Form No. DTMB-3521 (Rev. 10/2015)
AUTHORITY: Act 431 of 1984
COMPLETION: Required
PENALTY: Contract change will not be executed unless form is filed

STATE OF MICHIGAN

DEPARTMENT OF TECHNOLOGY, MANAGEMENT & BUDGET

PROCUREMENT

525 W. ALLEGAN STREET
LANSING, MI 48933

P.O. BOX 30026
LANSING, MI 48909

CHANGE NOTICE NO. 8

to

CONTRACT NO. 071B0200069

between

THE STATE OF MICHIGAN

and

NAME & ADDRESS OF CONTRACTOR	PRIMARY CONTACT	EMAIL
Magellan Medicaid Administration	Sherrill Bryant	swbryant@magellanhealth.com
11013 W. Broad St.	PHONE	CONTRACTOR'S TAX ID NO. (LAST FOUR DIGITS ONLY)
Glen Allen VA, 23060	804-548-0467	*****9793

STATE CONTACTS	AGENCY	NAME	PHONE	EMAIL
PROGRAM MANAGER / CCI	DHHS	Trish O Keefe	517-241-4686	okeefet@michigan.gov
CONTRACT ADMINISTRATOR	DTMB	Brandon Samuel	(517) 284-7025	SamuelB@michigan.gov

CONTRACT SUMMARY			
DESCRIPTION: Pharmacy Benefits Manager (PBM) Services For Medicaid and other DHHS Programs			
INITIAL EFFECTIVE DATE	INITIAL EXPIRATION DATE	INITIAL AVAILABLE OPTIONS	EXPIRATION DATE BEFORE CHANGE(S) NOTED BELOW
April 1, 2010	March 31, 2013	4 - 1 Year	March 31, 2016
PAYMENT TERMS		DELIVERY TIMEFRAME	
ALTERNATE PAYMENT OPTIONS			EXTENDED PURCHASING
☐ P-card	☐ Direct Voucher (DV)	☐ Other	☐ Yes ☒No
MINIMUM DELIVERY REQUIREMENTS			

DESCRIPTION OF CHANGE NOTICE				
EXERCISE OPTION?	LENGTH OF OPTION	EXERCISE EXTENSION?	LENGTH OF EXTENSION	REVISED EXP. DATE
☒	12 months	☐		March 31, 2017
CURRENT VALUE	VALUE OF CHANGE NOTICE	ESTIMATED AGGREGATE CONTRACT VALUE		
$50,011,194.70	$ 10,303,244.95	$60,314,439.65		

DESCRIPTION: Effective March 21, 2016, this Contract is exercising the remaining option year and is increased by $10,303,244.95. The revised contract expiration date is March 31, 2017. Additionally, the attached Sections 1.022.O.68-72, 73a, 77.e; and 1.031.A.1.j are incorporated addressing the deletion / addition of work and deliverables and Key Personnel. Please note the Contract Administrator has changed to Brandon Samuel. All other terms, conditions, specifications and pricing remain the same. Per contractor and agency agreement, DTMB Procurement approval, and State Administrative Board approval on March 15, 2016.

Note: Contract language to be removed from the contract is shown below via a ~~strikethrough.~~ Contract language to be added to the contract is highlighted in yellow below.

1.022 Work and Deliverables

O. <u>Provider Relations</u>

Following are work and deliverables related to provider enrollment; provider website; and provider manuals for claims processing and related services.

Provider Enrollment

Requirements:

1. The Contractor must develop and maintain a provider enrollment process for the Department including, but not limited to, the following actions:

   ~~a. Provide online provider enrollment to prospective pharmacy providers;~~

   ~~b. Review and approve completed provider enrollment applications;~~

   ~~c. Update pharmacy provider eligibility;~~

   ~~d. Disenroll pharmacy providers, when appropriate;~~

   e. ~~Re-enroll all pharmacy providers within the Department's network every three years;~~

   f. Assure all pharmacy provider files maintain accurate updated information; and

   g. Provide customer service to pharmacy providers regarding enrollment.

~~2. The Contractor must review and process all applications for enrollment from pharmacy providers according to the Department's requirements including, but not limited to, the following:~~

   ~~a. Capture the information included on the Department's Pharmacy Provider Enrollment & Trading Partner Agreement form which will be provided during the Design, Development and Implementation phase of the Contract;~~

   ~~b. Verify pharmacy licensure;~~

   ~~c. Assure the provider enrollment file indicator for independent and chain pharmacies is applied appropriately to support product cost reimbursement logic according to the Department's policy;~~

   ~~d. Assure the provider enrollment file includes an indicator for long-term-care pharmacies;~~

   ~~e. Include an indicator for out-of-state/beyond borderland providers;~~

   ~~f. Inform providers about limitations on payment for services;~~

   ~~g. Search the federal sanction databases to verify sanctions do not exist for individuals or entities (e.g., owners, managing employees) identified in the enrollment application; and~~

   ~~h. Review monthly reports to ensure accuracy of the provider enrollment files.~~

~~3. At the direction of the Department, the Contractor must deny enrollment or disenroll providers including pharmacies found to be under federal or State sanction. In the event a pharmacy is to be disenrolled, the Contractor must inactivate the pharmacy within its system and prohibit reimbursement to the disenrolled provider.~~

~~4. The Contractor must provide web-based provider enrollment functionality including initial enrollment, reenrollment, and updates to enrollment information in compliance with the Department's policies and procedures for electronic signatures that will be provided during the Design, Development, and Implementation phase of this Contract.~~

~~5. The Contractor must provide customer support services for provider enrollment including, but not limited to, the following requirements:~~

~~a. Maintain a Provider Help Line as indicated in Section 1.022P Call Centers and Help Lines;~~

~~b. Develop and maintain a pharmacy application guide to assist pharmacies in the enrollment process;~~

~~c. Develop and maintain an internal enrollment processing manual;~~

~~d. Notify a pharmacy in writing to confirm successful enrollment in the Department's programs or provider network; and~~

~~e. Notify a pharmacy in writing in the event the Contractor is unable to enroll a provider, or where disenrollment is to occur, indicating the cause for the unsuccessful enrollment or disenrollment and instructions for subsequent actions.~~

~~The Department will provide a copy of the current internal enrollment processing manual and provider enrollment extract file during the Design, Development, and Implementation phase of this Contract.~~

6. The Contractor must research any undelivered provider mail and make reasonable attempts to identify a new address for such providers.

73a. The Contractor must review and research inquiries from pharmacy providers according to the Department's requirements including, but not limited to, the following:

a. Inform providers about limitations on payment for services;

b. Available from at least 8:00 a.m. to 5:00 p.m. Eastern Time, Monday through Friday, except designated State holidays, to support pharmacy enrollment, pharmacy EFT requests, and other services or inquiries.

Provider Website

Requirements:

7. The Contractor must provide website support, updates, and maintenance customized to meet the needs of the Department guaranteeing any data exchange on its website between the Contractor and the Department or providers will be secure.

8. The Contractor must update its websites maintained for the Department after the content of such updates has been approved by the Department. The Contractor's postings to its website must include, but not be limited to:

a. Special updates and urgent alerts to providers to ensure there are no interruptions to beneficiary access to care;

b. Drug Utilization Review (DUR) Board meeting schedules, meeting agendas and notices, meeting minutes, member contact information, Prospective DUR (ProDUR) edits;

c. Pharmacy and Therapeutics (P&T) Committee meeting schedules, meeting agendas and notices, meeting minutes, member contact information, procedures for public comment requests, workgroup assignments and recommendations;

d. Other Department-designated committee activities;

e. Provider forms and reference policies or links to forms and policies, if applicable;

f. Drug information including the Michigan Preferred Drug List (PDL) summary document, Michigan Pharmaceutical Product List (MPPL), managed care carve-out lists, special drug policies, Maximum Allowable Cost (MAC) policies and prices, frequently asked questions from manufacturers or providers;

g. Manuals including the Pharmacy Claims Processing Manual and links to the Michigan Medicaid Provider Manual;

h. Bulletin updates issued by the Department;

i. Special provider policies and requirements including e-prescribing support;

j. Web-based educational programs on the PDL, DUR, and other topics specified by the Department;

k. Web-based provider enrollment including initial enrollment and updates to enrollment information; and

l. Web-based PA requests.

Provider Manuals for Claims Processing and Related Services
The Department will provide current versions of required during the Design, Development, and Implementation phase of this Contract.
Requirements:
9. Contractor must keep current electronic versions of Department-approved manuals including, but not limited to, the following:

    a. Pharmacy Claims Processing Manual which must include instructions on POS, batch, and paper claims processing and be posted on the Internet;

    b. Provider Enrollment Manual; and

    c. Batch Claim Submission Requirement for Michigan Department of Community Health – Medicaid Health Plan Billings for Selected Carve-Out Drug Classes.

    d. The Contractor must maintain and update, on an on-going basis, the manuals, and submit them to the Department for approval, prior to implementation of revisions.

P. <u>Call Centers and Help Lines</u>
Requirements:
10. The Contractor must maintain telephone access in support of technical and business operations. The Contractor must maintain call center services and help lines to respond to claims inquiries, PA, questions and problems regarding operations, and for provider and beneficiary support. The Contractor must supply all required information systems, telecommunications, and personnel to perform these operations. Each of the following help lines must be available through a designated telephone number:

    a. ***Technical Help Line*** available toll-free 24x7x365 to respond to questions on coverage, claims processing and beneficiary eligibility;

    b. ***Clinical Help Line*** (including toll-free telephone and toll-free fax access) available toll-free from at least 7:00 a.m. to 7:00 p.m. Eastern Time, Monday through Friday, to handle PA requests from prescribers, and to address coinsurance payments, drug dispensing questions, or other requests from pharmacies;

    c. ***Beneficiary Help Line*** available toll-free 24x7x365 to respond to inquiries from beneficiaries on general pharmacy coverage, pharmacy locations, or other beneficiary requests;

    d. ***MAC Help Line*** (including toll-free telephone and toll-free fax access) from at least 8:00 a.m. to 5:00 p.m. Eastern Time, Monday through Friday, except designated State holidays, to address providers, Department staff, and others questions on the MAC rates; changes in product availability; and

    ~~e. ***Provider Relations Help Line*** available from at least 8:00 a.m. to 5:00 p.m. Eastern Time, Monday through Friday, except designated State holidays, to support pharmacy enrollment, pharmacy EFT requests, and other services or inquiries.~~

1.031 Contractor Staff, Roles, and Responsibilities

A. <u>Key Personnel</u>
Requirements:
1. The Contractor must provide sufficient staff to meet requirements listed in this Contract including the following Department-designated “key personnel” complying with the requirements below.

    a. ***Project/Account Director*** – 100 percent dedicated to this Contract; experienced in pharmacy program management; desired licensed pharmacist

b. ***Clinical Account Manager (Pharmacist)*** – 100 percent dedicated to this Contract; experienced in pharmacy program management, DUR, and formulary development; traveling on-site to Michigan required as specified by the Department

c. ***Contract Manager*** – 100 percent dedicated to this Contract; experienced in account management in the healthcare sector; desired experience in pharmacy benefits management

d. ***Operations Manager*** – May be the same individual as Contractor Account Manager; 100 percent dedicated to this Contract; experienced in the healthcare sector

e. ***Implementation Manager*** – 100 percent dedicated through the Design, Development, and Implementation (DDI) phase to the Operations phase; experienced in overall POS management or comparable healthcare claims management systems

f. ***Systems Manager (Operations)*** – At least 25 percent dedicated to this Contract; experienced in POS claims processing and decision support systems

g. ***Provider Relations Manager*** – *Component 1 – Claims Processing and Related Services only*; 40 percent dedicated to this Contract; experienced in provider relations management

h. ***Call Center Pharmacist Manager*** – *Component 1 – Claims Processing and Related Services only*; 100 percent dedicated to this Contract; licensed pharmacist; experienced in Medicaid pharmacy program management

i. ***Clinical Pharmacist for Rebate/PDL*** – *Component 2 – PDL and Manufacturer Drug Rebate Administration only*; at least 50 percent dedicated to this Contract; licensed pharmacist; experienced with Medicaid manufacturer drug rebate administration including federal and supplemental rebates

j. ***Senior Health Care Analyst*** – *Component 1 – Claims Processing and Related Services only*, at least 50 percent dedicated to this Contract; experienced pharmacy health care analyst; collects data and provides analyses for a broad array of issues across disciplines and functional areas, with primary focus on clinical analytics involving pharmacy and medical claims data; has sole responsibility for analytical projects, ranging from mid-size to large datasets.

2. The Contractor must ensure its professional key personnel have and maintain current licensure or certification. The Contractor's key personnel are *not* required have Michigan licensure or certification.

3. The Contractor's Clinical Account Manager (Pharmacist) and other Department-designated staff must attend Department meetings on-site in Lansing, Michigan or via conference call as directed by the Department. The Contractor's key personnel are *not* required to reside in Michigan.

4. The Contractor must provide the Department written notification of anticipated vacancies of the Department's designated key personnel positions within two business days of receiving the individual's resignation notice, the Contractor's notice to terminate an individual, or the position otherwise becoming vacant. The Department's designated key personnel positions must not remain vacant or filled with an interim appointee longer than 60 days unless approved by the Department.

5. The Contractor must submit to the Department an updated organizational chart including e-mail addresses and all business phone numbers for key staff and for any Subcontractors upon changes.

Form No. DTMB-3521 (Rev. 2/2015)
AUTHORITY: Act 431 of 1984
COMPLETION: Required
PENALTY: Contract change will not be executed unless form is filed

STATE OF MICHIGAN
DEPARTMENT OF TECHNOLOGY, MANAGEMENT AND BUDGET
PROCUREMENT
P.O. BOX 30026, LANSING, MI 48909
OR
525 W. ALLEGAN, LANSING, MI 48933

CHANGE NOTICE NO. 7

to

CONTRACT NO. 071B0200069

Between

THE STATE OF MICHIGAN

and

NAME & ADDRESS OF CONTRACTOR	PRIMARY CONTACT	EMAIL
Magellan Medicaid Administration	Sherrill Bryant	swbryant@magellanhealth.com
11013 W Broad St. Suite 500	PHONE	VENDOR FEIN # (LAST FOUR DIGITS ONLY)
Glen Allen, VA 23060	(804) 548-0467	9793

STATE CONTACTS	AGENCY	NAME	PHONE	EMAIL
PROGRAM MANAGER	DCH	Trish O'Keefe	517-335-5442	okeefet@michigan.gov
CONTRACT ADMINISTRATOR	DTMB	Lance Kingsbury	517-284-7017	kingsburyl@michigan.gov

CONTRACT SUMMARY

DESCRIPTION:
Pharmacy Benefits Manager Services (PBM) for Medicaid and Other Michigan Department of Community Health (DCH) Programs - DCH

INITIAL EFFECTIVE DATE	INITIAL EXPIRATION DATE	INITIAL AVAILABLE OPTIONS	EXPIRATION DATE BEFORE CHANGE(S) NOTED BELOW
April 1, 2010	March 31, 2013	4, 1 Year Options	March 31, 2015

PAYMENT TERMS	F.O.B.	SHIPPED TO
N/A	N/A	N/A

ALTERNATE PAYMENT OPTIONS	EXTENDED PURCHASING
☐ P-card ☐ Direct Voucher (DV) ☐ Other	☐ Yes ☒ No

MINIMUM DELIVERY REQUIREMENTS

N/A

DESCRIPTION OF CHANGE NOTICE

EXTEND CONTRACT EXPIRATION DATE	EXERCISE CONTRACT OPTION YEAR(S)	EXTENSION BEYOND CONTRACT OPTION YEARS	LENGTH OF OPTION/EXTENSION	EXPIRATION DATE AFTER CHANGE
☐ No ☒ Yes	☒	☐	1 year	March 31, 2016

CURRENT VALUE	VALUE/COST OF CHANGE NOTICE	ESTIMATED REVISED AGGREGATE CONTRACT VALUE
$40,606,607.61	$9,404,587.09	$50,011,194.70

DESCRIPTION:
Effective April 1, 2015, this Contract is exercising the Third option year and is INCREASED by $9,404,587.09. The REVISED Contract expiration date is March 31, 2016. All other terms, conditions, specifications and pricing remain the same. Per vendor and agency agreement, DTMB Procurement approval, and State Administrative Board approval on March 10, 2015.

Form No. DTMB-3521 (Rev. 4/2012)
AUTHORITY: Act 431 of 1984
COMPLETION: Required
PENALTY: Contract change will not be executed unless form is filed

STATE OF MICHIGAN
DEPARTMENT OF TECHNOLOGY, MANAGEMENT AND BUDGET
PROCUREMENT
P.O. BOX 30026, LANSING, MI 48909
OR
530 W. ALLEGAN, LANSING, MI 48933

CHANGE NOTICE NO. 6
to
CONTRACT NO. 071B0200069
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF CONTRACTOR:	PRIMARY CONTACT	EMAIL
Magellan Medicaid Administration	Sherrill Bryant	swbryant@magellanhealth.com
11013 W Broad St. Suite 500	TELEPHONE	CONTRACTOR #, MAIL CODE
Glen Allen, VA 23060	(804) 548-0467	

STATE CONTACTS	AGENCY	NAME	PHONE	EMAIL
CONTRACT COMPLIANCE INSPECTOR	DCH	Kevin Dunn	517-335-5096	dunnk3@michigan.gov
BUYER	DTMB	Lance Kingsbury	517-241-3768	kingsburyl@michigan.gov

CONTRACT SUMMARY:

DESCRIPTION: **Pharmacy Benefits Manager Services (PBM) for Medicaid and Other Michigan Department of Community Health (DCH) Programs - DCH**

INITIAL EFFECTIVE DATE	INITIAL EXPIRATION DATE	INITIAL AVAILABLE OPTIONS	EXPIRATION DATE BEFORE CHANGE(S) NOTED BELOW
April 1, 2010	March 31, 2013	4, 1 Year Options	March 31, 2015
PAYMENT TERMS	**F.O.B**	**SHIPPED**	**SHIPPED FROM**
N/A	N/A	N/A	N/A

ALTERNATE PAYMENT OPTIONS:			AVAILABLE TO MiDEAL PARTICIPANTS
☐ P-card	☐ Direct Voucher (DV)	☐ Other	☐ Yes ☒ No

MINIMUM DELIVERY REQUIREMENTS:
N/A

DESCRIPTION OF CHANGE NOTICE:

EXTEND CONTRACT EXPIRATION DATE	EXERCISE CONTRACT OPTION YEAR(S)	EXTENSION BEYOND CONTRACT OPTION YEARS	LENGTH OF OPTION/EXTENSION	EXPIRATION DATE AFTER CHANGE
☒ No ☐ Yes	☐	☐		

VALUE/COST OF CHANGE NOTICE:	ESTIMATED REVISED AGGREGATE CONTRACT VALUE:
$1,026,261.00	$40,606,607.61

Effective July 1, 2014, due to the contractor's call center volume increase, this Contract's monthly fee will be increased by $114,029.00 for nine months. Upon Administrative Board approval this Contract is hereby INCREASED by $1,026,261.00.

Please note the Contract Compliance Inspector has been changed to Kevin Dunn.

All other terms, conditions, specifications, and pricing remain the same. Per vendor and agency agreement,

DTMB Procurement approval, and State Administrative Board approval on September 30, 2014.

Form No. DTMB-3521 (Rev. 4/2012)
AUTHORITY: Act 431 of 1984
COMPLETION: Required
PENALTY: Contract change will not be executed unless form is filed

STATE OF MICHIGAN
DEPARTMENT OF TECHNOLOGY, MANAGEMENT AND BUDGET
PROCUREMENT
P.O. BOX 30026, LANSING, MI 48909
OR
530 W. ALLEGAN, LANSING, MI 48933

CHANGE NOTICE NO. 5

to

CONTRACT NO. 071B0200069

between

THE STATE OF MICHIGAN

and

NAME & ADDRESS OF CONTRACTOR:	PRIMARY CONTACT	EMAIL
Magellan Medicaid Administration	Donna M. Mellen	dmmellen@magellanhealth.com
4300 Cox Road	TELEPHONE	CONTRACTOR #, MAIL CODE
Glen Allen, VA 23060	(508) 562-2655	

STATE CONTACTS	AGENCY	NAME	PHONE	EMAIL
CONTRACT COMPLIANCE INSPECTOR	DCH	Greg Rivet	517-335-5096	rivetr@michigan.gov
BUYER	DTMB	Lance Kingsbury	517-241-3768	kingsburyl@michigan.gov

CONTRACT SUMMARY:

DESCRIPTION: **Pharmacy Benefits Manager Services (PBM) for Medicaid and Other Michigan Department of Community Health (DCH) Programs - DCH**

INITIAL EFFECTIVE DATE	INITIAL EXPIRATION DATE	INITIAL AVAILABLE OPTIONS	EXPIRATION DATE BEFORE CHANGE(S) NOTED BELOW
April 1, 2010	March 31, 2013	4, 1 Year Options	March 31, 2014
PAYMENT TERMS	**F.O.B**	**SHIPPED**	**SHIPPED FROM**
N/A	N/A	N/A	N/A

ALTERNATE PAYMENT OPTIONS:			AVAILABLE TO MiDEAL PARTICIPANTS	
☐ P-card	☐ Direct Voucher (DV)	☐ Other	☐ Yes	☒ No

MINIMUM DELIVERY REQUIREMENTS:

N/A

DESCRIPTION OF CHANGE NOTICE:

EXTEND CONTRACT EXPIRATION DATE	EXERCISE CONTRACT OPTION YEAR(S)	EXTENSION BEYOND CONTRACT OPTION YEARS	LENGTH OF OPTION/EXTENSION	EXPIRATION DATE AFTER CHANGE
☐ No ☒ Yes	☒	☐	1 year	March 31, 2015

VALUE/COST OF CHANGE NOTICE:	ESTIMATED REVISED AGGREGATE CONTRACT VALUE:
$8,336,061.41	$39,580,346.61

Effective March 26, 2014, this contract exercises a contract option year and is hereby increased in the amount of $8,336,061.41. Please see attached documents with the following changes to 1.022 Work and Deliverables, S. Drug Utilization Review (DUR), Academic Detailing and other Educational programs 118b. and Appendix D.15. All other terms, conditions, pricing and specifications remain the same. Per vendor and agency agreement, DTMB Procurement approval and the approval of the State Administrative Board on March 26, 2014.

c. Review at least 600 beneficiary profiles monthly and determine which warrant further action, (e.g., sending letters to prescribers, beneficiaries and pharmacies), unless instructed otherwise by the Department.

116. The Contractor must develop and maintain RetroDUR therapeutic criteria tables which provide quantitative significance values or severity ratings for therapeutic exception standards. The Contractor must collect RetroDUR claims data and apply the criteria tables monthly.

117. The Contractor must update RetroDUR files and criteria tables as recommended by the DUR Board within 10 business days of the Department's approval.

Academic Detailing and Other Educational Programs

Requirements:

118. The Contractor's academic detailing program must comply with, but is not limited to, the following requirements and capabilities:

a. Train its academic detailers as agreed upon and approved by the Department;
b. Provide up to 220 direct face-to-face visits per contract period with no more than 2 separate educational focuses for a 12-month contract period;
c. Perform, at least quarterly, an automated periodic review of claims data and other records to identify patterns of fraud, abuse, overuse, or inappropriate or medically unnecessary care among prescribers, pharmacies, beneficiaries or on claims associated with specific drugs or drug groups; [This review must involve pattern analysis using predetermined standards of prescribing practices and drug use by individual beneficiaries along with integrating pharmacy data with hospital, practitioner, laboratory, and other healthcare medical data provided by the Department.]
d. Identify and monitor beneficiaries and providers who have been found to exhibit verified drug use or prescribing aberrations;
e. Profile beneficiaries and providers for possible face-to-face intervention and provider education using criteria recommended by the DUR Board and approved by the Department; and
f. Track academic detailing feedback and activities in a web-based application that is accessible to designated Department staff.

119. The Contractor must provide academic detailing in conjunction with an organization which is capable of providing a team of Michigan-licensed pharmacists who are subject matter experts in academic detailing.

120. The Contractor's academic detailing face-to-face meetings with the Department's healthcare providers must include, at a minimum, topics related to ProDUR and RetroDUR, PDL, PA, and other beneficiary-specific issues. The Contractor's academic detailing team may also meet with healthcare provider groups, providing education that is not beneficiary specific.

121. The Contractor must develop and implement an effective educational program to address current pharmacy coverages and any future changes. Both the Contractor's educational program and printed materials must include Department-approved topics and must focus on prescribers, pharmacies, and beneficiaries. It must commence on a mutually agreed upon date and continue throughout this Contract. The Contractor's educational program must include, but is not limited to, the following:

a. MPPL;
b. P&T Committee;
c. PDL and its therapeutic drug classes;
d. PA criteria and procedures;
e. Best practice guidelines;
f. Beneficiary-specific prescribing patterns; and
g. Compliance with claims processing and editing requirements.

122. The Contractor must obtain feedback and evaluation from providers after its face-to-face interventions with them including, but not limited to, post-intervention follow up through phone and web-based tools.

Appendix D – Key Interface Files

While this appendix contains an extensive list of interface files, it is not meant to be comprehensive or all inclusive of all needed files to perform the work, deliverables, and other requirements for Components 1 and 2 described in Article 1 Statement of Work of this document. The Department will provide a finalized list of interface files and related record specifications during the Design, Development, and Implementation phase of this Contract.

COMPONENT 1 – CLAIMS PROCESSING AND RELATED SERVICES		
Data Files	**Schedule**	**Comments**
One-Time Department Files to the Contractor		
1. Claims History Load	1-Time	Paid claims from January 1, 2006 through start of the Operations Phase.
2. PA History Load	1-Time	PA transactions from January 1, 2006 through start of the Operations Phase
3. MAC Pricing History	1-Time	MAC pricing history file
4. Pharmacy Provider Extract	1-Time	Pharmacy enrollment history file
Operational Department Files to the Contractor		
5. Beneficiary Eligibility	Daily	Formatted either as an update, refresh file, or a full file
6. Practitioner File	Weekly	Includes updates of the NPIs and address records for enrolled practitioners. Likely to be replaced by the NCPDP HCIdea file below
7. Third Party Liability	Weekly	Includes Weekly Carrier File TPL data is included in Daily Beneficiary Eligibility File for beneficiaries with eligibility changes
8. Department-Specified MACs	Weekly	Includes Department-specified MAC rates to augment Contractor-developed MAC rates. Sent via email in MS Excel spreadsheet
9. Medical Claims File	Weekly	Includes the Department's claims for inpatient hospital, outpatient hospital, practitioner, laboratory, etc. Supports automatic prior authorization processing in the Contractor's claims processing system and DUR activities
Contractor Files to the Department		
10. Pharmacy Provider Extract	Weekly	A pharmacy enrollment history file
11. Claims Extract	Weekly	Includes claims which were paid or voided during the prior week's invoice cycle
12. Compound Claim Detail Extract	Weekly	Includes the Compound segment of paid pharmacy claims and is linked to the claim level record during the prior week's invoice cycle
13. 100% Carve-Out File	Weekly	Includes the 100% carve-out paid claims for managed care beneficiaries that are sent to the Medicaid Health Plans
Other Reference Files Needed by the Contractor		
14. NCPDP HCIdea File	Weekly	The National Council for Prescription Drug Program's file maintaining NPIs and Drug Enforcement Administration (DEA) numbers Purchased by the Contractor
15. NCPDP/NABP - plus at least one user license for the web look-up tool for verification between monthly files	Monthly	Includes pharmacy provider data maintained by the NCPDP, e.g., address, licensing, pharmacy classification, etc. Purchased by the Contractor
16. First DataBank Tables	Weekly	Purchased by the Contractor
Contractor Files to Other Vendors		
17. Claims Extract for Audit Vendor	Weekly	For separate PBM audit vendor
Other Needed Interface Files, ONLY If Separate Contractors Are Chosen for Components 1 and 2		
18. Pharmacy Provider Extract	Weekly	Pharmacy enrollment history file for the Component 2 Contractor
19. Rebate Claims Extract	Weekly	Claims data supporting the manufacturer drug rebate administration for the Component 2 Contractor
20. Michigan PDL Summary Document	Quarterly	For posting on the website of the Component 1 Contractor Currently an Microsoft Excel® spreadsheet
21. Michigan Pharmaceutical Product List	Monthly	For posting on the website of the Component 1 Contractor

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STATE OF MICHIGAN
DEPARTMENT OF TECHNOLOGY, MANAGEMENT AND BUDGET
PROCUREMENT
P.O. BOX 30026, LANSING, MI 48909
OR
530 W. ALLEGAN, LANSING, MI 48933

CHANGE NOTICE NO. 4
to
CONTRACT NO. 071B0200069
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF CONTRACTOR:	PRIMARY CONTACT	EMAIL
Magellan Medicaid Administration	Donna M. Mellen	dmmellen@magellanhealth.com
4300 Cox Road	TELEPHONE	CONTRACTOR #, MAIL CODE
Glen Allen, VA 23060	(508) 562-2655	

STATE CONTACTS	AGENCY	NAME	PHONE	EMAIL
CONTRACT COMPLIANCE INSPECTOR	DCH	Greg Rivet	517-335-5096	rivetr@michigan.gov
BUYER	DTMB	Lance Kingsbury	517-241-3768	kingsburyl@michigan.gov

CONTRACT SUMMARY:

DESCRIPTION: **Pharmacy Benefits Manager Services (PBM) for Medicaid and Other Michigan Department of Community Health (DCH) Programs - DCH**

INITIAL EFFECTIVE DATE	INITIAL EXPIRATION DATE	INITIAL AVAILABLE OPTIONS	EXPIRATION DATE BEFORE CHANGE(S) NOTED BELOW
April 1, 2010	March 31, 2013	4, 1 Year Options	March 31, 2013
PAYMENT TERMS	**F.O.B**	**SHIPPED**	**SHIPPED FROM**
N/A	N/A	N/A	N/A

ALTERNATE PAYMENT OPTIONS:			AVAILABLE TO MiDEAL PARTICIPANTS
☐ P-card	☐ Direct Voucher (DV)	☐ Other	☐ Yes ☒ No

MINIMUM DELIVERY REQUIREMENTS:

N/A

DESCRIPTION OF CHANGE NOTICE:

EXTEND CONTRACT EXPIRATION DATE	EXERCISE CONTRACT OPTION YEAR(S)	EXTENSION BEYOND CONTRACT OPTION YEARS	LENGTH OF OPTION/EXTENSION	EXPIRATION DATE AFTER CHANGE
☐ No ☒ Yes	☒	☐	1 year	March 31, 2014

VALUE/COST OF CHANGE NOTICE:	ESTIMATED REVISED AGGREGATE CONTRACT VALUE:
$9,954,205.20	$31,244,285.20

Effective March 27, 2013, this contract exercises a contract option year. The new contract end date is March 31, 2014. Contract is also increased by $9,954,205.20. The Statement of Understanding (SOU) for the Medical Pharmacy Management Program will not be part of the services included in the 1-Year contract extension and pages 40-52 incorporated in Change Notice No. 3 are being removed accordingly. Please reference attached SOU for Michigan Department of Community Health Hemophilia Utilization Management Program and SOU for EnhanceMed. Please note, the contract compliance inspector changed to Greg Rivet. All other terms, conditions, pricing and specifications remain the same. Per vendor and agency agreement, DTMB Procurement approval and the approval of the State Administrative Board on February 19, 2013.

AMENDMENT TO
STATEMENT OF UNDERSTANDING (SOU) FOR THE
MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
MEDICAL PHARMACY MANAGEMENT PROGRAM

This AMENDMENT TO THE STATEMENT OF UNDERSTANDING (SOU) FOR THE DEPARTMENT OF COMMUNITY HEALTH MEDICAL PHARMACY MANAGEMENT PROGRAM (the "Amendment") between the State of Michigan and Magellan Medicaid Administration, Inc. is effective as of August 2, 2011. Michigan and Magellan Medicaid Administration are together referred to hereinafter as the "Parties." Capitalized terms used in this Amendment and not defined herein shall have the meanings ascribed to them in the Agreement and SOU (defined hereinafter).

WHEREAS, the State of Michigan and Magellan Medicaid Administration are Parties to Contract No. 071B0200069, effective April 1, 2010 (the "Agreement"); and

WHEREAS, the State of Michigan and Magellan Medicaid Administration are Parties to a Statement of Understanding for the Michigan Department of Community Health Medical Pharmacy Management Program dated August 2, 2011 ("SOU"), which SOU has been incorporated into the Agreement;

WHEREAS, the Parties desire to amend certain terms and provisions of the SOU;

NOW, THEREFORE, in consideration of the foregoing and of the mutual covenants set forth herein, and intending to be legally bound hereby, the Parties agree the SOU shall be amended as follows:

1. A new Section 5 ("Intellectual Property") shall be inserted into the SOU as follows:

   5.0 Intellectual Property
   It is understood and agreed that the Proprietary Reimbursement Schedule and Claims Edits described in Section 1 of the SOU ("Executive Overview") are "preexisting licensed works" within the meaning of Section 2.262 of the Agreement, and accordingly shall remain the property of Magellan Medicaid Administration and Magellan Medicaid Administration's subsidiary, ICORE Healthcare, LLP."

All other terms and conditions of the SOU remain unchanged and shall be in full force and effect.

IN WITNESS WHEREOF, the Parties hereto each by its officers duly authorized, have executed this Amendment as of the date first written above.

STATE OF MICHIGAN

By: _____

Name: _____

Title: _____

MAGELLAN MEDICAID ADMINISTRATION, INC.

By: _____

Name: Timothy P. Nolan

Title: President

Statement of Understanding (SOU) for Michigan Department of Community Health Hemophilia Utilization Management Program

March 19, 2013

MAGELLAN

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Revision History

Date	Name	Comments
03/19/2013	Sherrill Bryant	Initial creation

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Approvals Signature Page

Magellan Medicaid Administration will deliver the requested change outlined in this Statement of Understanding by 4.1.2013 if Client signature approval is received by 3.31.2013.

Any changes to the Requirements, Assumptions, Constraints, and Issues/Concerns/Questions may require modification to this Statement of Understanding and the cost estimates.

Signature	Timothy P. Nola Printed Name
President Title	3/20/2013 Date
Signature	Trish M. O'Keefe Printed Name
MDCH Pharmacy Mgmt Division Director Title	3/20/2013 Date
Signature	Printed Name
Title	Date
Signature	Printed Name
Title	Date

1.0 Overview

Magellan Medicaid Administration will provide the Michigan Department of Community Health (MDCH) with a Hemophilia Utilization Management program.

The core program being offered to MDCH is the utilization management of Hemophilia Factor drugs (factor). This program has two components:

- **Prior Authorization (PA):** The first component is recommended to ensure appropriateness of the use of Hemophilia Factor for eligible patients, and to ensure the requesting physician and pharmacy providers are in-network. Prescriptions are prior authorized across all sites of care (Hemophilia Treatment Centers (HTCs), Home Infusion Pharmacies (HI), and Specialty Pharmacies (SPP)) and renewed annually.
- **Assay Management:** Hemophilia Factor prescriptions are typically written stating the assay required (e.g., "1,000 units") with an allowable variance of "+/- 10%." Such wide variances are unnecessary and amount to overutilization. Magellan Medicaid Administration's allowable variance is "+/- 3%."

2.0 Scope of Work

The State of Michigan authorizes Magellan Medicaid Administration to provide the services outlined in *Section 2.0 – Scope of Work*. This Statement of Understanding (SOU) is an amendment to the Pharmacy Benefits Manager Services (PBM) for Medicaid and other Michigan Department of Community Health (DCH) Programs' agreement #071B0200069 ("PBM Services Agreement").

Magellan Medicaid Administration shall implement its Hemophilia Utilization Management Program with MDCH for its Fee-for-Service (FFS) membership, and its Medicaid Managed Care Organization membership (MMCO), currently estimated to be 632,000 members and 1,200,000 members respectively.

2.1 Objectives

The primary objectives of this SOU are to

- Develop MDCH's strategy and implementation plan for Hemophilia Factor;
- Provide IT Consulting services to MDCH for claims editing logic necessary for program implementation;
- Decrease unnecessary spend of Hemophilia Factor drugs via Prior Authorization (PA) and Assay Management;
- Prior Authorize all MDCH members receiving Hemophilia Factor drugs on an annual basis;
- Conduct Case Review of all Hemophilia Factor requests from MDCH network pharmacy providers, hemophilia treatment centers, and home health care agencies;
- Manage Assays of dispensed Hemophilia Factor drugs to +/- 3% of the prescribed Assay;
- Communicate the program to MDCH's provider network pharmacies, hemophilia treatment centers, and home health care agencies; and
- Measure and report savings.

2.2 Deliverables

Magellan Medicaid Administration will provide MDCH with the following specific deliverables:

Activities	Deliverable	Timing
Implementation Activities ▪ Coordinate joint implementation workgroups ▪ Document business requirements ▪ Work jointly under Magellan Health Services to leverage existing MDCH files and data to support hemophilia management program	▪ Gather project business requirements ▪ Implement project and supporting processes through leveraging MDCH eligibility data, provider files, pharmacy paid claims data, etc., currently available for Magellan Medicaid Administration services	Beginning 03/18/2013
Internal Program Education ▪ Review hemophilia management program with key MDCH departments: – Children Special Health Care Services – Provider – Policy – Pharmacy – Medical	▪ Provide education and training to MDCH-identified internal teams and resources on project objectives and components	Beginning 03/18/2013
Communication Plan ▪ Develop detailed provider communication plan for program notification – Specialty Pharmacies – Hematologists – Other hemophilia health care practitioners – Hemophilia Treatment Centers	▪ Joint workgroup discussions to identify provider and beneficiary communication plans ▪ Draft all communication materials for MDCH to provide comment and final review ▪ Jointly identify providers that require outreach to discuss program enhancement and process change (onsite or via conference call) ▪ Execute multi-channel communication plan	Beginning 03/18/2013

Activities	Deliverable	Timing
Assay and Use Management ▪ Dispensing providers will be required to obtain prior authorization from MMA ▪ Review units prescribed by ordering physician against units requested by the dispensing provider and authorize assays within +/- 3% of the written prescription ▪ Manage number of emergency doses prophylactic treatment patients have on hand and allow a maximum of five on-demand doses.	▪ Document prior authorization request information and provide data elements to Magellan Medicaid Administration daily to support subsequent pharmacy claim adjudication.	04/01/2013
Measurement ▪ Measure program savings ▪ Present savings to MDCH leadership	▪ Savings reports	Quarterly

Implementation and operational phase performance standards and guarantees do not apply to services to be provided under this SOU.

3.0 Time Period of Agreement

This amendment to the PBM Services Agreement will be effective beginning April 1, 2013, and run concurrently with the pharmacy benefits administration contract, which concludes March 31, 2015. The Operational phase of this agreement will commence on or about April 1, 2013.

4.0 Pricing and Deliverables

4.1 Pricing Components

- **Annual Fee and Timing**: Magellan Medicaid Administration's annual fee will be applied during the Operational phase, beginning April 1, 2013. The State of Michigan agrees to reimburse Magellan Medicaid Administration a fee of $381,000.00 annually for the services provided. Payments will be made on a monthly basis in the amount of $31,750.00 per month.
- **Annual Fee Adjustment**: For subsequent contract years, the annual fee shall increase by the amount and percentage in the table below. The date of adjustment will coincide with the renewal date of Magellan Medicaid Administration's contract, April 1.

Contract Year	Monthly Fee	Annual Fee	Maximum Annual Fee Adjustment
April 1, 2013 – March 31, 2014	$31,750.00	$381,000.00	
April 1, 2014 – March 31, 2015	$32,946.98	$395,363.70	3.77%
April 1, 2015 – March 31, 2016	$34,189.18	$410,270.16	3.77%
April 1, 2016 – March 31, 2017	$35,478.11	$425,737.35	3.77%

- **Estimated Annual Savings and Implementation Dates for Services selected:**

  Based on the services selected by MDCH, program savings are projected to be approximately $800,000.00 annually. This projection is not guaranteed, and depends on, among other factors, MDCH's acceptance, and implementation of all the services set forth below:

  - Prior Authorization (PA): April 1, 2013
  - Assay Management: April 1, 2013

- **State of Michigan:** The following deliverables will be required of the State of Michigan to meet contract implementation deadlines, and operational guidelines throughout the life of this contract:
  - March 29, 2013 – Signature of this SOU
  - Operational Phase (April 1, 2013 – throughout contract)
    - Maintenance and updating of Hemophilia Factor drug NDCs and J-codes within the MI DCH MMIS system
    - Assistance with Provider relations
    - Quarterly teleconferences with Magellan Medicaid Administration on program results and adjustments
    - Annual review with Magellan Medicaid Administration staff

5.0 Intellectual Property

It is understood and agreed that the proprietary components of the MMA Program described in *Section 1.0 – Executive Overview* of the SOU are "preexisting licensed works" within the meaning of *Section 2.262* of the *PBM Services Agreement*, and accordingly shall remain the property of Magellan Medicaid Administration.

IN WITNESS WHEREOF, the parties hereto have caused this agreement to be executed by their respective duly authorized representatives as of the effective date.

Michigan Department of Community Health	Magellan Medicaid Administration
Signature	Signature
Trish M. O'Keefe	Timothy P. Nolan
Name	Name
Director, MDCH Pharmacy Mgmt Division	President
Title	Title

6.0 Attachment A

Michigan Department of Community Health - Hemophilia Case Review Form

If you have questions or concerns, please call (800) 327-1395.
Fax completed form to (888) 656-1952.

☐ URGENT REQUEST – For Acute Bleeding Episodes and/or PRN Dosing

Pharmacy Information

Name: | NPI:
Contact Name: | Phone #: | Fax #:

Patient Information

Last Name: | First Name: | Middle: | DOB (mm/dd/yy):
Daytime Phone: | Evening Phone:

Insurance Information

Policy Holder's Name: | ID # on Insurance Card:

Physician Information

Name: | Specialty:
Address:
Phone #: | Fax #: | NPI:

Primary Diagnosis (ICD-9 / ICD-10)

- ☐ 286.0 / D66 - Congenital factor VIII disorder (Hemophilia A)
- ☐ 286.1 / D67 - Congenital factor IX disorder (Hemophilia B)
- ☐ 286.2 / D68.1 - Congenital factor XI deficiency (Hemophilia C)
- ☐ 286.3 / D68.2 - Deficiency of other clotting factors
- ☐ 286.4 / D68.0 - von Willebrand disease
- ☐ 286.7 / D68.32 - Hemorrhagic dis. due to extrinsic circulating anticoagulants
- ☐ 286.7 / D68.4 - Acquired coagulation factor deficiency
- ☐ 286.9 / D68.8 - Other specified coagulation defects
- ☐ 286.9 / D68.9 - Unspecified coagulation defects

Clinical Information

Native Factor Level: | Target Factor Level: | Patient Weight (kg):

Reason(s) for Use:

☐ Prophylaxis Only ☐ Prophylaxis and Episodic ☐ Surgical Prophylaxis Date: _____ ☐ Acute Bleeding Episode
☐ Episodic Only ☐ Dental Procedure Date: _____ ☐ Inhibitors

Acute Bleeding Summary:

Severity of Bleed: ☐ Mild ☐ Moderate ☐ Severe | Date of Bleed: From ____/____/____ To ____/____/____ | Location of Bleed:

# of Doses Used for Bleed: | Total Units Used for Bleed:

Patient Inventory (Medication on Hand)

# of Doses on Hand: | Total Units on Hand:

Prescription Information (Copy of Physician Rx Required)

Product Name	Dose: (IU/RCOF/MCG)	Frequency	Total Dose (IU/RCOF/MCG)

Dispensing Information (Based on Rx)			Dispensing Information (Pharmacy Assay Availability)			
Frequency	Dose (IU/RCOF/MCG)	Total Doses Requested for Month	Vial Strength	Assay Availability	Qty of Vials Dispensed	Total Units Dispensed
☐ Prophylaxis Dose #1						
☐ Prophylaxis Dose #2						
☐ Episodic/PRN Use						
☐ Surgery/Dental Use						

7.0 Attachment B

7.1 Monthly MMA Hemophilia Utilization Management Report

Report Period: 04/01/2013 – 04/30/2013
Summary

Client Organization: MDCH

Health Plan: Michigan Department of Community Health

Turn Around Time (TAT) Summary

Completed Reviews	Average TAT (Days)
44	0

MMA PA Review Savings Summary						Assay/UM Savings	
Medication Trade Name	Physician Base Rx (IU)	Dispensing Pharmacy Requested Quantity (IU)	Dispensing Pharmacy Assay Tolerance	MMA Authorized Quantity (IU)	ICORE Assay Tolerance	Savings (IU)	Total Savings
Advate	384,738	388,207	0.90%	387,838	0.81%	388	$364.32
Alphanate	14,536	14,580	0.30%	14,580	0.30%	0	$0.00
AlphaNine	N/A	N/A	N/A	N/A	N/A	N/A	N/A
BeneFIX	151,429	154,709	2.17%	154,709	2.17%	0	$0.00
Helixate	25,500	25,282	-0.93%	25,282	-0.93%	0	$0.00
Hemofil	45,300	50,542	11.57%	49,085	8.38%	1,467	$1,034.47
Humate-P	1,325	1,588	19.85%	1,588	19.85%	0	$0.00
Kogenate	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Monoclone	N/A	N/A	N/A	N/A	N/A	N/A	N/A
NovoSeven	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Recombinate	270,643	277,563	2.56%	266,728	-1.46%	10,835	$10,726.65
Kynthe	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Total		$12,442		899,782		12,690	$12,125.44

MAGELLAN
MEDICAID
ADMINISTRATION™

Statement of Understanding (SOU) for EnhanceMed

January 4, 2012

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Privacy Rules

The Health Insurance Portability and Accountability Act of 1996 (HIPAA – Public Law 104-191) and the HIPAA Privacy Final Rule[1] and the American Recovery and Reinvestment Act (ARRA) of 2009 provides protection for personal health information. Magellan Medicaid Administration developed and maintains HIPAA Privacy Policies and Procedures to ensure operations are in compliance with the legislative mandates.

