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STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF MEDICAID BUSINESS AND POLICY

Nicholas A. Toumpas
Commissioner

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

Kathleen A. Dunn
Associate Commissioner
Medicaid Director

August 4, 2014

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

25% General fund
75% Federal fund

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

Attachment 1

Bid Summary

Activity/Item/Averaged Score	Capitol	First Health	OWMS	Health Care
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
Amendment #4 to the Magellan Medicaid Administration, Inc. Contract**

This 4th Amendment to the Magellan Medicaid Administration, Inc. contract (hereinafter referred to as "Amendment #4") dated this 9th day of July, 2014, 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 an agreement (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), 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, the State and the Contractor have agreed to make changes to the scope of work, payment schedules and terms and conditions of the contract; and

WHEREAS, pursuant to the General Provisions, Paragraph 18, the State may at its sole discretion, amend the Contract by written agreement of the parties and approval of the Governor and Executive Council; and

WHEREAS the parties agree to amend the Contract; 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 as follows:

To amend as follows:

1. Form P-37, General Provisions, Item 1.8, to read:
\$16,239,703
2. Exhibit A, Scope of Services, Effective Date, to read:
Date of Governor and Executive Council approval through Form P-37, General Provisions, Item 1.7.
3. Exhibit B, Methods and Conditions of Payment, I) Terms of Payment, 2, to read:
The maximum total amount of this Contract shall not exceed Form P-37, General Provisions, Item 1.8.



**New Hampshire Department of Health & Human Services
Magellan Medicaid Administration, Inc. Contract**

4. Exhibit B, Methods and Conditions of Payment, I) Terms of Payment, 2., f., to read:

For the period from December 1, 2013 through December 31, 2015 payments shall not exceed \$5,486,258.

5. Standard Exhibit E, Certificate Regarding Lobbying, Contract Period, to read:
July 1, 2010 through December 31, 2015.



**New Hampshire Department of Health & Human Services
Magellan Medicaid Administration, Inc. Contract**

This amendment shall be effective upon the date of Governor and Executive 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

8/4/14
Date

Kathleen A. Dunn
Kathleen A. Dunn
Associate Commissioner &
Medicaid Director

Contractor: Magellan Medicaid Administration

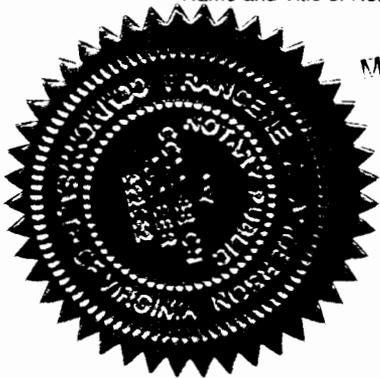
7/24/14
Date

Timothy P. Nolan
Name: Timothy P. Nolan
Title: President

Acknowledgement:
State of Virginia, County of Henrico on 7/24/14,
before the undersigned officer, personally appeared the person identified 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

Francene W. Anderson, Notary Public
Name and Title of Notary or Justice of the Peace

My Commission Expires May 31, 2018



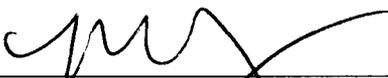


**New Hampshire Department of Health & Human Services
Magellan Medicaid Administration, Inc. Contract**

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

OFFICE OF THE ATTORNEY GENERAL

8/14/14
Date


Name: Megan A. Hagan
Title: Attorney - NH Attorney General's Office

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

OFFICE OF THE SECRETARY OF STATE

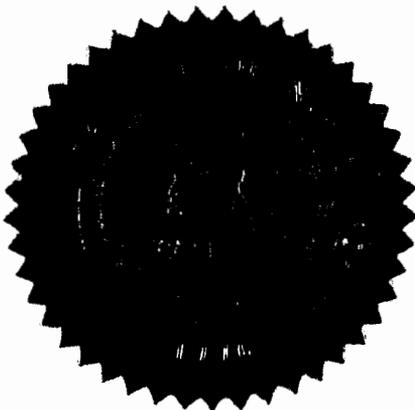
Date

Name:
Title:

State of New Hampshire
Department of State

CERTIFICATE

I, William M. Gardner, Secretary of State of the State of New Hampshire, do hereby certify that Magellan Medicaid Administration, Inc. a(n) Virginia corporation, is authorized to transact business in New Hampshire and qualified on November 5, 2004. I further certify that all fees and annual reports required by the Secretary of State's office have been received.



In TESTIMONY WHEREOF, I hereto
set my hand and cause to be affixed
the Seal of the State of New Hampshire,
this 26th day of June, A.D. 2014

A handwritten signature in black ink, appearing to read "William M. Gardner". The signature is written in a cursive style with a prominent initial "W".

William M. Gardner
Secretary of State

**MAGELLAN MEDICAID ADMINISTRATION, INC.
SECRETARY'S CERTIFICATE**

I, Daniel N. Gregoire, hereby certify that I am the duly elected and qualified Secretary of Magellan Medicaid Administration, Inc., a Virginia corporation (the "Corporation"), and that the individual named below is a duly elected officer of the Corporation and is hereby is authorized, empowered and directed to make, execute, deliver, file and/or record the attached document on behalf of the Corporation:

Timothy N. Nolan – Chief Operating Officer

IN WITNESS WHEREOF, I have signed my name this 24th day of July, 2014.


Daniel N. Gregoire



CERTIFICATE OF LIABILITY INSURANCE

10/1/2014

DATE (MM/DD/YYYY)
5/29/2014

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 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 Lockton Companies 1185 Avenue of the Americas, Suite 2010 New York 10036 646-572-7300	CONTACT NAME:	
	PHONE (A/C, No, Ext):	FAX (A/C, No):
E-MAIL ADDRESS:		
INSURER(S) AFFORDING COVERAGE		NAIC #
INSURER A : Lexington Insurance Company		19437
INSURER B : Liberty Mutual Fire Insurance Company		23035
INSURER C : Liberty Insurance Corporation		42404
INSURER D :		
INSURER E :		
INSURER F :		

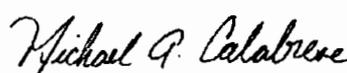
COVERAGES MAGHE01 CERTIFICATE NUMBER: 12315493 REVISION NUMBER: XXXXXXXX

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	ADOL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS
A	<input checked="" type="checkbox"/> COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS-MADE <input checked="" type="checkbox"/> OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: <input checked="" type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC <input type="checkbox"/> OTHER	N	N	7055341	6/17/2014	6/17/2015	EACH OCCURRENCE \$ 1,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 50,000 MED EXP (Any one person) \$ 5,000 PERSONAL & ADV INJURY \$ 1,000,000 GENERAL AGGREGATE \$ 3,000,000 PRODUCTS - COMP/OP AGG \$ 1,000,000 \$
B	<input checked="" type="checkbox"/> AUTOMOBILE LIABILITY <input checked="" type="checkbox"/> ANY AUTO <input type="checkbox"/> ALL OWNED AUTOS <input type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> HIRED AUTOS <input type="checkbox"/> NON-OWNED AUTOS <input checked="" type="checkbox"/> COMP. \$1,000 <input checked="" type="checkbox"/> COLL \$1,000	N	N	AS2-651-004219-113	10/1/2013	10/1/2014	COMBINED SINGLE LIMIT (Ea accident) \$ 1,000,000 BODILY INJURY (Per person) \$ XXXXXXXX BODILY INJURY (Per accident) \$ XXXXXXXX PROPERTY DAMAGE (Per accident) \$ XXXXXXXX \$ XXXXXXXX
A	<input type="checkbox"/> UMBRELLA LIAB <input type="checkbox"/> OCCUR <input checked="" type="checkbox"/> EXCESS LIAB <input checked="" type="checkbox"/> CLAIMS-MADE DED RETENTION \$	N	N	7055342	6/17/2014	6/17/2015	EACH OCCURRENCE \$ 10,000,000 AGGREGATE \$ 10,000,000 \$ XXXXXXXX
C	<input checked="" type="checkbox"/> WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	Y/N	N/A	WC7-651-004219-103	10/1/2013	10/1/2014	<input checked="" type="checkbox"/> PER STATUTE <input type="checkbox"/> OTH-ER E L EACH ACCIDENT \$ 1,000,000 E L DISEASE - EA EMPLOYEE \$ 1,000,000 E L DISEASE - POLICY LIMIT \$ 1,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional Remarks Schedule, may be attached if more space is required)
 INSURED: MAGELLAN MEDICAID ADMINISTRATION, INC. CONTRACT NO: 2013-046

CERTIFICATE HOLDER**CANCELLATION**

12315493 State of New Hampshire The Director, Division of Public Health NH DHHS 29 Hazen Drive Concord NH 03301-6504	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 
--	---

9/24



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 SYCS DEPT OF, HHS:
OFC OF MEDICAID & BUS PLCY, OFF.OF MEDICAID BUS. POLICY, MEDICAID ADMINISTRATION

<u>State Fiscal</u>	<u>Class/Account</u>	<u>Class Title</u>	<u>Current</u>	<u>Increase/</u>	<u>Revised</u>
<u>Year</u>			<u>Modified Budget</u>	<u>(Decrease)</u>	<u>Modified Budget</u>
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

Amendment 3

Magellan Medicaid Administration Inc. (formerly known as First Health Services Corporation)

Page 3 of 4

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%.

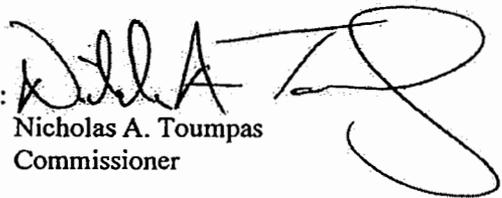
In the event that federal funds become no longer available, additional general funds will not be requested to support this agreement.

Respectfully submitted,



Kathleen A. Dunn, MPH
Associate Commissioner
Medicaid Director

Approved by:



Nicholas A. Toumpas
Commissioner

Attachment 1

Bid Summary

Appraiser/ Averaged Score	Quality	Financial	Access	Health Care
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
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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
Amendment 3 to the
Magellan Medicaid Administration**

This 3rd Amendment to the Magellan Medicaid Administration, Inc. Contract (hereinafter referred to as "Amendment 3") dated this 25th day of September, 2013 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 "Magellan Medicaid Administration", and/or "the Contractor") with a place of business at 110113 West Broad Street, Glen Allen, VA 23060.

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor and Executive Council on June 9, 2010, item #82, vendor code # 175784, amended June 20, 2012 item # 65, and amended June 5, 2013 item #87, the Contractor agrees to perform certain services based upon the terms and conditions specified in the Contract, and in consideration of certain sums specified; and

WHEREAS, pursuant to paragraph 18 of the General Provisions, Form P-37, the Contract may be modified or amended only by a written instrument executed by the parties thereto, and only after approval of such modification by the Governor and Executive Council; and

WHEREAS, the State and the Contractor have agreed to amend the Contract in certain respects; and

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

Scope of Amendment

Changes to General Provisions, Form P-37

Delete in Box 1.7 Completion Date:

12/31/2013

Replace with:

12/31/2015

Delete in Box 1.8 Price Limitation:

\$10,753,445.00

Replace with:

\$16,187,203.00

Add to Effective Date, Paragraph 3:

All exhibits and attachments to the original Contract remain in effect unless otherwise specified; Amendment 3 and exhibits and attachments to Amendment 3 are effective as of the date of Governor and Executive Council approval or December 1, 2013, whichever is later.

Contractor Initials: YPN

Date: 9/25/2013

Changes to Exhibit A Scope of Services

Delete:

Contract Period: Later of: One week after Governor and Executive Council approval or July 1, 2010 through December 31, 2013

Replace:

Contract Period: Later of: One week after Governor and Executive Council approval or December 1, 2013 through December 31, 2015.

Delete:

Section III, C, 3, h. Medical claims for physician-administered drugs processed by the MMIS to the Contractor-“J” and “S” Codes only (Quarterly) for quarterly rebate processing;

Replace with:

Section III, C, 3, 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;

Add:

Section III, C, 3, k. Managed care pharmacy data to the Contractor for quarterly rebate processing.

Delete:

Section III, L, 7. Subject to the State’s prior approval, Contractor shall utilize the services of a third party to assist in the identification of responsible third party payors (“TPL subcontractor”). The TPL subcontractor shall have a proprietary database containing information not captured by the State, which can be used to supplement the State’s TPL data. The State shall provide to the TPL subcontractor eligibility files and claims extracts on a scheduled basis. TPL subcontractor shall perform retroactive billing to recoup monies owed by responsible third party payors using State and TPL subcontractor information. All monies recuperated by the TPL subcontractor shall be returned to the State. Contractor is solely responsible for payment of fees to TPL subcontractor.

Delete:

Section III, M, 2. SAS 70 Audit: 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 SAS 70, as issued by the American Institute of Certified Public Accountants. The independent auditor is required to complete a SAS 70 Type II 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 SAS 70 Type II audit must be completed for each year of the Contract period. The SAS 70 Audit shall be provided to the State’s Contract Manager.

