to meet the standard, the Contractor will be assessed Liquidated Damages equal to 10% of the administrative fee in the Contract month in which the incident occurred.
4. Reporting Requirements	The Contractor shall provide all scheduled reports, ad hoc reports, and paid claims transactional history files where the Scope of Work specifies a timeframe within the stated time periods, and to provide the on-line query capability described in The Contractor's response.	For failure to meet the standard, The Contractor shall be assessed Liquidated Damages equal to 10% of the administrative fee in the Contract month in which the incident occurred.
5. Average Speed to Answer	Beneficiary and pharmacy calls received shall be answered within an average of thirty (30) seconds. Reporting shall be provided monthly by the 7th day of the month.	For failure to meet the standard, The Contractor shall be assessed Liquidated Damages equal to 10% of the administrative fee in the Contract month in which the incident occurred.
6. Call Abandonment and Call Blocking Rate	No more than 2% of all beneficiary and pharmacy calls shall be abandoned or blocked. Reporting shall be provided monthly by the 7th day of the month.	For failure to meet the standard, The Contractor shall be assessed Liquidated Damages equal to 10% of the administrative fee in the Contract month in which the incident occurred.
7. Customer Service Resolution Rate	All customer service interactions shall be logged in The Contractor's information systems with 95% of all issues	For failure to meet the standard, The Contractor shall be assessed Liquidated Damages equal to 10% of the administrative fee in

	resolved the same day. 99% of issues resolved within 30 days. Reporting shall be provided monthly by the 7th day of the month.	the Contract month in which the incident occurred.
8. Prior Authorizations	100% of requests for PA shall be completed within twenty-four (24) hours.	For failure to meet the standard, The Contractor shall be assessed Liquidated Damages equal to 10% of the administrative fee in the Contract month in which the incident occurred.
9. Legislative Ad Hoc Report Requests	All requests for legislative ad hoc reports shall be completed within two (2) weeks of request unless otherwise negotiated at the time of the request from the State.	For failure to meet the standard, The Contractor shall be assessed Liquidated Damages equal to 10% of the administrative fee in the Contract month in which the incident occurred.

4. PAYMENT ADDRESS

All payments shall be sent to the following address:
The Contractor Medicaid Administration, Inc. 11013 West Broad St. Suite 500, Glen Allen VA 23060

5. OVERPAYMENTS TO THE CONTRACTOR

The Contractor shall promptly, but no later than fifteen (15) business days, return to the State the full amount of any overpayment or erroneous payment upon discovery or notice from the State.

6. CREDITS

The State may apply credits due to the State arising out of this Contract, against the Contractor's invoices with appropriate information attached.

The Contractor shall keep detailed records of their activities related to State-funded programs and services and have records available for Department review, as requested.

7. Notwithstanding anything to the contrary herein, the Contractor agrees that funding under this agreement may be withheld, in whole or in part, in the event of non-compliance with any Federal

or State law, rule or regulation applicable to the services provided, or if the services or have not been satisfactorily completed in accordance with the terms and conditions of this Contract. Payments may be withheld pending receipt of required reports or documentation.

8. Notwithstanding paragraph 18 of the General Provisions P-37, changes limited to adjusting amounts within the price limitation and adjusting encumbrances between State Fiscal Years may be made through the Budget Office by written agreement of both parties, without obtaining additional approval of the Governor and Executive Council, if needed and justified.

6. The final invoice shall be due to the State no later than forty (40) days after the contract completion date specified in Form P-37, General Provisions Block 1.7 Completion Date.

REVISIONS TO STANDARD CONTRACT LANGUAGE

1. Revisions to Form P-37, General Provisions

1.1. Section 4, Conditional Nature of Agreement, is replaced as follows:

4. CONDITIONAL NATURE OF AGREEMENT.

Notwithstanding any provision of this Agreement to the contrary, all obligations of the State hereunder, including without limitation, the continuance of payments, in whole or in part, under this Agreement are contingent upon continued appropriation or availability of funds, including any subsequent changes to the appropriation or availability of funds affected by any state or federal legislative or executive action that reduces, eliminates, or otherwise modifies the appropriation or availability of funding for this Agreement and the Scope of Services provided in Exhibit A, Scope of Services, in whole or in part. In no event shall the State be liable for any payments hereunder in excess of appropriated or available funds. In the event of a reduction, termination or modification of appropriated or available funds, the State shall have the right to withhold payment until such funds become available, if ever. The State shall have the right to reduce, terminate or modify services under this Agreement immediately upon giving the Contractor notice of such reduction, termination or modification. The State shall not be required to transfer funds from any other source or account into the Account(s) identified in block 1.6 of the General Provisions, Account Number, or any other account in the event funds are reduced or unavailable.

1.2. Section 10, Termination, is amended by adding the following language:

10.1 The State may terminate the Agreement at any time for any reason, at the sole discretion of the State, 30 days after giving the Contractor written notice that the State is exercising its option to terminate the Agreement.

10.2 In the event of early termination, the Contractor shall, within 15 days of notice of early termination, develop and submit to the State a Transition Plan for services under the Agreement, including but not limited to, identifying the present and future needs of clients receiving services under the Agreement and establishes a process to meet those needs.

10.3 The Contractor shall fully cooperate with the State and shall promptly provide detailed information to support the Transition Plan including, but not limited to, any information or data requested by the State related to the termination of the Agreement and Transition Plan and shall provide ongoing communication and revisions of the Transition Plan to the State as requested.

10.4 In the event that services under the Agreement, including but not limited to clients receiving services under the Agreement are transitioned to having services delivered by another entity including contracted providers or the State, the Contractor shall provide a process for uninterrupted delivery of services in the Transition Plan.

10.5 The Contractor shall establish a method of notifying clients and other affected individuals about the transition. The Contractor shall include the proposed communications in its Transition Plan submitted to the State as described above.

2. Revisions to Standard Exhibits

Exhibit I, Health Insurance Portability and Accountability Act Business Associate Agreement, is modified as follows:

Consistent with the terms of the Department's standard Exhibit I, and by way of addition thereto in addition to providing the Department with notice of any breach, or alleged or potential breach of Personal Health information (PHI) security and/r any other information protected by HIPAA, as required by law, or breach of any confidential recipient or provider information, the Contractor will pay all costs incurred by the Department to meet state and

federal notice requirements and the cost of any identify-theft protection the Department might wish to extend to potentially injured parties. The Contractor will not deal with any providers or recipients directly, but will give notice of breach, or alleged or potential breach to the Department. The Department's method of complying with notice requirements and/or extension of identify-theft protection, shall be solely at the discretion of the Department.

CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The Vendor identified in Section 1.3 of the General Provisions agrees to comply with the provisions of Sections 5151-5160 of the Drug-Free Workplace Act of 1988 (Pub. L. 100-690, Title V, Subtitle D; 41 U.S.C. 701 et seq.), and further agrees to have the Contractor's representative, as identified in Sections 1.11 and 1.12 of the General Provisions execute the following Certification:

ALTERNATIVE I - FOR GRANTEES OTHER THAN INDIVIDUALS

US DEPARTMENT OF HEALTH AND HUMAN SERVICES - CONTRACTORS
US DEPARTMENT OF EDUCATION - CONTRACTORS
US DEPARTMENT OF AGRICULTURE - CONTRACTORS

This certification is required by the regulations implementing Sections 5151-5160 of the Drug-Free Workplace Act of 1988 (Pub. L. 100-690, Title V, Subtitle D; 41 U.S.C. 701 et seq.). The January 31, 1989 regulations were amended and published as Part II of the May 25, 1990 Federal Register (pages 21681-21691), and require certification by grantees (and by inference, sub-grantees and sub-contractors), prior to award, that they will maintain a drug-free workplace. Section 3017.630(c) of the regulation provides that a grantee (and by inference, sub-grantees and sub-contractors) that is a State may elect to make one certification to the Department in each federal fiscal year in lieu of certificates for each grant during the federal fiscal year covered by the certification. The certificate set out below is a material representation of fact upon which reliance is placed when the agency awards the grant. False certification or violation of the certification shall be grounds for suspension of payments, suspension or termination of grants, or government wide suspension or debarment. Contractors using this form should send it to:

Commissioner
NH Department of Health and Human Services
129 Pleasant Street,
Concord, NH 03301-6505

1. The grantee certifies that it will or will continue to provide a drug-free workplace by:
   - 1.1. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;
   - 1.2. Establishing an ongoing drug-free awareness program to inform employees about
     - 1.2.1. The dangers of drug abuse in the workplace;
     - 1.2.2. The grantee's policy of maintaining a drug-free workplace;
     - 1.2.3. Any available drug counseling, rehabilitation, and employee assistance programs; and
     - 1.2.4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
   - 1.3. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a);
   - 1.4. Notifying the employee in the statement required by paragraph (a) that, as a condition of employment under the grant, the employee will
     - 1.4.1. Abide by the terms of the statement; and
     - 1.4.2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
   - 1.5. Notifying the agency in writing, within ten calendar days after receiving notice under subparagraph 1.4.2 from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer on whose grant activity the convicted employee was working, unless the Federal agency

has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

1.6. Taking one of the following actions, within 30 calendar days of receiving notice under subparagraph 1.4.2, with respect to any employee who is so convicted

1.6.1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or

1.6.2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

1.7. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs 1.1, 1.2, 1.3, 1.4, 1.5, and 1.6.

2. The grantee may insert in the space provided below the site(s) for the performance of work done in connection with the specific grant.

Place of Performance (street address, city, county, state, zip code) (list each location)

Check ☐ if there are workplaces on file that are not identified here.

Vendor Name:

12/4/19
Date

Name: Meredith Delk
Title: GM & SVP Government Markets

CERTIFICATION REGARDING LOBBYING

The Vendor identified in Section 1.3 of the General Provisions agrees to comply with the provisions of Section 319 of Public Law 101-121, Government wide Guidance for New Restrictions on Lobbying, and 31 U.S.C. 1352, and further agrees to have the Contractor's representative, as identified in Sections 1.11 and 1.12 of the General Provisions execute the following Certification:

US DEPARTMENT OF HEALTH AND HUMAN SERVICES - CONTRACTORS
US DEPARTMENT OF EDUCATION - CONTRACTORS
US DEPARTMENT OF AGRICULTURE - CONTRACTORS

Programs (indicate applicable program covered):
*Temporary Assistance to Needy Families under Title IV-A
*Child Support Enforcement Program under Title IV-D
*Social Services Block Grant Program under Title XX
*Medicaid Program under Title XIX
*Community Services Block Grant under Title VI
*Child Care Development Block Grant under Title IV

The undersigned certifies, to the best of his or her knowledge and belief, that:

1. No Federal appropriated funds have been paid or will be paid by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement (and by specific mention sub-grantee or sub-contractor).

2. If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement (and by specific mention sub-grantee or sub-contractor), the undersigned shall complete and submit Standard Form LLL, (Disclosure Form to Report Lobbying, in accordance with its instructions, attached and identified as Standard Exhibit E-I.)

3. The undersigned shall require that the language of this certification be included in the award document for sub-awards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans, and cooperative agreements) and that all sub-recipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Vendor Name:

12/4/19
Date

Name: Meredith Delk
Title: GM & SVP Government Markets

Exhibit I

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT BUSINESS ASSOCIATE AGREEMENT

The Contractor identified in Section 1.3 of the General Provisions of the Agreement agrees to comply with the Health Insurance Portability and Accountability Act, Public Law 104-191 and with the Standards for Privacy and Security of Individually Identifiable Health Information, 45 CFR Parts 160 and 164 applicable to business associates. As defined herein, "Business Associate" shall mean the Contractor and subcontractors and agents of the Contractor that receive, use or have access to protected health information under this Agreement and "Covered Entity" shall mean the State of New Hampshire, Department of Health and Human Services.