Protected health information (PHI) includes any health information and confidential information, whether verbal, written, or electronic, created, received, or maintained by Magellan Medicaid Administration. It is health care data plus identifying information that would allow the data to tie the medical information to a particular person. PHI relates to the past, present, and future physical or mental health of any individual or recipient; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual. Claims data, prior authorization information, and attachments such as medical records and consent forms are all PHI.

[1] 45 CFR Parts 160 and 164, Standards for Privacy of Individually Identifiable Health Information; Final Rule

Revision History

Date	Name	Comments

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Approvals Signature Page

Magellan Medicaid Administration will deliver the requested change outlined in this Statement of Understanding by May 1, 2012, if Client signature approval is received by February 1, 2012.

Any changes to the Requirements, Assumptions, Constraints, and Issues/Concerns/Questions may require modification to this Statement of Understanding and the cost estimates.

Susan Moran	Susan Moran
Signature	Printed Name
Director, Medicaid Program Operations Bureau	2-6-12
Title	Date
	Timothy P. Nolan
Signature	Printed Name
President, Magellan Medicaid Administration	2-21-12
Title	Date
Signature	Printed Name
Title	Date
Signature	Printed Name
Title	Date

1.0 Overview and Scope

Magellan Health Services combines our expertise in pharmaceutical and behavioral health care to create ***EnhanceMed***^{SM}, an academic detailing program focusing on behavioral health that offers providers the support and guidance they need when prescribing behavioral health medications. *EnhanceMed*^{SM} was developed with extensive provider input to create a series of dynamic pharmacy management programs to meet this need.

EnhanceMed^{SM} **targets providers that practice outside the bounds of evidence-based medicine. These outlier prescribers of certain expensive medications are identified through the use of proprietary clinical algorithms.** The identification of these prescribers creates educational opportunities aimed at changing prescriber behavior through the use of vetted evidence-based guidelines. *EnhanceMed*^{SM} offers providers the support and guidance they need when prescribing behavioral health medications to be able to provide expert quality of care while reducing costs.

1.1 What is EnhanceMed^{SM}?

EnhanceMed^{SM} is an advanced academic detailing program that includes over 100 literature-based algorithms developed by our expert clinical team of adult and child psychiatrists, and psychiatric clinical pharmacists. These evidence-based algorithms encompass prescriber adherence to established guidelines, pediatric- and geriatric-specific prescribing concerns, poly-pharmacy, multiple prescribers, dosing aberrancies, and abuse. *EnhanceMed*^{SM} is designed to meet the needs of this dynamic market and is continually evolving to incorporate current literature and develop new protocols.

EnhanceMed^{SM} is a monthly provider intervention. Over hundreds of complex clinical algorithms comprise our *EnhanceMed*^{SM} protocols. Protocols are applied retrospectively to pharmacy claims each month to capture patient-specific information related to prescribing and utilization scenarios out-of-line with best practices.

EnhanceMed^{SM} Protocol (examples)
Age Alert – Geriatric Beers Criteria: Patients 65 years of age and older on medication(s) not recommended by the Beers criteria
Age Alert – Pediatric Antidepressants: Patient age below approved range for specific antidepressant medications
Age Alert – Pediatric Antipsychotics: Patient age below approved range for specific antipsychotic medications
Age Alert – Pediatric Stimulants: Patient age below approved range for specific stimulants for ADHD

EnhanceMed℠ Protocol (examples)
Age Alert – Geriatric Antipsychotics: Patients 65 years of age and older on antipsychotic medication(s) is not recommended
Dosing Efficiency: Patient on antipsychotics and antidepressants that have a more appropriate regimen to allow for fewer units per day
Duplicate Therapy: Patient on multiple medications from the same behavioral health class for 60 days or more from the same RBHA provider
Maximum Dose: Patient on dose that exceeds FDA-approved maximum
Maximum Dose - Multiple Prescription: Patient on dose that exceeds protocol across multiple prescriptions for the same drug
Minimum Dose: Patient on dose below recommended dose
Low Dose Seroquel® (quetiapine): Patient on dose less than 150 mg
Generic Optimization: Patient on brand name drug when a same-class generic is available

1.2 How EnhanceMed℠ Works

Pharmacy claims are processed through our proprietary algorithms retrospectively, on a monthly basis. When a unique combination of claims/attributes meets the requirements for an algorithm, the algorithm is triggered and results in the identification of "out-of-compliance" prescribing behavior. This process will identify prescribers whose prescribing patterns are inconsistent with current practice guidelines.

If a provider is identified as being out of compliance with a protocol, a message is generated and listed in a printed report showing the member-specific quality opportunity. The top strata (5–10%) of providers with the most opportunities and identified prescribing concerns are targeted for consultation.

Providers identified through the system as potentially needing guidance on clinical guidelines or the need to discuss their prescribing patterns are contacted directly for a personalized consultation. A personalized consultation with a Magellan behavioral health clinical pharmacist is then scheduled to review the identified findings and review current literature and practice guidelines. The program also provides several resources for providers, such as web-based resources, practice guidelines, and CME provider forums, to assist them in selecting evidenced-based choices.

For those providers not requiring personalized consultation, Magellan will produce a patient-specific *EnhanceMed℠* packet that will be delivered to the prescriber (through mail) and followed up with through either a face-to-face encounter or through other outreach (e.g., mail, telephone, etc.), when appropriate.

1.3 Key Components

Data Analysis

Monthly analysis of pharmacy claims data through our proprietary algorithms to identify outlier behavior. Magellan Medicaid Administration will deliver a full claims file to our *EnhanceMed*℠ management tool. Analysis requires 1) claims set, 2) provider file, and 3) member file.

Clinical Consultation

The program will interface with providers with the highest degree of opportunity for improvement (either clinical or financial outcomes) through direct mail and follow-up consultation with a pharmacist specializing in psychiatric pharmacology or a psychiatrist is necessary/available if the health care professional wishes to have further consultation.

Direct Mailings

Targeted educational packets that include patient-specific information related to prescribing and utilization scenarios that fall out of line with best practices are mailed to providers monthly after each case finding.

Telephonic Consultations: Provider Help Line

A provider help line will offer providers access to a telephone consultation with one of our psychiatric pharmacists or board-certified psychiatrists for questions related to behavioral health prescribing.

E-mail Communications: Dedicated E-Mail Box

A dedicated provider e-mail address that offers providers access to a ask questions or schedule discussions directly with one of our psychiatric pharmacists or board-certified psychiatrists (when appropriate) for questions related to behavioral health prescribing.

Provider Forums

Our dedicated clinical pharmacist will attend provider workshops and meetings to educate and promote the program. The pharmacist will also create and maintain stakeholder relationships with relevant associations and other stakeholders identified by the state.

In addition, three to four (depending on participation/sign-up) pre-implementation forums will be held for doctors/NPs. Forums will be held at a dinner event, where the program will be detailed via a slide-deck, to the providers.

For those unable to participate in person web-based forums will be held for providers to view and call in to hear the presentation of the slide deck, that would traditionally be used for provider forums. Magellan Medicaid Administration will create promotional/marketing material as necessary.

Steps

Implementation: Three Months

Data transfer set-up and Program Rollout, including provider forums with CMEs and other outreach, as appropriate. Recruitment, hiring, and training of clinical pharmacist.

Provider Targeting

Monthly engine run of pharmacy claims data using *EnhancedMed*℠'s proprietary data analytics and analysis engine. Targeted providers identified. Geographical area targeted.

Provider *EnhancedMed*℠ Packets Produced

Member-level detail, mailed with customized introductory letter.

Consultations Scheduled

First packets targeted to be mailed April 2012 (depending on when implementation starts). Consultations scheduled between Magellan Medicaid Administration *EnhancedMed*℠ clinical pharmacist and targeted providers.

Evaluation and Impact Assessment

Monthly activity and outcomes reporting.

2.0 Requirements

Monthly pharmacy claims data, provider file, and member file will be delivered from Magellan Medicaid Administration to Magellan Data Warehouse for loading into the *EnhancedMed*℠ Engine. The engine will run the selected protocols monthly and identify the top 10–20% of outlier prescribers for review. The targeted outlier prescribers will have a letter template (to be approved by client) generated and mailed from the Magellan mailing center to the address provided in the prescriber file. A sample of the letters will be audited for quality prior to mailing.

If the practitioner wishes to have further consultation with a behavioral health pharmacist or a psychiatrist, they may request consultation via telephone or e-mail.

Staffing

Team Member	Roles and Responsibilities
Executive Account Sponsor: Melissa Lamer	Senior-level authority and responsibility of the teams within Magellan to ensure delivery of the highest quality services. Full oversight of the implementation and the on-going operations of the program.
Clinical Manager: To be Hired	Clinical Pharmacist specialized in psychiatry will work closely with all the Magellan Medicaid Administration PBM staff and MI pharmacy team to coordinate clinical activities and administer the program to meet the needs of your plan.

2.1 Operational Workflow

Generic-EnhanceMed -DataFlow.pdf

2.2 Requirements from Client

- Quality data in appropriate format
- Approval of the cover letter and protocol templates
- Support of clinical initiative by requesting participation by providers for this quality initiative

3.0 Constraints

Prescriber addresses are received from NPI file, and the accuracy of this file requires that the prescribers update their addresses with the national registry.

4.0 Proposed Pilot

Magellan Medicaid Administration proposes a three-month pilot of this program. The Pilot will be comprised of **two** MI-selected *EnhanceMed*^{SM} protocols and will consist only of mailings and inbound consultations.

5.0 Estimates and Costing

$150,000 for implementation; payable upon completion.

$450,000 in annual fees, invoiced and paid in 12 (twelve) equal monthly payments.

Implementation includes: Interface set ups including ftp process to load data into operational data store (ODS), creation of automated load process, claims, member and provider file interfaces, and testing of file transfers. Creation of operational data stores (ODS) within data warehouse. Configuration and customization of lettering for Michigan.

Any changes to the Requirements, Assumptions, Constraints, and Issues/Concerns/Questions may require modification to this Statement of Understanding and the cost estimates.

THE PRICES CONTAINED IN THIS COST PROPOSAL SHALL REMAIN VALID FOR A PERIOD OF NINETY (90) DAYS FROM THE DATE OF THIS PROPOSAL. AFTER THE EXPIRATION OF THE ABOVE PERIOD, THESE PRICES MAY ONLY BE ACCEPTED OR THE TIME PERIOD EXTENDED WITH THE WRITTEN CONSENT OF MAGELLAN MEDICAID ADMINISTRATION.

Form No. DMB 234 (Rev. 1/96)
AUTHORITY: Act 431 of 1984
COMPLETION: Required
PENALTY: Contract will not be executed unless form is filed

STATE OF MICHIGAN
DEPARTMENT OF TECHNOLOGY, MANAGEMENT AND BUDGET **December 6, 2011**
PROCUREMENT
P.O. BOX 30026, LANSING, MI 48909
OR
530 W. ALLEGAN, LANSING, MI 48933

CHANGE NOTICE NO. 3
TO
CONTRACT NO. 071B0200069
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF CONTRACTOR	TELEPHONE (508) 562-2655 **Donna M. Mellen**
Magellan Medicaid Administration **4300 Cox Road** **Glen Allen, VA 23060** **dmmellen@magellanhealth.com**	BUYER/CA (517) 241-3768 **Lance Kingsbury**
Contract Compliance Inspector: Laura Dotson (517.241.4686) **Pharmacy Benefits Manager Services (PBM) for Medicaid and Other Michigan Department of Community Health (DCH) Programs - DCH**	
CONTRACT PERIOD: From: **April 1, 2010** To: **March 31, 2013**	
TERMS **N/A**	SHIPMENT **N/A**
F.O.B. **N/A**	SHIPPED FROM **N/A**
MINIMUM DELIVERY REQUIREMENTS **N/A**	
MISCELLANEOUS INFORMATION:	

NATURE OF CHANGE(S):

Effective immediately, this contract is hereby INCREASED by $528,460.00 and the attached Statements of Understanding are hereby incorporated. Article 2 of this Contract is amended to include the following provision:

The Contractor agrees to comply with all disclosure regulations as defined in Federal Regulation 42 C.F.R. § 455.104, detailed below:

Disclosure by providers and fiscal agents: Information on ownership and control.

(a) *Information that must be disclosed.* The Medicaid agency must require each disclosing entity to disclose the following information in accordance with paragraph (b) of this section:
(1) The name and address of each person with an ownership or control interest in the disclosing entity or in any Subcontractor in which the disclosing entity has direct or indirect ownership of five percent or more;
(2) Whether any of the persons named, in compliance with paragraph (a)(1) of this section, is related to another as spouse, parent, child, or sibling.
(3) The name of any other disclosing entity in which a person with an ownership or control interest in the disclosing entity also has an ownership or control interest. This requirement applies to the extent that the disclosing entity can obtain this information by requesting it in writing from the person. The disclosing entity must:
(i) Keep copies of all these requests and the responses to them;
(ii) Make them available to the Secretary or the Medicaid agency upon request; and

(iii) Advise the Medicaid agency when there is no response to a request.

(b) *Time and manner of disclosure.* (1) Any disclosing entity that is subject to periodic survey and certification of its compliance with Medicaid standards must supply the information specified in paragraph (a) of this section to the State survey agency at the time it is surveyed. The survey agency must promptly furnish the information to the Secretary and the Medicaid agency.
(2) Any disclosing entity that is not subject to periodic survey and certification and has not supplied the information specified in paragraph (a) of this section to the Secretary within the prior 12-month period, must submit the information to the Medicaid agency before entering into a contract or agreement to participate in the program. The Medicaid agency must promptly furnish the information to the Secretary.
(3) Updated information must be furnished to the Secretary or the State survey or Medicaid agency at intervals between recertification or contract renewals, within 35 days of a written request.

(c) *Provider agreements and fiscal agent contracts.* A Medicaid agency must not approve a provider agreement or a contract with a fiscal agent, and must terminate an existing agreement or contract, if the provider or fiscal agent fails to disclose ownership or control information as required by this section.

(d) *Denial of federal financial participation (FFP).* FFP is not available in payments made to a provider or fiscal agent that fails to disclose ownership or control information as required by this section.

All other terms, conditions, specifications and pricing remain unchanged.

AUTHORITY/REASON:

Per agency request, Ad Board approval on 1/17/2012, and DTMB Procurement.

INCREASE: $528,460.00

TOTAL REVISED ESTIMATED CONTRACT VALUE: $21,290,080.00

Statement of Understanding (SOU) for Extract Changes State of Michigan

April 9, 2009

HIPAA Privacy Rules

The Health Insurance Portability and Accountability Act of 1996 (HIPAA – Public Law 104-191) and the HIPAA Privacy Final Rule[1] provides protection for personal health information. The regulations became effective April 14, 2003. First Health Services developed HIPAA Privacy Policies and Procedures to ensure operations are in compliance with the legislative mandated.

Protected health information (PHI) includes any health information whether verbal, written, or electronic, that is created, received, or maintained by First Health Services Corporation. It is health care data plus identifying information that allows someone using the data to tie the medical information to a particular person. PHI relates to the past, present, and future physical or mental health of any individual or recipient; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual. Claims data, prior authorization information, and attachments such as medical records and consent forms are all PHI.

The Privacy Rule permits a covered entity to use and disclose PHI, within certain limits and providing certain protections, for treatment, payment, and health care operations activities. It also permits covered entities to disclose PHI without authorization for certain public health and workers' compensation purposes, and other specifically identified activities.

[1] 45 CFR Parts 160 and 164, Standards for Privacy of Individually Identifiable Health Information; Final Rule

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Approvals Signature Page

First Health Services will deliver the requested change outlined in this Statement of Understanding by June 13, 2009, if Client signature approval is received by April 30, 2009.

Signature	Printed Name: Susan Moran
Title: Director, Medicaid Program Operations and Quality Assurance Bureau	Date: 6-15-09
Signature	Printed Name: Peter J. Quinn
Title: Chief Operating Officer	Date: 7-9-09
Signature	Printed Name
Title	Date
Signature	Printed Name
Title	Date

1.0 Overview

The Michigan Department of Community Health is requesting additional information added to the current weekly paid claims extract.

2.0 Requirements

Claim Extract (4694): Adding the ICN number to claims extract:

- Populate new ICN number in filler space on current extract (positions 4-20).
- Reversal ICN info in filler space on current extract (positions 139-155).
- ICN information should also be added to compound extract.

Claim Extract (4694): Adding additional fields.

- Add additional information in filler space on current extract (position 544-645).
- Additional Data:
  - Transaction Code
  - Claim Type
  - Claim Status
  - Adjudicated Group ID
  - Pharmacy Panel ID

3.0 Assumptions

- All other data elements within the extract remain the same.
- First Health Services assumes that historical claims before implementation will be referred back using the old ICN numbers in voids after implementation.
- Since the FirstRX database is a transactional database the status of the claim may change relative to the date and time of the extract is performed. The status of a claim at the time of the extract will be reported in the claim status field.
- The level of effort is an estimate and the actual cost may have variation of up to 20%.

4.0 Constraints

- Limitations within the layout may require additional length at the end of the layout.
- First Health Services will map the new fields to data elements in FirstRX database. The values will be populated in the extract as long as it is available in the source database.

5.0 Issues and Concerns

- Claim Extract (4694): Adding additional fields (denied claims)
- Add additional information in filler space on current extract (position 544-645).
- Additional Data
  - Transaction Code
  - Claim Type
  - Claim Status

6.0 Scope of Work

- Prepare technical specifications and requirements including the new layout and mapping to the FirstRX data base. The Technical Specifications and Requirements (TSR) document will be submitted to the state for approval by the state.
- Develop application script to incorporate the changes as defined in the approved TSR.
- Test and deploy the changes to production. (see section 7.0 for detailed test plan).
- Transmit weekly files using existing mechanisms and schedules.

7.0 Test Plan

- Unit Testing

- First Health Services software development team will do the unit testing. The results of the unit testing will be documented for internal use.

- System Testing.
  - First Health Services will perform system testing and will share the results with the state.
  - First Health Services will run three simulated cycles in our QC region,
  - The first cycle will be executed with the current application
  - The second cycle will be executed with the new application. The second cycle will have claims that were processed in the first cycle.
  - The Third cycle will be executed with the new application. The Third cycle will have claims that were processed in the first and second cycles.

- Test Cases.
  - Original claims – Test for change in ICN numbers.
  - Void claims – Test for ICN and original ICN for claims in first and second cycles. Voids for claims in the first cycle will refer to old ICN format and voids for claims in the second cycle will refer to the new ICN.
  - Validate values in the FirstRX database with the values in the second and third cycle for the following fields.
    - Transaction Code
    - Claim Type
    - Claim Status
    - Adjudicated Group ID
    - Pharmacy Panel ID

8.0 Operational Impact

- There should be minimal operational impact once changes are moved to production.

9.0 Estimates and Costing

Activities	ETL	Totals	Target Completion Date
Concept	10	10	
Planning	4	4	
Requirements	6	6	
Design	14	14	June 1, 2009*
Construction	16	16	June 4, 2009
Testing	24	24	June 9, 2009
Implementation	4	4	June12, 2009
Post Implementation	2	2	June 13, 2009
Total Implementation	**80**	**80**	

* Design documentation updates.

Estimated Resource Costs			
Resource Type	Hours	Rate	Charges
ETL	80	$110.00	$8,800.00
Total Implementation	**80**		**$8,800.00**

- Implementation Fee– The implementation fee for this project is $8,800.00. The implementation cost will be billed as a one time charge.

Any changes to the Requirements, Assumptions, Constraints, and Issues/Concerns/Questions may require modification to this Statement of Understanding and the cost estimates.

THE PRICES CONTAINED IN THIS COST PROPOSAL SHALL REMAIN VALID FOR A PERIOD OF NINETY (90) DAYS FROM THE DATE OF THIS PROPOSAL. AFTER THE EXPIRATION OF THE ABOVE PERIOD, THESE PRICES MAY ONLY BE ACCEPTED OR THE TIME PERIOD EXTENDED WITH THE WRITTEN CONSENT OF FIRST HEALTH SERVICES CORPORATION.

First Health
Services Corporation
A Coventry Health Care Company

Statement of Understanding (SOU) for Provider File Extract Changes State of Michigan

July 15, 2009

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HIPAA Privacy Rules

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Approvals Signature Page

First Health Services will deliver the requested change outlined in this Statement of Understanding by June 25, 2009, if Client signature approval is received by July 03, 2009.

Any changes to the Requirements, Assumptions, Constraints, and Issues/Concerns/Questions may require modification to this Statement of Understanding and the cost estimates.

Susan Moran	Susan Moran
Signature	Printed Name
Director, Medicaid Program Operations and Quality Assurance Bureau	July 30, 2009
Title	Date
[illegible]	Peter J. Quinn
Signature	Printed Name
Chief Operating Officer	8-7-09
Title	Date
Signature	Printed Name
Title	Date
Signature	Printed Name
Title	Date

1.0 Overview

The Michigan Department of Community Health is requesting a new Provider File extract to be used with their new CHAMPS system.

2.0 Requirements

2.1 4702-Header-Record

2.1.1 Record Layout for CHAMPS

For each of the seven record types, the same format is used for the header and trailer records. Each header/footer record contains information about the type of record within the set and the count of records within the set.

Record Format: rc1031.15-hdr									
Element Number	Data Element Name	Picture	Usage	Format	From	To	Validated	Required	Definition
1	HD-EDI-HEADER-TYPE	X(04)	4		1	4	Yes	Yes	HDDR
2	HD-EDI-APPLICATION	X(02)	2		5	6	No	Yes	MA
3	HD-EDI-USER	X(04)	4		7	10	No	Yes	DCH0
4	HD-EDI-USER-ID	X(04)	4		11	14	No	Yes	16
5	HD-EDI-CREATION-DATE	X(08)	8	CCYYMMDD	15	22	Yes - valid calendar date	Yes	
6	HD-EDI-TRANSFER-DATE	X(08)	8	CCYYMMDD	23	30	Yes - valid calendar date	Yes	
7	HD-EDI-TRANSFER-TIME	X(04)	4	HHMM	31	34	Yes - valid time	Yes	

Record Format: re1031.15-hdr									
Element Number	Data Element Name	Picture	Usage	Format	From	To	Validated	Required	Definition
8	HD-EDI-FILE-ID-BEGIN	X(04)	4		35	338	Yes	Yes	4702
9	HD-EDI-RUN-TYPE	X(01)	1		39	39	Yes	Yes	P - Production
T - Test									
10	HD-EDI-DAY-OF-WEEK	X(02)	2		40	41	No	Yes	ZEROS
11	HD-EDI-SEQUENCE	X(01)	1		42	42	No	Yes	1
12	FILLER	X(514)	514		43	556	No	No	Ignore all data within this element.

2.2 Layout of the Trailer Record

2.2.1 4702-Trailer Record

Record Format: re1031.15-trlr									
Element Number	Data Element Name	Picture	Usage	Format	From	To	Validated	Required	Definition
1	TR-EDI-HEADER-TYPE	X(04)	4		1	4	Yes	Yes	TRLR
2	TR-EDI-APPLICATION	X(02)	2		5	6	No	Yes	MA
3	TR-EDI-USER	X(04)	4		7	10	No	Yes	DCH0

Record Format: rc1031.15.trlr									
Element Number	Data Element Name	Picture	Usage	Format	From	To	Validated	Required	Definition
4	TR-EDI-USER-ID	X(04)	4		11	14	No	Yes	16
5	TR-EDI-CREATION-DATE	X(08)	8	CCYYMMDD	15	22	Yes - valid calendar date	Yes	
6	TR-EDI-TRANSFER-DATE	X(08)	8	CCYYMMDD	23	30	Yes - valid calendar date	Yes	
7	TR-EDI-TRANSFER-TIME	X(04)	4	HHMM	31	34	Yes - valid time	Yes	
8	TR-EDI-FILE-ID-BEGIN	X(04)	4		35	38	Yes	Yes	4702
9	TR-EDI-RUN-TYPE	X(01)	1		39	39	Yes	Yes	P - Production
T - Test									
10	TR-EDI-DAY-OF-WEEK	X(02)	2		40	41	No	Yes	ZEROS
11	TR-EDI-SEQUENCE	X(01)	1		42	42	No	Yes	1
12	TR-EDI-RECORD-COUNT	9(10)	10		43	52	Yes	Yes	Total number of records + 2
13	FILLER	X(504)	504		53	556	No	Yes	Ignore everything in this element

2.3 Layout of the Detail Record

Each Provider Information record is comprised of basic information about a pharmacy. In the header/footer records, the associated Record Type Identifier is '1'.

If a service provider is being terminated the Delete Date field is populated with non-zeroes. All of its associated memberships and supporting information will also be terminated using the same Termination Date.

Each Medicaid Information record contains a state-specific Medicaid ID that is associated with a pharmacy. These records are sent as a master file. In the header/footer record, the associated Record Type Identifier is '6'. This data will not be loaded from the CHAMPS layout.

Record Format: rc1031-15									
Element Number	Data Element Name	Picture	Usage	Format	From	To	Validated	Required	Definition
1	PH-REC-CODE	X(03)	3		1	3	Yes	Yes	PG1
2	PH-PROV- TYPE	X(04)	4		4	7	Yes	Yes	A170 for Pharmacy Providers
3	PH-DBA-NAME	X(50)	50		8	57	No	Yes	Store as CHAMPS DBA Name
									Pharmacy Name "As Licensed", cannot be blank
4	PH-LEGAL-ENTITY-NAME	X(50)	50		58	107	No	Yes	Store as CHAMPS Legal Entity Name
5	PH-LIC-NUMBER	X(10)	10		108	117	Yes - for MI providers	Yes	State License Number
6	DEA NUMBER	X(9)	9		118	126	No	Yes	
7	PH-NATL-PROV-ID	X(10)	10		127	136	Yes	Yes	Pharmacy's NPI, validate with check digit
8	PH-FED-EMPLOYER-NO	X(09)	9		137	145	No	Yes	Store as CHAMPS Federal Tax ID Number

Record Format: rc1031.15									
Element Number	Data Element Name	Picture	Usage	Format	From	To	Validated	Required	Definition
9	PH-NATL-PHARM-NO	X(7)	7		146	152	Yes (format only)	Yes	NCPDP Number
10	PH-COUNTY-NAME	X(2)	2		153	154	Yes	No	Send two digit identifier for the appropriate MI county: 01 - Alcona 02 - Alger 03 - Allegan 04 - Alpena 05 - Antrim 06 - Arenac 07 - Baraga 08 - Barry 09 - Bay 10 - Benzie 11 - Berrien 12 - Branch 13 - Calhoun 14 - Cass 15 - Charlevoix 16 - Cheboygan 17 - Chippewa 18 - Clare 19 - Clinton 20 - Crawford 21 - Delta 22 - Dickinson 23 - Eaton 24 - Emmet 25 - Genesee 26 - Gladwin 27 - Gogebic 28 - Grand Traverse 29 - Gratiot 30 - Hillsdale 31 - Houghton

Record Format: rc1031 15									
Element Number	Data Element Name	Picture	Usage	Format	From	To	Validated	Required	Definition
									32 - Huron 33 - Ingham 34 - Ionia 35 - Iosco 36 - Iron 37 - Isabella 38 - Jackson 39 - Kalamazoo 40 - Kalkaska 41 - Kent 42 - Keweenaw 43 - Lake 44 - Lapeer 45 - Leelanau 46 - Lenawee 47 - Livingston 48 - Luce 49 - Mackinac 50 - Macomb 51 - Manistee 52 - Marquette 53 - Mason 54 - Mecosta 55 - Menominee 56 - Midland 57 - Missaukee 58 - Monroe 59 - Montcalm 60 - Montmorency 61 - Muskegon 62 - Newaygo 63 - Oakland 64 - Oceana 65 - Ogemaw 66 - Ontonagon 67 - Osceola 68 - Oscoda

Record Format: rc1031.15									
Element Number	Data Element Name	Picture	Usage	Format	From	To	Validated	Required	Definition
									69 - Otsego 70 - Ottawa 71 - Presque Isle 72 - Roscommon 73 - Saginaw 74 - St Clair 75 - St Joseph 76 - Sanilac 77 - Schoolcraft 78 - Shiawassee 79 - Tuscola 80 - Van Buren 81 - Washtenaw 82 - Wayne 83 – Wexford 84 –Out of State – (Non-borderland) 85 – 86 – Ohio City 87 – Wisconsin City 88 – Indiana City 89 – Minnesota City Spaces to be sent by First Health until County Code is available
11	PH-ELIG-BEGIN-DT	X(08)	8	CCYYMMDD	155	162	Yes - valid calendar date	Yes	Only receive one occurrence of eligibility begin and end from First Health.
12	PH-ELIG-END-DT	X(08)	8	CCYYMMDD	163	170	Yes - valid calendar date	Yes	Only receive one occurrence of eligibility begin and end from First Health.
									30000101 = open-ended
13	PH-ADDR-TYPE (S)	X(01)	1		171	171	Yes	Yes	S (service address)

Record Format: rc1031.15									
Element Number	Data Element Name	Picture	Usage	Format	From	To	Validated	Required	Definition
									Store as: CHAMPS PPL Address
14	PH-ATTN-LINE (S)	X(50)	50		172	221	No	No	Store as CHAMPS Address Line 2
15	PH-STREET (S)	X(30)	30		222	251	No	Yes	Store as CHAMPS Address Line 1
16	PH-PO-BOX (S)	X(05)	5		252	256	No	No	Store as CHAMPS Address Line 3
17	PH-CITY (S)	X(30)	30		257	286	No	Yes	
18	PH-STATE (S)	X(02)	2		287	288	No	Yes	
19	PH-ZIP (S)	X(06)	6		289	293	No	Yes	
20	PH-ZIP-4 (S)	X(04)	4		294	297	No	No	
21	PH-TELE-NO (S)	X(10)	10		298	307	No	Yes	
22	PH-ADDR-TYPE (C)	X(01)	1		308	308	Yes	Yes	C (correspondence address)
									Store as: CHAMPS Correspondence/Mailing Address
23	PH-ATTN-LINE (C)	X(50)	50		309	358	No	No	Store as CHAMPS Address Line 2
24	PH-STREET (C)	X(30)	30		359	388	No	Yes	Store as CHAMPS Address Line 1
25	PH-PO-BOX (C)	X(05)	5		389	393	No	No	Store as CHAMPS Address Line 3
26	PH-CITY (C)	X(30)	30		394	423	No	Yes	

Record Format: rc1031.15									
Element Number	Data Element Name	Picture	Usage	Format	From	To	Validated	Required	Definition
27	PH-STATE (C)	X(02)	2		424	425	No	Yes	
28	PH-ZIP (C)	X(06)	6		426	430	No	Yes	
29	PH-ZIP-4 (C)	X(04)	4		431	434	No	No	
30	INDEPENDENT PANEL INDICATOR	X(1)	1		435	435	Yes	Yes	Independent Panel
									Y = Yes, N = No
31	CHAIN PANEL INDICATOR	X(1)	1		436	436	Yes	Yes	Chain Panel
									Y = Yes, N = No
32	IV INFUSION PANEL INDICATOR	X(1)	1		437	437	Yes	No	IV Infusion Panel
									Y = Yes, N = No
33	LONG TERM CARE PANEL INDICATOR	X(1)	1		438	438	Yes	No	Long Term Panel
									Y = Yes, N = No
34	MAIL ORDER PANEL INDICATOR	X(1)	1		439	439	Yes	No	Mail Order Panel
									Y = Yes, N = No
35	PANEL INDICATOR 6	X(1)	1		440	440	Yes	No	Place holder for future expansion
									Y = Yes, N = No

Record Format: rc1031.15									
Element Number	Data Element Name	Picture	Usage	Format	From	To	Validated	Required	Definition
36	PANEL INDICATOR 7	X(1)	1		441	441	Yes	No	Place holder for future expansion
									Y = Yes, N = No
37	PANEL INDICATOR 8	X(1)	1		442	442	Yes	No	Place holder for future expansion
									Y = Yes, N = No
38	PANEL INDICATOR 9	X(1)	1		443	443	Yes	No	Place holder for future expansion
									Y = Yes, N = No
39	PANEL INDICATOR 10	X(1)	1		444	444	Yes	No	Place holder for future expansion
									Y = Yes, N = No
40	TAXONOMY	X(100)	100		445	544	Yes	Yes	Validate that each taxonomy exists within CHAMPS reference tables.
									Up to 10 taxonomy values can be sent. Each should be 10 chars long and immediately follow each other without any delimiter (space delimited).
41	MANAGING EMPLOYEE FNAME	X(20)	20		545	564	No	No	Store as CHAMPS Office Manager Fname
42	MANAGING EMPLOYEE LNAME	X(30)	30		565	594	No	No	Store as CHAMPS Office Manager Lname

Record Format: rc1031.15									
Element Number	Data Element Name	Picture	Usage	Format	From	To	Validated	Required	Definition
43	MANAGING EMPLOYEE SSN	X(9)	9		595	603	No	No	Store as CHAMPS Office Manager SSN
44	# OF OWNERSHIP SEGMENTS	9(2)	2		604	605	Yes	Yes	0 <= # <= 20
									0 = no owners with at least 5% ownership.
45	# OF OWNERSHIP IN OTHER ENTITIES SEGMENTS	9(2)	2		606	607	Yes	Yes	0 <= # <= 20
	OWNERSHIP (UP TO 20 OCCURRENCES)								
46	OWNER TYPE	X(10)	10				Yes	Yes	I -Individual/Sole Proprietor
									P - Partnership
									C - Corporate
									CC -Corporate - Charitable 501[c]3
									CN - Corporate - Non Charitable
									G - Government
									F - Foreign, Nonresident Alien
47	FIRST NAME	X(20)	20				No	Yes	
48	LAST NAME	X(30)	30				No	Yes	
49	SUFFIX	X(10)	10				No	No	

Record Format: rc1031_15									
Element Number	Data Element Name	Picture	Usage	Format	From	To	Validated	Required	Definition
50	LEGAL ENTITY NAME	X(100)	100				No	Yes	
51	ENTITY BUSINESS NAME (DBA)	X(50)	50				No	Yes	
52	SSN	X(9)	9				No	Yes	
53	EIN/TIN	X(9)	9				No	Yes	
54	PERCENTAGE OWNED (5% OR MORE)	9(3)	3				Yes	Yes	5 <= X <= 100
									Whole numbers only
55	RELATIONSHIP	X(50)	50				No	Yes	
56	START DATE	9(8)	8	YYYYMMDD			Yes - valid calendar date	Yes	
57	END DATE	9(8)	8	YYYYMMDD			Yes - valid calendar date	Yes	
58	ADDRESS LINE 1	X(55)	55				No	Yes	
59	ADDRESS LINE 2	X(55)	55				No	No	
60	CITY/TOWN	X(50)	50				No	Yes	
61	STATE/PROVINCE	X(30)	30				No	Yes	
62	COUNTY	X(30)	30				No	No	
63	COUNTRY	X(30)	30				No	Yes	

Record Format: p1031.15									
Element Number	Data Element Name	Picture	Usage	Format	From	To	Validated	Required	Definition
64	ZIP	X(6)	6				No	Yes	
64.1	ZIP4	X(4)	4				No	No	
65	PHONE NUMBER	X(10)	10				No	Yes	
	OTHER MEDICAID/MEDICARE ENTITIES (UP TO 20 OCCURRENCES)								
66	OWNER TYPE	X(10)	10				No	Yes	
67	LEGAL ENTITY NAME	X(100)	100				No	Yes	
68	ENTITY BUSINESS NAME (DBA)	X(50)	50				No	Yes	
69	ENTITY EIN/TIN	X(9)	9				No	Yes	
70	PERCENTAGE OWNED (5% OR MORE)	9(3)	3				Yes	Yes	5 <= X <= 100
									Whole numbers only
71	RELATIONSHIP	X(50)	50				No	Yes	
72	START DATE	9(8)	8	YYYYMM DD			Yes - valid calendar date	Yes	
73	END DATE	9(8)	8	YYYYMM DD			Yes - valid calendar date	Yes	
74	ADDRESS LINE 1	X(55)	55				No	Yes	
75	ADDRESS LINE 2	X(55)	55				No	No	

Record Format: rc1031.15									
Element Number	Data Element Name	Picture	Usage	Format	From	To	Validated	Required	Definition
76	CITY/TOWN	X(50)	50				No	Yes	
77	STATE/PROVINCE	X(30)	30				No	Yes	
78	COUNTY	X(30)	30				No	No	
79	COUNTRY	X(30)	30				No	Yes	
80	ZIP	X(6)	6				No	Yes	
80.1	ZIP4	X(4)	4				No	Yes	
81	PHONE NUMBER	X(10)	10				No	Yes	
82	PH-DISENROLL-REASON	X(2)	2				Yes	No	04 -Voluntary Suspension
									05 -Involuntary Suspension
									06 -Voluntary Termination
									07 -Involuntary Termination
									09 -Non-Renewal of License
									10 -Retired
									11 -Deceased
									12 -Closure for Business and Institutions
									14 -Returned Mail
									20 -Change in Ownership
									21 -Provider Left Group
									50 -Re-validation Not Complete

Record Format: rc1031.15									
Element Number	Data Element Name	Picture	Usage	Format	From	To	Validated	Required	Definition
									99 -Terminated for Non-Payment/Auto-Process

Fixed values (35 to 39 will be "N," 41 to 43 will be spaces, and 44 & 45 will be zero)

The end of the record layout will no be included as this information is not available.

Currently being populated in existing extract

3.0 Assumptions

- The level of effort in this document is the final estimate
- Field 10, COUNTY-NAME, was on the old extract and was spaces. This will continue unless otherwise directed.
  If we are to populate this field, we will need to define business rules on how to populate this field; e.g., we could use zip code to assign county.
- The new indicator fields look like they are available and we will have to define the business rules for each:
  - 30 INDEPENDENT PANEL INDICATOR, 31 CHAIN PANEL INDICATOR, 32 IV INFUSION PANEL INDICATOR, 33 LONG TERM CARE PANEL INDICATOR, 34 MAIL ORDER PANEL INDICATOR
- The new field, 40 TAXONOMY, seems to be an available field.
- It does not appear that we have information to populate the Managing Employee name fields: 41 MANAGING EMPLOYEE FNAME, 42 MANAGING EMPLOYEE LNAME, and 43 MANAGING EMPLOYEE SSN. These will be spaces.
- Field 44, # OF OWNERSHIP SEGMENTS, will be set to zero.
  "OWNERSHIP (UP TO 20 OCCURRENCES)" fields will not be placed in the extract file:
  - 46 OWNER TYPE, 47 FIRST NAME, 48 LAST NAME, 49 SUFFIX, 50 LEGAL ENTITY NAME, 51 ENTITY BUSINESS NAME (DBA), 52 SSN, 53 EIN/TIN, 54 PERCENTAGE OWNED (5% OR MORE), 55 RELATIONSHIP, 56 START DATE, 57 END DATE, 58 ADDRESS LINE 1, 59 ADDRESS LINE 2, 60 CITY/TOWN, 61 STATE/PROVINCE, 62 COUNTY, 63 COUNTRY, 64 ZIP, and 65 PHONE NUMBER
- Field 45, # OF OWNERSHIP IN OTHER ENTITIES SEGMENTS, will be set to zero.
  "OTHER MEDICAID/MEDICARE ENTITIES (UP TO 20 OCCURRENCES)" fields will not be placed in the extract file:
  - 66 OWNER TYPE, 67 LEGAL ENTITY NAME, 68 ENTITY BUSINESS NAME (DBA), 69 ENTITY EIN/TIN, 70 PERCENTAGE OWNED (5% OR MORE), 71 RELATIONSHIP, 72 START DATE, 73 END DATE, 74 ADDRESS LINE 1, 75 ADDRESS LINE 2, 76 CITY/TOWN, 77 STATE/PROVINCE, 78 COUNTY, 79 COUNTRY, 80 ZIP, 81 PHONE NUMBER, 82 PH-DISENROLL-REASON, 82 PH-DISENROLL-REASON
- Field 82 PH-DISENROLL-REASON was a field in the old extract but it looks like it has been rolled up into "OTHER MEDICAID/MEDICARE ENTITIES (UP TO 20 OCCURRENCES)". This appears to be in error and this field will need to be populated. Currently it contains spaces so it is unclear if this needs a value.

- There are some business rules that need to be reviewed. These are for certain hard coded values for certain providers like Indian Reservations and hard coded logic for address line 1 and 2.
- All fields on the header and trailer appear to be possible.

4.0 Constraints

- First Health Services will map the new fields to data elements in FirstRx™ database. The values will be populated in the extract as long as it is available in the source database.

5.0 Issues and Concerns

- Due to time constraints the first test file will be sent only for format testing.

6.0 Scope of Work

- Test and deploy the changes to production. (See *Section 7.0 – Test Plan* for detailed test plan).
- Transmit weekly files using existing mechanisms and schedules.

7.0 Test Plan

- Unit Testing
  - First Health Services' software development team will do the unit testing. The results of the unit testing will be documented for internal use.
- System Testing.
  - First Health Services will perform system testing and will share the results with the State.
- Test File
  - Provide an initial test file with at least 10 records for format testing using the fixed record length and the header and trailer records, and default values identified in the proposed layout.
  - Provide test file with data from FirstRx™ QC database to test and validate values in the FirstRx™ database with the values in the data file.

8.0 Operational Impact

There should be minimal operational impact once changes are moved to production.

9.0 Estimates and Costing

Activities	ETL	Totals	Target Completion Date
Concept	32	32	6/25/09
Planning	24	24	6/25/09
Requirements	48	48	7/7/09
Design	36	36	7/15/09
Construction	60	60	7/27/09
Testing	80	80	8/13/09
Implementation	8	8	8/14/09
Post Implementation	2	2	8/17/09
Total Implementation	**290**	**290**	

Estimated Resource Costs			
Resource Type	**Hours**	**Rate**	**Charges**
ETL	290	$115.00	$33,350.00
Total Implementation	**290**		**$33,350.00**

Implementation Fee -- The implementation fee for this project is $33,350.00. The implementation cost will be billed as a one time charge.

Any changes to the Requirements, Assumptions, Constraints, and Issues/Concerns/Questions may require modification to this Statement of Understanding and the cost estimates.

THE PRICES CONTAINED IN THIS COST PROPOSAL SHALL REMAIN VALID FOR A PERIOD OF NINETY DAYS FROM THE DATE OF THIS PROPOSAL. AFTER THE EXPIRATION OF THE ABOVE PERIOD, THESE PRICES MAY ONLY BE ACCEPTED OR THE TIME PERIOD EXTENDED WITH THE WRITTEN CONSENT OF FIRST HEALTH SERVICES CORPORATION.

MAGELLAN
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Statement of Understanding (SOU) for the Michigan Department of Community Health Medical Pharmacy Management Program

August 2, 2011

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Privacy Rules

The Health Insurance Portability and Accountability Act of 1996 (HIPAA – Public Law 104-191) and the HIPAA Privacy Final Rule[1] and the American Recovery and Reinvestment Act (ARRA) of 2009 provides protection for personal health information. Magellan Medicaid Administration developed and maintains HIPAA Privacy Policies and Procedures to ensure operations are in compliance with the legislative mandates.

Protected health information (PHI) includes any health information and confidential information, whether verbal, written, or electronic, created, received, or maintained by Magellan Medicaid Administration. It is health care data plus identifying information that would allow the data to tie the medical information to a particular person. PHI relates to the past, present, and future physical or mental health of any individual or recipient; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual. Claims data, prior authorization information, and attachments such as medical records and consent forms are all PHI.

[1] 45 CFR Parts 160 and 164, Standards for Privacy of Individually Identifiable Health Information; Final Rule

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Approvals Signature Page

As part of the implementation process for the Medical Pharmacy Management Program, the State of Michigan authorizes Magellan Medicaid Administration to provide the services outlined in Section 2.0 - Scope of Work.

