1. **Parties.** This is a contract for personal services between Office of Vermont Health Access (hereafter called "State"), and, with a principal place of business in MedMetrics Health Partners, Inc., 100 Century Drive, Worcester, MA 01606 (hereafter called "Contractor"). Contractor's form of business organization is a non-profit corporation. Contractor is required by law to have a Business Account Number from the Vermont Department of Taxes. The Account Number is: 430-201031924F-01.

2. **Subject Matter.** The subject matter of this contract is personal services generally on the subject of pharmacy benefits management. Detailed services to be provided by the Contractor are described in Attachment A.

3. **Maximum Amount.** In consideration of the services to be performed by Contractor, the State agrees to pay Contractor, in accordance with the payment provisions specified in Attachment B, a sum not to exceed **$ 8,318,624.00.**

4. **Contract Term.** The period of Contractor's performance shall begin on November 1, 2005 and end on October 31, 2008. By mutual agreement, the Contract may be extended for a period or periods totaling up to two additional years beyond the initial termination date.

5. **Prior Approvals.** If approval by the Attorney General's Office or the Secretary of Administration is required, (under current law, bulletins, and interpretations), neither this contract nor any amendment to it is binding until it has been approved by either or both such persons.

   Approval by the Attorney General's Office **is** required.

   Approval by the Secretary of Administration **is** required.

6. **Amendment.** No changes, modifications, or amendments in the terms and conditions of this contract shall be effective unless reduced to writing, numbered and signed by the duly authorized representative of the State and Contractor.

7. **Cancellation.** This contract may be cancelled by either party by giving written notice at least 90 days in advance.

8. **Attachments.** This contract consists of 65 pages which includes Attachments A through F, and Attachment G which includes a CD with pdf files, which are incorporated herein:
   Attachment A - Specifications of Work to be Performed
   Attachment B - Payment Provisions
   Attachment C - "Customary State Contract provisions"
   Attachment D - Certificate of Insurance
   Attachment E - Business Associate Agreement
   Attachment F - AHS Policy 96-23
   Attachment G – CD with the following pdf files
   Folder RFP - Request for Proposal (RFP) for Pharmacy Benefit Management Services, March 18, 2005 & State Reponses to Bidder Questions, April 29, 2005
   Folder Technical- MedMetrics Health Partners, Inc. Proposal to RFP, May 20, 2005, Programmatic/Technical Components
   Folder Costs - MedMetrics Health Partners, Inc. Proposal to RFP May 20, 2005 Cost Proposal

The order of precedence of documents shall be as follows:

1). This document
2). Attachment C
3). Attachment A
4). Attachment B
5). Attachment E
6). Attachment F
7) Attachment G- CD with pdf files-State Request for Proposal (RFP) for Pharmacy Benefit Management Services, March 18, 2005 & State Reponses to Bidder Questions, April 29, 2005
8) Attachment G – CD MedMetrics Health Partners, Inc., Proposal to Provide Pharmacy Benefit Management Services, May 20, 2005 for Programmatic/Technical & Costs
9) Attachment D

WE THE UNDERSIGNED PARTIES AGREE TO BE BOUND BY THIS CONTRACT.

BY THE STATE OF VERMONT:

Date: 10-17-2005

Signature:

Name: Joshua Slen

Title: Director

Office of Vermont Health Access

BY THE CONTRACTOR:

Date: 10/28/2005

Signature:

Name: Robert D. Wakefield, Jr.

Fed. ID: 20-1031924

Title: Chief Executive Officer

Phone: 508-793-1191
e-mail: robert.wakefield@umassmed.edu

APPROVED AS TO FORM:

Attorney General:

Date: 10/19/05

ATTACHMENT A
SPECIFICATIONS OF WORK TO BE PERFORMED

I. Introduction and Objectives

The State's primary objectives in executing this Contract are to continue to enhance quality of care; improve access to those who need it; control pharmacy expenditures on behalf of the individuals for whom the State provides coverage; and reduce program administrative costs. In working with the Contractor, the State seeks innovative methods to respond to the implementation of the Medicare drug provisions of Part D. Of particular concern is the State's commitment to address current levels of drug coverage for soon to be Part D beneficiaries currently receiving benefits through traditional Medicaid, the 1115(a) Medicaid waiver, and state-only funded programs.

The State expects to meet these objectives in a number of ways. They include but are not limited to the following:

- Maintaining a Preferred Drug List (PDL) to assure clinically appropriate and cost-effective coverage in high use and high cost drug categories;
- Increasing the use of clinically appropriate generic and other lower cost drugs;
- Managing the drug benefits through more intensive clinical management to improve overall quality and outcomes;
- Protecting the health of beneficiaries through use of retrospective and prospective drug utilization review (DUR) to prevent inappropriate drug dispensing and/or use;
- Maintaining positive relationships with the provider community including providing appropriate clinical information to improve prescribing and cost information to assist in product selection;
- Negotiating lower prices through multi-state supplemental rebates; the equivalent of regular Medicaid program rebates for state-only coverage; and, where possible, financial concessions through a preferred PDP sponsor of Medicare Part D benefits for Vermont program beneficiaries;
- Limiting paid claims to those submitted for eligible clients, by eligible providers, or for covered drug services;
- Preventing payment of fraudulent or duplicate claims;
- Cost-avoiding claims for beneficiaries with third party liability coverage (hereinafter referred to as COB and/or TPL) for pharmacy services;
- Providing maximum efficiency in pharmacy claims processing;
- Managing the program at the lowest administrative cost possible; and
- Using Vermont's federally designated State Pharmacy Assistance Program (SPAP) to provide wraparound benefits to Vermont program beneficiaries to be enrolled in Medicare Part D.

The State views this Contract as part a "progressive effort." That is, new interventions may be instituted over time during the term of the contract.

The State has a goal to aggregate as many lives as possible into a relationship with the PBM Contractor. By doing so, the State intends to maximize its ability to manage the benefit, improve the quality of care, control costs, and negotiate rebate dollars. Recognizing the complexities of Pharmacy Benefit Management, the State intends to work closely with the successful Contractor to assure the best possible results. The Contractor is expected to work with prescribers, beneficiaries, drug retailers, and drug manufacturers to find the most effective ways to control drug costs. These efforts will include appropriate therapeutic controls and careful monitoring of performance and pricing.

II. Claims Processing and Systems

1. Overview

Claims adjudication is the responsibility of the Contractor. However, provider payments are made by the State's current MMIS Contractor. Under this system, the Contractor is expected to transmit adjudicated claims electronically to the MMIS Contractor, and the MMIS Contractor performs all of the tasks associated with payments to providers and financial reporting to the State. Under the terms of this contract, the State will continue to use the current MMIS Contractor to make payments for adjudicated claims to providers.

In adjudicating claims the Contractor will perform a number of prescribed functions, including applying DUR edits, Prior Authorizations, and COB functions. Those responses will be transmitted back to the pharmacy. Once the claim is adjudicated by the Contractor, a file will be transmitted to the MMIS provider for payment to providers on a weekly basis. Details of this processing will be concluded with the Contractor during the implementation phase.

The Contractor will be responsible for all claims processing for drug claims for any Healthy Vermonters Program beneficiaries included in the contract even though currently there is no provider payment involved. This population has a non-funded pharmacy benefit similar to a discount card. Beneficiaries pay the entire cost of the prescription in the Medicaid pharmacy network at the time they obtain it. Payment from the HVP beneficiary to the pharmacy is at Medicaid rates.

2. Systems Implementation

The Contractor shall have an implementation schedule that conforms to the schedule that enables the system to go live effective January 1, 2006, unless otherwise approved by the State. The Contractor shall provide the State with a requirements analysis and will design, code, and test all systems requirements and benefit plan designs based on State specifications.

The State shall conduct user acceptance testing. The Contractor is responsible for providing user training. The Contractor shall provide conversion of data and file loads. Contractor will work collaboratively with State systems staff and State's MMIS Contractor in the development of interfaces and file transfers. As required, the State shall conduct an operational readiness review and post implementation review. The Contractor shall provide implementation support sufficient to complete implementation within the required timeframes. During the implementation period, the Contractor's staff shall be responsible for prescriber and network provider training and consumer education as directed by the State.

Prior to commencement by the Contractor of operational services, the State shall review and approve in writing all edits, criteria, and procedures used by the Contractor in any drug utilization review services provided by the Contractor.

3. System Requirements

The Contractor shall integrate drug coverage design with the eligibility system by utilizing eligibility, drug, and benefit systems to adjudicate claims for appropriate coverage. Batch, POS, and paper claims are adjudicated through the same adjudication model.

The Contractor shall provide the ability to perform a drug search by eligible beneficiary with the following capabilities:

1. Drug coverage; e.g., covered, for that beneficiary, on that day, etc.
2. Drug limitations; e.g., requires PA, has quantity limits, has beneficiary limits (e.g., calendar year, benefit period, lifetime, etc.), etc.
3. PA status; e.g., PA required, PA exists and expiration date, etc.; and
4. Cost sharing.

The Contractor shall maintain a claims processing system with the following capacities or specifications:

1. A comprehensive security program.

2. POS, on-line, real-time 24 hours per day/7 days per week capabilities for the adjudication and reversal of pharmacy claims.

3. Support for paper or batch (electronic tape/disk) claims processing.

4. A claims capture system in the event of scheduled or unscheduled downtime.

5. A fully documented disaster recovery program.

6. Compliance with all applicable published HIPAA requirements within the time frames established in the HIPAA rules.

7. Compliance with NCPDP standards.

8. The inclusion of "Lock-In" functions to lock a beneficiary into at least two pharmacies and/or three prescribers, including the ability to perform multiple lock-in functions. The Contractor's system shall allow the State to lock a beneficiary into a specific pharmacy or pharmacies, prescriber(s), or combinations of both.

9. Assurances that a transaction is subject to all syntax editing (e.g., number-only fields are all numeric) and that the transaction is subject to all relational editing (e.g., member number is on file).

10. Eligibility verification prior to pricing claims. The Contractor shall interface with the State's eligibility system (ACCESS) for ongoing eligibility file downloads necessary to support all claims functions. The Contractor shall be responsible for any conversion of file and data loads to support their systems.

11. In cases of retroactive eligibility the ability to address paid claims where a beneficiary's benefit increases/decreases liability. At a minimum, the Contractor shall instruct the provider to reverse the original claim, reimburse the beneficiary for any overpayment, and submit a new claim.

12. The ability to track variable benefit limits; e.g., monthly, quarterly, annually, lifetime.

13. Editing for prescriber and pharmacy eligibility prior to pricing claims. The Contractor shall interface with the State's MMIS Contract for at least weekly provider file updates. The Contractor shall accept daily third party liability files on beneficiary coverage and weekly third party liability carrier files.

14. The ability to accept compound prescriptions claims that allow providers to use the NDCs for each ingredient (NCPDP compliant) and bill for labor.

15. Support for a Preferred Drug List.

16. Support of prior authorization (PA) requirements.

17. Ability to accept PAs entered directly to the system manually, by batch, and electronically.

18. Ability to grandfather; that is, create a PA based on known conditions.

19. Allowance for claims processing exceptions to specific benefit designs by a certain panel of providers or by location.

20. Ability to accept three years of claims history at implementation and retain at least three years in operations.

21. Systems capacity to adjudicate claims using claims history to verify formulary status, diagnosis, and approval or denial of claims.

22. Support for pricing methodologies based on:

    a. Variable pricing and benefit design as set by the State for specified populations; e.g., Medicaid including the Vermont Health Access Program and Vermont publicly-supported health care programs, elderly or disabled populations, Healthy Vermonters Program individuals, or other populations supported by the system;

    b. Federal Upper Limit (FUL), State MAC, or Contractor's MAC;

    c. Lesser of logic: U&C, gross amount, State pricing, FDB pricing; FUL pricing; MAC pricing;

    d. Brand vs. Generic (typically indicators from vendors like First Data Bank are used to determine brand vs. generic; however, the proposed system shall allow for the State's determination of a drug's brand/generic status when applicable);

    e. Standard vs. non-standard package size;

    f. Unique service pricing; e.g, compounded prescriptions and infusion claims;

    g. Dispensing fee with the capacity to pay variable fees (e.g., Clozaril, unit dose medications);

    h. Other insurance price reductions;

    i. Beneficiary payments including full or partial reimbursement and cost-sharing; i.e., co-payments, deductibles, and coinsurance; and

23. The ability to apply COB edits for other insurance coverage in terms of benefits and cost sharing to the extent possible according to NCPDP standards.

24. The ability to apply COB edits for Medicare Part D coverage both in terms of benefits and cost sharing to the extent possible according to NCPDP standards. This includes the formularies for each Medicare Part D Pharmacy Drug Provider (PDP) in the State's region; other coverage information billed using the Medicare Part D; and cost sharing details including deductibles, coinsurance, and the application of the coverage gap ("donut hole").

25. The ability to allow for provider-submitted TPL overrides when other benefits have been exhausted or partially exhausted. The carrier/plan name, client identifier, and member information shall be communicated to the provider using messaging information in the NCPDP response record. Multiple carrier/plan data shall be provided to the pharmacist as part of the cost avoidance override process.

26. The ability to accept NCPDP values for COB/Other Payer Detail Reject Codes.

27. The ability to allow for voluntary beneficiary payments.

28. The capacity to message pharmacy providers on claims matters at POS.

29. The capacity to send messages to pharmacy providers when a new PA is required within 30 days or less of the date of service.

30. An interface with the State's MMIS for transfer of information according to the following:

    a. The Contractor shall send paid and denied claims transaction information per the State's direction to the State's fiscal agent to allow for claims payment on a weekly basis, database population functions, and Federal and State reporting purposes.

    b. Contractor shall receive medical claims data per agreed upon schedule to carry out DUR and Utilization and Disease State Management functions.

III. Auditing

1. Overview

The Contractor will be required to carry out a complete, comprehensive audit program that will include both desk and on-site audits where compliance deficiencies would be reported to the State's Program Integrity Unit for appropriate follow up.

The Contractor will be required to manage required audit and compliance programs for its network for the uninsured, if applicable. This includes appropriate sanctions and recoveries.

2. Requirements

The Contractor will provide a comprehensive audit program plan in order to detect questionable pricing/discounting, duplication of claims, or other types of potential fraud, abuse and misuse of the prescription drug benefits. This plan shall be submitted to the State by March 31, 2006. All prescription claims may be reviewed and analyzed during the detection phase. The Contractor's approach to pharmacy audits may include all or portions of the following: collaborating with State Program Integrity staff to identify data

reporting/capturing that may be responsible for erroneous fraud, waste and abuse detection; identifying and analyzing statistically valid samples of claims; performing desk audits and, where necessary, reviewing original documents on-site; interviewing providers, beneficiaries, and related persons; reviewing cases with medical consultants; referring all cases to the State Program Integrity Unit; keeping qualitative and quantitative statistics on substantiated cases and compiling reports; initiating all necessary recovery reports; and maintaining documentation of findings and recoveries as applicable.

The Contractor shall develop audit criteria for desk and on-site audits that will be reviewed and approved by the State prior to use. Such criteria may include providers that deviate from other providers by a set percentage or more from average claim statistics such as number of claims per beneficiary, total payment per beneficiary, and number of brand certifications; evidence of abuse of usual and customary charges for processed claims; number of claims in excess of high dollar thresholds or number of "high-cost" compound claims; excluded drug category prescriptions dispensed; and any other such criteria proposed by the Contractor and approved by the State. The Contractor shall work with State clinical and Program Integrity staff to determine the criteria for special audit selection procedures and directives. The number of audits to be performed will be determined by the State. The Contractor shall work closely with the State to identify outlier criteria in order to determine the amount of on-site reviews. As directed by the State, the Contractor shall conduct audits of the outliers identified through desk audits, using criteria developed with the State. On-site audit personnel shall also be approved by the State.

If required, full on-site pharmacy abuse compliance audits, in which all claims are selected for review and checked against the hard copy of the prescription on-site, will include:

1. Verification of patient name and eligibility
2. Drug information per authorized prescription
3. Dispense as written code
4. Quantity authorized to dispense and refill limitations
5. Brand/Generic substitution
6. Day supply
7. Co-payment collection
8. DEA compliance
9. Dispensing accuracy
10. Signature log
11. Unfilled prescription policy and procedures
12. Telephone order authorization
13. Reversal of unclaimed prescriptions
14. Adequate inventory and purchases to support the volume of drugs billed

Upon completion of an audit, a final report shall be generated and mailed within 30 days to the affected pharmacy or third party administrator when released by the State. The Contractor shall keep reports about each audit and about any about specific audit concerns. The Contractor shall provide quarterly reports to State to summarize and detail audits performed.

Audits shall be shared with the State's Medicaid Provider Fraud Unit under a protocol established by the State.

IV. Analysis and Reporting

1. Overview

The State has determined that analysis and reporting is critical to effective management of drug benefits. As programs grow in complexity and cost, more sophisticated reporting and analysis will assist the State in focusing its efforts to manage the growth in expenditures, educate providers, and make required program changes. The reporting process must be flexible and timely. The creation of federally required MMIS reports including MARS and SURS shall not be required of the PBM Contractor. The creation of federally required reports related specifically to the pharmacy benefit including the annual CMS DUR report are the responsibility of the Contractor.

Neither the State nor the Contractor will have ownership in any of the software developed or owned by the other party and used in connection with services rendered under the contract. The State will agree that it acquires no right, title, interest, or license to the Contractor's system by virtue of the contract. In the event the State is granted possession of, or access to, any of the Contractor' s proprietary software products, the State will execute in advance a Software License Agreement as agreed to with the Contractor.

2. Requirements

The Contractor shall provide an electronic copy of all paid pharmacy claims to the State on a scheduled basis as determined by the State in a file format agreed to by the State. These claims will be separated by type, i.e. Medicaid, Medicaid 1115(a) coverage and expansions (VHAP, VHAP-Pharmacy, and VScript), VScript Expanded, any Part D supplement coverage plan, AMAP, GA, Healthy Vermonters, and any program developed for the uninsured.

The Contractor will provide reports and reporting capability subject to approval by the State. Reports may be standardized for routine production or for periodic production using templates with changeable data elements or customized using the ad-hoc report manager. The format will be subject to State approval.