(1) Definitions.

a. "Breach" shall have the same meaning as the term "Breach" in section 164.402 of Title 45, Code of Federal Regulations.

b. "Business Associate" has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations.

c. "Covered Entity" has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations.

d. "Designated Record Set" shall have the same meaning as the term "designated record set" in 45 CFR Section 164.501.

e. "Data Aggregation" shall have the same meaning as the term "data aggregation" in 45 CFR Section 164.501.

f. "Health Care Operations" shall have the same meaning as the term "health care operations" in 45 CFR Section 164.501.

g. "HITECH Act" means the Health Information Technology for Economic and Clinical Health Act, TitleXIII, Subtitle D, Part 1 & 2 of the American Recovery and Reinvestment Act of 2009.

h. "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 and the Standards for Privacy and Security of Individually Identifiable Health Information, 45 CFR Parts 160, 162 and 164 and amendments thereto.

i. "Individual" shall have the same meaning as the term "individual" in 45 CFR Section 160.103 and shall include a person who qualifies as a personal representative in accordance with 45 CFR Section 164.501(g).

j. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Parts 160 and 164, promulgated under HIPAA by the United States Department of Health and Human Services.

k. "Protected Health Information" shall have the same meaning as the term "protected health information" in 45 CFR Section 160.103, limited to the information created or received by Business Associate from or on behalf of Covered Entity.

l. "Required by Law" shall have the same meaning as the term "required by law" in 45 CFR Section 164.103.

m. "Secretary" shall mean the Secretary of the Department of Health and Human Services or his/her designee.

n. "Security Rule" shall mean the Security Standards for the Protection of Electronic Protected Health Information at 45 CFR Part 164, Subpart C, and amendments thereto.

o. "Unsecured Protected Health Information" means protected health information that is not secured by a technology standard that renders protected health information unusable, unreadable, or indecipherable to unauthorized individuals and is developed or endorsed by a standards developing organization that is accredited by the American National Standards Institute.

p. Other Definitions - All terms not otherwise defined herein shall have the meaning established under 45 C.F.R. Parts 160, 162 and 164, as amended from time to time, and the HITECH
Act.

(2) Business Associate Use and Disclosure of Protected Health Information.

a. Business Associate shall not use, disclose, maintain or transmit Protected Health Information (PHI) except as reasonably necessary to provide the services outlined under Exhibit A of the Agreement. Further, Business Associate, including but not limited to all its directors, officers, employees and agents, shall not use, disclose, maintain or transmit PHI in any manner that would constitute a violation of the Privacy and Security Rule.

b. Business Associate may use or disclose PHI:
   I. For the proper management and administration of the Business Associate or to carry out the legal responsibilities of Business Associate relating to this contract;
   II. As permitted by law or required by law, pursuant to the terms set forth in paragraph d. below; or
   III. For data aggregation purposes for the health care operations of Covered Entity.

c. To the extent Business Associate is permitted under the Agreement or this Exhibit I to disclose PHI to a third party for the purposes set forth in Section 2(b) above, Business Associate must obtain, prior to making any such disclosure, (i) reasonable assurances from the third party that such PHI will be held confidentially and used or further disclosed only as required by law or for the purpose for which it was disclosed to the third party; and (ii) an agreement from such third party to notify Business Associate, in accordance with the HIPAA Privacy, Security, and Breach Notification Rules of any breaches of the confidentiality of the PHI, to the extent it has obtained knowledge of such breach.

d. The Business Associate shall not, unless such disclosure is reasonably necessary to provide services under Exhibit A of the Agreement, disclose any PHI in response to a

request for disclosure on the basis that it is required by law, without first notifying Covered Entity so that Covered Entity has an opportunity to object to the disclosure and to seek appropriate relief. If Covered Entity objects to such disclosure, the BusinessAssociate shall refrain from disclosing the PHI until Covered Entity has exhausted all remedies.

e. If the Covered Entity notifies the Business Associate that Covered Entity has agreed to be bound by additional restrictions over and above those uses or disclosures or security safeguards of PHI pursuant to the Privacy and Security Rule, the Business Associate shall be bound by such additional restrictions and shall not disclose PHI in violation of such additional restrictions and shall abide by any additional security safeguards.

(3) **Obligations and Activities of Business Associate.**

a. The Business Associate shall notify the Covered Entity's Privacy Officer immediately or as soon as practicable after the Business Associate suspects or becomes aware of any use or disclosure of protected health information not provided for by the Agreement or any security incident that may have an impact on the protected health information of the Covered Entity and immediately after the business associate becomes aware of a breach of unsecured protected health information..

b. The Business Associate shall immediately commencea risk assessment when it becomes aware of any of the above situations and provide the Department with timely status reports as the risk assessment progresses The risk assessment shall include, but not be limited to:

- The nature and extent of the protected health information involved, including the types of identifiers and the likelihood of re-identification;
- The unauthorized person used the protected health information or to whom the disclosure was made;
- Whether the protected health information was actually acquired or viewed
- The extent to which the risk to the protected health information has been mitigated.

The Business Associate shall complete the risk assessment within 14 days ofthe breach and immediately report the findings of the risk assessment in writing to the Covered Entity.

c. The Business Associate shall comply with all applicable sections of the Privacy, Security, and Breach Notification Rule.

d. Business Associate shall make available all of its internal policies and procedures, books and records relating to the use and disclosure of PHI received from, or created or received by the Business Associate on behalf of Covered Entity to the Secretary for purposes of determining Covered Entity's compliance with HIPAA and the Privacy and Security Rule.

e. Business Associate shall require all of its business associates that receive, use or have access to PHI under the Agreement, to agree in writing to adhere to the same restrictions and conditions on the use and disclosure of PHI contained herein, including the duty to return or destroy the PHI as provided under Section 3 (l). The Covered Entity

shall be considered a direct third party beneficiary of the Contractor's business associate agreements with Contractor's intended business associates, who will be receiving PHIpursuant to this Agreement, with rights of enforcement and indemnification from such business associates who shall be governed by standard Paragraph #13 of the standard contract provisions (P-37) of this Agreement for the purpose of use and disclosure of protected health information.

f. Within five (5) business days of receipt of a written request from Covered Entity, Business Associate shall make available during normal business hours at its offices all records, books, agreements, policies and procedures relating to the use and disclosure of PHI to the Covered Entity, for purposes of enabling Covered Entity to determine Business Associate's compliance with the terms of the Agreement.

g. Within ten (10) business days of receiving a written request from Covered Entity, Business Associate shall provide access to PHI in a Designated Record Set to the Covered Entity, or as directed by Covered Entity, to an individual in order to meet the requirements under 45 CFR Section 164.524.

h. Within ten (10) business days of receiving a written request from Covered Entity for an amendment of PHI or a record about an individual contained in a Designated Record Set, the Business Associate shall make such PHI available to Covered Entity for amendment and incorporate any such amendment to enable Covered Entity to fulfill its obligations under 45 CFR Section 164.526.

i. Business Associate shall document such disclosures of PHI and information related to such disclosures as would be required for Covered Entity to respond to a request by an individual for an accounting of disclosures of PHI in accordance with 45 CFR Section 164.528.

j. Within ten (10) business days of receiving a written request from Covered Entity for a request for an accounting of disclosures of PHI, Business Associate shall make available to Covered Entity such information as Covered Entity may require to fulfill its obligations to provide an accounting of disclosures with respect to PHI in accordance with 45 CFR Section 164.528.

k. In the event any individual requests access to, amendment of, or accounting of PHI directly from the Business Associate, the Business Associate shall within two (2) business days forward such request to Covered Entity. Covered Entity shall have the responsibility of responding to forwarded requests. However, if forwarding the individual's request to Covered Entity would cause Covered Entity or the Business Associate to violate HIPAA and the Privacy and Security Rule, the Business Associate shall instead respond to the individual's request as required by such law and notify Covered Entity of such response as soon as practicable.

l. Within thirty (30) business days of termination of the Agreement, for any reason, the Business Associate shall return or destroy, as specified by Covered Entity, all PHI received from, or created or received by the Business Associate in connection with the Agreement, and shall not retain any copies or back-up tapes of such PHI. If return or destruction is not feasible, or the disposition of the PHI has been otherwise agreed to in the Agreement, Business Associate shall continue to extend the protections of the

Agreement, to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as BusinessAssociate maintains such PHI. If Covered Entity, in its sole discretion, requires that the Business Associate destroy any or all PHI, the Business Associate shall certify to Covered Entity that the PHI has been destroyed.

(4) Obligations of Covered Entity

a. Covered Entity shall notify Business Associate of any changes or limitation(s) in its Notice of Privacy Practices provided to individuals in accordance with 45 CFR Section 164.520, to the extent that such change or limitation may affect Business Associate's use or disclosure of PHI.

b. Covered Entity shall promptly notify Business Associate of any changes in, or revocation of permission provided to Covered Entity by individuals whose PHI may be used or disclosed by Business Associate under this Agreement, pursuant to 45 CFR Section 164.506 or 45 CFR Section 164.508.

c. Covered entity shall promptly notify Business Associate of any restrictions on the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 CFR 164.522, to the extent that such restriction may affect Business Associate's use or disclosure of PHI.

(5) Termination for Cause

In addition to Paragraph 10 of the standard terms and conditions (P-37) of this Agreement the Covered Entity may immediately terminate the Agreement upon Covered Entity's knowledge of a material breach by Business Associate of the Business Associate Agreement set forth herein as Exhibit I. The Covered Entity may alternatively provide an opportunity for Business Associate to cure the alleged breach within a timeframe specified by Covered Entity.

(6) Miscellaneous

a. Definitions and Regulatory References. All terms used, but not otherwise defined herein, shall have the same meaning as those terms in the Privacy and Security Rule, amended from time to time. A reference in the Agreement, as amended to include this Exhibit I, to a Section in the Privacy and Security Rule means the Section as in effect or as amended.

b. Amendment. Covered Entity and Business Associate agree to take such action as is necessary to amend the Agreement, from time to time as is necessary for Covered Entity to comply with the changes in the requirements of HIPAA, the Privacy and Security Rule, and applicable federal and state law.

c. Data Ownership. The Business Associate acknowledges that it has no ownership rights with respect to the PHI provided by or created on behalf of Covered Entity.

d. Interpretation. The parties agree that any ambiguity in the Agreement shall be resolved

to permit Covered Entity to comply with HIPAA, the Privacy and Security Rule.

e. Segregation. If any term or condition of this Exhibit I or the application thereof to any person(s) or circumstance is held invalid, such invalidity shall not affect other terms or conditions which can be given effect without the invalid term or condition; to this end the terms and conditions of this Exhibit I are declared severable.

f. Survival. Provisions in this Exhibit I regarding the use and disclosure of PHI, return or destruction of PHI, extensions of the protections of the Agreement in section (3) I, the defense and indemnification provisions of section (3) e and Paragraph 13 of the standard terms and conditions (P-37), shall survive the termination of the Agreement.

IN WITNESS WHEREOF, the parties hereto have duly executed this Exhibit I.

Department of Health and Human Services	Magellan Medicaid Administration, Inc.
The State	Name of the Contractor
Signature of Authorized Representative	Signature of Authorized Representative
Henry D. Lipman	Meredith Delk
Name of Authorized Representative	Name of Authorized Representative
Medicaid Director	GM & SVP Government Markets
Title of Authorized Representative	Title of Authorized Representative
12/6/19	12/4/19
Date	Date

CERTIFICATION REGARDING THE FEDERAL FUNDING ACCOUNTABILITY AND TRANSPARENCY ACT (FFATA) COMPLIANCE

The Federal Funding Accountability and Transparency Act (FFATA) requires prime awardees of individual Federal grants equal to or greater than $25,000 and awarded on or after October 1, 2010, to report on data related to executive compensation and associated first-tier sub-grants of $25,000 or more. If the initial award is below $25,000 but subsequent grant modifications result in a total award equal to or over $25,000, the award is subject to the FFATA reporting requirements, as of the date of the award.
In accordance with 2 CFR Part 170 (Reporting Subaward and Executive Compensation Information), the Department of Health and Human Services (DHHS) must report the following information for any subaward or contract award subject to the FFATA reporting requirements:

1. Name of entity
2. Amount of award
3. Funding agency
4. NAICS code for contracts / CFDA program number for grants
5. Program source
6. Award title descriptive of the purpose of the funding action
7. Location of the entity
8. Principle place of performance
9. Unique identifier of the entity (DUNS #)
10. Total compensation and names of the top five executives if:
    - 10.1. More than 80% of annual gross revenues are from the Federal government, and those revenues are greater than $25M annually and
    - 10.2. Compensation information is not already available through reporting to the SEC.