Magellan Medicaid Administration will deliver the requested change outlined in this Statement of Understanding by the date mutually agreed to between the State of Michigan and Magellan Medicaid Administration.

Authorizing Signatures

State of Michigan	Magellan Medicaid Administration
Susan Morris	[illegible]
NAME	NAME
Director of Medicaid Program Operations Bureau	President
TITLE	TITLE
8-10-11	8/17/11
DATE	DATE

1.0 Executive Overview

Magellan Medicaid Administration will provide Michigan Department of Community Health (MDCH) a Medical Pharmacy Management program. We will partner with ICORE Healthcare, LLC ("ICORE"), a sister company of Magellan Medicaid Administration, to provide this program. ICORE was founded in 2003 to help state, federal, and commercial payors improve the costs associated with specialty pharmaceuticals, while supporting the quality of care of the plan and program beneficiaries. ICORE occupies a unique competitive position in the specialty pharmacy sector, by virtue of their work with injectable products on both medical and pharmacy benefits.

The core program being offered to MDCH is the cost management of drugs paid under the medical benefit. The scope of this management program includes oncology and oncology support, rheumatoid arthritis, Crohn's disease and psoriasis, intravenous immune globulin (IVIG), and other key drugs paid under the medical benefit. This program has two components.

1. **Reimbursement:** The first component focuses on unit costs. We have a proprietary reimbursement schedule that aligns the provider's interests with those of MDCH and thereby improves the mix of drugs used, such that lower cost agents, when appropriate, are used more frequently.
2. **Claims Edits:** Our technology platform enables management of drugs paid under the medical benefit; specifically, claim entry errors, fraudulent claims, previously paid claims, and off-label drug use are mitigated. These edits are similar to the techniques used in the management of drugs paid under the pharmacy benefit without disrupting workflow in the provider's office.

The potential savings available from this program are substantial. Based on ICORE's thorough analysis of MDCH's claims, we estimate minimum savings of 10 percent ($2.0M for the broader fee-for-service (FFS) population, with an expected range of $2M to $3M additional with the inclusion of Dual Eligibles and CSHCS) for the services selected by MDCH. The potential savings is general in nature and provided for informational purposes. It is not a statement of guarantee.

A unique service provided by this program is the comprehensive clinical management approach for conditions treated with specialty drugs that may lie on either the medical or drug benefits. For example: rheumatoid arthritis has oral therapies covered under the pharmacy benefit (e.g., methotrexate), self injected specialty agents paid under the pharmacy benefit (e.g., Humira, Enbrel), and provider administered infused drugs paid under the medical benefit, such as Remicade and Orencia. Our partnership will enable the management of these costly, equally effective drugs regardless of where the claim is dispensed, administered, or paid. It is now

critical for MDCH to develop and implement an injectable cost management approach, since seven of the top 10 drugs will be specialty agents in the next few years and more than half of these drugs will be paid under the medical benefit. Moreover, the injectable drug pipeline is far more robust than that of traditional oral drugs. As MDCH faces these fundamental market changes, along with budget shortfalls and expanding enrollment, we believe the tools that ICORE and Magellan Medicaid Administration have built will create significant value for MDCH.

2.0 Scope of Work

The State of Michigan authorizes Magellan Medicaid Administration and its affiliate, ICORE, to provide the services outlined in *Section 2.0 - Scope of Work*. This SOU is an amendment to the *Pharmacy Benefits Manager Services (PBM) for Medicaid and Other Michigan Department of Community Health (DCH) Programs agreement #071B0200069*.

Magellan Medicaid Administration proposes to implement its Medical Pharmacy Management Program with MDCH for its fee for service (FFS) membership, currently estimated to be 415,000 members. ICORE thoroughly analyzed claims for this membership to arrive at our $2M savings estimate. The estimated Dual Eligible (218,000 members) and Children's Special Health Care Services – Title V (CSHCS – 20,200 members) participants, although not included in ICORE's in-depth analysis, will be included in this program. Spend for this population is 2x as high as the above population, and savings for this population will be an additional $2M to $3M. We estimate a minimum savings of 10 percent after implementation of the initiatives outlined below.

Objectives

The primary objectives of this SOU are to

- Develop MDCH's strategy and implementation plan for provider administered injectable drugs;
- Provide IT Consulting services to MDCH for claims editing logic necessary for program implementation;
- Decrease spend in specific drug categories by incentivizing use of generic drugs;
- Revise MDCH's fee schedule for generic drugs, effective January 1, 2012 ;
- Ensure provider administered drug claims are paid correctly and fraud is mitigated;
- Communicate the program to MDCH's provider network; and
- Measure and report savings.

Deliverables

Magellan Medicaid Administration will provide MDCH with the following specific deliverables:

Activities	Deliverable	Timing
Strategy Development ▪ Review current strategy ▪ Identify improvements to existing strategy ▪ Size improvements ▪ Develop implementation plans ▪ Support implementation	Provider-administered injectable management strategy meeting and identification of new opportunities for savings	Beginning 10/01/2011
IT Consulting ▪ ICORE will license use of its proprietary claims edits to MDCH ▪ ICORE IT staff will work with MDCH and its MMIS vendor to program these edits into their claims payment system	▪ On-site meetings between ICORE and MDCH to establish review system needs and architecture ▪ Install edit logic	Beginning 10/01/2011
Reimbursement ▪ Create quarterly provider reimbursement fee schedules to encourage use of generics ▪ Support implementation of new fee schedules	Revised provider-administered injectable reimbursement schedule	Fifth business day of each quarter
Post Service Claims Editing (PSCE) ▪ Recommend edits to be installed (see above) ▪ Update editing logic quarterly, on an as-needed basis ▪ Recommend correct payment of units ▪ Recommend correct payment by diagnosis	Final list of j-codes to be edited (*Attachment A*)	To be determined
Provider Communication ▪ Communicate program to network providers ▪ Gain provider consensus ▪ Conduct provider profiling ▪ Develop generic drug use optimization plan	Train up to 20 provider group practices on: ▪ PSCE ▪ Reimbursement methodology	Beginning 10/15/2011

Activities	Deliverable	Timing
Measurement ▪ Measure program savings ▪ Present savings to MDCH leadership ▪ Measure improvements in drug mix ▪ Report quarterly changes, by provider ▪ Identify new savings opportunities ▪ Size new savings opportunities ▪ Develop implementation plans for new opportunities	▪ Savings reports ▪ Generic drug use and change over time report by physician ▪ Report of new savings initiatives, implementation plans, and savings size	Quarterly

Implementation and Operational phase performance standards and guarantees do not apply to services to be provided under this SOU.

3.0 Time Period of Agreement

This agreement will be effective beginning October 1, 2011, and run concurrently with the pharmacy benefits administration contract. The Implementation Phase will begin upon signature of this SOU, but no later than October 1, 2011, assuming that the State of Michigan executes and delivers this SOU on or before such date. The Operational Phase of this Agreement will commence on or about January 1, 2012, assuming that the State of Michigan supplies the required deliverables listed in *Section 4.0 – Pricing and Deliverables*, #5 on or before October 15, 2011.

4.0 Pricing and Deliverables

Pricing Components

1. Implementation Fee & Timing: The State of Michigan agrees to reimburse Magellan Medicaid Administration a one-time Implementation Fee of $100,000.00, to be paid on November 1, 2011. The Implementation phase will begin October 1, 2011, and will conclude on December 30, 2011.

2. Annual Fee and Timing: Magellan Medicaid Administration's annual fee will be applied during the Operational Phase, beginning January 1, 2012. The State of Michigan agrees to reimburse Magellan Medicaid Administration a fee of $300,000.00 annually for the services provided. For the first year of the contract (October 1, 2011 through March 31, 2012) the prorated fee is $175,000.00 for services delivered from October 1, 2011 through March 31, 2012. Payments will be made on a monthly basis in the amount of $25,000.00 per month. Fees listed are considered the minimum necessary to operate this program for MDCH, regardless of services selected.

3. Annual Fee Adjustment: For subsequent contract years, the Annual Fee shall increase by the amount and percentage in the table below. The date of adjustment will coincide with the renewal date of Magellan Medicaid Administration's contract, April 1.

Contract Year	Monthly Fee	Annual Fee	Maximum Annual Fee Adjustment
January 1, 2012 – March 31, 2012	$25,000	*$175,000	
April 1, 2012 – March 31, 2013	$25,943	$311,310	3.77%
April 1, 2013 – March 31, 2014	$26,923	$323,078	3.78%
April 1, 2014 – March 31, 2015	$27,938	$335,258	3.77%

*** Annual Fee includes Implementation Fee**

4. Estimated Annual Savings and Implementation Dates for Services Selected: Based on the services selected by MDCH, program savings are projected to be approximately $2.0M dollars.

   - Reimbursement (VFS): January 1, 2012.
   - Post Service Claims Edits (PSCE): January 1, 2012. Drugs included in the PSCE program are defined in Attachment A.

5. State of Michigan: The following deliverables will be required of the State of Michigan to meet contract implementation deadlines, and operational guidelines throughout the life of this contract:

- July 15, 2011 – Signature of this SOU
- Implementation Phase (October 1, 2011-December 31, 2011)
  - Current Fee Schedule of J-coded drugs (by October 15, 2011)
  - Coordination of meetings between Magellan Medicaid Administration and MDCH IT staff (by October 15, 2011) to review and recommend PSCE edits list (Attachment A)
  - Scheduling MDCH internal training meetings on program
  - Scheduling kick-off meetings with key Provider groups
  - Assistance with deliverables outlined in *Section 2.0 – Scope of Work*, where MDCH's input would reasonably be required

6. Operational Phase (January 1, 2012 – throughout contract)
   - Maintenance and updating of PSCE within the MI DCH MMIS system
   - Assistance with Provider relations
   - Quarterly teleconferences with Magellan Medicaid Administration on program results and adjustments
   - Annual Review with Magellan Medicaid Administration staff

Attachment A – HCPCS Codes for PSCE Services

HCPCS Code	Brand Name
J9310	Rituxan
J2353	Sandostatin
J3487	Zometa
J9035	Avastin
J9170	Taxotere
J9217	Lupron
J9264	Abraxane
J9350	Hycamtin
J9001	Doxil
J1561	Gamunex
J9201	Gemzar
J9041	Velcade
J9263	Eloxatin
J1745	Remicade
J9055	Erbitux
J9355	Herceptin
J9202	Zoladex
J3315	Trelstar
J1566	IVIG
J1950	Lupron
J2469	Aloxi
J1441	Neupogen
J9305	Alimta
J2820	Leukine
J0885	Procrit
J9265	Taxol
J9045	Paraplatin

Form No. DMB 234 (Rev. 1/96)
AUTHORITY: Act 431 of 1984
COMPLETION: Required
PENALTY: Contract will not be executed unless form is filed

STATE OF MICHIGAN
DEPARTMENT OF TECHNOLOGY, MANAGEMENT AND BUDGET **January 24, 2011**
PROCUREMENT & REAL ESTATE SERVICES ADMINISTRATION
P.O. BOX 30026, LANSING, MI 48909
OR
530 W. ALLEGAN, LANSING, MI 48933

CHANGE NOTICE NO. 2
TO
CONTRACT NO. 071B0200069
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF CONTRACTOR **Magellan Medicaid Administration** **4300 Cox Road** **Glen Allen, VA 23060** **dmmellen@magellanhealth.com**	TELEPHONE (508) 562-2655 **Donna M. Mellen** BUYER/CA (517) 241-3768 **Lance Kingsbury**
Contract Compliance Inspector: Laura Dotson (517.241.4686) **Pharmacy Benefits Manager Services (PBM) for Medicaid and Other Michigan Department of Community Health (DCH) Programs - DCH**	
CONTRACT PERIOD: From: **April 1, 2010** To: **March 31, 2013**	
TERMS **N/A**	SHIPMENT **N/A**
F.O.B. **N/A**	SHIPPED FROM **N/A**
MINIMUM DELIVERY REQUIREMENTS **N/A**	
MISCELLANEOUS INFORMATION:	

NATURE OF CHANGE(S):

Effective immediately, this Contract is hereby INCREASED by $254,676.00 and the attached Statement of Understanding is hereby incorporated.

Also, the buyer has been changed to Lance Kingsbury.

All other terms, conditions, specifications and pricing remain unchanged.

AUTHORITY/REASON:

Per vendor and agency agreement, Ad Board approval on 1/18/2011, and DTMB/Procurement & Real Estate Services Administration.

INCREASE: $254,676.00

TOTAL REVISED ESTIMATED CONTRACT VALUE REMAINS: $20,761,620.00

MAGELLAN
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Statement of Understanding (SOU) for the Michigan Managed Care Rebate Invoicing Program

August 25, 2010

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Privacy Rules

The Health Insurance Portability and Accountability Act of 1996 (HIPAA – Public Law 104-191) and the HIPAA Privacy Final Rule[1] and the American Recovery and Reinvestment Act (ARRA) of 2009 provides protection for personal health information. Magellan Medicaid Administration developed and maintains HIPAA Privacy Policies and Procedures to ensure operations are in compliance with the legislative mandates.

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[1] 45 CFR Parts 160 and 164, Standards for Privacy of Individually Identifiable Health Information; Final Rule

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Approvals Signature Page

As part of the implementation process for the Managed Care Rebate Invoicing Program, the State of Michigan authorizes Magellan Medicaid Administration to provide the services outlined in Section 2.0 - Detailed Scope of Work.

Magellan Medicaid Administration will deliver the requested change outlined in this Statement of Understanding by the date mutually agreed to between the State of Michigan and Magellan Medicaid Administration.

Authorizing Signatures

State of Michigan	Magellan Medicaid Administration
Susan Moran	
NAME	NAME
Susan Moran	
TITLE	TITLE
Bureau Director Medicaid Program Operations & Quality Assurance Medical Services Administration Michigan Department of Community Health	
DATE	DATE
8/25/2010 8/25/10	

1.0 Executive Overview

On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act (PPACA) into law. Along with the Health Care and Education Affordability Reconciliation Act of 2010 (signed into law on March 30, 2010), this law will have a significant impact on the Medicaid drug rebates—both Federal and Supplemental.

The PPACA increases the minimum Federal Rebate for single source and innovator multiple source drugs from 15.1 to 23.1 percent and for generic drugs from 11 to 13 percent (the rebate for clotting factors and outpatient drugs approved exclusively for pediatric indications increases from 15.1 to 17.1 percent), effective January 1, 2010. Additionally, the Federal Rebate is now capped at 100 percent of AMP.

This increase in the Federal Rebate is exempt from FMAP (Federal Medical Assistance Percentage) regulations, thus the Federal Government will receive 100 percent of the additional rebate resulting from this law.

In addition to the changes stated above, this law also requires the states to collect CMS level rebates on all Medicaid MCO utilization. According to CMS, the rebate accrual period begins the date the bill was signed into law by President Obama, March 23, 2010.

In order to quickly react to and be in full compliance with this new law, Magellan Medicaid Administration has identified the actions necessary for the State of Michigan to move this initiative forward to meet compliance requirements.

Magellan Medicaid Administration has provided CMS drug rebate services for the State of Michigan since 2002. During this time, we have established a solid working relationship with the State and have developed an understanding of its goals and expectations regarding the CMS rebate program, as well as its supplemental drug rebate program.

Magellan Medicaid Administration core rebate functions will be utilized to support this additional MCO Rebate Invoicing initiative using FirstRebate™, our proprietary and MITA-aligned rebate administration tool that allows for invoicing and allocation for rebates on all drug claims, regardless of source. Medicaid MCO drug utilization is invoiced and posted at an NDC/year/quarter level. In addition to providing a complete accounting of all invoices and collections, FirstRebate™ also allows for:

- Complete tracking of rate changes and utilization adjustments (i.e., voids/reversals)
- Thirteen-week T-bill rates used for interest accrual calculations
- Provider and labeler demographics
- 340B/PHS providers, HCPCS Code/NDC conversion tables

- Dispute resolution functions.

Magellan Medicaid Administration has the necessary rebate experience, and the existing tools and infrastructure are in place to quickly and successfully implement these new MCO Rebate requirements. With the experience of Magellan Medicaid Administration, Michigan will receive a complete solution designed to meet the requirements of the new law. The total estimated saving including state and federal share combined for Michigan is $120,000,000. This is based on The Lewin Group study dated September 22, 2008 titled "*Analysis of Drug Rebate Equalization Act's Savings to the Medicaid Program.*"

2.0 Detailed Scope of Work

The major functions and activities that are part of the Managed Care Rebate Invoicing Program that affect the State CMS rebate program are the Implementation activities necessary to interface, test, and report on MCO utilization data and the ongoing quarterly services necessary to process, invoice, collect, and report the additional drug utilization data for each MCO. The primary activities for this initiative are as follows:

Implementation

- **Data Interface** - Magellan Medicaid Administration has developed a standard data interface program; the required MCO data elements are provided in Attachment A. Any non-standard interface files will require customized programming and are not included in the prices contained in this SOU. Additional support for activities necessary to support submission of non-standard interface files will be performed at an all-inclusive hourly rate of $135.00 per hour.
- **Testing** - The aggregated MCO data interface file provided by the State will be tested and validated. Communication between the State and our test team will be needed to work through any data issues to finalization. Validated MCO data interface file will be run through a test environment to simulate all FirstRebate™ processing and resultant reporting.
- **Reporting** - All existing reporting will be verified and reviewed with the State for final approvals. Magellan Medicaid Administration's standard rebate reports will be utilized to support this Managed Care Rebate Invoicing Program. Any additional or customized reports are not included in the prices contained in this SOU. Additional support for activities necessary to support customized reporting and ad hoc reporting will be performed at an all-inclusive hourly rate of $135.00 per hour.

Operations

- **Rebate Billing** - Based on claims processed by the MCO, Magellan Medicaid Administration will receive drug utilization data from Michigan on a monthly basis or

more frequently if available using the specified file format described in Attachment A. MCOs will be required to pass NDC level information including J-code conversions consistent with CMS regulations. Utilization data will be aggregated quarterly and invoiced to the appropriate manufacturers using the quarterly CMS Federal URA. The manufacturers will submit payment to Magellan Medicaid Administration in the same fashion that CMS rebates are submitted today. Invoicing of manufacturers will be done within CMS guidelines. One hundred percent of the rebates pass through to the State.

- **Reconciliation and Reporting** - Magellan Medicaid Administration will maintain quarterly unit rebate amounts data back to the first quarter of 1991 (or future CMS-mandated dates) as provided on the quarterly CMS tape and use those rates for the manufacturer billing. In addition, DCH will be provided the standard rebate report package that is in production today for its FFS programs. This will allow for support of the Federal CMS reporting in the MCO programs. Future requirements from CMS, in regards to rate, rebate offset or FMAP calculations will be provided through the Change Management Process or independent SOU.
- **Limited Dispute Resolution** - Magellan Medicaid Administration will provide claims level detail to manufacturers to assist in dispute resolution. We will work with the MCOs to resolve disputes related to unit discrepancies. However, since we are not the point-of-sale claims processor, resolution of unit disputes will be dependant upon the level of MCO cooperation. Magellan Medicaid Administration assumes that State assistance will be required from time-to-time to assist with dispute resolution.
- **Current Applications** - Magellan Medicaid Administration will modify the existing rebate application currently used to support the Magellan Medicaid Administration Rebate, Diabetic Supply, and Preferred Drug List (PDL) programs to support MCO invoicing activities described above and in compliance with the Managed Care Rebate Invoicing Program.
- **Operational Ad Hoc Reporting** – In order to report individual MCO information, please refer to Attachment B that houses the Location Code relationship to each MCO. This will be a required field in order to perform any ad hoc reporting. Operational ad hoc reporting will be done at the all-inclusive hourly rate of $135 per hour.

3.0 Time Period of Agreement

This agreement will be effective beginning August 2010 and running through March 31, 2013. The Implementation Phase will begin when the SOU is signed. Rebates will begin to be invoiced and collected for the quarter the period beginning March 23, 2010. This time period coincides with the term of the existing contract between Magellan Medicaid Administration and the State of Michigan.

4.0 Pricing and Deliverables

The Managed Care Rebate Invoicing Program initiative pricing contains three components and is based on the assumption of the State aggregating and providing Magellan Medicaid Administration with the 14 Medicaid MCOs drug utilization. The following list of Medicaid MCOs is applicable:

- BlueCaid of Michigan
- CareSource of Michigan
- Great Lakes Health Plan
- Health Plan of Michigan
- HealthPlus Partners, Inc.
- McLaren Health Plan
- Midwest Health Plan
- Molina Healthcare of Michigan
- Physicians Health Plan of Mid-Michigan
- Priority Health Government Programs, Inc.
- ProCare Health Plan
- Total Health Care
- Omnicare
- Upper Peninsula Health Plan

Pricing Components

1. One-time Implementation Fee of $48,009 based on the State of Michigan providing aggregated MCO utilization data according to the record layouts in Attachments A and B. This implementation fee of $48,009 will be due on the agreed upon implementation date.
2. Annual Processing Fee - In exchange for delivering the Managed Care Rebate Invoicing Program services described in this SOU, the State of Michigan agrees to reimburse Magellan Medicaid Administration $80,000.000 per year. Michigan's annual fee is $80,000 for the 12 months beginning upon the agreed upon implementation date for the services provided. Payments will be made on a monthly basis in the amount of $6,666.67 per month.
3. Staffing to be sufficient to collect, aggregate, invoice, and reconcile payments. The following tiered staffing will be used.

Number of MCO Entities	Staffing
One to four	Data Entry Specialist (1 FTE) Pharmacy Services Analyst (1 FTE)
Five to ten	Data Entry Specialist (1 FTE) Pharmacy Services Analysts (2 FTEs)
Eleven or more	Data Entry Specialist (1 FTE) Pharmacy Services Analysts (3 FTEs)

The program will start on the first month of the quarter in which rebates are invoiced.

Attachment A

FirstRebate™ Claim Layout

The standard Magellan Medicaid Administration Claim File Data Format to support Rebate Billing for the MCO Managed Care Rebate Invoicing Program is shown in the following table. A Tag File is required to validate transmission record count for claims. "ST" will be replaced with the State abbreviation in file name. The file naming convention is ST_RBTEXT_YYYYMMDD.TXT.

Number	Column Name	Type and Size	Start	End	Description	Defaults
1.	CLIENT_ID	INTEGER (4)	1	4	Client ID. Please populate with 0003.	Required
	FILLER	CHAR(1)	5	5	Space is the delimiter	Required
2.	ICN	CHAR (20)	6	25	Claim number	Required
	FILLER	CHAR(1)	26	26	Space is the delimiter	Required
3.	CLAIM_LINE_NO	INTEGER (4)	27	30	Claim line number	Required
	FILLER	CHAR(1)	31	31	Space is the delimiter	Required
4.	STATUS	CHAR (1)	32	32	O - Original V - Void	Required
	FILLER	CHAR(1)	33	33	Space is the delimiter	Required
5.	YRQTR	CHAR (5)	34	38	Year and Quarter the claim is applied. For Void claims, YRQTR would be the same as the original claim. YYYYQ	Required
	FILLER	CHAR(1)	39	39	Space is the delimiter	Required

Number	Column Name	Type and Size	Start	End	Description	Defaults
6.	NDC	CHAR (11)	40	50	National Drug Code	Required for Pharmacy
	FILLER	CHAR(1)	51	51	Space is the delimiter	Required
7.	UNITS	DECIMAL(12, 3)	52	65	Metric decimal quantity of NDC dispensed. +123456789.123 or -123456789.123	Required
	FILLER	CHAR(1)	66	66	Space is the delimiter	Required
8.	PAID_AMT	DECIMAL(11, 2)	67	79	Total amount to be paid by the claims processor. +123456789.12 or -123456789.12	Required
	FILLER	CHAR(1)	80	80	Space is the delimiter	Required
9.	BILLED_AMT	DECIMAL(11, 2)	81	93	Provider submitted +123456789.12 or -123456789.12	Required
	FILLER	CHAR(1)	94	94	Space is the delimiter	Required
10.	PROVIDER_ID	CHAR (15)	95	109	National Provider Identifier for the billing provider (e.g. pharmacy or medical provider)	Required
	FILLER	CHAR(1)	110	110	Space is the delimiter	Required
11.	PRESCRIB_PROV	CHAR (15)	111	125	Prescribing provider for pharmacy claims	Required
	FILLER	CHAR(1)	126	126	Space is the delimiter	Required
12.	DATE_OF_SERVICE	SMALLDATETIME	127	136	Date of service- fill date of claim MM/DD/YYYY	Required
	FILLER	CHAR(1)	137	137	Space is the delimiter	Required
13.	RECIPIENT_ID	CHAR (15)	138	152	Patient ID	Required
	FILLER	CHAR(1)	153	153	Space is the delimiter	Required
14.	RX_NBR	CHAR (10)	154	163	Prescription Number	Required for Pharmacy Optional for JCODE
	FILLER	CHAR(1)	164	164	Space is the delimiter	Required
15.	PROC_CODE	CHAR (7)	165	171	Procedure code for medical claims (HCPC)	Required for JCODE Optional for Pharmacy

Number	Column Name	Type and Size	Start	End	Description	Defaults
	FILLER	CHAR(1)	172	172	Space is the delimiter	Required
16.	TPL_AMT	DECIMAL(11, 2)	173	185	Third party paid amount. +123456789.12 or -123456789.12	Required
	FILLER	CHAR(1)	186	186	Space is the delimiter	Required
17.	COPAY_AMT	DECIMAL(11, 2)	187	199	Amount to be collected from a patient due to a per prescription co-pay/co-insurance. +123456789.12 or -123456789.12	Required
	FILLER	CHAR(1)	200	200	Space is the delimiter	Required
18.	PAID_DATE	SMALLDATETIME	201	210	Date claim was paid MM/DD/YYYY	Required
	FILLER	CHAR(1)	211	211	Space is the delimiter	Required
19.	DATE_RECVD	SMALLDATETIME	212	221	Date claim was received (loaded) by Magellan Medicaid Administration. MM/DD/YYYY Unique date for the whole extract/file when it was created	Required
	FILLER	CHAR(1)	222	222	Space is the delimiter	Required
20.	DAW	CHAR (1)	223	223	Dispense as written indicator	Required
	FILLER	CHAR(1)	224	224	Space is the delimiter	Required
21.	COMPOUND_IND	CHAR (1)	225	225	Y or N	Required; Default to 'N' if not a compound claim
	FILLER	CHAR(1)	226	226	Space is the delimiter	Required
22.	EXCLUSION_RSN	CHAR (1)	227	227	Magellan Medicaid Administration defined field.	
	FILLER	CHAR(1)	228	228	Space is the delimiter	Required
23.	DAYS_SUPPLY	INTEGER(4)	229	232	The number of days of therapy that the claimed drugs will supply.	Required
	FILLER	CHAR(1)	233	233	Space is the delimiter	Required
24.	SOURCE_CD	CHAR (3)	234	236	Claim Source POS = Point of Sale JCD = Medical	Required
	FILLER	CHAR(1)	237	237	Space is the delimiter	Required

Number	Column Name	Type and Size	Start	End	Description	Defaults
25.	DISPENSE_FEE	DECIMAL(5, 2)	238	244	Dispensing fee submitted by pharmacy. +123.12 or -123.12	Optional
	FILLER	CHAR(1)	245	245	Space is the delimiter	Required
26.	REFILL_CD	CHAR (2)	246	247	Provider submitted fill number	Optional
	FILLER	CHAR(1)	248	248	Space is the delimiter	Required
27.	INVOICE_YR QTR	CHAR (5)	249	253	Year and quarter claim is paid or voided. YYYYQ; Derive based on paid date	Required
	FILLER	CHAR(1)	254	254	Space is the delimiter	Required
28.	PROGRAM_ID	CHAR (3)	255	257	Unique ID to distinguish different Client Use MIO	Required
	FILLER	CHAR(1)	258	258	Space is the delimiter	Required
29.	GROUP_ID	VARCHAR(15)	259	273	Recipient Group Code Group Associated to a Recipient ID	Optional
	FILLER	CHAR(1)	274	274	Space is the delimiter	Required
30.	FUND_CODE	VARCHAR (2)	275	276	Funding source	Optional
	FILLER	CHAR(1)	277	277	Space is the delimiter	Required
31.	TOWN_CODE	CHAR(4)	278	281	Recipient/Provider city code In case of a Future Report	Optional
	FILLER	CHAR(1)	282	282	Space is the delimiter	Required
32.	LOCATION_CODE	CHAR (2)	283	284	MCO entity (see attachment B below)	Required
	FILLER	CHAR(1)	285	285	Space is the delimiter	Required
33.	ORIGINAL_PROVIDER_ID	CHAR (15)	286	300	Provider ID prior to NPI implementation. For void claims the ID of the original claims (NABP/Medicaid/NPI)	Required

Tag File

A Tag File is a small text file that contains information about a specific data file. A Tag File must accompany each data file transmitted to Magellan Medicaid Administration's Rebate staff in order for MMA to catalogue and process the data content included in the submission.

Magellan Medicaid Administration only processes data files and tag files in pairs. Orphaned data files or Tag Files will not be processed.

The data supplier should provide the following content in the Tag Files:

Field Name	Data Type	Size	Comments	Defaults
Record count	Integer	10	Identifies the number of records included in the data content file	
Filler	Char	1	Pipe(|) is the delimiter	
Transmission Date	Char	10	Identifies the date the file was sent	
Filler	Char	1	Pipe(|) is the delimiter	
Contact Name	Char	30	Provides contact name information that can be used for follow up in the event of problems reading or interpreting the data content file.	
Filler	Char	1	Pipe(|) is the delimiter	
Contact Phone	Char	12	Provides contact phone information that can be used for follow up in the event of problems reading or interpreting the data content file.	
Filler	Char	1	Pipe(|) is the delimiter	
Contact Email	Char	30	Provides contact email information that can be used for follow up in the event of problems reading or interpreting the data content file.	
Filler	Char	1	Pipe(|) is the delimiter	
Comments	Char	50	Provides space for comments regarding the data content, such as data type, or special instructions, etc.	

Attachment B

Location Code	MCO Entity
01	BlueCaid of Michigan
02	CareSource of Michigan
03	Great Lakes Health Plan
04	Health Plan of Michigan
05	HealthPlus Partners, Inc.
06	McLaren Health Plan
07	Midwest Health Plan
08	Molina Healthcare of Michigan
09	Omnicare Health Plan
10	Physicians Health Plan of Mid-Michigan - Family Care
11	Priority Health Government Programs, Inc.
12	ProCare Health Plan
13	Total Health Care
14	Upper Peninsula Health Plan

FirstRebate™ Provider Layout

The standard Magellan Medicaid Administration Provider Data Format to support Rebate Billing for the Managed Care Rebate Invoicing Program is shown in the following table. "ST" will be replaced with the State abbreviation in the file name. The file naming convention is ST_RBPROV_YYYYMMDD.TXT. A Tag File is required to validate transmission record count for claims.

Field Name	Data Type	Size	Comments	Defaults
Client ID	Integer	4	Magellan Medicaid Administration assigned client id number	Magellan Medicaid Administration assigned client ID number Please populate with _0003__
Filler	Char	1	Semi colon is the delimiter	Required
Provider ID	Char	15	The NPI Pay-to-provider for medical claims. What If I do not have an NPI? Medicaid # can be	Required

Field Name	Data Type	Size	Comments	Defaults
			sent.	
Filler	Char	1	Semicolon is the delimiter	Required
Name	Char	50	Provider Name (e.g. Pharmacy or Medical Provider)	Required
Filler	Char	1	Semicolon is the delimiter	Required
Address 1	Char	50	Provider Mailing Address	Required
Filler	Char	1	Semicolon is the delimiter	Required
Address 2	Char	50	Provider	Optional
Filler	Char	1	Semicolon is the delimiter	Required
City	Char	30	Provider City	Optional
Filler	Char	1	Semicolon is the delimiter	Required
State - Abbreviation	Char	2	Provider State	Optional
Filler	Char	1	Semicolon is the delimiter	Required
ZIP Code	Char	9	Provider ZIP Code	Optional
Filler	Char	1	Semicolon is the delimiter	Required
Phone No.	Char	10	Provider Phone Number	Optional

Tag File

A Tag File is a small text file that contains information about a specific data file. A Tag File must accompany each data file transmitted to Magellan Medicaid Administration Rebate staff in order for Magellan Medicaid Administration to catalogue and process the data content included in the submission.

Magellan Medicaid Administration only processes data files and Tag Files in pairs. Orphaned data files or Tag Files will not be processed.

The data supplier should provide the following content in the Tag Files:

Field Name	Data Type	Size	Comments	Defaults
Record count	Integer	10	Identifies the number of records included in the data content file	
Filler	Char	1	Pipe(|) is the delimiter	
Transmission Date	Char	10	Identifies the date the file was sent	
Filler	Char	1	Pipe(|) is the delimiter	

Field Name	Data Type	Size	Comments	Defaults
Contact Name	Char	30	Provides contact name information that can be used for follow up in the event of problems reading or interpreting the data content file.	
Filler	Char	1	Pipe(|) is the delimiter	
Contact Phone	Char	12	Provides contact phone information that can be used for follow up in the event of problems reading or interpreting the data content file.	
Filler	Char	1	Pipe(|) is the delimiter	
Contact Email	Char	30	Provides contact email information that can be used for follow up in the event of problems reading or interpreting the data content file.	
Filler	Char	1	Pipe(|) is the delimiter	
Comments	Char	50	Provides space for comments regarding the data content, such as data type, or special instructions, etc.	

Form No. DMB 234 (Rev. 1/96)
AUTHORITY: Act 431 of 1984
COMPLETION: Required
PENALTY: Contract will not be executed unless form is filed

STATE OF MICHIGAN
DEPARTMENT OF TECHNOLOGY, MANAGEMENT AND BUDGET **July 23, 2010**
PURCHASING OPERATIONS
P.O. BOX 30026, LANSING, MI 48909
OR
530 W. ALLEGAN, LANSING, MI 48933

CHANGE NOTICE NO. 1
TO
CONTRACT NO. 071B0200069
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF CONTRACTOR	TELEPHONE (508) 562-2655 **Donna M. Mellen**
Magellan Medicaid Administration **4300 Cox Road** **Glen Allen, VA 23060** **dmmellen@magellanhealth.com**	BUYER/CA (517) 241-4225 **Kevin Dunn**
Contract Compliance Inspector: Laura Dotson (517.241.4686) **Pharmacy Benefits Manager Services (PBM) for Medicaid and Other Michigan Department of Community Health (DCH) Programs - DCH**	
CONTRACT PERIOD: From: **April 1, 2010** To: **March 31, 2013**	
TERMS **N/A**	SHIPMENT **N/A**
F.O.B. **N/A**	SHIPPED FROM **N/A**
MINIMUM DELIVERY REQUIREMENTS **N/A**	
MISCELLANEOUS INFORMATION:	

NATURE OF CHANGE(S):

Effective July 1, 2010, First Health Services Corporation will officially operate under the name of Magellan Medicaid Administration. The Contractor address and FEIN will remain the same.

All other terms, conditions, specifications, and pricing remain unchanged.

AUTHORITY/REASON:

Per Contractor request (letter dated 5/17/2010), and DTMB/Purchasing Operations' approval.

CURRENT AUTHORIZED SPEND LIMIT REMAINS: $20,506,944.00

Form No. DMB 234 (Rev. 1/96)
AUTHORITY: Act 431 of 1984
COMPLETION: Required
PENALTY: Contract will not be executed unless form is filed

STATE OF MICHIGAN
DEPARTMENT OF MANAGEMENT AND BUDGET
PURCHASING OPERATIONS
P.O. BOX 30026, LANSING, MI 48909
OR
530 W. ALLEGAN, LANSING, MI 48933

December 7, 2010

NOTICE
TO
CONTRACT NO. 071B0200069
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF CONTRACTOR **First Health Services Corporation** **4300 Cox Road** **Glen Allen, VA 23060** **dmmellen@cvty.com**	TELEPHONE (508) 562-2655 **Donna M. Mellen** BUYER/CA (517) 241-4225 **Kevin Dunn**
Contract Compliance Inspector: Laura Dotson (517.241.4686) **Pharmacy Benefits Manager Services (PBM) for Medicaid and Other Michigan Department of Community Health (DCH) Programs - DCH**	
CONTRACT PERIOD: From: **April 1, 2010** To: **March 31, 2013**	
TERMS **N/A**	SHIPMENT **N/A**
F.O.B. **N/A**	SHIPPED FROM **N/A**
MINIMUM DELIVERY REQUIREMENTS **N/A**	
MISCELLANEOUS INFORMATION:	

The terms and conditions of this Contract are those of RFP #071I9200185, this Contract Agreement and the Contractor's quote dated 6/30/2009. In the event of any conflicts between the specifications, and terms and conditions, indicated by the State and those indicated by the Contractor, those of the State take precedence.

Current Authorized Spend Limit: $20,506,944.00

Form No. DMB 234 (Rev. 1/96)
AUTHORITY: Act 431 of 1984
COMPLETION: Required
PENALTY: Contract will not be executed unless form is filed

STATE OF MICHIGAN
DEPARTMENT OF MANAGEMENT AND BUDGET
PURCHASING OPERATIONS
P.O. BOX 30026, LANSING, MI 48909
OR
530 W. ALLEGAN, LANSING, MI 48933

CONTRACT NO. 071B0200069
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF CONTRACTOR	TELEPHONE (508) 562-2655 **Donna M. Mellen**
First Health Services Corporation **4300 Cox Road** **Glen Allen, VA 23060** **dmmellen@cvty.com**	BUYER/CA (517) 241-4225 **Kevin Dunn**

Contract Compliance Inspector: Laura Dotson (517.241.4686)

Pharmacy Benefits Manager Services (PBM) for Medicaid and Other Michigan Department of Community Health (DCH) Programs - DCH

CONTRACT PERIOD:	From: **April 1, 2010**	To: **March 31, 2013**

TERMS	SHIPMENT
N/A	**N/A**
F.O.B.	SHIPPED FROM
N/A	**N/A**

MINIMUM DELIVERY REQUIREMENTS
N/A

MISCELLANEOUS INFORMATION:

The terms and conditions of this Contract are those of RFP #071I9200185, this Contract Agreement and the Contractor's quote dated 6/30/2009. In the event of any conflicts between the specifications, and terms and conditions, indicated by the State and those indicated by the Contractor, those of the State take precedence.

Current Authorized Spend Limit: $20,506,944.00

THIS IS NOT AN ORDER: This Contract Agreement is awarded on the basis of our inquiry bearing the RFP #071I9200185. Orders for delivery may be issued directly by the Department of Community Health through the issuance of a Purchase Order Form.

FOR THE CONTRACTOR:	**FOR THE STATE:**
First Health Services Corporation Firm Name	Signature
	Sergio Paneque, Director **DMB Business Services Administration**
Authorized Agent Signature	Name/Title
	Purchasing Operations
Authorized Agent (Print or Type)	Division
Date	Date

STATE OF MICHIGAN
Department of Management and Budget
Purchasing Operations

Contract Number 071B0200069

Pharmacy Benefits Manager Services (PBM)
for Medicaid and Other Michigan Department of Community Health Programs

Buyer Name: Kevin Dunn
Telephone Number: (517) 241-4225
Email Address: dunnk3@michigan.gov

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DEFINITIONS

"24x7x365" means 24 hours a day, seven days a week, and 365 days a year (including the 366th day in a leap year).

"Additional Service" means any Services/Deliverables within the scope of the Contract, but not specifically provided under any Statement of Work, that once added will result in the need to provide the Contractor with additional consideration.

"Audit Period" has the meaning given in **Section 2.112.**

"Blanket Purchase Order" is an alternate term for Contract and is used in the State's computer system.

"Business Critical" means any function identified in any Statement of Work as Business Critical.

"Business Day," whether capitalized or not, shall mean any day other than a Saturday, Sunday or State-recognized legal holiday (as identified in the Collective Bargaining Agreement for State employees) from 8:00 a.m. Eastern Time through 5:00 p.m. Eastern Time unless otherwise stated.

"Chronic Failure" is defined in any applicable Service Level Agreements.

"Days" means calendar days unless otherwise specified.

"Deleted/Not Applicable" means that section is not applicable or included in this Contract. This is used as a placeholder to maintain consistent numbering.

"Deliverable" means physical goods and/or commodities as required or identified by a Statement of Work.

"DMB" means the Michigan Department of Management and Budget.

"Excusable Failure" has the meaning given in **Section 2.244.**

"Hazardous Material" means any material defined as hazardous under the latest version of federal Emergency Planning and Community Right-to-Know Act of 1986 (including revisions adopted during the term of the Contract).

"Incident" means any interruption in Services.

"ITB" is a generic term used to describe an Invitation to Bid. The ITB serves as the document for transmitting the RFP to potential bidders.

"Key Personnel" means any Personnel designated in **Section 1.031** as Key Personnel.

"New Work" means any Services/Deliverables outside the scope of the Contract and not specifically provided under any Statement of Work, that once added will result in the need to provide the Contractor with additional consideration.

"PO" means purchase order.

"Recycling" means the series of activities by which materials that are no longer useful to the generator are collected, sorted, processed, and converted into raw materials and used in the production of new products. This definition excludes the use of these materials as a fuel substitute or for energy production.

"Reuse" means using a product or component of municipal solid waste in its original form more than once.

"RFP" means a Request for Proposal designed to solicit proposals for services.

"Services" means any function performed for the benefit of the State.

"Source Reduction" means any practice that reduces the amount of any hazardous substance, pollutant, or contaminant entering any waste stream or otherwise released into the environment prior to recycling, energy recovery, treatment, or disposal.

"SOW" means statement of work.

"State Location" means any physical location where the State performs work. State Location may include state-owned, leased, or rented space.

"Subcontractor" means a company that the Contractor delegates performance of a portion of the Services to, but does not include independent contractors engaged by Contractor solely in a staff augmentation role.

"Unauthorized Removal" means the Contractor's removal of Key Personnel without the prior written consent of the State.

"Waste prevention" means source reduction and reuse, but not recycling.

"Waste Reduction" or "Pollution Prevention" means the practice of minimizing the generation of waste at the source and, when wastes cannot be prevented, utilizing environmentally sound on-site or off-site reuse and recycling. The term includes equipment or technology modifications, process or procedure modifications, product reformulation or redesign, and raw material substitutions. Waste treatment, control, management, and disposal are not considered pollution prevention, per the definitions under Part 143, Waste Minimization, of the Natural Resources and Environmental Protection Act (NREPA), 1994 PA 451, as amended.

"Work in Progress" means a Deliverable that has been partially prepared, but has not been presented to the State for approval.

"Work Product" refers to any data compilations, reports, and other media, materials, or other objects or works of authorship created or produced by the Contractor as a result of or in furtherance of performing the services required by this Contract.

PROJECT-SPECIFIC DEFINITIONS

"ABW" means Adult Benefits Waiver, a Department program which provides healthcare benefits for Michigan's childless adult residents (age 18 through 64) with an annual income at or below 35 percent of the Federal Poverty Level (FPL). Covered services and maximum co-payments for beneficiaries in this eligibility category are detailed in the Michigan Provider Manual. Unless noted in Medicaid provider-specific chapters, service coverage and authorization requirements for the fee-for-service beneficiaries enrolled in the ABW program mirror those required for Medicaid. Only those providers enrolled to provide services through the Michigan Medicaid program may provide services for fee-for-service ABW Beneficiaries.

"Beneficiary" refers to an individual who has healthcare coverage through Medicaid, Adult Benefits Waiver, or other Department programs.

"CMS" means the Centers for Medicare & Medicaid Services of the United States Department of Health and Human Services.

"COB" means Coordination of Benefits which refers to the mechanism used to designate the order in which multiple carriers are responsible for benefit payments and, thus, prevents of duplicate payments.

"County Health Plan" or "CHP" means County-Administered Health Plan for the Adult Benefit (ABW). ABW beneficiaries enrolled in CHPs are subject to the requirements of the respective CHP. In those counties operating nonprofit CHPs, all covered services for ABW beneficiaries must be provided through the health plan. CHPs administering the ABW program are required to provide the services noted in the Coverage and Limitations Section of the Adult Benefits Waiver chapter of the Medicaid Provider Manual. CHP providers rendering services to ABW beneficiaries enrolled in a CHP are not required to enroll as providers in the Medicaid program, but they must comply with all Medicaid provider requirements as detailed in the Medicaid Provider Manual.

"Cost Avoidance" means a claims processing edit, which rejects a claim, when there is an identified liable third party.

"CSHCS" means Children's Special Health Care Services, created under Title V of the Social Security Act. Only those providers enrolled to provide services through the Michigan Medicaid Program may provide services for fee-for-service CSHCS beneficiaries.

"DDI" means Design, Development and Implementation phase.

"DEA" means Drug Enforcement Administration.

"Department" means the Michigan Department of Community Health or its successor responsible for administration of the pharmacy programs described in this Contract. When any work or deliverables listed in this document specify *notify the Department, approved by the Department*, etc., the Contractor must contact the Project Manager or other designated-Department staff as agreed upon during the Design, Development, and Implementation (DDI) phase of the Contract.