Replace with:

Section III, M, 2. 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

Contractor Initials: JPN
Date: 9/25/2013

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 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 audit must be completed for each year of the Contract period. The SSAE-16 Audit shall be provided to the State's Contract Manager.

Delete:

Section III, M, 4. The Contractor shall provide a complete and comprehensive audit program, subject to the approval of the Department, which shall include pharmacy desk and on-site audits designed to detect questionable pricing/discounting, duplication of claims, or other types of potential fraud, abuse and misuse of the prescription drug benefits. The Contractor shall maintain an auditing system with the capacities or specifications set forth in its response to the RFP. Contractor shall work with the State to conduct a limited number of onsite audits when requested by the State, not to exceed fifteen (15) onsite audits per calendar year. All monies identified by the audits shall be recovered by and through the State.

Delete:

Section III, N: 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 Supplemental Rebate requirements.

Replace with:

Section III, N: 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 Supplemental Rebate requirements for all Medicaid pharmacy claims inclusive of both fee-for-services and managed care.

Delete:

Section III, N, 3: At the option of the Department, which may be exercised no less often than annually, the Contractor shall utilize the National Medicaid Pooling Initiative (NMPI) for the supplemental rebate process or subsequent to submitting PDL classes to the DUR Board, conduct supplemental rebate analysis and, at the direction of the Department, negotiate with pharmaceutical manufacturers for state only rebates agreements for New Hampshire. The Department on an annual basis shall make election of participation in NMPI.

Replace with:

Section III, N, 3: At the option of the Department, which may be exercised no less often than annually, the Contractor shall negotiate Medicaid Supplemental rebates with pharmaceutical manufacturers 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 the DUR Board for review and approval.

Delete:

Section III, Q, 2: The Contractor shall provide a full-time clinical manager (RPh or PharmD 100% dedicated to the NH Medicaid program) to coordinate with the State DUR Board.

Replace with:

Contractor Initials: YPN

Date: 9/25/2013

Section III, Q, 2: The Contractor shall provide a clinical manager (RPh or PharmD 70% dedicated to the NH Medicaid program) to coordinate with the State DUR Board.

Delete:

Section III, R, 2: The Clinical Manager shall meet regularly with a minimum of 50 providers yearly to educate and support providers' efficient and accurate use of the Medicaid pharmacy benefits program and to provide evidence-based academic detailing to promote appropriate drug utilization by Medicaid providers. The Clinical Manager will also conduct periodic utilization management provider contact as needed. All travel costs associated with provider education shall be the Contractor's responsibility.

Replace with:

Section III, R, 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 Manager will also conduct periodic utilization management provider contact as needed. All travel costs associated with provider education shall be the Contractor's responsibility.

Delete:

Section III, U, 4, 7, 8 and 9:

4. The Contractor shall perform prescriber education and outreach to include written communications, electronic outreach and face-to-face meeting to appropriately promote and ensure the proper use of the e-prescribing program and at a minimum will include specific outreach to the Medicaid program's top one hundred (100) prescribers.

7. All costs associated with the e-prescribing program are incorporated into the E-prescribing transaction fee in Exhibit B.

8. An e-prescribing transaction fee will be invoiced monthly to the State. A transaction is defined as a positive inquiry (including some or all of the following: eligibility, formulary inquiry, and medication history look-up) for a Medicaid beneficiary.

9. The Contractor is responsible for all of the duties of program implementation and maintenance including any duties that may be the responsibility of any subcontractor.

Delete:

Section III, X, 1: The Contractor shall, provide two (2) full time equivalent staff members also located within 120 minutes of Concord, New Hampshire.

Replace with:

Section III, X, 1: The Contractor shall, provide two (2) staff members also located within 120 minutes of Concord, New Hampshire; one 70% FTE Clinical Manager and one 70% FTE Reporting Specialist.

Changes to Exhibit B

Delete:

Table 1: Reimbursement for Routine Services

Description	Reimbursement
Amount per paid adjudicated claim	\$1.49
Administrative Review Fee (for administrative review not requiring clinical evaluation: e.g., early refill overrides, quantity limit edits, WebPA)-per completed request	\$4.26

Contractor Initials: JAN
Date: 9/15/2013

AutoPA per paid claim	\$0.43
Clinical Review Fee (a review for a prior auth request performed by a pharmacy technician or pharmacist)-per completed request	\$12.76
E-prescribing Transaction Fee-per Eligibility & Drug History Hit	\$0.19
System Modification	\$140.40/hour

Replace with:

Description	Reimbursement
All Inclusive Administrative Fee	\$193,083/month
FastMAC Fee	\$16,917/month
System Modification (as needed)	\$140.40/hour
3% increase for Admin and FastMAC fee beginning January 1, 2015	

Delete:

I, 2: The maximum total amount of this contract shall not exceed \$10,753,445 for the period from July 1, 2010 through December 31, 2013 as set forth below:

Replace with:

The maximum total amount of this contract shall not exceed 16,187,203 for the period from July 1, 2010 through December 31, 2015 as set forth below:

Add:

I, 2, f: For the period from December 31, 2013 through December 31, 2015 payments shall not exceed \$5,433,758.

Delete:

Table

3

Table 3: Contract Cost Overview

Service	Rate	Estimated Volume	SFY2011 (6 Months) Estimated Payment	Estimated Volume	SFY2012 Estimated Payment	Estimated Volume	2013 Estimated Payment	Estimated Volume	2014 (6 months) Estimated Payment	Total
Paid Claim	\$1.49	812786	\$1,211,051	1690595	\$2,518,986	1707501	\$2,544,176	853750	\$1,272,088	
Administrative review	\$4.26	4838	\$20,610	19352	\$82,440	21287	\$90,683	11176	\$47,609	
Auto PA	\$0.43	6296	\$2,707	26569	\$11,425	29226	\$12,567	15490	\$6,661	
Clinical Review	\$12.76	11551	\$147,391	12129	\$154,760	11765	\$150,117	5882	\$75,059	
E-prescribing	\$0.19	9948	\$1,890	59688	\$11,341	77714	\$14,766	77714	\$14,766	
System Modification	\$140.40	50	\$7,020	112	\$15,725	112	\$15,725	56	\$7,862	
New MMIS implementation					\$105,000					
			\$1,390,669		\$2,899,676		\$2,828,035		\$1,424,044	\$8,542,425
Implementation Cost	\$1,250,000		\$1,250,000							\$1,250,000
			\$2,640,669							\$9,792,425

Exhibit J: Standard Exhibit J is attached.

Contractor Initials: *JAN*
 Date: *9/25/2013*

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

Date: 10/4/13

State of New Hampshire
Department of Health and Human Services

Kathleen A. Dunn
Kathleen A. Dunn, MPH
Associate Commissioner, Medicaid Director

Date: 9/25/13

Magellan Medicaid Administration

Timothy Nolan
Timothy Nolan
President

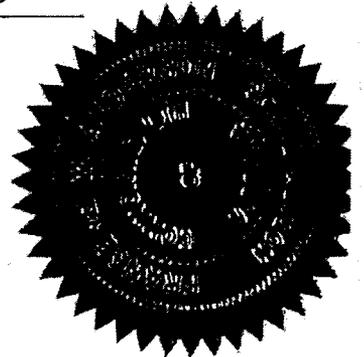
STATE OF Virginia
County of Henrico

25th The foregoing instrument was acknowledged before me, the undersigned notary, this
day of September, 2013, by Timothy Nolan.

IN WITNESS WHEREOF, I hereunto set my hand and official seal.

Francene M. Anderson
Notary Public
Registration No. 322352

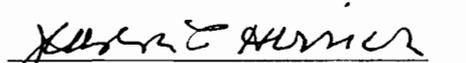
My commission expires:
May 31, 2014
(Date)



Contractor Initials: JPN
Date: 9/25/2013

Amendment 3
Magellan Medicaid Administration Inc. (formerly known as First Health Services Corporation)
Page 7 of 9

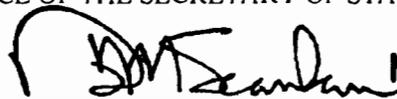
Approved by the New Hampshire Attorney General's Office by


Name: Jeannette P. Herrick
Title: Attorney

4 Oct. 2013

I hereby certify that the foregoing instrument was approved by the Governor and Executive Council of the State of New Hampshire at the Meeting on: _____.

OFFICE OF THE SECRETARY OF STATE

By:  NOV 08 2013
DEPUTY SECRETARY OF STATE

Contractor Initials: DPN
Date: 9/25/2013

Handwritten initials/signature



Nicholas A. Toumpas
Commissioner

Kathleen A. Dunn
Associate Commissioner

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

May 8, 2013

Approved by GTC
Date 5-5-13
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

<u>State Fiscal Year</u>	<u>Class/Account</u>	<u>Class Title</u>	<u>Current Modified Budget</u>	<u>Increase/ (Decrease)</u>	<u>Revised Modified Budget</u>
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
			<u>\$10,003,445.00</u>	<u>\$750,000.00</u>	<u>\$10,753,445.00</u>

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 stale 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

Amendment 2

Magellan Medicaid Administration Inc. (formerly known as First Health Services Corporation)

Page 2 of 4

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

Amendment 2

Magellan Medicaid Administration Inc. (formerly known as First Health Services Corporation)

Page 3 of 4

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%.

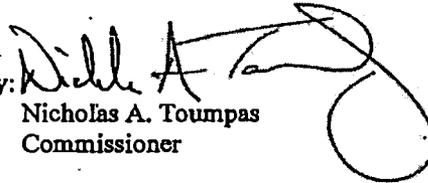
In the event that federal funds become no longer available, additional general funds will not be requested to support this agreement.

Respectfully submitted,



Kathleen A. Dunn, MPH
Associate Commissioner, Medicaid Director

Approved by:



Nicholas A. Toumpas
Commissioner

Attachment 1
Bid Summary

Category / Description	Cost	Revenue	Profit	Total Bid
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. B-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



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/ltn
RFP 2010-038B

cc: Leslie Mason, DoIT
Valerie Brown, DHHS

Amendment 2

Magellan Medicaid Administration Inc. (formerly known as First Health Services Corporation)

Page 1 of 6

**State of New Hampshire
Department of Health and Human Services
Amendment 2 to the
Magellan Medicaid Administration**

This 2nd Amendment to the Magellan Medicaid Administration, Inc. Contract (hereinafter referred to as "Amendment 2") dated this 25 day of April, 2013 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 "Magellan Medicaid Administration", and/or "the Contractor") with a place of business formerly located at 4300 Cox Road, Glen Allen, VA 23060.

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor and Executive Council on June 9, 2010, Item 82, vendor code # 175784, Amended June 20, 2012 Item 65, the Contractor agrees to perform certain services based upon the terms and conditions specified in the Contract, and in consideration of certain sums specified; and

WHEREAS, pursuant to paragraph 18 of the General Provisions, Form P-37, the Contract may be modified or amended only by a written instrument executed by the parties thereto, and only after approval of such modification by the Governor and Executive Council; and

WHEREAS, the State and the Contractor have agreed to amend the Contract in certain respects; and

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

Scope of Amendment

1. Except as specifically amended and modified by the terms and conditions in this Amendment 2, the obligations of the parties shall remain in full force and effect in accordance with the terms and conditions set forth in the Contract referenced above.

General Provisions, Form P-37

2. In Box 1.4 Contractor's Address delete 4300 Cox Road Glen Allen, VA 23060 and replace with 110113 West Broad Street Glen Allen, VA 23060.
3. In Box 1.8 Price limitation of \$10,003,445.00 is deleted and changed to \$10,753,445.00

Exhibit A Scope of Services

4. Effective Date: All exhibits and attachments to the original Contract remain in effect unless otherwise specified; Amendment 2 and exhibits and attachments to Amendment 2 are effective as of the date of Governor and Executive Council approval.

Exhibit A, Section III, Scope of Work, letter E # 7f. Delete "Department of Treasury, Abandoned Property Division for any checks outstanding from previous fiscal year according to the Statute and Administrative rules of the State of New Hampshire", and replace with Department of Health and Human Services, Office Medicaid Business and Policy so it may

Contractor Initials: [Signature]
Date: 4/25/13

Amendment 2

Magellan Medicaid Administration Inc. (formerly known as First Health Services Corporation)

Page 2 of 6

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.

The Contract total price for State Fiscal Year 2013 is being amended. Beginning July 1, 2012 NH Medicaid now includes the Child Health Insurance Program (CHIP) population. The increase in the number of clients caused an increase in number of claims per month, which also caused an increase in Administrative reviews, Automatic Prior Authorizations, and Clinical Reviews. As part of transition from the legacy to the New MMIS system the Contractor has been completing programming and reporting tasks for the new interface files and participating in weekly transition meetings. These expenses were not part of the original Contract.

Exhibit J: Standard Exhibit J is attached.