Prime grant recipients must submit FFATA required data by the end of the month, plus 30 days, in which the award or award amendment is made.
The Contractor identified in Section 1.3 of the General Provisions agrees to comply with the provisions of The Federal Funding Accountability and Transparency Act, Public Law 109-282 and Public Law 110-252, and 2 CFR Part 170 (Reporting Subaward and Executive Compensation Information), and further agrees to have the Contractor's representative, as identified in Sections 1.11 and 1.12 of the General Provisions execute the following Certification:
The below named Contractor agrees to provide needed information as outlined above to the NH Department of Health and Human Services and to comply with all applicable provisions of the Federal Financial Accountability and Transparency Act.

Contractor Name:

12/4/19
Date

Name: Meredith Delk
Title: GM & SVP Government Markets

FORM A

As the Contractor identified in Section 1.3 of the General Provisions, I certify that the responses to the below listed questions are true and accurate.

1. The DUNS number for your entity is: 06-601-5611

2. In your business or organization's preceding completed fiscal year, did your business or organization receive (1) 80 percent or more of your annual gross revenue in U.S. federal contracts, subcontracts, loans, grants, sub-grants, and/or cooperative agreements; and (2) $25,000,000 or more in annual gross revenues from U.S. federal contracts, subcontracts, loans, grants, subgrants, and/or cooperative agreements?

   X NO _____ YES

   If the answer to #2 above is NO, stop here

   If the answer to #2 above is YES, please answer the following:

3. Does the public have access to information about the compensation of the executives in your business or organization through periodic reports filed under section 13(a) or 15(d) of the Securities Exchange Act of 1934 (15 U.S.C.78m(a), 78o(d)) or section 6104 of the Internal Revenue Code of 1986?

   _____ NO _____ YES

   If the answer to #3 above is YES, stop here

   If the answer to #3 above is NO, please answer the following:

4. The names and compensation of the five most highly compensated officers in your business or organization are as follows:

   Name: _____ Amount: _____

   Name: _____ Amount: _____

   Name: _____ Amount: _____

   Name: _____ Amount: _____

   Name: _____ Amount: _____

A. Definitions

The following terms may be reflected and have the described meaning in this document:

1. "Breach" means the loss of control, compromise, unauthorized disclosure, unauthorized acquisition, unauthorized access, or any similar term referring to situations where persons other than authorized users and for an other than authorized purpose have access or potential access to personally identifiable information, whether physical or electronic. With regard to Protected Health Information, " Breach" shall have the same meaning as the term "Breach" in section 164.402 of Title 45, Code of Federal Regulations.

2. "Computer Security Incident" shall have the same meaning "Computer Security Incident" in section two (2) of NIST Publication 800-61, Computer Security Incident Handling Guide, National Institute of Standards and Technology, U.S. Department of Commerce.

3. "Confidential Information" or "Confidential Data" means all confidential information disclosed by one party to the other such as all medical, health, financial, public assistance benefits and personal information including without limitation, Substance Abuse Treatment Records, Case Records, Protected Health Information and Personally Identifiable Information.

   Confidential Information also includes any and all information owned or managed by the State of NH - created, received from or on behalf of the Department of Health and Human Services (DHHS) or accessed in the course of performing contracted services - of which collection, disclosure, protection, and disposition is governed by state or federal law or regulation. This information includes, but is not limited to Protected Health Information (PHI), Personal Information (PI), Personal Financial Information (PFI), Federal Tax Information (FTI), Social Security Numbers (SSN), Payment Card Industry (PCI), and or other sensitive and confidential information.

4. "End User" means any person or entity (e.g., contractor, contractor's employee, business associate, subcontractor, other downstream user, etc.) that receives DHHS data or derivative data in accordance with the terms of this Contract.

5. "HIPAA" means the Health Insurance Portability and Accountability Act of 1996 and the regulations promulgated thereunder.

6. "Incident" means an act that potentially violates an explicit or implied security policy, which includes attempts (either failed or successful) to gain unauthorized access to a system or its data, unwanted disruption or denial of service, the unauthorized use of a system for the processing or storage of data; and changes to system hardware, firmware, or software characteristics without the owner's knowledge, instruction, or consent. Incidents include the loss of data through theft or device misplacement, loss or misplacement of hardcopy documents, and misrouting of physical or electronic

mail, all of which may have the potential to put the data at risk of unauthorized access, use, disclosure, modification or destruction.

7. "Open Wireless Network" means any network or segment of a network that is not designated by the State of New Hampshire's Department of Information Technology or delegate as a protected network (designed, tested, and approved, by means of the State, to transmit) will be considered an open network and not adequately secure for the transmission of unencrypted PI, PFI, PHI or confidential DHHS data.

8. "Personal Information" (or "PI") means information which can be used to distinguish or trace an individual's identity, such as their name, social security number, personal information as defined in New Hampshire RSA 359-C:19, biometric records, etc., alone, or when combined with other personal or identifying information which is linked or linkable to a specific individual, such as date and place of birth, mother's maiden name, etc.

9. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 C.F.R. Parts 160 and 164, promulgated under HIPAA by the United States Department of Health and Human Services.

10. "Protected Health Information" (or "PHI") has the same meaning as provided in the definition of "Protected Health Information" in the HIPAA Privacy Rule at 45 C.F.R. § 160.103.

11. "Security Rule" shall mean the Security Standards for the Protection of Electronic Protected Health Information at 45 C.F.R. Part 164, Subpart C, and amendments thereto.

12. "Unsecured Protected Health Information" means Protected Health Information that is not secured by a technology standard that renders Protected Health Information unusable, unreadable, or indecipherable to unauthorized individuals and is developed or endorsed by a standards developing organization that is accredited by the American National Standards Institute.

I. RESPONSIBILITIES OF DHHS AND THE CONTRACTOR

A. Business Use and Disclosure of Confidential Information.

1. The Contractor must not use, disclose, maintain or transmit Confidential Information except as reasonably necessary as outlined under this Contract. Further, Contractor, including but not limited to all its directors, officers, employees and agents, must not use, disclose, maintain or transmit PHI in any manner that would constitute a violation of the Privacy and Security Rule.
2. The Contractor must not disclose any Confidential Information in response to a

request for disclosure on the basis that it is required by law, in response to a subpoena, etc., without first notifying DHHS so that DHHS has an opportunity to consent or object to the disclosure.

3. If DHHS notifies the Contractor that DHHS has agreed to be bound by additional restrictions over and above those uses or disclosures or security safeguards of PHI pursuant to the Privacy and Security Rule, the Contractor must be bound by such additional restrictions and must not disclose PHI in violation of such additional restrictions and must abide by any additional security safeguards.
4. The Contractor agrees that DHHS Data or derivative there from disclosed to an End User must only be used pursuant to the terms of this Contract.
5. The Contractor agrees DHHS Data obtained under this Contract may not be used for any other purposes that are not indicated in this Contract.
6. The Contractor agrees to grant access to the data to the authorized representatives of DHHS for the purpose of inspecting to confirm compliance with the terms of this Contract.

II. METHODS OF SECURE TRANSMISSION OF DATA

1. Application Encryption. If End User is transmitting DHHS data containing Confidential Data between applications, the Contractor attests the applications have been evaluated by an expert knowledgeable in cyber security and that said application's encryption capabilities ensure secure transmission via the internet.
2. Computer Disks and Portable Storage Devices. End User may not use computer disks or portable storage devices, such as a thumb drive, as a method of transmitting DHHS data.
3. Encrypted Email. End User may only employ email to transmit Confidential Data if email is encrypted and being sent to and being received by email addresses of persons authorized to receive such information.
4. Encrypted Web Site. If End User is employing the Web to transmit Confidential Data, the secure socket layers (SSL) must be used and the web site must be secure. SSL encrypts data transmitted via a Web site.
5. File Hosting Services, also known as File Sharing Sites. End User may not use file hosting services, such as Dropbox or Google Cloud Storage, to transmit Confidential Data.
6. Ground Mail Service. End User may only transmit Confidential Data via *certified* ground mail within the continental U.S. and when sent to a named individual.
7. Laptops and PDA. If End User is employing portable devices to transmit Confidential Data said devices must be encrypted and password-protected.
8. Open Wireless Networks. End User may not transmit Confidential Data via an open

wireless network. End User must employ a virtual private network (VPN) when remotely transmitting via an open wireless network.

9. Remote User Communication. If End User is employing remote communication to access or transmit Confidential Data, a virtual private network (VPN) must be installed on the End User's mobile device(s) or laptop from which information will be transmitted or accessed.
10. SSH File Transfer Protocol (SFTP), also known as Secure File Transfer Protocol. If End User is employing an SFTP to transmit Confidential Data, End User will structure the Folder and access privileges to prevent inappropriate disclosure of information. SFTP folders and sub-folders used for transmitting Confidential Data will be coded for 24-hour auto-deletion cycle (i.e. Confidential Data will be deleted every 24 hours).
11. Wireless Devices. If End User is transmitting Confidential Data via wireless devices, all data must be encrypted to prevent inappropriate disclosure of information.

III. RETENTION AND DISPOSITION OF IDENTIFIABLE RECORDS

The Contractor will only retain the data and any derivative of the data for the duration of this Contract. After such time, the Contractor will have 30 days to destroy the data and any derivative in whatever form it may exist, unless, otherwise required by law or permitted under this Contract. If it is infeasible to return or destroy the Confidential Data, protections pursuant to this Information Security Requirements Exhibit survive this contract. Notwithstanding the above, Magellan may retain one copy of any such Confidential Data necessary to comply with applicable professional actuarial standards and requirements for archival and work product documentation, retention, and destruction. This condition is subject to the protections of this Exhibit which survive this contract." To this end, the parties must:

A. Retention

1. The Contractor agrees it will not store, transfer or process data collected in connection with the services rendered under this Contract outside of the United States. This physical location requirement shall also apply in the implementation of cloud computing, cloud service or cloud storage capabilities, and includes backup data and Disaster Recovery locations.
2. The Contractor agrees to ensure proper security monitoring capabilities are in place to detect potential security events that can impact State of NH systems and/or Department confidential information for contractor provided systems.
3. The Contractor agrees to provide security awareness and education for its End Users in support of protecting Department confidential information.
4. The Contractor agrees to retain all electronic and hard copies of Confidential Data in a secure location and identified in section IV. A.2

5. The Contractor agrees Confidential Data stored in a Cloud must be in a FedRAMP/HITECH compliant solution and comply with all applicable statutes and regulations regarding the privacy and security. All servers and devices must have currently-supported and hardened operating systems, the latest anti-viral, anti-hacker, anti-spam, anti-spyware, and anti-malware utilities. The environment, as a whole, must have aggressive intrusion-detection and firewall protection.
6. The Contractor agrees to and ensures its complete cooperation with the State's Chief Information Officer in the detection of any security vulnerability of the hosting infrastructure.

B. Disposition

1. If the Contractor will maintain any Confidential Information on its systems (or its sub-contractor systems), the Contractor will maintain a documented process for securely disposing of such data upon request or contract termination; and will obtain written certification for any State of New Hampshire data destroyed by the Contractor or any subcontractors as a part of ongoing, emergency, and or disaster recovery operations. When no longer in use, electronic media containing State of New Hampshire data shall be rendered unrecoverable via a secure wipe program in accordance with industry-accepted standards for secure deletion and media sanitization, or otherwise physically destroying the media (for example, degaussing) as described in NIST Special Publication 800-88, Rev 1, Guidelines for Media Sanitization, National Institute of Standards and Technology, U. S. Department of Commerce. The Contractor will document and certify in writing at time of the data destruction, and will provide written certification to the Department upon request. The written certification will include all details necessary to demonstrate data has been properly destroyed and validated. Where applicable, regulatory and professional standards for retention requirements will be jointly evaluated by the State and Contractor prior to destruction.
2. Unless otherwise specified, within thirty (30) days of the termination of this Contract, Contractor agrees to destroy all hard copies of Confidential Data using a secure method such as shredding.
3. Unless otherwise specified, within thirty (30) days of the termination of this Contract, Contractor agrees to completely destroy all electronic Confidential Data by means of data erasure, also known as secure data wiping.

IV. PROCEDURES FOR SECURITY

A. Contractor agrees to safeguard the DHHS Data received under this Contract, and any derivative data or files, as follows:

1. The Contractor will maintain proper security controls to protect Department confidential information collected, processed, managed, and/or stored in the delivery

of contracted services.

2. The Contractor will maintain policies and procedures to protect Department confidential information throughout the information lifecycle, where applicable, (from creation, transformation, use, storage and secure destruction) regardless of the media used to store the data (i.e., tape, disk, paper, etc.).