"Dispensing Fee" refers to payment for filling a prescription and all related services performed by a pharmacist.

"Dual Eligibles" refers to persons who are entitled to Medicare (Part A and/or Part B) and who are also eligible for Medicaid.

"DUR" means Drug Utilization Review which refers to a process designed to ensure that prescriptions are appropriate, medically necessary and not likely to result in adverse medical outcomes.

"EFT" means Electronic Funds Transfer.

“First DataBank” is a drug pricing and information service as described at www.FirstDataBank.com.

“Federal Drug Rebate Program” refers to the program established by the Omnibus Budget Reconciliation Act of 1990 (OBRA 90), which requires labelers to sign a rebate agreement with CMS in order to have their products covered for Medicaid beneficiaries. State Medicaid agencies administer the program and collect rebates from the Labelers.

“FFP” means Federal Financial Participation.

“FFY” means Federal Fiscal Year, which refers to the one-year period used by the Federal government for accounting purposes that begins October 1 and ends September 30 of the following calendar year.

“FPL” means Federal Poverty Level.

“HCIdea™” refers to the National Council for Prescription Drug Programs (NCPDP) prescriber information relational database which includes DEA numbers, National Provider Identifiers (NPIs), State licenses numbers and renewal dates.

“HCPCS” means Healthcare Common Procedure Coding System.

“HIPAA” refers to the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191) and its regulations at 42 CFR §§ 160 through 164, as amended. A federal law enacted in 1996 that allows the U.S. Department of Health and Human Services to establish and mandate the use of : a) national standards for electronic healthcare transactions; b) national identifiers for providers, health plans and employers, and c) security and privacy of health information. When referenced in this Contract it includes all related rules, regulations, orders, notifications, and procedures.

“LTC” means Long-Term Care. “LTC Pharmacy” refers to pharmacies specializing in the provision of drugs and services in institutional settings such as a nursing facility, medical care facility or hospital long term care unit.

“MAC” means Maximum Allowable Cost which refers to the maximum cost allowed rate by MDCH for certain multiple-source brands, generics, cross-licensed drugs and sometimes for sole-source drugs or classes.

“MDCH” means the Michigan Department of Community Health.

“Medicaid” refers to the healthcare coverage program, created in 1965 by Title XIX of the Social Security Act, which provides healthcare coverage for low-income people and long-term care coverage for low-income elderly. Coverage groups include: pregnant women and children; members of families with a dependent child; those who are disabled or blind, or those age 65 or older. Medicaid is regulated by the U.S. Department of Health and Human Services (DHHS) through the Centers for Medicare & Medicaid Services (CMS) and is jointly funded by the federal government and the states. The Michigan Department of Community Health is designated the single state agency responsible for administering this program in Michigan.

“Medicaid Health Plan” or “MHP” means Medicaid Health Plan which refers to a Medicaid managed care plan that provides medical assistance through the delivery of covered services to beneficiaries and that holds a Comprehensive Health Care Program Medicaid Contract with the State of Michigan.

“MMIS” means Medicaid Management Information System which refers to a CMS approved system that supports the operation of the Medicaid program. The MMIS includes the following types of sub-systems or files: beneficiary eligibility, Medicaid provider, claims processing, pricing, Surveillance and Utilization Review Subsystem (SURS), Management and Administrative Reporting Subsystem (MARS).

“MOMS” means Maternity Outpatient Medical Services, a program that covers pregnant women who have family incomes up to 185 percent of the Federal Poverty Level or who are covered by the Medicaid Emergency Services Only program. The MOMS program covers outpatient pregnancy-related and inpatient delivery-related services. Only those providers enrolled to provide services through the Michigan Medicaid program may provide services for fee-for-service MOMS beneficiaries.

“MPPL” means Michigan Pharmaceutical Product List, which identifies covered pharmaceutical products, related prior authorization, and other utilization controls. The MPPL coverage may vary for each of the Department’s programs or be limited by age, clinical parameters, and gender.

“NCPDP” means National Council for Prescription Drug Programs which is an American National Standard Institute (ANSI)-accredited group that maintains a number of standard formats for use by the retail pharmacy industry; some of which have been adopted as HIPAA standards.

“NDC” means National Drug Code which refers to the eleven-digit code assigned to prescription and over-the-counter products by the labeler/manufacturer of the product under U.S. Food and Drug Administration (FDA) regulations.

“NPI” means National Provider Identifier which refers to a HIPAA-mandated standard identifier for all healthcare providers.

“P&T Committee” means Pharmacy and Therapeutics Committee.

“PA” means Prior Authorization.

“PBM” means Pharmacy Benefits Manager or Pharmacy Benefits Management.

“PDL” means Preferred Drug List.

“PERM” means Payment Error Rate Measurement.

“Pharmacy Claims Processing Manual” refers to the Pharmacy Claims Processing Manual for the Michigan Department of Community Health.

“*Plan First!*” is a Federal Section 1115 Waiver, approved in 2006, for a single-benefit Medicaid family planning program. Family planning benefits are available on a fee-for-service basis to uninsured women age 19 through 44 living in families with income up to 185 percent of the Federal Poverty Level. Only those providers enrolled to provide services through the Michigan Medicaid program may provide services for *PlanFirst!* beneficiaries.

“POS” means point-of-sale which provides real-time on-line adjudication of pharmacy claims submitted to a pharmacy benefits manager. Point of-sale provides participating pharmacies real-time access to beneficiary eligibility, drug coverage and pricing information, guidelines and notifications for drug use, etc.

“ProDUR” means Prospective Drug Utilization Review.

“Provider” refers to a person, firm, corporation, association, agency, institution, or legal entity [e.g., pharmacy] which is providing, has formerly provided, or has been approved to provide health care to a beneficiary under any of the Department’s programs.

“RetroDUR” means Retrospective Drug Utilization Review.

“Sanctioned Provider” means a provider, entity or individual, who has been suspended, terminated or excluded from furnishing, ordering, or prescribing items or services to Medicaid beneficiaries.

“SFY” means State Fiscal Year which refers to the one-year period used by Michigan state government, for accounting purposes, that begins October 1 and ends September 30 of the following calendar year. Michigan’s fiscal year is the same as the federal fiscal year.

“State” means the State of Michigan.

“Supplemental Rebate” means a rebate negotiated by a state and paid by a drug manufacturer to a state for drugs.

"Third Party Administrator (TPA) means an entity who processes claims pursuant to a service contract and who may also provide one or more other administrative services pursuant to a service contract, other than under a worker's compensation self-insurance program pursuant to Section 611 of the Worker's Disability Compensation Act of 1969, 1969 PA 317, MCL 418.611. Third Party Administrator does not include a carrier or employer sponsoring a plan."

“TPL” means Third Party Liability, also called Other Insurance, which refers to an insurance plan or carrier (e.g., individual, group, employer-related, self-insured or self-funded plan), commercial carrier (e.g., automobile insurance and workers’ compensation) or program (e.g., Medicare) that has liability for all or part of a beneficiary’s healthcare coverage.

Article 1 – Statement of Work (SOW)

1.010 Project Identification

1.011 Project Request

This is a Contract for pharmacy benefits manager (PBM) services for the following programs and possible other pharmacy component of future programs administered by the Michigan Department of Community Health (DCH, also known as the "Department").

1. Medicaid fee-for-service and managed care carve-outs for psychotropics and other select drugs
2. Adult Benefits Waiver (ABW) fee-for-service and managed care carve-outs for psychotropics and other select drugs
3. Children's Special Health Care Services (CSHCS)
4. Maternity Outpatient Medical Services (MOMS)
5. Plan First!

The period of November 6, 2009 through March 31, 2010 will be for implementation and transition for the Contractor; no payment will be made to the Contractor during this period. This Contract will be effective April 1, 2010 through March 31, 2013. The Contractor must begin providing all Services, without interruption, on April 1, 2010.

1.012 Background

A. Introduction

The Department is the administrator for Medicaid, ABW, CSHCS, MOMS and *Plan First!* – which cover nearly 1.7 million beneficiaries (Table 1). Each program has different eligibility requirements, benefit designs, and capitated managed care mandates affecting pharmacy coverage. For example, of the 1.6 million Medicaid beneficiaries, approximately 1.0 million receive most prescription drugs through capitated managed care plans except for a carve-out for psychotropics and select other drugs. Another nearly 196,700 beneficiaries dually eligible for Medicare and Medicaid receive most prescription drugs through Medicare Part D and not Medicaid. The next sections describe key pharmacy policies and procedures.

Table 1: State Program Eligibility Counts – Report Week Ending October 1, 2008

Program Code and Description	Eligibles
MEDICAID PROGRAMS [1, 2, 3, 4]	**1,585,606**
A-Medicaid for Aged SSI Beneficiaries	16,288
B-Medicaid for Blind SSI Beneficiaries	1,204
C-Aid to Families with Dependent Children	187,767
E-Medicaid for Disabled SSI Beneficiaries	203,410
I-Refugee Assistance Program	425
J-Refugee Assistance (Medical Only)	388
L-MICH-Care Medicaid and Medicaid for Pregnant Women[3]	526,282
M-Medicaid for the Aged	72,083
N-Medicaid for Caretaker Relatives and Families with Dependent Children	404,377
O-Medicaid for the Blind	1,198
P-Medicaid for the Disabled	114,120
Q-Medicaid for Persons Under 21	58,060
CHILDRENS SPECIAL HEALTH CARE SERVICES	**29,750**
Children's Special Health Care Services with Medicaid (TITLE XIX/TITLEV)	18,007
Children's Special Health Care Services Only (TITLE V)	11,743
ADULT BENEFITS WAIVER PROGRAM	**57,871**
TOTAL	**1,655,220**

[1] Includes 30,419 *Plan First!* enrollments and 5,033 MOMS enrollments

[2] Includes 116,570 spenddown individuals of which 26,520 actually met eligibility requirements

[3] Includes 196,755 beneficiaries enrolled in Medicaid and Medicare, who receive most pharmacy coverage from Part D

[4] Includes over 1.0 million beneficiaries enrolled in capitated Medicaid Health Plans, which administer much of their pharmacy coverage

B. Medicaid Pharmacy

1. ***Fee-For-Service and Capitated Medicaid Health Plan Population*** – Medicaid provides healthcare benefits for low-income children, adults, the elderly and disabled. It is jointly funded by the State and the federal government. Michigan Medicaid benefits are available under a traditional fee-for-service program administered by the Department and under a risk-based capitated model provided by multiple current capitated Medicaid Health Plans (as of April 30, 2009, there are 14 Medicaid Health Plans; however, please note, these services are currently out to bid and the number of Health Plans may vary in the future). Approximately 63 percent of all Medicaid beneficiaries receive their health care through the capitated Medicaid Health Plans. The Medicaid beneficiaries not enrolled in managed care receive fee-for-service coverage. Included are beneficiaries receiving care in institutions or through home and community-based waiver programs (six percent); beneficiaries with spenddown eligibility (five percent); beneficiaries dually eligible for Medicare and Medicaid (six percent); beneficiaries transitioning to a managed care plan (seven percent); beneficiaries located in an area of the State where mandatory managed care enrollment is not in place; beneficiaries who received an exception to managed care enrollment for medical reasons; or beneficiaries enrolled in special Medicaid programs (e.g., *Plan First!*).

2. ***Pharmacy under Capitated Medicaid Health Plans*** – A capitated Medicaid Health Plan has the flexibility to contract with its own PBM and to establish its own pharmacy coverages, reimbursement levels, provider networks, Prior Authorization (PA) requirements, and utilization controls – except for a pharmacy carve-out for psychotropic drugs and other select drugs. There are two types of Medicaid managed care pharmacy carve-outs. First, select drugs are 100 percent carved-out of a health plan's capitation rate and reimbursed under the fee-for-service benefit by the Department's PBM directly to pharmacies. Second, the Medicaid Health Plans act as the Department's fiscal intermediaries and make pharmacy payment to providers for another group of carve-out drugs, applying Medicaid fee-for-service prior authorization (PA) and utilization controls. The Medicaid Health Plans then provide carve-out payment files to the Department's fee-for-service PBM which in turn pays the health plans 60 percent of the rates available under the Medicaid fee-for-service methodology.

3. ***Pharmacy under Fee-For-Service Medicaid*** – Following are other key aspects of the Medicaid pharmacy program. Further detail is available in the Department's Medicaid Provider Manual, bulletins, and Pharmacy Claims Processing Manual for the Michigan Department of Community Health ("Pharmacy Claims Processing Manual").

   a. A ***Preferred Drug List (PDL)*** highlights preferred and non-preferred products of drug classes reviewed by the Department's Pharmacy and Therapeutics (P&T) Committee.
   b. The ***Michigan Pharmaceutical Product List (MPPL)*** identifies covered pharmaceutical products and related PA and other utilization controls. The MPPL coverage may vary for each of the Department's programs or be limited by age, clinical parameters, gender, etc.
   c. ***Dual eligibles***, who are beneficiaries dually eligible for Medicare and Medicaid, receive most of their prescription drugs through Medicare Part D. Medicaid, however, continues to cover some drug classes not covered by Medicare Part D. Examples are select benzodiazepines, over-the-counter drugs, barbiturates, vitamins and minerals, etc. as explained in the Michigan Medicaid Provider Manual and the MPPL.
   d. ***Reimbursement*** is the lower of usual and customary charge or the Department's payment limits for product cost and dispensing fee minus the beneficiary co-payment. If a beneficiary has other insurance or Medicare coverage, the related payments are subtracted from the Department's payment.
   e. ***Product cost payment limits*** are based on the National Drug Code (NDC) the pharmacy identifies as the product dispensed. Reimbursement is the lower of Average Wholesale Price (AWP) minus a discount, the Maximum Allowable Cost (MAC) rate, or the provider's charge (see the Michigan Department of Community Health Medicaid Provider Manual and Bulletins).
   f. ***Dispensing fee limits*** are subject to appropriations authorized by the State's legislature (see the Michigan Department of Community Health Medicaid Provider Manual and Bulletins).
   g. ***Beneficiary co-payments*** are listed in the Michigan Department of Community Health Medicaid Provider Manual and Bulletins.

C. Adult Benefits Wavier (ABW)

ABW coverage is limited to ambulatory benefits for childless adults, age 18 through 64, with incomes up to 35 percent of the Federal Poverty Level (FPL). ABW enrollment was approximately 41,800 adults as of February 2009. New enrollment applications are limited to periodic intervals throughout the year. The annual average enrollment for ABW is 62,000 beneficiaries. The majority of this enrollment received care through one of 27 capitated County Health Plans. A County Health Plan has the flexibility to contract with its own PBM and establish its own pharmacy coverages, reimbursement levels, provider networks, PA, and utilization controls – except for an ABW pharmacy carve-out for

psychotropic drugs and other select drugs. The carve-out drugs are reimbursed 100 percent under the fee-for-service program by the Department's PBM to pharmacies. ABW fee-for-service drug coverages are listed on the MPPL.

D. Other Pharmacy Programs – CSHCS, MOMS and *Plan First!*

The Department's coverage for these programs is limited to selected drug classes listed on the MPPL. Beneficiaries enrolled in CSCHS, MOMS or *Plan First!* have no pharmacy co-payments. Only those providers enrolled to provide services through the Michigan Medicaid program may provide services for these beneficiaries.

1. ***CSHCS*** pharmacy coverage is different from Medicaid – certain drug classes unrelated to CSHCS qualifying diagnoses may not be covered. When a CSHCS beneficiary also is a Medicaid enrollee, reimbursement for Medicaid covered products is provided. All CSHCS beneficiaries (even those with Medicaid coverage) have no pharmacy co-payments.
2. ***MOMS*** provides outpatient pregnancy-related and inpatient delivery-related services to pregnant women with family income up to 185 percent of the FPL or who are covered by the Medicaid Emergency Services Only program.
3. ***Plan First!*** is a federal Section 1115 waiver program that offers a Medicaid family planning benefit to childbearing women age 19 through 44 with family incomes up to 185 percent of the FPL.

E. Key Program Statistics

Table 2 provides key statistics describing the Department's pharmacy expenditures and PBM services during the State fiscal year (SFY) 2008 (October 1, 2007 through September 30, 2008).

Table 2: Key Statistics for the Department's Pharmacy Programs in SFY 2008

	Volume Estimate
Total Processed Claims	14,751,302
Paid Claims	7,577,784
Total Paid to Pharmacies	$506,652,506
Percent of Processed Point-of-Sale (POS) and Batch Claims	99.9%
Number of Processed Paper Claims	2,300
Enrolled Providers on October 1, 2008	2,784
New Pharmacies Enrolled	121
Pharmacies Disenrolled (without re-enrollment)	188
PA Requests Processed (Approvals, Changes in Therapy, and Denials)	82,870
Percent PAs Processed by Technicians	80%
Percent PAs Processed by Pharmacists	19.8%
Percent PAs Processed through Web-Based PA	0.2%
Technical Center Calls	90,448
Beneficiary Help Line Calls	7,180
Beneficiary Appeals	20

1.020 Scope of Work and Deliverables

1.021 In Scope

"In Scope" tasks associated with this Contract can be summarized broadly under the following three categories. Services and deliverables are identified in Section 1.022 Work and Deliverables and in other sections of Article 1.

Core Requirements – Common to Components 1 and 2

A. General requirements
B. Contractor liability for fiscal sanctions
C. Notifying the Department of requests for records
D. Right to audit
E. Statements of Auditing Standards (SAS) 70 Level II
F. Contractor quality assurance
G. Disaster recovery plan
H. Privacy and security
I. Identity theft prevention and reporting

Component 1 – Claims Processing and Related Services

J. Mandatory minimum requirements for claims processing and related services
K. Claims Processing
L. HIPAA compliance – transactions and code sets
M. Reimbursement and benefit design
N. Third Party Liability (TPL) and Coordination of Benefits (COB)
O. Provider relations
P. Call centers and help lines
Q. Maximum Allowable Cost (MAC) administration
R. Prior Authorization (PA)
S. Drug Utilization Review (DUR)
T. Clinical pharmacy support services for claims processing and related services
U. Electronic prescribing
V. Appeals – provider and beneficiary
W. Audit trails for claims processing and related services
X. Validation of accurate pricing and claims coverage
Y. Claims processing corrective action plan

Component 2 – PDL and Manufacturer Drug Rebate Administration

Z. Mandatory minimum requirements for PDL and manufacturer drug rebates
AA. Pharmacy and Therapeutic (P&T) Committee
BB. Formulary maintenance
CC. Clinical pharmacy support services for PDL and manufacturer drug rebates
DD. Manufacturer drug rebate administration
EE. Audit trails for PDL and manufacturer drug rebates
FF. Contractor's manual and documentation maintenance for PDL and manufacturer drug rebates

1.022 Work and Deliverables

The Contractor must provide deliverables/services and staff, and otherwise do all things necessary for or incidental to the performance of work, as set forth below. The work and deliverables described in this section are grouped into the following three categories:

- Core Requirements, Common to Components 1 and 2.
- Component 1 – Claims Processing and Related Services; and
- Component 2 – PDL and Manufacturer Rebate Administration.

Note: Numbering is continuous throughout the above three categories; however, various **underlined** headings and ***italicized*** sub-headings group work and deliverables under general topics.

CORE REQUIREMENTS – COMMON TO BOTH COMPONENTS 1 AND 2

A. General Requirements

Requirements:

11. The Contractor must provide an existing pharmacy claims processing system and related services or PDL and manufacturer drug rebate administrative services and provide necessary system design, modification, and implementation to interface properly with all current and future information systems used or contracted by the Department at no additional cost to the Department including, but not limited to, the following:

    a. Implement changes in covered populations and programs;
    b. Cooperate with any current or future vendor for the Department's pharmacy programs and implement needed or required functionality; and
    c. Implement any new functionality of the Department's Medicaid Management Information System (MMIS) related to Contract work or deliverables.

12. Any upgrade or modification required within the Contractor's central site hardware, systems software, or online application software during this Contract must be made at no additional cost to the Department. The Contractor must provide the Department a minimum of five business days notice prior to any such updates and modifications. If the POS processing, manufacturer drug rebate invoicing, or other performance will be impacted, the Department's

prior approval is required. Such prior approval does not exempt the Contractor from any performance guarantees or Service Level Arguments (SLAs) listed in this Contract.

13. The Contractor must use weekly updated data from First DataBank, at no additional cost to the Department, for the following work and deliverables. If needed data is unavailable from First DataBank, the Contractor must recommend and utilize a replacement source, as approved by the Department, at no additional cost.

    a. Process claims and perform other PBM services;
    b. Price claims based on Average Wholesale Price (AWP), Wholesaler Acquisition Cost (WAC), Manufacturer Direct Price or any other current or future rates available from First DataBank; and
    c. Provide reporting and other functionality specified by the Department.

14. If the Contractor uses another source (e.g., First DataBank) and not the Centers for Medicare and Medicaid Services (CMS) to identify approved manufacturers participating in the federal Medicaid drug rebate program or to identify termination dates of NDCs; the Contractor must verify the alternative source's data with the CMS data files available at www.cms.hhs.gov/MedicaidDrugRebateProgram. When discrepancies exist, the Contractor must use data as reported in the CMS files or CMS rebate notices for the Department's required work and deliverables.

B. Contractor Liability for Fiscal Sanctions

Requirements:

15. If any State or federal agency or court of law imposes fiscal sanctions against the Department as a result of the Contractor's or any Subcontractor's action or inaction; the Contractor will be liable and must compensate the Department any and all amounts lost by the Department because of the imposition of the State or federal agency or court of law sanctions. The Contractor's liability will include:

    a. All costs associated with correcting erroneous payments, including costs for re-processing, back-out processing, distribution of corrections, and so forth; and
    b. All costs related to loss of Federal Financial Participation (FFP) between the enhanced FFP for administrative services and the FFP actually received by the Department including any losses due to lack of or loss of MMIS certification.

C. Notifying the Department of Requests for Information

Requirements:

16. The Contractor must notify the Department within 24 hours of any beneficiary, provider, or other individual or entity requesting information on the Contractor's work and deliverables under this Contract.

D. Right to Audit

Requirements:

The Contractor must comply with the requirements listed in Section 2.110 Records and Inspections and with the following:

17. The Contractor and any Subcontractors must cooperate with audits by Department staff, other State departments, the United States Department of Health and Human Services, State or federal designees, or others authorized to perform audits relating to the work and deliverables rendered by the Contractor and any Subcontractors. Contractor and Subcontractor audit support must include, but is not limited to, the following:

    a. Enable read and copy access to files, documentation, and personnel including inventory control files; recipient master files; formulary, diagnosis and procedure files; provider master files; all pricing files; intermediate files; adjudicated claims file; all software and operating manuals; all documentation along with rules, regulations, memos, internal reports, training manuals, and detail design documentation;
    b. Enable access to computer resources including, but are not limited to, all application programs and libraries, all system programs and libraries, the operating system along with job accounting and software;
    c. Notify audit staff within 24 hours of any changes made to computer programs and edit logic between processing runs related to audit activities;
    d. Provide the ability to retrieve and print claims, remittance advices, and requests for exemptions from Medicaid utilization thresholds; and
    e. Provide the personnel and resources necessary for automated or manual sampling of claims and reference file data including the retrieval of historical data.

18. The Contractor must notify the Department within 24 hours of any federal agent presenting on-site in a Contractor's facility or requesting by mail, telephone, or email to discuss, view or audit work and deliverables related to this Contract.

E. Statements of Auditing Standards (SAS) 70 Level II

Requirements:

19. The Contractor and any Subcontractors, at their expense, must have an annual independent audit that conforms to American Institute of Certified Public Accounting's (AICPA) Statements of Auditing Standards (SAS) 70 Level II. The SAS-70 Level II requirement is a review and actual test of the claims processing and rebate systems and their controls. The audit must include procedures and tests that the auditor(s) considers necessary under the circumstances to evaluate the design of the control procedures and to evaluate the operating effectiveness of those control procedures.

20. The Department reserves the right to designate the organization that conducts the audit examination and the time period to be covered by the examination.

21. The Department, at its sole discretion, may waive or modify a Contractor's or a Subcontractor's annual independent audit requirement upon a written request from the Contractor or Subcontractor.

22. The Contractor must provide the Department its and any Subcontractor's annual SAS 70 Level II audit report in an agreed-upon format within 30 days after the examination is complete or on or before the first business day of August in each year of this Contract, whichever occurs first.

23. As requested by the Department, the Contractor must provide the Department progress reports of its and any Subcontractor's corrective actions plans needed to address identified deficiencies.

F. Contractor Quality Assurance

Requirements:

24. The Contractor must develop and implement quality management and assurance using best practices consistent with industry standards, principles, and processes including, but not limited to:

    a. Recurring process reengineering evaluation;
    b. Continuous performance measurement and improvement through the use of technical reviews, internal audits, and Contractor Satisfaction Surveys; and
    c. Ongoing Contractor staff training.

25. The Contractor must conduct Contractor Satisfaction Surveys with the Department at least biannually, or as specified by the Department. The Department, in its sole discretion, may modify these requirements. The Contractor's surveys must include, but are not limited to:

    a. Performance inquiries consistent with the duties and responsibilities of the Contractor and any Subcontractor;
    b. Performance expectations and measurement criteria for managing the ongoing long-term business relationship with the Contractor and for monitoring performance; and
    c. Inquiries on technology, quality, responsiveness, delivery, cost and continuous improvement.

26. Subject to review by the Department as needed, the Contractor must implement and document quality assurance processes and procedures to ensure integrity of services and of the processing and storage of the Contractor's data including, but not limited to, the following:

    a. Maintain separate testing environments, emulating the production environment, where users can test systems changes, edits, and pricing without affecting the production systems;
    b. Allow online update and inquiry of all data repositories in the test environment(s) to simulate the production environment;
    c. Generate test results to evaluate the fiscal impact of changed edits or other test conditions;
    d. Validate and document internal systems by balancing input and output data; execute batch jobs appropriately, and generate outputs appropriate for the executed cycle;
    e. Comply with the requirements of the Payment Error Rate Measurement (PERM) program and other quality assurance programs as specified by CMS, the State, and the Department; and
    f. Maintain internal quality control procedures for functionality and data integrity.

27. Contractor must integrate quality assurance functionality including, but not limited to, the following:

    a. Reports of the quantities of system errors by “error type” over a given time period;
    b. Automated test generation tools accessible by the Department; and
    c. Electronic access to current programming codes and detailed database structures.

28. The Contractor must conduct triage with the Department to determine the severity level of deficiencies or defects identified and to determine timelines for fixes or resolutions.

29. The Contractor must provide corrective action plans to the Department within five business days of the discovery of severe defects found through internal quality control reviews and identify options for corrective actions. The Contractor must initiate corrective actions plans, at no additional cost to the Department, only after the written approval of the Department.

G. Disaster Recovery Plan

Requirements:

The Contractor must comply with requirements listed in Section 2.037 Disaster Recovery and with the following:

30. The Contractor solely must maintain adequate backup to ensure continued automated and manual provision of required work and deliverables. The State reserves the right to inspect the Contractor’s disaster recovery backup site(s) and procedures at any time with 24 hour notification to the Contractor.

    a. ***Alternative Operations Site*** – The Contractor must maintain or otherwise arrange for alternate site(s) for its system operations, in particular POS claims processing, in the event a catastrophic or other disastrous event prevents continued operations at the Contractor’s primary site(s).
    b. ***Backup Files and Secure Off-Site Storage*** – The Contractor must maintain off-site storage of transactions, records, and master files.
    c. ***Backup Call Center Support*** – The Contractor must maintain a plan for immediate rollover of the call centers to alternate locations in the event of the disruption of public utilities or other interruptions of the call center or help lines.

H. Privacy and Security

Requirements:

31. The Contractor’s work and deliverables must comply with all applicable State information technology policies and standards including the Michigan Department of Information Technology (MDIT) 1350 Enterprise Security Policy and 1410.17 Michigan State Government Network Security Policy, as applicable.

32. The Contractor must develop a security plan that includes physical security, business continuity, change management, and that identifies all controls for confidentiality, integrity, and availability.

33. The Contractor must have written policies and procedures addressing the use of any protected health data and information that falls under the Health Insurance Portability and Accountability Act (HIPAA) requirements. The policies and procedures must meet all applicable federal and State requirements including HIPAA requirements. These policies and procedures must include restricted access to the protected health data and information by the Contractor’s employees.

34. The Contractor must immediately notify the Department upon learning of any suspected or actual unauthorized use or disclosure of protected health data and information that falls under the HIPAA requirements about which the Contractor becomes aware. The Contractor must work with the Department to mitigate any breach and provide assurances to the Department on corrective actions to prevent future unauthorized uses or disclosures.

35. In accordance with HIPAA requirements, the Contractor is liable for any claim, loss or damage relating to unauthorized use or disclosure of protected health data and information by the Contractor received from the Department or any other source.

36. The Contractor must immediately notify the Department upon learning of any breach of system or data security. Subject to the approval of the Department, the Contractor must undertake such additional safeguards or changes as recommended by a subsequent independent security audit at the Contractor's expense.

37. Failure to comply with any of these contractual requirements may result in a breach of contract notification, per Section 2.151, or the termination of this Contract.

I. Identity Theft Prevention and Reporting

Requirements:

38. In the delivery and provision of information technology hardware, software, systems, and services through this Contract, the Contractor must prevent unauthorized access to the "Identity Information" of any individual. "Identity Information" includes, but is not limited to, an individual's first name or initial and last name, in combination with any of the following:

    a. Social Security Number;
    b. Driver's license number;
    c. System access identification number and associated passwords;
    d. Account information such as account number(s), credit/debit/mihealth card number(s), and/or passwords or security codes.

39. The Contractor must immediately notify the Department upon learning of any unauthorized breach, access, theft, or release of State data containing "Identity Information."

40. For even a single known violation of the identity theft prevention and reporting requirements, the State may terminate for default its Contract(s) and may withhold payment(s) owed to the Contractor in an amount sufficient to pay the cost of notifying individuals of unauthorized access or security breaches.

COMPONENT 1 – CLAIMS PROCESSING AND RELATED SERVICES

J. Mandatory Minimum Requirements for Claims Processing and Related Services

Requirements:

41. The Contractor must have at least two years experience with projects of similar size and scope to the Department's that include customization, implementation, and operation of a Medicaid POS pharmacy claims processing system in compliance with all federal and State regulations, which includes customized eligibility verification, POS edits and transmission messaging, PA, DUR, reimbursement, benefit design, and reporting.

K. Claims Processing

Following are work and deliverables related to Third Party Administrator (TPA) licensure, POS, batch, paper invoice claims processing; Contractor payments to pharmacies and remittance advices; and customized explanation edits, transmission messages, and claims processing logic.

Requirements:

Third Party Administrator (TPA) Licensure

42. The Contractor must be a licensed Third Party Administrator (TPA) in the State of Michigan.

Point-of-Sale (POS) Claims Processing

43. The Contractor must provide a POS claims processing system and ensure its POS claims processing system provides:

    a. Online, real-time operations for receipt, adjudication, and notification to billing providers regarding the disposition of a claim (e.g., as payable, denied, or requiring more information);
    b. Medicaid Management Information System (MMIS) certification by CMS, i.e., the Department's costs must be eligible for 75 percent Federal Financial Participation (FFP) from CMS;
    c. Online POS operations 24x7x365 available no less than 99.9 percent of the time – except for Contractor scheduled downtime approved by the Department; and
    d. Average POS response time of three seconds or less on all transactions (response time means the time from when the claim is received by the Contractor's processor to the time the results are transmitted from the Contractor's processor and includes all procedures required to complete claim adjudication).

44. The Contractor must notify staff designated by the Department of performance issues impacting POS adjudication within 15 minutes of the Contractor's knowledge of the system problems. The Department will provide procedures for after-hours contact during the Design, Development, and Implementation phase of this Contract, if applicable.

45. The Contractor's POS claims processing system must include National Council for Prescription Drug Program (NCPDP) Implementation Guide Scenario 20.9 functionality for Governmental Programs to allow appropriate reimbursement and coordination of a beneficiary's benefits. This requirement includes, but is not limited to claim adjudication using NCPDP fields Other Coverage Code, Patient Paid Amount Submitted, and Other Payer Amount.

46. The Contractor's POS claims processing system must include NCPDP Multi-Ingredient Compound functionality to process compounded claims in accordance with current Department policy and procedures.

47. The Contractor is not required to supply hardware or software to providers, but must support providers in their interaction with the Contractor's POS systems including, but not limited to, the following:

    a. Establish testing procedures;
    b. Coordinate with network vendors to ensure smooth operation of the POS system; and
    c. Certify provider practice management systems (e.g., service bureaus, switches, etc.) as compatible and ready to interface with the Contractor's POS system.

48. The Contractor must not use its position as the Department's pharmacy claims processor to:

    a. Create barriers to value added networks, providers, or pharmacy practice management vendors who wish to participate with the Department's pharmacy programs; or
    b. Levy connection or access charges to value added networks or other switching companies to provide market advantages to any network over another.

49. A Contractor providing POS services for the Department who also performs switching services and billing services must:

    a. Place an organizational "firewall" to separate the Department's functions from the Contractor's services as an agent of providers; and
    b. Maintain the switch and billing agent functions as separate and distinct operations from the Department's work and deliverables.

Batch Electronic Claims Processing

Requirements:

50. The Contractor must process batch electronic claims to allow batch electronic and POS claims to be adjudicated together.

51. The Contractor must appoint a staff coordinator for batch electronic claims processing, who must:

    a. Resolve pharmacy (or their vendor's) questions on batch processing;
    b. Coordinate testing of batch electronic processing as requested by providers or their vendors;
    c. Assign secure File Transfer Protocol (FTP) sites for transmitting batch claims;
    d. Assign batch submitter ID numbers; and
    e. Other related tasks specified by the Department.

52. The Contractor must receive batch electronic claims daily and within 24 hours must process and return required responses to billing providers – except for Contractor scheduled downtime approved by the Department.

Paper Invoice Claims Processing

Requirements:

53. The Contractor must process paper invoice claims to allow paper, batch electronic and POS claims to be adjudicated together - ensuring all pertinent data from the paper invoice claims is added to the Contractor's claims processing system immediately upon processing the Universal Claim Form.

54. The Contractor must process paper claims submitted on the Universal Claim Form within 10 days of receipt.

55. The Contractor must create electronic imaged copies of all paper claims and attachments within 24 hours of receipt.

Contractor Payments to Pharmacies and Remittance Advices

Requirements:

56. The Contractor must provide weekly payments to providers and must comply with Department-specified requirements for financial reporting including, but not limited, to the following:

    a. Submit pharmacy payment invoices to the Department by Thursday at 12:00 noon Eastern Time of each week; and
    b. Make pharmacy payments by Monday at 5:00 p.m. Eastern Time each week.

    Pharmacy payments will be 100 percent funded by the Department via a wire transfer following the Contractor's submission of the weekly pharmacy payment invoice.

57. The Contractor must provide payment by Electronic Funds Transfer (EFT) or paper checks as requested by providers.

58. The Contractor must provide remittance advices electronically or as specified by the Department. The Contractor must base its electronic remittance advices transmissions on HIPAA-mandated transactions and code sets in compliance with HIPAA rules. As updates to the HIPAA transaction sets become available and are mandated, the Contractor must continue to be in compliance and, at no additional cost to the Department, the Contractor must:

    a. Implement the updated version; and
    b. Maintain compatibility with pharmacies using the previous version elements and those pharmacies using the updated version(s), according to the timeline approved by the Department.

59. The Contractor must register providers and provide log-in identifications, passwords, and other information necessary for providers to access the Contractor's File Transfer Protocol (FTP) site to download files.

60. The Contractor must send pending balance notices to providers quarterly and adhere to the Department's pending balance collection procedures and other related Department instructions. Pending balance collection procedures will be provided during the Design, Development and Implementation phase of this Contract.

Customized Explanation Edits, Transmission Messages, and Claims Processing Logic
Requirements:

61. The Contractor's claims processing system must be capable of adding, changing, or removing adjudication rules, edits, and customized transmission messages to accommodate Department-required changes for its current and future pharmacy programs. To fulfill this scope of work, at no additional cost to the Department, the Contractor capabilities must include, but not be limited to, the following:

    a. Audit trails tracking additions, changes, and deletions to the Contractor's adjudication rules by date of service and date of payment; and
    b. Adjudication rules customized for each of the Department's programs by program codes within Medicaid; managed care status; beneficiary age and sex; ambulatory, long-term care or hospice setting; drug or drug class; managed care status; Medicare-Medicaid dual eligible status and other criteria specified by the Department.

62. The Contractor's claims processing system must have functionality to provide unique edit and claims processing logic as specified by the Department for each of its individual programs including, but not limited to, the following:

    a. ***Prescriber Validation*** – Validate the prescriber entry on the claim using either a National Provider (NPI) check digit or an HCIdea National Provider Identifier Lookup from the NCPDP, as specified by the Department;
    b. ***Co-Payments*** – Calculate different co-payment amounts for different pharmacy programs, for different drugs, and for beneficiaries based on age or any other specifications provided by Department;
    c. ***Prior Authorization (PA) Requirements*** – Edit for drugs requiring PA or by-pass PA requirements when authorization is granted for the date of dispensing or automated authorization is allowed based on pharmacy or medical claims history files;
    d. ***Diagnosis-Specific Requirements*** – Edit for drugs requiring submission of specific diagnosis codes;
    e. ***Age-Specific Requirements*** – Edit for drugs requiring specific beneficiary age restrictions, as approved by the Department;
    f. ***Managed Care*** – Edit billings for beneficiaries enrolled in managed care to determine whether a particular drug is carved-out of the managed care capitation rate and eligible for 100 percent or 60 percent fee-for-service reimbursement;

g. ***Other Reference Files*** – Apply Department-specified payment criteria based on First DataBank and other reference files designated by the Department;
h. ***Preferred Drug List and Other Formulary Requirements*** – Deny payment for non-covered drugs based on the table of Department-approved Generic Sequence Numbers (GSNs), or NDCs, or drug classes not covered by a beneficiary's pharmacy program and notify the provider through an online, real-time response when a drug is not covered. Exceptions must be allowed based on Department-approved PA criteria; step therapy criteria; and grandfathered exceptions;
i. ***Authorized Prescribers*** – Limit payment for selected drugs, classes, or specific Department programs to authorized prescribers as designated by the Department;
j. ***Compounded Drugs*** – Capture, edit, and adjudicate compounded drug claims as specified by the Department;
k. ***Quantity, Days Supply, and Frequency of Service*** – Validate claims to assure that the quantity of services is consistent with the Department's policy (i.e., verify drug specific minimum and maximum quantity limitations are followed including any days supply limitations and frequency limitations);
l. ***Benefit Restrictions*** – Impose pharmacy benefits restrictions that apply to a given recipient including, but not limited to: benefit restrictions based on the beneficiary monitoring program, living arrangements (e.g., ambulatory versus long-term care settings), managed care status, and eligibility for the Department's different pharmacy programs;
m. ***Approved Manufacturers*** – Deny payment for drugs distributed by manufacturers not participating in the federal manufacturer drug rebate program, except as directed by the Department for specific pharmacy programs or products;
n. ***Proposed Less-Than-Effective Drugs*** – Deny payment for drugs that the federal government has identified as proposed less-than-effective under the Drug Efficacy Study Implementation (DESI) program and as identical, related, or similar to such drugs;
o. ***Other CMS-Restricted Drugs*** – Deny payment for any drug that CMS identifies as restricted;
p. ***Out-Of-State Providers*** – Allow payment when out-of-state providers meet the Department's reimbursement criteria for out-of-state or beyond borderland providers, as specified by the Department; and
q. ***Sanctioned Providers*** – Deny payment for sanctioned providers (e.g., pharmacies or prescribers) designated by the federal government and the State.

63. The Contractor's claims processing system must provide POS customized transmission response messages as specified by the Department for its current or future programs including, but not limited to, the following:

a. Bill Health Plan [name] and [phone number];
b. Covered for CSHCS and End-Stage Renal Disease only;
c. Bill Medicare Part B;
d. Bill Medicare Part D [name] and [phone number];
e. Program has no pharmacy benefit;
f. Bill as Medical Supplier;
g. Drug not covered – included in long-term care per diem rate;
h. Doctor not authorized, pharmacy not authorized, doctor/NDC not authorized, or pharmacy/NDC not authorized related to the Beneficiary Monitoring Program; and
i. No prescriptions allowed for prescriber.

L. <u>HIPAA Compliance – Transactions and Code Sets</u>

Requirements:

64. The Contractor must comply with requirements listed in Section 1.070 Additional Terms and Section 2.210 Governing Law and in particular must note its electronic transactions and code sets, received and transmitted, must fully comply with HIPAA requirements in effect on the date of this Contract start date and with any subsequent additions or amendments. To fulfill this scope of work, at no additional cost to the Department, the Contractor must:

a. Submit an impact analysis to the Department within 30 days of the publishing of a proposed HIPAA rule;
b. Submit an implementation plan for acceptance by the Department within 30 days of the publishing of a final or modified HIPAA rule; and
c. Implement future HIPAA rules published during this Contract according to the timeframes in the HIPAA rule or as specified by the Department.

65. The Contractor must base its POS transmissions and batch electronic transmissions on NCPDP and other HIPAA-mandated transactions and code sets. As additions and updates to HIPAA transactions and code sets become

available and are mandated, the Contractor must continue to be in compliance and, at no additional cost to the Department, the Contractor must:

a. Implement new and updated HIPAA transactions and code sets; and
b. Maintain compatibility with pharmacies using the previous version data elements and those providers using the updated version(s), according to the timeline approved by the Department.

66. The Contractor's functionality must include, but not be limited to, B1 (Billing); B2 (Reversal), and B3 (Re-Bill) transaction types, and others specified by the Department. The Pharmacy Claims Processing Manual lists the Department's current mandatory, situational, and optional segments for the B1, B2, and B3 transaction types.

M. Reimbursement and Benefit Design

Following are work and deliverables related to general reimbursement and benefit design; managed care carve-out of psychotropics and select drugs; CSHCS; and the beneficiary monitoring program – pharmaceutical lock-in.

General

Requirements:

67. The Contractor must pay pharmacy claims for the Department's current programs and any future programs consistent with the Department's coverage and reimbursement policies and procedures specified in the Michigan Medicaid Provider Manual, the Pharmacy Claims Processing Manual, MPPL, and other Department notifications. The Department's current programs are:

a. Medicaid Fee-For-Service (including Medicaid Health Plan managed care carve-outs);
b. ABW (including ABW County Health Plan managed care carve-outs);
c. CSHCS;
d. MOMS; and
e. Plan First!

68. The Contractor must provide functionality to apply different reimbursement logic or benefit coverages as specified by Department including, but not limited to, the following:

a. ***Dispensing Fee Payments*** based on program type, generic and brand name drugs, compounded drugs, specialty drugs, infusion therapy, beneficiaries residing in a nursing facility, program type, etc.
b. ***Product Cost Payments*** based on program type, managed care carve-out percentage, pharmacy type (e.g., pharmacies with one to four stores, pharmacies with five or more stores), generic and brand name drugs, specialty drugs, infusion therapy, etc.
c. ***Beneficiary Cost Sharing*** based on program or program code, managed care status, beneficiary age, drug or drug class, Medicare-Medicaid dual eligibility, and beneficiaries residing in a nursing facility, etc.
d. ***Drug Coverages and Prior Authorization*** based on program or program code, managed care status, beneficiary age, drug or drug class, Medicare-Medicaid dual eligibles, beneficiaries residing in a nursing facility, etc.
e. ***Utilization Controls*** based on program or program code, managed care status, beneficiary age, drug or drug class, Medicare-Medicaid dual eligibles, beneficiaries residing in a nursing facility, etc.
f. ***Managed Care Pharmacy Carve-Outs*** based on program eligibility (e.g., Medicaid, ABW, etc.), percent of reimbursement (i.e., 60 percent, 100 percent), etc.

69. As requested by the Department and at no additional cost, the Contractor must process:

a. Post-payment claim reversals for pharmacy claims, such as TPL adjustments and other adjustments; and
b. Financial gross adjustments to pharmacy payments, such as corrective actions identified from post-payment audit findings and other adjustments.

Managed Care Carve-Out for Psychotropic and Other Select Drugs

Requirements:

70. The Contractor must process claims for the managed care 100 percent carve-out for Medicaid Health Plans and ABW County Health Plans in accordance with Department-specified requirements including, but not limited to, the following:

a. Reimbursing pharmacies – not Medicaid Health Plans or ABW County Health Plans – for the managed care 100 percent carve-out drug classes as approved by the Department;

b. Setting payment at the rates under the Medicaid or ABW fee-for-service methodology; and
c. Providing the Department a file of Medicaid and ABW managed care 100 percent carve-out claims, as specified by the Department.