Remainder of page intentionally left blank

Contractor Initials: 4/25/13
Date: 4/25/13

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

Date: 5/2/13

State of New Hampshire
Department of Health and Human Services

Kathleen A. Dunn
Kathleen A. Dunn
Associate Commissioner, Medicaid Director

Date: 4/25/13

Magellan Medicaid Administration

Timothy Nolan
Timothy Nolan
President

STATE OF Virginia
County of Henrico

The foregoing instrument was acknowledged before me, the undersigned notary, this
25th day of April, 2013, by Timothy Nolan.

IN WITNESS WHEREOF, I hereunto set my hand and official seal.

Kavanaugh W. Anderson
Notary Public

My commission expires:

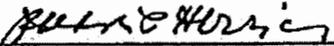
May 31, 2014
(Date)
Registration No. 322352



Contractor Initials: [Signature]
Date: 4/25/13

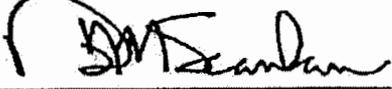
Amendment 2
Magellan Medicaid Administration Inc. (formerly known as First Health Services Corporation)
Page 4 of 6

Approved by the New Hampshire Attorney General's Office by:


Name: Kanne P. Herick
Title: Attorney

I hereby certify that the foregoing instrument was approved by the Governor and
Executive Council of the State of New Hampshire at the Meeting on: JUN 05 2013

OFFICE OF THE SECRETARY OF STATE

By: 
DEPUTY SECRETARY OF STATE

Remainder of page intentionally left blank

Contractor Initials: 
Date: 4/25/13



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 1-800-852-3346 Ext. 9384
 Fax: 603-271-8431 TDD Access: 1-800-735-2964

Nicholas A. Toumpas
 Commissioner

Kathleen A. Dunn
 Director

Approved by GTC
 Date 6-20-12
 Page _____
 Item # #65
 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, BHS:
 COMMISSIONER, OFF MEDICAID & BUSINESS POLICY, PHARMACY SERVICES

<u>State Fiscal Year</u>	<u>Class/Object</u>	<u>Class Title</u>	<u>Current Modified Budget</u>	<u>Increase/ (Decrease)</u>	<u>Revised Modified Budget</u>
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

His Excellency John H. Lynch
and the Honorable Executive Council
May 15, 2012
Page 2 of 3

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.

His Excellency John H. Lynch
and the Honorable Executive Council
May 15, 2012
Page 3 of 3

Geographic Area to be Served: Statewide

Funding for this request is General Funds 25% and Federal Funds 75%.

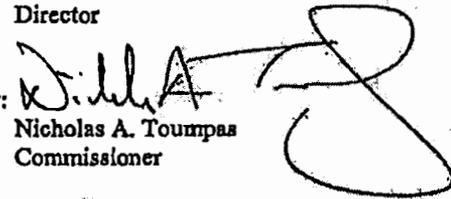
In the event that federal funds become no longer available, additional general funds will not be requested to support this agreement.

Respectfully submitted,



Kathleen A. Dunn, MPH
Director

Approved by:



Nicholas A. Toumpas
Commissioner

Bid Summary

Criteria/Category/Score	Score	Weighted Score	Weighted Score	Weighted Score
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



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

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,

A handwritten signature in black ink, appearing to read "S. William Rogers".

S. William Rogers

SWR/ltn
RFP 2010-038A

cc: Leslie Mason, DoIT
Valerie Brown, DHHS

State of New Hampshire
Department of Health and Human Services
Amendment 1 to the
First Health Services Corporation (d/b/a Magellan Medicaid Administration, Inc.)
Contract

This 1st Amendment to the First Health Services Corporation contract (d/b/a Magellan Medicaid Administration, Inc.) (hereinafter referred to as "amendment 1") dated this 21st day of May, 2012 is by and between the State of New Hampshire, Department of Health and Human Services (hereinafter referred to as the "State" or "Department") and First Health Services Corporation (d/b/a Magellan Medicaid Administration, Inc.) (hereinafter referred to as "First Health Services, d/b/a as Magellan" and/or "the Contractor") with a place of business at 4300 Cox Road, Glen Allen, VA 23060.

WHEREAS, pursuant to an agreement (the "contract") approved by the Governor and Executive Council on June 9, 2010, Item 82, vendor code # 175784, the Contractor agrees to perform certain services based upon the terms and conditions specified in the contract, and in consideration of certain sums specified; and

WHEREAS, pursuant to paragraph 18 of the General Provisions, Form P-37, the contract may be modified or amended only by a written instrument executed by the parties thereto, and only after approval of such modification by the Governor and Executive Council; and

WHEREAS, the State and the Contractor have agreed to amend the contract in certain respects; and

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

Scope of Amendment

1. Except as specifically amended and modified by the terms and conditions in this amendment 1, the obligations of the parties shall remain in full force and effect in accordance with the terms and conditions set forth in the Contract referenced above.

General Provisions, Form P-37

2. In Box 1.3 Contractor name is changed to Magellan Medicaid Administration, Inc.
3. In Box 1.8 Price limitation of \$9,792,425.00 is deleted and changed to \$10,003,445.00 ✓
4. In Box 1.10 State Agency Telephone Number: "603-271-5258" is deleted and replaced with "603-271-9384".

Exhibit A Scope of Services

5. Effective Date: All exhibits and attachments to the original contract remain in effect unless otherwise specified; amendment 1 and exhibits and attachments to amendment 1 are effective as of the date of Governor and Executive Council approval. ✓

Contractor Initials: CP

Date: 5/07/12

Amendment I

First Health Services Corporation (d/b/a Magellan Medicaid Administration, Inc.)

Page 2 of 6

6. The Contractor Name is changed from First Health Services Corporation to Magellan Medicaid Administration, Inc.

Exhibit A, Section BB. DHHS Contract Officer

Telephone number (603) 271-4419 is deleted and replaced with the following:

Telephone: (603) 271-9427

Exhibit B Replace:

Exhibit B, Section I Terms of Payment, number 2, part c replace \$2,899,677, with \$3,110,697.

Exhibit B, Section IV. The following is hereby deleted

Name: Donna Arcand
Title: Pharmacy Financial Manager
Mailing Address: Office Medicaid Business and Policy
Department Health and Human Services
129 Pleasant Street, Concord, NH 03301-3857
Telephone: (603) 271-8376
Fax: (603) 271-8431

and replaced with the following:

Name: David J Morán
Title: Pharmacy Financial Manager
Mailing Address: Office Medicaid Business and Policy
Department Health and Human Services
129 Pleasant Street, Concord, NH 03301-3857
Telephone: (603) 271-9428
Fax: (603) 271-8431

The contract total price for State Fiscal Year 2012 is being amended since at the time of the original projections there was an unforeseen increase in the number of Medicaid clients being served by the State. The increase in the number of clients caused an increase in number of claims per month, which also caused an increase in 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 pricing formulary increased the monthly costs of the contract by \$16,667.00 per month for State Fiscal Year 2012. This pricing formulary has saved the state an average of \$734,685.00 in drug expenses on a monthly basis since its implementation.

Exhibit J: Standard Exhibit J is attached.

Contractor Initials: 

Date: 5/23/12

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

Date: 5/24/12

State of New Hampshire
Department of Health and Human Services

Kathleen A. Dunn
Kathleen A. Dunn
Medicaid Director

Date: 5/23/12

Magellan Medicaid Administration

Timothy Nolan
Timothy Nolan
President

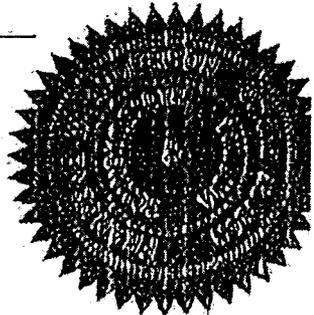
STATE OF Virginia
County of Henrico

The foregoing instrument was acknowledged before me, the undersigned notary, this 23rd day of May, 2012, by Timothy Nolan.

IN WITNESS WHEREOF, I hereunto set my hand and official seal.

Gracene W. Anderson
Notary Public
Registration No. 322352

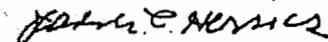
My commission expires:
May 31, 2014
(Date)



Contractor Initials: JD
Date: 5/23/12

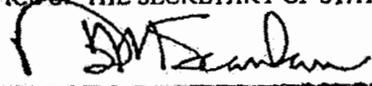
Amendment 1
First Health Services Corporation (d/b/a Magellan Medicaid Administration, Inc.)
Page 4 of 6

Approved by the New Hampshire Attorney General's Office by


Name: Jeanine P. Herlihy
Title: Attorney

I hereby certify that the foregoing instrument was approved by the Governor and
Executive Council of the State of New Hampshire at the Meeting on: JUN 20 2012

OFFICE OF THE SECRETARY OF STATE

By: 
Title: DEPUTY SECRETARY OF STATE

Contractor Initials: 
Date: 5/23/12



Important Notice Regarding Payments

First Health Services is now Magellan Medicaid Administration

Make checks payable to Magellan Medicaid Administration and send to one of the following addresses:

Standard Mail Address

Magellan Behavioral Health Lockbox
PO Box 785341
Philadelphia, PA 19178-5341

Courier Address

Wachovia Bank
Magellan Behavioral Health Lockbox
Box 785341
401 Market Street
Philadelphia, PA 19106

****Please Include your Invoice # with your payment****

If paying **electronically**, please use the following information:

Bank Name:	Wachovia Bank
Account Name:	Magellan Behavioral Health
Account Number:	2000026932396
ABA for Wires and ACH:	055 003 201

****Please reference the Invoice # and Magellan Medicaid Administration****

If you have any questions, please contact Ron Schmitz, Director of Finance, at (804) 965-7572 or rwschmitz@magellanhealth.com.



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 1-800-852-3846 Ext. 8166
 Fax: 603-271-8431 TDD Access: 1-800-735-2964

Nicholas A. Toumpas
 Commissioner

Kathleen A. Dunn
 Director

His Excellency, Governor John H. Lynch
 and the Honorable Executive Council
 State House
 Concord, New Hampshire 03301

May 1, 2010
 V 175784
 PO # 108933
 1008933
 Approved by GTC
 Date 6-9-10
 Page _____
 Item No. 82

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 ~~01/01/2011~~ ~~01/01/2012~~ to ~~12/31/2013~~. 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	\$2,899,677
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%

His Excellency John H. Lynch
and the Honorable Executive Council
May 1, 2010
Page 3 of 5

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-OMB-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:

<u>Bidder</u>	<u>Final Score</u>
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

His Excellency John H. Lynch
and the Honorable Executive Council
May 1, 2010
Page 4 of 5

Approved by:



Nicholas A. Toupas
Commissioner

The Department of Health and Human Services' Mission is to join communities and families in providing opportunities for citizens to achieve health and independence.

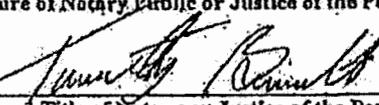
Subject: First Health Services Corporation Pharmacy Benefits Management Contract

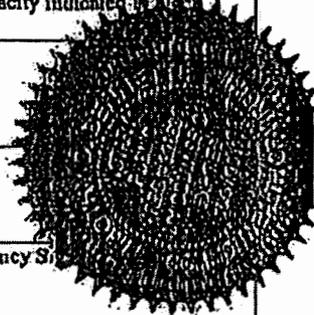
AGREEMENT

The State of New Hampshire and the Contractor hereby mutually agree as follows:

GENERAL PROVISIONS

1. IDENTIFICATION.

1.1 State Agency Name Department of Health and Human Services Office of Medicaid Business and Policy		1.2 State Agency Address 129 Pleasant Street Concord, NH 03301-3857	
1.3 Contractor Name First Health Services Corporation a subsidiary of Magellan Health Services		1.4 Contractor Address 4300 Cox Road Glen Allen, Virginia 23060	
1.5 Contractor Phone Number 804-965-7555	1.6 Account Number 10-61340000-500731	1.7 Completion Date 12/31/2013	1.8 Price Limitation 9,792,425.00
1.9 Contracting Officer for State Agency Kathleen A. Dunn		1.10 State Agency Telephone Number 603-271-5258	
1.11 Contractor Signature 		1.12 Name and Title of Contractor Signatory Timothy Nolan, President	
1.13 Acknowledgement: State of New Hampshire , County of Merrimack On <u>5/24/10</u> before the undersigned <u>Notary Public</u> , personally appeared the person identified in block 1.12, or satisfactorily proven to be the person whose name is signed in block 1.11, and acknowledged that s/he executed this document in the capacity indicated in block 1.12.			
1.13.1 Signature of Notary Public or Justice of the Peace [Seal] 			
1.13.2 Name and Title of Notary or Justice of the Peace <u>Manager of Accounting</u>			
1.14 State Agency Signature <u>Kathleen A. Dunn</u>		1.15 Name and Title of State Agency Signatory Kathleen A. Dunn, Director	
1.16 Approval by the N.H. Department of Administration, Division of Personnel (If applicable) By: _____ Director, On: _____			
1.17 Approval by the Attorney General (Form, Substance and Execution) By: <u>Richard Woodard</u> Attorney On: <u>5/24/10</u>			
1.18 Approval by the Governor and Executive Council By: _____ On: _____			



2. EMPLOYMENT OF CONTRACTOR/SERVICES TO BE PERFORMED. The State of New Hampshire, acting through the agency identified in block 1.1 ("State"), engages contractor identified in block 1.3 ("Contractor") to perform, and the Contractor shall perform, the work or sale of goods, or both, identified and more particularly described in the attached EXHIBIT A which is incorporated herein by reference ("Services").