Standardized report capability will be provided for the following periods: month, quarter, and year to date by Calendar Year, State Fiscal Year, and Federal Fiscal Year. Reports involving beneficiaries will include number of beneficiaries (eligibles), number of recipients (users), number of prescriptions and cost per prescription, cost per beneficiary/recipient, as well as total cost for all specified periods. All standardized reports shall be clearly titled and dated, and include appropriate data element keys and row and column totals and percents, where appropriate. The Contractor shall provide documentation for all standardized reports providing data field descriptions and sources.

The Contractor shall provide personal computer software for ad-hoc reporting to the State for at least 10 users. The Contractor shall provide an ad-hoc information system for utilization management screenings. The Contractor will provide documentation/user manuals for the software and the Contractor's application of it.

The Contractor will provide training for standardized and ad-hoc reporting tools at the State with designated staff, which shall include refresher training up to one time per year, and training for all new hires who will be using the ad-hoc reporting tools. The initial training will be at a State designated facility. Thereafter training should be in the State or via the Internet. Exceptions to this will be solely at the approval of the State. The Contractor will provide a designated individual who, on an ongoing basis, will be responsible for addressing questions from State users regarding use of the ad-hoc reporting system.

Standardized reports or reporting capability shall include but not be limited to the following:

Utilization Reports:

1. Claims summary report
2. Claims detail report
3. Denied claims analysis
4. PMPM report
5. Cost and utilization reports
6. Drug utilization analysis
7. Therapeutic class analysis
8. Patient claim history report
9. New drug listing report
10. Drug Utilization Review Reports

Financial Reports:

1. MAC savings report
2. Drug Trend Report
    a. Baseline
    b. Projections
3. Generic analysis reporting
4. Beneficiary summary
5. Monthly summary
6. Twelve-month summary
7. Cost sharing analysis
8. DAW1 and DAW 8 analysis
9. Balancing reports

Provider Reports:

1. Top "X" beneficiary user ranking report
2. Top "X" prescribers
3. Top "X" pharmacy providers
4. Physician report cards
5. Pharmacy report cards
6. LTC report cards

Auditing Reports:

1. Monthly listing of claims with excess dollars
2. Over and under utilization reviews
3. Quarterly desk audit summary
4. On-site audit review summary
5. Lock-in reports

Preferred Drug List Reports:

1. Market shift reports
2. Drug Trend report
3. Top 20 Prior Authorized Drugs
4. Physician compliance reports

Claims processing reports:

1. Daily POS transaction detail, by script
2. Daily POS transaction time (in 1 second intervals)
3. Daily POS transaction by pharmacy and by prescriber
4. POS capture detail (when, for how long, and why)
5. Eligibility reports
6. Patient claim history report
7. Prescribing provider ranking by region as defined by the State
8. Dispensing provider ranking by region as defined by the State
9. Prescribing provider ranking by peer group
10. Dispensing provider ranking by peer group
11. Drug ranking
12. Drug search
13. Distribution report

Coordination of benefit (COB) reports:

1. Other insurance frequency by state/county
2. Other insurance frequency by dispensing provider
3. COB override frequency reports by NCPDP value by state
4. COB override frequency reports by NCPDP value by dispensing provider
5. Fraud and abuse detection reports

As requested by the State, the Contractor will prepare for use by the State:

1. The compilation that constitutes the preferred drug list or list of drugs subject to prior authorization or any other utilization review procedures;

2. Any utilization review procedures, including any prior authorization procedures; and

3. The procedures by which drugs are identified as preferred on the preferred drug list, and the procedures by which drugs will be selected for prior authorization or any other utilization review procedure.

The Contractor shall provide data, materials, documents or analyses sufficient to assist the State in reporting quarterly to the Legislative Health Access Oversight Committee concerning the following:

1. The efforts undertaken to educate health care providers about the preferred drug list and the program's utilization review procedures;

2. The number of prior authorization requests made, the number of requests denied, the number of denial appeals, and the result of such appeals; and

3. The number of utilization review events (other than prior authorization requests), the number of such cases in which coverage of a drug is denied, the number of denial appeals, and the results of such appeals.

The Contractor shall assist the State in preparing an annual report on or before January 1 of each year for the duration of the contract, concerning implementation of the contract. The report shall include:

1. A description of the activities of the Contractor;

2. An analysis of the success of the Contractor in achieving each of the State's public policy goals, together with the Contractor's report of its activities and achievements;

3. An assessment of Medicaid including the Vermont Health Access Program and Vermont publicly-supported health care programs administrative costs relating to prescription drug benefits, including any recommendations for increasing the administrative efficiency of such programs;

4. A fiscal report on the state fiscal costs and savings to the State of the contract, including an accounting of any payments, fees, offsets, savings and other financial transactions or accountings; and

5. Any recommendations for enhancing the benefits of the contract, and an identification of, and any recommendations for minimizing any problems with the contract.

The Contractor shall compile and produce a performance report on its contract administration on an annual basis. This should report annual performance including reports on the Performance Standards that are part of this Contract. It should also include operational reporting on an annual basis and since the inception of the contract. Operational reporting should include, but not be limited to, claims processing statistics, specialty pharmacy use, audits performed and savings generated, PDL compliance, generic use, prescriber performance, and any other performance indicators that would be useful in reporting on the Contractor's and the Vermont Health Access Pharmacy Benefit Management Program's performance.

V. Drug Coverage Management

1. Overview

The State will retain the right to formulate its own drug coverage list(s). The Contractor shall be expected to apply the State's list(s) in Claims Processing.

In Vermont, for HIV and AIDS-related medications used by individuals with HIV or AIDS, a preferred drug list and any utilization review procedures may not be more restrictive than the drug list and the application of the list used for the State's HIV/AIDS Medication Assistance Program. The list and procedures for these medications is formulated by the Vermont Department of Health. Thus, HIV and AIDS-related medications are not subject to the Contractor's Drug Coverage Management responsibilities.

The General Assistance program is limited to specific therapeutic classes. Thus, it is not subject to the Contractor's Drug Coverage Management responsibilities.

The Medicaid Preferred Drug List (PDL) and any variation for state funded programs are formulated under the direction of the Vermont DUR Board acting as Vermont's Pharmacy and Therapeutics (P&T) Committee and

applicable State law. Applications for drug coverage, approval for coverage, policy formulation, and the drug coverage parameters will continue to be part of the State's oversight, although the Contractor shall provide expert consultation and input at these activities.

The Contractor is expected to administer the drug coverage design developed with the guidance of the State's DUR Board. The drug coverage rules include prior authorization drugs and appropriate generic substitution, maximum allowable cost enforcement, and other utilization review edits such as early refills.

The Contractor is expected to approve or deny benefits to covered individuals based on reliance upon the eligibility lists provided by the State. In the event of any retroactive termination of members, the State will assume liability for all claims approved for such members prior to loading of the eligibility data deleting such members.

2. Requirements

a. Drug Coverage

The requirements for the Contractor's management of the drug coverage process include the following.

1. The Contractor shall implement the drug coverage parameters established with the DUR Board, which includes State health care professionals who advise the State on the development of the PDL with input from the Contractor.
2. The Contractor shall apply the current reimbursement methodology for the State's programs. The Contractor shall apply any exemptions from the PDL that the State identifies. The PDL indicates drug product limitations in billing. It applies to drugs billed by retail pharmacies and long-term care pharmacies.
3. The Contractor shall assign a clinical manager (RPh or PharmD) who shall be responsible for daily oversight of drug coverage parameters and all clinical programs and interfaces with the DUR Board.
4. The Contractor shall assign plan management staff who shall be responsible for coverage file updates at the direction of the clinical manager.
5. The Contractor's clinical manager shall collaborate with the Contractor's clinical resources in the analysis of data and materials on drug use and in the development of recommendations for changes in approach in program administration.
6. The Contractor's clinical manager must attend each DUR Board meeting and present the Committee with a written report containing the following information when requested by the State: based on previous quarter's pharmacy claims, recommendations for additions or changes in drug coverage and prior authorization, dispensing limitations, generic substitution protocols, and other relevant or innovative suggestions; supportive clinical research, documentation, financial impact analysis, and recommendations for newly approved therapies and indications to the DUR Board for consideration.
7. The Contractor shall provide a written and electronic report weekly to identify any changes made to the drug file.
8. The Contractor shall provide the State with the ability to review changes in national drug codes' or GCNSeq's supporting data on a weekly basis.
   - Review changes to GC3 (Specific Therapeutic Drug Class, GCNS) or DF (Drug Form), which is an exception report now generated by FDB to assure valid drug coverages. In the event that a vendor other than FDB is used an alternative comparative review must occur.
   - Review reports of new generic sequence numbers added to FDB file, which is generated weekly and taken to the DUR Committee to consider for inclusion into the Medicaid PDL. In the event that a vendor other than FDB is used an alternative comparative review must occur.

9. The Contractor shall update its drug prices and other supporting drug data on a weekly basis using First DataBank (FDB) or a comparative source. As the Contractor proposed to use another entity than FDB, it must present justifications for using an alternative. Current coverages are keyed by FDB's generic code sequence (GCNSeq) and the national drug code (NDC). In the event that a vendor other than FDB is used comparative supporting data must be available.
10. The Federal Upper Limit (FUL) will be updated weekly using First Data Bank (FDB) or an alternative vendor.
11. The Contractor shall recommend State Maximum Allowable Cost (MAC) limits. The State may propose alternative limits. Limits, when approved by the State will be updated monthly or more often when indicated.
12. The Contractor shall have the ability to accept electronic files from other insurers. These files would identify the insurer's formulary and coverage conditions and would be used in COB activities in claims processing.
13. The Contractor shall maintain a quality assurance program in respect to auditing of the claims processing system for benefit design, PDL adjudication, and COB activities. The Contractor will supply any client reports demonstrating specific program and overall quality assurance of the claims processing department.
14. The drug coverage design shall integrate with the Contractor's eligibility system and POS/batch/paper adjudication edits. For example, each pay code or program code in the eligibility system must be maintained so that unique drug coverages can be assigned.

b. Medicaid Preferred Drug List (PDL)

The State maintains a preferred drug list PDL for select classes. All drugs in classes not specifically identified are considered preferred. The PDL applies to Medicaid, Medicaid 1115(a) coverage and expansion programs, and VScript Expanded. It does not apply to AMAP, GA, or HVP. A PDL may be developed for State funded programs in the future.

The Contractor shall propose additions or changes to the preferred list of covered prescription drugs that identifies preferred choices within therapeutic classes for particular diseases and conditions including generic alternatives. The Contractor through its Pharmacy and Therapeutics (P & T) Committee shall determine through evaluation of available clinical data, which drugs within the same therapeutic class are equivalent in terms of clinical efficacy and safety, and make recommendations to the State DUR Board for review and approval. The preferred list is designed to reduce the cost of providing prescription drugs while maintaining high quality in prescription drug therapies. The Contractor shall support the State in ensuring that all affected interests, including consumers, health care providers, pharmacists, and others with pharmaceutical expertise have an opportunity to comment on changes in the preferred drug list prior to adoption and implementation.

The Contractor shall make recommendations for the management of drugs newly introduced into the market. The Contractor shall recommend procedures that the State can establish for the timely review of prescription drugs newly approved by the federal Food and Drug Administration, including procedures for the review of newly approved prescription drugs in emergency circumstances.

The Contractor shall assign a clinical manager (RPh or PharmD) for daily oversight of State's clinical program. The clinical manager should collaborate with the Contractor's clinical resources in the analysis of data and materials on drug use and in the development of recommendations for changes in approach in program administration. The clinical manager recommends the preferred drug list drugs to the State for consideration; presents the preferred drug list to the DUR Board and other groups as requested; recommends drugs for prior authorization; attends meetings of the DUR Board; is available to the State for consultation and oversight activities related to the management of the State's PDL; and gathers and reviews information as requested by the

State in order to facilitate and support preferred drug list management.

At each meeting of the DUR Board, the clinical manager shall be expected to provide written information as requested by the State or Board. The clinical manager shall provide recommendations for additions or changes in the programs and provide educational materials including supportive clinical research, protocols, and financial analysis for newly approved therapies and indications.

The preferred drug list shall be readily available to prescribers and providers through mailings, manuals, and in a manner that could be accessed via a website, including the State's website. Minimally, the drug list shall be available as follows: on paper, electronically for website posting, and via ePocrates®.

The Contractor shall provide the State with a copy of the preferred drug list suitable for use by beneficiaries, including a description of the process by which exceptions to the preferred list may be made.

The Contractor shall provide electronic point-of-sale preferred drug list messages to all participating pharmacies so that the pharmacists know prior to dispensing when a prescribed drug is not on the preferred list. If appropriate, the pharmacist can talk to the patient or call the prescriber's office to see if a preferred brand or generic substitution can be made.

The Contractor shall authorize pharmacy benefit coverage when a patient's health care provider prescribes a prescription drug which is not one of the list's preferred choices, under the same terms as coverage for preferred choice drugs, if:

1. The preferred choice has not been effective, or with reasonable certainty is not expected to be effective, in treating the patient's condition or

2. The preferred choice causes or is reasonably expected to cause adverse or harmful reactions in the patient.

3. The prescriber has provided documentation of the above conditions in a matter dictated by the DUR Board.

The Contractor shall provide the State with subscriptions covering the term of this Contract to: Price Alert, Medispan, Consulting Pharmacist, and Drug Topics Redbook.

VI. Network, Formulary and Rebates for the Uninsured

1. Overview

Network management requirements will differ for the two types of programs to be administered. The Contractor will not be responsible for contracting or credentialing the network to be used for Medicaid, Medicaid 1115(a) coverage and expansion programs, AMAP, VScript Expanded, GA, and the Healthy Vermonters Program. However, the Contractor will be responsible for managing the network(s) for the Healthy Vermonters Program when the Contractor implements a program that provides additional benefits to this population.

The State is assured rebates from drug manufacturers through the process defined in the OBRA '90 legislation. Unfortunately, these rebates are not assured for other groups, such as Healthy Vermonters Program enrollees or any additional programs that the State may wish to offer the uninsured within the State.

2. Requirements:

The State will be responsible for enrolling pharmacy providers for its publicly-supported health care programs. The Contractor may be responsible for enrolling pharmacy providers for uninsured enrollees if a special network is used. The Contractor will be responsible for negotiating provider discounts and rebates for uninsured beneficiaries within the context of a strategy agreed to between the State and the Contractor. If the State approves the Contractor's plan to providing additional discounts for enrollees in the Healthy Vermonters Program, the Contractor will assume network management responsibilities for this program no earlier than July 1, 2006.

VII. Medicaid (OBRA '90), Supplemental, and State only Rebates

A. OBRA Rebates and State Only Rebates

OBRA and State Only rebate functions for the VScript Expanded program are currently performed by the State's MMIS contractor. This will continue under the provisions of this contract.

B. Supplemental and Part D State Only Rebates

1. Overview

Working relations with Pharmaceutical Manufacturers are a key component for the long term success of the State's cost control initiatives particularly any multi-state or state only rebate initiative and the negotiation and maintenance of favorable rebate agreements.

Supplemental rebates and multi-state pooling

The State Supplemental Rebate process was established with the assistance of the State's previous PBM Contractor. It was undertaken as a multi-state effort, initially in conjunction with the State of Michigan. This initiative was approved by CMS in April of 2004. Multiple state participation increases the leverage of participating states by increasing the number of lives covered by the process.

Under the pooling program, the purchasing power of multiple states is combined for the purposes of negotiating supplemental rebates with pharmaceutical manufacturers in connection with the Preferred Drug List management systems. Supplemental rebates are in addition to the baseline "standard CMS rebates" that all pharmaceutical manufacturers must pay states to participate in the Medicaid program under the provisions of OBRA'90. Under this pooling approach, flexibility and choice remains with the individual state and its DUR Board/P&T Committee to determine which classes to include on the PDL and which drugs to select as preferred. Under the Vermont model, 100% of all rebate revenues are returned to the State. They are not shared with the Contractor.

State only Part D related rebates and discounts and/or rebates for the uninsured

The State is considering the solicitation and negotiation of rebates for the costs of drugs paid by 100% State funds on behalf of Part D beneficiaries. If CMS approval is granted and if financially advantageous to the State, the Contractor may be asked to negotiate and collect those rebates.

If the State approves the Contractor's plan to providing additional discounts for enrollees in the Healthy

Vermonters Program, the Contractor will assume responsibility for the management of any discounts or rebates associated with the program. Discounts or rebates shall be used to reduce costs to program enrollees based on the program design approved by the State.

2. Requirements

a. Rebate Negotiation

The Contractor may be requested to negotiate, participate in the negotiation, and/or collect supplemental or state only Part D related rebates. If so, the Contractor may be required to provide a standard, (CMS-approved) Supplemental Rebate Agreement for use in Vermont and/or a proposed State only rebate agreement. State staff must review any proposed agreement to incorporate any legal requirements that are specific to the State. Only the approved agreement will be used with the manufacturers during the negotiation process. Any negotiated changes must be acceptable to CMS and/or the State. The Contractor may be responsible for obtaining CMS approval when required.

All terms, conditions, and details of any negotiated drug manufacturer agreement/contract shall be considered confidential and shall not be disclosed to any person or entity not a party to the agreement/contract. Confidential information, including trade secrets, will not be disclosed, or used except in connection with an agreement/contract or as may be required by law.

Pursuant to 42 USC 1396r-8(b)(3)(D), and other applicable state and federal laws, the Contractor shall agree that the agreement/contract will not be disclosed. The Contractor shall agree that they will not duplicate or use information, except in connection with the agreement/contract or as required by judicial order. The Contractor agrees that any information provided by a manufacturer to the State, the State's designees, or the Contractor pursuant to the agreement/contract and the agreement/contract itself constitute trade secrets and/or confidential or proprietary commercial and financial information not subject to public disclosure. Furthermore, the Contractor agrees that any manufacturer information disclosed to the Contractor pursuant to the agreement/contract and distributed to the State or its designees shall constitute trade secrets and/or confidential or proprietary commercial and financial information of the manufacturer not subject to public disclosure. If the services of a third party are used to administer any portion of the agreement/contract all conditions herein shall apply to the third party. In the event that the Contractor cannot give satisfactory assurance that rebate pricing data shall be exempt from public disclosure under applicable state law, then the State shall limit the amount of such data available to the Contractor. For purposes hereof "satisfactory assurance" shall be deemed given when the Contractor can produce the statutory cite of any applicable exemption. In the event that the Contractor is required by law to disclose any provision of the agreement/contract or pricing information to any person, the Contractor shall provide written notice to the State in advance of the proposed disclosure to the State to seek a protective order or other relief.