71. The Contractor must process batch electronic claims for the managed care 60 percent carve-out in accordance with Department-specified requirements including, but not limited to, the following:

a. Set payment at 60 percent of the rates under the Medicaid fee-for-service methodology; and
b. Provide Medicaid Health Plans payment only for carve-out drug classes as approved by the Department; and
c. Utilize select claims processing edits separate from those used for the Medicaid fee-for-service program.

72. The Contractor must design, develop, and implement a plan to transition batch electronic managed care 60 percent carve-out claims to POS claims processing including, but not limited to, the following:

a. Discuss options with the Medicaid Health Plans and their PBMs that would allow the 60 percent carve-out claims to be transmitted directly to the Contractor via POS claims processing;
b. Present a plan to the Department for implementation; and
c. Implement the Department-approved plan working with the PBMs of the Medicaid Health Plans.

Children's Special Health Care Services Program (CSHCS)
Requirements:
73. The Contractor's claims processing system must deny prescription payment for CSHCS-only beneficiaries, as stipulated by the Department, when the prescriber is not listed as authorized on the beneficiary's eligibility record. Exceptions include, but are not limited to:

a. The prescription's cost is less than the payment amount specified by the Department;
b. The billed drug falls into Department-exempted therapeutic classes;
c. Other implementation criteria as specified by the Department; and
d. This program may not occur on the same DDI timeline and will be determined post award by the Department.

Beneficiary Monitoring Program (Pharmaceutical Lock-In)
The Department established the Beneficiary Monitoring Program to conduct surveillance and utilization review of Medicaid fee-for-service beneficiaries. The Pharmaceutical Lock-In is a control mechanism used for beneficiaries who are identified as abusing/misusing drug(s) that are identified by the Department as subject to abuse (see the MDCH Medicaid Provider Manual). The Department is responsible for approving all utilization management targeting protocols and Medicaid beneficiary Pharmaceutical Lock-In candidates. Any and all overrides for Beneficiary Monitoring Program beneficiaries must be authorized by the Department's Office of Medical Affairs.

Requirements:
74. The Contractor must coordinate the Pharmaceutical Lock-In control mechanism of the Beneficiary Monitoring Program including, but not limited to, the following:

a. Implement claims processing customized editing and transmission messaging for the Lock-In Program;
b. Identify beneficiaries in the claims processing system using beneficiary eligibility files and State Program Integrity Unit information; and
c. Provide information to the Department on the lock-in program activities including, but not limited to, current prescription utilization and costs per lock-in beneficiary as requested.

N. <u>Third Party Liability (TPL) and Coordination of Benefits (COB)</u>
Following are work and deliverables related to general TPL/COB and COB for mail order pharmacy coverage from another insurer.

Requirements:
General
75. The Contractor's claims processing system must validate claims to determine whether there is a liable third party that must be billed prior to billing the Department's programs including, but not limited to, the following:

a. Denying payment for claims when a beneficiary is covered by one or more carriers until the billing provider indicates the claim has been fully adjudicated (paid or denied) by the other payer(s);

b. Utilizing the Department's TPL data and eligibility records to ensure that all payment opportunities are exhausted;
c. Processing claims where multiple third parties are liable;
d. Overriding COB editing as specified by the Department;
e. Maintaining indicators to identify Medicare Part B drugs and process the claim balance remaining after subtracting the Medicare Part B payment for beneficiaries dually enrolled in Medicare and any of the Department's programs;
f. Coordinating benefits automatically with all primary payers including capturing and storing the primary payer's data; and
g. Obtaining maximum cost avoidance and reimbursement for beneficiaries covered by third parties.

76. The Contractor's claims processing system must have functionality to report TPL plan information to billing providers when another payer is primary (or available) including, but not limited to:

a. Payer names, identifiers, addresses, and trading partner information; and
b. The payer's Bank Identification Number (BIN) and Processor Control Number (PCN).

Coordination of Benefits (COB) for Mail Order Pharmacy Coverage from Another Insurer
The Department encourages mail order pharmacies to submit mail order co-payment claims electronically. However, in the past some mail order pharmacies have refused to coordinate benefits, so the Department developed a mechanism to ensure beneficiaries use the maximum benefit available under their primary insurance and following with the mail order pharmacy rules. The current mechanism involves beneficiaries completing a Department mail order co-payment reimbursement form. A claim is created based on the details on the form and submitted to the POS system for processing. If the claim processes successfully, following normal POS claim processing rules, the allowed payment is mailed to the requesting beneficiary or his/her guardian. There is an average of 215 mail order co-payment claims processed each month.

Requirements:
77. The Contractor and its claim processing system must be able to support the Department's current COB process for mail order pharmacy coverage from another insurer (described above).

O. <u>Provider Relations</u>
Following are work and deliverables related to provider enrollment; provider website; and provider manuals for claims processing and related services.

Provider Enrollment
Requirements:
78. The Contractor must develop and maintain a provider enrollment process for the Department including, but not limited to, the following actions:

h. Provide online provider enrollment to prospective pharmacy providers;
i. Review and approve completed provider enrollment applications;
j. Update pharmacy provider eligibility;
k. Disenroll pharmacy providers, when appropriate;
l. Re-enroll all pharmacy providers within the Department's network every three years;
m. Assure all pharmacy provider files maintain accurate updated information; and
n. Provide customer service to pharmacy providers regarding enrollment.

79. The Contractor must review and process all applications for enrollment from pharmacy providers according to the Department's requirements including, but not limited to, the following:

i. Capture the information included on the Department's Pharmacy Provider Enrollment & Trading Partner Agreement form which will be provided during the Design, Development and Implementation phase of the Contract;
j. Verify pharmacy licensure;
k. Assure the provider enrollment file indicator for independent and chain pharmacies is applied appropriately to support product cost reimbursement logic according to the Department's policy;
l. Assure the provider enrollment file includes an indicator for long-term-care pharmacies;
m. Include an indicator for out-of-state/beyond borderland providers;
n. Inform providers about limitations on payment for services;

o. Search the federal sanction databases to verify sanctions do not exist for individuals or entities (e.g., owners, managing employees) identified in the enrollment application; and
p. Review monthly reports to ensure accuracy of the provider enrollment files.

80. At the direction of the Department, the Contractor must deny enrollment or disenroll providers including pharmacies found to be under federal or State sanction. In the event a pharmacy is to be disenrolled, the Contractor must inactivate the pharmacy within its system and prohibit reimbursement to the disenrolled provider.

81. The Contractor must provide web-based provider enrollment functionality including initial enrollment, reenrollment, and updates to enrollment information in compliance with the Department's policies and procedures for electronic signatures that will be provided during the Design, Development, and Implementation phase of this Contract.

82. The Contractor must provide customer support services for provider enrollment including, but not limited to, the following requirements:

f. Maintain a Provider Help Line as indicated in Section 1.022P Call Centers and Help Lines;
g. Develop and maintain a pharmacy application guide to assist pharmacies in the enrollment process;
h. Develop and maintain an internal enrollment processing manual;
i. Notify a pharmacy in writing to confirm successful enrollment in the Department's programs or provider network; and
j. Notify a pharmacy in writing in the event the Contractor is unable to enroll a provider, or where disenrollment is to occur, indicating the cause for the unsuccessful enrollment or disenrollment and instructions for subsequent actions.

The Department will provide a copy of the current internal enrollment processing manual and provider enrollment extract file during the Design, Development, and Implementation phase of this Contract.

83. The Contractor must research any undelivered provider mail and make reasonable attempts to identify a new address for such providers.

Provider Website

Requirements:

84. The Contractor must provide website support, updates, and maintenance customized to meet the needs of the Department guaranteeing any data exchange on its website between the Contractor and the Department or providers will be secure.

85. The Contractor must update its websites maintained for the Department after the content of such updates has been approved by the Department. The Contractor's postings to its website must include, but not be limited to:

m. Special updates and urgent alerts to providers to ensure there are no interruptions to beneficiary access to care;
n. Drug Utilization Review (DUR) Board meeting schedules, meeting agendas and notices, meeting minutes, member contact information, Prospective DUR (ProDUR) edits;
o. Pharmacy and Therapeutics (P&T) Committee meeting schedules, meeting agendas and notices, meeting minutes, member contact information, procedures for public comment requests, workgroup assignments and recommendations;
p. Other Department-designated committee activities;
q. Provider forms and reference policies or links to forms and policies, if applicable;
r. Drug information including the Michigan Preferred Drug List (PDL) summary document, Michigan Pharmaceutical Product List (MPPL), managed care carve-out lists, special drug policies, Maximum Allowable Cost (MAC) policies and prices, frequently asked questions from manufacturers or providers;
s. Manuals including the Pharmacy Claims Processing Manual and links to the Michigan Medicaid Provider Manual;
t. Bulletin updates issued by the Department;
u. Special provider policies and requirements including e-prescribing support;
v. Web-based educational programs on the PDL, DUR, and other topics specified by the Department;
w. Web-based provider enrollment including initial enrollment and updates to enrollment information; and
x. Web-based PA requests.

Provider Manuals for Claims Processing and Related Services
The Department will provide current versions of required during the Design, Development, and Implementation phase of this Contract.
Requirements:

86. Contractor must keep current electronic versions of Department-approved manuals including, but not limited to, the following:

    d. Pharmacy Claims Processing Manual which must include instructions on POS, batch, and paper claims processing and be posted on the Internet;
    e. Provider Enrollment Manual; and
    f. Batch Claim Submission Requirement for Michigan Department of Community Health – Medicaid Health Plan Billings for Selected Carve-Out Drug Classes.
    d. The Contractor must maintain and update, on an on-going basis, the manuals, and submit them to the Department for approval, prior to implementation of revisions.

P. <u>Call Centers and Help Lines</u>
Requirements:

87. The Contractor must maintain telephone access in support of technical and business operations. The Contractor must maintain call center services and help lines to respond to claims inquiries, PA, questions and problems regarding operations, and for provider and beneficiary support. The Contractor must supply all required information systems, telecommunications, and personnel to perform these operations. Each of the following help lines must be available through a designated telephone number:

    f. ***Technical Help Line*** available toll-free 24x7x365 to respond to questions on coverage, claims processing and beneficiary eligibility;
    g. ***Clinical Help Line*** (including toll-free telephone and toll-free fax access) available toll-free from at least 7:00 a.m. to 7:00 p.m. Eastern Time, Monday through Friday, to handle PA requests from prescribers, and to address coinsurance payments, drug dispensing questions, or other requests from pharmacies;
    h. ***Beneficiary Help Line*** available toll-free 24x7x365 to respond to inquiries from beneficiaries on general pharmacy coverage, pharmacy locations, or other beneficiary requests;
    i. ***MAC Help Line*** (including toll-free telephone and toll-free fax access) from at least 8:00 a.m. to 5:00 p.m. Eastern Time, Monday through Friday, except designated State holidays, to address providers, Department staff, and others questions on the MAC rates; changes in product availability; and
    j. ***Provider Relations Help Line*** available from at least 8:00 a.m. to 5:00 p.m. Eastern Time, Monday through Friday, except designated State holidays, to support pharmacy enrollment, pharmacy EFT requests, and other services or inquiries.

88. The Contractor must provide operational and customer service that is scalable to meet the Department's future needs and includes, but is not limited to, the following:

    a. An automated call distribution voice-response system;
    b. A voice message system to receive calls after business hours;
    c. Capacity to handle all telephone calls at all times including times of peak call volume and to meet the Department's needs and performance expectations with acceptable call completion and abandonment rates;
    d. Management tracking and reporting capabilities;
    e. A Quality Assurance program that includes call sampling and follow up to confirm efficient handling and caller satisfaction;
    f. Language translation services;
    g. Call response from individuals with hearing or visual impairments;
    h. Access to a pharmacist consultant 24 hours a day;
    i. A reference document with guidelines on how to handle caller inquiries; and
    j. A backup system available to operate in the event of line trouble or other problems.

89. The Contractor must comply with the following performance standards for the technical, clinical, beneficiary, MAC, and provider relations help lines.

    a. ***Average Speed of Answer*** – Answer incoming calls, on average, within 30 seconds or less, and
    b. ***Call Abandonment Rate*** – Ensure an average call abandonment rate of 5 percent or less.

90. Upon this Contract's termination, the Department reserves the right to have the Contractor release the toll-free phone numbers used during the course of this Contract to another vendor for use during a subsequent contract. This request will not obligate the Contractor to costs and fees of the subsequent contract. If the Contractor is unable to release the toll-free phone numbers, the Contractor must provide an automated message for each toll-free line provided during the course of this Contract. The automated message, which must be operational for four months, must direct callers to new phone numbers, as directed by the Department.

91. The Contractor must provide a general toll-free line available from at least 8:00 a.m. to 5:00 p.m. Eastern Time, Monday through Friday for Department staff to contact Contractor staff.

Q. Maximum Allowable Cost (MAC) Administration

Requirements:

92. The Contractor must administer the Department's MAC program, by setting rates on:

    a. Multiple-source generic and brand products (both prescription and over-the-counter);
    b. Select supply products including, but not limited to: condoms, syringes, intravenous therapy and irrigation solutions;
    c. Select single-source drugs or drug classes including, but not limited to: antihemophilic factors, prenatal vitamins, potassium replacement supplements, and growth hormone; and
    d. Any products as specified by the Department.

93. The Contractor must set MAC rates on all multiple-source drugs rated as therapeutic equivalents (A-rated) according to the FDA Approved Drug Products with Therapeutic Equivalence Evaluations (the Orange Book), unless otherwise directed by the Department.

94. The Contractor must comply with the requirements in Sections 1.070 Additional Terms and 2.210 Governing Law; and in particular must refer to:

    a. Provisions as specified in the Department's fiscal year 2008-2009 Appropriations Act, requiring MAC pricing for generic drugs be based on wholesaler pricing to providers that is available from at least two wholesalers who deliver in the State of Michigan; and
    b. Requirements explained at www.cms.hhs.gov/reimbursement for Federal Upper Limits and Medicaid Prescription Drugs under DRA (the Deficit Reduction Act of 2005).

95. The Contractor must monitor the Department's MAC rates daily to assure products are available at the MAC rates and are appropriate estimates of providers' actual acquisition costs.

96. The Contractor must publish weekly additions, deletions, and revisions to the MAC rates on a Contractor-maintained website.

97. The Contractor must notify the Department at least 10 business days prior to placing a MAC rate on a product, when a MAC has never been previously placed on that product.

98. The Contractor must ensure the Department's MAC rates when compared with Federal Upper Limit (FUL) rates published by CMS, in aggregate, do not exceed FUL rates for CMS-specified products including, but not limited to, taking the following actions:

    a. Monthly compare the Department's Medicaid expenditures and utilization on CMS-specified FUL products to what would have been paid if the FUL rates were used;
    b. Prepare a monthly summary report of findings for the Department; and
    c. Prepare an action plan within ten business days of becoming aware that the Department's Medicaid expenditures exceeded, in aggregate, projected expenditures if the FUL rates had been used.

99. The Contractor must provide toll-free telephone and toll-free fax numbers for providers, Department staff, and others to reach the Contractor with questions on the MAC rates, changes in product availability, etc. The telephone line must be available at least 8:00 a.m. to 5:00 p.m. Eastern Time, Monday through Friday, except designated State holidays. A voice message system must be in place to receive calls after business hours. The toll-free fax number must be available 24x7x365.

100. The Contractor must implement and maintain a provider contact and problem resolution tracking system. The system must, at a minimum, document and track contacts with providers, identify issues and describe problem resolution. The Contractor must review the data submitted by providers, obtain any corroborating information, and prepare an analysis of the issues. The analyses must be reviewed with Department staff at regularly scheduled meetings.

R. Prior Authorization (PA)

Following are work and deliverables related to PA processing, PA policies and procedures manual, and PA database management system.

PA Processing

Requirements:

101. The Contractor must manage and operate a PA process for the Department that:

    a. Complies with the requirements of Sections 1.070 Additional Terms and 2.210 Governing Law; and in particular, the Contractor must refer to the provisions of Michigan Public Acts 248 and 250 of 2004; and
    b. Allows flexibility to implement different PA requirements for each of the Department's existing (or future) programs.

102. The Contractor must comply with all Department PA requirements including a mandate that a provider telephone hotline must be:

    a. Accessible 24x7x365 – except for Contractor downtime approved in advance by the Department; and
    b. Compatible with real-time electronic editing of medication requests based on paid claims history, beneficiary eligibility, and reference medical data supplied to the Contractor.

103. The Contractor's PA processing must support toll-free telephone, toll-free facsimile, mail, and web-based requests from in-state and out-of-state providers.

104. The Contractor must integrate, process, and track web-based PAs with requests received through other means (e.g., fax, phone, other PA format).

105. As approved by the Department, the Contractor must have functionality to automatically override PA requirements during POS processing based on data available from pharmacy claims paid by the Contractor and on medical claims history files provided by the Department to the Contractor.

106. The Contractor must notify staff designated by the Department of performance issues impacting PA processing within one hour of the Contractor's knowledge of system problems.

107. The Contractor's PA processing must include a review of the beneficiary's eligibility record to retrieve the following information needed for PA determinations:

    a. Program eligibility;
    b. Long-term care status;
    c. Managed care status;
    d. Existence of authorized prescribers;
    e. Existence of program coverage restrictions; and
    f. Other elements specified and approved by the Department.

108. The Contractor must comply with the following performance standards for PA:

    a. Approve routine PA requests while the requester is still on the telephone;
    b. Respond to requests escalated to the Contractor's pharmacist staff within one hour;
    c. Respond to all other PA requests within 24 hours after receipt; and
    d. Provide the Department access to PA staff from at least 7:00 a.m. to 7:00 p.m. Eastern Time, Monday through Friday, except State holidays.

109. The Contractor must, with the Department's involvement and approval, develop and maintain approved protocols and criteria for processing PA requests including, but not limited to, the following:

    a. Products not listed on the MPPL;
    b. Products listed on the MPPL requiring PA;
    c. Products listed as non-preferred on the Michigan PDL;
    d. Restricted products typically not covered;
    e. Products exceeding the Department's MAC rates;
    f. Prescriptions exceeding utilization controls on age, sex, quantity, and frequency limits; and
    g. Prescriptions not meeting other clinical and technical criteria.

110. The Contractor's PA process must allow determinations based on various data elements identifying drug products including, but not limited to, the following:

    a. The first nine digits of a product's NDC;
    b. First DataBank's Generic Sequence Number (GSN); and
    c. First DataBank's Hierarchical Ingredient Code Sequence (HICSeq).

111. The Contractor must ensure PA requests meeting Department-approved protocols and criteria must result in immediate approval. Others not meeting Department-approved protocols and criteria must be expedited to a registered pharmacist employed by the Contractor to discuss special circumstances with the requesting provider.

112. If a provider's PA request cannot be approved based on Department-approved protocols and criteria, the Contractor must forward the request to designated Department staff for review and action.

113. When PA is denied by the Department, the Contractor must produce and mail a Department-approved letter to the beneficiary, and the Department's appeals unit.

114. The Contractor's letter to the beneficiary must include instructions on how to appeal the decision denying the PA. If an appeal results from a denied PA, the Contractor must coordinate and provide support to the Department and other State personnel who oversee the appeals process.

115. Except for non-covered drug classes, the Contractor must allow for the dispensing of at least a 72-hour supply (or other Department-approved amount) of a drug product in an emergency situation as specified by the Department.

116. The Contractor must continuously review and evaluate PA protocols and criteria, pharmaceutical use, and received requests for the appropriateness of continued PA. The Contractor must analyze historical PA determinations and pharmacy claims data and must provide quarterly recommendations and protocols for PA to the Department and its P&T Committee for review and action.

PA Policies and Procedures Manual

Requirements:

117. The Contractor must maintain an electronic version of a PA policies and procedures manual. The PA policies and procedures manual must include Department-approved product protocols and criteria for PA processing.

    The Department will provide the Contractor the current manual during the Design, Development, and Implementation phase of this Contract.

PA Database Management System

Requirements:

118. The Contractor's database management system must have flexible administrative reporting and capabilities to retrieve and track PA requests and determinations by pharmacy program, beneficiary and by drug.

119. The Contractor must provide a PA database management system which maintains all pertinent information about PA requests and determinations including, but not limited to, the following:

    a. Requesting provider name;
    b. Date and time of request;
    c. Beneficiary identifiers;

d. Requested drug name, strength, form, and quantity;
e. Enrolled Department program of the beneficiary (including managed care carve-out status);
f. Request status (i.e., approved, pended, denied);
g. Reason for denial or exception (e.g., lost or stolen prescription);
h. Authorization begin and end dates;
i. Date and time of action on the request;
j. Authorization of a 72-hour emergency drug supply; and
k. Comprehensive and flexible "free-text" notation functionality.

120. The Contractor's PA database management system must include functionality for the Contractor's staff and Department staff to access the following data using multiple search fields such as beneficiary name, beneficiary identification number, date of authorization, and authorization status code.

a. PA determinations; and
b. Beneficiary paid claims history.

S. <u>Drug Utilization Review (DUR)</u>

Following are work and deliverables related to prospective and retrospective DUR, academic detailing and other educational programs, pharmacy support for DUR activities, and the annual DUR report required by CMS.

Prospective DUR (ProDUR)

Requirements:

121. The Contractor must provide a ProDUR management system, which links to the POS claims processing system to medical and drug history information of the Department's beneficiaries.

122. The Contractor's ProDUR editing process must be reviewed and approved by the Department prior to implementation and must have flexibility to adjust to changes in criteria or procedures, as specified by the Department including, but not limited to, the following:

a. Drug-to-drug interaction, therapeutic duplication, early refill prevention, drug to disease, and other edits requested by the Department in the Contractor's ProDUR management system;
b. Pharmacy overrides for selected ProDUR edits.

123. The Contractor must maintain a list of the ProDUR edits in the Pharmacy Claims Processing Manual.

Retrospective DUR (RetroDUR)

Requirements:

124. The Contractor's RetroDUR management system must have functionality to merge medical service claims provided by the Department with pharmacy claims to identify and monitor drug usage on:

a. Overutilization;
b. Underutilization;
c. Therapeutic duplication;
d. Drug-disease contraindications;
e. Drug-drug interactions;
f. Incorrect drug dosage;
g. Incorrect duration of drug therapy;
h. Drug-induced illness;
i. Beneficiary clinical abuse and drug misuse;
j. Therapeutic appropriateness; and
k. Other criteria identified by the Department or its DUR Board.

125. The Contractor's RetroDUR management system must have pharmacist oversight and include data warehouse analytic/reporting tools, clinical rules, algorithms, and profiling including, but not limited to, the following:

a. Identify prescribing and utilization patterns which fall outside best practice guidelines;
b. Alert prescribers by letter of potential drug therapy problems among their beneficiaries including therapeutic duplication, drug-disease contraindications, incorrect drug dosage or duration, drug-induced illness, or clinical abuse and beneficiary misuse; and

c. Review at least 600 beneficiary profiles monthly and determine which warrant further action, (e.g., sending letters to prescribers, beneficiaries and pharmacies), unless instructed otherwise by the Department.

126. The Contractor must develop and maintain RetroDUR therapeutic criteria tables which provide quantitative significance values or severity ratings for therapeutic exception standards. The Contractor must collect RetroDUR claims data and apply the criteria tables monthly.

127. The Contractor must update RetroDUR files and criteria tables as recommended by the DUR Board within 10 business days of the Department's approval.

Academic Detailing and Other Educational Programs

Requirements:

128. The Contractor's academic detailing program must comply with, but is not limited to, the following requirements and capabilities:

a. Train its academic detailers as agreed upon and approved by the Department;
b. Provide at least 130 face-to-face encounters quarterly with prescribers or pharmacies throughout all geographic areas of the State;
c. Perform, at least quarterly, an automated periodic review of claims data and other records to identify patterns of fraud, abuse, overuse, or inappropriate or medically unnecessary care among prescribers, pharmacies, beneficiaries or on claims associated with specific drugs or drug groups; [This review must involve pattern analysis using predetermined standards of prescribing practices and drug use by individual beneficiaries along with integrating pharmacy data with hospital, practitioner, laboratory, and other healthcare medical data provided by the Department.]
d. Identify and monitor beneficiaries and providers who have been found to exhibit verified drug use or prescribing aberrations;
e. Profile beneficiaries and providers for possible face-to-face intervention and provider education using criteria recommended by the DUR Board and approved by the Department; and
f. Track academic detailing feedback and activities in a web-based application that is accessible to designated Department staff.

129. The Contractor must provide academic detailing in conjunction with an organization which is capable of providing a team of Michigan-licensed pharmacists who are subject matter experts in academic detailing.

130. The Contractor's academic detailing face-to-face meetings with the Department's healthcare providers must include, at a minimum, topics related to ProDUR and RetroDUR, PDL, PA, and other beneficiary-specific issues. The Contractor's academic detailing team may also meet with healthcare provider groups, providing education that is not beneficiary specific.

131. The Contractor must develop and implement an effective educational program to address current pharmacy coverages and any future changes. Both the Contractor's educational program and printed materials must include Department-approved topics and must focus on prescribers, pharmacies, and beneficiaries. It must commence on a mutually agreed upon date and continue throughout this Contract. The Contractor's educational program must include, but is not limited to, the following:

a. MPPL;
b. P&T Committee;
c. PDL and its therapeutic drug classes;
d. PA criteria and procedures;
e. Best practice guidelines;
f. Beneficiary-specific prescribing patterns; and
g. Compliance with claims processing and editing requirements.

132. The Contractor must obtain feedback and evaluation from providers after its face-to-face interventions with them including, but not limited to, post-intervention follow up through phone and web-based tools.

Pharmacy Support for DUR Activities

Requirements:

133. The Contractor must facilitate DUR board meetings and prepare Department-approved meeting materials including, but not limited to, the following actions:

    a. Prepare and distribute meeting agendas to DUR Board members;
    b. Post meeting agendas on the website required under this Contract;
    c. Record meeting minutes and forward them to the Department within 10 business days after the meeting; and
    d. Post meeting minutes on the Contractor's website.

134. The Contractor must provide monthly and quarterly DUR summary reports to the Department and DUR Board as specified by the Department.

135. The Contractor must conduct regular program review; facilitate quarterly evaluations of focused ProDUR and RetroDUR criteria and interventions; recommend draft standards and criteria; and implement approved changes including, but not limited, to the following actions:

    a. Conduct literature reviews related to its ProDUR and RetroDUR activities and report findings to the Department and DUR Board regularly;
    b. Present findings to the Department and DUR Board including educational material on supportive clinical research, protocols, and financial analyses for drug therapies and their indications and use research models such as control-comparison groups or repeated time series to assess the effectiveness of current ProDUR and RetroDUR practices;
    c. Implement DUR Board recommended changes after Department approval; and
    d. Generate educational materials for prescribers, pharmacies, and beneficiaries to support Department-approved interventions.

136. The Contractor must provide a pharmacist consultant to manage and direct the Department's DUR program and act as the Contractor's representative at the DUR Board meetings.

137. The Contractor must monitor and report on the outcomes of its academic detailing and other DUR educational efforts quarterly or as otherwise specified by the Department.

Annual DUR Report Submitted to CMS

Requirements:

138. The Contractor must draft and finalize the CMS annual DUR report with the Department as described in Section 1927(g)(3)(D) of the Social Security Act and the required cost savings analysis including, but not limited to, the following:

    a. Provide the draft CMS-required DUR Annual Report to the Department on or before April first of each year;
    b. Incorporate any changes recommended by the Department into the CMS annual report;
    c. Perform additional research requested by the Department; and
    d. Provide the final CMS-required DUR Annual Report to the Department on or before June first of each year.

T. <u>Clinical Pharmacy Support Services for Claims Processing and Related Services</u>

Requirements:

139. The Contractor must provide the services of a clinical pharmacist manager to proactively research, analyze, present findings, and advise the Department, its P&T Committee, and its DUR Board on topics requested by the Department including, but not limited to:

    a. POS claims processing;
    b. PA requirements, protocols, and staffing;
    c. Prescription spending trends focusing on the Department's programs and on national trends;
    d. Reimbursement strategies for product costs, dispensing fees, and beneficiary cost sharing;
    e. Cost containment strategies;
    f. ProDUR;
    g. RetroDUR; and
    h. Educational materials for DUR and academic detailing initiatives.

140. The Contractor must continuously research, analyze, and proactively present findings to the Department on utilization management strategies and pharmacy policies including evaluation and identification of areas of improvement for both clinical impact and cost effectiveness of the Department's programs.

141. The Contractor must prepare discussion packages and coordinate meetings (by conference call) with the Department. The Contractor must hold weekly meetings (or less frequently if requested by the Department) including, but not limited to, the following topics:

    a. PA, PDL, and other clinical issues;
    b. MAC rates;
    c. POS claims processing and operations; and
    d. Managed care carve-outs and operations.

U. Electronic Prescribing

Requirements:

142. The Contractor must work with the Department to meet the goals of the Department for electronic prescribing and for providing prescribers and pharmacies information promoting electronic prescribing including, but not limited to, the following:

    a. Background on www.GetRxConnected.com and www.RxSuccess.com; and
    b. Other best practices, communication tools, and resources.

143. The Contractor must provide electronic prescribing companies (e.g., SureScripts-RxHub) access to the following data for the Department's various programs:

    a. Beneficiary eligibility;
    b. Formulary;
    c. Drug claims history; and
    d. Other Department-specified data.

V. Appeals – Provider and Beneficiary

Requirements:

144. The Contractor must comply with State and federal policies and procedures for beneficiary or provider appeals including, but not limited to, the following:

    a. Notify providers and beneficiaries of their appeals rights in accordance with the Department's policy, utilization language and letter templates provided by the Department;
    b. Coordinate, where appropriate, with the Department's and other State departments' personnel who oversee the grievance and appeals process;
    c. Prepare the appropriate reports and documents to support the Contractor's actions resulting in the request for an appeal from a beneficiary or provider;
    d. Track each appeal and its status in the hearing process;
    e. Provide to the State (via telephone or in person) a registered pharmacist to address an appeal related to pharmacy benefit services;
    f. Provide to the State (via telephone or in person) the appropriate Contractor's employee(s) for an appeal related to a claims dispute; and
    g. Comply with the mandates and timelines stipulated by the Administrative Law Judge (ALJ).

W. Audit Trails for Claims Processing and Related Services

Requirements:

145. The Contractor must provide audit trails to document, identify, and track chronological records and transactions throughout the Contractor's systems including, but not limited to, additions, deletions, and changes to:

    a. Master file data related to beneficiaries, providers, pricing, other reference data, etc.;
    b. PA;
    c. Beneficiary Monitoring Program;
    d. All edits encountered, resolved, or overridden; and
    e. POS transactions, including data submitted by providers and responses sent to the provider.

X. Validation of Accurate Pricing and Claim Coverage

Requirements:

146. The Contractor's claims processing accuracy must be 99.95 percent or greater.

147. The Contractor must sample and reconcile its claims processing system and files to ensure accurate and timely payments including, but not limited to, the following:

    a. Conduct a random sample of a minimum of 100 claims each quarter;
    b. Stratify the sampling technique by variables, such as the Department's programs, reimbursement methodology, product type (e.g., sole-source, multiple-source, generics, etc.), or as specified by the Department for each reporting quarter;
    c. Report quarterly review findings to the Department; and
    d. Provide an action plan to address processing errors.

    Error definition includes any type of error (e.g., failure to apply plan design parameters such as co-payments, inaccurate eligibility application, payment application, coordination of third party liability, formulary, etc.) whether a payment or a non-payment error results. All errors on a single claim are counted once and no more than one error can be assigned to one claim.

148. The Contractor must analyze probable erroneous payments that have been brought to the Department's attention by providers or that have been identified through the Department's evaluation of paid claim samples.

Y. Claims Processing Corrective Action Plan

Requirements:

149. The Contractor must notify the Department staff of "any and all" claims that have been erroneously processed, and present a corrective action plan to the Department within five days.

150. The Contractor must initiate corrective actions, at no additional cost to the Department, only after the written approval of the Department.

COMPONENT 2 – PDL AND MANUFACTURER DRUG REBATE ADMINISTRATION

Z. Mandatory Minimum Requirements for PDL and Manufacturer Drug Rebate Administration

Requirements:

151. The Contractor must have at least two years experience administering a Medicaid manufacturer rebate program and preferred drug list complying with federal Medicaid laws, regulations and notifications including all the following activities:

    a. Negotiate Medicaid supplemental rebates through a multiple-state pool or coalition to maximize the Department's rebate revenue;
    b. Administer a Medicaid PDL and related formulary management;
    c. Coordinate activities of a P&T Committee;
    d. Invoicing and collecting rebates under a federal and supplemental Medicaid manufacturer drug rebate program;
    e. Maintain a manufacturer rebate database management system; and
    f. Resolve invoice disputes.

AA. Pharmacy and Therapeutics (P&T) Committee

Requirements:

152. The Contractor must provide information and staff support to the P&T Committee as needed to ensure timely implementation and ongoing maintenance of the PDL and PA criteria. The Contractor's activities must include, but are not limited to, the following:

    a. Conduct clinical reviews of new name-brand drugs and new generic drugs on clinical safety and efficacy, and for possible inclusion in the PDL;
    b. Generate therapeutic class utilization reports for drug classes under discussion by the P&T Committee or its workgroups;

c. Conduct clinical reviews of existing drugs for new indications or changes to indications that might affect their inclusion in the PDL;
d. Present PDL research and utilization reports at the P&T Committee quarterly and as necessary at P&T workgroup meetings;
e. Review drugs within covered therapeutic classes at least annually;
f. Develop changes to drug review criteria for the PDL based on new information;
g. Analyze cost information relative to drug alternatives as they affect the PDL;
h. Monitor PDL compliance and provide findings to the Department in monthly reports and in aggregated quarterly reports;
i. Support and facilitate meetings of the P&T Committee as necessary to maintain the PDL; and
j. Bring all proposed PDL changes to the Department and P&T Committee for review and approval prior to implementation.

153. The Contractor must facilitate review of all therapeutic classes by the P&T Committee at the beginning of this Contract's Operations Phase, and thereafter, at least annually.

154. The Contractor must facilitate the P&T Committee's use of clinical subject matter experts in reviewing various classes of drugs or individual drugs, if such expertise is needed and is not represented among the P&T Committee members.

155. The Contractor must provide research and recommendations to support the P&T Committee review to determine whether a drug class should be included in the PDL process, excluded from the PDL process, and whether there should be a "grandfather" provision for those beneficiaries with an existing prescription.

156. The Contractor must facilitate and document the Department's process for acting on or deviating from P&T Committee recommendations.

157. The Contractor must prepare and present drug monographs to the P&T Committee listing all medications in a therapeutic class for comparative efficacy, side effects, dosing, prescribing trends, and other clinical indications.

158. The Contractor must provide P&T meeting documents to the Department at least one week prior to a P&T Committee meeting or to a P&T Workgroup meeting.

159. The Contractor must provide quarterly reports on the activities of the P&T Committee.

160. The Contractor must provide a clinical pharmacist consultant to manage and direct the Department's P&T Committee activities and act as the Contractor's representative at P&T Committee and its workgroup meetings. The Contractor's clinical pharmacist consultant must attend P&T Committee meetings on-site in Lansing, Michigan as directed by the Department.

BB. <u>Formulary Maintenance</u>

Requirements:

161. The Contractor must maintain the drug lists specific to the Department's programs and provide online access to historical copies to Department-designated staff. This includes:

a. The PDL summary for posting on the applicable vendor's website quarterly;
b. The MPPL for posting on the applicable vendor's website monthly;
c. Drugs qualifying for the Department's Part D supplemental coverages for beneficiaries dually eligible for Medicare and Medicaid (the dual eligibles) at least quarterly or otherwise specified by the Department; and
d. Part B products covered by Medicaid for the dual eligibles only after Medicare is billed as the primary payer at least quarterly or otherwise specified by the Department.

The Department will provide an up-to-date version of the PDL and MPPL during the Design, Development, and Implementation phase of this Contract.

162. The Contractor's drug lists must be forwarded to the applicable vendor providing claims processing and related services for the Department's programs.

163. The Contractor must maintain and support the formularies and coverages of the Department's programs on Epocrates®.

CC. Clinical Pharmacy Support Services for PDL and Manufacturer Drug Rebate Administration

Requirements:

164. The Contractor must provide the services of a clinical pharmacist manager to continuously research, analyze, present findings, and proactively advise the Department and its P&T Committee. The clinical pharmacist manager must also research, present, and advise on topics requested by the Department, as needed.

165. The Contractor must continuously research, analyze, and proactively present findings to the Department on utilization management strategies and pharmacy policies including evaluation and identification of areas of improvement for both clinical impact and cost effectiveness of the Department's programs.

166. The Contractor must prepare discussion packages and coordinate meetings (by conference call) with the Department. The Contractor must hold weekly meetings (or less frequently if requested by the Department) on PA, PDL, and other clinical issues specified by the Department.

DD. Manufacturer Drug Rebate Administration

Following are work and deliverables related to general manufacturer drug rebate administration; drug rebate calculation and invoicing; prior period adjustments to previous manufacturer drug rebate invoices;
manufacturer dispute resolution; manufacturer drug rebate program accounting; online manufacturer drug rebate management system; rebate reporting required by CMS; and operational rebate reporting.

General

Requirements:

167. The Contractor must manage the Department's manufacturer drug rebates for the:

    a. Federal Medicaid rebate program;
    b. State supplemental Medicaid rebate program; and
    c. Medicaid-like rebate program for the Department's non-Medicaid programs.

168. The Contractor must comply with requirements listed in Section 1.070 Additional Terms and Section 2.210 Governing Law and in particular should refer to the provisions explained at www.cms.hhs.gov/MedicaidDrugRebateProgram.

169. The Contractor must maintain an electronic policies and procedures manual documenting all aspects of the Contractor's administration of the Department's manufacturer drug rebate programs.

170. The Contractor must not engage in any contracts or agreements during this Contract, and any renewal thereof, to receive direct compensation from pharmaceutical manufacturers (e.g., fees associated with data, rebates, rebate management, compliance, or clinical programs) which pertain to prescription claims data collected from the Department's programs.

171. The Contractor must develop and maintain a predictive pricing methodology that incorporates rebate and administration cost algorithms to estimate potential rebate recovery and the net costs to the Department associated with individual PDL decisions on a drug.

172. The Contractor must conduct a review of rebate contracting and program performance at least quarterly with representatives from the Department.

173. The Contractor must seek State supplemental and non-Medicaid rebates from manufacturers through a competitive, market-driven bidding process including, but not limited to, the following:

    a. Provide an opportunity for manufacturers to offer supplemental drug rebates to the Department based on an individual product's PDL status within defined therapeutic categories;
    b. Attend negotiation sessions with manufacturers and provide utilization and rebate modeling analysis capabilities; and
    c. Submit all potential rebate arrangements to the Department for approval prior to implementing supplemental rebates.

174. The Contractor must provide manufacturers with an annual opportunity to enhance their State supplemental rebate proposals for individual drugs in all therapeutic classes.

175. The Contractor must allow the Department to review and audit all manufacturer rebate contracts, upon request.

176. The Contractor must administer federal, State supplemental, and Medicaid-like manufacturer drug rebate programs in accordance with the requirements outlined in the following sections related to: drug rebate calculation and invoicing; manufacturer drug rebate program accounting; prior period adjustments to previous manufacturer rebate invoices; manufacturer dispute resolution; online manufacturer drug rebate management system; rebate reporting required by CMS; and operational rebate reporting.

Drug Rebate Calculation and Invoicing

Requirements:

177. The Contractor must integrate the following Department claims data to calculate manufacturer rebates owed to the Department.

    a. NDC claims data paid by the Contractor; and
    b. Practitioner and outpatient hospital claims data for physician-administered drugs paid by the Department and forwarded to the Contractor.

178. The Contractor must calculate the total rebate amounts due from each manufacturer based on:

    a. The number of units paid per an NDC; and
    b. Unit rebate amounts applicable for the Department's programs, which are (1) distributed by CMS for the federal Medicaid rebate program; (2) negotiated by the Contractor as State supplemental unit rebate amounts or (3) negotiated by the Contractor as Medicaid-like unit rebate amounts for the Department's non-Medicaid programs.

179. The Contractor must invoice manufacturer rebates quarterly (or by other time periods specified by the Department or CMS) including, but not limited to, the following requirements:

    a. Invoice 100 percent of participating manufacturers for federal, State supplemental, and Medicaid-like rebates no later than 60 days after the end of the quarter, or in compliance with the timelines of the federal government and the Department for generating manufacturer drug rebate invoices; and
    b. Submit the manufacturer rebate invoice summary for the Department's approval at least three business days prior to invoicing participating manufacturers.

180. The Contractor's rebate invoicing format and reported data elements must comply with CMS standards and with CMS policies and procedures for original invoices, for any needed prior period adjustments for previously invoiced quarters, and for interest on outstanding balances owed by a manufacturer.

181. The Contractor must provide manufacturers with electronic invoices in a format agreed upon with the Department e.g., compact disks (CD-ROMs).

182. The Contractor must utilize pre-invoicing quality control edits to proactively reduce manufacturer disputes of invoiced rebate amounts (e.g., quarter-to-quarter percent change in rebate amount invoiced by NDC; rebate amount exceeds reimbursed amount; quantity exceeds expected amounts, etc.). The Contractor must obtain Department approval on all pre-invoicing edits and must provide an audit trail of all pre-invoicing adjustments along with justification recorded into the Contractor's rebate management system. The Contractor must provide the Department a quarterly report of each adjustment and related justification by NDC.

183. The Contractor must provide a pre-invoicing automatic default of the unit rebate amount to the most recently paid rebate or submitted rebate amount if the unit rebate amount for an NDC on the CMS quarterly rebate file is zero ($0.00). The Contractor must investigate federal unit rebate amounts for NDCs not found on the CMS rebate file; include corrected rebate amounts for the related NDCs in the next prior period adjustment invoice; and make corrections so that the same NDCs are not missed in subsequent rebate invoices.

184. The Contractor must provide a pre-invoicing capability to convert unit types, when mismatches occur between the pharmacy claim unit types paid and the CMS unit rebate types.

185. The Contractor must exclude claims submitted by providers covered under Section 340B of the Public Health Service Act (PHSA) from rebate invoices processed for manufacturers. To fulfill this scope or work, the Contractor capabilities must include, but not be limited to, the following:

    a. Identify Michigan 340B providers each quarter based on federal resources and submit a 340B provider list to the Department for review;
    b. Work in cooperation with the Department to ascertain how specific 340B providers report 340B pricing. This may include requesting 340B providers to complete the "Basis of Cost Determination" field (NCPDP 423-DN) to indicate 340B pricing was used;
    c. Upon the Department's approval, exclude 340B claims from rebate processing activities based on the listing of 340B-covered providers and if applicable on the specific drugs the providers purchase under the 340B program.

Prior Period Adjustments to Previous Manufacturer Drug Rebate Invoices

Requirements

186. The Contractor must track and process prior period adjustments including, but not limited to, the following:

    a. Maintain all quarters of manufacturer drug rebate invoices and other information to accommodate prior period adjustment processing including a minimum of 12 quarters (available online);
    b. Identify and process, at NDC level, any corrections to rebate information received from CMS or from a manufacturer; and
    c. Provide capabilities to manually enter and report corrections at the NDC level on manufacturer drug rebate invoices.

187. The Contractor must recoup outstanding balances for rebates due on original invoices, unprocessed prior period adjustments, unprocessed interest amounts, and outstanding rebate disputes originating prior to this Contact.

Manufacturer Dispute Resolution

Requirements:

188. The Contractor must provide a rebate dispute resolution process that complies with CMS Best Practices for Dispute Resolution and must meet all State and federal requirements for pursuing recoveries in a timely manner. The Contractor's dispute resolution will be deemed timely when the Contractor:

    a. Responds to a manufacturer's initial dispute and any subsequent inquiries within five days;
    b. Obtains dispute resolution within 60 days of the initial dispute;
    c. Seeks manufacturer cooperation for all open disputes at least quarterly; and
    d. Seeks CMS Regional Office assistance with non-responsive manufacturers after minimum of two quarters of non-responsiveness.

189. The Contractor must provide a method to extract claims and other documentation for NDCs that are in dispute.

190. The Contractor must compare invoices to the Reconciliation of State Invoice (ROSI) returned by a manufacturer to determine which NDC and rebate amounts are in dispute.

191. The Contractor will provide documentation, upon Department request, of its repeated efforts to resolve aged disputes.

192. The Contractor must manually correct invoice records at the quarter and NDC level to support the dispute resolution process and log the updated amounts into its rebate management system.

193. The Contractor must maintain an automated drug rebate dispute tracking system. This system must track by labeler and NDC: the manufacturer name, manufacturer code, invoiced amount, invoiced quantity, manufacturer's paid quantity for the NDC, unpaid quantity (positive or negative), rebate amount per unit, unpaid rebate amount, dispute reason, interest owed, and quarter.

194. The Contractor must maintain an electronic table of all paid pharmacy claims for disputed products (by NDC) for the rebate quarter under review to facilitate dispute research.

195. The Contractor must generate notices to billing pharmacies regarding claims with disputed manufacturer rebate amounts. These notices will be sent within five business days of receiving approval by the Department with a copy of the notice being sent to the Department.