3. EFFECTIVE DATE/COMPLETION OF SERVICES.
3.1 Notwithstanding any provision of this Agreement to the contrary, and subject to the approval of the Governor and Executive Council of the State of New Hampshire, this Agreement, and all obligations of the parties hereunder, shall not become effective until the date the Governor and Executive Council approve this Agreement ("Effective Date").
3.2 If the Contractor commences the Services prior to the Effective Date, all Services performed by the Contractor prior to the Effective Date shall be performed at the sole risk of the Contractor, and in the event that this Agreement does not become effective, the State shall have no liability to the Contractor, including without limitation, any obligation to pay the Contractor for any costs incurred or Services performed. Contractor must complete all Services by the Completion Date specified in block 1.7.

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 hereunder, are contingent upon the availability and continued appropriation of funds, and in no event shall the State be liable for any payments hereunder in excess of such available appropriated funds. In the event of a reduction or termination of appropriated funds, the State shall have the right to withhold payment until such funds become available, if ever, and shall have the right to terminate this Agreement immediately upon giving the Contractor notice of such termination. The State shall not be required to transfer funds from any other account to the Account identified in block 1.6 in the event funds in that Account are reduced or unavailable.

5. CONTRACT PRICE/PRICE LIMITATION/PAYMENT.
5.1 The contract price, method of payment, and terms of payment are identified and more particularly described in EXHIBIT B which is incorporated herein by reference.
5.2 The payment by the State of the contract price shall be the only and the complete reimbursement to the Contractor for all expenses, of whatever nature incurred by the Contractor in the performance hereof, and shall be the only and the complete compensation to the Contractor for the Services. The State shall have no liability to the Contractor other than the contract price.
5.3 The State reserves the right to offset from any amounts otherwise payable to the Contractor under this Agreement those liquidated amounts required or permitted by N.H. RSA 80:7 through RSA 80:7-c or any other provision of law.
5.4 Notwithstanding any provision in this Agreement to the contrary, and notwithstanding unexpected circumstances, in

no event shall the total of all payments authorized, or actually made hereunder, exceed the Price Limitation set forth in block 1.8.

6. COMPLIANCE BY CONTRACTOR WITH LAWS AND REGULATIONS/ EQUAL EMPLOYMENT OPPORTUNITY.
6.1 In connection with the performance of the Services, the Contractor shall comply with all statutes, laws, regulations, and orders of federal, state, county or municipal authorities which impose any obligation or duty upon the Contractor, including, but not limited to, civil rights and equal opportunity laws. In addition, the Contractor shall comply with all applicable copyright laws.
6.2 During the term of this Agreement, the Contractor shall not discriminate against employees or applicants for employment because of race, color, religion, creed, age, sex, handicap, sexual orientation, or national origin and will take affirmative action to prevent such discrimination.
6.3 If this Agreement is funded in any part by monies of the United States, the Contractor shall comply with all the provisions of Executive Order No. 11246 ("Equal Employment Opportunity"), as supplemented by the regulations of the United States Department of Labor (41 C.F.R. Part 60), and with any rules, regulations and guidelines as the State of New Hampshire or the United States issue to implement these regulations. The Contractor further agrees to permit the State or United States access to any of the Contractor's books, records and accounts for the purpose of ascertaining compliance with all rules, regulations and orders, and the covenants, terms and conditions of this Agreement.

7. PERSONNEL.
7.1 The Contractor shall at its own expense provide all personnel necessary to perform the Services. 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.
7.2 Unless otherwise authorized in writing, during the term of this Agreement, and for a period of six (6) months after the Completion Date in block 1.7, the Contractor shall not hire, and shall not permit any subcontractor or other person, firm or corporation with whom it is engaged in a combined effort to perform the Services to hire, any person who is a State employee or official, who is materially involved in the procurement, administration or performance of this Agreement. This provision shall survive termination of this Agreement.
7.3 The Contracting Officer specified in block 1.9, or his or her successor, shall be the State's representative. In the event of any dispute concerning the interpretation of this Agreement, the Contracting Officer's decision shall be final for the State.

8. EVENT OF DEFAULT/REMEDIES.

Contractor Initials TPN
Date 4/16/12

8.1 Any one or more of the following acts or omissions of the Contractor shall constitute an event of default hereunder ("Event of Default"):

- 8.1.1 failure to perform the Services satisfactorily or on schedule;
- 8.1.2 failure to submit any report required hereunder; and/or
- 8.1.3 failure to perform any other covenant, term or condition of this Agreement.

8.2 Upon the occurrence of any Event of Default, the State may take any one, or more, or all, of the following actions:

- 8.2.1 give the Contractor a written notice specifying the Event of Default and requiring it to be remedied within, in the absence of a greater or lesser specification of time, thirty (30) days from the date of the notice; and if the Event of Default is not timely remedied, terminate this Agreement, effective two (2) days after giving the Contractor notice of termination;
- 8.2.2 give the Contractor a written notice specifying the Event of Default and suspending all payments to be made under this Agreement and ordering that the portion of the contract price which would otherwise accrue to the Contractor during the period from the date of such notice until such time as the State determines that the Contractor has cured the Event of Default shall never be paid to the Contractor;
- 8.2.3 set off against any other obligations the State may owe to the Contractor any damages the State suffers by reason of any Event of Default; and/or
- 8.2.4 treat the Agreement as breached and pursue any of its remedies at law or in equity, or both.

9. DATA/ACCESS/CONFIDENTIALITY/PRESERVATION.

9.1 As used in this Agreement, the word "data" shall mean all information and things developed or obtained during the performance of, or acquired or developed by reason of, this Agreement, including, but not limited to, all studies, reports, files, formulas, surveys, maps, charts, sound recordings, video recordings, pictorial reproductions, drawings, analyses, graphic representations, computer programs, computer printouts, notes, letters, memoranda, papers, and documents, all whether finished or unfinished.

9.2 All data and any property which has been received from the State or purchased with funds provided for that purpose under this Agreement, shall be the property of the State, and shall be returned to the State upon demand or upon termination of this Agreement for any reason.

9.3 Confidentiality of data shall be governed by N.H. RSA chapter 91-A or other existing law. Disclosure of data requires prior written approval of the State.

10. **TERMINATION.** In the event of an early termination of this Agreement for any reason other than the completion of the Services, the Contractor shall deliver to the Contracting Officer, not later than fifteen (15) days after the date of termination, a report ("Termination Report") describing in detail all Services performed, and the contract price earned, to and including the date of termination. The form, subject matter, content, and number of copies of the Termination Report shall be identical to those of any Final Report described in the attached EXHIBIT A.

11. **CONTRACTOR'S RELATION TO THE STATE.** In the performance of this Agreement the Contractor is in all respects an independent contractor, and is neither an agent nor an employee of the State. Neither the Contractor nor any of its officers, employees, agents or members shall have authority to bind the State or receive any benefits, workers' compensation or other emoluments provided by the State to its employees.

12. **ASSIGNMENT/DELEGATION/SUBCONTRACTS.** The Contractor shall not assign, or otherwise transfer any interest in this Agreement without the prior written consent of the N.H. Department of Administrative Services. None of the Services shall be subcontracted by the Contractor without the prior written consent of the State.

13. **INDEMNIFICATION.** The Contractor shall defend, indemnify and hold harmless the State, its officers and employees, from and against any and all losses suffered by the State, its officers and employees, and any and all claims, liabilities or penalties asserted against the State, its officers and employees, by or on behalf of any person, on account of, based or resulting from, arising out of (or which may be claimed to arise out of) the acts or omissions of the Contractor. Notwithstanding the foregoing, nothing herein contained shall be deemed to constitute a waiver of the sovereign immunity of the State, which immunity is hereby reserved to the State. This covenant in paragraph 13 shall survive the termination of this Agreement.

14. INSURANCE.

14.1 The Contractor shall, at its sole expense, obtain and maintain in force, and shall require any subcontractor or assignee to obtain and maintain in force, the following insurance:

14.1.1 comprehensive general liability insurance against all claims of bodily injury, death or property damage, in amounts of not less than \$250,000 per claim and \$2,000,000 per occurrence; and

14.1.2 fire and extended coverage insurance covering all property subject to subparagraph 9.2 herein, in an amount not less than 80% of the whole replacement value of the property.

14.2 The policies described in subparagraph 14.1 herein shall be on policy forms and endorsements approved for use in the State of New Hampshire by the N.H. Department of Insurance, and issued by insurers licensed in the State of New Hampshire.

14.3 The Contractor shall furnish to the Contracting Officer identified in block 1.9, or his or her successor, a certificate(s) of insurance for all insurance required under this Agreement. Contractor shall also furnish to the Contracting Officer identified in block 1.9, or his or her successor, certificate(s) of insurance for all renewal(s) of insurance required under this Agreement no later than fifteen (15) days prior to the expiration date of each of the insurance policies. The certificate(s) of insurance and any renewals thereof shall be attached and are incorporated herein by reference. Each certificate(s) of insurance shall contain a clause requiring the insurer to endeavor to provide the Contracting Officer

identified in block 1.9, or his or her successor, no less than ten (10) days prior written notice of cancellation or modification of the policy.

15. WORKERS' COMPENSATION.

15.1 By signing this agreement, the Contractor agrees, certifies and warrants that the Contractor is in compliance with or exempt from, the requirements of N.H. RSA chapter 281-A ("Workers' Compensation").

15.2 To the extent the Contractor is subject to the requirements of N.H. RSA chapter 281-A, Contractor shall maintain, and require any subcontractor or assignee to secure and maintain, payment of Workers' Compensation in connection with activities which the person proposes to undertake pursuant to this Agreement. Contractor shall furnish the Contracting Officer identified in block 1.9, or his or her successor, proof of Workers' Compensation in the manner described in N.H. RSA chapter 281-A and any applicable renewal(s) thereof, which shall be attached and are incorporated herein by reference. The State shall not be responsible for payment of any Workers' Compensation premiums or for any other claim or benefit for Contractor, or any subcontractor or employee of Contractor, which might arise under applicable State of New Hampshire Workers' Compensation laws in connection with the performance of the Services under this Agreement.

16. WAIVER OF BREACH. No failure by the State to enforce any provisions hereof after any Event of Default shall be deemed a waiver of its rights with regard to that Event of Default, or any subsequent Event of Default. No express failure to enforce any Event of Default shall be deemed a waiver of the right of the State to enforce each and all of the provisions hereof upon any further or other Event of Default on the part of the Contractor.

17. NOTICE. Any notice by a party hereto to the other party shall be deemed to have been duly delivered or given at the time of mailing by certified mail, postage prepaid, in a United States Post Office addressed to the parties at the addresses given in blocks 1.2 and 1.4, herein.

18. AMENDMENT. This Agreement may be amended, waived or discharged only by an instrument in writing signed by the parties hereto and only after approval of such amendment, waiver or discharge by the Governor and Executive Council of the State of New Hampshire.

19. CONSTRUCTION OF AGREEMENT AND TERMS. This Agreement shall be construed in accordance with the laws of the State of New Hampshire, and is binding upon and inures to the benefit of the parties and their respective successors and assigns. The wording used in this Agreement is the wording chosen by the parties to express their mutual intent, and no rule of construction shall be applied against or in favor of any party.

20. THIRD PARTIES. The parties hereto do not intend to benefit any third parties and this Agreement shall not be construed to confer any such benefit.

21. HEADINGS. The headings throughout the Agreement are for reference purposes only, and the words contained therein shall in no way be held to explain, modify, amplify or aid in the interpretation, construction or meaning of the provisions of this Agreement.

22. SPECIAL PROVISIONS. Additional provisions set forth in the attached EXHIBIT C are incorporated herein by reference.

23. SEVERABILITY. In the event any of the provisions of this Agreement are held by a court of competent jurisdiction to be contrary to any state or federal law, the remaining provisions of this Agreement will remain in full force and effect.

24. ENTIRE AGREEMENT. This Agreement, which may be executed in a number of counterparts, each of which shall be deemed an original, constitutes the entire Agreement and understanding between the parties, and supersedes all prior Agreements and understandings relating hereto.

Contractor Initials: TPN
Date: 4/16/10



STATE OF NEW HAMPSHIRE
DEPARTMENT OF INFORMATION TECHNOLOGY

27 Hazen Dr., Concord, NH 03301
603-271-2843 1-800-852-3345 x2843
Fax: 603-271-1516 TDD Access: 1-800-735-2964
www.nh.gov/doit

Richard C. Bailey, Jr.
Chief Information Officer

April 10, 2010

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 enter into Contract No. 10-OMBP-PBM-01 Pharmacy Benefit Management Services, with First Health Services Corporation, of Glen Allen, VA. as described below and referenced as DoIT No. 2010-038.