Notwithstanding the non-renewal or termination of this Contract or the manufacturer agreement/contract, these confidentiality provisions remain in full force and effect and apply to the Contractor, their employees, their subcontractors, and/or their designees.

The Contractor shall develop and maintain working relations with pharmaceutical manufacturers. The Contractor may be required to identify, schedule, and coordinate meetings with the designated manufacturers on behalf of the State. The contractor shall evaluate rebate proposals to determine what proposals are most appropriate clinically and financially for the State and provide the State with options.

The State will have final approval on the preferred drug list for its beneficiaries.

Manufacturers and the State will be provided with a projection of rebate dollars due for the next quarter.

b. Rebate Collection

If the Contractor performs supplemental rebate collection functions, the following requirements must be met. The Contractor shall implement all accounting functions that are part of the drug rebate program, including but not limited to preparing and submitting manufacturer invoices quarterly. Invoices include the following data: NDC, drug name, CMS unit, unit rebate amount, total units reimbursed, total amount claimed, number of prescriptions, total reimbursed amount, correction record flag, TPL prescriptions, and TPL payment amount. Invoicing is based on the date of payment. Invoices shall be issued within sixty (60) days after each rebate period for Medicaid beneficiaries.

The pharmacies must be allowed to submit claims for obsolete NDCs for two (2) years post obsolete date to allow for shelf life. Post two (2) years from the obsolete date pharmacies should receive an on-line message indicating denial is due to "NDC obsolete".

If a claim is reversed post invoicing a manufacturer for the rebate, the State staff must be able to see all transactions: the initial payment, the reversal, and the possible subsequent re-bill.

The Contractor shall maintain quarterly unit rebate amount data supplied by CMS from the inception of the program.

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

The Contractor shall be capable of calculating interest due on overdue payments per any agreements in the contracts.

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

The Contractor shall perform quarterly posting of the reconciliation of the invoice from manufacturers and transmit reports to the State of payment receipts.

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

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

The Contractor shall be able to respond to any changes in State or CMS requirements.

VIII. Drug Utilization Review and Federal DUR Requirements

1. Overview

The State has responsibility for meeting federal DUR requirements, including analysis of claims, identification of prescribing patterns inconsistent with best clinical practices, and education of providers. Federal requirements included annual reporting on DUR activities, which in Vermont are performed under the direction of the State Drug Utilization Review Board (DUR Board). The Contractor is expected to perform these functions.

Drug Utilization Review includes ProDUR, Concurrent DUR, RetroDUR, potential fraud and/or abuse assessment, and educational programs. The Contractor shall consider these programs as a clinical continuum of utilization management of prescribing habits, provider dispensing practices, and beneficiary abuses or misuses of the system. The Contractor must use advanced ProDUR techniques and RetroDUR, which profiles patients, pharmacies, and disease states, to direct educational and intervention initiatives. The goal of these activities is to ensure that prescriptions are appropriate, medically necessary and that they do not result in adverse drug events. The DUR program functions as an adjunct and support to the prescriber and the pharmacist's education and professional judgment and does not replace the human cognitive review process.

The purpose of the DUR program is to improve the quality of pharmaceutical care by ensuring that prescriptions are appropriate, medically necessary, and that they are not likely to result in adverse medical results, in accordance with OBRA '90. The program must be designed to educate physicians and pharmacists to identify and reduce the frequency of patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care. The program must evaluate drug use patterns among physicians, pharmacists and beneficiaries, and those associated with specific drugs or groups of drugs. DUR compares data on drug use against predetermined standards, consistent with peer-reviewed literature and the recommendations of the State DUR Board. The assessment must include, but need not be limited to:

- Monitoring for therapeutic appropriateness
- Over-utilization and under-utilization
- Therapeutic duplication
- Drug-disease contraindications
- Age/gender contraindications
- Drug-drug interactions
- Drug allergy interactions
- Incorrect drug dosage or duration of drug treatment
- Clinical abuse/misuse
- Appropriate use of generic products

Prospective DUR provides for a review of drug therapy before each prescription is filled or delivered to a beneficiary. The review must include screening for the items listed above. The Contractor must maintain a program that encourages pharmacists to comply with applicable pharmacy, State, and Federal requirements, laws, and regulations, which require pharmacists to offer to discuss anything about the prescription that the pharmacist feels is important, based on the Prospective DUR. The Contractor will also encourage pharmacists to make a reasonable effort to obtain, record, and maintain specific beneficiary profile information.

In compliance with OBRA '90, pharmacists are required to counsel beneficiaries on the significant findings of the Prospective DUR. The Contractor should encourage pharmacists to comply with this law. The States are responsible for establishing the standards for this counseling, and the Contractor should provide expert advice to the DUR Board in this regard.

The Retrospective DUR should assess data on drug use against explicit predetermined standards and introduce appropriate remedial strategies to improve the quality of care and reduce medical care costs.

Finally, the Contractor will need to develop active and ongoing educational outreach programs to educate practitioners on common drug therapy problems, in order to improve prescribing or dispensing practices.

The DUR Board is responsible for approving all Prospective and Retrospective DUR programs prior to their

distribution or implementation.

2. Requirements

The requirements for the Contractor's DUR and education programs shall minimally include the requirements listed under the following subheadings: General, Prospective DUR, Concurrent DUR, Fraud and Abuse Programs, and Educational Programs.

General

1. The dedicated clinical manager (RPh or PharmD) will be responsible for daily oversight of the pharmacy programs and provide clinical analysis and guidance to the DUR Board.
2. The Contractor/clinical manager must coordinate with the DUR Board, which includes health care professionals who are responsible for approving all DUR programs.
3. By March 31, 2006 and annually thereafter, the Contractor's clinical manager shall present an annual DUR plan to the DUR Board for consideration, including a profile of all proposed DUR programs and dates for execution, as well as expert advice regarding standards for pharmacist counseling of beneficiaries.
4. On an annual basis, the Contractor shall prepare a report to the State that includes a description of the DUR activities (part of annual clinical plan), scope and nature of the Prospective and Retrospective drug use review programs, a summary of the interventions used, and an assessment of the impact of these educational interventions on the quality of care, and an estimate of the cost savings generated as a result. This report will be used to evaluate the effectiveness of the DUR program.
5. A clinical manager will be required to attend each DUR Board meeting and present the committee with reports, as requested by the State or Board, addressing issues identified by the State or Board. Examples include the following types of information:
    a. Based on previous quarter's pharmacy claims, current ten (10) top therapeutic classes and top five (5) high growth therapeutic classes, their current DUR protocol, and recommendations for additions or changes in the DUR program.
    b. Educational materials including supportive clinical research, protocols and financial analysis for newly approved therapies and indications to the DUR Board for consideration. If approved, this information would be included as part of the Prospective and Retrospective DUR program to targeted physicians.
6. As requested by the State, provide face-to-face clinical detailing, with detailed criteria provided by the State.
7. The Contractor's DUR programs must comply with all OBRA '90 and PL 104-191 requirements.

Prospective DUR

1. The Contractor must provide a Prospective Drug Utilization Review process that is linked to the electronic claims management network, so as to furnish medical and drug history information for each beneficiary. This process is subject to the review and recommendation of the DUR Board. This process must have the flexibility to adjust to changes in criteria or procedures as recommended by the DUR Board.
2. The Contractor will be required, if requested by the State, to provide educational materials targeted to pharmacists informing pharmacists about their legal obligation to provide counseling to beneficiaries regarding meaningful Prospective DUR findings.

Concurrent DUR

The Concurrent DUR system must have the following capabilities at a minimum:

1. A table with days supply limits by drug
2. Quantity limits by drug
3. A dual-tracking system for early refills that tracks both current and cumulative usage
4. Age and gender edits

Retrospective DUR

1. The Contractor shall analyze pharmacy and non-pharmacy claims on an ongoing basis and present recommendations quarterly for additions or changes to the Retrospective DUR programs and interventions. The State shall be responsible for providing non-pharmacy claims data from its MMIS application. The proposed DUR programs shall address both high risk and high cost/utilization drug therapies and tie where applicable to the top drugs/disease states that are being used by the beneficiaries.
2. The program must, on a monthly and quarterly basis, assess data on drug use against explicit predetermined standards including but not limited to monitoring for therapeutic appropriateness, over-utilization and under-utilization, incorrect drug dosage, or duration of drug treatment and clinical abuse/misuse and, as necessary, introduce remedial strategies to improve the quality of care and to conserve program funds or personal expenditures.
3. The Retrospective DUR program shall provide ongoing interventions for physicians and pharmacists targeted toward therapy problems or individuals identified in the course of Retrospective DUR activities.
4. The Retrospective DUR program shall include written, oral, or electronic reminders containing beneficiary-specific or drug-specific (or both) information and suggested changes in prescribing or dispensing practices, communicated in a manner designed to ensure the privacy of beneficiary-related information.
5. The Contractor's process shall include intensified review or monitoring of selected prescribers or dispensers, proposing detailed program interventions to the DUR Board for consideration.
6. The Contractor's process shall include periodic evaluation of interventions to determine if the interventions improved the quality of drug therapy. The Contractor is to evaluate the success of interventions and make modifications as necessary.

Fraud and Abuse Programs

1. The Contractor must have methods and models used to screen and identify potential fraud and abuse by prescribers, pharmacists, pharmacies, and beneficiaries.
2. The Contractor approach must be able to distinguish between blatant fraud, creative fraud and unintentional processing errors.
3. The Contractor's approach should include manual and system supported tools to track and monitor cases where the potential exists.
4. The Contractor must have processes to report cases of suspected fraud as designated by the State.

Educational Programs

1. At least on a quarterly basis, the Contractor will provide educational materials including supportive clinical research, protocols, and financial analyses for newly approved therapies and indications to the DUR Board for consideration. Upon approval, this information shall be included as part of the Retrospective DUR Program to targeted physicians and other prescribers.
2. The DUR Program must integrate with edits (whether POS, batch, or paper claims processing), and provide communications and education to pharmacies that are not appropriately complying with these edits, including encouraging pharmacists to counsel beneficiaries on DUR findings.
3. The Contractor is expected to provide effective physician and pharmacy targeting that is focused on the high value prescribers who contribute the largest impact on improved quality of care and/or drug cost reduction.
4. The Contractor shall have systems and data that can be used to demonstrate success in attaining prescriber agreement to use a clinically appropriate alternative product or generic, if relevant, in the same therapeutic class.
5. The Contractor must be able to demonstrate the effect of face-to-face discussions between health care professionals who are experts in rational drug therapy and selected prescribers and pharmacists who have been targeted for educational intervention, including discussion of optimal prescribing, dispensing, or pharmacy care practices and follow-up face-to-face discussions.
6. The Contractor must have clinically appropriate staff to meet with targeted physicians. The face-to-face meetings may include retrospective, beneficiary specific DUR issues. The staff may also meet with physician groups, providing prospective and retrospective DUR education that is not beneficiary specific.

In performing the DUR function, the Contractor shall comply with all federal regulations regarding DUR including OBRA '90 and PL 104 – 191 requirements. The Contractor shall perform prospective and concurrent DUR online, real-time, 24 hours per day/7 days per week, and perform retrospective DUR through analysis of claims history. The Contractor shall have a POS system-based process for exceptions that can be made by the local pharmacist for any DUR hard edits. Standards for exceptions will be approved by the State based on the recommendations of the Contractor. The DUR system shall be operated in such a manner that there is not any unnecessary delay in access to appropriate medications by beneficiaries.

The dedicated clinical manager (RPh or PharmD) shall coordinate with the State DUR Board. The Contractor shall present analysis, education materials and a list of targeted prescribers with specific profiles to the DUR Board for approval. The Contractor shall also:

1. Develop and present an annual DUR plan
2. Prepare an annual DUR report for both the State and CMS
3. Coordinate the agenda for each DUR Board meeting with State staff
4. Attend each DUR Board meeting, report on activities and the results of interventions since the last meeting, and prepare and distribute analyses and recommendations for consideration by the Board.

The Contractor shall apply automated tools in support of fraud and abuse activities. The Contractor's program representative shall be responsible for collaborating with the clinical manager to review fraud and abuse reports, submit a quarterly activity report to the State, and work with the pharmacies on recoupment activities.

As requested by the State, the Contractor shall offer to retail pharmacists educational materials informing them, not only about their legal obligations to provide counseling to beneficiaries, but information on different levels of potential DUR therapeutic interventions.

The Contractor shall implement a clinical detailing program that is approved by the State. Included in the

program shall be the following:

a. Policies and procedures for the clinical detailing program that have been reviewed and approved by the State. This program may use clinical pharmacist educators recruited from the local area or the Contractor may propose other methods.
b. A process for orientation and training as applicable.
c. The Contractor shall introduce the program to the provider community prior to start-up in order to gain acceptance and cooperation, and modify the process based on feedback from the provider community. To the extent feasible, any clinical detailing program may be integrated with similar programs operated by other payers and clinical detailing efforts will be coordinated and/or integrated with similar efforts underway in the State. As part of this effort the Contractor shall develop educational materials for prescribers.
d. The Contractor shall identify target drug therapies and/or targeted prescribers. The Contractor shall use targeted drug/prescribers profiles to perform face-to-face interventions. Clinical detailing will focus on the preferred drug list, less costly drug therapy options, and methods to improve prescribing patterns for identified prescribers, including over treatment/under treatment, treatment failure, drug to drug interactions, iatrogenic effects/adverse reactions, therapeutic duplication, drugs with diagnosis/drugs without diagnosis, drugs without procedure, or other issues identified in the prescriber profile.

IX. Utilization Management (UM)

1. Overview

Clinical programs should be integrated to best preserve both clinical and fiscal resources. The State's utilization management plan includes ProDUR, RetroDUR, educational programs, and disease state management. These processes focus on controlling/reducing unnecessary or inappropriate pharmacy utilization, while integrating disease management and retrospective DUR to identify beneficiaries, pharmacy providers and prescribers who are candidates for intervention. However, the State's utilization management plan involves the use of predictive models to identify those beneficiaries "at risk," pharmacies who are candidates for further investigation, and prescribers practicing outside standards of care. A key aspect of the use of predictive models involves the use of historical data to identify trends of interest and to identify variables that can be used as early, reliable predictors of subsequent outcomes. Predictive model case management will identify parameters that can be used to target individuals who are at increased risk for a given outcome. Outcomes of interest vary and may include any specific clinical result, hospitalization, over utilization, or excessive expenditures.

Utilization Management must focus on beneficiary, physician, and pharmacist utilization patterns and must be integrated with both the Retrospective DUR and network management programs. The utilization management protocols will be proposed by the Contractor to the DUR Boards and presented to the State for approval. While the primary focus of utilization management is controlling/reducing pharmacy utilization, utilization management programs may also integrate with disease management and Retrospective DUR, identifying beneficiaries who are non-compliant or inconsistently using their therapies.

Utilization management consists of reviewing, on a regular basis, the utilization patterns of beneficiaries. Examples would include beneficiaries receiving a large number of prescriptions each month, high cost prescriptions, controlled substances, or seeing multiple physicians and/or receiving prescriptions from multiple pharmacists (referred to as poly-physician, poly-pharmacy). Once beneficiaries are systematically identified,

they shall be assessed by a clinician to determine the appropriate intervention, which may include referring the beneficiary to a case management program, physician notification, beneficiary lock-in, or other interventions.

Physician utilization management is integrated with Retrospective DUR and assists in targeting the appropriate method of communication and intervention with the physician.

Pharmacy utilization management consists of systematic reviews of pharmacy prescribing patterns, focusing on unusual activity such as disproportionate drug dispensing patterns and generic substitution opportunities. Pharmacy utilization management shall integrate with pharmacy network management, identifying potential candidates for further investigation or on-site audits.

The State is responsible for approving all utilization management targeting protocols and making beneficiary lock-in decisions.

2. Requirements

The dedicated clinical manager (RPh or PharmD) shall be responsible for daily oversight and clinical review of beneficiaries, physicians, and pharmacies that have been identified through the utilization management program. The Contractor/clinical manager shall coordinate with the State who shall be responsible for approving all utilization management programs.

By March 31, 2006 and annually thereafter, the Contractor's clinical manager shall present an annual utilization management plan to the State for consideration. The Contractor shall present the plan for review and adoption by the State. In developing this plan, the Contractor shall analyze claims and present recommendations for utilization management programs to be undertaken by both the Contractor and the State's clinical staff. The Contractor shall provide the capacity to provide utilization management reminders containing specific information and suggested changes in prescribing and dispensing practices.

The Contractor shall analyze utilization patterns on a quarterly basis for beneficiaries/pharmacies/prescribers along the following characteristics, or other characteristics recommended by the Contractor and agreed to by the State:

a. Large number of prescriptions per month;
b. High cost of prescriptions;
c. Prescriptions from multiple pharmacies or prescribers;
d. Disproportionate dispensing patterns;
e. Low generic substitution;
f. High dispense as written rate; and
g. High number of DUR overrides.

XI. Disease Management

1. Overview

Disease management is a name applied to use of pre-established protocols or best practices, as identified by qualified medical personnel, to review care and services received by beneficiaries with a specified condition or condition(s) to validate that care offered is optimal and conforms to best practice treatment guidelines. This review may apply to either acute illness (e.g., pneumonia in adults) or to chronic medical conditions such as

asthma, hypertension, and schizophrenia.

A disease management system/process must be developed in consultation with the State, must have physician oversight, and will focus on beneficiary, physician, and pharmacist education. Therefore, the Contractor will coordinate meetings with these organizations and other organizations and State agencies specified by the State. The Contractor will facilitate literature review, select a topic or topics for implementation, analyze the capacity of data to support such a topic, and prepare strategies for translating disease management protocols and observed findings to educational opportunities for eligible beneficiaries of applicable pharmacy programs with the selected condition, and the pharmacy and physician providers caring for them. Of necessity, this function will rely on identification of physician services and other data containing diagnoses, if available, in addition to pharmacy and other paid claims information detailing treatments.