196. The Contractor must automatically recalculate the utilization for each disputed NDC for all manufacturers after all adjustments have been recorded and log the updated amounts into its online rebate management system.

197. The Contractor must at least annually, or as directed by the Department, attend and actively participate in CMS-sponsored dispute resolution meetings on behalf of, or in addition to, the Department's staff. Costs associated with Contractor staff attending such meetings will be the Contractor's responsibility.

Manufacturer Drug Rebate Program Accounting

Requirements:

198. The Contractor must reconcile payments received from manufacturers with the amount invoiced by program, program code, quarter, and National Drug Code (NDC).

199. The Contractor must recalculate invoices if the amount the manufacturer submits is different from the invoice and make corrections, and log the updated amounts into its online rebate management system.

200. The Contractor must maintain the original and corrected invoice information at the NDC level.

201. The Contractor must identify discrepancies between the rebate amount due and amount paid to pharmacy (e.g., rebate amount exceeds amount paid). The Contractor must determine reasons for any discrepancy (e.g., pharmacy billing errors, CMS imposed manufacturer penalty) and resolve the discrepancy. The Contractor must log such resolutions in its online rebate management system.

202. The Contractor must transmit accounts receivable and balances to the Department's accounting system, as specified by the Department.

203. The Contractor must calculate and invoice interest on unpaid quarterly manufacturer rebate amounts in accordance with federal notifications. The Contractor must report interest invoicing separately from rebates.

204. The Contractor must maintain proper internal controls to ensure the integrity and security of rebate and interest payments remitted by manufacturers. The Contractor must instruct manufacturers to return their rebate checks and the Reconciliation of State Invoice (ROSI) to the Department's lockbox. The Contractor will receive and process copies of account batch listing, check listing, checks, and originals of all envelopes and enclosures (e.g., ROSI and letters) from the daily transmissions from the Department's lockbox bank.

Online Manufacturer Drug Rebate Management System

Requirements:

205. The Contractor's manufacturer drug rebate management system must house and maintain the following data by program, program codes, quarter, NDC, and claim:

    a. Listings of manufacturers participating in the federal manufacturer drug rebate program;
    b. Federal unit rebate amounts for the Department's Medicaid program;
    c. State supplemental rebate amounts for the Department's Medicaid program;
    d. Medicaid-like rebate amounts for the Department's non-Medicaid programs;
    e. Rebate invoiced claims data including physician and outpatient hospital administered drugs paid by the Department and pharmacy prescriptions paid by the POS claims processing system Contractor;
    f. Rebates received;
    g. Pre-invoicing adjustments to unit rebate amounts and utilization;
    h. Recalculated invoice amounts based on data submitted from manufacturers;
    i. Manufacturer invoices;
    j. Prior period adjustments;
    k. Manufacturer disputes;
    l. Dispute resolutions and utilization adjustments supporting dispute resolution; and
    m. Other data specified by the Department.

206. The Contractor's manufacturer drug rebate management system must have functionality to:

    a. Maintain complete records of all rebate data and transactions;
    b. Provide online access for Department-designated staff as listed in the Section 1.042 Reports;
    c. Retain rebate records conforming to federal regulations and notifications or as otherwise specified by the Department;
    d. Age the accounts;
    e. Apply adjustments for any given time period; and
    f. Allow multiple select keys and sort preferences (e.g., by manufacturer; by year/quarter, by type of rebate; by program or program code; managed care carve-out versus fee-for-service; claim level, etc.).

207. The Contractor must import into its manufacturer drug rebate management system historical quarterly rebate data back to 1991 available from the Department's current rebate vendor. The Contractor must assume all administrative and management tasks associated with rebates for historical quarters back to 1991 as well as future quarters occurring during this Contract.

Rebate Reporting Required by CMS

Requirements:

208. Quarterly, the Contractor must generate and transmit to CMS a file of all manufacturer rebate invoices including, but not limited to, original invoices, interest amounts, prior period adjustments, and adjustments resulting from resolved disputes.

209. The Contractor must provide quarterly drug rebate information in a form compatible for the Department's submission of the Quarterly Expense Report of the Medicaid Budget and Expenditure System (CMS-64) reporting requirements on or before 15 days following the close of a quarter's end.

Operational Rebate Reporting

Requirements:

210. The Contractor must deliver operational rebate reports to the Department within two business days after the reporting period or as otherwise specified by the Department. The Contractor must provide reports online for the Department-designated staff in downloadable versions of Microsoft® Excel or other Department-specified format.

211. The Contractor's online manufacturer drug rebate management system and operational rebate reporting functionality must separately report manufacturer rebate payments at the following levels:

    a. Quarter;
    b. Pharmacy program (e.g., Medicaid; CSHCS; CSHCS/Medicaid; ABW; etc.);
    c. Program code (e.g., Program Code J, Refugee Assistance Medical Only within Medicaid);
    d. Rebate type (e.g., federal rebate, State supplemental, federal rebate interest, State supplemental interest, Medicaid-like rebates, and Medicaid-like interest);
    e. Managed care carve-out versus fee-for-service;
    f. Family planning drugs;
    g. Drugs crossed-walk from Healthcare Common Procedure System (HCPCS) codes to NDCs by the Department (i.e., practitioner and outpatient hospital claims for physician-administered drugs; and
    h. Prescription claim level.

212. Prior to invoicing manufacturers quarterly, the Contractor must provide pre-invoicing quality control, operational reports to the Department. Examples of reporting items include, but are not limited to, NDCs for which:

    a. Rebate amounts exceed total reimbursement plus payment from other insurers;
    b. Rebate amounts exceed quarter-over-quarter variability thresholds (e.g., +/- 15 percent);
    c. Pre-invoicing adjustment amounts have been made by the Contractor;
    d. Zero rebate amounts are listed on the CMS file; and
    e. Reimbursement has been made by the Contractor but the NDC is not found on CMS rebate file.

213. The Contractor must reconcile drug rebate data with the Department's fiscal records monthly, quarterly, and annually. Such efforts must include detailed reports that identify adjustments, unit amount rebate changes, write-offs, and other accounting transactions that impact the Department rebate reporting.

214. The Contractor must provide monthly, quarterly, and year-to-date by calendar year and by SFY operational rebate reports, in a format agreed upon and approved by the Department, which track:

    a. Rebate recoveries;
    b. Current reporting period disputes by manufacturers with aged disputes for previous quarters along with adjustments and recoveries resulting from dispute resolution activities;
    c. Pre-invoicing adjustments, unit rebate amount changes, write-offs, and other accounting transactions;
    d. Current and past accounts receivable by manufacturer;
    e. Interest billed and collected;
    f. Feasibility determinations of rebate write-offs; and
    g. Amount rebated compared to amount paid by quarter, manufacturer, and NDC.

EE. Audit Trails for PDL and Manufacturer Drug Rebates

Requirements:

215. The Contractor must provide automated audit trails to document, identify, and track chronological records and transactions throughout the Contractor's systems including, but not limited to, additions, deletions, and changes to:

    a. Original rebate invoices;
    b. Rebate interest billing;
    c. Pre-invoicing adjustments;
    d. Rebate write-offs;
    e. Prior period adjustments;
    f. Rebate accounts receivable and balances;
    g. Dispute resolution; and
    h. PDL and formulary maintenance.

1.030 Roles and Responsibilities

1.031 Contractor Staff, Roles, and Responsibilities

A. Key Personnel

Requirements:

6. The Contractor must provide sufficient staff to meet requirements listed in this Contract including the following Department-designated "key personnel" complying with the requirements below.

    k. ***Project/Account Director*** – 100 percent dedicated to this Contract; experienced in pharmacy program management; desired licensed pharmacist
    l. ***Clinical Account Manager (Pharmacist)*** – 100 percent dedicated to this Contract; experienced in pharmacy program management, DUR, and formulary development; traveling on-site to Michigan required as specified by the Department
    m. ***Contract Manager*** – 100 percent dedicated to this Contract; experienced in account management in the healthcare sector; desired experience in pharmacy benefits management
    n. ***Operations Manager*** – May be the same individual as Contractor Account Manager; 100 percent dedicated to this Contract; experienced in the healthcare sector
    o. ***Implementation Manager*** – 100 percent dedicated through the Design, Development, and Implementation (DDI) phase to the Operations phase; experienced in overall POS management or comparable healthcare claims management systems
    p. ***Systems Manager (Operations)*** – At least 25 percent dedicated to this Contract; experienced in POS claims processing and decision support systems
    q. ***Provider Relations Manager*** – *Component 1 – Claims Processing and Related Services only*; 40 percent dedicated to this Contract; experienced in provider relations management
    r. ***Call Center Pharmacist Manager*** – *Component 1 – Claims Processing and Related Services only*; 100 percent dedicated to this Contract; licensed pharmacist; experienced in Medicaid pharmacy program management
    s. ***Clinical Pharmacist for Rebate/PDL*** – *Component 2 – PDL and Manufacturer Drug Rebate Administration only*; at least 50 percent dedicated to this Contract; licensed pharmacist; experienced with Medicaid manufacturer drug rebate administration including federal and supplemental rebates

7. The Contractor must ensure its professional key personnel have and maintain current licensure or certification. The Contractor's key personnel are *not* required have Michigan licensure or certification.

8. The Contractor's Clinical Account Manager (Pharmacist) and other Department-designated staff must attend Department meetings on-site in Lansing, Michigan or via conference call as directed by the Department. The Contractor's key personnel are *not* required to reside in Michigan.

9. The Contractor must provide the Department written notification of anticipated vacancies of the Department's designated key personnel positions within two business days of receiving the individual's resignation notice, the Contractor's notice to terminate an individual, or the position otherwise becoming vacant. The Department's designated key personnel positions must not remain vacant or filled with an interim appointee longer than 60 days unless approved by the Department.

10. The Contractor must submit to the Department an updated organizational chart including e-mail addresses and all business phone numbers for key staff and for any Subcontractors upon changes.

B. Physical Location of Contractor

Requirements:

1. The Contractor must identify where key personnel staff identified above, whether employed by the Contractor or Subcontractor, will be physically located for the duration of this Contract.

2. Contractor must list any call centers, their related contract responsibilities, and the city and state where they will be physically located for the duration of this Contract.

C. Special Staffing Needs – Sanctioned Individual Notice

Requirements:

1. Monthly, the Contractor must verify whether any employee of the Contractor or any Subcontractor(s) supporting the Department's work and deliverables has been designated as a sanctioned healthcare provider by the federal government or the State.

2. The Contractor must immediately notify the Department when an employee of the Contractor or any Subcontractor has been sanctioned by the federal government or the State.

1.040 Project Plan

1.041 Project Plan Management

A. Project Plan Management Phases

Requirements:

Table 4 presents the Department's proposed timetable for the three project management phases.

1. The Contractor must obtain Department approval on its submitted project work plan describing its approach to how the Contractor will accomplish required work and deliverables.

2. This Contract award is not the Department's acceptance or approval of the Contractor's submitted work plan or approach.

Table 4: Project Phases for the Contractor's Project Plan Management Plan

Phase	Date
Design, Development and Implementation (DDI)	Mutual Contract Execution, after Administrative Board approval, through Month 6 (e.g., October 1, 2009 through March 31, 2010)
Operations – Services Rendered	Month 7 (April 1, 2010) to 180 days prior to the Contract's end date
Transition/Turnover	180 days prior to the Contract's end date through the Contract's end date

B. Design, Development and Implementation (DDI) Phase

Requirements:

The Contractor must perform the following tasks during the DDI phase in preparation for the Operations phase. The Contractor must perform those DDI phase tasks the Department deems necessary.

1. ***Planning Activities*** including, but not limited to, the following:

    a. Review documentation on current system operations and requirements, user documentation, and clarify deficiencies as necessary;
    b. Establish a project control and reporting system, and establish protocols for problem reporting, a standards manual, and controls for transfers;
    c. Develop a detailed implementation schedule defining all key milestones, deliverables, activity-level schedules, and staffing levels; and
    d. Provide design modification recommendations to the Department, understanding that the Department is under no obligation to accept or implement any recommended modifications.

2. ***Testing Activities*** including, but not limited to, the following:

    a. Develop procedures and supporting documentation for testing;
    b. Establish a testing schedule;
    c. Perform testing with input files from the current Contractor;
    d. Compare the results of runs on the Contractor's system to identical runs on the current system;
    e. Analyze and record test results;
    f. Develop and test data conversion programs; and
    g. Work with the Department and other State Contractors, as necessary, to establish appropriate interfaces and system integration.

3. ***Implementation Activities Leading to Start of Operations*** including, but not limited to, the following:

    a. Finalize the implementation schedule, and obtain approval from the Department;
    b. Obtain final and in-process files, transactions, and other data from the current Contractor, and perform final conversions;
    c. Participate in the Department's operational readiness assessment;
    d. Begin claims processing and other transactions; and
    e. Advise the Department of commencement of full system operations, and request approval for the start of operations.

C. Operations Phase

Requirements:

1. The Contractor must implement and provide all required work and deliverables during the Operations phase of this Contract.

2. Activities include, but are not limited to, maintenance of system files, software, and hardware; correction of system problems and deficiencies; and system modifications as necessary to accommodate the Department's needs without additional cost to the Department.

D. Transition/Turnover Phase

Requirements:

1. At least 180 days before the end of this Contract, the Contractor must develop and implement a Department-approved Turnover Plan. The Turnover Plan must be comprehensive detailing the proposed schedule, activities, and resource requirements associated with turnover tasks.

2. The Contractor must turnover all completed and Contract deliverable work including all working documents, in accordance with the Department-approved Turnover Plan.

3. Activities include, but are not limited to maintenance of system files, software, and hardware; correction of system problems and deficiencies; and system modifications as necessary to accommodate the Department's needs without additional cost to the Department.

1.042 Reports

A. Reporting Package

Requirements:

1. The Contractor's reporting package must:

    a. Provide flexibility to accommodate new reports or modifications to existing reports at the request of the Department, at no additional cost to the Department;
    b. Deliver reports in a format acceptable to the Department (e.g., Microsoft Excel®) and be available both electronically and in hard copy;
    c. Provide a secure web-based report repository where all reports are stored in an organized manner and easily accessed online by Department staff to view, print, copy, and download;
    d. Provide updated monthly, quarterly, and annual data including year-to-date totals by calendar year and SFY, or as otherwise specified and approved by the Department; and
    e. Provide functionality to produce reports for the Department's current (or future) program categories and other Department-specified coverage groups or claim types (e.g., programs, managed care carve-out status, batch claim submitter, E-Prescriptions/compounds/home infusions/mail order claims, and eligibility data elements such as beneficiary age grouping, levels of care, dual eligible status, etc.).

2. The Contractor must provide reporting functionality comparable or more comprehensive than the reports described in Appendix C, including a suite of reports to support the following:

    a. Drug Utilization Review (monthly, quarterly, and the required CMS annual report);
    b. P&T Committee product reviews (information on new products, historical utilization data, etc.);
    c. Federal, state supplemental, and Medicaid-like rebate programs;
    d. MAC pricing cost effectiveness and compliance with CMS requirements;
    e. Claims processing efficiency (e.g., denied claim trends by pharmacy);
    f. TPL cost avoidance;
    g. Contractor performance guarantees;
    h. Provider enrollment;
    i. Pharmacy trends tracking PA, utilization, expenditures, enrollment, etc. of the Department's pharmacy programs; and
    j. Program evaluation for subsequent reporting periods and outlook for future years.

3. The Contractor must deliver reports within the timelines that follow or as otherwise specified by the Department for select reports (e.g., the CMS-64 and other operational reporting for manufacturer drug rebate administration, pharmacy payment invoices, DUR, etc.)

    a. Weekly and bi-weekly reports must be delivered to the Department on or before the second business day following end of the reporting period;
    b. Monthly reports must be delivered to the Department on or before the tenth day of the month following the end of the reporting period;
    c. Quarterly reports must be delivered to the Department on or before the tenth day of the month following the end of the reporting period;
    d. Semi-annual and annual reports must be delivered to the Department no later than 60 days following the close of the reporting period.

B. Interface Files

Requirements:

1. The Contractor must develop and deliver or receive the interface files listed in Appendix D. While this appendix contains an extensive list of interface files, it is not meant to be comprehensive or all inclusive of all needed files to perform the Department's work, deliverables, and other requirements.

2. The Contractor must maintain documentation of any changes made to the interface processing rules or processing timelines.

3. The Contractor must receive (download) and transmit (upload) files via a dedicated and secure File Transfer Protocol (FTP) site and develop and deliver Department-approved load and error reports for each interface file.

a. File download from the Department to the Contractor must be 100 percent accurate and timely by the day and time designated by the Department; and
b. File upload from the Contractor to the Department must be 100 percent accurate and timely by the day and time designated by the Department.

4. The Contractor must prepare a Root Cause Analysis Report each time an interface problem is identified and resolved. This analysis must be well-researched, clearly explained, and provide a valid description of a Contractor file interface problem and must include corrective measures taken to prevent future occurrences. The Contractor must forward the Root Cause Analysis Report to the Department within 10 business days of resolution of a file interface problem.

C. Decisions Support System, Ad Hoc Reporting, and Online Access to Databases and Records

Requirements:

1. The Contractor must provide a Decision Support System with functionality to generate numerous ad hoc reports at the Department's request. Provision of the Decision Support System does not relieve the Contractor from ad hoc reporting requirements.

2. The Contractor must complete Department requests for ad hoc reports within 10 business days of a request unless an alternative response time is negotiated with the Department at the time the request is made. Some ad hoc requests might require a faster turn-around and the Department will specify such requirements at the time of the request.

3. The Contractor's Decision Support System must allow Department-designated individuals the ability to remotely query the online systems and generate ad hoc reports.

4. The Contractor must provide required software, software support, and free web-based access by Department-designated staff for systems including, but not limited to those outlined below:

   a. ***Component 1 – Claims Processing and Related Services***
      i. Online claims processing system;
      ii. PA system;
      iii. Provider enrollment system;
      iv. DUR system;
      v. Testing system; and
      vi. Other agreed upon claims processing and related systems.

   b. ***Component 2 – PDL and Manufacturer Drug Rebate Administration***
      i. Online manufacturer drug rebate management system, including, but not limited to: rebate invoices, disputes, rebate status by NDC, accounting, reporting; and
      ii. Other agreed upon PDL and manufacturer drug rebate administration systems.

5. The Contractor must provide documentation manuals and training on-site in Lansing, Michigan to individuals designated by the Department. The Contractor's training must be provided by a fully qualified and experienced user of the Contractor's online systems. The Department anticipates approximately 15 staffers will require training.

D. Performance Report Card

Requirements:

1. Within 15 days of the end of each month during the Operations phase, the Contractor must produce and deliver a report card on its actual performance. Select Contract and performance standard requirements identified in this Contract will be part of the report card in any given month.

2. Standards will be added or deleted for future report cards, at the Department's discretion, with 30 days notice to the Contractor. The Department, or its designee(s), reserve the right to audit records and data related to the Contractor's performance at any time during this Contract.

3. The Contractor must provide a corrective action plan for any performance standard deficiencies within five business days of delivering the report card to the Department. The Department, at its sole discretion, may accept the Contractor's corrective action plan or modify it. The Contractor must implement the corrective action plan accepted by the Department within 30 days or as otherwise specified by the Department.

1.050 Acceptance

1.051 Criteria
The following criteria will be used by the Department to determine acceptance of the work and deliverables provided under this Statement of Work:

A. Project Manager Responsibilities Related to Acceptance of Work and Deliverables

The Department's Project Manager will be responsible for verifying that the work:
a. Was performed in the time period referenced;
b. Meets the work or deliverable criteria; and
c. Was performed according to Contract specifications.

B. Approval Process of Work and Deliverables

1. The Department's approval process of work and deliverables require formal written approval, according to the following procedures:

   a. Formal approval by the Department requires the Department to confirm in writing that the work and deliverables meet its specifications and requirements. The approval process will be facilitated by ongoing consultation between the parties, inspection of interim and intermediate work and deliverables and collaboration on key decisions.
   b. The Department will approve, in writing, work and deliverables after confirming that it conforms to and performs according to its specifications with material deficiency. The Department may, but is not required to, conditionally approve, in writing, work and deliverables that contain material deficiencies if the Department elects to permit the Contractor to rectify them post-approval. In any case, the Contractor will be responsible for working diligently to correct within a reasonable time at the Contractor's expense all deficiencies in the work and deliverables that remain outstanding at the time of the Department approval.
   c. If, after three opportunities (the original and two repeat efforts), the Contractor is unable to correct all deficiencies preventing Operations Phase Go Live Approval, the Department may: (i) demand that the Contractor cure the deficiency and give the Contractor additional time to cure the deficiency at the sole expense of the Contractor; or (ii) keep this Contract in force and do, either itself or through other parties, whatever the Contractor has failed to do, and recover the difference between the cost to cure the deficiency and this Contract price(s) plus an additional sum equal to 10 percent of the cost to cure the deficiency to cover the Department's general expenses provided the Department can furnish proof of the general expenses; or (iii) terminate the particular Statement of Work for default, either in whole or in part by notice to the Contractor provided the Contractor is unable to cure the breach. Notwithstanding the foregoing, the Department cannot use, as a basis for exercising its termination rights under this Section, deficiencies discovered in a repeat Department Review Period that could reasonably have been discovered during a prior Department Review Period.
   d. The Department, at any time and in its reasonable discretion, may halt the testing or approval process if the process reveals deficiencies in or problems with a Deliverable/Service in a sufficient quantity or of a sufficient severity that renders continuing the process unproductive or unworkable. If that happens, the Department may stop using the Service or return the applicable Deliverable to Contractor for correction and re-delivery before resuming the testing or approval process.

2. Upon work and deliverable approval, the Department's Project Manager will forward the approved invoice for additional review and payment according to the Department approval path.

1.052 Final Acceptance – Deleted/Not Applicable

1.060 Pricing

1.061 Pricing Instructions

A. Pricing Schedule A – Total Evaluated Price
Pricing Schedule A summarizes the Total Evaluated Price for all activities during this Contract, including DDI activities and the three base years of operations.

B. Pricing Schedule B – Design, Development and Implementation (DDI) Price

Pricing Schedule B includes the details for all DDI activities including planning, testing, and implementation that result in the Total DDI Fixed Price included in the Total Evaluated Price.

DDI Payments – During the DDI phase, pro-rated payments will be made to the Contractor at completion and Department acceptance of critical planning activities, testing activities, and implementation activities; subject to all remedies afforded to the State under law and this Contract.

C. Pricing Schedule C – Operations

Pricing Schedule C will be the Total Operations Fixed Price for performance of all operational tasks and maintenance during the three base years of operations. Other pertinent instructions and specifications follow.

Operations Payments – During the Operations phase, a monthly payment, unless otherwise specified by the Department, will be made to the Contractor as prorated from the fixed price for each Contract Year in Schedule C, subject to all remedies afforded to the State under law and this Contract.

a. The Department will provide invoicing instructions during the DDI phase.
b. The Contractor's September administrative invoice to the Department must be submitted by October 5 of each year of this Contract.
c. The Contractor's invoices for administrative and other fees submitted to the Department must be 100 percent accurate.

1.062 Price Term – Firm Fixed Price

Prices quoted are firm for the entire three years of this Contract. Pricing requirements during renewal option years follows.

A. Pricing for Renewal Option Years

The following procedures and criteria will apply to options to renew this Contract (if exercised):

1. The Contractor must demonstrate a *material change* in both variable costs and claim volume. No adjustment for fixed cost increases will be made by the Department.

2. In the event the Contractor demonstrates such material changes, the Department will make a financial adjustment for operations during the renewal period based on the Contractor's material increase in variable costs, as defined by the Department. Any adjustment in the prices quoted payable to the Contractor for operations must be dependent on the verification and certification that actual claim volume counts are accurate and fully consistent with the definition of a claim below.

3. In the event the Contractor experiences a material change decrease in claim volume, the Department reserves the right to recoup payment based on the Contractor's decrease in variable costs, as determined by the Department and the Contractor. The Contractor must provide the Department with the requested Contract Year variable costs documentation. If the Contractor fails to provide such documentation, the Department may estimate or use any previous calculation of the Contractor's variable costs to determine a material change or decrease.

4. Definition of Claim Related to "Material Change in Claim Volume"
   For purposes of claim volume accounting and determining pricing for renewal option years, the following claim definition and qualifying criteria will apply:

   a. Pharmacy claims are standard electronic transactions paper documents requesting payment for each specific NDC rendered to a single beneficiary, by a single billing provider, that has been processed by the Contractor and are ready for payment. All claim formats, electronic or paper, will be accounted for in the same manner. Any transaction not meeting these explicit definitions will not be counted as a claim.

   b. In addition, the following types of transactions are NOT considered a claim for purposes of volume accounting and determining adjustments to Contractor payments:

      i. Claims suspended for resolution;
      ii. Denied claims;
      iii. Claims returned to a provider, regardless of the reasons, prior to assignment of a unique control number;

iv. Adjustments to paid claims, regardless of the number of adjustments and the reasons for the adjustments;
v. Claims requiring re-processing, adjustment, or modification due to Contractor errors;
vi. Financial transactions, inquiries including eligibility and claim status, PAs, referrals, online and batch updates to any MMIS data, and claim corrections; and
vii. Medicare crossover claims that are 100 percent paid or denied, and monetary and non-monetary adjustments.

1.063 Tax Excluded from Price

(a) Sales and Use Tax, Generally: The State is generally exempt from sales and use tax for direct purchases. The Contractor's prices must not include sales or use tax unless a specific exception applies.

(b) Use Tax, Specific Exception. MCL 205.93f sets out a specific exception to the State's general use tax exemption. This exception applies to contracts for purchase of medical services provided after April 1, 2009 from entities identified in MCL 400.106(2)(a) or MCL 400.109f MCL 205.93f(2), involving certain Medicaid contracted health plans and some specialty prepaid health plans. Purchases of services that fall under these provisions are subject to use tax.

(c) Federal Excise Tax: The State may be exempt from Federal Excise Tax, or the taxes may be reimbursable, if articles are purchased under this Contract for the State's exclusive use. Certificates showing exclusive use for the purposes of substantiating a tax-free, or tax-reimbursable sale will be sent upon request. If a sale is tax exempt or tax reimbursable under the Internal Revenue Code, prices must not include the Federal Excise Tax.

1.064 Holdback – Deleted/Not Applicable

1.070 Additional Requirements

1.071 Additional Terms and Conditions specific to this Contract

A. Performance Guarantees/Service Level Agreement (SLA)

Requirements:

The Contractor must ensure that the SLAs are measureable using the Contractor's standard management information systems. The Department reserves the right to independently verify the Contractor's assessment of its performance, either by State employee or third party review. Disagreements regarding SLAs will be subject to Dispute Resolution, per Section 2.190. The SLAs in are related to on-going Services, and will apply throughout the duration of this Contract, including any optional renewal periods (if exercised).

B. Compliance with State and Federal Laws, Rules, Regulations, Policies, and Notifications

Requirements:

1. The Contractor must comply with the requirements listed in Section 2.210 Governing Law and must provide necessary system design, modification, and implementation needed to comply with changes in laws, regulations, and notifications of State and federal government at no additional cost to the Department. The Contractor in particular must note the following:

    a. ***False Claims*** – Any services or deliverables paid in association with this Contract will be from State and federal funds and any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable State or federal laws and regulations.
    b. ***Fraud and Abuse*** – The Contractor must comply with all applicable provisions of section 1902(a)(68)(A) of the Social Security Act as amended by Section 6032 of the Deficit Reduction Act of 2005, and the Medicaid False Claims Act, and any subsequent amendments.
    c. ***HIPAA*** – The Contractor must comply in all material respects with all State and federal mandated regulations, rules, orders, or notifications with application to privacy and security, electronic transactions and code sets, including without limitation, regulations promulgated under Title II Subtitle F of the Health Insurance Portability and Accountability Act (Public Law 104-191) (HIPAA).
    d. ***Privacy of Individually Identifiable Health Information*** – The Contractor must comply with all State and federal legislation, regulations, rules, orders, or notifications to which the Contractor is subject now or in the future including, without limitation, the Standards for Privacy of Individually Identifiable Health Information or similar legislation (collectively, "Laws") to ensure the Contractor is at all times in conformance with all Laws.

e. ***MMIS Certification*** – The Contractor must comply with all requirements for MMIS certification issued by CMS that govern the Contractor's service, performance, work, or deliverables. (See the Medicaid Enterprise Certification Toolkit available at www.cms.hhs.gov/MMIS).

C. <u>PBM Record Retention</u>

Requirements:

1. At no additional cost to the Department, Contractor must retain and make available for inspection all "historical records" related to the Contractor's work and Deliverables in compliance with: Section 2.110 Records and Inspections; Section 2.112 Examination of Records; Section 2.113 Retention of Records; and the following requirements.

2. Examples of "historical records" include, but are not limited to, the following:

   a. ***For Component 1 – Claims Processing and Related Services***
      i. Claims as submitted by providers;
      ii. Claims data adjudicated by the Contractor;
      iii. Current and historical reference files including, but not limited to, reimbursement logic, product cost, dispensing fees, beneficiary co-payments, and formulary files;
      iv. Claims processing edit logic and rules;
      v. PA records;
      vi. Provider enrollment agreements;
      vii. Provider enrollment data;
      viii. Beneficiary enrollment records;
      ix. DUR meeting notes;
      x. Scanned images and electronic attachments;
      xi. Financial transactions;
      xii. Letters and notices sent to providers or beneficiaries;
      xiii. Communication logs; and
      xiv. Other claims processing and related data and reference files specified by the Department.

   b. ***For Component 2 – PDL and Manufacturer Drug Rebate Administration***
      i. Claims as submitted by providers;
      ii. Current and historical reference files including, but not limited to, approved manufacturers, PDLs, formulary, unit rebate amounts, and other historical records listed below in Section 1.022DD Manufacturer Drug Rebate Administration;
      iii. Current and historical reference files including, but not limited to, PDLs and formularies;
      iv. P&T Committee meeting notes;
      v. Scanned images and electronic attachments;
      vi. Financial transactions;
      vii. Letters and notices sent to providers or manufacturers;
      viii. Communication logs; and
      ix. Other PDL and manufacturer drug rebate data and reference files specified by the Department.

3. The Contractor must deliver historical records or provide State and federal agencies and their authorized representative(s) access to historical records for review, analysis, inspection, audit, and reproduction during this Contract and as further specified in Section 2.112.

4. All historical records will be the property of the Department and must be returned upon demand. At the end of the required retention of records period, the Contractor must either transfer the records to the Department or its designee or dispose of the records as instructed by the Department or designee.

5. The Contractor must maintain historical records "online" for a minimum of 36 months from the date of service in the electronic format specified by the Department.

6. The Contractor must restore "off-line" archived historical records to "online" status for viewing, copying, and printing of the restored records within one business day of the Department's request or as otherwise specified by the Department.

D. <u>Business Associate Agreements</u>

Requirements:

The Contractor must execute any necessary Business Associate Agreements and flow down this requirement to any and all related independent contractors, subcontractors, and vendor partners.

E. Invoicing for the Contractor's Work and Deliverables

Requirements:

The Contractor must design, structure, and provide appropriate invoicing detail, as necessary and requested by the Department, to comply with CMS reporting and invoicing requirements related to the Contractor's work and deliverables under this Contract.

Article 2 - Terms and Conditions

2.000 Contract Structure and Term

2.001 Contract Term
This Contract is for a period of three years starting April 1, 2010 through March 31, 2013. All outstanding Purchase Orders must also expire upon the termination (cancellation for any of the reasons listed in **Section 2.150**) of this Contract, unless otherwise extended under this Contract. Absent an early termination for any reason, Purchase Orders issued but not expired, by the end of this Contract's stated term, will remain in effect for the balance of the fiscal year for which they were issued.

2.002 Options to Renew
This Contract may be renewed in writing by mutual agreement of the parties not less than 30 days before its expiration. This Contract may be renewed for up to four additional one-year periods.

2.003 Legal Effect
Contractor must show acceptance of this Contract by signing two copies of this Contract and returning them to the Contract Administrator. The Contractor must not proceed with the performance of the work to be done under this Contract, including the purchase of necessary materials, until both parties have signed this Contract to show acceptance of its terms, and the Contractor receives a contract release/purchase order that authorizes and defines specific performance requirements.

Except as otherwise agreed in writing by the parties, the State assumes no liability for costs incurred by Contractor or payment under this Contract, until Contractor is notified in writing that this Contract (or Change Order) has been approved by the State Administrative Board (if required), approved and signed by all the parties, and a Purchase Order against this Contract has been issued.

2.004 Attachments, Appendices & Exhibits
All Attachments, Appendices, and Exhibits affixed to any and all Statement(s) of Work, or appended to or referencing this Contract, are incorporated in their entirety and form part of this Contract.

2.005 Ordering
The State will issue a written Purchase Order, Blanket Purchase Order, Direct Voucher or Procurement Card Order, which must be approved by the Contract Administrator or the Contract Administrator's designee, to order any Services/Deliverables under this Contract. All orders are subject to the terms and conditions of this Contract. No additional terms and conditions contained on either a Purchase Order or Blanket Purchase Order apply unless they are also specifically contained in that Purchase Order's or Blanket Purchase Order's accompanying Statement of Work. Exact quantities to be purchased are unknown; however, the Contractor will be required to furnish all such materials and services as may be ordered during this Contract period. Quantities specified, if any, are estimates based on prior purchases, and the State is not obligated to purchase in these or any other quantities.

2.006 Order of Precedence
(a) This Contract, including any Statements of Work and Exhibits, to the extent not contrary to this Contract, each of which is incorporated for all purposes, constitutes the entire agreement between the parties with respect to the subject matter and supersedes all prior agreements, whether written or oral, with respect to the subject matter and as additional terms and conditions on the purchase order must apply as limited by **Section 2.005.**

(b) In the event of any inconsistency between the terms of this Contract and a Statement of Work, the terms of the Statement of Work will take precedence (as to that Statement of Work only); provided, however, that a Statement of Work may not modify or amend the terms of this Contract, which may be modified or amended only by a formal Contract amendment.

2.007 Headings
Captions and headings used in this Contract are for information and organization purposes. Captions and headings, including inaccurate references, do not, in any way, define or limit the requirements or terms and conditions of this Contract.

2.008 Form, Function & Utility – Deleted/Not Applicable

2.009 Reformation and Severability
Each provision of this Contract is severable from all other provisions of this Contract and, if one or more of the provisions of this Contract is declared invalid, the remaining provisions of this Contract remain in full force and effect.

2.010 Consents and Approvals
Except as expressly provided otherwise in this Contract, if either party requires the consent or approval of the other party for the taking of any action under this Contract, the consent or approval must be in writing and must not be unreasonably withheld or delayed.

2.011 No Waiver of Default
If a party fails to insist upon strict adherence to any term of this Contract then the party has not waived the right to later insist upon strict adherence to that term, or any other term, of this Contract.

2.012 Survival
Any provisions of this Contract that impose continuing obligations on the parties, including without limitation the parties' respective warranty, indemnity and confidentiality obligations, survive the expiration or termination of this Contract for any reason. Specific references to survival in this Contract are solely for identification purposes and not meant to limit or prevent the survival of any other section.

2.020 Contract Administration

2.021 Issuing Office
This Contract is issued by the Department of Management and Budget, Purchasing Operations and Michigan Department of Community Health (collectively, including all other relevant State of Michigan departments and agencies, the "State"). Purchasing Operations is the sole point of contact in the State with regard to all procurement and contractual matters relating to this Contract. Purchasing Operations **is the only State office authorized to change, modify, amend, alter or clarify the prices, specifications, terms and conditions of this Contract.** The Contractor Administrator within Purchasing Operations for this Contract is:

Kevin Dunn, Buyer Specialist
Purchasing Operations
Department of Management and Budget
Mason Bldg, 2nd Floor
PO Box 30026
Lansing, MI 48909
Email: dunnk3@michigan.gov
Phone: 517-241-4225

2.022 Contract Compliance Inspector (CCI)
After DMB-Purchasing Operations receives the properly executed Contract, it is anticipated that the Director of Purchasing Operations, in consultation with the Department will direct the person named below, or any other person so designated, to monitor this Contract during its term. However, monitoring of this Contract implies **no authority to change, modify, clarify, amend, or otherwise alter the prices, terms, conditions and specifications of this Contract as that authority is retained by DMB Purchasing Operations**. The Contract Compliance Inspector for this Contract is:

Laura Dotson
Michigan Department of Community Health
Lewis Cass Building
320 South Walnut Street
Lansing Michigan 48913
Email: DotsonL1@michigan.gov
Phone: (517) 241-4686
Fax: (517) 241-4845

2.023 Project Manager
The following individual will manage, coordinate and oversee this Contract on a day-to-day basis during its term, including all communications regarding coordination, operations and implementation. However, the management and coordination

of this Contract implies **no authority to change, modify, clarify, amend, or otherwise alter the prices, terms, conditions and specifications of this Contract as that authority is retained by DMB Purchasing Operations**:

Trish O'Keefe, RN, MPA
Pharmacy Services Manager
Bureau of Medicaid Operations and Quality Assurance
Medical Services Administration
Michigan Department of Community Health
400 S. Pine Street
Lansing, Michigan 48933
Email: OKeefeT@michigan.gov
Phone: (517) 335-5442
Fax: (517) 335-7959

2.024 Change Requests

During the course of ordinary business, it may become necessary for the State to discontinue certain business practices or create Additional Services/Deliverables. The State reserves the right, by giving Contractor written notice of a change request within a reasonable time, to request any changes to the requirements and specifications of this Contract and the work to be performed by the Contractor under this Contract. In such an event, the Contractor must provide a detailed outline of all work to be done, including tasks necessary to accomplish the services/deliverables, timeframes, listing of key personnel assigned, estimated hours for each individual per task, and a complete and detailed proposal to implement the change.

The State may accept a Contractor's proposal for change, reject it, or reach another agreement with the Contractor. Should the parties agree on carrying out a change, a written Contract Change Notice must be prepared and issued under this Contract, describing the change and its effects on the Services and any affected components of this Contract (a "Contract Change Notice"). No proposed Change may be performed until the proposed Change has been specified in a duly executed Contract Change Notice issued by the Department of Management and Budget, Purchasing Operations. If the Contractor fails to notify the State before beginning to work on the requested activities, then the Contractor waives any right to assert any claim for additional compensation or time for performing the requested activities.

If the State requests or directs the Contractor to perform any activities that Contractor believes constitute a change to the Statement of Work, the Contractor must notify the State that it believes the requested activities are a change before beginning to work on the requested activities. If the Contractor fails to notify the State before beginning to work on the requested activities, then the Contractor waives any right to assert any claim for additional compensation or time for performing the requested activities. If the Contractor commences performing work outside the scope of this Contract and then ceases performing that work, the Contractor must, at the request of the State, retract any out-of-scope work that would adversely affect this Contract.

2.025 Notices

Any notice given to a party under this Contract must be deemed effective, if addressed to the party as addressed to the person named in Section 2.021 and/or on this Contract cover page: (i) delivery, if hand delivered; (ii) receipt of a confirmed transmission by facsimile if a copy of the notice is sent by another means specified in this Section; (iii) the third Business Day after being sent by U.S. mail, postage pre-paid, return receipt requested; or (iv) the next Business Day after being sent by a nationally recognized overnight express courier with a reliable tracking system.

Either party may change its address where notices are to be sent by giving notice according to this Section.

2.026 Binding Commitments

Representatives of Contractor must have the authority to make binding commitments on Contractor's behalf within the bounds set forth in this Contract. Contractor may change the representatives from time to time upon written notice.

2.027 Relationship of the Parties

The relationship between the State and Contractor is that of client and independent contractor. No agent, employee, or servant of Contractor or any of its Subcontractors may be deemed to be an employee, agent or servant of the State for any reason. Contractor will be solely and entirely responsible for its acts and the acts of its agents, employees, servants and Subcontractors during the performance of this Contract.

2.028 Covenant of Good Faith
Each party must act reasonably and in good faith. Unless stated otherwise in this Contract, the parties will not unreasonably delay, condition or withhold the giving of any consent, decision or approval that is either requested or reasonably required of them in order for the other party to perform its responsibilities under this Contract.

2.029 Assignments
(a) Neither party may assign this Contract, or assign or delegate any of its duties or obligations under this Contract, to any other party (whether by operation of law or otherwise), without the prior written consent of the other party; provided, however, that the State may assign this Contract to any other State agency, department, division or department without the prior consent of Contractor and Contractor may assign this Contract to an affiliate so long as the affiliate is adequately capitalized and can provide adequate assurances that the affiliate can perform this Contract. The State may withhold consent from proposed assignments, subcontracts, or notations when the transfer of responsibility would operate to decrease the State's likelihood of receiving performance on this Contract or the State's ability to recover damages.

(b) Contractor may not, without the prior written approval of the State, assign its right to receive payments due under this Contract. If the State permits an assignment, the Contractor is not relieved of its responsibility to perform any of its contractual duties, and the requirement under this Contract that all payments must be made to one entity continues.

(c) If the Contractor requests consent to assign this Contract or any of the Contractor's rights or duties under this Contract, the Contractor must notify the State in writing at least 180 days before the proposed assignment would take effect. The Contractor also must provide the State with adequate information about the assignee within a reasonable amount of time before the assignment for the State to determine whether to approve the assignment.

2.030 General Provisions

2.031 Media Releases
News releases (including promotional literature and commercial advertisements) pertaining to this Contract or project to which it relates must not be made without prior written State approval, and then only in accordance with the explicit written instructions from the State. No results of the activities associated with this Contract are to be released without prior written approval of the State and then only to persons designated.

2.032 Contract Distribution
Purchasing Operations retains the sole right of Contract distribution to all State agencies and local units of government unless other arrangements are authorized by Purchasing Operations.

2.033 Permits
Contractor must obtain and pay any associated costs for all required governmental permits, licenses and approvals for the delivery, installation and performance of the Services. The State must pay for all costs and expenses incurred in obtaining and maintaining any necessary easements or right of way.

2.034 Website Incorporation
The State is not bound by any content on the Contractor's website, even if the Contractor's documentation specifically referenced that content and attempts to incorporate it into any other communication, unless the State has actual knowledge of the content and has expressly agreed to be bound by it in a writing that has been manually signed by an authorized representative of the State.

2.035 Future Bidding Preclusion
Contractor acknowledges that, to the extent this Contract involves the creation, research, investigation or generation of a future RFP, it may be precluded from bidding on the subsequent RFP. The State reserves the right to disqualify any Bidder if the State determines that the Bidder has used its position (whether as an incumbent Contractor, or as a Contractor hired to assist with the RFP development, or as a Vendor offering free assistance) to gain a competitive advantage on the RFP.

2.036 Freedom of Information
All information in any proposal submitted to the State by Contractor and this Contract is subject to the provisions of the Michigan Freedom of Information Act, 1976 Public Act No. 442, as amended, MCL 15.231, et seq. (the "FOIA").

2.037 Disaster Recovery
Contractor and the State recognize that the State provides essential services in times of natural or man-made disasters. Therefore, except as so mandated by federal disaster response requirements, Contractor personnel dedicated to

providing Services/Deliverables under this Contract will provide the State with priority service for repair and work around in the event of a natural or man-made disaster.

2.040 Financial Provisions

2.041 Fixed Prices for Services/Deliverables – Deleted/Not Applicable

2.042 Adjustments for Reductions in Scope of Services/Deliverables
If the scope of the Services/Deliverables under any Statement of Work issued under this Contract is subsequently reduced by the State, the parties must negotiate an equitable reduction in Contractor's charges under such Statement of Work commensurate with the reduction in scope.

2.043 Services/Deliverables Covered
For all Services/Deliverables to be provided by Contractor (and its Subcontractors, if any) under this Contract, the State will not be obligated to pay any amounts in addition to the charges specified in this Contract.

2.044 Invoicing and Payment – In General
Correct invoices will be due and payable by the State, in accordance with the State's standard payment procedure as specified in 1984 Public Act No. 279, MCL 17.51 et seq., provided the State determines that the invoice was properly rendered.

(a) Each Contractor invoice will show details as to charges by Service/Deliverable component and location at a level of detail reasonably necessary to satisfy the State's accounting and charge-back requirements. Invoices for Services performed on a time and materials basis will show, for each individual, the number of hours of Services performed during the billing period, the billable skill/labor category for such person and the applicable hourly billing rate.

(b) Correct invoices will be due and payable by the State, in accordance with the State's standard payment procedure as specified in 1984 Public Act No. 279, MCL 17.51 et seq., provided the State determines that the invoice was properly rendered.

(c) All invoices should reflect actual work done. Specific details of invoices and payments will be agreed upon between the Contract Administrator and the Contractor after this Contract has been signed and accepted by both the Contractor and the Director of Purchasing Operations, Department of Management & Budget. This activity will occur only upon the specific written direction from Purchasing Operations.