First Health shall implement a state-wide Pharmacy Benefit Management (PBM) system for Medicaid beneficiaries based upon best practice models; maintain an accurate and efficient automated systematic adjudication and payment of pharmacy claims, and other services indicated in the contract; provide clinical management programs designed to improve quality and maximize cost savings to the State of New Hampshire Medicaid Program; provide specialty pharmacy management to ensure appropriate clinical utilization and cost savings; along with other responsibilities as defined in the contract.

The contract will be effective upon Governor and Executive Council approval through December 31, 2013, in the amount of \$9,792,425. 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,

Richard C. Bailey, Jr.

RCB/ltn
RFP 2010-038
RID #10006

Evaluator	Position	Expertise
Donna Arcand	Pharmacy Financial Manager	6 years managing the finances of the N.H. Medicaid Pharmacy Program
Margaret Clifford, R.Ph.	Chief Compliance Investigator, N.H. Board of Pharmacy	Former manager of the N.H. Medicaid Pharmacy Program, 5 years Chief Compliance Officer for the NH Board of Pharmacy
Lise Farrand, R.Ph.	Pharmacist Services Specialist for the Medicaid Program	16 years daily oversight of the N.H. Medicaid Pharmacy Program.
Athena Gagnon	Administrator, Medicaid Budget Office	4 years oversight of finances for the N.H. Medicaid Program
Doris Lotz, MD, MPH	Medicaid Medical Director	9 years oversight of Clinical and Quality Improvement for N.H. Medicaid Program
Stephen Mosher	Administrator, Office of Improvement, Integrity, & Information	Oversight of Program Integrity and Audits

	First Health	Goold	UMass	HealthTrans
Finance Auditing, Rebates (40 points)	32.0	24.0	20.0	14.7
Reporting, Analysis (15 points)	10.0	6.0	9.0	8.0
Clinical Management (40 points)	37.3	24.0	21.3	10.7
Electronic Prescribing (5 points)	4.3	2.7	3.0	3.0
Communications, Provider Network (15 points)	12.0	9.0	10.0	7.0
Vendor Staffing (5 points)	4.7	2.7	1.7	1.7
Innovations (10 points)	8.7	4.7	4.7	4.7
Cost Proposal (70 points total)				
a. Implementation ACS/EDS (10 points)	9.0	5.5	3.5	9.8
b. All Inclusive Administrative per paid Claim (35 points)	25.3	35.0	16.5	8.7
c. Administrative Review per Completed Request (5 points)	5.0	2.1	3.7	1.1
d. Clinical Review per Completed Request (15 points)	15.0	11.8	6.9	4.5
e. E-Prescribing per Eligibility/History Hit (5 points)	4.0	4.7	1.7	3.5
GRAND TOTAL*	167.3	132.1	101.9	77.0

*Due to rounding totals may appear different than actual addition by less than 0.2.

NH Department of Health and Human Services

EXHIBIT A

SCOPE OF SERVICES

EFFECTIVE DATE: Later of: One week after Governor and Executive Council approval or July 1, 2010

CONTRACT PERIOD: Later of: One week after Governor and Executive Council approval or July 1, 2010 through December 31, 2013

CONTRACTOR:
NAME: First Health Services Corporation

ADDRESS: 4300 Cox Road
Glen Allen, VA 23060

TELEPHONE: (804) 965-7555

Account Manager: David W. Pinkston

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.

This Contract between the DHHS and the Contractor consists of the following contract documents:

- 1) New Hampshire Standard Contract Terms and Conditions, Form P-37 (1/09) together with the following Exhibits:
 - a) Exhibit A – Scope of Services
 - b) Exhibit B – Methods and Conditions Precedent to Payment
 - c) Exhibit C – Special Provisions
 - d) Exhibit C-1 – Additional Special Provisions
 - e) Exhibit D – Certification Regarding Drug Free Workplace
 - f) Exhibit E – Certification Regarding Lobbying
 - g) Exhibit F – Certification Regarding Debarment, suspension, and other Responsibility Matters
 - h) Exhibit G – Certification Regarding Americans with Disabilities Act Compliance
 - i) Exhibit H – Certification Regarding Tobacco-Free Workplace
 - j) Exhibit I – Certification Regarding Health Insurance Portability and Accountability Act Compliance (9/09)

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- k) All Attachments/Appendices, including Ownership and Control Statement pursuant to 42 CFR 455.10, Certificate of Vote, Certificate of Good Standing, Certificate of Insurance.
- 2) Request for Proposal (RFP) for Pharmacy Benefit Management Services (PBM), issued June 30, 2009 that is the basis for this Contract
- 3) Contractor's Proposal to Provide Pharmacy Benefit Management Services (Technical and Cost Proposals) or parts thereof as accepted by DHHS, submitted September 28, 2009, Material provided at oral presentation on November 3, 2009, and the revised PBM Clarification Response 2-4-2010.

The parties agree that in resolving any inconsistencies, discrepancies, or ambiguities regarding any of the contract documents, the order of precedence shall be the order that the documents are listed above, from top to bottom. The RFP, Contractor's Proposal, Oral Presentation Materials and PBM Clarifications Response are incorporated by reference.

The duration of the contract is 42 months. The Contract may be extended, at the discretion of DHHS, and subject to Governor and Executive Council approval and pending availability of funds for two periods of no more than two years each.

II. DEFINITIONS

1. 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 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.
2. 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.
3. The term "Contractor" means First Health Services of Glen Allen, Virginia, a wholly owned subsidiary of Magellan Health Services, Inc. of Avon, CT.
4. The terms "Department", "DHHS", "OMBP" 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).
5. The term "Federal Upper Limit" means the maximum amount that Medicaid can reimburse for a drug product as established by CMS.
6. The term "First DataBank" means the drug pricing service with which the Contractor provides for weekly drug price updates.
7. The term "Fiscal Pend" means adjudicated claims and financial transactions, based on user-defined parameters for exclusion from payment during selected future financial cycles.
8. The term "Lock In" means to identify clients who are restricted, when obtaining drugs, medical services or supplies, to one or more specified providers.

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Date: 5/10/10

WV

9. The term "Maximum Allowable Cost" means the maximum amount NH Medicaid will reimburse for a drug product as established by First Health (FH) in accordance with Centers for Medicare and Medicaid Services (CMS) guidelines.
10. "Paid Adjudicated claim" is claim for which a check or payment has actually been sent to the provider or state approved payees.
11. The term "Preferred Drug List" or "PDL" means a list of covered drugs available without prior authorization.
12. 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.
13. The term "Prospective Drug Utilization Review" or "ProDUR" means the provision of certain information, on-line, to authorized providers prior to filling a prescription.
14. The term "Provider" means an enrolled NH Medicaid provider.
15. 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.
16. The term "Prescriber" means the individual writing the prescription for the recipient and who is authorized to do so.
17. The term "Recipient" or "client" or "beneficiary" or "member" means a person or persons eligible for New Hampshire Medicaid.
18. The term "Retrospective Drug Utilization Review" or "RetroDUR" means the review of provider dispensing patterns and client use of drugs.
19. The term "Third Party Liability" or "TPL" means any source of payment or potential source of payment for prescription drugs, other than Medicaid.

III. SCOPE OF WORK

A. Implementation

The Implementation Phase shall begin on the later of: one week after Governor and Executive Council approval or July 1, 2010. The thirty-six months Operational term shall commence January 1, 2011.

The implementation Phase shall include the Design, Development and Implementation (DDI) of the PBM system enhancements required to meet the system requirements and to deliver the services covered under the RFP and Section III: Scope of Work. The Contractor shall work cooperatively with the State to develop and deliver an updated detailed Project Work Plan following the execution of this contract. The Contractor shall identify all tasks necessary for the successful implementation of the PBM system enhancements so that the required functionality shall be ready for the start of operations on January 1, 2011 and shall meet the requirements for CMS Certification. The implementation phase shall include the implementation of the secure web portal and all required web-based functionality, implementation of an Interactive Voice Response (IVR) System for eligibility verification and Prior Authorization processing, and the implementation of all other system modifications to support the functions and services required under the RFP and Scope of Work. Once agreed upon by the State and the Contractor, the Detailed Project Work Plan shall be incorporated as part of this contract. The Work Plan may be amended or adjusted subject to the approval of the State.

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The Implementation Phase shall consist of four sub-phases and the Work Plan shall include identified tasks and deliverables that are subject to State approval for each of the sub-phases:

- Project Initiation, Planning, and Analysis
- Design
- Construction
- Testing/Deployment (includes State User Acceptance Testing and Operational Readiness Testing)

B. Information Technology (IT) Systems Requirements

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

1. Secure Web-based solutions;
2. Point of Sale (POS) Pharmacy Claims Adjudication (Paid, Denied, Reversed, Adjusted, Voids);
3. Provider Management;
4. Recipient Management;
5. Prior Authorization Management;
6. Third Party Coverage and Cost Avoidance Management;
7. Financial Management (Financial Transactions, Fund Codes, Fiscal Pend);
8. Payment Management (Checks, EFT, Remittance Advices, Banking);
9. Drug Rebate Management;
10. Reference Data Management (Drug Codes, Rates, Edits, Audits);
11. Reporting (Ad hoc and Pre-Defined/Scheduled and On-Demand);
12. Call Center Management;
13. E-prescribing;
14. Access Management; and
15. Other components as necessary to meet the requirements of the RFP.

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.

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.

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

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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 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.

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.

C. Systems Capability and Performance Standards

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

- a. 24x7x365, 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. 24x7x365 operational support, 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 Vendor will send to the State:

- a. Third party liability (TPL) extract to the Contractor (Daily);

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Date: 5/10/12

- 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. Medical claims for physician-administered drugs processed by the MMIS 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.
4. Provider and Patient Pharmacy Web Access. The Contractor will create secure web access for Medicaid providers and Medicaid beneficiaries 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.
- a. 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.
 - b. Beneficiary 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.
 - c. 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.
 - d. 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.
 - e. The website shall provide an e-mail link to the Contractor to allow Medicaid beneficiaries 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.

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- i. 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 (1) per month.
- f. The Contractor will provide reports to include but not be limited to: number of "hits" per month by provider and beneficiary; 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.
- g. Contractor shall have this website system available not later than January 1, 2011.
- h. 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.

D. 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.

E. 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;

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Date: 5/10/10

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 Wachovia Bank, National Association (formerly First Union), 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 Treasury, Abandoned Property Division for any checks outstanding from the previous fiscal year according to the Statute and Administrative rules of the State of New Hampshire.
 - 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 state dated check report that includes check number, check amount, amount invoiced, batch date, date issued, payee identification number, payee name and payee address.
8. Generation of HIPAA compliant electronic remittance advice (RA);
9. Generation of checks or Electronic Funds Transfer (EFT) and mail checks with paper RA to providers;
10. Negative balance tracking and collection according to State policies;
11. Allocation of drug rebate collections across fund codes and counties based on claims paid;
12. Support electronic funds transfer (EFT), allowing providers to elect EFT or check payment; and
13. The capability to fiscally pend both administrative fees and claim payments at the request of the State.

F. 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 appeals.

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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.

G. 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.

H. 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

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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.

I. 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.

J. Monthly Invoicing

On a monthly basis, Contractor shall send documentation to the State in support of Contractor's monthly invoice. Documentation shall include: the number of claims processed and number of claims paid for that month; the number of PA's completed in that month; and the number of e-prescribing transactions.

K. 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 assure accurate pricing.

L. 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.
3. 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.
4. The Contractor's PBM solution for the State shall have the capability to electronically and paper bill other insurance carriers for pharmacy claims where other insurance was determined after

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Medicaid has paid, in accordance with the federal Deficit Reduction Act (DRA) and State laws. The bills for each claim shall, at a minimum, be generated twice. The first bill will be generated monthly and reflect all claims for the past three (3) years where other insurance was active, but not known until the previous month. The second bill will be 120-calendar days after the first bill and will contain all claims that have not been written off or paid since the original billing. The 120-day billing will be generated monthly. The Contractor's bills to the insurance carrier or other entities must include, at a minimum: pharmacy name and address; pharmacy NPI, recipient's name and address; MID; recipient's date of birth; insurance policy number and group number; subscriber name; insurance carrier name and address; state billing address and TPL phone number; date prescription filled; prescriber NPI; National Drug Code (NDC); name of drug; prescription number; supply count and quantity; total charge; amount Medicaid paid; and the federal tax identification number for the State.

5. The Contractor shall report on receivables by insurance carrier and Medicaid member, and report outstanding funds owed to the State by insurance carrier.
6. Contractor's claims processing must be able to capture and reflect the payment of a claim at the claim detail level, including partial payment and overpayment, and any denial of payment, including reason for denial. Any adjustment to the claim must be reflected without changing the original claim as paid to the pharmacy.
7. Subject to the State's prior approval, Contractor shall utilize the services of a third party to assist in the identification of responsible third party payors ("TPL subcontractor"). The TPL subcontractor shall have a proprietary database containing information not captured by the State, which can be used to supplement the State's TPL data. The State shall provide to the TPL subcontractor eligibility files and claims extracts on a scheduled basis. TPL subcontractor shall perform retroactive billing to recoup monies owed by responsible third party payors using State and TPL subcontractor information. All monies recuperated by the TPL subcontractor shall be returned to the State. Contractor is solely responsible for payment of fees to TPL subcontractor.