3. The Contractor will maintain appropriate authentication and access controls to contractor systems that collect, transmit, or store Department confidential information where applicable.

4. The Contractor will ensure proper security monitoring capabilities are in place to detect potential security events that can impact State of NH systems and/or Department confidential information for contractor provided systems.

5. The Contractor will provide regular security awareness and education for its End Users in support of protecting Department confidential information.

6. If the Contractor will be sub-contracting any core functions of the engagement supporting the services for State of New Hampshire, the Contractor will maintain a program of an internal process or processes that defines specific security expectations, and monitoring compliance to security requirements that at a minimum match those for the Contractor, including breach notification requirements.

7. The Contractor will work with the Department to sign and comply with all applicable State of New Hampshire and Department system access and authorization policies and procedures, systems access forms, and computer use agreements as part of obtaining and maintaining access to any Department system(s). Agreements will be completed and signed by the Contractor and any applicable sub-contractors prior to system access being authorized.

8. If the Department determines the Contractor is a Business Associate pursuant to 45 CFR 160.103, the Contractor will execute a HIPAA Business Associate Agreement (BAA) with the Department and is responsible for maintaining compliance with the agreement.

9. The Contractor will work with the Department at its request to complete a System Management Survey. The purpose of the survey is to enable the Department and Contractor to monitor for any changes in risks, threats, and vulnerabilities that may occur over the life of the Contractor engagement. The survey will be completed annually, or an alternate time frame at the Departments discretion with agreement by the Contractor, or the Department may request the survey be completed when the scope of the engagement between the Department and the Contractor changes.

10. The Contractor will not store, knowingly or unknowingly, any State of New Hampshire or Department data offshore or outside the boundaries of the United States unless

prior express written consent is obtained from the Information Security Office leadership member within the Department.

11. Data Security Breach Liability. In the event of any security breach Contractor shall make efforts to investigate the causes of the breach, promptly take measures to prevent future breach and minimize any damage or loss resulting from the breach. The State shall recover from the Contractor all costs of response and recovery from the breach, including but not limited to: credit monitoring services, mailing costs and costs associated with website and telephone call center services necessary due to the breach.

12. Contractor must, comply with all applicable statutes and regulations regarding the privacy and security of Confidential Information, and must in all other respects maintain the privacy and security of PI and PHI at a level and scope that is not less than the level and scope of requirements applicable to federal agencies, including, but not limited to, provisions of the Privacy Act of 1974 (5 U.S.C. § 552a), DHHS Privacy Act Regulations (45 C.F.R. §5b), HIPAA Privacy and Security Rules (45 C.F.R. Parts 160 and 164) that govern protections for individually identifiable health information and as applicable under State law.

13. Contractor agrees to establish and maintain appropriate administrative, technical, and physical safeguards to protect the confidentiality of the Confidential Data and to prevent unauthorized use or access to it. The safeguards must provide a level and scope of security that is not less than the level and scope of security requirements established by the State of New Hampshire, Department of Information Technology. Refer to Vendor Resources/Procurement at https://www.nh.gov/doit/vendor/index.htm for the Department of Information Technology policies, guidelines, standards, and procurement information relating to vendors.

14. Contractor agrees to maintain a documented breach notification and incident response process. The Contractor will notify the State's Privacy Officer and the State's Security Officer of any security breach immediately, at the email addresses provided in Section VI. This includes a confidential information breach, computer security incident, or suspected breach which affects or includes any State of New Hampshire systems that connect to the State of New Hampshire network.

15. Contractor must restrict access to the Confidential Data obtained under this Contract to only those authorized End Users who need such DHHS Data to perform their official duties in connection with purposes identified in this Contract.

16. The Contractor must ensure that all End Users:

    a. comply with such safeguards as referenced in Section IV A. above, implemented to protect Confidential Information that is furnished by DHHS under this Contract from loss, theft or inadvertent disclosure.

    b. safeguard this information at all times.

c. ensure that laptops and other electronic devices/media containing PHI, PI, or PFI are encrypted and password-protected.

d. send emails containing Confidential Information only if encrypted and being sent to and being received by email addresses of persons authorized to receive such information.

e. limit disclosure of the Confidential Information to the extent permitted by law.

f. Confidential Information received under this Contract and individually identifiable data derived from DHHS Data, must be stored in an area that is physically and technologically secure from access by unauthorized persons during duty hours as well as non-duty hours (e.g., door locks, card keys, biometric identifiers, etc.).

g. only authorized End Users may transmit the Confidential Data, including any derivative files containing personally identifiable information, and in all cases, such data must be encrypted at all times when in transit, at rest, or when stored on portable media as required in section IV above.

h. in all other instances Confidential Data must be maintained, used and disclosed using appropriate safeguards, as determined by a risk-based assessment of the circumstances involved.

i. understand that their user credentials (user name and password) must not be shared with anyone. End Users will keep their credential information secure. This applies to credentials used to access the site directly or indirectly through a third party application.

Contractor is responsible for oversight and compliance of their End Users. DHHS reserves the right to conduct onsite inspections to monitor compliance with this Contract, including the privacy and security requirements provided in herein, HIPAA, and other applicable laws and Federal regulations until such time the Confidential Data is disposed of in accordance with this Contract.

V. LOSS REPORTING

The Contractor must notify the State's Privacy Officer and Security Officer of any Security Incidents and Breaches immediately, at the email addresses provided in Section VI.

The Contractor must further handle and report Incidents and Breaches involving PHI in accordance with the agency's documented Incident Handling and Breach Notification procedures and in accordance with 42 C.F.R. §§ 431.300 - 306. In addition to, and notwithstanding, Contractor's compliance with all applicable obligations and procedures, Contractor's procedures must also address how the Contractor will:

1. Identify Incidents;

2. Determine if personally identifiable information is involved in Incidents;
3. Report suspected or confirmed Incidents as required in this Exhibit or P-37;
4. Identify and convene a core response group to determine the risk level of Incidents and determine risk-based responses to Incidents; and
5. Determine whether Breach notification is required, and, if so, identify appropriate Breach notification methods, timing, source, and contents from among different options, and bear costs associated with the Breach notice as well as any mitigation measures.

Incidents and/or Breaches that implicate PI must be addressed and reported, as applicable, in accordance with NH RSA 359-C:20.

VI. PERSONS TO CONTACT

A. DHHS Privacy Officer:

DHHSPrivacyOfficer@dhhs.nh.gov

B. DHHS Security Officer:

DHHSInformationSecurityOffice@dhhs.nh.gov

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STATE OF NEW HAMPSHIRE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF MEDICAID SERVICES

Jeffrey A. Meyers
Commissioner

Deborah H. Fournier
Medicaid Director

129 PLEASANT STREET, CONCORD, NH 03301
603-271-9422 1-800-852-3345 Ext. 9422
Fax: 603-271-8431 TDD Access: 1-800-735-2964 www.dhhs.nh.gov

September 22, 2017

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
State House
Concord, New Hampshire 03301

REQUESTED ACTION

Authorize the Department of Health and Human Services, Office of Medicaid Services to enter into a sole source amendment to an existing agreement with Magellan Medicaid Administration, Inc., 110113 West Broad Street Glen Allen, VA 23060 (Vendor # 175784), to manage pharmacy benefits for the Medicaid Program by increasing the price limitation by $4,731,804 from $21,055,303 to $25,787,107 and by extending the completion date from December 31, 2017 to December 31, 2019 effective upon Governor and Executive Council approval. 25% General Funds and 75% Federal Funds.

The Governor and Executive Council approved the original agreement on June 9, 2010, (Item # 82), Amendment #1 on June 20, 2012 (Item # 65), Amendment #2 on June 5, 2013 (Item #87), Amendment #3 on November 6, 2013 (Item #54), Amendment #4 on August 3, 2014 (Item #12), and Amendment #5 on December 16, 2015 (Item #12).

Funds are available in the following accounts for State Fiscal Years 2011 through 2019, and anticipated to be available in State Fiscal Year 2020 upon the availability and continued appropriation of funds in the future operating budget, with authority to adjust encumbrances between State Fiscal Years through the Budget Office without further approval of the Governor and Executive Council, if needed and justified.

05-95-95-956010-6143 HEALTH AND SOCIAL SERVICES, DEPT OF HEALTH AND HUMAN SVCS, HHS: COMMISSIONER, OFF MEDICAID & BUSINESS POLICY, PHARMACY SERVICES

State Fiscal Year	Class/ Account	Class Title	Current Modified Budget	Increase/ (Decrease)	Revised Modified Budget
2011	102/500731	Contracts for Program Services	$2,640,669	$0	$2,640,669
2012	102/500731	Contracts for Program Services	$3,110,697	$0	$3,110,697
2013	102/500731	Contracts for Program Services	$3,578,034	$0	$3,578,034
SFY 2011 through SFY 2013 Subtotal:			***$9,329,400***	***$0***	***$9,329,400***

05-095-047-470010-79370000 HEALTH AND SOCIAL SERVICES, DEPT. OF HEALTH AND HUMAN SVSC, HHS: COMMISSIONER, OFF MEDICAID & BUSINESS POLICY, MEDICAID ADMINISTRATION

State Fiscal Year	Class/Account	Class Title	Current Modified Budget	Increase/ (Decrease)	Revised Modified Budget
2014	102/500731	Contracts for Program Services	$3,002,203	$0	$3,002,203
2015	102/500731	Contracts for Program Services	$2,610,300	$0	$2,610,300
2016	102/500731	Contracts for Program Services	$2,501,700	$0	$2,501,700
2017	102/500731	Contracts for Program Services	$2,407,800	$0	$2,407,800
2018	102/500731	Contracts for Program Services	$1,203,900	$1,165,470	$2,369,370
2019	102/500731	Contracts for Program Services	$0	$2,365,902	$2,365,902
2020	102/500731	Contracts for Program Services	$0	$1,200,432	$1,200,432
		SFY 2014 through 2020 Subtotal:	***$11,725,903***	***$4,731,804***	***$16,457,707***
		Contract Total:	**$21,055,303**	**$4,731,804**	**$25,787,107**

EXPLANATION

This amendment is **sole source** because the price limitation exceeds 10% of the total contract value and there are no renewal options left in the contract. The Department is requesting the contract completion date be extended through December 31, 2019 in order to continue pharmacy benefits management services to the Department in its administration of the Medicaid pharmacy program while the Department prepares a Request for Proposals.

The Contractor will continue providing Pharmacy Benefits Management services to the State of New Hampshire in its administration of the Medicaid pharmacy program. Pharmacy Benefits Management services include, but are not limited to:

- Pharmacy claims management.
- Pharmacy benefits management.
- Drug rebate management.
- A call center.
- Prior authorization services.
- Formulary management to assure the availability of the most effective pharmaceuticals at the most efficient price to New Hampshire Medicaid patients.

The Contractor will continue to manage the Medicaid preferred drug list for the Fee for Service program that includes the supplemental drug rebate program and the Centers for Medicare and Medicaid Services drug rebate programs for the Fee for Service and Managed Care Program. In State fiscal year 2017 the State's share of the drug rebates collected was $25.9 million. These funds were used to reduce the General Fund portion for the Provider Payment expenses. The vendor monitors the new drugs to market and makes recommendations to the Department regarding the most suitable management strategy to

assure clinically appropriate and cost efficient drug utilization. All the other terms and conditions of the original contract remain in full force and effect.

Should the Governor and Executive Council not approve this request, the Department would be unable to process the monthly charges for claim adjudication, administrative reviews, automatic prior authorizations, clinical reviews, and drug rebate management that are related to NH Medicaid clients. If the administrative charges are not paid in a timely manner this may cause a delay in processing drug claims for New Hampshire Medicaid recipients.

Geographic Area to be Served: Statewide

Funding for this request is General Funds 25% and Federal Funds 75% (CFDA# 93.778; U.S. Department of Health and Human Services; Centers for Medicare and Medicaid Services; Medical Assistance Program; Medicaid; Title XIX.)

In the event that federal funds become no longer available, additional general funds will not be requested to support this agreement.