Following consensus with the State and the other organizations to be consulted, the Contractor will identify the selected disease(s), the beneficiaries to be reviewed, the findings of the review, the analyses of strategies to improve the findings, and re-measurement of the findings after interventions with the beneficiary, physician, and pharmacist communities.

2. Requirements

Subject to the approval of the State, and in conjunction with the State's clinical staff, the Contractor shall provide disease management programs that will promote appropriate medical and pharmaceutical utilization. The Contractor shall identify and manage troublesome therapies for some or all of the following conditions, or other conditions agreed to by the state:

1. Diabetes
2. Asthma
3. Obesity
4. Depression
5. Congestive heart failure
6. Coronary artery disease
7. Chronic obstructive pulmonary disease
8. Peptic ulcer disease
9. Rheumatoid arthritis

The Contractor shall provide a disease state management process by developing algorithms through predictive modeling, ranking patients' risk of preventable adverse therapeutic outcomes, providing interventions and education. The Contractor shall provide a disease management overview that includes broad based clinical programs, education of prescribers about matters of clinical practice, and measures to influence patient behavior to take an active role in own care. Annually, the Contractor shall provide a clinical and economic outcome assessment for the disease management programs.

The Contractor shall furnish the State with a schedule and implementation plan for each disease management program prior to implementation. The implementation plan shall include appropriate provider and beneficiary education. Implementation shall be subject to State approval.

XI. Prior Authorization (PA)

1. Overview

An aggressive PA program in concert with a PDL has been demonstrated to provide savings to the program, without degrading quality of care. PA can be effectively employed for Medicaid beneficiaries if PA adheres to OBRA '90 rules. OBRA '90 rules require that Requests for Prior Authorizations for Medicaid recipients must be acted upon within 72 hours.

2. Requirements

The Contractor shall recommend drugs for prior authorization to the State consistent with the State's criteria in the OVHA Policy Manual at M106.2; the Preferred Drug List; and, in the case of HIV and AIDS-related medications used by individuals with HIV or AIDS, with the State's criteria as determined by the Vermont Department of Health. The Contractor shall have a process for informing providers and consumers of any additions to the list of drugs requiring PA. This process will be developed in conjunction with the State and may be modified over time as circumstances warrant.

All PA requests will be processed a rapidly as possible, but in no case shall a PA request be dispositioned later than 72 consecutive hours after the request is filed.

The prior authorization program shall be fully automated and an integral part of the POS/ProDUR system. The PA system shall be operated in such a manner that there is not any unnecessary delay in access to appropriate medications by beneficiaries. The Contractor shall insure the integration of prior authorization and preferred drug list and any step therapy protocol.

The Contractor shall provide prior authorization tracking process so that providers do not have to submit a claim with a PA number.

Any medication requiring prior authorization will be entered into the system to reject at the point of sale. This rejection will include messaging describing the reason for the denial and the Contractor's toll-free telephone number for the pharmacist or the prescriber. The prescriber must initiate a prior authorization request. A certified pharmacy associate shall manage initial PA requests. If the information furnished by the prescriber satisfies criteria, the associate may grant an approval.

If there is any doubt that the criteria have been met, the associate will refer the PA to a licensed clinical pharmacist will review the patient specifics with the prescriber. The Contractor shall assist the prescriber in changing to a more appropriate therapy rather than simply denying the initial request. If the prescriber is unwilling to switch the patient to an acceptable therapy, the pharmacist will issue a denial, or as indicated consult with the Contractor's Medical Director or clinical staff for resolution. If still unresolved, the case will be referred to the OVHA Medical Director or clinical staff as directed by the State. If the recommendation of the Contractor is overridden by the State, an authorization will be entered into the system. All clinical decisions remain the final responsibility of the State. If a request for prior authorization is denied, the Contractor shall issue a notice to the beneficiary notifying them of the denial and of their rights to a fair hearing. The format for such notices will be approved in advance by the State. If requested by the State, the Contractor shall provide the clinical criteria and rationale for each denial.

The Contractor shall provide personal computer software that permits State staff, including member services staff, to view in real-time, prior authorization requests and the status and disposition of requests. Information

will be accessible based on a variety of key elements including, but not limited to patient name, drug name, and drug class. The Contractor will work with State staff to create an interface with the State's global clinical record system.

The Contractor shall provide a reporting process to summarize PA activity, both in detail and in summary. The clinical manager provided by the Contractor will review medical necessity with the State's clinical staff.

XII. Medicare Part D

1. Overview

The State is committed to ensuring, to the extent supported by State appropriations, that Medicare beneficiaries of current state funded pharmacy programs will not be disadvantaged with respect to pharmacy coverage when the Medicare Part D drug program is implemented.

Medicare will be the primary carrier for pharmacy coverage for Medicare eligibles in Vermont's publicly funded programs. From a claims and pharmacy benefit management (PBM) point of view, Vermont's programs will be only be primary for Part D non-covered drugs for Medicaid eligibles. Otherwise, Vermont's pharmacy programs will be no more than secondary to Part D covered drugs. Vermont's coverage will only include the beneficiaries' deductibles, coinsurance, and coverage in the coverage gap ("donut hole") and then only covering up to each beneficiary's individual Medicare Part D Prescription Drug Plan (PDP) formulary.

Part D beneficiaries will thus not require the following PBM services: specialty pharmacy; auditing; drug coverage management other than identified above; Medicaid (OBRA'90) rebate management including disputes and collections; Medicaid supplemental rebate negotiation and management including disputes and collections; drug utilization review; utilization management; disease management; prior authorization; and optional services. The State may explore state-only rebates for the "donut hole" coverage subject to CMS approval. If this should occur, at that time, the State will require negotiation and management services including disputes resolution and rebate collections.

The State believes that VScript Expanded beneficiaries will be subject to VScript state-only OBRA'90 equivalent rebate management including disputes and collections. This function will be performed by the MMIS Contractor.

2. Requirements

The Contractor shall have systems in place to interface with Medicare designated PDPs enrolling Vermont beneficiaries to appropriately coordinate benefits in the model described above. The Contractor shall perform the following functions with respect to Part D beneficiaries:

a. Claims processing to coordinate benefits with the beneficiary's PDP

b. Drug coverage management only to the extent that coordinated benefits for VScript and VScript Expanded will be limited to maintenance drugs as identified by HIC3 codes

c. Analysis and reporting

d. Telephone support

Subject to final specification from CMS, the Contractor should have the following claims processing capacity relative to Medicare Part D claims.

1. Claims should edit against identified PDPs coverage list to identify what is covered or non-covered by PDP.
2. The system should be able to cost avoid by drug and drug class.
3. The system should be able to edit for subsidy level (the level of beneficiary cost sharing) and set counters for maximums based on subsidy level. (It is anticipated that there will be 5-6 levels).
4. The system should be able to accept transactions from the TROOP coordinator.
5. The system should be able to report on Part D. At a minimum:
    a. Counter reports for claims review and recovery activity on PDPs
    b. Fraud/abuse indicators on pharmacies
6. The system should accept changes to PDPs and or cost sharing levels, identify claims erroneously processed, and set the claims for reversal.

XIII. Beneficiary and Provider Telephone Support

1. Overview

The State presently provides telephone support for its Medicaid beneficiaries through its Member Services Unit (MSU). The State maintains provider services functions for provider enrollment and payment through the MMIS Contractor. The Contractor must have an interface with the State's MSU to assist in addressing beneficiary issues. This should include telephone response and an electronic capacity to provide coverage, including PA status, and claims status information. The Contractor is responsible for providing telephone support for prescribers and network pharmacies on all PBM matters other than enrollment and payments.

2. Requirements

The Contractor shall provide access to appropriate staff to support Member Services activities. The Contractor must provide toll-free telephone access to support system (technical) operations. The Contractor shall supply all required information systems, telecommunications, and personnel to perform these operations.

The Contractor shall appropriately staff its systems' hotline, with positions such as a manager, hotline team leaders, and hotline representatives, all of whom shall be extensively trained.

The Contractor's hotline staff shall have complete on-line access to all computer files and databases that support the system for applicable pharmacy programs.

The Contractor's hotline should provide sufficient telecommunications capacity to meet the State's existing needs with acceptable call completion and abandonment rates. It shall also be scalable to future demand. It shall also possess an advanced telephone system that provides the State with extensive management tracking and reporting capabilities.

A QA program shall be in place that samples calls and follows up to confirm efficient handling and caller satisfaction. The Contractor must maintain toll-free telephone access (available for in-state and out-of-state providers) to support prior authorization. The Contractor must have professional (licensed) medical and pharmacological advisory staff and other resources necessary to provide pharmacists at the point of sale with advice pertaining to the proper use of prescription drugs, consistent with Prospective Drug Utilization and other medical standards, as they apply to each beneficiary's unique needs and medical conditions.

The Contractor shall produce reports on usage of the hotline(s), including number of inquiries, types of inquiries, and timeliness of responses. These reports shall be submitted to the State based on a schedule agreed to between the Contractor and the State.

For the State's publicly-supported health care programs and the Healthy Vermonter Program, the Contractor shall provide ongoing training and support to Member Services staff. For beneficiaries enrolled in the State's publicly-supported health care programs, Member Services is the single point of contact for ongoing consumer member services. The State's Member Services Unit will continue to be that contact.

The Contractor shall be responsible for prescription drug program announcement letters; prescription drug program benefit brochures; and patient profile order forms and pre-addressed envelopes. The Contractor shall be available to the Member Services Unit if need be to resolve beneficiary questions or issues. The contractor shall provide:

1. The system ability to identify if individual drugs are covered and any conditions of coverage; for example, if PA is required, any beneficiary limits (e.g., annual, lifetime, etc.); if cost sharing applies, etc.
2. The system ability to identify why some drugs are not covered; for example, not covered in the coverage program, not covered because of rebate, etc.
3. The system ability to identify the status of a PA; for example, if it is pending and if so, when a decision is due; if it is active and if so, when it expires; etc.
4. The system capacity to identify claims status information including reasons for denial that can be translated into beneficiary terms.

For the State's publicly-supported health care programs and the Healthy Vermonter Program, the Contractor shall provide ongoing training and support to existing and new prescribers and providers:

1. Network providers shall continue to be enrolled through the State's fiscal agent. Upon receipt of enrollment notification, the Contractor shall supply providers with information on PBM program specifics and on claim filing preparation and will issue an up-to-date, relevant provider manual. The contractor shall also be responsible for provider education as program changes are implemented. The Contractor shall handle all questions on these matters.

2. In the event that a mail order option (generally or as part of a specialized pharmacy service) is made available, the following may be required of the Contractor on a ongoing basis for consumers: a prescription drug program announcement letter, customized and printed on State specified letterhead announcing that a new mail order prescription benefit is available and providing a toll-free customer service number; a mail order prescription drug program benefit brochure customized with the State specified name and logo highlighting features of the option including convenience, quality, and the benefits of the use of generics and containing information on how to participate, ordering instructions, using the toll-free customer service number and a 24 hours per day/7 days per week refill request line.

XIV. ID Cards and Member Materials

Requirements

The Contractor will use the identification cards issued by the State for its publicly-supported health care programs, and provide identification cards for other populations. The State will issue ID cards and other

member or recipient materials for these programs. If the Contractor is required to issue ID cards and other member or recipient materials for some portions of the recipients to be covered pursuant to the Contract, the specifications issued by the National Council for Prescription Drug Programs (NCPDP) shall apply to ID cards.

XV. Educational and Public Relations Functions and Other

1. Overview

Provider and beneficiary education are essential to the success of the program. The Contractor is expected to provide a variety of educational strategies for prescribers and beneficiaries in order for them to understand the need for pharmacy program and its requirements. Any member education material will be reviewed and approved by the State prior to distribution.

2. Requirements

The Contractor will support the implementation of the commercial product ePocrates® for communication of the Vermont Preferred Drug List to prescribing physicians, pharmacists and any other parties wishing to download this information. The Contractor shall contract for ePocrates® directly. The Contractor will maintain this information through the provision of quarterly updates for ePocrates®.

The Contractor shall develop working relations with groups including but not limited to professional pharmacy associations such as the Vermont Pharmacy Association and National Association of Chain Drug Stores (NACDS); medical groups such as the Vermont Medical Society; and other groups including advocacy and consumer groups, the Medicaid Advisory Board, and any other group designated by the State. The Contractor shall have ongoing working relations with the State's MMIS contractor and fiscal agent, EDS. The Contractor shall attend Legislative or Legislative Oversight Committee meetings or other meetings designed to explain the Pharmacy Benefit Management (PBM) program or address issues raised by this contract.

The State will be responsible for enrolling pharmacy providers for its publicly-supported health care programs. The Contractor shall be responsible for enrolling pharmacy providers for uninsured enrollees if a limited network is used and approved by the State.

The Contractor will be responsible for the education of prescribers on program specifics and benefits, the preferred drug list, and the program's utilization review and prior authorization procedures.

The Contractor will perform education of network providers on program specifics and on claim filing preparation and drafting and issuing up-to-date provider manuals to every pharmacy in the network. The provider manuals shall be consistent with other State provider manuals and shall be subject to State approval. The Contractor shall also be responsible for provider education as each program change is implemented.

The Contractor will be responsible for Consumer education activities, including such items as prescription drug program announcement letters; prescription drug program benefit brochure; and patient profile order forms and pre-addressed envelopes. Patient profile order forms are used to obtain both mailing and medical information about the patient, such as drug allergies and/or existing health conditions, and in the event that a mail order option becomes available, serves as the order form. Pre-addressed envelopes will be supplied for the participant's convenience.

The Contractor shall provide beneficiary brochures and text for Member Handbooks for all beneficiaries that provide information about the beneficiary's pharmacy benefits. Emphasis should include, but not be limited to

information regarding the preferred drug list and the use of generics. Any member education material will be reviewed and approved by the State prior to distribution.

The Contractor shall assign one (1) Program Representative to be responsible for the execution of the communication strategies and training plans that will be developed for each identified impacted group. The Contractor in conjunction with the State will identify the groups to be contacted.

These strategies will be implemented by:

a. Direct involvement with physician prescribers and pharmacy providers to educate them about the program intent, the process that was used to determine the PDL and the content of the PDL, the processes to be followed to obtain a PA if necessary, resolution of issues that arise, and how they can assist to make the program a success.

b. Direct involvement with constituent groups to help facilitate their understanding of the program and the processes that will be followed.

The Program Representative will also act as a point of contact for the provider community to get additional information on the program as well as being a focal point for issues that need to be addressed.

If requested by the State, a pocket preferred drug list guide will be mailed to identified enrollees within 30 days after all preferred drug list decisions are finalized and communicated to the Contractor. On an ongoing basis, a pocket preferred drug list guide shall be mailed to new enrollees with their ID card, if requested by the State. This function will be coordinated with the State's fiscal agent who issues beneficiary ID cards.

A preferred drug list guide will be provided to all participating prescribers was soon as possible, but within 30 days after all preferred drug list changes and decisions are finalized and communicated to the Contractor. Changes in the preferred drug list will be communicated to prescribers prior to implementation.

XVI. Staffing Requirements

The Contractor shall meet the following staffing requirements.

The Contractor shall provide a dedicated Project/Account or Conversion Manager who will act as the single point of contact representing the Contractor during the conversion and implementation phase. The term "dedicated" is used to indicate that the Project/Account Manager or Conversion Manager is committed full-time to the conversion and implementation and is accessible to the State during work hours during the conversion and implementation phases. This individual shall be authorized to commit the resources of the Contractor in matters pertaining to the implementation performance of the contract.

The Contractor shall provide specific full time staff dedicated to the operations of the contract. The following positions shall be located in Williston unless the Contractor proposes alternative solutions that are approved by the State. The State shall provide space and appropriate furniture in its Williston office for this staff. The Contractor shall provide computers and monitors and appropriate security software in support of this staff that complies with the State's specifications for its network. The Contractor will be responsible for the maintenance of this hardware and software.

The Williston staff positions include:

- An account manager. Preference shall be given to an individual with a business degree, pharmacy related experience, and knowledge in state government affairs.
- A clinical manager (RPh or PharmD) to support clinical, PDL and DUR activities.
- A program representative responsible for program support activities, program performance review, the development of consumer education/communication strategies; the execution of provider communication strategies, provider training/education plans, and provider relations.
- A data manager to be responsible for all state data requirements and reporting needs including those that exceed the standard reporting package and the information available through decision support tool provided by the Contractor.

The Contractor shall inform the State of all proposed on-site employees prior to selection. The Contractor shall reconsider offering the position to an alternate candidate or initiating a new recruitment if the State provides the Contractor with sound reasons why the selection would not be in the best interests of the Contractor or the State.

The Contractor shall provide access to clinical and technical staff at the Contractor's home office. This staff should be available to the State and to the State's agents. The Contractor shall provide the State with a key contact list to include name, area of expertise/responsibility, telephone number/extension, and e-mail address.

XVII. Disaster Recovery

In the event of a natural disaster and unnatural disasters, including but not limited to hacking and acts of terrorism, the Contractor shall have systems in place for processing claims so that beneficiaries are not denied access to prescriptions.

The Contractor shall present to the State a disaster recovery and business continuity plan that must be approved as part of the implementation phase.

XVIII. Security Program

Contractor shall have in place a comprehensive, integrated security program and framework to protect the State's data including but not limited to physical access, systems/data access, and personnel controls.

The Contractor shall present to the State a security plan that must be approved as part of the implementation phase.

XIX. Post Implementation

The Contractor shall be responsible for routine system maintenance. Routine maintenance shall include changes required because of determinations by the State or by the Contractor that a deficiency exists with the operational system, including deficiencies found after the implementation of any modifications, or that continued efficiency could be maintained or achieved through the proposed activity.

Modifications may be required that are outside routine system maintenance. They would result when the State or the Contractor determines that an additional requirement needs to be met or that a modification of the existing file structures or current processing is needed. If modifications include changes to interfaces, Contractor will work collaboratively with State systems staff and State's MMIS Contractor. Modification costs shall be subject to negotiation.