M. Auditing

1. General: The Contractor shall manage the audit and compliance programs for the State's Medicaid provider network(s). This work effort includes imposition of appropriate sanctions and recoveries. Contractor shall conduct audits and report all audit findings to the State Surveillance and Utilization Review System (SURS) unit. 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.
2. SAS 70 Audit: 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 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 SAS 70, as issued by the American Institute of Certified Public Accountants. The independent auditor is required to complete a SAS 70 Type II 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 SAS 70 Type II must be completed for each year of the Contract period. The SAS 70 Audit shall be provided to the State's contract manager.

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The minimum contents of the SAS 70 Audit are as follows: The independent auditor will 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.
3. The Contractor Audit Reports: The Contractor shall provide to the Department audit reports on the Contractor's operations including external financial performance audit reports, internal corporate audit reports, and system control audit reports, within two (2) months of their release. The Contractor shall make available, for review, upon request of all corresponding audit and compliance work papers supporting the respective audit reports. These reports are subject to release by the Department to designated Department staff, the State's auditors and other State governmental bodies.
 4. Claims Audit: The Contractor shall provide a complete and comprehensive audit program, subject to the approval of the Department, which shall include pharmacy desk and on-site audits designed to detect questionable pricing/discounting, duplication of claims, or other types of potential fraud,

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abuse and misuse of the prescription drug benefits. The Contractor shall maintain an auditing system with the capacities or specifications set forth in its response to the RFP. Contractor shall work with the State to conduct a limited number of onsite audits when requested by the State, not to exceed fifteen (15) onsite audits per calendar year. All monies identified by the audits shall be recovered by and through the State.

5. Tamper Resistant Prescription Drug Pads: The Contractor shall audit pharmacy compliance with Section 7002(b) of the United States Troop Readiness, Veterans' Care, Katrina Recovery and Iraq Accountability Appropriations Act of 2007, which sets requirements regarding the use of tamper resistant prescription drug pads in Medicaid including, but not limited to:
 - a. Ensure written prescriptions are compliant with the above listed federal requirements; and
 - b. If it is determined that a payment was made on a claim for a prescription that was not in compliance with the Medicaid tamper-resistant prescription requirements, the Contractor shall recover the payment on behalf of the State.

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

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 Supplemental Rebate requirements.

1. 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".

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- 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.

2. 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.

3. NMPI:

At the option of the Department, which may be exercised no less often than annually, the Contractor shall utilize the National Medicaid Pooling Initiative (NMPI) for the supplemental rebate process or subsequent to submitting PDL classes to the DUR Board, conduct supplemental rebate analysis and, at the direction of the Department, negotiate with pharmaceutical manufacturers for state only rebates agreements for New Hampshire. The Department on an annual basis shall make election of participation in NMPI.

O. Analysis and Reporting

1. The Contractor shall provide one (1) full-time dedicated Reporting Specialist who shall be located in 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 vendor employees. Each report shall identify: issue; status (problem identified, resolution being developed, resolution being implemented, problem resolved); person responsible for

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- 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;
 - i. 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.
 - j. 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. Total number of PA appealed;
 - viii. Total number of PA denied requests on appeal;
 - ix. By each initiative (i.e. PA, Quantity Limits, State MAC, etc.);
 - x. Benchmark relative to industry;
 - xi. Annualized savings per drug category;
 - xii. Total dollar amount of claims by eligibility type;
 - xiii. Top ten reasons for denial;
 - xiv. Generic substitution rate;
 - xv. Generic dispensing rate;
 - xvi. Average time and range for adjudication of claims by mode of processing;
 - xvii. Average time and range for PA approvals and denials;
 - xviii. Average time for PA appeals;
 - xix. Number of seventy-two (72) hour overrides;
 - xx. Number of PA not resolved within 24 hours;
 - xxi. Reasons for PA resolved in greater than 24 hours;
 - xxii. Cost savings for each PBM initiative;
 - xxiii. Administrative cost by initiative for PBM program;
 - xxiv. Analysis of cost shifting;
 - xxv. Volume of claims paid for preferred drugs vs. non-preferred drugs;
 - xxvi. PA as a percent of total claims;
 - xxvii. Lock in program; and
 - xxviii. Any other reports referred through the RFP.
 - k. 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.

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- l. 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.
- m. The Contractor shall provide ad hoc reports needed for legislative compliance, as required.
- n. 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.
- o. 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.

P. Medicaid Drug Coverage Management

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:

1. Implement the drug coverage parameters established by DHHS with input from the Contractor;
2. Duplicate the current reimbursement methodology, as stated in the Request for Proposal (RFP) for Pharmacy Benefit Management Services (PBM), issued June 30, 2009, to the extent the current practices provide the best price for drugs of the State Medicaid Drug Program;
3. 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;
4. The Clinical Manager shall attend each DUR Board meeting and present the Board with a written report containing the following information:
 - a. 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.
 - b. Provide supportive evidence-based clinical research, documentation, financial impact analysis, and recommendations for newly approved therapies and indications to the Committee for consideration.
5. Contractor shall update its drug prices and other supporting drug data on a weekly basis using a recognized vendor. Current coverage is keyed by FDB's generic sequence number (GSN) and the NDC.
6. 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

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weekly and taken to Pharmacy Services for consideration and inclusion into the Medicaid Drug List.

Q. 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 full-time clinical manager (RPh or PharmD 100% dedicated to the NH Medicaid program) to coordinate with the State DUR Board.
3. 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.
4. The Contractor shall prepare an 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.
5. 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.
6. 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. 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.

Contractor is responsible for all costs involving travel for meeting attendance and provider education.

7. ProDUR

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

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shall have the flexibility to adjust to changes in criteria or procedures as recommended by the DUR Board.

8. 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.

9. 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.

10. 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.
- c. The Clinical Manager shall meet with targeted prescribers. These face-to-face meetings are expected to include retrospective, beneficiary-specific DUR and are separate and distinct from academic detailing.
- d. All travel costs associated with provider education shall be Contractor's responsibility.

R. 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,

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- physicians and pharmacists, with guidance and recommendations to OMBP. 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.
2. The Clinical Manager shall meet regularly with a minimum of 50 providers yearly to educate and support providers' efficient and accurate use of the Medicaid pharmacy benefits program and to provide evidence-based academic detailing to promote appropriate drug utilization by Medicaid providers. The Clinical Manager will also conduct periodic utilization management provider contact as needed. All travel costs associated with provider education shall be the Contractor's responsibility.
 3. The Contractor's Clinical Manager shall coordinate with the Department, which shall be responsible for approving all UM programs.
 4. Upon State approval of changes proposed by Contractor in its RFP proposal, such changes shall be ready for implementation by January 1, 2011. The criteria for UM plans shall be recommended by Contractor and approved by the State.
 5. 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.
 6. On a quarterly basis, the Contractor shall provide a written report profiling the top one hundred (100) utilizing beneficiaries, prescribers and pharmacies for the State. 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.
 7. Data and UM management strategies shall be coordinated with the State's care coordination contractor, Medicaid medical home providers or any accountable care organizations that may exist during the timeframe of this contract.
 8. The Contractor shall consider UM strategies that are the least administratively burdensome to prescribers, in accordance with federal law 42USC1396a(a)(19).
 9. 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.
 10. UM shall include written, oral (face-to-face and telephonic) 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 beneficiary-related information.

S. 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 develop an appeals process in accordance with Department procedures and subject to the prior approval of the Department.
7. The Contractor shall provide regular reporting to the Department to summarize PA activity on a monthly basis.

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T. 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-injectables;
 - 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;

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- viii. Miscellaneous such as: interferon, botulinum toxin, imiglucerase, levprolide, amalizinab and goserlin;
- ix. Other as mutually agreed upon.

U. 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 PQS and ProDUR systems on January 1, 2011.
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.
4. The Contractor shall perform prescriber education and outreach to include written communications, electronic outreach and face-to-face meeting to appropriately promote and ensure the proper use of the e-prescribing program and at a minimum will include specific outreach to the Medicaid program's top one hundred (100) prescribers.
5. The Contractor will provide reports including: transaction reports for billing; prescriber adoption and use reports; transaction processing performance (including but not limited to speed, volume, incomplete transactions and switch downtime).
6. Performance standards shall include but not be limited to: end to end transaction performance between prescriber and the Contractor is < 3 seconds; end to end transaction performance between Contractor and the Point of Sale Pharmacy Provider is < 5 seconds.
7. All costs associated with the e-prescribing program are incorporated into the E-prescribing transaction fee in Exhibit B.
8. An e-prescribing transaction fee will be invoiced monthly to the State. A transaction is defined as a positive inquiry (including some or all of the following: eligibility, formulary inquiry, and medication history look-up) for a Medicaid beneficiary.
9. The Contractor is responsible for all of the duties of program implementation and maintenance including any duties that may be the responsibility of any subcontractor.

V. Beneficiary 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.

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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 shall produce reports on usage of the telephone line(s), including number of inquiries, types of inquiries, complaints received, and timeliness of responses.
6. 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.
7. 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.
8. 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 beneficiary's unique needs and medical conditions.
9. 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.
10. 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.
11. Contractor shall provide additional, secured web-based communications in accordance with the specifications set forth in Systems Capability and Performance Standards set forth above.

W. Provider Network and External Stakeholders

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:

1. Provider eligibility verification;
2. Maintaining a history of eligible providers;
3. 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
4. Provider outreach and education to include provider profiling, education visits and other communications and provider customer service.
5. The Contractor shall maintain working and contractual relations with pharmaceutical manufacturers.
6. 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.
7. The Contractor shall cooperate with the Department's Fiscal Agent in order to achieve an effective and efficient PBM program.
8. 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.
9. 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.

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X. Staffing Requirements

1. The Contractor shall, provide two (2) full time equivalent staff members also located within 120 minutes of Concord, New Hampshire.
2. 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.
3. 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.
4. 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.
5. 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.

Y. MMIS Federal Certification

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.

Z. Innovations

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:

1. Enhanced MAC Program to include specialty pharmacy products/specialty MAC;
2. Use of interactive voice response (IVR) PA;
3. Denied PA follow-up;
4. Web claim submission/web-based remittance advices;
5. Diabetic supply procurement program; and
6. Distribution Services surrounding hemophilia factor (part of proposal, section 3.19, page 67).

AA. 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.

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BB. Department Contract Officer

The OMBP 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 OMBP in regard to authorizing modifications, maintenance requests, resolving staffing issues, or other contractual responsibilities. This person shall be:

Name: Lise Farrand, R.Ph.
Title: Medicaid Pharmacist
Mailing Address: Office of Medicaid Business and Policy
Department of Health and Human Services
129 Pleasant Street, Concord, NH 03301-3857
Telephone: (603) 271-4419
Fax: (603) 271-8431
Email: lfarrand@dhhs.state.nh.us

or a designated successor.

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

<u>NH Dept Health & Human Servs.</u> The State Agency Name	<u>First Health Services Corp.</u> Name of the Contractor
<u>Kathleen Quinn</u> Signature of Authorized Representative	<u>[Signature]</u> Signature of Authorized Representative
<u>Kathleen A Quinn</u> Name of Authorized Representative	<u>Timothy P. Nolan</u> Name of Authorized Representative
<u>5/19/10</u> Date	<u>5/18/10</u> Date

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Date: 5/18/10

NH Department of Health and Human Services

EXHIBIT B

METHODS AND CONDITIONS OF PAYMENT

D) Terms of Payment

1. Subject to the Contractor's compliance with the terms and conditions of the agreement and for routine services provided, the Department shall reimburse the Contractor as follows:

Table 1: Reimbursement for Routine Services

Description	Reimbursement
Amount per paid adjudicated claim	\$1.49
Administrative Review Fee (for administrative review not requiring clinical evaluation; e.g., early refill overrides, quantity limit edits, WebPA)-per completed request	\$4.26
AutoPA per paid claim	\$0.43
Clinical Review Fee (a review for a prior auth request performed by a pharmacy technician or pharmacist)-per completed request	\$12.76
E-prescribing Transaction Fee-per Eligibility & Drug History Hit	\$0.19
System Modification	\$140.40/hour

2. The maximum total amount of this contract shall not exceed \$9,792,425 for the period from July 1, 2010 through December 31, 2013 as set forth below:
 - a. For the design, development and implementation period from July 1, 2010 to December 31, 2010, payments shall not exceed \$1,250,000 as stated below:

Table 2: Implementation Overview and Payment Schedule

Phase	Estimated Completion Date	Implementation Payment Installment
Initiation, Planning & Analysis	09/23/10	\$370,792
Design	10/29/10	\$410,293
Construction	11/19/10	\$294,302
Testing & Deployment	12/31/10	\$174,613
TOTAL IMPLEMENTATION PRICE		\$1,250,000

The implementation costs shall be paid when each deliverable is implemented and accepted by OMBP. If, through the course of the project, a deliverable associated with a payment is completed on a mutually agreed upon date other than those

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listed above, payment shall coincide with the completion of the deliverable. Payment in full to the Contractor shall be the later of the implementation of the final deliverable or on January 31, 2011.