Respectfully submitted,

Deborah H. Fournier
Director

Approved by:

Jeffrey A. Meyers
Commissioner

STATE OF NEW HAMPSHIRE
DEPARTMENT OF INFORMATION TECHNOLOGY
27 Hazen Dr., Concord, NH 03301
Fax: 603-271-1516 TDD Access: 1-800-735-2964
www.nh.gov/doit

Denis Goulet
Commissioner

October 6, 2017

Jeffrey A. Meyers, Commissioner
Department of Health and Human Services
State of New Hampshire
129 Pleasant Street
Concord, NH 03301

Dear Commissioner Meyers:

This letter represents formal notification that the Department of Information Technology (DoIT) has approved your agency's request to enter into a **sole source** contract amendment with Magellan Medicaid Administration, Inc., of Glen Allen, VA as described below and referenced as DoIT No. 2010-038F.

The purpose of this request is to enter into a **sole source** contract amendment with Magellan Medicaid Administration, Inc. to continue to manage pharmacy benefits for the Medicaid Program. Pharmacy management services include claims management, benefits management, drug rebate management, prior authorization services, and manage the Medicaid preferred drug list.

The funding amount for this amendment is $4,731,804.00, increasing the current contract from $21,055,303.00 to $25,787,107.00. The amendment shall become effective upon Governor and Council approval, through December 31, 2019.

A copy of this letter should accompany the Department of Health and Human Services' submission to the Governor and Executive Council for approval.

Sincerely,

Denis Goulet

DG/kaf
DoIT #2010-038F

cc: Bruce Smith, IT Manager, DoIT

STATE OF NEW HAMPSHIRE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF MEDICAID BUSINESS AND POLICY

129 PLEASANT STREET, CONCORD, NH 03301-3857
603-271-9422 1-800-852-3345 Ext. 9422
Fax: 603-271-8431 TDD Access: 1-800-735-2964 www.dhhs.nh.gov

Nicholas A. Toumpas
Commissioner

Kathleen A. Dunn
Associate
Commissioner

November 15, 2015

G&C Approved

Date 12/16/15

Item # 12

Her Excellency, Governor Margaret Wood Hassan
and the Honorable Executive Council
State House
Concord, New Hampshire 03301

REQUESTED ACTION

Authorize the Department of Health and Human Services, Office of Medicaid Business and Policy to exercise a renewal option to an existing agreement with Magellan Medicaid Administration, Inc., located at 110113 West Broad Street Glen Allen, VA 23060 (Vendor # 175784), to manage pharmacy benefits for the Medicaid Program by increasing the price limitation by $4,815,600 from $16,239,703 to $21,055,303 and extending the contract completion date from December 31, 2015 to December 31, 2017, upon Governor and Executive Council approval.

The Governor and Executive Council approved the original agreement on June 9, 2010, (Item # 82) and Amendment #1 on June 20, 2012 (Item # 65), and Amendment #2 on June 5, 2013 (Item #87), Amendment #3 on November 6, 2013 (Item #54), Amendment #4 on September 3, 2014.

Funds are available in the following accounts for State Fiscal Years 2016 and 2017 and are anticipated to be available for State Fiscal Year 2018 upon continued appropriation of funds with the authority to adjust encumbrances between State Fiscal Years without further Governor and Executive Council Approval, if needed and justified.

FISCAL DETAILS ATTACHED

EXPLANATION

The purpose of this amendment is to exercise a renewal option to an existing agreement by extending the contact end date from December 31, 2015 to December 31, 2017 and to increase the price limitation by $4,815,600 from $16,239,703 to $21,055,303.

This contract provides pharmacy claims management, pharmacy benefits management, drug rebate management, a call center, prior authorization services, and formulary management to assure the availability of the most effective pharmaceuticals at the most efficient price to New Hampshire Medicaid patients. These services enable the Department to continue to improve the quality of beneficiary health while managing the high cost of pharmaceuticals.

The vendor will continue to manage the Medicaid preferred drug list for the Fee For Service program, which includes the Fee for Service supplemental drug rebate program. The Centers for Medicare and Medicaid Services drug rebate programs for the Fee for Service and Managed Care Program. In State fiscal year 2015, the State share of the drug rebates collected was $30.2 million. These funds were used to reduce the General Fund portion for the Provider Payment expenses. The vendor monitors the new drugs to market and makes recommendations to the Department regarding the most suitable management strategy to assure clinically appropriate and cost efficient drug utilization.

Should the Governor and Executive Council not approve this request, the Department would not be able to process the monthly charges for Administrative reviews, Automatic Prior Authorizations, and Clinical Reviews that are related to the drug claims of the newly enrolled NH Health Protection Program population. If the administrative charges are not paid in a timely manner this would cause a delay in processing drug claims for New Hampshire Medicaid recipients.

Geographic Area to be Served: Statewide

Funding for this request is General Funds 25% and Federal Funds 75%.

In the event that federal funds become no longer available, additional general funds will not be requested to support this agreement.

Respectfully submitted,

for Kathleen A. Dunn, MPH
Associate Commissioner
Medicaid Director

Approved by:
Nicholas A. Toumpas
Commissioner

FISCAL DETAILS

05-95-95-956010-6143 HEALTH AND SOCIAL SERVICES, DEPT OF HEALTH AND HUMAN SVCS, HHS: COMMISSIONER, OFF MEDICAID & BUSINESS POLICY, PHARMACY SERVICES

State Fiscal Year	Class/ Account	Class Title	Current Modified Budget	Increase/ (Decrease)	Revised Modified Budget
2011	102/500731	Contracts for Program Services	$2,640,669	$0	$2,640,669
2012	102/500731	Contracts for Program Services	$3,110,697	$0	$3,110,697
2013	102/500731	Contracts for Program Services	$3,578,034	$0	$3,578,034
		SFY 2011 through SFY 2013 Subtotal:	***$9,329,400***	***$0***	***$9,329,400***

05-095-047-470010-79370000 HEALTH AND SOCIAL SERVICES, DEPT. OF HEALTH AND HUMAN SVSC, HHS: COMMISSIONER, OFF MEDICAID & BUSINESS POLICY, MEDICAID ADMINISTRATION

State Fiscal Year	Class/Account	Class Title	Current Modified Budget	Increase/ (Decrease)	Revised Modified Budget
2014	102/500731	Contracts for Program Services	$3,002,203	$0	$3,002,203
2015	102/500731	Contracts for Program Services	$2,610,300	$0	$2,610,300
2016	102/500731	Contracts for Program Services	$1,297,800	$1,203,900	$2,501,700
2017	102/500731	Contracts for Program Services	$0.00	$2,407,800	$2,407,800
2018	102/500731	Contracts for Program Services	$0.00	$1,203,900	$1,203,900
		SFY 2014 through 2018 Subtotal:	***$6,910,303***	***$4,815,600***	***$11,725,903***
		Contract Total:	**$16,239,703**	**$4,815,600**	**$21,055,303**

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STATE OF NEW HAMPSHIRE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF MEDICAID BUSINESS AND POLICY

129 PLEASANT STREET, CONCORD, NH 03301-3857
603-271-9422 1-800-852-3345 Ext. 9422
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Nicholas A. Toumpas
Commissioner

Kathleen A. Dunn
Associate Commissioner
Medicaid Director

August 4, 2014

G&C Approved
Date 9/3/14
Item # 12

Her Excellency, Governor Margaret Wood Hassan
and the Honorable Executive Council
State House
Concord, New Hampshire 03301

REQUESTED ACTION

Authorize the Department of Health and Human Services, Office of Medicaid Business and Policy to amend an existing agreement (Amendment 4) with Magellan Medicaid Administration, Inc., located at 110113 West Broad Street Glen Allen, VA 23060 (Vendor # 175784), by increasing the price limitation by $52,500 from $16,187,203 to $16,239,703 to manage pharmacy benefits for the Medicaid Program effective August 15, 2014, or the date of Governor and Executive Council approval, whichever is later, with no change to the contract end date of December 31, 2015.

The Governor and Executive Council approved the original agreement on June 9, 2010, (Item # 82) and Amendment #1 on June 20, 2012 (Item # 65), and Amendment #2 on June 5, 2013 (Item #87), and Amendment #3 on November 6, 2013 (Item #54).

Funds are available in State Fiscal Years 2011 through 2015 and anticipated for State Fiscal Year 2016, in the following accounts with authority to adjust encumbrances between State Fiscal Years, through the Budget Office, without further approval from the Governor and Executive Council, if needed and justified.

05-95-95-956010-6143 HEALTH AND SOCIAL SERVICES, DEPT OF HEALTH AND HUMAN SVCS, HHS: COMMISSIONER, OFF MEDICAID & BUSINESS POLICY, PHARMACY SERVICES

State Fiscal Year	Class/ Account	Class Title	Current Modified Budget	Increase/ (Decrease)	Revised Modified Budget
2011	102/500731	Contracts for Program Services	$2,640,669	$0	$2,640,669
2012	102/500731	Contracts for Program Services	$3,110,697	$0	$3,110,697
2013	102/500731	Contracts for Program Services	$3,578,034	$0	$3,578,034
		SFY 2011 through SFY 2013 Subtotal:	***$9,329,400***	***$0***	***$9,329,400***

05-095-047-470010-79370000 HEALTH AND SOCIAL SERVICES, DEPT. OF HEALTH AND HUMAN SVSC, HHS: COMMISSIONER, OFF MEDICAID & BUSINESS POLICY, MEDICAID ADMINISTRATION

State Fiscal Year	Class/ Account	Class Title	Current Modified Budget	Increase/ (Decrease)	Revised Modified Budget
2014	102/500731	Contracts for Program Services	$3,002,203	$0	$3,002,203
2015	102/500731	Contracts for Program Services	$2,557,800	$52,500	$2,610,300
2016	102/500731	Contracts for Program Services	$1,297,800	$0	$1,297,800
		SFY 2014 through 2016 Subtotal:	***$6,857,803***	***$52,500***	***$6,910,303***
		Contract Total:	**$16,187,203**	**$52,500**	**$16,239,703**

EXPLANATION

The purpose of this amendment is to increase the price limitation by $52,500 from $16,187,203 to $16,239,703 with no change to the contract end date. The increase in price limitation will allow the vendor to provide additional staff required to fill the needs of the additional clients who will become enrolled as part of the New Hampshire Health Protection Program, which will be implemented on August 15, 2014.

The implementation of the New Hampshire Health Protection Program will cause an increase in demand for services provided by the vendor. The increase in the number of individuals receiving services will directly impact the number of claims adjudicated per month; the number of administrative reviews completed per month; the number of requests for prior authorizations; and the number of clinical reviews completed each month.

This contract provides Pharmacy Benefits Management services to the State of New Hampshire in its administration of the Medicaid pharmacy program. This contract provides pharmacy claims management, pharmacy benefits management, drug rebate management, a call center, prior authorization services, and formulary management to assure the availability of the most effective pharmaceuticals at the most efficient price to New Hampshire Medicaid patients. These services enable the State of New Hampshire to continue to improve the quality of beneficiary health while managing the high cost of pharmaceuticals.

This amendment will raise the price limitation of this contract by $52,500.00 to allow the vendor to continue to manage the Medicaid preferred drug list and the Centers for Medicare and Medicaid Services supplemental drug rebate program for the Fee for Service, Managed Care Program and the NH Health Protection Program. In State fiscal year 2014 the State share of the drug rebates collected was $28.9 million that was used to reduce the General Fund portion for the Pharmacy drug expenses. The vendor monitors the new drugs to market and makes recommendations to the Department regarding the most suitable management strategy to assure clinically appropriate and cost efficient drug utilization. All the other terms and conditions of the original contract remain the same.

This contract is the result of a competitive bidding process. The Department released a Request for Proposals on June 30, 2009. The request for proposal was advertised in the New

Hampshire Union Leader through July 2, 2009, listed on both the Department of Health and Human Services' and Department of Administrative Services' websites, and directly mailed to sixty-six (66) vendors who expressed interest in bidding on the request for proposal. Four (4) proposals were received and evaluated by a committee of six (6) individuals in response to the request for proposal. The four bidders included HealthTrans, University of Massachusetts Medical School with MedMetrics Health Partners, Inc., Goold Health Systems, and Magellan Medicaid Administration Inc.

Magellan Medicaid Administration Inc. achieved the highest evaluation and was selected. Additionally, the evaluation committee was confident that, given its prior eight years of performance in New Hampshire, Magellan Medicaid Administration Inc. would continue to succeed in its ability to maintain aggressive drug pricing and a high level of proficiency in program administration.