MedMetric Health Partners Anticipated Implementation Plan

**Dates Subject to Change as Implementation Planning Progresses

Project Start Date: Mon 10/3/05 Project Finish Date: Thu 1/12/06

ID	Task_Name	Duration	Start_Date	Finish_Date
1	**Vermont Health Access Pharmacy Plan Implementation**	80 days	Mon 9/26/05	Thu 1/12/06
2	**Project Planning Activities**	7 days	Mon 9/26/05	Tue 10/4/05
3	Pre-Kickoff Planning / Review / Administrative Tasks	2 days	Mon 9/26/05	Tue 9/27/05
4	Implementation Planning	2 days	Wed 9/28/05	Thu 9/29/05
5	Rick Analysis, Quantification, Qualification and Mitigation	1 day	Fri 9/30/05	Fri 9/30/05
6	Revise Project Plan with Consolidated Project Team	2 days	Mon 10/3/05	Tue 10/4/05
7	Preliminary Planning complete	0 days	Tue 10/4/05	Tue 10/4/05
8	**Human and Hardware Capacity Planning**	7.75 days	Wed 10/5/05	Fri 10/14/05
9	**Staffing Plan**	1 day	Wed 10/5/05	Wed 10/5/05
10	Help Desk	4 hrs	Wed 10/5/05	Wed 10/5/05
11	Operations	1 day	Wed 10/5/05	Wed 10/5/05
12	I/S	1 day	Wed 10/5/05	Wed 10/5/05
13	Account Management	2 hrs	Wed 10/5/05	Wed 10/5/05
14	Execute Staffing Plan	2 days	Thu 10/6/05	Fri 10/7/05
15	**Data Center Plan**	1.75 days	Thu 10/6/05	Fri 10/7/05
16	Connectivity	4 hrs	Thu 10/6/05	Thu 10/6/05
17	I-Series	4 hrs	Thu 10/6/05	Thu 10/6/05
18	Disk	4 hrs	Fri 10/7/05	Fri 10/7/05
19	Miscellaneous	2 hrs	Fri 10/7/05	Fri 10/7/05
20	Execute Data Center Plan	5 days	Fri 10/7/05	Fri 10/14/05
21	Capacity Planning Complete	0 days	Fri 10/14/05	Fri 10/14/05
22	**Connectivity and Security**	40 days	Fri 10/7/05	Fri 12/2/05
23	Determine permanent connectivity solution	4 hrs	Fri 10/7/05	Mon 10/10/05
24	Determine interim implementation solution	4 hrs	Mon 10/10/05	Mon 10/10/05
25	Determine back-up connectivity plan	4 hrs	Mon 10/10/05	Tue 10/11/05
26	Execute Connectivity Solution	40 days	Fri 10/7/05	Fri 12/2/05
27	Setup FTP folder with User ID/Password	2 hrs	Fri 10/7/05	Fri 10/7/05
28	Provide Secure FTP Client/Procedures	2 hrs	Mon 10/10/05	Mon 10/10/05
29	Determine FTP procedures (inbound/outbound)	4 hrs	Mon 10/10/05	Mon 10/10/05
30	Discuss Authority Matrix	2 hrs	Tue 10/11/05	Tue 10/11/05
31	Gather list of User Ids, short job description	4 hrs	Tue 10/11/05	Tue 10/11/05
32	Provide Preliminary Access to RxCLAIM	1 day	Wed 10/12/05	Wed 10/12/05
33	Determine Client Data Partitions	1 day	Thu 10/13/05	Thu 10/13/05
34	Create and Test Internal User IDs	1 day	Wed 10/12/05	Wed 10/12/05
35	Provide Internal User IDs	2 hrs	Thu 10/13/05	Thu 10/13/05
36	Discuss External User requirements	1 day	Tue 10/11/05	Wed 10/12/05
37	Create and test External User IDs	1 day	Wed 10/12/05	Thu 10/13/05
38	Provide External User IDs	2 hrs	Thu 10/13/05	Thu 10/13/05
39	Security and Connectivity Solution Complete	0 days	Fri 12/2/05	Fri 12/2/05

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Project Start Date: Mon 10/3/05 Project Finish Date: Thu 1/12/06

ID	Task_Name	Duration	Start_Date	Finish_Date
40	**Eligibility Processes**	19.75 days	Wed 10/5/05	Tue 11/1/05
41	Provide Group and Member formats	2 hrs	Wed 10/5/05	Wed 10/5/05
42	Analysis of current eligibility hierarchy	2 days	Wed 10/5/05	Fri 10/7/05
43	Determine Carrier/Account/Group structure	2 days	Fri 10/7/05	Tue 10/11/05
44	Discuss ID Card impact	1 day	Tue 10/11/05	Wed 10/12/05
45	Identify BIN/PCN/GROUP Requirements	1 day	Wed 10/12/05	Thu 10/13/05
46	Set up transaction control tables (routing information)	2 days	Thu 10/13/05	Mon 10/17/05
47	Load test group file	4 days	Mon 10/17/05	Fri 10/21/05
48	Load sample member file	4 days	Fri 10/21/05	Thu 10/27/05
49	Load sample member file with member or plan, if applicable	2 days	Thu 10/27/05	Mon 10/31/05
50	Creation of an Eligibility Receipt schedule	4 hrs	Mon 10/31/05	Mon 10/31/05
51	Determine production operations schedule	1 day	Mon 10/31/05	Tue 11/1/05
52	Eligibility Process Requirements Complete	0 days	Tue 11/1/05	Tue 11/1/05
53	**Program Analysis and Plan Development**	42.25 days	Fri 9/30/05	Tue 11/29/05
54	Obtain existing plan definitions	1 day	Fri 9/30/05	Fri 9/30/05
55	**Detailed plan discussion/analysis**	9.75 days	Mon 10/3/05	Fri 10/14/05
56	Eligibility Edits	4 hrs	Mon 10/3/05	Mon 10/3/05
57	Customer Location Edits	2 hrs	Mon 10/3/05	Mon 10/3/05
58	Pharmacy Networks	4 hrs	Mon 10/3/05	Tue 10/4/05
59	Care Facility Networks	2 hrs	Tue 10/4/05	Tue 10/4/05
60	Prescriber Networks	4 hrs	Tue 10/4/05	Tue 10/4/05
61	Prescriber Validation	2 hrs	Wed 10/5/05	Wed 10/5/05
62	Physician Specialty	2 hrs	Wed 10/5/05	Wed 10/5/05
63	Compound Edits	2 hrs	Wed 10/5/05	Wed 10/5/05
64	Drug Formulary	4 hrs	Wed 10/5/05	Thu 10/6/05
65	NDC and/or GPI List	4 hrs	Thu 10/6/05	Thu 10/6/05
66	Product Specialty Edits	2 hrs	Thu 10/6/05	Thu 10/6/05
67	Special Product Messaging	2 hrs	Fri 10/7/05	Fri 10/7/05
68	Max Amount Paid	4 hrs	Fri 10/7/05	Fri 10/7/05
69	Specific Physician Specialty	1 hr	Fri 10/7/05	Fri 10/7/05
70	Alternate Pricing	4 hrs	Fri 10/7/05	Mon 10/10/05
71	Maintenance List	4 hrs	Mon 10/10/05	Mon 10/10/05
72	Day/Qty Limits	4 hrs	Mon 10/10/05	Tue 10/11/05
73	Refill Limits	4 hrs	Tue 10/11/05	Tue 10/11/05
74	OTC Exclusions	2 hrs	Tue 10/11/05	Wed 10/12/05
75	Brand/Generic DAW matrix	2 hrs	Wed 10/12/05	Wed 10/12/05
76	Third Party Exceptions	2 hrs	Wed 10/12/05	Wed 10/12/05
77	DEA Class Exclusions	2 hrs	Wed 10/12/05	Wed 10/12/05
78	Route Administration Exclusion	2 hrs	Wed 10/12/05	Thu 10/13/05

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Project Start Date: Mon 10/3/05 Project Finish Date: Thu 1/12/06

ID	Task_Name	Duration	Start_Date	Finish_Date
79	Dosage Form Exclusions	2 hrs	Thu 10/13/05	Thu 10/13/05
80	DESI Exclusions	1 hr	Thu 10/13/05	Thu 10/13/05
81	Packaging Exclusions	2 hrs	Thu 10/13/05	Thu 10/13/05
82	FDA Ratings Exclusions	2 hrs	Thu 10/13/05	Thu 10/13/05
83	Therapeutic Category Edits	2 hrs	Fri 10/14/05	Fri 10/14/05
84	Pricing	4 hrs	Fri 10/14/05	Fri 10/14/05
85	Creation of model plans	3 days	Fri 10/14/05	Wed 10/19/05
86	Preliminary Quality Assurance of model plans	2 days	Wed 10/19/05	Fri 10/21/05
87	Creation of Plan matrix / documentation	2 days	Fri 10/21/05	Tue 10/25/05
88	Creation of price schedules	1 day	Tue 10/25/05	Wed 10/26/05
89	Creation of patient pay schedules	1 day	Tue 10/25/05	Wed 10/26/05
90	Creation of DED/OOP/MAB definitions	1 day	Tue 10/25/05	Wed 10/26/05
91	Load test NDC/GPI Lists	3 days	Tue 10/25/05	Fri 10/28/05
92	Load full NDC/GPI Lists	1 day	Fri 10/28/05	Mon 10/31/05
93	Add custom messages	4 hrs	Wed 10/19/05	Thu 10/20/05
94	Review of Contingent Therapy requirements	1 day	Fri 10/21/05	Mon 10/24/05
95	**Clinical Intervention Programs**	10.5 days	Mon 10/24/05	Tue 11/8/05
96	Duplicate prescriptions	4 hrs	Mon 10/24/05	Tue 10/25/05
97	Duplicate Therapy	4 hrs	Tue 10/25/05	Tue 10/25/05
98	Drug Interactions	4 hrs	Tue 10/25/05	Wed 10/26/05
99	Drug Interaction Overrides	1 day	Wed 10/26/05	Thu 10/27/05
100	Dosage Check	4 hrs	Thu 10/27/05	Thu 10/27/05
101	Compliance Check	4 hrs	Thu 10/27/05	Fri 10/28/05
102	Acute vs. Maintenance	4 hrs	Fri 10/28/05	Fri 10/28/05
103	Drug Inferred Health State	4 hrs	Fri 10/28/05	Mon 10/31/05
104	Drug Diagnosis	4 hrs	Mon 10/31/05	Mon 10/31/05
105	Drug Allergy	4 hrs	Mon 10/31/05	Tue 11/1/05
106	Custom Clinical Intervention Plans	5 days	Tue 11/1/05	Tue 11/8/05
107	Create Drug Utilization Program Plans	2 days	Tue 11/8/05	Thu 11/10/05
108	Create Contingent Therapy Plans	2 days	Thu 11/10/05	Mon 11/14/05
109	Create Prior Auth Programs	2 days	Mon 11/14/05	Wed 11/16/05
110	Creation of Plan Designs	10 days	Tue 11/8/05	Tue 11/22/05
111	Quality Assurance of Plans	5 days	Tue 11/22/05	Tue 11/29/05
112	Plan Analysis and Creation Complete	0 days	Tue 11/29/05	Tue 11/29/05
113	**Training**	19 days	Fri 12/2/05	Thu 12/29/05
114	**RxCLAIM (Primary)**	6 days	Fri 12/2/05	Mon 12/12/05
115	Pre-Training Discussion	2 hrs	Fri 12/2/05	Fri 12/2/05
116	Submit RxClaim training request	2 hrs	Mon 12/5/05	Mon 12/5/05
117	Determine Training schedule	4 hrs	Mon 12/5/05	Mon 12/5/05
118	Execute initial Training Class	5 days	Mon 12/5/05	Mon 12/12/05

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**Dates Subject to Change as Implementation Planning Progresses

Project Start Date: Mon 10/3/05 Project Finish Date: Thu 1/12/06

ID	Task_Name	Duration	Start_Date	Finish_Date
119	**RxCLAIM (Secondary)**	13 days	Mon 12/12/05	Thu 12/29/05
120	Help Desk (1-2 Days)	10 days	Mon 12/12/05	Mon 12/26/05
121	Manual Claims (1 Day)	1 day	Mon 12/26/05	Tue 12/27/05
122	Secondary User Community	2 days	Tue 12/27/05	Thu 12/29/05
123	**RxTRACK**	5.25 days	Fri 12/2/05	Fri 12/9/05
124	Send RxTRACK training agenda	2 hrs	Fri 12/2/05	Fri 12/2/05
125	Schedule 2 day training class	4 hrs	Mon 12/5/05	Mon 12/5/05
126	Enable Claim Extract Selection	1 day	Mon 12/5/05	Tue 12/6/05
127	Enable RxTRACK	4 hrs	Tue 12/6/05	Tue 12/6/05
128	Install Desktop Cognos Software	1 day	Wed 12/7/05	Wed 12/7/05
129	Execute RxTRACK Training Class	2 days	Thu 12/8/05	Fri 12/9/05
130	Training Complete	0 days	Mon 12/12/05	Mon 12/12/05
131	**Batch Conversion Interfaces**	41 days	Fri 10/14/05	Mon 12/12/05
132	Review batch conversion layouts	3 days	Fri 10/14/05	Wed 10/19/05
133	Create specifications for interfaces	5 days	Wed 10/19/05	Wed 10/26/05
134	Interface development and unit testing	30 days	Wed 10/26/05	Wed 12/7/05
135	Load test Claims History File	3 days	Wed 12/7/05	Mon 12/12/05
136	Load Care Facility Lists	2 days	Wed 12/7/05	Fri 12/9/05
137	Load current Pharmacy Networks	3 days	Wed 12/7/05	Mon 12/12/05
138	Load test Benefit Adjustments file	2 days	Wed 12/7/05	Fri 12/9/05
139	Load test Prior Auth file	2 days	Wed 12/7/05	Fri 12/9/05
140	Batch processes complete	0 days	Mon 12/12/05	Mon 12/12/05
141	**Pharmacy/Member Payment and Funding Procedures**	4.5 days	Wed 10/5/05	Tue 10/11/05
142	Review Pharmacy Payment Procedures	4 hrs	Wed 10/5/05	Wed 10/5/05
143	Determine funding requirements	4 hrs	Wed 10/5/05	Wed 10/5/05
144	Determine payment cycle for members	4 hrs	Thu 10/6/05	Thu 10/6/05
145	Setup no pay pharmacy information (if applicable)	1 day	Thu 10/6/05	Fri 10/7/05
146	Provide Member and Pharmacy EOB sample	4 hrs	Fri 10/7/05	Fri 10/7/05
147	Provide sample Cash Requirements Report	4 hrs	Mon 10/10/05	Mon 10/10/05
148	Create production pharmacy and member Payment schedule	1 day	Mon 10/10/05	Tue 10/11/05
149	Payment and Funding process established	0 days	Tue 10/11/05	Tue 10/11/05
150	**Information Outputs**	13.25 days	Mon 12/12/05	Thu 12/29/05
151	**Standard Reporting**	6.25 days	Mon 12/12/05	Tue 12/20/05
152	Provide Standard Report Catalog	2 hrs	Mon 12/12/05	Mon 12/12/05
153	Review standard reporting needs	3 days	Tue 12/13/05	Thu 12/15/05
154	Determine standard report needs and parameters	2 days	Fri 12/16/05	Mon 12/19/05
155	Establish standard report production schedule	1 day	Tue 12/20/05	Tue 12/20/05
156	**Claims Experience Detail**	3.25 days	Mon 12/12/05	Thu 12/15/05
157	Provide claims file format to NHP	2 hrs	Mon 12/12/05	Mon 12/12/05
158	Determine unique claims file requirements	2 days	Tue 12/13/05	Wed 12/14/05
159	Setup production schedule	1 day	Thu 12/15/05	Thu 12/15/05

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**Dates Subject to Change as Implementation Planning Progresses

Project Start Date: Mon 10/3/05 Project Finish Date: Thu 1/12/06

ID	Task Name	Duration	Start Date	Finish Date
160	**OLAP and Ad Hoc Reporting**	10 days	Fri 12/16/05	Thu 12/29/05
161	Review exiting Data Cubes	1 day	Fri 12/16/05	Fri 12/16/05
162	Setup Data Cube process	2 days	Mon 12/19/05	Tue 12/20/05
163	Distribute Software	3 days	Wed 12/21/05	Fri 12/23/05
164	Install Software	1 day	Mon 12/26/05	Mon 12/26/05
165	Review / Test Implementation	3 days	Tue 12/27/05	Thu 12/29/05
166	Information Output Complete	0 days	Tue 12/20/05	Tue 12/20/05
167	**Review ID Card Requirements/Processes/Interfaces**	14 days	Fri 10/14/05	Thu 11/3/05
168	Determine Impact on existing ID Card Format/Data	2 days	Fri 10/14/05	Tue 10/18/05
169	Determine impact on existing ID card processes	2 days	Tue 10/18/05	Thu 10/20/05
170	Request changes to ID Cards as appropriate	10 days	Thu 10/20/05	Thu 11/3/05
171	ID Card and Processes complete	0 days	Thu 11/3/05	Thu 11/3/05
172	**Pharmacy Network Management**	50 days	Wed 10/12/05	Tue 12/20/05
173	Analysis of existing pharmacy network	10 days	Wed 10/12/05	Tue 10/25/05
174	Perform GEO Access analysis (eligibility, members)	5 days	Wed 10/26/05	Tue 11/1/05
175	Perform GeoAccess analysis (utilizing pharmacies)	5 days	Wed 11/2/05	Tue 11/8/05
176	Develop/Agreement on Addendum/solicitation material	3 days	Wed 10/26/05	Fri 10/28/05
177	Review Pharmacy Audit Plan	3 days	Mon 10/31/05	Wed 11/2/05
178	Develop Physician Education/Communications Plan	2 days	Thu 11/3/05	Fri 11/4/05
179	Pharmacy Network Solicitation	25 days	Mon 11/7/05	Fri 12/9/05
180	Review and report Solicitation results	3 days	Mon 12/12/05	Wed 12/14/05
181	Create updated network definition	2 days	Thu 12/15/05	Fri 12/16/05
182	Load new pharmacy network definition	2 days	Mon 12/19/05	Tue 12/20/05
183	Pharmacy Network activities complete	0 days	Tue 12/20/05	Tue 12/20/05
184	**Formulary and Rebate Management**	65 days	Fri 10/14/05	Thu 1/12/06
185	Gap analysis - existing to proposed formulary	5 days	Fri 10/14/05	Fri 10/21/05
186	Develop customer specific formulary	30 days	Fri 10/21/05	Fri 12/2/05
187	Develop P&T process	5 days	Fri 12/2/05	Fri 12/9/05
188	Develop physician education/communications plan	5 days	Fri 12/9/05	Fri 12/16/05
189	Develop member education/communication plan	20 days	Fri 12/16/05	Thu 1/12/06
190	Rebate and Formulary Management complete	0 days	Thu 1/12/06	Thu 1/12/06
191	Plan Administration Operational Procedures and Standards	11 days	Tue 11/29/05	Wed 12/14/05
192	Benefit Plan Design	2 days	Tue 11/29/05	Thu 12/1/05
193	Plan Change Control	2 days	Thu 12/1/05	Mon 12/5/05
194	Manual Claims	1 day	Mon 12/5/05	Tue 12/6/05
195	Eligibility	1 day	Tue 12/6/05	Wed 12/7/05
196	Prior Authorizations	2 days	Wed 12/7/05	Fri 12/9/05
197	MAC Maintenance	2 days	Fri 12/9/05	Tue 12/13/05
198	Network	1 day	Tue 12/13/05	Wed 12/14/05
199	Plan Admin/Clinical Service activities complete	0 days	Wed 12/14/05	Wed 12/14/05
200	**Pre-Go Live Planning and Activities**	23.5 days	Tue 11/29/05	Fri 12/30/05
201	**Account Management Transition Planning**	11 days	Wed 12/14/05	Thu 12/29/05
202	Develop Account Manager Transition Plan	1 day	Wed 12/14/05	Thu 12/15/05
203	Execute Account Manager Transition Plan	10 days	Thu 12/15/05	Thu 12/29/05