- b. For the period from January 1, 2011 through June 30, 2011 payments shall not exceed \$1,390,669, (See Table 3, next page);
- c. For the period from July 1, 2011 through June 30, 2012 payments shall not exceed \$2,899,677, This amount includes the new MMIS implementation requirements.(See Table 3, next page);
- d. For the period from July 1, 2012 through June 30, 2013 payments shall not exceed \$2,828,034, (See Table 3, next page);
- e. For the period from July 1, 2013 through December 31, 2013 payments shall not exceed \$1,424,045, (See Table 3, next page).

II) Contractor's Prescription Cost Guarantee

1. The Contractor guarantees the State that its prescription benefit management programs will meet or exceed specific drug cost "targets". These targets shall be used for the purpose of objectively assessing the Contractor's program and cost performance. In addition, the targets shall be used for calculating any liquidated damages due from the Contractor.
2. The program and costs performance measured against the target will be calculated each calendar quarter of the contract commencing January 1, 2011.
3. The specifics of the calculation are as follows: the average net-net cost of a prescription shall be calculated by taking the total cost of prescription paid claims in each calendar quarter and subtracting both OBRA 90 rebates and Supplemental Rebates for paid claims in that quarter, and dividing that difference by the number of paid claims in that quarter. For purposes of this calculation, the date of service reported on the paid claims will be used to determine which claims are included in the quarterly calculations.
4. Liquidated Damages, if any, shall be determined in each calendar quarter by comparing the calculated average net cost of a prescription in that quarter to the applicable quarterly target (see Table 6, below).
5. The State has had a Pharmacy Benefits manager since 2001 and has had many savings initiatives to manage the cost per script paid. In order to continue, the quarterly target shall be determined by using the National Health Expenditure Prescription Drug growth percentage for prescription drugs applied to the actual cost per prescription that the State has been paying. The charts below show the cost per script as calculated by DHHS and the National Health Expenditure Prescription Drug percentage increase.

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Table 3: Contract Cost Overview

Service	Rate	Estimated Volume	SFY2011 (6 Months)		SFY2012		2013		2014 (6 months)		Total
			Estimated Payment	Estimated Volume	Estimated Payment	Estimated Volume	Estimated Payment	Estimated Volume	Estimated Payment	Estimated Volume	
Paid Claim	\$1.49	812786	\$1,211,051	1690595	\$2,518,986	1707501	\$2,544,176	853750	\$1,272,088		
Administrative review	\$4.26	4838	\$20,610	19352	\$82,440	21287	\$90,683	11176	\$47,609		
Auto PA	\$0.43	6296	\$2,707	26569	\$11,425	29226	\$12,567	15490	\$6,661		
Clinical Review	\$12.76	11551	\$147,391	12129	\$154,760	11765	\$150,117	5882	\$75,059		
E-prescribing	\$0.19	9948	\$1,890	59688	\$11,341	7714	\$14,766	7714	\$14,766		
System Modification	\$140.40	50	\$7,020	112	\$15,725	112	\$15,725	56	\$7,862		
New MMIS implementation					\$105,000						
					\$2,899,676					\$1,424,044	\$8,542,425
Implementation Cost	\$1,250,000										\$1,250,000
											\$9,792,425

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Table 4: National Health Expenditure Prescription Drug Percentage Growth

Year	Drug Growth Percentage
2008	10.5%
2009	12.3%
2010	9.9%
2011	7.9%
2012	7.3%

TABLE 5: Expected Net-Net Cost Per Prescription for current contract and Cost per Prescription Contractor Target*

State Fiscal Quarter	Target Cost per Prescription
Q3 2011	\$39.93
Q4 2011	\$40.72
Q1 2012	\$41.53
Q2 2012	\$42.35
Q3 2012	\$43.12
Q4 2012	\$43.91
Q1 2013	\$44.71
Q2 2013	\$45.52

*Contract Quarters relate to State Fiscal Year (e.g., January 1, 2011 is the beginning of Q3 SFY 2011)

6. Target numbers may be adjusted as actual numbers are calculated in accordance with this section.
7. If the net-net cost per script is less than fifteen (15) percent more than the target then no liquidated damages to the State shall be paid. If the net-net cost per script is between fifteen (15) percent and thirty (30) percent more than the target then the Contractor shall reimburse the State ten (10) percent of the administrative fee for the quarter as liquidated damages. If the net-net cost per script is over thirty (30) percent more than the target, then the Contractor shall reimburse the State twenty (20) percent of the administrative fee for the quarter as liquidated damages.
8. If one or more of the following conditions occur, either party may request adjustments in the target as listed in Table 5, above. However, all adjustments are subject to the mutual agreement of the parties. The conditions are as follows:
 - a. The annual drug trend changes as set forth below. The annual drug trend is made up of three (3) components: inflation, utilization growth and impacts from new drug technologies. This is published in several industry sources each year. Because the cost per prescription guarantee does not have a utilization component, only the following sub conditions will be contemplated:

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- i. There is an impact of new drug technology that changes its overall contribution to the annual drug trend by more than twenty (20) percent compared to the previous year's percentage as reported in Medco Health Solutions, Inc. and Express Scripts annual drug trend publications.
 - ii. There is an impact from drug inflation that changes inflation's overall contribution to annual drug trend by more than ten (10) percent compared to the previous year as reported by the federal Bureau of Labor Statistics.
 - iii. Legal, regulatory, or policy changes that result in a change in the makeup of the Medicaid-eligible population.
 - b. Whenever any substantial change in recipient cost sharing is implemented.
 - c. There are significant changes in clinical practice that affect the overall cost contribution of a specific drug in a given therapeutic class by more than twenty-five (25) percent, as compared to its average cost prior to the impact of the clinical practice change.
 - d. There is a substantial change in drug coverage mandated by State statute, administrative rule, or federal law.
 - e. The retail pharmacy network reimbursement rates are changed (i.e., AWP reimbursement rate or dispensing fee).
 - f. The distribution channels for products covered by the program are substantially changed.
 - g. The DHHS (i) elects not to continue one or more of the current savings programs, or (ii) chooses, in the implementation and/or operation of any of the savings initiatives, not to follow recommendations of the Contractor that meet Medicaid industry acceptable standards, that comport with State laws, administrative rules, and require, when necessary, CMS approval.
9. To implement an adjustment based on one of the above conditions, either party may request an adjustment in the quarterly net cost per prescription. The request for an adjustment arising from a change in one (1) or more of the above conditions must be in writing (i) by the Contractor, submitted with its quarterly report, and (ii) by DHHS within thirty (30) business days of receipt of Contractor's quarterly report as described above. The request for an adjustment shall also identify the proposed change(s) to Table 5 and shall include documentation supporting the proposed change(s). The party receiving the request for adjustment shall have thirty (30) business days to agree to the proposed change(s) in Table 5, or propose a modification to the requested change(s), or reject the proposed change(s).
10. The State and the Contractor shall develop methodologies for calculating the change in each condition, if needed. The methodologies shall include review and approval by the State before a quarterly target can be modified. Any agreed upon target adjustment shall be in writing as an amendment to this Agreement and shall be effective after approval by the Governor and Executive Council.

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11. If a condition has occurred that will cause a change(s) that can only be measured in future periods, the parties may agree to the adjustments to the average cost data for a quarter that is no further than one hundred eighty (180) days from the original written request for such adjustment. Either party may request at anytime, within the SFY, an adjustment, based on a change that was not known by the requesting party until the end of the quarter in which it arose.
12. Notwithstanding the above, the Contractor shall have the right to engage, at its own expense, an independent third party actuary knowledgeable in health care to recommend appropriate savings calculations applying the mutually agreed upon methodologies.
13. Notwithstanding any other provision of the Agreement, in the event the parties are unable to agree on any proposed adjustment to any net cost per prescription target, the State reserves the exclusive right to terminate this Contractor's contract thirty (30) days after providing the Contractor with written notice of such termination and without liability to the State.

III) Liquidated Damages

1. The Department and the Contractor agree that it will be extremely 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 Department'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 will be assessed, the Department shall notify the Contractor of the potential assessment in writing.
4. Contractor agrees that as determined by the DHHS, failure to provide services meeting the performance standards described below will 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 6.

Table 6: Liquidated Damages

Service Category	Minimum Standard	Potential Liquidated Damages
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1. Retail Point-of-Sale Claims Adjudication Accuracy	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 will 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	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 will not be part of this guarantee.	For failure to meet the standard, the Vendor will be assessed Liquidated Damages equal to 10% of the administrative fee in the Contract month in which the incident occurred.
3. Drug Rebates	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	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 will be assessed Liquidated Damages equal to 10% of the administrative fee in the Contract month in which the incident occurred.
5. Audit	Contractor shall perform onsite and desktop audits throughout the life of the Contract and report to the	For failure to meet the standard the Contractor will be assessed damages equal to 10% of the annual

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	State all audit findings so the State can recover monies due to the State.	administrative fee in the Contract year where the incident occurred.
6. Average Speed to Answer	At least 95% of all beneficiary and pharmacy calls received will be answered within an average of thirty (30) seconds. Reporting shall be provided monthly by the 7 th day of the month.	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.
7. Call Abandonment and Call Blocking Rate	No more than 2% of all beneficiary and pharmacy calls will be abandoned or blocked. Reporting shall be provided monthly by the 7 th day of the month.	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.
8. 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 7 th day of the month.	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.
9. Prior Authorizations	100% of requests for PA shall be completed within twenty-four (24) hours.	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.
10. 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 will be assessed Liquidated Damages equal to 10% of the administrative fee in the Contract month in which the incident occurred.

IV. Schedule Of Payment

The Contractor shall bill the Department on a monthly basis for the services in Exhibit A provided during the previous month. Invoices shall calculate the service payment in detail

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including the units, volume and price by service for each group under the contract as well as report the transactions 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. The invoice shall be sent to the New Hampshire Department of Health and Human Services Office of Medicaid Business and Policy 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: Donna Arcand
Title: Pharmacy Financial Manager
Mailing Address: Office of Medicaid Business and Policy
Department of Health and Human Services
129 Pleasant Street, Concord, NH 03301-3857
Telephone: (603) 271-8376
Fax: (603) 271-8431
Email: daarcand@dhhs.state.nh.us

or a designated successor.

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

<u>NH Dept of Health & Human Services</u> The State Agency Name	<u>First Health Services Corp.</u> Name of the Contractor
<u>Kathleen A. Quinn</u> Signature of Authorized Representative	<u>[Signature]</u> Signature of Authorized Representative
<u>Kathleen A. Quinn</u> Name of Authorized Representative	<u>Timothy P. Nolan</u> Name of Authorized Representative
<u>5/19/10</u> Date	<u>5/19/10</u> Date

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Date: 5/19/10

NH Department of Health and Human Services

STANDARD EXHIBIT C

SPECIAL PROVISIONS

1. **Contractors Obligations:** The Contractor covenants and agrees that all funds received by the Contractor under the Contract shall be used only as payment to the Contractor for services provided to eligible individuals and, in the furtherance of the aforesaid covenants, the Contractor hereby covenants and agrees as follows:
2. **Compliance with Federal and State Laws:** If the Contractor is permitted to determine the eligibility of individuals such eligibility determination shall be made in accordance with applicable federal and state laws, regulations, orders, guidelines, policies and procedures.
3. **Time and Manner of Determination:** Eligibility determinations shall be made on forms provided by the Department for that purpose and shall be made and remade at such times as are prescribed by the Department.
4. **Documentation:** In addition to the determination forms required by the Department, the Contractor shall maintain a data file on each recipient of services hereunder, which file shall include all information necessary to support an eligibility determination and such other information as the Department requests. The Contractor shall furnish the Department with all forms and documentation regarding eligibility determinations that the Department may request or require.
5. **Fair Hearings:** The Contractor understands that all applicants for services hereunder, as well as individuals declared ineligible, have a right to a fair hearing regarding that determination. The Contractor hereby covenants and agrees that all applicants for services shall be permitted to fill out an application form and that each applicant or re-applicant shall be informed of his/her right to a fair hearing in accordance with Department regulations.
6. **Gratuities or Kickbacks:** The Contractor agrees that it is a breach of this Contract to accept or make a payment, gratuity or offer of employment on behalf of the Contractor, any Sub-Contractor or the State in order to influence the performance of the Scope of Work detailed in Exhibit A of this Contract. The State may terminate this Contract and any sub-contract or sub-agreement if it is determined that payments, gratuities or offers of employment of any kind were offered or received by any officials, officers, employees or agents of the Contractor or Sub-Contractor.
7. **Retroactive Payments:** Notwithstanding anything to the contrary contained in the Contract or in any other document, contract or understanding, it is expressly understood and agreed by the parties hereto, that no payments will be made hereunder to reimburse the Contractor for costs incurred for any purpose or for any services provided to any individual prior to the Effective Date of the Contract and no payments shall be made for expenses incurred by the Contractor for any services provided prior to the date on which the individual applies for services or (except as otherwise provided by the federal regulations) prior to a determination that the individual is eligible for such services.
8. **Conditions of Purchase:** Notwithstanding anything to the contrary contained in the Contract, nothing herein contained shall be deemed to obligate or require the Department to purchase services hereunder at a rate which reimburses the Contractor in excess of the Contractor's costs, at a rate which exceeds the amounts reasonable and necessary to assure the quality of such service, or at a rate which exceeds the rate charged by the Contractor to ineligible individuals or other third party funders for

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such service. If at any time during the term of this Contract or after receipt of the Final Expenditure Report hereunder, the Department shall determine that the Contractor has used payments hereunder to reimburse items of expense other than such costs, or has received payment in excess of such costs or in excess of such rates charged by the Contractor to ineligible individuals or other third party funders, the Department may elect to:

- 8.1 Renegotiate the rates for payment hereunder, in which event new rates shall be established;
- 8.2 Deduct from any future payment to the Contractor the amount of any prior reimbursement in excess of costs;
- 8.3 Demand repayment of the excess payment by the Contractor in which event failure to make such repayment shall constitute an Event of Default hereunder. When the Contractor is permitted to determine the eligibility of individuals for services, the Contractor agrees to reimburse the Department for all funds paid by the Department to the Contractor for services provided to any individual who is found by the Department to be ineligible for such services at any time during the period of retention of records established herein.