Should the Governor and Executive Council not approve this request, the Department would not be able to process the monthly charges for Administrative reviews, Automatic Prior Authorizations, and Clinical Reviews that are related to the drug claims of the newly enrolled NH Health Protection Program population. If the administrative charges are not paid in a timely manner this would cause a delay in processing drug claims for New Hampshire Medicaid recipients.

Geographic Area to be Served: Statewide

Funding for this request is General Funds 25% and Federal Funds 75%.

In the event that federal funds become no longer available, additional general funds will not be requested to support this agreement.

Respectfully submitted,

Kathleen A. Dunn, MPH
Associate Commissioner and
Medicaid Director

Approved by:
Nicholas A. Toumpas
Commissioner

Magellan Medicaid Administration Inc. (formerly known as First Health Services Corporation)

Attachment 1

Bid Summary

Evaluation Criteria	[illegible]	[illegible]	[illegible]	[illegible]
Finance Auditing, Rebates (40 points)	24.0	32.0	20.0	14.7
Reporting, Analysis (15 points)	6.0	10.0	9.0	8.0
Clinical Management (40 points)	24.0	37.3	21.3	10.7
Electronic Prescribing (5 points)	2.7	4.3	3.0	3.0
Communications, Provider Network (15 points)	9.0	12.0	10.0	7.0
Vendor Staffing (5 points)	2.7	4.7	1.7	1.7
Innovations (10 points)	4.7	8.7	4.7	4.7
Cost Proposal (70 points total)	[illegible]	[illegible]	[illegible]	[illegible]
a. Implementation ACS/EDS (10 points)	5.5	9.0	3.5	9.6
b. All Inclusive Administrative per paid Claim (35 points)	35.0	25.3	16.5	8.7
c. Administrative Review per Completed Request (5 points)	2.1	5.0	3.7	1.1
d. Clinical Review per Completed Request (15 points)	11.8	15.0	6.9	4.5
e. E-Prescribing per Eligibility/History Hit (5 points)	4.7	4.0	1.7	3.5
GRAND TOTAL	132.1	167.3	101.9	77.0

PHARMACY BENEFIT MANAGEMENT SERVICES RFP
Evaluation Team
Office of Medicaid Business and Policy

Name	Title
Donna Arcand	Business Administrator IV, OMBP
Lise C. Farrand, R.Ph.	Pharmaceutical Services Specialist, OMBP
Athena Gagnon	Administrator III, OMBP
Margaret A. Clifford, R.Ph	Chief Compliance Investigator, NH Board Of Pharmacy
~~Doris H. Lotz, MD, MPH~~	~~Medicaid Medical Director, OMBP~~
Stephen J. Mosher	Financial Support Services, NH DHHS
Diane Delisle (or designee	Director of MMIS, NH DoIT

STATE OF NEW HAMPSHIRE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF MEDICAID BUSINESS AND POLICY

129 PLEASANT STREET, CONCORD, NH 03301-3857
603-271-9422 1-800-852-3345 Ext. 9422
Fax: 603-271-8431 TDD Access: 1-800-735-2964 www.dhhs.nh.gov

Nicholas A. Toumpas
Commissioner

Kathleen A. Dunn
Associate Commissioner

September 24, 2013

Her Excellency, Governor Margaret Wood Hassan
and the Honorable Executive Council
State House
Concord, New Hampshire 03301

REQUESTED ACTION

Authorize the Department of Health and Human Services, Office of Medicaid Business and Policy to exercise a renewal option (Amendment 3) of an existing contract (Purchase Order # 1008933), with Magellan Medicaid Administration, Inc., (formerly First Health Services Corporation), formerly of 4300 Cox Road, now located at 110113 West Broad Street Glen Allen, VA 23060 (Vendor # 175784), by extending the completion date from December 31, 2013 to December 31, 2015 and providing additional funds to manage pharmacy benefits for the Medicaid Program by increasing the price limitation by $5,433,758.00 from $10,753,445.00 to an amount not to exceed $16,187,203.00 effective December 1, 2013, or the date of Governor and Executive Council approval, whichever is later. This agreement was originally approved by Governor and Executive Council on June 5, 2010, Item # 82, amended on June 20, 2012 Item # 65, amended June 5, 2013 # 87. Funds are available in the following account for State Fiscal Year 2014 and 2015 and will be requested for State Fiscal Year 2016 with authority to adjust amounts if needed and justified between State Fiscal Years.

05-00095-047-470010-7937 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT OF, HHS: OFC OF MEDICAID & BUS PLCY, OFF.OF MEDICAID BUS. POLICY, MEDICAID ADMINISTRATION

State Fiscal Year	Class/Account	Class Title	Current Modified Budget	Increase/ (Decrease)	Revised Modified Budget
2011	102/500731	Contracts for Program Services	$2,640,669.00	$0.00	$2,640,669.00
2012	102/500731	Contracts for Program Services	$3,110,697.00	$0.00	$3,110,697.00
2013	102/500731	Contracts for Program Services	$3,578,034.00	$0.00	$3,578,034.00
2014	102/500731	Contracts for Program Services	$1,424,045.00	$1,578,158.00	$3,002,203.00
2015	102/500731	Contracts for Program Services	$0.00	$2,557,800.00	$2,557,800.00
2016	102/500731	Contracts for Program Services	$0.00	$1,297,800.00	$1,297,800.00
			$10,753,445.00	$5,433,758.00	$16,187,203.00

EXPLANATION

The purpose of this amendment is to extend the completion date, increase the total value, and to have Magellan Medicaid Administration include the process of collecting data and invoicing for CMS Obra 90 and NH Supplemental Drug Rebates that are related the Managed Care program. In Exhibit A of the contract, approved by Governor and Council, 6/5/10 # 82, allows for an extension of two periods of no more than two years each. Amendment 3 is to extend the contract end date from 12/31/2013 to 12/31/2015. Amendment 3 will increase the price limitation for State Fiscal Year 2014 in the amount of $1,578,158.00. The increase in price limitation for State Fiscal Year 2014 includes an increase in the need for services provided by the vendor due to an increase in the number of Medicaid clients during the period of July 2013 through December 2013. The increase in New Hampshire Medicaid Members was due to the inclusion of the Children's Health Insurance Program population in New Hampshire Medicaid. The increased population has caused an increase in the number of claims per month, and increased demands for Administrative reviews, Automatic Prior Authorizations, and Clinical Reviews.

This contract provides Pharmacy Benefits Management services to the State of New Hampshire in its administration of the Medicaid pharmacy program. This contract provides pharmacy claims management, pharmacy benefits management, drug rebate management, a call center, prior authorization services, and formulary management to assure the availability of the most effective pharmaceuticals at the most efficient price to New Hampshire Medicaid patients. These services enable the State of New Hampshire to continue to improve the quality of beneficiary health while managing the high cost of pharmaceuticals.

This amendment will raise the price limitation of this contract by $5,433,758.00 to allow the vendor to continue to manage the Medicaid preferred drug list and the Centers for Medicare and Medicaid Services and supplemental drug rebate programs for the Fee For Service and Managed Care Programs. In State fiscal year 2013 the State share of the drug rebates collected was $27.6 million that was used to reduce the General Fund portion for the Pharmacy drug expenses. The vendor monitors the new drugs to market and makes recommendations to the Department regarding the most suitable management strategy to assure clinically appropriate and cost efficient drug utilization. All the other terms and conditions of the original contract remain the same.

Competitive Bidding

This contract is the result of a competitive bidding process. The Department released a Request For Proposals on June 30, 2009. The request for proposal was advertised in the New Hampshire Union Leader through July 2, 2009, listed on both the Department of Health and Human Services' and Department of Administrative Services' websites, and directly mailed to sixty-six (66) vendors who expressed interest in bidding on the request for proposal. Four (4) proposals were received and evaluated by a committee of seven (7) individuals in response to the request for proposal. The four bidders included HealthTrans, University of Massachusetts Medical School with MedMetrics Health Partners, Inc., Goold Health Systems, and Magellan Medicaid Administration Inc., (formerly First Health Services Corporation).

Magellan Medicaid Administration Inc., (formerly First Health Services Corporation), achieved the highest evaluation and was selected (bid summary attached). Additionally, the evaluation committee was confident that, given its prior eight years of performance in New Hampshire, Magellan Medicaid Administration Inc., (formerly First Health Services Corporation), would continue to succeed in its ability to maintain aggressive

drug pricing and a high level of proficiency in program administration. Final scoring results are attached as Attachment 1.

Should the Governor and Executive Council not approve this request, the Department would not be able to process the monthly charges for Administrative reviews, Automatic Prior Authorizations, and Clinical Reviews that are related to the drug claims. If the administrative charges are not paid in a timely manner this would cause a delay in processing drug claims for New Hampshire Medicaid recipients.

Geographic Area to be Served: Statewide

Funding for this request is General Funds 25% and Federal Funds 75%.

In the event that federal funds become no longer available, additional general funds will not be requested to support this agreement.

Respectfully submitted,

Kathleen A. Dunn, MPH
Associate Commissioner
Medicaid Director

Approved by:
Nicholas A. Toumpas
Commissioner

Attachment 1

Bid Summary

All Evaluators Average Scores [illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Finance Auditing, Rebates (40 points)	24.0	32.0	20.0	14.7
Reporting, Analysis (15 points)	6.0	10.0	9.0	8.0
Clinical Management (40 points)	24.0	37.3	21.3	10.7
Electronic Prescribing (5 points)	2.7	4.3	3.0	3.0
Communications, Provider Network (15 points)	9.0	12.0	10.0	7.0
Vendor Staffing (5 points)	2.7	4.7	1.7	1.7
Innovations (10 points)	4.7	8.7	4.7	4.7
Cost Proposal (70 points total)				
a. Implementation ACS/EDS (10 points)	5.5	9.0	3.5	9.6
b. All Inclusive Administrative per paid Claim (35 points)	35.0	25.3	16.5	8.7
c. Administrative Review per Completed Request (5 points)	2.1	5.0	3.7	1.1
d. Clinical Review per Completed Request (15 points)	11.8	15.0	6.9	4.5
e. E-Prescribing per Eligibility/History Hit. (5 points)	4.7	4.0	1.7	3.5
GRAND TOTAL	132.1	167.3	101.9	77.0

PHARMACY BENEFIT MANAGEMENT SERVICES RFP
Evaluation Team
Office of Medicaid Business and Policy

Name	Title
Donna Arcand	Business Administrator IV, OMBP
Lise C. Farrand, R.Ph.	Pharmaceutical Services Specialist, OMBP
Athena Gagnon	Administrator III, OMBP
Margaret A. Clifford, R.Ph	Chief Compliance Investigator, NH Board Of Pharmacy
~~Doris H. Lotz, MD, MPH~~	~~Medicaid Medical Director, OMBP~~
Stephen J. Mosher	Financial Support Services, NH DHHS
Diane Delisle (or designee	Director of MMIS, NH DoIT

STATE OF NEW HAMPSHIRE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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129 PLEASANT STREET, CONCORD, NH 03301-3857
603-271-9422 1-800-852-3345 Ext. 9422
Fax: 603-271-8431 TDD Access: 1-800-735-2964 www.dhhs.nh.gov

Nicholas A. Toumpas
Commissioner

Kathleen A. Dunn
Associate Commissioner

May 8, 2013

Approved by G+C
Date 6-5-13
Page
Item # 87
Contract #

Her Excellency, Governor Margaret Wood Hassan
and the Honorable Executive Council
State House
Concord, New Hampshire 03301

REQUESTED ACTION

Authorize the Department of Health and Human Services, Office of Medicaid Business and Policy to enter into a contract amendment (Amendment 2) of an existing contract (Purchase Order # 1008933), with Magellan Medicaid Administration, Inc., (formerly First Health Services Corporation), formerly of 4300 Cox Road, now located at 110113 West Broad Street Glen Allen, VA 23060 (Vendor # 175784), to manage pharmacy benefits for the Medicaid Program by increasing the price limitation by $750,000.00 from $10,003,445.00 to an amount not to exceed $10,753,445.00 effective June 1, 2013, or the date of Governor and Executive Council approval, whichever is later. This agreement was originally approved by Governor and Executive Council on June 9, 2010, Item # 82 and amended on June 20, 2012 Item # 65. Funds are available in the following account for State Fiscal Year 2013 with authority to adjust amounts if needed and justified between State Fiscal Years.