MedMetric Health Partners Anticipated Implementation Plan

**Dates Subject to Change as Implementation Planning Progresses

Project Start Date: Mon 10/3/05 Project Finish Date: Thu 1/12/06

ID	Task_Name	Duration	Start_Date	Finish_Date
204	**Pharmacy Network Activities**	3 days	Wed 12/14/05	Mon 12/19/05
205	Create Payer Sheets	1 day	Wed 12/14/05	Thu 12/15/05
206	Notify Pharmacy Network of implementation	2 days	Thu 12/15/05	Mon 12/19/05
207	Notify Switches and Chains	2 days	Thu 12/15/05	Mon 12/19/05
208	**Go Live Communications Plan**	6.25 days	Wed 12/14/05	Thu 12/22/05
209	Develop Go Live Communications Plan	2 days	Wed 12/14/05	Fri 12/16/05
210	Review Go Live Communications Plan	2 days	Fri 12/16/05	Tue 12/20/05
211	Distribute Go Live Communications Plan	2 hrs	Tue 12/20/05	Tue 12/20/05
212	Pre-Go Live Meetings as Required	2 days	Tue 12/20/05	Thu 12/22/05
213	**On-Call Plan**	10 days	Wed 12/14/05	Wed 12/28/05
214	Develop Go-Line On-Call Plan	0.5 days	Wed 12/14/05	Wed 12/14/05
215	Distribute Go Live On-Call Plan	2 hrs	Wed 12/14/05	Wed 12/14/05
216	Develop War-Room Staffing Plan	0.5 days	Thu 12/15/05	Thu 12/15/05
217	Distribute War Room Staffing Plan	2 hrs	Thu 12/15/05	Thu 12/15/05
218	**Batch Conversions**	10 days	Wed 12/14/05	Wed 12/28/05
219	Load Claims History	10 days	Wed 12/14/05	Wed 12/28/05
220	Production load of full file eligibility	3 days	Wed 12/14/05	Mon 12/19/05
221	Load Benefit Adjustment files	1 day	Wed 12/14/05	Thu 12/15/05
222	Production load of daily eligibility update files	1 day	Thu 12/15/05	Fri 12/16/05
223	**Implementation Go Live Review**	23.5 days	Tue 11/29/05	Fri 12/30/05
224	Review QA Test Results	2 days	Tue 11/29/05	Thu 12/1/05
225	Review Regression Test Results	2 days	Tue 12/27/05	Thu 12/29/05
226	Batch Conversion Review	1 day	Thu 12/29/05	Fri 12/30/05
227	Customer Signoff	4 hrs	Fri 12/30/05	Fri 12/30/05
228	Pre Go Live Activities Complete	0 days	Fri 12/30/05	Fri 12/30/05
229	**Regression Testing and Review**	10.5 days	Mon 12/12/05	Tue 12/27/05
230	Define Regression Test Plan	2 days	Mon 12/12/05	Wed 12/14/05
231	Setup Regression Test Environment	2 days	Wed 12/14/05	Fri 12/16/05
232	Execute Regression Test Plan	1 day	Fri 12/16/05	Mon 12/19/05
233	Analysis of Regression Test Results/Develop Action Items	2 days	Mon 12/19/05	Wed 12/21/05
234	Make changes as defined	1 day	Wed 12/21/05	Thu 12/22/05
235	Setup Regression Test Environment	0.5 days	Thu 12/22/05	Fri 12/23/05
236	Execute Regression Test Plan	1 day	Fri 12/23/05	Mon 12/26/05
237	Analysis of Regression Test Results/Develop Action Plan	1 day	Mon 12/26/05	Tue 12/27/05
238	Regression Test Complete	0 days	Tue 12/27/05	Tue 12/27/05
239	Production Cutover	0 days	Sun 1/1/06	Sun 1/1/06
240	**Post Go-Live Monitoring and Support**	10 days	Sun 1/1/06	Thu 1/12/06
241	Load Post-Go Live Claims History	2 days	Sun 1/1/06	Mon 1/2/06
242	Load final Benefit Adjustment file	1 day	Sun 1/1/06	Sun 1/1/06
243	Load final Prior Auth file	1 day	Sun 1/1/06	Sun 1/1/06
244	War Room Operations Available	10 days	Sun 1/1/06	Thu 1/12/06

Attachment B -Payment Provisions

1. Payments and Contract Amount

The maximum amount payable under this Contract is $2,633,159 for the period ending October 31, 2006. The amount includes two (2) months of development and implementation and ten (10) months of operations. The maximum amount payable from the date of execution of the Contract through the period ending October 31, 2008 is $8,318,624.

2. Cost Structure

Subject to Contractor compliance with the terms and conditions of this Contract and for services provided as set forth in this Contract, the State shall reimburse the Contractor at the rates set out in the following cost structure.

1) Claims processing: For payment purposes, claims volumes are determined annually on a calendar year basis. Payment is based on the greater of $20,000 per month or the amount determined by the volume of claims processed, according to the following schedule:

   14 cents per claim up to 2 million claims

   13 cents per claim for claims between 2 million and up to 3.5 million

   12 cents per claim for claims between 3.5 million and up to 5 million

   11 cents per claim for claims over 5 million

2) Claims processing, paper claims: payment for claims processing is dependent on annual calendar year volumes as follows:

   75 cents per keyed claim for claims up to 4,999

   70 cents per keyed claim for claims between 5,000 and 7,499

   65 cents per keyed claim for claims between 7,500 and 9,999

   60 cents per keyed claim for claims between 10,000 and 15,000

3) Medicare Part D: an additional five (5) cents per claim for each actual Medicare Part D claim processed

4) On-site auditing: $1,500 per day for each day performing an audit on-site

5) Drug coverage management: $6,125/month

6) Analysis and reporting, and decision support ad hoc capacity: $1,885/month,

7) VPN connectivity: $300/ month. The State will have unlimited access to RxClaim, the Contractor's on-line claims system

8) Rx Track Cognos: $750/month per user

9) Rx Track Showcase: $200 per month for up to three users.

10) Supplemental rebate negotiation, rebate management and disputes and collection: $6,500/month

11) SPAP rebate negotiations, rebate management and disputes and collections: $6,500/month.

12) DUR and DUR Board support: $8,954/month

13) Utilization management: $6,125/month

14) Clinical detailing: Not to exceed $75,000 per year. Actual amount to be determined based on program design agreed to with the State

15) Disease management: $6,125/month

16) Prior authorizations (Pharmacists and Associates): the greater of $21,833/month or $5.20 per prior authorization

17) Telephone support – pharmacy providers and prescribers: the greater of $16,666/month, or $13.22 per call up to 60 calls daily, and $12.25 for calls over 60 daily

18) ID cards: $2.10, including mailing costs (pass through cost)

19) ePocrates contract: actual cost up to $152,796 per year ($120,000 per year plus $2,733/month)

20) Four (4) on-site dedicated staffing: actual cost up to $343,200/year beginning January 1, 2006, including fringe benefits plus reasonable expenses no greater than allowed for State employees.

21) Dedicated staff, eligibility and plan maintenance, Medicare Part D: Actual cost up to $80,000 per year, including fringe benefit costs plus reasonable State approved expenses no greater than allowed for State employees.

22) Administrative fee: the greater of 13 cents per member per month (PMPM - A) or $19,177/month

3. Development, Implementation and Training

A maximum of $400,000 will be paid for development, implementation and training for the period commencing with the execution of the contract and ending December 31, 2005. The payments shall be apportioned as follows: $150,000 for development, implementation and training related to Medicare Part D and $250,000 development, implementation and training related to all other programs covered by this contract. If the State opts to reduce the requirements related to Part D, the amount apportioned to development, implementation, and training may be reduced subject to negotiation, Payments for development, implementation, and training costs will be made upon submission of an invoice to the Contract Administrator detailing actual costs incurred. The payment schedule is as follows:

- For the period ending November 01, 2005: Maximum of $150,000: $50,000 for Part D related activities and $100,000 for activities related to other programs.

- For the period ending November 30, 2005: Maximum of $125,000: $50,000 for Part D related activities and $75,000 for activities related to other programs.
- For the period ending December 31: Maximum of $125,000: $50,000 for Part D related activities and $75,000 for activities related to other programs, subject to successful completion of all required development, implementation and training activities and systems implementation effective January 1, 2006.

The State may opt to defer or eliminate some coordination of benefits aspects of the Part D. Should that occur, payments related to Part D activities may be deferred or eliminated as well. Amounts will be subject to negotiation between the State and the Contractor.

Failure to implement the claims adjudication system effective January 1, 2006 will result in forfeiture of 10% of the invoice for the period ending December 31, 2005.

The Maximum Total Amount of this contract shall not exceed $8,318,624 for the period from November 1, 2005 through October 31, 2008. For the period commencing with contract award to the date of going operational no payments will be made except for development, implementation and training. From start of operations, scheduled to be January 1, 2006, payments shall be rendered by the State based on the rate schedule enumerated above.

Unexpended funds in any given State Fiscal Year (SFY) shall be carried forward into the next SFY so long as the Maximum Total Amount for the length of the contract does not exceed $8,318,624. In the event of appreciable decreases or increases in volume, caseload, or costs, the State and the Contractor may by mutual agreement amend the amount of this Contract.

4. Definitions

For the purposes of this Contract, a "transaction" or a "claim" is a transaction as defined by the NCPDP transaction code that is received, processed, and responded to by the Contractor. A transaction is either a paid or a denied claim. A transaction can be received in multiple media as:

POS - a transaction received electronically via telephone lines from the provider's Point-of-Service;

Electronic Media - a batch of transactions received by the Contractor in electronic media (tape, diskette or electronic bulletin board) and submitted to Contractor's system for processing; and

Paper - a transaction received on paper and data entered by the Contractor and submitted to the Contractor's System for processing.

Per Member Per Month (PMPM): Two (2) levels are used in rate schedule as follows:

PMPM – A: Includes all populations covered by the RFP.

PMPM – U: Includes only the uninsured (may include the Healthy Vermonters Program beneficiaries and others).

Per Authorization (PA): For Prior Authorizations only – per approved or denied PA, provided by a pharmacist or associate. Only one decision applies on each PA request. A PA request referred to a pharmacist by an associate is neither approved or denied until the final decision is rendered.

5. Schedule of Payment:

The Contractor shall bill the State on a monthly basis for services during the previous month. Invoices shall calculate the service payment in detail using the appropriate payment metric. Each service category shall be enumerated separately followed by the cost, with a total of all categories. If necessary, narrative explanations or clarifications of any invoice item shall be included.

Effective for services beginning January 1, 2006, the Contractor may invoice the State according to the above schedule for all services covered by the Contract and rendered in a given month. On-site auditing, state only rebate negotiation and collection, clinical detailing, disease management services, and ID cards may be invoiced when authorized and actually provided.

The invoice shall be sent to the Contract Administrator at the Office of Vermont Health Access at the address below in order to facilitate payment. The Contractor shall be paid on a monthly basis following approval of invoices by the Contract Administrator. All invoices shall be sent to the State within three (3) months of the date of service.

Contract Administrator
Ann Rugg, Deputy Director
Office of Vermont Health Access
312 Hurricane Lane, Suite 201
Williston, Vermont 05495

The State shall mail all approved payments to:

Robert Wakefield, Jr., Chairman
MedMetrics Health Partners, Inc.
100 Century Drive
Worcester, MA 01606

If the Contractor is issuing payments, in the event any overpayments are made to providers or sub-contractors, whether through Contractor fault or otherwise, the Contractor may, in addition to any other rights or remedies it may have by law or in equity, recover such overpayments within the Contractor's system through offsets against subsequent payments otherwise due to such providers or sub-contractors. Notwithstanding the recovery mechanism provided above, the Contractor shall not be liable for any overpayments unless such overpayments are solely the fault of the Contractor. If any network of pharmacies other than that of the Contractor is to be used under this Contract, the State shall assure that all agreements with pharmacies provide for such offset by those pharmacies.

6. Performance Standards and Penalties

The Contractor shall abide by the following Performance Standards and Penalties.

The Contractor agrees to a retainage of ten percent (10%) of the total contract amount in the final contract year. Some or all of the retainage will be returned to the Contractor after the contract ends based on a determination by the State on the extent to which the Contractor has met contract requirements in that year. The retainage applies to operational payments made to the Contractor.

Performance Standards and Penalties

Service Performance Standards	Guarantee	Description of Penalty and Frequency
1. **Network Size (For Uninsured)**	Contractor must provide access to at least 90% of all plan members using the parameters of 2 pharmacies within 15 miles.	Measure: GeoAccess survey of network providers relative to the population served Frequency: Annually Penalty: 1% of Administrative fee
2. **File Updates**	Contractor performs required file updates – eligibility, provider, drug coverage – as required based on the frequency established by the State, with 99% accuracy.	Measure: # of errors/total file updates (including all individual updates) Frequency: Every six months Penalty: 0.5% of Administrative fee
3. **Point-of-Sale Network System Downtime**	Contractor's unscheduled system downtime will be no greater than 2 hours per incident; not to exceed 1.5% on an annual basis.	Measure: # of downtime incidents and duration of system downtime Hours of unscheduled system downtime and number of incidents/total system hours Frequency: Annually Penalty: 1% of Administrative fee

4. Prior Authorizations	All requests for Prior Authorization shall be acted upon within 72 hours of receiving a completed request.	Measure: # of prior authorizations acted upon within 72 hours/total number of prior authorizations in a given month Frequency: Quarterly Penalty: 1% of Administrative fee
5. Retail Point-of-Sale Claims Adjudication Accuracy	Contractor must agree to a financial accuracy rate of at least 99% for all pharmacy claims processed at point-of-sale.	Measure: # of accurate claims processed at POS/total claims processed at the POS Frequency: Annually Penalty: 1% of Administrative fee
6. Payment Accuracy	The MMIS contractor and Contractor have the lead responsibility to ensure that erroneous payments from the MMIS are quickly identified, reported to OVHA and corrected to ensure that no overpayments or under-payments are made from State or Federal funds.	Measure: No known unresolved overpayments Frequency: Annually Penalty: 1% of Administrative fee
7. Formulary Rebates	To the extent that the Contractor receives payments resulting from the formulary and rebate process, all rebate reporting and payments will be made within thirty days of the receipt, if any, of these rebates from drug manufacturers. Reporting must describe the source of the rebates at the item level, and the date payment was received from the manufacturer.	Measure: Date of rebates received and sent to the State within 30 days/total rebates received Frequency: Every six months Penalty: 2% of Administrative fee

8. Reporting Requirements	Contractor must agree to provide all the reports specified in this RFP within the stated time periods, and to provide the query capability described in the Contractor's response.	Measure: # of reports delivered within contractually required reporting times/total reports required. Frequency: Every six months Penalty: 1% of Administrative fee
9. On-Site Audits	Contractor performs on-site audits on the number of pharmacy providers specified by the State in each year of the Contract.	Measure: Total number of audits completed/total number of audits requested by the State Frequency: Annually Penalty: 1% of Administrative fee
10. Call Answering Time	At least 95% of all eligible persons' calls received are answered within 30 seconds.	Measure: Total number of calls answered within 30 seconds/total number of calls received Frequency: Every six months Penalty: 1% of Administrative fee
11. Call Abandonment Rate	Not more than 3% of all eligible persons' calls are abandoned.	Measure: Total calls abandoned/total calls received Frequency: Every six months Penalty: 1% of Administrative fee
12. ID Cards	100% of ID cards are mailed within ten business days of the receipt of any card file.	Measure: Total number of cards mailed within 10 days of card file/total number of cards requested Frequency: Every six months Penalty: 1% of Administrative fee