RECORDS: MAINTENANCE, RETENTION, AUDIT, DISCLOSURE AND CONFIDENTIALITY:

- 9. **Maintenance of Records:** In addition to the eligibility records specified above, the Contractor covenants and agrees to maintain the following records during the Contract Period:

- 9.1 **Fiscal Records:** books, records, documents and other data evidencing and reflecting all costs and other expenses incurred by the Contractor in the performance of the Contract, and all income received or collected by the Contractor during the Contract Period, said records to be maintained in accordance with accounting procedures and practices which sufficiently and properly reflect all such costs and expenses, and which are acceptable to the Department, and to include, without limitation, all ledgers, books, records, and original evidence of costs such as purchase requisitions and orders, vouchers, requisitions for materials, inventories, valuations of in-kind contributions, labor time cards, payrolls, and other records requested or required by the Department.

- 9.2 **Statistical Records:** Statistical, enrollment, attendance or visit records for each recipient of services during the Contract Period, which records shall include all records of application and eligibility (including all forms required to determine eligibility for each such recipient), records regarding the provision of services and all invoices submitted to the Department to obtain payment for such services.

- 9.3 **Medical Records:** Where appropriate and as prescribed by the Department regulations, the Contractor shall retain medical records on each patient/recipient of services.

- 10. **Audit:** Contractor shall submit an annual audit to the Department within 60 days after the close of the agency fiscal year. It is recommended that the report be prepared in accordance with the provision of Office of Management and Budget Circular A-133, "Audits of States, Local Governments, and Non Profit Organizations" and the provisions of Standards for Audit of Governmental Organizations, Programs, Activities and Functions, issued by the US General Accounting Office (GAO standards) as they pertain to financial compliance audits

- 10.1 **Audit and Review:** During the term of this Contract and the period for retention hereunder, the Department, the United States Department of Health and Human Services, and any of their designated

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Date: 5/16/17

representatives shall have access to all reports and records maintained pursuant to the Contract for purposes of audit, examination, excerpts and transcripts.

10.2 Audit Liabilities: In addition to and not in any way in limitation of obligations of the Contract, it is understood and agreed by the Contractor that the Contractor shall be held liable for any state or federal audit exceptions and shall return to the Department, all payments made under the Contract to which exception has been taken or which have been disallowed because of such an exception.

- 11. Confidentiality of Records:** All information, reports, and records maintained hereunder or collected in connection with the performance of the services and the Contract shall be confidential and shall not be disclosed by the Contractor, provided however, that pursuant to state laws and the regulations of the Department regarding the use and disclosure of such information, disclosure may be made to public officials requiring such information in connection with their official duties and for purposes directly connected to the administration of the services and the Contract; and provided further, that the use or disclosure by any party of any information concerning a recipient for any purpose not directly connected with the administration of the Department or the Contractor's responsibilities with respect to purchased services hereunder is prohibited except on written consent of the recipient, his attorney or guardian.

Notwithstanding anything to the contrary contained herein the covenants and conditions contained in the Paragraph shall survive the termination of the Contract for any reason whatsoever.

- 12. Reports: Fiscal and Statistical:** The Contractor agrees to submit the following reports at the following times if requested by the Department.

12.1 Interim Financial Reports: Written interim financial reports containing a detailed description of all costs and non-allowable expenses incurred by the Contractor to the date of the report and containing such other information as shall be deemed satisfactory by the Department to justify the rate of payment hereunder. Such Financial Reports shall be submitted on the form designated by the Department or deemed satisfactory by the Department.

12.2 Final Report: A final report shall be submitted within thirty (30) days after the end of the term of this Contract. The Final Report shall be in a form satisfactory to the Department and shall contain a summary statement of progress toward goals and objectives stated in the Proposal and other information required by the Department.

- 13. Completion of Services: Disallowance of Costs:** Upon the purchase by the Department of the maximum number of units provided for in the Contract and upon payment of the price limitation hereunder, the Contract and all the obligations of the parties hereunder (except such obligations as, by the terms of the Contract are to be performed after the end of the term of this Contract and/or survive the termination of the Contract) shall terminate, provided however, that if, upon review of the Final Expenditure Report the Department shall disallow any expenses claimed by the Contractor as costs hereunder the Department shall retain the right, at its discretion, to deduct the amount of such expenses as are disallowed or to recover such sums from the Contractor.

- 14. Credits:** All documents, notices, press releases, research reports and other materials prepared during or resulting from the performance of the services of the Contract shall include the following statement:

14.1 The preparation of this (report, document etc.) was financed under a Contract with the State of New Hampshire, Department of Health and Human Services, Office of Medicaid Business and

WV Contractor Initials: YPN
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Policy, with funds provided in part by the State of New Hampshire and/or such other funding sources as were available or required, e.g., the United States Department of Health and Human Services.

15. **Operation of Facilities: Compliance with Laws and Regulations:** In the operation of any facilities for providing services, the Contractor shall comply with all laws, orders and regulations of federal, state, county and municipal authorities and with any direction of any Public Officer or officers pursuant to laws which shall impose an order or duty upon the contractor with respect to the operation of the facility or the provision of the services at such facility. If any governmental license or permit shall be required for the operation of the said facility or the performance of the said services, the Contractor will procure said license or permit, and will at all times comply with the terms and conditions of each such license or permit. In connection with the foregoing requirements, the Contractor hereby covenants and agrees that, during the term of this Contract the facilities shall comply with all rules, orders, regulations, and requirements of the State Office of the Fire Marshal and the local fire protection agency, and shall be in conformance with local building and zoning codes, by-laws and regulations.
16. Additional special provisions are set forth in Exhibit C-1 attached hereto and incorporated by reference.

SPECIAL PROVISIONS - DEFINITIONS

As used in the Contract, the following terms shall have the following meanings:

COSTS: Shall mean those direct and indirect items of expense determined by the Department to be allowable and reimbursable in accordance with cost and accounting principles established in accordance with state and federal laws, regulations, rules and orders.

DEPARTMENT: NH Department of Health and Human Services.

FINANCIAL MANAGEMENT GUIDELINES: Shall mean that section of the Contractor Manual which is entitled "Financial Management Guidelines" and which contains the regulations governing the financial activities of contractor agencies which have contracted with the State of NH to receive funds.

PROPOSAL: If applicable, shall mean the document submitted by the Contractor on a form or forms required by the Department and containing a description of the Services to be provided to eligible individuals by the Contractor in accordance with the terms and conditions of the Contract and setting forth the total cost and sources of revenue for each service to be provided under the Contract.

UNIT: For each service that the Contractor is to provide to eligible individuals hereunder, shall mean that period of time or that specified activity determined by the Department and specified in Exhibit B of the Contract.

FEDERAL/STATE LAW: Wherever federal or state laws, regulations, rules, orders, and policies, etc. are referred to in the Contract, the said reference shall be deemed to mean all such laws, regulations, etc. as they may be amended or revised from the time to time.

CONTRACTOR MANUAL: Shall mean that document prepared by the NH Department of Administrative Services containing a compilation of all regulations promulgated pursuant to the New Hampshire Administrative Procedures Act, NH RSA Ch 541-A, for the purpose of implementing State of NH and federal regulations promulgated thereunder.

SUPPLANTING OTHER FEDERAL FUNDS: The Contractor guarantees that funds provided under this Contract will not supplant any existing federal funds available for these services.

Contractor Initials: YFN
Date: 5/10/10

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NH Department of Health and Human Services

STANDARD EXHIBIT C-1

ADDITIONAL SPECIAL PROVISIONS

Para 1. Consistent with the terms of the Department's standard Exhibit I, and by way of addition thereto, the Contractor acknowledges that it has reviewed and is aware of the additional HIPAA requirements stemming from the American Recovery and Reinvestment Act (ARRA) including but not limited to the provisions of the HITECH ACT of 2009 and the Interim Final Rule. To the extent, if any, that Exhibit I requires the Department to notify the Contractor of changes to HIPAA requirements, the Department has done so.

Para 2. 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/or 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.

Contractor Initials: YAN
Date: 5/14/10

NH Department of Health and Human Services

STANDARD EXHIBIT D

DRUG FREE WORKPLACE

The Contractor 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:

**CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS
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 3017.6300 of the regulation provides that a grantee (and by inference, sub-grantees and sub-contractors) that 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, 6 Hazen Drive,
Concord, NH 03301-6505.

- (A) The grantee certifies that it will or will continue to provide a drug-free workplace by:
- (a) 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;
 - (b) Establishing an ongoing drug-free awareness program to inform employees about—
 - (1) The dangers of drug abuse in the workplace;
 - (2) The grantee's policy of maintaining a drug-free workplace;
 - (3) Any available drug counseling, rehabilitation, and employee assistance programs; and

Contractor Initials: YPN
Date: 5/18/60

**CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS
ALTERNATIVE I - FOR GRANTEEES OTHER THAN INDIVIDUALS, cont'd**

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

- (4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
 - (c) 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);
 - (d) Notifying the employee in the statement required by paragraph (a) that, as a condition of employment under the grant, the employee will—
 - (1) Abide by the terms of the statement; and
 - (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;
 - (e) Notifying the agency in writing, within ten calendar days after receiving notice under subparagraph (d)(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;
 - (f) Taking one of the following actions, within 30 calendar days of receiving notice under subparagraph (d)(2), with respect to any employee who is so convicted—
 - (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
 - (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;
 - (g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e) and (f).
- B. The grantee may insert in the space provided below the site(s) for the performance of work done in connection with the specific grant.

Contractor Initials: YTY
Date: 5/12/02

**CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS
ALTERNATIVE I - FOR GRANTEES OTHER THAN INDIVIDUALS, cont'd**

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

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.

Fresh Health Services Corp. From: July 1, 2010 To: December 31, 2013
Contractor Name Period Covered by this Certification

Timothy P. Nolan - President
Name and Title of Authorized Contractor Representative

[Signature] 5/10/10
Contractor Representative Signature Date

JPF: AMENDFORM 8-10
(DHS 09/05/91)
(CERTIFICATION 20-22)

Contractor Initials: YPN
Date: 5/10/10

NH Department of Health and Human Services

STANDARD EXHIBIT E

CERTIFICATE REGARDING LOBBYING

The Contractor 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:

CERTIFICATION REGARDING LOBBYING

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

Programs (indicate applicable program covered):

Aid to Families with Dependent Children Program under Title IV-A
Child Support Enforcement Program under Title IV-D
Job Opportunities and Basic Skills (JOBS) Program under Title IV-F
Medicaid Program under Title XIX
Social Services Block Grant Program under Title XX
The Food Stamp Program under Title VII

Contract Period: July 1, 2010 through December 31, 2013

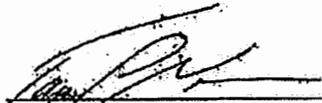
The undersigned certifies, to the best of his or her knowledge and belief, that:

- (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-1.
- (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.

Contractor Initials: J.P.N.
Date: 5/10/10

US DEPARTMENT OF HEALTH AND HUMAN SERVICES - CONTRACTORS
US DEPARTMENT OF EDUCATION - CONTRACTORS
US DEPARTMENT OF AGRICULTURE - CONTRACTORS
CERTIFICATION REGARDING LOBBYING, cont'd

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.


Contractor Signature

President
Contractor's Representative Title

Timothy R. Nelson
Contractor Name

5/10/10
Date

First Health Services Corp.

Contractor Initials: TRN
Date: 5/10/10