05-95-95-956010-6143 HEALTH AND SOCIAL SERVICES, DEPT OF HEALTH AND HUMAN SVCS, HHS: COMMISSIONER, OFF MEDICAID & BUSINESS POLICY, PHARMACY SERVICES

State Fiscal Year	Class/Account	Class Title	Current Modified Budget	Increase/ (Decrease)	Revised Modified Budget
2011	102/500731	Contracts for Program Services	$2,640,669.00	$0.00	$2,640,669.00
2012	102/500731	Contracts for Program Services	$3,110,697.00	$0.00	$3,110,697.00
2013	102/500731	Contracts for Program Services	$2,828,034.00	$750,000.00	$3,578,034.00
2014	102/500731	Contracts for Program Services	$1,424,045.00	$0.00	$1,424,045.00
			$10,003,445.00	$750,000.00	$10,753,445.00

EXPLANATION

The purpose of this amendment is to increase the price limitation for State Fiscal Year 2013, update the Contractor address, and to update the process of the contractor returning state dated payments to the State of New Hampshire. There has been an increase in the need for services provided by the vendor due to an increase in the number of Medicaid clients. Magellan Medicaid Administration Inc., (formerly First Health Services

Corporation), is a subsidiary of Magellan Behavioral Health, Inc., which is a subsidiary of Magellan Health Services, Inc, a publicly traded corporation.

The increase in price limitation is the result of an increase in the need for services provided by the vendor due to an increase in the number of Medicaid clients, and system transition work that was completed for processing the drug interface file from the legacy Medicaid Management Information System, New Hampshire Advanced Information Management, to the new Medicaid Management Information System Health Enterprise system. The increase in New Hampshire Medicaid Members was due to the inclusion of the Children's Health Insurance Program population in New Hampshire Medicaid. The increased population has caused an increase in the number of claims per month, and increased demands for Administrative reviews, Automatic Prior Authorizations, and Clinical Reviews.

This contract provides Pharmacy Benefits Management services to the State of New Hampshire in its administration of the Medicaid pharmacy program. This contract provides pharmacy claims management, pharmacy benefits management, drug rebate management, a call center, prior authorization services, and formulary management to assure the availability of the most effective pharmaceuticals at the most efficient price to New Hampshire Medicaid patients. These services enable the State of New Hampshire to continue to improve the quality of beneficiary health while managing the high cost of pharmaceuticals.

This amendment will raise the price limitation of this contract by $750,000.00 to allow the vendor to continue to manage the Medicaid preferred drug list and the supplemental and the Centers for Medicare and Medicaid Services drug rebate programs. The vendor monitors the new drugs to market and makes recommendations to the Department regarding the most suitable management strategy to assure clinically appropriate and cost efficient drug utilization. This contract will continue to support the electronic prescribing for Medicaid recipients, which began on July 1, 2008. Electronic prescribing reduces medical errors, improves clinical adherence to pharmacy management strategies, and improves health outcomes. All the other terms and conditions of the original contract remain the same.

Competitive Bidding

This contract is the result of a competitive bidding process. The Department released a Request For Proposals on June 30, 2009. The request for proposal was advertised in the New Hampshire Union Leader through July 2, 2009, listed on both the Department of Health and Human Services' and Department of Administrative Services' websites, and directly mailed to sixty-six (66) vendors who expressed interest in bidding on the request for proposal. Four (4) proposals were received and evaluated by a committee of six (6) individuals in response to the request for proposal. The four bidders included HealthTrans, University of Massachusetts Medical School with MedMetrics Health Partners, Inc., Goold Health Systems, and Magellan Medicaid Administration Inc., (formerly First Health Services Corporation).

Magellan Medicaid Administration Inc., (formerly First Health Services Corporation), achieved the highest evaluation and was selected (bid summary attached). Additionally, the evaluation committee was confident that, given its prior eight years of performance in New Hampshire, Magellan Medicaid Administration Inc., (formerly First Health Services Corporation), would continue to succeed in its ability to maintain aggressive drug pricing and a high level of proficiency in program administration. Final scoring results are attached as Attachment 1.

Should the Governor and Executive Council not approve this request, the Department would not be able to process the monthly charges for Administrative reviews, Automatic Prior Authorizations, and Clinical

Reviews that are related to the drug claims. If the administrative charges are not paid in a timely manner this would cause a delay in processing drug claims for New Hampshire Medicaid recipients.

Geographic Area to be Served: Statewide

Funding for this request is General Funds 25% and Federal Funds 75%.

In the event that federal funds become no longer available, additional general funds will not be requested to support this agreement.

Respectfully submitted,

Kathleen A. Dunn, MPH
Associate Commissioner, Medicaid Director

Approved by:
Nicholas A. Toumpas
Commissioner

Attachment 1

Bid Summary

Finance Auditing, Rebates (40 points)	24.0	32.0	20.0	14.7
Reporting, Analysis (15 points)	6.0	10.0	9.0	8.0
Clinical Management (40 points)	24.0	37.3	21.3	10.7
Electronic Prescribing (5 points)	2.7	4.3	3.0	3.0
Communications, Provider Network (15 points)	9.0	12.0	10.0	7.0
Vendor Staffing (5 points)	2.7	4.7	1.7	1.7
Innovations (10 points)	4.7	8.7	4.7	4.7
Cost Proposal (70 points total)				
a. Implementation ACS/EDS (10 points)	5.5	9.0	3.5	9.6
b. All Inclusive Administrative per paid Claim (35 points)	35.0	25.3	16.5	8.7
c. Administrative Review per Completed Request ((5 points)	2.1	5.0	3.7	1.1
d. Clinical Review per Completed Request. (15 points)	11.8	15.0	6.9	4.5
e. E-Prescribing per Eligibility/History Hit. (6 points)	4.7	4.0	1.7	3.5
GRAND TOTAL	132.1	167.3	101.9	77.0

STATE OF NEW HAMPSHIRE
DEPARTMENT OF INFORMATION TECHNOLOGY
27 Hazen Dr., Concord, NH 03301
Fax: 603-271-1516 TDD Access: 1-800-735-2964
www.nh.gov/doit

Peter C. Hastings
Acting Commissioner

May 1, 2013

Nicholas A. Toumpas, Commissioner
State of New Hampshire
Department of Health and Human Services
129 Pleasant Street
Concord, NH 03301-3857

Dear Commissioner Toumpas:

This letter represents formal notification that the Department of Information Technology (DoIT) has approved your agency's request amend Contract No. 1008933 Pharmacy Benefit Management Services, with Magellan Medicaid Administration Inc. (formerly First Health Services Corporation) of Glen Allen, VA as described below and referenced as DoIT No. 2010-038B.

Magellan provides pharmacy benefit management services for Medicaid beneficiaries. The increase in price limitation is the result of an increase in the need for services provided by the vendor due to an increase in the number of Medicaid clients and system transition work that was completed for processing the drug interface file from the legacy MMIS System, NHAIM, to the new MMIS Health Enterprise. The increase in NH Medicaid members was due to the inclusion of the Children's Health Insurance Program population in NH Medicaid. The increased population has caused an increase in the number of claims per month and increased demands for Administrative reviews, Automatic Prior Authorizations, and Clinical Reviews. The amount of the contract shall increase by $750,000, from $10,003,466 to $10,753,445, effective upon Governor and Executive Council approval. This project is set forth in the Department of Health and Human Services' Information Technology Plan, dated October 21, 2005, Project No. 76, OMBP/MMIS MMIS Reprocurement.

A copy of this letter should accompany the Department of Health and Human Services' submission to Governor and Executive Council for approval.

Sincerely,

Peter C. Hastings

PCH/ltm
RFP 2010-038B

cc: Leslie Mason, DoIT
Valerie Brown, DHHS

STATE OF NEW HAMPSHIRE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF MEDICAID BUSINESS AND POLICY

129 PLEASANT STREET, CONCORD, NH 03301-3857
603-271-9384 1-800-852-3345 Ext. 9384
Fax: 603-271-8431 . TDD Access: 1-800-735-2964

Nicholas A. Toumpas
Commissioner

Kathleen A. Dunn
Director

Approved by GYC
Date 6-20-12
Page
Item # 465
Contract #

May 15, 2012

His Excellency, Governor John H. Lynch
and the Honorable Executive Council
State House
Concord, New Hampshire 03301

REQUESTED ACTION

Authorize the Department of Health and Human Services, Office of Medicaid Business and Policy to enter into a contract amendment (amendment 1) of an existing contract (Purchase Order # 1008933), with First Health Services Corporation (d/b/a Magellan Medicaid Administration, Inc.), 4300 Cox Road, Glen Allen, VA 23060 (Vendor # 175784), to manage pharmacy benefits for the Medicaid Program by increasing the price limitation by $211,020.00 from $9,792,425.00 to an amount not to exceed $10,003,445.00 effective June 1, 2012, or the date of Governor and Executive Council approval, whichever is later. This agreement was originally approved by Governor and Council on June 9, 2010, Item # 82. Funds are available in the following account for FY 2012 with authority to adjust amounts if needed and justified between State Fiscal Years.

05-95-95-956010-6143 HEALTH AND SOCIAL SERVICES, DEPT OF HEALTH AND HUMAN SVCS, HHS: COMMISSIONER, OFF MEDICAID & BUSINESS POLICY, PHARMACY SERVICES

State Fiscal Year	Class/Object	Class Title	Current Modified Budget	Increase/ (Decrease)	Revised Modified Budget
2011	102/500731	Contracts for Program Services	$2,640,669.00	$0.00	$2,640,669.00
2012	102/500731	Contracts for Program Services	$2,899,677.00	$211,020.00	$3,110,697.00
2013	102/500731	Contracts for Program Services	$2,828,034.00	$0.00	$2,828,034.00
2014	102/500731	Contracts for Program Services	$1,424,045.00	$0.00	$1,424,045.00
			$9,792,425.00	$211,020.00	$10,003,445.00

EXPLANATION

The purpose of this amendment is to increase the price limitation for State Fiscal Year 2012, change the name of the Contractor from First Health Services Corporation to Magellan Medicaid Administration, Inc. and update State contact information. First Health Services Corporation (d/b/a Magellan Medicaid Administration, Inc.) is a subsidiary of Magellan Behavioral Health, Inc., which is a subsidiary of Magellan Health Services, Inc, a publicly traded corporation. The name change is not a result in change of ownership.

The increase in price limitation is the result of an increase in the need for services provided by the vendor due to an increase in the number of Medicaid clients. This has caused an increase in the number of claims per month, and increased demands for Administrative reviews, Automatic Prior Authorizations, and Clinical Reviews. As of October 1, 2011 the State adopted a FastMAC pricing algorithm, which updates the

Maximum Allowable Cost for a drug on a weekly basis. Previously the State updated the Maximum Allowable Cost pricing on a monthly basis. This has increased the monthly cost of the contract by $16,667.00 per month for State Fiscal Year 2012. As a result of the FastMac pricing algorithm, the state has saved an average of $734,685.00 on a monthly basis since it's implementation in the drug expense line item.

This contract provides Pharmacy Benefits Management services to the State of New Hampshire in its administration of the Medicaid pharmacy program. This contract provides pharmacy claims management, pharmacy benefits management, drug rebate management, a call center, prior authorization services, and formulary management to assure the availability of the most effective pharmaceuticals at the most efficient price to New Hampshire Medicaid patients. These services enable the State of New Hampshire to continue to improve the quality of beneficiary health while managing the high cost of pharmaceuticals.

This amendment will raise the price limitation of this contract by $211,020.00 to allow the vendor to continue to manage the Medicaid preferred drug list and the supplemental and the Centers for Medicare and Medicaid Services drug rebate programs. The vendor monitors the new drugs to market and makes recommendations to the Department regarding the most suitable management strategy to assure clinically appropriate and cost efficient drug utilization. This contract will continue to support the electronic prescribing for Medicaid recipients, which began on July 1, 2008. Electronic prescribing reduces medical errors, improves clinical adherence to pharmacy management strategies, and improves health outcomes. All the other terms and conditions of the original contract remain the same.

Competitive Bidding

This contract is the result of a competitive bidding process. The Department released a Request For Proposals on June 30, 2009. The request for proposal was advertised in the New Hampshire Union Leader through July 2, 2009, listed on both the Department of Health and Human Services' and Department of Administrative Services' websites, and directly mailed to sixty-six (66) vendors who expressed interest in bidding on the request for proposal. Four (4) proposals were received and evaluated by a committee of six (6) individuals in response to the request for proposal. The four bidders included HealthTrans, University of Massachusetts Medical School with MedMetrics Health Partners, Inc., Goold Health Systems, and First Health Services Corporation.