The specific payment schedule for any Contract(s) entered into, as the State and the Contractor(s) will mutually agreed upon. The schedule should show payment amount and should reflect actual work done by the payment dates, less any penalty cost charges accrued by those dates. As a general policy, statements shall be forwarded to the designated representative by a mutually agreed upon timeframe.

The State may make progress payments to the Contractor when requested as work progresses, but not more frequently than monthly, in amounts approved by the Contract Administrator, after negotiation. Contractor must show verification of measurable progress at the time of requesting progress payments.

2.045 Pro-ration
To the extent there are any Services that are to be paid for on a monthly basis, the cost of such Services must be pro-rated for any partial month.

2.046 Antitrust Assignment
The Contractor assigns to the State any claim for overcharges resulting from antitrust violations to the extent that those violations concern materials or services supplied by third parties to the Contractor, toward fulfillment of this Contract.

2.047 Final Payment
The making of final payment by the State to Contractor does not constitute a waiver by either party of any rights or other claims as to the other party's continuing obligations under this Contract, nor will it constitute a waiver of any claims by one party against the other arising from unsettled claims or failure by a party to comply with this Contract, including claims for Services and Deliverables not reasonably known until after acceptance to be defective or substandard. Contractor's acceptance of final payment by the State under this Contract constitutes a waiver of all claims by Contractor against the State for payment under this Contract, other than those claims previously filed in writing on a timely basis and still unsettled.

2.048 Electronic Payment Requirement
Electronic transfer of funds is required for payments on State Contracts. Contractors are required to register with the State electronically at http://www.cpexpress.state.mi.us. As stated in Public Act 431 of 1984, all contracts that the State enters into for the purchase of goods and services must provide that payment will be made by electronic fund transfer (EFT).

2.050 Taxes

2.051 Employment Taxes
Contractors must collect and pay all applicable federal, state, and local employment taxes.

2.052 Sales and Use Taxes
Contractors must be registered and to remit sales and use taxes on taxable sales of tangible personal property or services delivered into the State. Contractors that lack sufficient presence in Michigan to be required to register and pay tax must do so as a volunteer. This requirement extends to: (1) all members of any controlled group as defined in § 1563(a) of the Internal Revenue Code and applicable regulations of which the company is a member, and (2) all organizations under common control as defined in § 414(c) of the Internal Revenue Code and applicable regulations of which the company is a member that make sales at retail for delivery into the State are registered with the State for the collection and remittance of sales and use taxes. In applying treasury regulations defining “two or more trades or businesses under common control”, the term “organization” means sole proprietorship, a partnership (as defined in § 701(a)(2) of the Internal Revenue Code), a trust, an estate, a corporation, or a limited liability company.

2.060 Contract Management

2.061 Contractor Personnel Qualifications
All persons assigned by Contractor to the performance of Services under this Contract must be employees of Contractor or its majority-owned (directly or indirectly, at any tier) subsidiaries (or a State-approved Subcontractor) and must be fully qualified to perform the work assigned to them. Contractor must include a similar provision in any subcontract entered into with a Subcontractor. For the purposes of this Contract, independent contractors engaged by Contractor solely in a staff augmentation role must be treated by the State as if they were employees of Contractor for this Contract only; however, the State understands that the relationship between Contractor and Subcontractor is an independent contractor relationship.

2.062 Contractor Key Personnel
(a) The Contractor must provide the State’s Project Manager with the names of the Key Personnel.

(b) Key Personnel must be dedicated as defined in the Statement of Work to this Contract for its duration in the applicable Statement of Work with respect to other individuals designated as Key Personnel for that Statement of Work.

(c) The State will have the right to recommend and approve in writing the initial assignment, as well as any proposed reassignment or replacement, of any Key Personnel. Before assigning an individual to any Key Personnel position, Contractor must notify the State of the proposed assignment, must introduce the individual to the appropriate State representatives, and must provide the State with a resume and any other information about the individual reasonably requested by the State. The State reserves the right to interview the individual before granting written approval. In the event the State finds a proposed individual unacceptable, the State will provide a written explanation including reasonable detail outlining the reasons for the rejection.

(d) Contractor must not remove any Key Personnel from their assigned roles on this Contract without the prior written consent of the State. The Contractor’s removal of Key Personnel without the prior written consent of the State is an unauthorized removal (“Unauthorized Removal”). Unauthorized Removals do not include replacing Key Personnel for reasons beyond the reasonable control of Contractor, including illness, disability, leave of absence, personal emergency circumstances, resignation, or for cause termination of the Key Personnel’s employment. Unauthorized Removals does not include replacing Key Personnel because of promotions or other job movements allowed by Contractor personnel policies or Collective Bargaining Agreement(s) as long as the State receives prior written notice before shadowing occurs and Contractor provides 30 days of shadowing unless parties agree to a different time period. The Contractor with the State must review any Key Personnel replacements, and appropriate transition planning will be established. Any Unauthorized Removal may be considered by the State to be a material breach of this Contract, in respect of which the State may elect to exercise its termination and cancellation rights.

(e) The Contractor must notify the Project Manager and the Contract Administrator at least 10 business days before redeploying non-Key Personnel, who are dedicated to primarily to the Project, to other projects. If the State does not object to the redeployment by its scheduled date, the Contractor may then redeploy the non-Key Personnel.

2.063 Re-assignment of Personnel at the State's Request
The State reserves the right to require the removal from this Contract of Contractor personnel found, in the judgment of the State, to be unacceptable. The State's request must be written with reasonable detail outlining the reasons for the removal request. Additionally, the State's request must be based on legitimate, good-faith reasons. Replacement personnel for the removed person must be fully qualified for the position. If the State exercises this right, and the Contractor cannot immediately replace the removed personnel, the State agrees to an equitable adjustment in schedule or other terms that may be affected by the State's required removal. If any incident with removed personnel results in delay not reasonably anticipatable under the circumstances and which is attributable to the State, the applicable SLAs for the affected Service will not be counted for a time as agreed to by the parties.

2.064 Contractor Personnel Location – Deleted/Not Applicable

2.065 Contractor Identification
Contractor employees must be clearly identifiable while on State property by wearing a State-issued badge, as required. Contractor employees must clearly identify themselves and the company they work for whenever making contact with State personnel by telephone or other means.

2.066 Cooperation with Third Parties
Contractor agrees to cause its personnel and the personnel of any Subcontractors to cooperate with the State and its agents and other contractors including the State's Quality Assurance personnel. As reasonably requested by the State in writing, the Contractor must provide to the State's agents and other contractors reasonable access to Contractor's Project personnel, systems and facilities to the extent the access relates to activities specifically associated with this Contract and must not interfere or jeopardize the safety or operation of the systems or facilities.

2.067 Contractor Return of State Equipment/Resources – Deleted/Not Applicable

2.068 Contract Management Responsibilities
The Contractor must assume responsibility for all contractual activities, whether or not that Contractor performs them. Further, the State considers the Contractor to be the sole point of contact with regard to contractual matters, including payment of any and all charges resulting from this Contract. If any part of the work is to be subcontracted, this Contract must include a list of Subcontractors, including firm name and address, contact person and a complete description of work to be subcontracted. The State reserves the right to approve Subcontractors and to require the Contractor to replace Subcontractors found to be unacceptable. The Contractor is totally responsible for adherence by the Subcontractor to all provisions of this Contract. Any change in Subcontractors must be approved by the State, in writing, prior to such change.

2.070 Subcontracting by Contractor

2.071 Contractor Full Responsibility
Contractor must have full responsibility for the successful performance and completion of all of the Services and Deliverables. The State will consider Contractor to be the sole point of contact with regard to all contractual matters under this Contract, including payment of any and all charges for Services and Deliverables.

2.072 State Consent to Delegation
Contractor must not delegate any duties under this Contract to a Subcontractor unless the Department of Management and Budget, Purchasing Operations has given written consent to such delegation. The State reserves the right of prior written approval of all Subcontractors and to require Contractor to replace any Subcontractors found, in the reasonable judgment of the State, to be unacceptable. The State's request will be written with reasonable detail outlining the reasons for the removal request. Additionally, the State's request will be based on legitimate, good-faith reasons. Replacement Subcontractor(s) for the removed Subcontractor must be fully qualified for the position. If the State exercises this right, and the Contractor cannot immediately replace the removed Subcontractor, the State will agree to an equitable adjustment in schedule or other terms that may be affected by the State's required removal. If any such incident with a removed Subcontractor results in delay not reasonably anticipated under the circumstances and which is attributable to the State, the applicable SLA for the affected Work will not be counted for a time agreed upon by the parties.

2.073 Subcontractor Bound to Contract
In any subcontracts entered into by Contractor for the performance of the Services, Contractor must require the Subcontractor, to the extent of the Services to be performed by the Subcontractor, to be bound to Contractor by the terms of this Contract and to assume toward Contractor all of the obligations and responsibilities that Contractor, by this Contract, assumes toward the State. The State reserves the right to receive copies of and review all subcontracts. The management of any Subcontractor will be the responsibility of Contractor, and Contractor must remain responsible for the performance of its Subcontractors to the same extent as if Contractor had not subcontracted such performance. Contractor must make all payments to Subcontractors or suppliers of Contractor. Except as otherwise agreed in writing by the State and Contractor, the State will not be obligated to direct payments for the Services other than to Contractor. The State's written approval of any Subcontractor engaged by Contractor to perform any obligation under this Contract shall not relieve Contractor of any obligations or performance required under this Contract.

2.074 Flow Down
Except where specifically approved in writing by the State on a case-by-case basis, Contractor must flow down the obligations in **Sections 1.070, 2.031, 2.060, 2.100, 2.110, 2.120, 2.130, 2.200** in all of its agreements with any Subcontractors.

2.075 Competitive Selection
The Contractor must select subcontractors (including suppliers) on a competitive basis to the maximum practical extent consistent with the objectives and requirements of this Contract.

2.080 State Responsibilities

2.081 Equipment – Deleted/Not Applicable

2.082 Facilities
The State must designate space as long as it is available and as provided in the Statement of Work, to house the Contractor's personnel whom the parties agree will perform the Services/Deliverables at State facilities (collectively, the "State Facilities"). The Contractor must have reasonable access to, and, unless agreed otherwise by the parties in writing, must observe and comply with all rules and regulations relating to each of the State Facilities (including hours of operation) used by the Contractor in the course of providing the Services. Contractor agrees that it will not, without the prior written consent of the State, use any State Facilities or access any State information systems provided for the Contractor's use, or to which the Contractor otherwise gains access in the course of performing the Services, for any purpose other than providing the Services to the State.

2.090 Security

2.091 Background Checks
On a case-by-case basis, the State may investigate the Contractor's personnel before they may have access to State facilities and systems. The scope of the background check is at the discretion of the State and the results will be used to determine Contractor personnel eligibility for working within State facilities and systems. The investigations will include Michigan State Police Background checks (ICHAT) and may include the National Crime Information Center (NCIC) Finger Prints. Proposed Contractor personnel may be required to complete and submit an RI-8 Fingerprint Card for the NCIC Finger Print Check. Any request for background checks will be initiated by the State and will be reasonably related to the type of work requested.

All Contractor personnel must comply with the State's security and acceptable use policies for State IT equipment and resources. See http://www.michigan.gov/dit. Furthermore, Contractor personnel must agree to the State's security and acceptable use policies before the Contractor personnel will be accepted as a resource to perform work for the State. The Contractor must present these documents to the prospective employee before the Contractor presents the individual to the State as a proposed resource. Contractor staff must comply with all Physical Security procedures in place within the facilities where they are working.

2.092 Security Breach Notification
If the Contractor breaches this Section, the Contractor must (i) promptly cure any deficiencies and (ii) comply with any applicable federal and state laws and regulations pertaining to unauthorized disclosures. Contractor and the State will cooperate to mitigate, to the extent practicable, the effects of any breach, intrusion, or unauthorized use or disclosure. Contractor must report to the State in writing any use or disclosure of Confidential Information, whether suspected or actual, other than as provided for by this Contract within 24 hours of becoming aware of the use or disclosure or the shorter time period as is reasonable under the circumstances.

2.093 PCI Data Security Requirements – Deleted/Not Applicable

2.100 Confidentiality

2.101 Confidentiality
Contractor and the State each acknowledge that the other possesses and will continue to possess confidential information that has been developed or received by it. As used in this Section, "Confidential Information" of Contractor means all non-public proprietary information of Contractor (other than Confidential Information of the State as defined below) which is marked confidential, restricted, proprietary or with a similar designation. "Confidential Information" of the State means any information which is retained in confidence by the State (or otherwise required to be held in confidence by the State under applicable federal, state and local laws and regulations) or which, in the case of tangible materials provided to Contractor by the State under its performance under this Contract, is marked as confidential, proprietary or with a similar designation by the State. "Confidential Information" excludes any information (including this Contract) that is publicly available under the Michigan FOIA.

2.102 Protection of Confidential Information
The State and Contractor must each use at least the same degree of care to prevent disclosing to third parties the Confidential Information of the other as it employs to avoid unauthorized disclosure, publication or dissemination of its own confidential information of like character, but in no event less than reasonable care. Neither Contractor nor the State will (i) make any use of the Confidential Information of the other except as contemplated by this Contract, (ii) acquire any right in or assert any lien against the Confidential Information of the other, or (iii) if requested to do so, refuse for any reason to promptly return the other party's Confidential Information to the other party. Each party must limit disclosure of the other party's Confidential Information to employees and Subcontractors who must have access to fulfill the purposes of this Contract. Disclosure to, and use by, a Subcontractor is permissible where (A) use of a Subcontractor is authorized under this Contract, (B) the disclosure is necessary or otherwise naturally occurs in connection with work that is within the Subcontractor's scope of responsibility, and (C) Contractor obligates the Subcontractor in a written Contract to maintain the State's Confidential Information in confidence. At the State's request, any employee of Contractor and of any Subcontractor having access or continued access to the State's Confidential Information may be required to execute an acknowledgment that the employee has been advised of Contractor's and the Subcontractor's obligations under this Section and of the employee's obligation to Contractor or Subcontractor, as the case may be, to protect the Confidential Information from unauthorized use or disclosure.

2.103 Exclusions
Notwithstanding the foregoing, the provisions of **Section 2.100** will not apply to any particular information which the State or Contractor can demonstrate (i) was, at the time of disclosure to it, in the public domain; (ii) after disclosure to it, is published or otherwise becomes part of the public domain through no fault of the receiving party; (iii) was in the possession of the receiving party at the time of disclosure to it without an obligation of confidentiality; (iv) was received after disclosure to it from a third party who had a lawful right to disclose the information to it without any obligation to restrict its further disclosure; or (v) was independently developed by the receiving party without reference to Confidential Information of the furnishing party. Further, the provisions of **Section 2.100** will not apply to any particular Confidential Information to the extent the receiving party is required by law to disclose the Confidential Information, provided that the receiving party (i) promptly provides the furnishing party with notice of the legal request, and (ii) assists the furnishing party in resisting or limiting the scope of the disclosure as reasonably requested by the furnishing party.

2.104 No Implied Rights
Nothing contained in this Section must be construed as obligating a party to disclose any particular Confidential Information to the other party, or as granting to or conferring on a party, expressly or impliedly, any right or license to the Confidential Information of the other party.

2.105 Respective Obligations
The parties' respective obligations under this Section must survive the termination or expiration of this Contract for any reason.

2.110 Records and Inspections

2.111 Inspection of Work Performed – Deleted/Not Applicable

2.112 Examination of Records

(a) For seven years after the Contractor provides any work under this Contract (the "Audit Period"), the State's authorized representatives must at all reasonable times, and within seven days prior written notice, be granted full access to Contractor's books and records, in print or electronic form, for examination and audit purposes.

(b) The State does not have the right to review any information deemed confidential by the Contractor to the extent access would require the Confidential Information to become publicly available, as further specified in **Section 2.103**.

(c) This Section also applies to the books, records, accounts, documents and papers, in print or electronic form, of any parent, affiliated or subsidiary organization of Contractor or any Subcontractor of Contractor performing services in connection with this Contract.

2.113 Retention of Records

(a) The Contractor must retain all records related to the Contractor's work and Deliverables until the end of the Audit Period. Records include, but are not limited to, those specified in **Section 1.071 C**.

(b) All financial and accounting records (including, but not limited to, time sheets and payroll records) must be retained until the end of the Audit Period and according to generally accepted accounting principles.

(c) If an investigation, audit, or litigation is anticipated or pending, all records must be retained for one year after all issues arising out of the investigation, audit or litigation is resolved or until the end of the Audit Period, whichever is later.

(d) If this Contract ends before the end of a federal fiscal year, the Audit Period is based on the seven years following the end of the federal fiscal year in which this Contract is terminated.

(e) The Audit Period may be extended by the Department for good cause with written notice to the Contractor.

2.114 Audit Resolution

If necessary, the Contractor and the State will meet to review each audit report promptly after issuance. The Contractor must respond to each audit report in writing within 30 days from receipt of the report, unless a shorter response time is specified in the report. The Contractor must develop, and the State, agree to an action plan to promptly address and resolve any deficiencies, concerns, and/or recommendations in the audit report.

2.115 Errors

(a) If the audit demonstrates any errors in the documents provided to the State, then the amount in error must be reflected as a credit or debit on the next invoice and in subsequent invoices until the amount is paid or refunded in full. However, a credit or debit may not be carried for more than four invoices. If a balance remains after four invoices, then the remaining amount will be due as a payment or refund within 45 days of the last quarterly invoice that the balance appeared on or termination of this Contract, whichever is earlier.

(b) In addition to other available remedies, the difference between the payment received and the correct payment amount is greater than 10 percent, then the Contractor must pay all of the reasonable costs of the audit.

2.120 Warranties

2.121 Warranties and Representations

The Contractor represents and warrants:

(a) It is capable in all respects of fulfilling and must fulfill all of its obligations under this Contract. The performance of all obligations under this Contract must be provided in a timely, professional, and workman-like manner and must meet the performance and operational standards required under this Contract.

(b) These Contract Appendices, Attachments and Exhibits identify the equipment and software and services necessary for the Deliverable(s) to perform and Services to operate in compliance with these Contract's requirements and other standards of performance.

(c) It is the lawful owner or licensee of any Deliverable licensed or sold to the State by Contractor or developed by Contractor under this Contract, and Contractor has all of the rights necessary to convey to the State the ownership rights or licensed use, as applicable, of any and all Deliverables. None of the Deliverables provided by Contractor to the State

under this Contract, nor their use by the State, will infringe the patent, copyright, trade secret, or other proprietary rights of any third party.

(d) If, under this Contract, Contractor procures any equipment, software or other Deliverable for the State (including equipment, software and other Deliverables manufactured, re-marketed or otherwise sold by Contractor under Contractor's name), then in addition to Contractor's other responsibilities with respect to the items in this Contract, Contractor must assign or otherwise transfer to the State or its designees, or afford the State the benefits of, any manufacturer's warranty for the Deliverable.

(e) The Contractor's signatory has the power and authority, including any necessary corporate authorizations, necessary to enter into this Contract, on behalf of Contractor.

(f) It is qualified and registered to transact business in all locations where required.

(g) Neither the Contractor nor any Affiliates, nor any employee of either, has, must have, or must acquire, any contractual, financial, business, or other interest, direct or indirect, that would conflict in any manner or degree with Contractor's performance of its duties and responsibilities to the State under this Contract or otherwise create an appearance of impropriety with respect to the award or performance of this Agreement. Contractor must notify the State about the nature of the conflict or appearance of impropriety within two days of learning about it.

(h) Neither Contractor nor any Affiliates, nor any employee of either has accepted or must accept anything of value based on an understanding that the actions of the Contractor or Affiliates or employee on behalf of the State would be influenced. Contractor must not attempt to influence any State employee by the direct or indirect offer of anything of value.

(i) Neither Contractor nor any Affiliates, nor any employee of either has paid or agreed to pay any person, other than bona fide employees and consultants working solely for Contractor or the Affiliate, any fee, commission, percentage, brokerage fee, gift, or any other consideration, contingent upon or resulting from the award or making of this Contract.

(j) The prices proposed by Contractor were arrived at independently, without consultation, communication, or agreement with any other Bidder for the purpose of restricting competition; the prices quoted were not knowingly disclosed by Contractor to any other Bidder; and no attempt was made by Contractor to induce any other person to submit or not submit a proposal for the purpose of restricting competition.

(k) All financial statements, reports, and other information furnished by Contractor to the State as part of its response to the RFP or otherwise in connection with the award of this Contract fairly and accurately represent the business, properties, financial condition, and results of operations of Contractor as of the respective dates, or for the respective periods, covered by the financial statements, reports, other information. Since the respective dates or periods covered by the financial statements, reports, or other information, there have been no material adverse changes in the business, properties, financial condition, or results of operations of Contractor.

(l) All written information furnished to the State by or for the Contractor in connection with this Contract, including its bid, is true, accurate, and complete, and contains no untrue statement of material fact or omits any material fact necessary to make the information not misleading.

(m) It is not in material default or breach of any other contract or agreement that it may have with the State or any of its departments, commissions, boards, or agencies. Contractor further represents and warrants that it has not been a party to any contract with the State or any of its departments that was terminated by the State or the department within the previous five years for the reason that Contractor failed to perform or otherwise breached an obligation of this Contract.

(n) If any of the certifications, representations, or disclosures made in the Contractor's original bid response change after this Contract award, the Contractor is required to report those changes immediately to the Department of Management and Budget, Purchasing Operations.

2.122 Warranty of Merchantability – Deleted/Not Applicable

2.123 Warranty of Fitness for a Particular Purpose – Deleted/Not Applicable

2.124 Warranty of Title – Deleted/Not Applicable

2.125 Equipment Warranty – Deleted/Not Applicable

2.126 Equipment to be New – Deleted/Not Applicable

2.127 Prohibited Products – Deleted/Not Applicable

2.128 Consequences for Breach
In addition to any remedies available in law, if the Contractor breaches any of the warranties contained in this section, the breach may be considered as a default in the performance of a material obligation of this Contract.

2.130 Insurance

2.131 Liability Insurance
The Contractor must provide proof of the minimum levels of insurance coverage as stated below. The insurance must protect the State from claims which may arise out of or result from the Contractor's performance of services under the terms of this Contract, whether the services are performed by the Contractor, or by any Subcontractor, or by anyone directly or indirectly employed by any of them, or by anyone for whose acts they may be liable.

The Contractor waives all rights against the State of Michigan, its departments, divisions, agencies, offices, commissions, officers, employees and agents for recovery of damages to the extent these damages are covered by the insurance policies the Contractor is required to maintain under this Contract.

All insurance coverage's provided relative to this Contract/Purchase Order are PRIMARY and NON-CONTRIBUTING to any comparable liability insurance (including self-insurances) carried by the State.

The insurance must be written for not less than any minimum coverage specified in this Contract or required by law, whichever is greater.

The insurers selected by Contractor must have an A.M. Best rating of A or better, or as otherwise approved in writing by the State, or if the ratings are no longer available, with a comparable rating from a recognized insurance rating agency. All policies of insurance required in this Contract must be issued by companies that have been approved to do business in the State.
See www.michigan.gov/dleg.

Where specific limits are shown, they are the minimum acceptable limits. If Contractor's policy contains higher limits, the State must be entitled to coverage to the extent of the higher limits.

The Contractor is required to pay for and provide the type and amount of insurance checked ☑ below:

☑ 1. Commercial General Liability with the following minimum coverage:
$2,000,000 General Aggregate Limit other than Products/Completed Operations
$2,000,000 Products/Completed Operations Aggregate Limit
$1,000,000 Personal & Advertising Injury Limit
$1,000,000 Each Occurrence Limit

The Contractor must list the State of Michigan, its departments, divisions, agencies, offices, commissions, officers, employees and agents as ADDITIONAL INSUREDS on the Commercial General Liability certificate. The Contractor must provide evidence that insurance policies contain a waiver of subrogation by the insurance company.

☑ 2. If a motor vehicle is used to provide services or products under this Contract, the Contractor must have vehicle liability insurance on any auto including owned, hired and non-owned vehicles used in Contractor's business for bodily injury and property damage as required by law.

The Contractor must list the State of Michigan, its departments, divisions, agencies, offices, commissions, officers, employees and agents as ADDITIONAL INSUREDS on the vehicle liability certificate. The Contractor must provide evidence that insurance policies contain a waiver of subrogation by the insurance company.

☑ 3. Workers' compensation coverage must be provided according to applicable laws governing the employees and employers work activities in the state of the Contractor's domicile. If the applicable coverage is provided by a self-insurer, proof must be provided of approved self-insured authority by the jurisdiction of domicile. For employees

working outside of the state of qualification, Contractor must provide appropriate certificates of insurance proving mandated coverage levels for the jurisdictions where the employees' activities occur.

Any certificates of insurance received must also provide a list of states where the coverage is applicable.

The Contractor must provide evidence that insurance policies contain a waiver of subrogation by the insurance company. This provision must not be applicable where prohibited or limited by the laws of the jurisdiction in which the work is to be performed.

☑ 4. Employers liability insurance with the following minimum limits:
$100,000 each accident
$100,000 each employee by disease
$500,000 aggregate disease

☑ 5. Employee Fidelity, including Computer Crimes, insurance naming the State as a loss payee, providing coverage for direct loss to the State and any legal liability of the State arising out of or related to fraudulent or dishonest acts committed by the employees of Contractor or its Subcontractors, acting alone or in collusion with others, in a minimum amount of $3,000,000.00 with a maximum deductible of $50,000.00.

2.132 Subcontractor Insurance Coverage
Except where the State has approved in writing a Contractor subcontract with other insurance provisions, Contractor must require all of its Subcontractors under this Contract to purchase and maintain the insurance coverage as described in this Section for the Contractor in connection with the performance of work by those Subcontractors. Alternatively, Contractor may include any Subcontractors under Contractor's insurance on the coverage required in this Section. Subcontractor(s) must fully comply with the insurance coverage required in this Section. Failure of Subcontractor(s) to comply with insurance requirements does not limit Contractor's liability or responsibility.

2.133 Certificates of Insurance and Other Requirements
Contractor must furnish to DMB-Purchasing Operations, certificate(s) of insurance verifying insurance coverage or providing satisfactory evidence of self-insurance as required in this Section (the "Certificates"). The Certificate must be on the standard "accord" form or equivalent. **THIS CONTRACT OR PURCHASE ORDER NO. MUST BE SHOWN ON THE CERTIFICATE OF INSURANCE TO ASSURE CORRECT FILING.** All Certificate(s) are to be prepared and submitted by the Insurance Provider. All Certificate(s) must contain a provision indicating that coverages afforded under the policies WILL NOT BE CANCELLED, MATERIALLY CHANGED, OR NOT RENEWED without 30 days prior written notice, except for 10 days for non-payment of premium, having been given to the Director of Purchasing Operations, Department of Management and Budget. The notice must include this Contract or Purchase Order number affected. Before this Contract is signed, and not less than 20 days before the insurance expiration date every year thereafter, the Contractor must provide evidence that the State and its agents, officers and employees are listed as additional insureds under each commercial general liability and commercial automobile liability policy. In the event the State approves the representation of the State by the insurer's attorney, the attorney may be required to be designated as a Special Assistant Attorney General by the Attorney General of the State of Michigan.

The Contractor must maintain all required insurance coverage throughout the term of this Contract and any extensions and, in the case of claims-made Commercial General Liability policies, must secure tail coverage for at least three years following the expiration or termination for any reason of this Contract. The minimum limits of coverage specified above are not intended, and must not be construed, to limit any liability or indemnity of Contractor under this Contract to any indemnified party or other persons. Contractor is responsible for all deductibles with regard to the insurance. If the Contractor fails to pay any premium for required insurance as specified in this Contract, or if any insurer cancels or significantly reduces any required insurance as specified in this Contract without the State's written consent, then the State may, after the State has given the Contractor at least 30 days written notice, pay the premium or procure similar insurance coverage from another company or companies. The State may deduct any part of the cost from any payment due the Contractor, or the Contractor must pay that cost upon demand by the State.

2.140 Indemnification

2.141 General Indemnification
To the extent permitted by law, the Contractor must indemnify, defend and hold harmless the State from liability, including all claims and losses, and all related costs and expenses (including reasonable attorneys' fees and costs of investigation, litigation, settlement, judgments, interest and penalties), accruing or resulting to any person, firm or corporation that may

be injured or damaged by the Contractor in the performance of this Contract and that are attributable to the negligence or tortious acts of the Contractor or any of its Subcontractors, or by anyone else for whose acts any of them may be liable.

2.142 Code Indemnification

To the extent permitted by law, the Contractor must indemnify, defend and hold harmless the State from any claim, loss, or expense arising from Contractor's breach of the No Surreptitious Code Warranty.

The No Surreptitious Code Warranty means that the Contractor represents and warrants that no copy of licensed Software provided to the State contains or will contain in any Self-Help Code or any Unauthorized Code as defined below. This may not apply if a Contractor's proposal does not contemplate providing software programs under this Contract.

As used in this Contract, "Self-Help Code" means any back door, time bomb, drop dead device, or other software routine designed to disable a computer program automatically with the passage of time or under the positive control of a person other than the licensee of the software. Self-Help Code does not include Software routines in a computer program, if any, designed to permit an owner of the computer program (or other person acting by authority of the owner) to obtain access to a licensee's computer system (e.g. remote access via modem) for purposes of maintenance or technical support.

As used in this Contract, "Unauthorized Code" means any virus, Trojan horse, spyware, worm or other Software routines or components designed to permit unauthorized access to disable, erase, or otherwise harm software, equipment, or data; or to perform any other such actions. The term Unauthorized Code does not include Self-Help Code.

2.143 Employee Indemnification

In any claims against the State of Michigan, its departments, divisions, agencies, sections, commissions, officers, employees and agents, by any employee of the Contractor or any of its Subcontractors, the indemnification obligation under this Contract must not be limited in any way by the amount or type of damages, compensation or benefits payable by or for the Contractor or any of its Subcontractors under worker's disability compensation acts, disability benefit acts or other employee benefit acts. This indemnification clause is intended to be comprehensive. Any overlap in provisions, or the fact that greater specificity is provided as to some categories of risk, is not intended to limit the scope of indemnification under any other provisions.

2.144 Patent/Copyright Infringement Indemnification

To the extent permitted by law, the Contractor must indemnify, defend and hold harmless the State from and against all losses, liabilities, damages (including taxes), and all related costs and expenses (including reasonable attorneys' fees and costs of investigation, litigation, settlement, judgments, interest and penalties) incurred in connection with any action or proceeding threatened or brought against the State to the extent that the action or proceeding is based on a claim that any piece of equipment, software, commodity or service supplied by the Contractor or its subcontractors, or the operation of the equipment, software, commodity or service, or the use or reproduction of any documentation provided with the equipment, software, commodity or service infringes any United States patent, copyright, trademark or trade secret of any person or entity, which is enforceable under the laws of the United States.

In addition, should the equipment, software, commodity, or service, or its operation, become or in the State's or Contractor's opinion be likely to become the subject of a claim of infringement, the Contractor must at the Contractor's sole expense (i) procure for the State the right to continue using the equipment, software, commodity or service or, if the option is not reasonably available to the Contractor, (ii) replace or modify to the State's satisfaction the same with equipment, software, commodity or service of equivalent function and performance so that it becomes non-infringing, or, if the option is not reasonably available to Contractor, (iii) accept its return by the State with appropriate credits to the State against the Contractor's charges and reimburse the State for any losses or costs incurred as a consequence of the State ceasing its use and returning it.

Notwithstanding the foregoing, the Contractor has no obligation to indemnify or defend the State for, or to pay any costs, damages or attorneys' fees related to, any claim based upon (i) equipment developed based on written specifications of the State; (ii) use of the equipment in a configuration other than implemented or approved in writing by the Contractor, including, but not limited to, any modification of the equipment by the State; or (iii) the combination, operation, or use of the equipment with equipment or software not supplied by the Contractor under this Contract.

2.145 Continuation of Indemnification Obligations

The Contractor's duty to indemnify under this Section continues in full force and effect, notwithstanding the expiration or early cancellation of this Contract, with respect to any claims based on facts or conditions that occurred before expiration or cancellation.

2.146 Indemnification Procedures

The procedures set forth below must apply to all indemnity obligations under this Contract.

(a) After the State receives notice of the action or proceeding involving a claim for which it will seek indemnification, the State must promptly notify Contractor of the claim in writing and take or assist Contractor in taking, as the case may be, any reasonable action to avoid the imposition of a default judgment against Contractor. No failure to notify the Contractor relieves the Contractor of its indemnification obligations except to the extent that the Contractor can prove damages attributable to the failure. Within 10 days following receipt of written notice from the State relating to any claim, the Contractor must notify the State in writing whether Contractor agrees to assume control of the defense and settlement of that claim (a "Notice of Election"). After notifying Contractor of a claim and before the State receiving Contractor's Notice of Election, the State is entitled to defend against the claim, at the Contractor's expense, and the Contractor must be responsible for any reasonable costs incurred by the State in defending against the claim during that period.

(b) If Contractor delivers a Notice of Election relating to any claim: (i) the State is entitled to participate in the defense of the claim and to employ counsel at its own expense to assist in the handling of the claim and to monitor and advise the State about the status and progress of the defense; (ii) the Contractor must, at the request of the State, demonstrate to the reasonable satisfaction of the State, the Contractor's financial ability to carry out its defense and indemnity obligations under this Contract; (iii) the Contractor must periodically advise the State about the status and progress of the defense and must obtain the prior written approval of the State before entering into any settlement of the claim or ceasing to defend against the claim and (iv) to the extent that any principles of Michigan governmental or public law may be involved or challenged, the State has the right, at its own expense, to control the defense of that portion of the claim involving the principles of Michigan governmental or public law. But the State may retain control of the defense and settlement of a claim by notifying the Contractor in writing within 10 days after the State's receipt of Contractor's information requested by the State under clause (ii) of this paragraph if the State determines that the Contractor has failed to demonstrate to the reasonable satisfaction of the State the Contractor's financial ability to carry out its defense and indemnity obligations under this Section. Any litigation activity on behalf of the State, or any of its subdivisions under this Section, must be coordinated with the Department of Attorney General. In the event the insurer's attorney represents the State under this Section, the insurer's attorney may be required to be designated as a Special Assistant Attorney General by the Attorney General of the State of Michigan.

(c) If Contractor does not deliver a Notice of Election relating to any claim of which it is notified by the State as provided above, the State may defend the claim in the manner as it may deem appropriate, at the cost and expense of Contractor. If it is determined that the claim was one against which Contractor was required to indemnify the State, upon request of the State, Contractor must promptly reimburse the State for all the reasonable costs and expenses.

2.150 Termination/Cancellation

2.151 Notice and Right to Cure

If the Contractor breaches this Contract, and the State in its sole discretion determines that the breach is curable, then the State will provide the Contractor with written notice of the breach and a reasonable time period to cure the breach. During the cure and resolution period, the Contractor must continue to provide Services in a manner to minimize the disruption of Services to members. The notice of breach and opportunity to cure is inapplicable for successive or repeated breaches or if the State determines in its sole discretion that the breach poses a serious and imminent threat to the health or safety of any person or the imminent loss, damage, or destruction of any real or tangible personal property.

2.152 Termination for Cause

(a) The State may terminate this Contract, for cause, by notifying the Contractor in writing, if the Contractor (i) breaches any of its material duties or obligations under this Contract (including a Chronic Failure to meet any particular SLA), or (ii) fails to cure a breach within the time period specified in the written notice of breach provided by the State

(b) If this Contract is terminated for cause, the Contractor must pay all costs incurred by the State in terminating this Contract, including but not limited to, State administrative costs, reasonable attorneys' fees and court costs, and any reasonable additional costs the State may incur to procure the Services/Deliverables required by this Contract from other sources. Re-procurement costs are not consequential, indirect or incidental damages, and cannot be excluded by any other terms otherwise included in this Contract, provided the costs are not in excess of 50 percent more than the prices for the Service/Deliverables provided under this Contract.

(c) If the State chooses to partially terminate this Contract for cause, charges payable under this Contract will be equitably adjusted to reflect those Services/Deliverables that are terminated and the State must pay for all

Services/Deliverables for which Final Acceptance has been granted provided up to the termination date. Services and related provisions of this Contract that are terminated for cause must cease on the effective date of the termination.

(d) If the State terminates this Contract for cause under this Section, and it is determined, for any reason, that Contractor was not in breach of this Contract under the provisions of this section, that termination for cause must be deemed to have been a termination for convenience, effective as of the same date, and the rights and obligations of the parties must be limited to that otherwise provided in this Contract for a termination for convenience.

2.153 Termination for Convenience

The State may terminate this Contract for its convenience, in whole or part, if the State determines that a termination is in the State's best interest. Reasons for the termination must be left to the sole discretion of the State and may include, but not necessarily be limited to (a) the State no longer needs the Services or products specified in this Contract, (b) relocation of office, program changes, changes in laws, rules, or regulations make implementation of the Services no longer practical or feasible, (c) unacceptable prices for Additional Services or New Work requested by the State, or (d) falsification or misrepresentation, by inclusion or non-inclusion, of information material to a response to any RFP issued by the State. The State may terminate this Contract for its convenience, in whole or in part, by giving Contractor written notice at least 30 days before the date of termination. If the State chooses to terminate this Contract in part, the charges payable under this Contract must be equitably adjusted to reflect those Services/Deliverables that are terminated. Services and related provisions of this Contract that are terminated for cause must cease on the effective date of the termination.

2.154 Termination for Non-Appropriation

(a) Contractor acknowledges that, if this Contract extends for several fiscal years, continuation of this Contract is subject to appropriation or availability of funds for this Contract. If funds to enable the State to effect continued payment under this Contract are not appropriated or otherwise made available, the State must terminate this Contract and all affected Statements of Work, in whole or in part, at the end of the last period for which funds have been appropriated or otherwise made available by giving written notice of termination to Contractor. The State must give Contractor at least 30 days advance written notice of termination for non-appropriation or unavailability (or the time as is available if the State receives notice of the final decision less than 30 days before the funding cutoff).

(b) If funding for this Contract is reduced by law, or funds to pay Contractor for the agreed-to level of the Services or production of Deliverables to be provided by Contractor are not appropriated or otherwise unavailable, the State may, upon 30 days written notice to Contractor, reduce the level of the Services or the change the production of Deliverables in the manner and for the periods of time as the State may elect. The charges payable under this Contract will be equitably adjusted to reflect any equipment, services or commodities not provided by reason of the reduction.

(c) If the State terminates this Contract, eliminates certain Deliverables, or reduces the level of Services to be provided by Contractor under this Section, the State must pay Contractor for all Work-in-Process performed through the effective date of the termination or reduction in level, as the case may be and as determined by the State, to the extent funds are available. This Section will not preclude Contractor from reducing or stopping Services/Deliverables or raising against the State in a court of competent jurisdiction, any claim for a shortfall in payment for Services performed or Deliverables finally accepted before the effective date of termination.

2.155 Termination for Criminal Conviction

The State may terminate this Contract immediately and without further liability or penalty in the event Contractor, an officer of Contractor, or an owner of a 25 percent or greater share of Contractor is convicted of a criminal offense related to a State, public or private contract or subcontract.

2.156 Termination for Approvals Rescinded

The State may terminate this Contract if any final administrative or judicial decision or adjudication disapproves a previously approved request for purchase of personal services under Constitution 1963, Article 11, § 5, and Civil Service Rule 7-1. In that case, the State will pay the Contractor for only the work completed to that point under this Contract. Termination may be in whole or in part and may be immediate as of the date of the written notice to Contractor or may be effective as of the date stated in the written notice.

2.157 Rights and Obligations upon Termination

(a) If the State terminates this Contract for any reason, the Contractor must (a) stop all work as specified in the notice of termination, (b) take any action that may be necessary, or that the State may direct, for preservation and protection of Deliverables or other property derived or resulting from this Contract that may be in Contractor's possession, (c) return all materials and property provided directly or indirectly to Contractor by any entity, agent or employee of the State, (d)

transfer title in, and deliver to, the State, unless otherwise directed, all Deliverables intended to be transferred to the State at the termination of this Contract and which are resulting from this Contract (which must be provided to the State on an "As-Is" basis except to the extent the amounts paid by the State in respect of the items included compensation to Contractor for the provision of warranty services in respect of the materials), and (e) take any action to mitigate and limit any potential damages, or requests for Contractor adjustment or termination settlement costs, to the maximum practical extent, including terminating or limiting as otherwise applicable those subcontracts and outstanding orders for material and supplies resulting from the terminated Contract.

(b) If the State terminates this Contract before its expiration for its own convenience, the State must pay Contractor for all charges due for Services provided before the date of termination and, if applicable, as a separate item of payment under this Contract, for Work In Process, on a percentage of completion basis at the level of completion determined by the State. All completed or partially completed Deliverables prepared by Contractor under this Contract, at the option of the State, becomes the State's property, and Contractor is entitled to receive equitable fair compensation for the Deliverables. Regardless of the basis for the termination, the State is not obligated to pay, or otherwise compensate, Contractor for any lost expected future profits, costs or expenses incurred with respect to Services not actually performed for the State.

(c) Upon a good faith termination, the State may assume, at its option, any subcontracts and agreements for services and deliverables provided under this Contract, and may further pursue completion of the Services/Deliverables under this Contract by replacement contract or otherwise as the State may in its sole judgment deem expedient.

2.158 Reservation of Rights
Any termination of this Contract or any Statement of Work issued under it by a party must be with full reservation of, and without prejudice to, any rights or remedies otherwise available to the party with respect to any claims arising before or as a result of the termination.

2.160 Deleted – Not Applicable

2.170 Transition Responsibilities

2.171 Contractor Transition Responsibilities
If the State terminates this Contract, for convenience or cause, or if this Contract is otherwise dissolved, voided, rescinded, nullified, expires or rendered unenforceable, the Contractor must comply with direction provided by the State to assist in the orderly transition of applicable equipment, services, software, leases, etc. to the State or a third party designated by the State. If this Contract expires or terminates, the Contractor must make all reasonable efforts to effect an orderly transition of services within a reasonable period of time that in no event will exceed 365 days. These efforts must include, but are not limited to, those listed in **Sections 2.171, 2.172, 2.173, 2.174, and 2.175.**

2.172 Contractor Personnel Transition
The Contractor must work with the State, or a specified third party, to develop a transition plan setting forth the specific tasks and schedule to be accomplished by the parties, to effect an orderly transition. The Contractor must allow as many personnel as practicable to remain on the job to help the State, or a specified third party, maintain the continuity and consistency of the services required by this Contract. In addition, during or following the transition period, in the event the State requires the Services of the Contractor's subcontractors or vendors, as necessary to meet its needs, Contractor must reasonably, and with good-faith, work with the State to use the Services of Contractor's subcontractors or vendors. Contractor will notify all of Contractor's subcontractors of procedures to be followed during transition.

2.173 Contractor Information Transition
The Contractor must provide reasonable detailed specifications for all Services/Deliverables needed by the State, or specified third party, to properly provide the Services/Deliverables required under this Contract. The Contractor must provide the State with asset management data generated from the inception of this Contract through the date on which this Contractor is terminated in a comma-delineated format unless otherwise requested by the State. The Contractor must deliver to the State any remaining owed reports and documentation still in Contractor's possession subject to appropriate payment by the State.

2.174 Contractor Software Transition
The Contractor must reasonably assist the State in the acquisition of any Contractor software required to perform the Services and/or use the Deliverables under this Contract. This must include any documentation being used by the Contractor to perform the Services under this Contract. If the State transfers any software licenses to the Contractor,

those licenses must, upon expiration of this Contract, transfer back to the State at their current revision level. Upon notification by the State, Contractor may be required to freeze all non-critical changes to Deliverables/Services.

2.175 Transition Payments
If the transition results from a termination for any reason, reimbursement must be governed by the termination provisions of this Contract. If the transition results from expiration, the Contractor will be reimbursed for all reasonable transition costs (i.e. costs incurred within the agreed period after this Contract expiration that result from transition operations) at the rates agreed upon by the State. The Contractor must prepare an accurate accounting from which the State and Contractor may reconcile all outstanding accounts.

2.176 State Transition Responsibilities
In the event that this Contract is terminated for any reason, the State must perform the following obligations, and any others upon which the State and the Contractor agree:
(a) Reconciling all accounts between the State and the Contractor;
(b) Completing any pending post-project reviews.

2.180 Stop Work

2.181 Stop Work Orders
The State may, at any time, by written stop work order to Contractor, require that Contractor stop all, or any part, of the work called for by this Contract for a period of up to 90 calendar days after the stop work order is delivered to Contractor, and for any further period to which the parties may agree. The stop work order must be identified as a stop work order and must indicate that it is issued under this **Section 2.180**. Upon receipt of the stop work order, Contractor must immediately comply with its terms and take all reasonable steps to minimize incurring costs allocable to the work covered by the stop work order during the period of work stoppage. Within the period of the stop work order, the State must either: (a) cancel the stop work order; or (b) terminate the work covered by the stop work order as provided in **Section 2.150**.