Implementation and Operating Costs

Item #	Type of Service	Basis of Cost	Unit Costs	Per Month	Annual	Implementation Costs 11/01/05 - 12/31/05	Operations Costs 01/01/06 - 10/31/06	Total Implementation & Operations Year 1 11/01/05 - 10/31/06	Operations Year 2 11/01/06 - 10/31/07	Operations Year 3 11/01/07 - 10/31/08	Grand Total
1	Claims processing (on-line and batch; with all pricing including MAC; including COB)	Per month cost	N/A	N/A	$ 692,500	$ -	$ 577,081	$ 577,081	$ 720,200	$ 749,008	$ 2,046,289
			Monthly based on 5 M; $.14 <= 2M; $.13 >2M <= 3.5M; $.12 > 3.5M <= 5M; $11 > 5M Part D Claims an additional $ .05 per claim for 750,000 claims								
			Plus 4%/year for year 2 and year 3								
2	Claims processing –Keying paper claims	Per month cost	N/A	N/A	$ 7,125	$ -	$ 5,937	$ 5,937	$ 7,410	$ 7,706	$ 21,054
			Annual based on 10,000 Annual; $.75 <= 4,999; $.70 >5,000 <= 7,499; $.65 > 7,500								
			Plus 4%/year for year 2 and year 3								
3	Auditing	Per on-site audit	$ 1,500.00	N/A	$ 22,500	$ -	$ 18,750	$ 18,750	$ 23,400	$ 24,336	$ 66,486
			Assumes 15 days on site Plus 4%/year for year 2 and year 3								
4	Drug coverage management (Preferred Drug List), including P & T Committee support	Per month cost	N/A	$ 6,125	$ 73,500	$ -	$ 61,250	$ 61,250	$ 76,440	$ 79,498	$ 217,187
			Plus 4%/year for year 2 and year 3								
5	Analysis and reporting – standard and decision support ad hoc capabilities	Per month cost	N/A	$ 1,885	$ 22,620	$ -	$ 18,850	$ 18,850	$ 23,525	$ 24,466	$ 66,841
			Plus 4%/year for year 2 and year 3								
6	Connectivity Fee			$ 300	$ 3,600	$ -	$ 3,000	$ 3,000	$ 3,744	$ 3,894	$ 10,638
			Plus 4%/year for year 2 and year 3								
	Total Page 1 of 3					**$ -**	**$ 684,868**	**$ 684,868**	**$ 854,719**	**$ 888,908**	**$ 2,428,494**

Implementation and Operating Costs

Item #	Type of Service	Basis of Cost	Unit Costs	Per Month	Annual	Implementation Costs 11/01/05 - 12/31/05	Operations Costs 01/01/06 - 10/31/06	Total Implementation & Operations Year 1 11/01/05 - 10/31/06	Operations Year 2 11/01/06 - 10/31/07	Operations Year 3 11/01/07 - 10/31/08	Grand Total
7	TrackCognos (10 Users)			$ 7,500.00	$ 90,000.00	$ -	$ 75,000	$ 75,000	$ 93,600	$ 97,344	$ 265,944
			Plus 4%/year for year 2 and year 3								
8	Showcase (6 Users)			$ 1,200.00	$ 14,400.00	$ -	$ 12,000	$ 12,000	$ 14,976	$ 15,575	$ 42,551
			Plus 4%/year for year 2 and year 3								
9	Supplemental & SPAP rebates negotiation, rebate managements and disputes, and collection	Per month cost – R2	N/A	$ 13,000.00	$ 156,000.00	$ -	$ 129,999	$ 129,999	$ 162,240	$ 168,730	$ 460,969
			Plus 4%/year for year 2 and year 3								
10	Drug Utilization Review, including DUR Board support for all beneficiairies except AMAP, GA, and HVP	Per month cost	N/A	$ 8,954.00	$ 107,448.00	$ -	$ 89,540	$ 89,540	$ 111,746	$ 116,216	$ 317,501
			Plus 4%/year for year 2 and year 3								
11	Utilization management for all beneficiairies except AMAP, GA, and HVP	Per month cost	N/A	$ 6,125.00	$ 73,500.00	$ -	$ 61,250	$ 61,250	$ 76,440	$ 79,498	$ 217,187
			Plus 4%/year for year 2 and year 3								
12	Clinical detailing	Annual cost	N/A		$ 75,000.00	$ -	$ 62,500	$ 62,500	$ 78,000	$ 81,120	$ 221,620
			Plus 4%/year for year 2 and year 3								
13	Disease management for all beneficiairies except AMAP, GA, and HVP	Per month cost	N/A	$ 6,125.00	$ 73,500.00	$ -	$ 61,250	$ 61,250	$ 76,440	$ 79,498	$ 217,187
			Plus 4%/year for year 2 and year 3								
14	Prior authorization	$5.20 per each PA	N/A	$ 21,833.00	$ 261,996.00	$ -	$ 218,329	$ 218,329	$ 272,476	$ 283,375	$ 774,180
			Plus 4%/year for year 2 and year 3								
15	Telephone support - Pharmacy providers and prescribers	PMPM – A	$ 0.11	$ 16,666.00	$ 199,992.00	$ -	$ 166,659	$ 166,659	$ 207,992	$ 216,311	$ 590,962
			Plus 4%/year for year 2 and year 3								
16	ID Cards - Including Mailing	Per Card	$ 2.10			$ -	$ -	$ -	$ -	$ -	$ -
			Plus 4%/year for year 2 and year 3								
17	Epocrates® contract	Cost per month	N/A	$ 12,733.00	$ 152,796.00	$ -	$ 127,329	$ 127,329	$ 158,908	$ 165,264	$ 451,501
			Annual Fee $120,000 and cost per month $2,733								
	Total Page 2 of 3					$ -	$ 1,003,856	$ 1,003,856	$ 1,252,817	$ 1,302,930	$ 3,559,603

Implementation and Operating Costs

Item #	Type of Service	Basis of Cost	Unit Costs	Per Month	Annual	Implementation Costs 11/01/05 - 12/31/05	Operations Costs 01/01/06 - 10/31/06	Total Implementation & Operations Year 1 11/01/05 - 10/31/06	Operations Year 2 11/01/06 - 10/31/07	Operations Year 3 11/01/07 - 10/31/08	Grand Total
18	Required staffing (list by each required staff – separate salary and benefit costs)	Four FTE's		$ 28,600.00	$ 343,200.00	$ -	$ 285,999	$ 285,999	$ 356,928	$ 371,205	$ 1,014,132
		Account Mgr	N/A	N/A	N/A						
		Clinical Mgr	N/A	N/A	N/A						
		Program Rep	N/A	N/A	N/A						
		Data Mgr	N/A	N/A	N/A						
			No Detail given on # of FTE's & Plus 4%/year for year 2 and year 3								
19	Staff for Dedicated Part D		N/A	$ 6,666.67	$ 80,000.00	$ -	$ 66,666	$ 66,666	$ 83,200	$ 86,528	$ 236,394
			Plus 4%/year for year 2 and year 3								
20	Other - Development, Implementation, & Training		N/A	$ 133,333.33	$ 400,000.00	$ 400,000	$ -	$ 400,000	$ -	$ -	$ 400,000
			One-time development and implementation Year 1 only								
21	Administrative Fee		N/A	$ 19,177.00	$ 230,124.00	$ -	$ 191,769	$ 191,769	$ 239,329	$ 248,902	$ 680,000
			Plus 4%/year for year 2 and year 3								
	Total Page 1 of 3					**$ -**	**$ 684,868**	**$ 684,868**	**$ 854,719**	**$ 888,908**	**$ 2,428,494**
	Total Page 2 of 3					**$ -**	**$ 1,003,856**	**$ 1,003,856**	**$ 1,252,817**	**$ 1,302,930**	**$ 3,559,603**
	Total Page 3 of 3					**$ 400,000**	**$ 544,434**	**$ 944,434**	**$ 679,457**	**$ 706,635**	**$ 2,330,527**
	Grand Total					**$ 400,000**	**$ 2,233,159**	**$ 2,633,159**	**$ 2,786,993**	**$ 2,898,473**	**$ 8,318,624**

ATTACHMENT C
CUSTOMARY STATE CONTRACT PROVISIONS

1. **Entire Agreement.** This contract represents the entire agreement between the parties on the subject matter. All prior agreements, representations, statements, negotiations, and understandings shall have no effect.

2. **Applicable Law.** This contract will be governed by the laws of the State of Vermont.

3. **Appropriations.** If this contract extends into more than one fiscal year of the state (July 1 to June 30), and if appropriations are insufficient to support this contract, the State may cancel at the end of the fiscal year, or otherwise upon the expiration of existing appropriations authority.

4. **No Employee Benefits for Contractors.** The Contractor understands that the State will not provide any individual retirement benefits, group life insurance, group health and dental insurance, vacation and sick leave, workers compensation or other benefits or services available to State employees, nor will the State withhold any federal or state taxes except as required under applicable tax laws, which shall be determined in advance of execution of the contract. The Contractor understands that all tax returns required by the Internal Revenue Code and the State of Vermont, including but not limited to income, withholding, sales and use, and rooms and meals, must be filed by the Contractor, and information as to contract income will be provided by the State of Vermont to the Internal Revenue Service and the Vermont Department of Taxes.

5. **Independence, Liability.** The Contractor will act in an independent capacity and not as officers or employees of the State. The Contractor shall indemnify, defend and hold harmless the State and its officers and employees from liability and any claims, suits, judgments, and damages arising as a result of the Contractor's acts and/or omissions in the performance of this contract. The Contractor shall notify its insurance company and the State within 10 days of receiving any claim for damages, notice of claims, pre-claims, or service of judgments or claims, for any act or omissions in the performance of this contract.

6. **Insurance.** Before commencing work on this contract the Contractor must provide certificates of insurance to show that the following minimum coverage are in effect. The Contractor must notify the State no more than 10 days after receiving cancellation notice of any required insurance policy. It is the responsibility of the Contractor to maintain current certificates of insurance on file with the State through the term of the contract. Failure to maintain the required insurance shall constitute a material breach of this contract.

   Workers Compensation: With respect to all operations performed, the Contractor shall carry workers compensation insurance in accordance with the laws of the State of Vermont.

   General Liability and Property Damage: With respect to all operations performed under the contract, the Contractor shall carry general liability insurance having all major divisions of coverage including, but not limited to:

   Premises - Operations
   Independent Contractors' Protective
   Products and Completed Operations
   Personal Injury Liability
   Contractual Liability

   The policy shall be on an occurrence form and limits shall not be less than:

$1,000,000 Per Occurrence
$1,000,000 General Aggregate
$1,000,000 Products/Completed Operations Aggregate
$ 50,000 Fire Legal Liability

Automotive Liability: The Contractor shall carry automotive liability insurance covering all owned, non-owned and hired vehicles used in connection with the contract. Limits of coverage shall not be less than: $1,000,000 Combined single limit.

Professional Liability: Before commencing work on this contract and throughout the term of this contract, the Contractor shall procure and maintain professional liability insurance for any and all services performed under this contract, with minimum coverage of *$ N/A* per occurrence.

No warranty is made that the coverage and limits listed herein are adequate to cover and protect the interests of the Contractor for the Contractor's operations. These are solely minimums that have been set to protect the interests of the State.

7. **Reliance by the State on Representations:** All payments by the State under this contract will be made in reliance upon the accuracy of all prior representations by the Contractor, including but not limited to bills, invoices, progress reports and other proofs of work.

8. **Records Available for Audit.** The Contractor will maintain all books, documents, payroll, papers, accounting records and other evidence pertaining to costs incurred under this agreement and make them available at reasonable times during the period of the contract and for three years thereafter for inspection by any authorized representatives of the State or Federal government. If any litigation, claim or audit is started before the expiration of the three year period, the records shall be retained until all litigation, claims or audit findings involving the records have been resolved. The State, by any authorized representative, shall have the right at all reasonable times to inspect or otherwise evaluate the work performed or being performed under this contract.

9. **Fair Employment Practices and Americans with Disabilities Act:** Contractor agrees to comply with the requirement of Title 21 V.S.A. Chapter 5, Subchapter 6, relating to fair employment practices, to the full extent applicable. Contractor shall also ensure, to the full extent required by the Americans with Disabilities Act of 1990, that qualified individuals with disabilities receive equitable access to the services, programs, and activities provided by the Contractor under this contract. Contractor further agrees to include this provision in all subcontracts.

10. **Set Off:** The State may set off any sums which the Contractor owes the State against any sums due the Contractor under this contract; provided, however, that any set off of amounts due the State of Vermont as taxes shall be in accordance with the procedures more specifically provided hereinafter.

11. **Taxes Due to the State.**

a. Contractor understands and acknowledges responsibility, if applicable, for compliance with State tax laws, including income tax withholding for employees performing services within the State, payment of use tax on property used within the State, corporate and/or personal income tax on income earned within the State.

b. Contractor certifies under the pains and penalties of perjury that, as of the date the contract is signed, the Contractor is in good standing with respect to, or in full compliance with, a plan to pay any and all taxes due the State of Vermont.

c. Contractor understands that final payment under this contract may be withheld if the Commissioner of Taxes determines that the Contractor is not in good standing with respect to or in full compliance with a plan to pay any and all taxes due to the State of Vermont.

d. Contractor also understands the State may set off taxes (and related penalties, interest and fees) due to the State of Vermont, but only if the Contractor has failed to make an appeal within the time allowed by law, or an appeal has been taken and finally determined and the Contractor has no further legal resource to contest the amounts due.

12. **Child Support.** (Applicable if Contractor is a natural person, not a corporation or partnership.) Contractor states that, as of the date the contract is signed, he/she:
a. is not under any obligation to pay child support; or
b. is under such an obligation and is in good standing with respect to that obligation; or
c. has agreed to a payment plan with the Vermont Office of Child Support Services and is in full compliance with that plan.
Contractor makes this statement with regard to support owed to any and all children residing in Vermont. In addition, if the Contractor is a resident of Vermont, Contractor makes this statement with regard to support owed to any and all children residing in any other state or territory of the United States.

13. **Subcontractors.** The Contractor shall not assign or subcontract the performance of this agreement or any portion thereof to any other contractor without the prior written approval of the State. Contractor also agrees to include in all subcontract agreements a tax certification in accordance with paragraph ll above.

Notwithstanding the foregoing, the State agrees that the Contractor may assign this contract, including all of the Contractor's rights and obligations hereunder, to any successor in interest to the Contractor arising out of the sale of or reorganization of the Contractor.

14. **No Gifts or Gratuities.** Contractor shall not give title or possession of any thing of substantial value (including property, currency, travel and/or education programs) to any officer or employee of the State during the term of this contract.

15. **Copies.** All written reports prepared under this contract will be printed using both sides of the paper.

16. **Access to Information.** The Contractor agrees to comply with the requirements of AHS Rule No. 96-23 concerning access to information. The Contractor shall require all of its employees performing services under this contract to sign the AHS affirmation of understanding or an equivalent statement.

17. **Suspension and Debarment.** Non-federal entities are prohibited by Executive Orders 12549 and 12689 from contracting with or making sub-awards under covered transactions to parties that are suspended or debarred or whose principals are suspended or debarred. Covered transactions include procurement contracts for goods or services equal to or in excess of $25,000 and all non-procurement transactions (sub-awards to sub-recipients). By signing this contract, current Contractor certifies as applicable, that the contracting organization and its principals are not suspended or debarred by GSA from federal procurement and non-procurement programs.

18. **Health Insurance Portability & Accountability Act (HIPAA).** The confidentiality of any health care information acquired by or provided to the independent contractor shall be maintained in compliance with any applicable state or federal laws or regulations.

19. **Abuse Registry.** The Contractor agrees not to employ any individual, or use any volunteer, to provide for the

care, custody, treatment, or supervision of children or vulnerable adults if there is a substantiation of abuse or neglect or exploitation against that individual. The Contractor will check the Adult Abuse Registry in the Department of Disabilities, Aging and Independent Living. Unless the Contractor holds a valid childcare license or registration from the Division of Child Development, Department for Children and Families, the Contractor shall also check the Central Child Abuse Registry. (See 33 V.S.A. §4919 & 33 V.S.A. §6911).

20. **Voter Registration.** When designated by the Secretary of State, the Contractor agrees to become a voter registration agency as defined by 17 V.S.A. §2103 (41), and to comply with the requirements of State and Federal law pertaining to such agencies.

21. **Non-Discrimination Based on National Origin as evidenced by Limited English Proficiency.** The Contractor agrees to comply with the non-discrimination requirements of Title VI of the Civil Rights Act of 1964, 42 USC Section 2000d, et seq., and with the federal guidelines promulgated pursuant to Executive Order 13166 of 2000, which require that contractors and sub-grantees receiving federal funds must assure that persons with limited English proficiency can meaningfully access services. To the extent the Contractor provides assistance to individuals with limited English proficiency through the use of oral or written translation or interpretive services in compliance with this requirement, such individuals cannot be required to pay for such services.

ATTACHMENT D - CERTIFICATE OF INSURANCE

ACORD CERTIFICATE OF LIABILITY INSURANCE

DATE(MM/DD/YY) 10/03/05

PRODUCER
Sullivan Insurance Group, Inc.
One Chestnut Place
Worcester, MA 01608-2804
508 791-2241

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW.

INSURERS AFFORDING COVERAGE

INSURED
Public Sector Partners, Inc.
P.O. Box 15153
Worcester, MA 01615-0153

INSURER A: The Hartford
INSURER B: PHILADELPHIA INSURANCE COMPANY
INSURER C: NIC Insurance Company
INSURER D:
INSURER E:

COVERAGES

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

INSR LTR	TYPE OF INSURANCE	POLICY NUMBER	POLICY EFFECTIVE DATE (MM/DD/YY)	POLICY EXPIRATION DATE (MM/DD/YY)	LIMITS	
A	GENERAL LIABILITY	08SBANB5817	01/22/05	01/22/06	EACH OCCURRENCE	$2,000,000
	[X] COMMERCIAL GENERAL LIABILITY				FIRE DAMAGE (Any one fire)	$300,000
	[ ] CLAIMS MADE [X] OCCUR				MED EXP (Any one person)	$10,000
					PERSONAL & ADV INJURY	$2,000,000
					GENERAL AGGREGATE	$4,000,000
	GEN'L AGGREGATE LIMIT APPLIES PER:				PRODUCTS - COMP/OP AGG	$4,000,000
	[ ] POLICY [ ] PRO-JECT [ ] LOC					
	AUTOMOBILE LIABILITY				COMBINED SINGLE LIMIT (Ea accident)	$
	[ ] ANY AUTO				BODILY INJURY (Per person)	$
	[ ] ALL OWNED AUTOS				BODILY INJURY (Per accident)	$
	[ ] SCHEDULED AUTOS				PROPERTY DAMAGE (Per accident)	$
	[ ] HIRED AUTOS					
	[ ] NON-OWNED AUTOS					
	GARAGE LIABILITY				AUTO ONLY - EA ACCIDENT	$
	[ ] ANY AUTO				OTHER THAN AUTO ONLY: EA ACC	$
					AGG	$
A	EXCESS LIABILITY	08SBANB5817	01/22/05	01/22/06	EACH OCCURRENCE	$2,000,000
	[X] OCCUR [ ] CLAIMS MADE				AGGREGATE	$2,000,000
						$
	[ ] DEDUCTIBLE					$
	[X] RETENTION $10000					$
A	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY	08WECGP0497	01/22/05	01/22/06	[ ] WC STATUTORY LIMITS [ ] OTHER	
					E.L. EACH ACCIDENT	$500,000
					E.L. DISEASE - EA EMPLOYEE	$500,000
					E.L. DISEASE - POLICY LIMIT	$500,000
B	OTHER Directors &	PHSD087655	05/01/05	05/01/06	$5,000,000	
C	Professional	NY04MPL076619NC	12/20/04	12/20/05	$1,000,000	

DESCRIPTION OF OPERATIONS/LOCATIONS/VEHICLES/EXCLUSIONS ADDED BY ENDORSEMENT/SPECIAL PROVISIONS

CERTIFICATE HOLDER

Medmetrics Health Partners Inc.
100 Century Drive
Worcester, MA 01605

ADDITIONAL INSURED; INSURER LETTER: ____

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, THE ISSUING INSURER WILL ENDEAVOR TO MAIL 30 DAYS WRITTEN NOTICE TO THE CERTIFICATE HOLDER NAMED TO THE LEFT, BUT FAILURE TO DO SO SHALL IMPOSE NO OBLIGATION OR LIABILITY OF ANY KIND UPON THE INSURER, ITS AGENTS OR REPRESENTATIVES.