First Health Services Corporation (d/b/a Magellan Medicaid Administration Inc.) achieved the highest evaluation and was selected (bid summary attached). Additionally, the evaluation committee was confident that, given its prior eight years of performance in New Hampshire, First Health would continue to succeed in its ability to maintain aggressive drug pricing and a high level of proficiency in program administration. Final scoring results are attached as Attachment 1.

Should the Governor and Executive Council not approve this request, the Department would not be able to process the monthly charges for Administrative reviews, Automatic Prior Authorizations, and Clinical Reviews that are related to the drug claims. If the administrative charges are not paid in a timely manner this would cause a delay in processing drug claims for New Hampshire Medicaid recipients.

Geographic Area to be Served: Statewide

Funding for this request is General Funds 25% and Federal Funds 75%.

In the event that federal funds become no longer available, additional general funds will not be requested to support this agreement.

Respectfully submitted,

Kathleen A. Dunn, MPH
Director

Approved by:
Nicholas A. Toumpas
Commissioner

Bid Summary

Finance Auditing; Rebates (40 points)	24.0	32.0	20.0	14.7
Reporting, Analysis (15 points)	6.0	10.0	9.0	8.0
Clinical Management (40 points)	24.0	37.3	21.3	10.7
Electronic Prescribing (5 points)	2.7	4.3	3.0	3.0
Communications; Provider Network (15 points)	9.0	12.0	10.0	7.0
Vendor Staffing (5 points)	2.7	4.7	1.7	1.7
Innovations (10 points)	4.7	8.7	4.7	4.7
Cost Proposal (70 points total)				
a. Implementation ACS/RDS (10 points)	5.5	9.0	3.5	9.6
b. All Inclusive Administrative per paid Claim (35 points)	35.0	25.3	16.5	8.7
c. Administrative Review per Completed Request (5 points)	2.1	5.0	3.7	1.1
d. Clinical Review per Completed Request (15 points)	11.8	15.0	6.9	4.5
e. E-Prescribing per Eligibility/History Hit (5 points)	4.7	4.0	1.7	3.5
GRAND TOTAL	132.1	167.3	101.9	77.0

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DEPARTMENT OF INFORMATION TECHNOLOGY
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www.nh.gov/doit

S. William Rogers
Commissioner

May 25, 2012

Nicholas A. Toumpas, Commissioner
State of New Hampshire
Department of Health and Human Services
129 Pleasant Street
Concord, NH 03301-3857

Dear Commissioner Toumpas:

This letter represents formal notification that the Department of Information Technology (DoIT) has approved your agency's request amend Contract No. 1008933 Pharmacy Benefit Management Services, with Magellan Medicaid Administration Inc. (formerly First Health Services Corporation) of Glen Allen, VA as described below and referenced as DoIT No. 2010-038A.

Magellan provides pharmacy benefit management services for Medicaid beneficiaries. Due to an increase in the number of clients served during fiscal year 2012, the Department of Health and Human Services is required to increase the contract's funding appropriation for the current fiscal year. The amount of the contract shall increase by $211,020, from $9,792,425 to $10,003,445, effective upon Governor and Executive Council approval. This project is set forth in the Department of Health and Human Services' Information Technology Plan, dated October 21, 2005, Project No. 76, OMBP/MMIS MMIS Reprocurement.

A copy of this letter should accompany the Department of Health and Human Services' submission to Governor and Executive Council for approval.

Sincerely,

S. William Rogers

SWR/ltm
RFP 2010-038A

cc: Leslie Mason, DoIT
Valerie Brown, DHHS

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF MEDICAID BUSINESS AND POLICY

129 PLEASANT STREET, CONCORD, NH 03301-3857
603-271-8166 1-800-852-3345 Ext. 8166
Fax: 603-271-8431 TDD Access: 1-800-735-2964

Nicholas A. Toumpas
Commissioner

Kathleen A. Dunn
Director

May 1, 2010

V 175784
PO # 08933
1008933

Approved by G+C
Date 6-9-10
Page
Item No. 82

His Excellency, Governor John H. Lynch
and the Honorable Executive Council
State House
Concord, New Hampshire 03301

REQUESTED ACTION

Authorize the New Hampshire Department of Health and Human Services, Office of Medicaid Business and Policy (OMBP), to enter into a contract with First Health Services Corporation, 4300 Cox Road, Glen Allen, VA 23060 (Vendor # 175784), to manage pharmacy benefits for the Medicaid Program from [redacted] The price limitation for this contract is $9,792,425, effective July 1, 2010, or the date of Governor and Council approval, whichever is later.. Funds are available in the following account for SFY 2011. Funding for FY 2012, FY 2013 and FY 2014 through December 31, 2013 is contingent upon the availability and continued appropriation of funds with the authority to adjust amounts if needed and justified between State Fiscal Years.

05-95-95-956010-6134 HEALTH AND SOCIAL SERVICES, DEPT OF HEALTH AND HUMAN SVCS, HHS: COMMISSIONER, OFF MEDICAID & BUSINESS POLICY, MEDICAID CLAIMS MANAGEMENT SYS

State Fiscal Year	Account Number	Description	Current Amount
2011	010 095 61340000 102 500731	Medicaid Contracts	$2,640,669
2012	010 095 61340000 102 500731	Medicaid Contracts	$2,892,677
2013	010 095 61340000 102 500731	Medicaid Contracts	$2,828,034
2014	010 095 61340000 102 500731	Medicaid Contracts	$1,424,045
	Total		$9,792,425

EXPLANATION

The purpose of the above requested action is to allow First Health Services Corporation to provide Pharmacy Benefits Management (PBM) services to the State of New Hampshire in its administration of the Medicaid pharmacy program. This contract will provide pharmacy claims management, pharmacy benefits management, drug rebate management, a call center, prior authorization services, and formulary management to assure the availability of the most effective pharmaceuticals at the most efficient price to New Hampshire Medicaid patients. These services will enable the State of New Hampshire to continue to improve the quality of beneficiary health while managing the high cost of pharmaceuticals.

Under the terms of the contract, First Health Services Corporation is required to demonstrate savings in the State of New Hampshire's total drug expenditures attributable to this contract. First Health Services Corporation will report savings on a quarterly basis as the average cost of a prescription, net of Center for Medicare and Medicaid Services OBRA90 drug rebates and supplemental drug rebates compared to contractually-stipulated quarterly targets. OMBP will independently verify that the drug cost savings has been

achieved. If drug cost savings have not been achieved, First Health Services Corporation will be obligated to pay back up to 20% of their administrative fees for the related period. In addition to its financial performance, OMBP will monitor First Health's administrative services. Failure to satisfactorily perform contracted administrative services, such as accuracy of claims payment, rebate and other scheduled reporting, and timely prior authorizations, will result in the collection of liquidated damages from the vendor.

Under the proposed contract, First Health Services Corporation shall continue to manage the Medicaid preferred drug list and the supplemental and the CMS drug rebate programs, both of which have yielded significant drug cost savings to the State of New Hampshire. The drug rebate programs have brought in over $41 million dollars of general fund revenues in the 12 month period ending February 2010. The net average cost per script has decreased despite manufacturer price increases in the past year, largely because of aggressive rebate management. Additionally, First Health Services Corporation monitors the new drugs to market and makes recommendations to the Department regarding the most suitable management strategy to assure clinically appropriate and cost efficient drug utilization. This contract will continue to support the electronic prescribing for Medicaid recipients begun on July 1, 2008. Electronic prescribing reduces medical errors, improves clinical adherence to pharmacy management strategies, and improves health outcomes.

Several innovations are included in this contract which will enhance the effectiveness and efficiency of the pharmacy benefit management program as it currently exists, including the development of a highly secure, web based provider interface that will allow prescribers to review patient drug histories, an additional option to electronically prescribe medications and enhanced compliance with all utilization management programs. The web based provider portal will assist in reducing provider administrative burdens and facilitate the transition to full electronic health information exchange. Additionally, highly secure web access will be developed to enable beneficiaries' participation in health management by knowing what medications have been prescribed for them and in having access to clinical information about their drugs. Enhancements in the Coordination of Benefits/Retrospective Coordination of Benefits program to include access to a reference database of third party payers, will improve both real time cost avoidance and additional recoveries from other insurers. Expanding the Maximum Allowable Cost list to include specialty pharmacy products will create a stable reimbursement strategy and price controls for very high cost medications. An Interactive Voice Response telephone system will be developed for many incoming prior authorization requests, enhancing the clinical integrity and speed while decreasing some of the provider burden and administrative costs associated with utilization management. The development of web-based claims submission and a web-based remittance advice will improve the accuracy of claims payment and reporting. Improved denied prior authorization follow-up will assure that beneficiaries do not go without needed medications.

Pricing for this contract continues the current administrative payment strategy in which OMBP reimburses First Health Services Corporation for claims processing services. A fixed fee of $1.49 ("claims processing rate") will be paid to First Health Services Corporation for each completed and paid drug claim only, eliminates payments for denied or voided claims. This claims processing rate includes all administrative services except for those related to e-prescribing and the clinical review of prior authorization requests. New Hampshire anticipates the volume of paid claims will increase from 1.5 million to over 1.7 million claims each year over the three years of the contract due to increased enrollment in the Medicaid program. The cost per clinical review reflects a lower per unit cost than in the previous First Health Services Corporation contract. Currently, there are over 12,000 clinical reviews and almost 10,000 automated reviews annually. OMBP anticipates an increase in the number of automated reviews to over 30,000 as the aforementioned enhancements to the prior authorization processes are completed and adopted by prescribers. Automated prior authorization reviews cost half the amount of the clinician reviews and are, given the technology associated, reimbursed at an enhanced federal match. Through this price reduction and greater electronic utilization management, the Department anticipates a decrease in administrative fees with this contract when compared to the prior contract. By analyzing the various components of this PBM contract and maximizing federal reimbursement rates of 75%

where applicable, OMBP anticipates an overall federal reimbursement of 71% of the total pharmacy program costs.

As the incumbent vendor, First Health Services Corporation, is already engaged in building the necessary interfaces for the new MMIS agent. This will provide a seamless transition to the new MMIS system thus assuring stable access for Medicaid beneficiaries to pharmacy services.

This contract is the result of a competitive bidding process. The Department released a Request For Proposals (RFP) on June 30, 2009. The RFP (#10-OMBP-PBM-01), was advertised in the New Hampshire Union Leader on June 30, July 1 and 2, 2009, listed on both the DHHS' and Department of Administrative Services' websites, and directly mailed to sixty-six (66) vendors who expressed interest in bidding on the RFP. On July 20, 2009 the Department received twelve (12) Letters of Intent in response to the RFP. The Commissioner appointed an evaluation committee consisting of six (6) individuals, internal and external to the Medicaid program, to score the proposals (Table 1 attached). On September 28, 2009, four (4) proposals were received in response to the RFP. The four bidders included HealthTrans, University of Massachusetts Medical School with MedMetrics Health Partners, Inc., Goold Health Systems, and First Health Services Corporation.

The Evaluation Team concluded that First Health Services Corporation was more likely than the other three bidders to be successful in balancing utilization management and pricing strategies, proposing competitive administrative costs when compared to the other vendor's proposals, executing the most innovative programs, and being the most successful in implementing through the State's fiscal agent transition. Additionally, the evaluation committee was confident that, given its prior eight years of performance in New Hampshire, First Health would continue to succeed in its ability to maintain aggressive drug pricing and a high level of proficiency in program administration. Final scoring results are as follows:

Bidder	Final Score
First Health Services Corporation	167.3
Goold health Systems	132.1
University of Massachusetts Medical School/Med Metrics Health Partners, Inc.	101.9
HealthTrans	77.0

Approval of this contract will provide the New Hampshire Medicaid Program with a stable yet modernized program to maintain access to needed medications, accurate processing of pharmacy claims, optimize Medicaid financial resources through improvements in efficiency and pricing, and allow provider and patients secure access to health care information.

The area served by the Contract is statewide.

Funding for this request is General Funds 29% and Federal Funds 71%.

In the event that Federal Funds become no longer available, additional General Funds will not be requested to support this agreement.

Respectfully submitted,

Kathleen A. Dunn, MPH
Director

Approved by:
Nicholas A. Toumpas
Commissioner