2.182 Cancellation or Expiration of Stop Work Order
The Contractor must resume work if the State cancels a Stop Work Order or if it expires. The parties will agree upon an equitable adjustment in the delivery schedule, this Contract price, or both, and this Contract must be modified, in writing, accordingly, if: (a) the stop work order results in an increase in the time required for, or in Contractor's costs properly allocable to, the performance of any part of this Contract; and (b) Contractor asserts its right to an equitable adjustment within 30 calendar days after the end of the period of work stoppage; provided that, if the State decides the facts justify the action, the State may receive and act upon a Contractor proposal submitted at any time before final payment under this Contract. Any adjustment will conform to the requirements of **Section 2.024**.

2.183 Allowance of Contractor Costs
If the stop work order is not canceled and the work covered by the stop work order is terminated for reasons other than material breach, the termination must be deemed to be a termination for convenience under **Section 2.150**, and the State will pay reasonable costs resulting from the stop work order in arriving at the termination settlement. The State is not liable to Contractor for loss of profits because of a stop work order issued under this **Section 2.180.**

2.190 Dispute Resolution

2.191 In General
Any claim, counterclaim, or dispute between the State and Contractor arising out of or relating to this Contract or any Statement of Work must be resolved as follows. For all Contractor claims seeking an increase in the amounts payable to Contractor under this Contract, or the time for Contractor's performance, Contractor must submit a letter, together with all data supporting the claims, executed by Contractor certifying that (a) the claim is made in good faith, (b) the amount claimed accurately reflects the adjustments in the amounts payable to Contractor or the time for Contractor's performance for which Contractor believes the State is liable and covers all costs of every type to which Contractor is entitled from the occurrence of the claimed event, and (c) the claim and the supporting data are current and complete to Contractor's best knowledge and belief.

2.192 Informal Dispute Resolution
(a) All disputes between the parties must be resolved under the Contract Management procedures in this Contract. If the parties are unable to resolve any disputes after compliance with the processes, the parties must meet with the Director of Purchasing Operations, DMB, or designee, for the purpose of attempting to resolve the dispute without the need for formal legal proceedings, as follows:

(i) The representatives of Contractor and the State must meet as often as the parties reasonably deem necessary to gather and furnish to each other all information with respect to the matter in issue which the parties believe to be appropriate and germane in connection with its resolution. The representatives must discuss the problem and negotiate in good faith in an effort to resolve the dispute without the necessity of any formal proceeding.

(ii) During the course of negotiations, all reasonable requests made by one party to another for non-privileged information reasonably related to this Contract will be honored in order that each of the parties may be fully advised of the other's position.

(iii) The specific format for the discussions will be left to the discretion of the designated State and Contractor representatives, but may include the preparation of agreed upon statements of fact or written statements of position.

(iv) Following the completion of this process within 60 calendar days, the Director of Purchasing Operations, DMB, or designee, must issue a written opinion regarding the issue(s) in dispute within 30 calendar days. The opinion regarding the dispute must be considered the State's final action and the exhaustion of administrative remedies.

(b) This Section must not be construed to prevent either party from instituting, and a party is authorized to institute, formal proceedings earlier to avoid the expiration of any applicable limitations period, to preserve a superior position with respect to other creditors, or under **Section 2.193**.

(c) The State will not mediate disputes between the Contractor and any other entity, except state agencies, concerning responsibility for performance of work under this Contract.

2.193 Injunctive Relief

The only circumstance in which disputes between the State and Contractor will not be subject to the provisions of **Section 2.192** is where a party makes a good faith determination that a breach of the terms of this Contract by the other party is the that the damages to the party resulting from the breach will be so immediate, so large or severe and so incapable of adequate redress after the fact that a temporary restraining order or other immediate injunctive relief is the only adequate remedy.

2.194 Continued Performance

Each party agrees to continue performing its obligations under this Contract while a dispute is being resolved except to the extent the issue in dispute precludes performance (dispute over payment must not be deemed to preclude performance) and without limiting either party's right to terminate this Contract as provided in **Section 2.150**, as the case may be.

2.200 Federal and State Contract Requirements

2.201 Nondiscrimination

In the performance of this Contract, Contractor must not to discriminate against any employee or applicant for employment, with respect to his or her hire, tenure, terms, conditions or privileges of employment, or any matter directly or indirectly related to employment, because of race, color, religion, national origin, ancestry, age, sex, height, weight, marital status, or physical or mental disability. The Contractor further agrees that every subcontract entered into for the performance of this Contract or any purchase order resulting from this Contract must contain a provision requiring non-discrimination in employment, as specified here, binding upon each Subcontractor. This covenant is required under the Elliot Larsen Civil Rights Act, 1976 PA 453, MCL 37.2101, et seq., and the Persons with Disabilities Civil Rights Act, 1976 PA 220, MCL 37.1101, et seq., and any breach of this provision may be regarded as a material breach of this Contract.

2.202 Unfair Labor Practices

Under 1980 PA 278, MCL 423.321, et seq., the State must not award a contract or subcontract to an employer whose name appears in the current register of employers failing to correct an unfair labor practice compiled under Section 2 of the Act. This information is compiled by the United States National Labor Relations Board. A Contractor of the State, in relation to this Contract, must not enter into a contract with a Subcontractor, manufacturer, or supplier whose name appears in this register. Under Section 4 of 1980 PA 278, MCL 423.324, the State may void any contract if, after award of this Contract, the name of Contractor as an employer or the name of the Subcontractor, manufacturer or supplier of Contractor appears in the register.

2.203 Workplace Safety and Discriminatory Harassment
In performing Services for the State, the Contractor must comply with CSC Rule 1-8.3 regarding Discriminatory Harassment and 2-20 regarding Workplace Safety. In addition, the Contractor must comply with Civil Service regulations and any applicable agency rules provided to the Contractor. For Civil Service Rules, see http://www.michign.gov/mdcs/.

2.204 Prevailing Wage – Deleted/Not Applicable

2.210 Governing Law

2.211 Governing Law
This Contract must in all respects be governed by, and construed according to, the substantive laws of the State of Michigan without regard to any Michigan choice of law rules that would apply the substantive law of any other jurisdiction to the extent not inconsistent with, or pre-empted by federal law.

2.212 Compliance with Laws
(a) Contractor must comply with all applicable State, federal, and local laws, and regulations.
(b) Contractor must comply with all State and federal Medicaid requirements, including, but not limited to, current and future rules, policies, guidelines, notifications, and notices, in providing the Services, work and Deliverables.

2.213 Jurisdiction
Any dispute arising from this Contract must be resolved in the State of Michigan. With respect to any claim between the parties, Contractor consents to venue in Ingham County, Michigan, and irrevocably waives any objections it may have to the jurisdiction on the grounds of lack of personal jurisdiction of the court or the laying of venue of the court or on the basis of forum non conveniens or otherwise. Contractor agrees to appoint agents in the State of Michigan to receive service of process.

2.220 Limitation of Liability

2.221 Limitation of Liability
Neither the Contractor nor the State is liable to each other, regardless of the form of action, for consequential, incidental, indirect, or special damages. This limitation of liability does not apply to claims for infringement of United States patent, copyright, trademark or trade secrets; to claims for personal injury or damage to property caused by the gross negligence or willful misconduct of the Contractor; to claims covered by other specific provisions of this Contract calling for liquidated damages; or to court costs or attorney's fees awarded by a court in addition to damages after litigation based on this Contract.

2.230 Disclosure Responsibilities

2.231 Disclosure of Litigation
(a) Disclosure. Contractor must disclose any material criminal litigation, investigations or proceedings involving the Contractor (and each Subcontractor) or any of its officers or directors or any litigation, investigations or proceedings under the Sarbanes-Oxley Act. In addition, the Contractor (and each Subcontractor) must notify the State of any material civil litigation, arbitration or proceeding which arises during the term of this Contract and extensions, to which Contractor (or, to the extent Contractor is aware, any Subcontractor) is a party, and which involves: (i) disputes that might reasonably be expected to adversely affect the viability or financial stability of Contractor or any Subcontractor; or (ii) a claim or written allegation of fraud against Contractor or, to the extent Contractor is aware, any Subcontractor by a governmental or public entity arising out of their business dealings with governmental or public entities. The Contractor must disclose in writing to the Contract Administrator any litigation, investigation, arbitration or other proceeding (collectively, "Proceeding") within 30 days of its occurrence. Details of settlements which are prevented from disclosure by the terms of the settlement may be annotated. Information provided to the State from Contractor's publicly filed documents referencing its material litigation will be deemed to satisfy the requirements of this Section.

(b) Assurances. If any Proceeding disclosed to the State under this Section, or of which the State otherwise becomes aware, during the term of this Contract would cause a reasonable party to be concerned about:

(i) the ability of Contractor (or a Subcontractor) to continue to perform this Contract according to its terms and conditions, or
(ii) whether Contractor (or a Subcontractor) in performing Services for the State is engaged in conduct which is similar in nature to conduct alleged in the Proceeding, which conduct would constitute a breach of this Contract

or a violation of Michigan law, regulations or public policy, then the Contractor must provide the State all reasonable assurances requested by the State to demonstrate that:

(a) Contractor and its Subcontractors will be able to continue to perform this Contract and any Statements of Work according to its terms and conditions, and

(b) Contractor and its Subcontractors have not and will not engage in conduct in performing the Services which is similar in nature to the conduct alleged in the Proceeding.

(c) Contractor must make the following notifications in writing:

(1) Within 30 days of Contractor becoming aware that a change in its ownership or officers has occurred, or is certain to occur, or a change that could result in changes in the valuation of its capitalized assets in the accounting records, Contractor must notify DMB Purchasing Operations.

(2) Contractor must also notify DMB Purchasing Operations within 30 days whenever changes to asset valuations or any other cost changes have occurred or are certain to occur as a result of a change in ownership or officers.

(3) Contractor must also notify DMB Purchasing Operations within 30 days whenever changes to company affiliations occur.

2.232 Call Center Disclosure

Contractor and/or all Subcontractors involved in the performance of this Contract providing call or contact center services to the State must disclose the location of its call or contact center services to inbound callers. Failure to disclose this information is a material breach of this Contract.

2.233 Bankruptcy

The State may, without prejudice to any other right or remedy, terminate this Contract, in whole or in part, and, at its option, take possession of the "Work in Process" and finish the Works in Process by whatever appropriate method the State may deem expedient if:

(a) the Contractor files for protection under the bankruptcy laws;

(b) an involuntary petition is filed against the Contractor and not removed within 30 days;

(c) the Contractor becomes insolvent or if a receiver is appointed due to the Contractor's insolvency;

(d) the Contractor makes a general assignment for the benefit of creditors; or

(e) the Contractor or its affiliates are unable to provide reasonable assurances that the Contractor or its affiliates can deliver the services under this Contract.

Contractor must fix appropriate notices or labels on the Work in Process to indicate ownership by the State. To the extent reasonably possible, materials and Work in Process must be stored separately from other stock and marked conspicuously with labels indicating ownership by the State.

2.240 Performance

2.241 Time of Performance

(a) Contractor must use commercially reasonable efforts to provide the resources necessary to complete all Services and Deliverables according to the time schedules contained in the Statements of Work and other Exhibits governing the work, and with professional quality.

(b) Without limiting the generality of **Section 2.241(a),** Contractor must notify the State in a timely manner upon becoming aware of any circumstances that may reasonably be expected to jeopardize the timely and successful completion of any Deliverables/Services on the scheduled due dates in the latest State-approved delivery schedule and must inform the State of the projected actual delivery date.

(c) If the Contractor believes that a delay in performance by the State has caused or will cause the Contractor to be unable to perform its obligations according to these specified Contract time periods, the Contractor must notify the State in a timely manner and must use commercially reasonable efforts to perform its obligations according to this Contract time periods notwithstanding the State's failure. Contractor will not be in default for a delay in performance to the extent the delay is caused by the State.

2.242 Service Level Agreements (SLAs)

(a) SLAs will be completed with the following operational considerations:

(i) SLAs will not be calculated for individual Incidents where any event of Excusable Failure has been determined; Incident means any interruption in Services.

(ii) SLAs will not be calculated for individual Incidents where loss of service is planned and where the State has received prior notification or coordination.

(iii) SLAs will not apply if the applicable Incident could have been prevented through planning proposed by Contractor and not implemented at the request of the State. To invoke this consideration, complete documentation relevant to the denied planning proposal must be presented to substantiate the proposal.

(iv) Time period measurements will be based on the time incidents are received by the Contractor and the time that the State receives notification of resolution based on 24x7x365 time period, except that the time period measurement will be suspended based on the following:

1. Time period(s) will not apply where Contractor does not have access to a physical State Location and where access to the State Location is necessary for problem identification and resolution.
2. Time period(s) will not apply where Contractor needs to obtain timely and accurate information or appropriate feedback and is unable to obtain timely and accurate information or appropriate feedback from the State.

(b) Chronic Failure for any Service(s) will be defined as three unscheduled outage(s) or interruption(s) on any individual Service for the same reason or cause or if the same reason or cause was reasonably discoverable in the first instance over a rolling 30 day period. Chronic Failure will result in the State's option to terminate the effected individual Service(s) and procure them from a different vendor for the chronic location(s) with Contractor to pay the difference in charges for up to three additional months. The termination of the Service will not affect any tiered pricing levels.

(c) Root Cause Analysis will be performed on any Business Critical outage(s) or outage(s) on Services when requested by the Project Manager. Contractor will provide its analysis within two weeks of outage(s) and provide a recommendation for resolution.

(d) All decimals must be rounded to two decimal places with five and greater rounding up and four and less rounding down unless otherwise specified.

2.243 Liquidated Damages

It is acknowledged that an Unauthorized Removal of Key Personnel will interfere with the timely and proper completion of this Contract, to the loss and damage of the State, and that it would be impracticable and extremely difficult to fix the actual damage sustained by the State as a result of any Unauthorized Removal. Therefore, Contractor and the State agree that in the case of any Unauthorized Removal in respect of which the State does not elect to exercise its rights under **Section 2.152**, the State may assess liquidated damages against Contractor as specified below.

For the Unauthorized Removal of any Key Personnel designated in the applicable Statement of Work, the liquidated damages amount is $25,000.00 per individual if the Contractor identifies a replacement approved by the State under **Section 2.060** and assigns the replacement to the Project to shadow the Key Personnel who is leaving for a period of at least 30 days before the Key Personnel's removal.

If Contractor fails to assign a replacement to shadow the removed Key Personnel for at least 30 days, in addition to the $25,000.00 liquidated damages for an Unauthorized Removal, Contractor must pay the amount of $833.33 per day for each day of the 30 day shadow period that the replacement Key Personnel does not shadow the removed Key Personnel, up to $25,000.00 maximum per individual. The total liquidated damages that may be assessed per Unauthorized Removal and failure to provide 30 days of shadowing must not exceed $50,000.00 per individual.

2.244 Excusable Failure

Neither party will be liable for any default, damage or delay in the performance of its obligations under this Contract to the extent caused by lightning, earthquake, war, water or other forces of nature or acts of God, delays or failures of transportation, equipment shortages, or acts or omissions of common carriers, fire; riots, civil disorders; strikes or other labor disputes, embargoes; injunctions (provided the injunction was not issued as a result of any fault or negligence of the party seeking to have its default or delay excused); or any other cause beyond the reasonable control of a party; provided the non-performing party and its Subcontractors are without fault in causing the default or delay, and the default or delay could not have been prevented by reasonable precautions and cannot reasonably be circumvented by the non-performing party through the use of alternate sources, workaround plans or other means, including disaster recovery plans.

If a party does not perform its contractual obligations for any of the reasons listed above, the non-performing party will be excused from any further performance of its affected obligation for as long as the circumstances prevail. But the party must use commercially reasonable efforts to recommence performance whenever and to whatever extent possible without delay. A party must promptly notify the other party in writing immediately after the excusable failure occurs, and also when it abates or ends.

If any of the above-enumerated circumstances substantially prevent, hinder, or delay the Contractor's performance of the Services and/or provision of Deliverables for more than 10 Business Days, and the State determines that performance is not likely to be resumed within a period of time that is satisfactory to the State in its reasonable discretion, then at the State's option: (a) the State may procure the affected Services/Deliverables from an alternate source, and the State is not be liable for payment for the unperformed Services/Deliverables not provided under this Contract for so long as the delay in performance continues; (b) the State may terminate any portion of this Contract so affected and the charges payable will be equitably adjusted to reflect those Services/Deliverables terminated; or (c) the State may terminate the affected Statement of Work without liability to Contractor as of a date specified by the State in a written notice of termination to the Contractor, except to the extent that the State must pay for Services/Deliverables provided through the date of termination.

The Contractor will not have the right to any additional payments from the State as a result of any Excusable Failure occurrence or to payments for Services not rendered/Deliverables not provided as a result of the Excusable Failure condition. Defaults or delays in performance by Contractor which are caused by acts or omissions of its Subcontractors will not relieve Contractor of its obligations under this Contract except to the extent that a Subcontractor is itself subject to an Excusable Failure condition described above and Contractor cannot reasonably circumvent the effect of the Subcontractor's default or delay in performance through the use of alternate sources, workaround plans or other means.

***2.250 Approval of Deliverables* – Deleted/Not Applicable**

2.260 Ownership

2.261 Ownership of Work Product by State
The State owns all Deliverables as they are works made for hire by the Contractor for the State. The State owns all United States and international copyrights, trademarks, patents or other proprietary rights in the Deliverables.

2.262 Vesting of Rights
With the sole exception of any preexisting licensed works identified in the SOW, the Contractor assigns, and upon creation of each Deliverable automatically assigns, to the State, ownership of all United States and international copyrights, trademarks, patents, or other proprietary rights in each and every Deliverable, whether or not registered by the Contractor, insofar as any the Deliverable, by operation of law, may not be considered work made for hire by the Contractor for the State. From time to time upon the State's request, the Contractor must confirm the assignment by execution and delivery of the assignments, confirmations of assignment, or other written instruments as the State may request. The State may obtain and hold in its own name all copyright, trademark, and patent registrations and other evidence of rights that may be available for Deliverables.

2.263 Rights in Data
(a) The State is the owner of all data made available by the State to the Contractor or its agents, Subcontractors or representatives under this Contract. The Contractor must not use the State's data for any purpose other than providing the Services, nor will any part of the State's data be disclosed, sold, assigned, leased or otherwise disposed of to the general public or to specific third parties or commercially exploited by or on behalf of the Contractor. No employees of the Contractor, other than those on a strictly need-to-know basis, may access to the State's data. Contractor must not possess or assert any lien or other right against the State's data. Without limiting the generality of this Section, the Contractor must only use personally identifiable information as strictly necessary to provide the Services and must disclose the information only to its employees who have a strict need-to-know the information. The Contractor must comply at all times with all laws and regulations applicable to the personally identifiable information.

(b) The State is the owner of all State-specific data under this Contract. The State may use the data provided by the Contractor for any purpose. The State will not possess or assert any lien or other right against the Contractor's data. Without limiting the generality of this Section, the State may use personally identifiable information only as strictly necessary to utilize the Services and must disclose the information only to its employees who have a strict need to know the information, except as provided by law. The State must comply at all times with all laws and regulations applicable to the personally identifiable information. Other material developed and provided to the State remains the State's sole and exclusive property.

2.264 Ownership of Materials
The State and the Contractor will continue to own their respective proprietary technologies developed before entering into this Contract. Any hardware bought through the Contractor by the State, and paid for by the State, must be owned by the State. Any software licensed through the Contractor and sold to the State, must be licensed directly to the State.

2.270 State Standards

2.271 Existing Technology Standards
The Contractor must adhere to all existing standards as described within the comprehensive listing of the State's existing technology standards at http://www.michigan.gov/dit.

2.272 Acceptable Use Policy
To the extent that Contractor has access to the State computer system, Contractor must comply with the State's Acceptable Use Policy, see http://www.michigan.gov/ditservice. All Contractor employees must be required, in writing, to agree to the State's Acceptable Use Policy before accessing the State system. The State reserves the right to terminate Contractor's access to the State system if a violation occurs.

2.273 Systems Changes
Contractor is not responsible for and not authorized to make changes to any State systems without written authorization from the Project Manager. Any changes Contractor makes to State systems with the State's approval must be done according to applicable State procedures, including security, access and configuration management procedures.

2.280 Extended Purchasing

2.281 MIDEAL – Deleted/Not Applicable

2.282 State Employee Purchases – Deleted/Not Applicable

2.290 Environmental Provision

2.291 Environmental Provision
Energy Efficiency Purchasing Policy – Deleted / Not Applicable

Environmental Purchasing Policy – The State of Michigan is committed to encouraging the use of products and services that impact the environment less than competing products. The State is accomplishing this by including environmental considerations in purchasing decisions, while remaining fiscally responsible, to promote practices that improve worker health, conserve natural resources, and prevent pollution. Environmental components that are to be considered include: recycled content and recyclability; energy efficiency; and the presence of undesirable materials in the products, especially those toxic chemicals which are persistent and bioaccumulative. The Contractor should be able to supply products containing recycled and environmentally preferable materials that meet performance requirements and is encouraged to offer such products throughout the duration of this Contract. Information on any relevant third party certification (such as Green Seal, Energy Star, etc.) should also be provided.

Hazardous Materials – Deleted / Not Applicable

Refrigeration and Air Conditioning – Deleted / Not Applicable

Environmental Performance:
Waste Reduction Program - Contractor must establish a program to promote cost-effective waste reduction in all operations and facilities covered by this Contract. The Contractor's programs must comply with applicable Federal, State, and local requirements, specifically including Section 6002 of the Resource Conservation and Recovery Act (42 U.S.C. 6962, et seq.).

2.300 Other Provisions

2.311 Forced Labor, Convict Labor, Forced or Indentured Child Labor, or Indentured Servitude Made Materials
Equipment, materials, or supplies, that will be furnished to the State under this Contract must not be produced in whole or in part by forced labor, convict labor, forced or indentured child labor, or indentured servitude.

"Forced or indentured child labor" means all work or service: exacted from any person under the age of 18 under the menace of any penalty for its nonperformance and for which the worker does not offer himself voluntarily; or performed by any person under the age of 18 under a contract the enforcement of which can be accomplished by process or penalties.

Appendix A - Pricing

PBM Services for Medicaid and Other Michigan Department of Community Health Programs

Pricing Schedule A - Total Evaluated Price

	Package A	Package B	Package C
Design, Development, Implementation (DDI) Phase Total Fixed Price (from Pricing Schedule B)	$0	$0	$0
Operations Phase			
Contract Year 1 (from Pricing Schedule C)	$5,839,213.00	$762,673.00	$6,601,886.00
Contract Year 2 (from Pricing Schedule C)	$6,043,585.00	$789,367.00	$6,832,952.00
Contract Year 3 (from Pricing Schedule C)	$6,255,111.00	$816,995.00	$7,072,106.00
Total Operations Base Contract Fixed Price Amount	$18,137,909.00	$2,369,035.00	$20,506,944.00
Total Evaluated Price (sum of DDI and Operations)	**$18,137,909.00**	**$2,369,035.00**	**$20,506,944.00**

Pricing Schedule B - Design, Development, and Implementation (DDI) Phase Pricing

	Package A	Package B	Package C
Planning Activities	$0.00	$0.00	$0.00
Testing Activities	$0.00	$0.00	$0.00
Implementation Activities Leading to Start of Operations	$0.00	$0.00	$0.00
Total DDI Fixed Price	$0.00	$0.00	$0.00

PBM Services for Medicaid and Other Michigan Department of Community Health Programs

Pricing Schedule C - Operations Phase - Fixed Price

	Contract Year 1	Contract Year 2	Contract Year 3	Three-Year Total
Package A				
Total for Component 1- Claims Processing and Related Services	$5,839,213.00	$6,043,585.00	$6,255,111.00	$18,137,909.00
Subtotal for Claims Processing Only	$2,933,576.00	$3,036,251.00	$3,142,520.00	$9,112,347.00
Subtotal for Provider Enrollment Only	$310,829.00	$321,708.00	$332,968.00	$965,505.00
Subtotal for Call Center and Help Lines Only	$2,470,045.00	$2,556,497.00	$2,645,974.00	$7,672,516.00
Subtotal for MAC Administration Only	$124,763.00	$129,129.00	$133,649.00	$387,541.00
Total Operations -- Package A	$5,839,213.00	$6,043,585.00	$6,255,111.00	$18,137,909.00
Package B				
Total for Component 2 - PDL & Manufacturer Drug Rebate Administration	$762,673.00	$789,367.00	$816,995.00	$2,369,035.00
Total Operations -- Package B	$762,673.00	$789,367.00	$816,995.00	$2,369,035.00
Package C				
Total for Component 1- Claims Processing and Related Services	$5,839,213.00	$6,043,585.00	$6,255,111.00	$18,137,909.00
Subtotal for Claims Processing Only	$2,933,576.00	$3,036,251.00	$3,142,520.00	$9,112,347.00
Subtotal for Provider Enrollment Only	$310,829.00	$321,708.00	$332,968.00	$965,505.00
Subtotal for Call Center and Help Lines Only	$2,470,045.00	$2,556,497.00	$2,645,974.00	$7,672,516.00
Subtotal for MAC Administration Only	$124,763.00	$129,129.00	$133,649.00	$387,541.00
Total for Component 2 - PDL & Manufacturer Drug Rebate Administration	$762,673.00	$789,367.00	$816,995.00	$2,369,035.00
Total Operations -- Package C	$6,601,886.00	$6,832,952.00	$7,072,106.00	$20,506,944.00

Appendix B – Performance Guarantees/Service Level Agreements (SLAs)

A. General

Contractor failure to meet the listed SLAs will result in the penalties set forth.

1. The Contractor must ensure that the SLAs set forth below are measurable using the Contractor's management information systems. The Department reserves the right to independently verify the Contractor's assessment of its performance, either by State employee or by third party review. Disagreements regarding SLAs will be subject to Dispute Resolution (**Section 2.190**).
2. The Department reserves the right to find that the Contractor had reasonable cause for failure to meet a SLA. In such cases, the Department will not hold the Contractor liable for the penalties. The Department's election not to invoke remedies in any instance of SLA deficiency must not be deemed to be a waiver of the Department's right to invoke remedies in any other instance.

B. Penalties for Failure to Meet SLAs

1. During the first 60 days of the Operations Phase, the Department will waive penalties for failure to meet any SLA.
2. After the first 60-day waiver period during the Operations Phase, the first failure to meet an SLA will be applied at 50 percent of penalty listed for any of the following SLAs. All subsequent failures will be applied at 100 percent of the penalties.
3. Enforcement of penalties does not preclude the Department from pursuing additional legal action afforded under this Contract and deemed necessary by the Department to ensure compliance.

SLA #1
POS System Availability (Claims Processing and Related Services)
Guarantee
The Contractor's POS system must be available 24x7x365 and online 99.9% of the time with the exception of Department-approved downtimes. The Contractor must measure and report its performance on this SLA monthly. Measurement includes when the POS system is not available for provider response at a minimum of 99.9% of the time
Penalty
The penalty for failure to meet this SLA is $5,000.00 per month.

SLA #2
POS System Response Time (Claims Processing and Related Services)
Guarantee
The Contractor's POS response time must average three seconds or less for all transactions. The Contractor must measure and report its performance on this SLA monthly. Measurement includes response time defined as the time from when the claim is received by the Contractor's processor to the time the results are transmitted from the Contractor's POS processor and includes all procedures required to complete claim adjudication.
Penalty
The penalty for failure to meet this SLA is $5,000.00 per month.

SLA #3
Timeliness of Manufacturer Drug Rebate Invoicing Timeliness (PDL & Manufacturer Drug Rebate Administration)
Guarantee
The Contractor must invoice 100% of the manufacturers for federal and supplemental rebates no later than 60 days after the end of each quarter, or according to other State or federal timelines in place at the time of invoicing. The Contractor must measure and report its performance on this SLA quarterly.
Penalty
The penalty for failure to meet this SLA is $20,000.00 per quarterly manufacturer invoice.

SLA #4
Timeliness of CMS-Required Rebate Reporting (PDL and Manufacturer Drug Rebate Administration)
Guarantee
The Contractor must generate and transmit to CMS a file of manufacturer rebate invoice information including original invoices, interest amounts, prior period adjustments, and adjustments resulting from resolved disputes quarterly after invoicing manufacturers, in a format specified by CMS. The Contractor must provide quarterly drug rebate information in a form compatible with the Department's submission of the Quarterly Expense Report of the Medicaid Budget and Expenditure System (CMS-64) reporting requirements on or before 15 days following the close of a quarter's end. The Contractor must measure and report its performance on this SLA quarterly. Measurement includes both provision of the CMS file of manufacturer rebate invoice information and drug rebate information for the CMS-64.
Penalty
The penalty for failure to meet this SLA is $5,000.00 per quarter.

Appendix C – Department Reporting

While this appendix contains an extensive list of required reporting, it is not meant to be comprehensive or all inclusive of all needed files to perform the work, deliverables, and other requirements described in Article 1 Statement of Work of this document. The Department will provide a finalized list of reports during the Design, Development, and Implementation phase of this Contract.

Report Description	Frequency	Type
Program Accounts Payable/Processing Report Claim and dollar totals by program for paid, denied and voided claims	Weekly	*.xls
Pharmacy Accounts Payable Report Claim and dollar totals by pharmacy	Weekly	*.xls
Beneficiary Call Report Beneficiary call center counts and statistics by call category and call type	Weekly	*.xls
Technical Call Center Report Technical call center counts and statistics by call category and call type	Weekly	*.xls
Clinical Call Center Report Clinical call center counts and statistics by call category and call type	Weekly	*.xls
Detailed Denied Claims Report Claim detail of denied claims showing pharmacy, NCPCP reject and other identifiers	Weekly	*.xls
Summary of Denied Claims Report Summary of denied claims by NCPDP reject code	Weekly	*.xls
Controlled Substance Report Claim detail of controlled substance paid claims	Weekly	*.xls
Non-Rebateable Condom Claims Claim detail and summary by program of paid non-rebateable condom claims	Weekly	*.xls
Non-Rebateable Medical Supply Claims Claim detail and summary by program of paid non-rebateable medical supply claims	Weekly	*.xls
Non-Rebateable Other Claim detail and summary by program of paid non-rebateable claims, excluding non-rebateable condoms and medical supplies	Weekly	*.xls
Monthly Reports		
Monthly ProDUR Message Report Summary by message, severity, count, amount and total	Monthly	*.xls
Monthly ProDUR Paid Savings Report Claim detail for ProDUR related reversals and savings	Monthly	*.xls
Monthly ProDUR Denied Savings Report Claim detail for ProDUR related denials and savings	Monthly	*.xls
Monthly ProDUR Drug Encounters Report Summary ProDUR Encounter Type, Frequency and Drug Description	Monthly	*.xls
Monthly ProDUR Payment Report Month-to-Date and Year-to-Date ProDUR counts and savings detail	Monthly	*.xls
Monthly ProDUR Top Encounters Report Coded outcomes by problem type with claim counts and overrides	Monthly	*.xls
Monthly ProDUR Top Interventions Report Coded interventions by problem type, drug, history and intervention codes	Monthly	*.xls
Monthly ProDUR Top Outcomes Report Top Encounters - interventions by problem type	Monthly	*.xls
Monthly Mail Order Co-Payment Summary Claim counts and dollar totals broken out into six co-pay ranges	Monthly	*.xls
Monthly Report Of 12121212 Overrides Claim detail of paid claims with 12121212 Override (Medicare eligible beneficiary <65)	Monthly	*.xls
Monthly Membership Data Two-year history of monthly beneficiary eligibility totals	Monthly	*.xls
Monthly Prior Authorization (PA)	Monthly	*.xls

Report Description	Frequency	Type
Detail summary by PA categories and PA type (e.g. tech, pharmacist, web)		
Monthly Technical Call Center Statistics Technical Call Center performance and volume statistics	Monthly	*.xls
Claim Processing Report Executive summary of claims (paid, denied void) , dispensing fees, ingredient cost paid, other insurance payments, and beneficiary co-payments	Monthly	*.xls
Michigan Pharmaceutical Product List (MPPL) Formulary Comprehensive formulary and coverage list for Department programs	Monthly	*.xls
Preferred Drug List (PDL) Preferred drug listing of all products where there is a supplemental rebate agreement	Monthly	*.xls
Provider Enrollment Report Provider enrollment classification(s), effective and termination dates for each pharmacy NPI/ NCPDP number	Monthly	*.xls
Monthly Pharmacy Accounts Payable Claim and dollar totals by pharmacy	Monthly	*.xls
Annual Reports		
Annual Expenditure Changes By Therapeutic Classes 00-56 Report by First DataBank's therapeutic class, total unit, total expenditure, change and percent change	Annual	*.xls
Annual Expenditure Changes By Therapeutic Classes 57-99 Report by First DataBank's therapeutic class, total unit, total expenditure, change and percent change	Annual	*.xls
Annual Population Statistics Percentages and totals report by age, drug, quantity, total paid, ingredient cost, claim count, and member months use	Annual	*.xls
Annual ProDUR Message Report Summary by message, severity, count, amount and total	Annual	*.xls
Annual ProDUR Paid Savings Report Claim detail for ProDUR related reversals and savings	Annual	*.xls
Annual ProDUR Denied Savings Report Claim detail for ProDUR related denials and savings	Annual	*.xls
Annual ProDUR Drug Encounters Report Summary ProDUR encounter type, frequency and drug description	Annual	*.xls
Annual ProDUR Payment Report Annual ProDUR counts and savings detail	Annual	*.xls
Annual ProDUR Top Encounters Report Coded outcomes by problem type with claim counts and overrides	Annual	*.xls
Annual ProDUR Top Interventions Report Coded interventions by problem type, drug, history and intervention codes	Annual	*.xls
Annual ProDUR Top Outcomes Report Top Encounters - interventions by problem type	Annual	*.xls
Annual Top Therapeutic Classes By Age Top 20 Classes by age category	Annual	*.xls
Annual Top New Products By Cost Top 30 selected new products by generic, brand, dosage and cost	Annual	*.xls
Annual Top New Products By First DataBank's Generic Sequence Number (GSN) Top 30 selected new products by GSN	Annual	*.xls
Ad Hoc Reports		
Client Report Card: Fee-For-Service Program metrics: PMPM use, brand vs. generic, rebates, costs, percent change, etc.	Quarterly	*.xls
Client Report Card: Health Plan Carve-Outs Program metrics: PMPM use, brand vs. generic, rebates, costs, percent change, etc.	Quarterly	*.xls
Pharmacy And Therapeutics Utilization Reports Claim and dollar totals for drugs under review (e.g. new products and PDL Classes)	Quarterly	*.xls
Lock-In Beneficiary Claim Detail Report Prescriber, pharmacy, drug, quantity and cost of claims for lock-in beneficiaries	Quarterly	*.xls
Rebate Reports		
Monthly Collections	Monthly	*.xls

Report Description	Frequency	Type
Rebate type (e.g. CMS, PDL, other) and payments collected by rebate quarter		
Monthly Dispute Monitoring Details on dispute monitoring procedure by labeler disputed amounts and quarters	Monthly	*.xls
High Level Executive Monthly Collections Details quarterly and monthly rebate collections	Monthly	*.xls
Billing Timeliness Report Invoice dates and amounts, performance guarantee satisfied (# days)	Quarterly	*.xls
Outstanding Disputes Details on outstanding disputes	Quarterly	*.xls
Federal Manufacturer Drug Rebate Invoice Invoice in CMS-required media and format	Quarterly	*.xls
Supplemental Manufacturer Drug Rebate Invoice Invoice formatted the same as federal manufacturer drug rebate invoice	Quarterly	*.xls
CMS-64 9r Report Highlights manufacturers not submitting rebate payments	Quarterly	*.xls
Customize Claims Level Detail for IMS Data Niche Includes NDC, status, year and quarter, units, pay-date, date of service, prescriber, paid amount, pharmacy, prescription number, dispensing fee, co-payment, billed amount, third party amount, refill code, invoiced quarter	Quarterly	*.xls
Public Health Service (PHS) Entities Includes 340B providers and National Provider Identifiers	Quarterly	*.xls
Annual PDL Financial Analysis Review of PDL Compliance % and Additional savings opportunities	Annual	*.xls
Financial Reports		
Weekly Drug Cost Invoice Invoice of claims and dollars for each Program Funding category	Weekly	*.xls
Weekly Claims Summary Report Program Funding summary of dollars and counts for paid, denied and voided claims	Weekly	*.xls
Weekly Pharmacy Pending Balance Report Details of claims resulting in pharmacy pending balance	Weekly	*.xls
Weekly Drug Cost Account Balancing Report Summary of account pharmacy payments and description of account balance(s)	Weekly	*.xls
Monthly Administration Invoice Invoice of monthly administrative fees	Monthly	*.xls
Monthly Refund Check Log Log of refund checks received and cashed	Monthly	*.xls
Maximum Allowable Cost (MAC) Reports		
MAC Call Center Report MAC call center counts and statistics by call category and call type	Weekly	*.xls
MAC Comprehensive Report Report of active MAC prices and effective dates used in claim processing	Weekly	*.xls
MAC Health Plan Carve-Out Report Report of active MAC prices on Health Plan Carve-outs	Weekly	*.xls
MAC vs. CMS FUL Compliance Report Report the count and percent of NDCs with MACs at or below the CMS FUL	Monthly	*.xls
Utilization Review Reports		
Drug Analysis All Groups Claim payment and percent details (e.g., ingredient cost, dispense fee, co-payment, and price type)	Monthly	*.xls
Drug Analysis Fee-For-Service Only Claim payment and percent details (e.g., ingredient cost, dispense fee, co-payment, and price type)	Monthly	*.xls
Drug Analysis Health Plan All Carve-Outs Claim payment and percent details (e.g., ingredient cost, dispense fee, co-payment, and price type)	Monthly	*.xls
Drug Analysis Health Plan 60/40 Carve-Outs Claim payment and percent details (e.g., ingredient cost, dispense fee, co-payment and price type)	Monthly	*.xls
Drug Analysis Health Plan 100% POS Carve-Outs	Monthly	*.xls

Report Description	Frequency	Type
Claim payment and percent details (e.g., ingredient cost, dispense fee co-payment and price type)		
Top 25 Drugs All Groups By Payment Top 25 Drugs showing claim count, payment amount, cost per unit, and percentages	Monthly	*.xls
Top 25 Drugs Fee-For-Service Only By Payment Top 25 Drugs showing claim count, payment amount, cost per unit, and percentages	Monthly	*.xls
Top 25 Drugs Health Plan All Carve-Outs By Payment Top 25 Drugs showing claim count, payment amount, cost per unit, and percentages	Monthly	*.xls
Top 25 Drugs Health Plan 60/40 Carve-Outs By Payment Top 25 Drugs showing claim count, payment amount, cost per unit, and percentages	Monthly	*.xls
Top 25 Drugs Health Plan 100% POS Carve-Outs By Payment Top 25 Drugs showing claim count, payment amount, cost per unit ,and percentages	Monthly	*.xls
Top 25 Drugs All Groups By Claim Count Top 25 Drugs showing claim count, payment amount, cost per unit, and percentages	Monthly	*.xls
Top 25 Drugs Fee-For-Service Only By Claim Count Top 25 Drugs showing claim count, payment amount, cost per unit, and percentages	Monthly	*.xls
Top 25 Drugs Health Plan All Carve-Outs By Claim Count Top 25 Drugs showing claim count, payment amount, cost per unit, and percentages	Monthly	*.xls
Top 25 Drugs Health Plan 60/40 Carve-Outs By Claim Count Top 25 Drugs showing claim count, payment amount, cost per unit, and percentages	Monthly	*.xls
Top 25 Drugs Health Plan 100% POS Carve-Outs By Claim Count Top 25 Drugs showing claim count, payment amount, cost per unit, and percentages	Monthly	*.xls

Appendix D – Key Interface Files

While this appendix contains an extensive list of interface files, it is not meant to be comprehensive or all inclusive of all needed files to perform the work, deliverables, and other requirements for Components 1 and 2 described in Article 1 Statement of Work of this document. The Department will provide a finalized list of interface files and related record specifications during the Design, Development, and Implementation phase of this Contract.

COMPONENT 1 – CLAIMS PROCESSING AND RELATED SERVICES		
Data Files	**Schedule**	**Comments**
One-Time Department Files to the Contractor		
1. Claims History Load	1-Time	Paid claims from January 1, 2006 through start of the Operations Phase.
2. PA History Load	1-Time	PA transactions from January 1, 2006 through start of the Operations Phase
3. MAC Pricing History	1-Time	MAC pricing history file
4. Pharmacy Provider Extract	1-Time	Pharmacy enrollment history file
Operational Department Files to the Contractor		
5. Beneficiary Eligibility	Daily	Formatted either as an update, refresh file, or a full file
6. Practitioner File	Weekly	Includes updates of the NPIs and address records for enrolled practitioners. Likely to be replaced by the NCPDP HCIdea file below
7. Third Party Liability	Weekly	Includes Weekly Carrier File TPL data is included in Daily Beneficiary Eligibility File for beneficiaries with eligibility changes
8. Department-Specified MACs	Weekly	Includes Department-specified MAC rates to augment Contractor-developed MAC rates. Sent via email in MS Excel spreadsheet
9. Medical Claims File	Weekly	Includes the Department's claims for inpatient hospital, outpatient hospital, practitioner, laboratory, etc. Supports automatic prior authorization processing in the Contractor's claims processing system and DUR activities
Contractor Files to the Department		
10. Pharmacy Provider Extract	Weekly	A pharmacy enrollment history file
11. Claims Extract	Weekly	Includes claims which were paid or voided during the prior week's invoice cycle
12. Compound Claim Detail Extract	Weekly	Includes the Compound segment of paid pharmacy claims and is linked to the claim level record during the prior week's invoice cycle
13. 100% Carve-Out File	Weekly	Includes the 100% carve-out paid claims for managed care beneficiaries that are sent to the Medicaid Health Plans
Other Reference Files Needed by the Contractor		
14. NCPDP HCIdea File	Weekly	The National Council for Prescription Drug Program's file maintaining NPIs and Drug Enforcement Administration (DEA) numbers Purchased by the Contractor
15. NCPDP/NABP	Monthly	Includes pharmacy provider data maintained by the NCPDP, e.g., address, licensing, pharmacy classification, etc. Purchased by the Contractor
16. First DataBank Tables	Weekly	Purchased by the Contractor
Contractor Files to Other Vendors		
17. Claims Extract for Audit Vendor	Weekly	For separate PBM audit vendor
Other Needed Interface Files, ONLY If Separate Contractors Are Chosen for Components 1 and 2		
18. Pharmacy Provider Extract	Weekly	Pharmacy enrollment history file for the Component 2 Contractor
19. Rebate Claims Extract	Weekly	Claims data supporting the manufacturer drug rebate administration for the Component 2 Contractor
20. Michigan PDL Summary Document	Quarterly	For posting on the website of the Component 1 Contractor Currently an Microsoft Excel® spreadsheet
21. Michigan Pharmaceutical Product List	Monthly	For posting on the website of the Component 1 Contractor

COMPONENT 2 – PDL AND MANUFACTURER DRUG REBATE ADMINISTRATION		
Data Files	**Schedule**	**Comments**
One-Time Department Files to the Contract		
22. Claims History Load	1-Time	Paid claims from January 1, 2006 through start of the Operations Phase.
23. Rebate History Load	1-Time	Manufacturer drug rebate data from rebates quarters beginning in 1991 through start of the Operations Phase.
Department Files to the Contractor		
24. Quarterly Rebate J-Code File	Quarterly	Includes NDC keyed data of physician-administered drugs billed on the 837 format with HCPCS codes and paid by the Department to physicians and outpatient hospitals
25. CMS Rebate File	Quarterly	Contains NDC level data, e.g., the current unit rebate amounts and prior period unit rebate adjustments Tape cartridge received by the Department from CMS and transmitted electronically to the Contractor
Contractor Files to the Department and Other Entities		
26. E-Rx Supporting Files	As specified	Files to support electronic prescribing companies (e.g., SureScripts-RxHub)
27. Epocrates Files	Quarterly	Maintenance of the Department's Medicaid and other pharmacy program's formulary on the Epocrates online formulary website
28. Quarterly Rebate Utilization File	Quarterly	Contains amounts invoiced to manufacturers along with pharmacy claims utilization for the federal manufacturer drug program Sent to CMS by the Contractor
29. NDC Formulary File for Website	Monthly	Michigan Pharmaceutical Product List (MPPL)
Other Reference Files Needed by the Contractor		
30. First DataBank Tables	Weekly	Purchased by the Contractor
Other Needed Interface Files, ONLY If Separate Contractors Are Chosen for Components 1 and 2		
31. Michigan PDL Summary Document	Quarterly	For posting on the website of the Component 1 Contractor Currently an Microsoft Excel® spreadsheet
32. Michigan Pharmaceutical Product List (MPPL)	Monthly	For posting on the website of the Component 1 Contractor
33. Pharmacy Provider Extract	Weekly	Pharmacy enrollment history file sent from the Component 1 Contractor