AUTHORIZED REPRESENTATIVE
John T. Sullivan

ATTACHMENT E

BUSINESS ASSOCIATE AGREEMENT

This Business Associate Agreement ("Agreement") is entered into by and between **the State of Vermont, Agency of Human Services, operating by and through its Office of Vermont Health Access** ("Covered Entities") and MedMetrics Health Partners, Inc. ("Business Associate"), as of November 01, 2005 ("Effective Date").

Preliminary Statement. Covered Entity and Business Associate have entered into the Contract to which this Business Associate Agreement is an attachment pursuant to which Business Associate provides to Covered Entity certain services ("Services") which may require the use and/or disclosure of health information. For the avoidance of any doubt, "Services" includes all work performed by the Business Associate for or on behalf of Covered Entity. This Agreement supplements and is made a part of the Contract.

The parties enter into this Agreement to comply with standards promulgated under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), including the Standards for the Privacy of Individually Identifiable Health Information, at 45 CFR Parts 160 and 164 ("Privacy Rule"), and the Security Standards, at 45 CFR Parts 160 and 164 ("Security Rule").

Agreement. In consideration of the foregoing, and in consideration of the desire of Covered Entity to continue receiving Services, and of Business Associate to continue providing Services, the parties agree as follows:

1. **Definitions**. All capitalized terms in this Agreement have the meanings identified in this Agreement, 45 CFR Part 160, or 45 CFR Part 164. The term "Individual" includes a person who qualifies as a personal representative in accordance with 45 CFR 164.502(g). All references to PHI mean Protected Health Information. All references to Electronic PHI mean Electronic Protected Health Information.

2. **Permitted and Required Uses/Disclosures of PHI**.

   2.1 Except as limited in this Agreement, Business Associate may use or disclose PHI to perform the Services, provided that any use or disclosure would not violate the minimum necessary policies and procedures of Covered Entity. Business Associate shall not use or disclose PHI in any manner that would constitute a violation of the Privacy Rule if used or disclosed by Covered Entity in that manner. Business Associate may not use or disclose PHI other than as permitted or required by this Agreement or as Required by Law.

   2.2 Business Associate may make PHI available to its employees who need access to provide Services (provided that Business Associate makes such employees aware of the use and disclosure restrictions in this Agreement and binds them to comply with such restrictions). Business Associate may only disclose PHI for the purposes authorized by this Agreement: (a) to its agents (including subcontractors), in accordance with Sections 6 and 14; or (b) as otherwise permitted by Section 3.

3. **Business Activities**. Business Associate may use PHI received in its capacity as a "Business Associate" to Covered Entity, if necessary, for its proper management and administration or to carry out its legal responsibilities. In addition, Business Associate may disclose PHI received in its capacity as "Business Associate" to Covered Entity, for its proper management and administration or to carry out its legal responsibilities, if a disclosure is Required by Law, or: (a) Business Associate obtains reasonable written assurances (via a written contract) from the person to whom the information is to be disclosed that the PHI shall remain confidential and be used or further disclosed only as Required by Law or for the purpose for which it was disclosed to the person; and (b) the person promptly notifies Business Associate (who in turn will promptly notify Covered Entity) in writing of any instances of which it is aware in which the confidentiality of the PHI has been breached. All uses and disclosures of PHI for the purposes identified above must be of the minimum amount of PHI necessary to accomplish such purposes.

4. **Safeguards**. Business Associate shall implement and use appropriate safeguards to prevent the use or disclosure of PHI, other than as provided for by this Agreement. Business Associate shall identify in writing, upon request from Covered Entity, all of the safeguards that it uses to prevent impermissible uses or disclosures of PHI.

5. **Reporting**. Business Associate shall report in writing to Covered Entity any use or disclosure of PHI in violation of this Agreement by Business Associate or its agents (including subcontractors). Business Associate shall provide such written report promptly after it becomes aware of any such use or disclosure. Business Associate shall provide Covered Entity with the information necessary for Covered Entity to investigate any such use or disclosure. Business Associate may use PHI to report violations of law to appropriate federal and state authorities, consistent with 45 CFR 164.502(j)(1).

6. **Agreements by Third Parties**. Business Associate shall ensure that any agent, including a subcontractor, to whom it provides PHI received from, or created or received by Business Associate on behalf of, Covered Entity, agrees in a written contract to the same restrictions and conditions that apply through this Agreement to Business Associate, with respect to such PHI. By way of example, the written contract must include those restrictions and conditions set forth in Section 12. Business Associate must enter into the written contract before any use or disclosure of PHI by such agent, and such written contract must identify Covered Entity as a direct and intended third party beneficiary, with the right to enforce any breach of the contract concerning the use or disclosure of PHI. Business Associate shall provide a copy of the written contract to Covered Entity upon request. Business Associate may not make any disclosure of PHI to any agent without the prior written consent of Covered Entity.

7. **Access to PHI**. Business Associate shall provide access to PHI in a Designated Record Set to Covered Entity or, as directed by Covered Entity, to an Individual, to meet the requirements under 45 CFR 164.524. Business Associate shall provide such access in the time and manner reasonably designated by Covered Entity. Business Associate shall promptly forward to Covered Entity for handling any request for access to PHI that Business Associate directly receives from an Individual.

8. **Amendment of PHI**. Business Associate shall make any amendments to PHI in a Designated Record Set that Covered Entity directs or agrees to pursuant to 45 CFR 164.526, whether at the request of Covered Entity or an Individual. Business Associate shall make such amendments in the time and manner reasonably designated by Covered Entity. Business Associate shall promptly forward to Covered Entity for handling any request for amendment to PHI that Business Associate directly receives from an Individual.

9. **Accounting of Disclosures**. Business Associate shall document disclosures of PHI and all information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 CFR 164.528. Business Associate shall provide such information to Covered Entity, or as directed by Covered Entity, to an Individual, to permit Covered Entity to respond to an accounting request. Business Associate shall provide such information in the time and manner reasonably designated by Covered Entity. Business Associate shall promptly forward to Covered Entity for handling any accounting request that Business Associate directly receives from an Individual.

10. **Books and Records**. Subject to the attorney-client and other applicable legal privileges, Business Associate shall make its internal practices, books, and records (including policies and procedures and PHI) relating to the use and disclosure of PHI received from, or created or received by Business Associate on behalf of, Covered Entity available to the Secretary in the time and manner designated by the Secretary. Business

Associate shall make the same information available to Covered Entity (without regard to the attorney-client or other applicable legal privileges), upon request, in the time and manner reasonably designated by Covered Entity, so that Covered Entity may determine whether Business Associate is in compliance with this Agreement.

11. Termination.

11.1 This Agreement commences on the Effective Date and shall remain in effect until terminated by Covered Entity, or until all of the PHI provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity, subject to Section 15.12.

11.2 If Business Associate breaches any material term of this Agreement, Covered Entity may either: (a) provide an opportunity for Business Associate to cure the breach, and Covered Entity may terminate each Services Agreement, without liability or penalty, if Business Associate does not cure the breach within the time specified by Covered Entity; or (b) immediately terminate each Services Agreement, without liability or penalty, if Covered Entity believes that cure is not reasonably possible; or (c) if neither termination nor cure are feasible, Covered Entity shall report the breach to the Secretary. Covered Entity has the right to seek to cure any breach by Business Associate and this right, regardless of whether Covered Entity cures such breach, does not lessen any right or remedy available to Covered Entity at law, in equity, or under this Agreement or any Services Agreement, nor does it lessen Business Associate's responsibility for such breach or its duty to cure such breach.

12. Return/Destruction of PHI.

12.1 Business Associate shall, in connection with the expiration or termination of a Services Agreement, return or destroy all PHI received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity, and pertaining to that Services Agreement, that Business Associate still maintains in any form or medium (including electronic), within thirty (30) days after such expiration or termination. Business Associate shall not retain any copies of such PHI. Business Associate shall certify for Covered Entity, in writing, when all PHI has been returned or destroyed, and that Business Associate does not continue to maintain any PHI, with such certification to be provided during such thirty (30) day period.

12.2 Business Associate shall provide to Covered Entity notification of any conditions that Business Associate believes make the return or destruction of PHI infeasible. If Covered Entity agrees that return or destruction is infeasible, Business Associate shall extend the protections of this Agreement to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such PHI.

13. Notice/Training. Business Associate understands that: (a) there may be civil or criminal penalties for misuse or misappropriation of PHI; and (b) violations of this Agreement may result in notification by Covered Entity to law enforcement officials and regulatory, accreditation, and licensure organizations. If requested by Covered Entity, Business Associate shall participate in information security awareness training regarding the use, confidentiality, and security of PHI.

14. Security Rule Obligations. The following provisions of this Section 14 apply to the extent that Business Associate creates, receives, maintains or transmits Electronic PHI on behalf of Covered Entity.

14.1 Business Associate shall implement and use administrative, physical, and technical safeguards that reasonably and appropriately protect the Confidentiality, Integrity and Availability of the Electronic PHI that it creates, receives, maintains or transmits on behalf of Covered Entity. Business Associate shall identify in writing, upon request from Covered Entity, all of the safeguards that it uses to protect such Electronic PHI.

14.2 Business Associate shall ensure that any agent, including a subcontractor, to whom it provides Electronic PHI agrees in a written contract to implement and use administrative, physical, and technical safeguards that reasonably and appropriately protect the Confidentiality, Integrity and Availability of the Electronic PHI. Business Associate must enter into the written contract before any use or disclosure of Electronic PHI by such agent, and such written contract must identify Covered Entity as a direct and intended third party beneficiary, with the right to enforce any breach of the contract concerning the use or disclosure of Electronic PHI. Business Associate shall provide a copy of the written contract to Covered Entity upon request. Business Associate may not make any disclosure of Electronic PHI to any agent without the prior written consent of Covered Entity.

14.3 Business Associate shall report in writing to Covered Entity any Security Incident pertaining to such Electronic PHI (whether involving Business Associate or an agent, including a subcontractor). Business Associate shall provide such written report promptly after it becomes aware of any such Security Incident. Business Associate shall provide Covered Entity with the information necessary for Covered Entity to investigate any such Security Incident.

14.4 Business Associate shall comply with any reasonable policies and procedures Covered Entity implements to obtain compliance under the Security Rule.

15. Miscellaneous.

15.1 Notwithstanding anything to the contrary in any Services Agreement, in no event shall any provision limiting Business Associate's liability to Covered Entity, including, but not limited to, provisions creating a cap on damages, excluding certain types of damages, limiting available remedies, or shortening a statute of limitations, present in any Services Agreement, apply with respect to any breach by Business Associate of any term of this Agreement.

15.2 In the event of any conflict or inconsistency between the terms of this Agreement and the terms of any Services Agreement, the terms of this Agreement shall govern, with respect to its subject matter. Otherwise, the terms of each Services Agreement continue in effect.

15.3 Any reference to "promptly" in this Agreement shall mean no more than seven (7) business days after the circumstance or event at issue has transpired. A reference in this Agreement to a section in the Privacy Rule or Security Rule means the section as in effect or as amended or renumbered.

15.4 Business Associate shall mitigate, to the extent practicable, any harmful effect that is known to it of a use or disclosure of PHI in violation of any provision of this Agreement.

15.5 Business Associate shall cooperate with Covered Entity to amend this Agreement from time to time as is necessary for Covered Entity to comply with the Privacy Rule, the Security Rule, or any other standards promulgated under HIPAA.

15.6 Any ambiguity in this Agreement shall be resolved to permit Covered Entity to comply with the Privacy

Rule, Security Rule, or any other standards promulgated under HIPAA.

15.7 In addition to applicable state law, the parties shall rely on applicable federal law (e.g., HIPAA, the Privacy Rule and Security Rule) in construing the meaning and effect of this Agreement.

15.8 This Agreement may be amended or modified, and any right under this Agreement may be waived, only by a writing signed by an authorized representative of each party.

15.9 Nothing express or implied in this Agreement is intended to confer, upon any person other than the parties hereto, any rights, remedies, obligations or liabilities whatsoever. Notwithstanding the foregoing, the Covered Entity in this Agreement is the Agency of Human Services, operating by and through its Department, Office, or Division of Office of Vermont Health Access. Covered Entity and Business Associate agree that the term "Covered Entity", as used in this Agreement, also means any other Department, Division or Office of the Agency of Human Services, to the extent that such other Department, Division, or Office has a relationship with Business Associate that would require, pursuant to the Privacy or Security Rules, entry into an agreement of this type.

15.10 As between Business Associate and Covered Entity, Covered Entity owns all PHI provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity.

15.11 Business Associate shall abide by the terms and conditions of this Agreement with respect to all PHI it receives from Covered Entity, or creates or receives on behalf of Covered Entity, even if some of that information relates to specific Services for which Business Associate may not be a "Business Associate" of Covered Entity under the Privacy Rule.

15.12 The provisions of this Agreement that by their terms encompass continuing rights or responsibilities shall survive the expiration or termination of this Agreement. For example: (a) the provisions of this Agreement shall continue to apply if Covered Entity determines that it would be infeasible for Business Associate to return or destroy PHI, as provided in Section 12.2; and (b) the obligation of Business Associate to provide an accounting of disclosures, as set forth in Section 9, survives the expiration or termination of this Agreement, with respect to accounting requests (if any) made after such expiration or termination.

15.13 This Agreement constitutes the entire agreement of the parties with respect to its subject matter, superseding all prior oral and written agreements between the parties in such respect.

ATTACHMENT F

Agency of Human Services Rule # 96-23
Final Adopted Rule for
Access to Information

Definition.

"Agency" means the Agency of Human Services or any of the offices, departments or programs that comprise the Agency.

"AHS" means the Vermont Agency of Human Services.

"Client" means an individual or family who is voluntarily served by a department, office, program, Contractor or grantee of the Agency of Human Services.

"Contractor" means an individual or entity with whom the Agency or any of its departments, offices, or programs has a contract to provide personal services.

"Employee" means any person who works in a full-time, part-time, temporary or contractual position for the Agency or any of its departments, offices, or programs.

1.6 "Grantee" means an individual or entity with whom the Agency or any part thereof has a grant to provide personal services.

1.7 "Program" means a set of services, (such as determining and processing ANFC benefits, verifying and setting up delivery for WIC foods) for which the Agency bears fiscal responsibility.

1.8 "Administrative Obligations" means activities pursuant to federal or state laws or regulations (such as verification of eligibility, verification of service delivery, detention of fraud, monitoring of quality assurance, audit of expenditure reports) which provide for accountability in the use of public funds.

Basic Principles

Presumption of Confidentiality

All information specific to, and identifying of, individuals and families is presumed to be confidential and subject to these standards. Employees shall not disclose the information unless a specific exception to the presumption applies or the disclosure is authorized by the client, a court or as otherwise authorized by law or rule.

Existing Statutes

These rules are not intended to expand or diminish current provisions in law relating to disclosure of confidential information.

Information Collection

Employees shall collect and record only that information needed to fulfill the goal of serving the client and meeting administrative or legal obligations.

Informing Clients

At the initial meeting with each client, or within two weeks, employees shall review and offer to provide the rules for access to information to the client.

Permissible Disclosures

Client consent

No information about a client shall be released without prior consent from the client, unless directly connected with the administration of a program or necessary for compliance with federal or state laws or regulations.

Sharing "Non-identifiable" Information

Information that does not identify a client may be used for statistical research, forecasting program needs, or other such purposes.

Public Information

Information defined as public by 1 VSA & 317 or other applicable statute is available to the public. The procedures in the public records statute shall be followed before public information is released.

Information Sharing for Administrative Purposes

Employees may share information which is necessary to satisfy the Agency's administrative obligations. Departments will develop written agreements limiting the kinds of information to be shared when programs are jointly administered by different Departments. No information shall be released to a person or entity that is out of state, unless directly connected with the administration of a program or necessary for compliance with federal or state laws or regulations.

Disclosure Without Consent in Limited Circumstances

Employees must release sufficient information to comply with mandatory reporting requirements for cases involving the abuse, neglect, or exploitation of children and persons who are elderly or who have disabilities. Information may be released without consent when Vermont law creates a duty to warn identified individuals of potential harm to their person or property, in response to court orders, or to investigate or report criminal activity as required by federal or state law or regulation. Only information relevant to the situation shall be disclosed. The employee shall document the date, purpose and content of the report, the name, address and affiliation of the person to whom the information was released, and shall notify the client that the information was disclosed.

Procedures Related to Consent

Obtaining Informed Consent

Prior to releasing confidential information the Agency shall obtain the client's informed consent. This includes providing information about consent in a language and format understandable to the client. Reasonable accommodations shall be made for special needs based on the individual or family's education, culture, or disability. Employees shall inform clients that granting consent is not a pre-requisite for receiving services, and shall explain that they may apply for services separately.

Consent of Minors to Release of Information

Employees shall obtain the consent of a minor client to release information concerning treatment for which parental consent is not required.

Format for Consent to Share Information

Consent for the sharing or release of information shall ordinarily be in writing. If an emergency situation requires granting of verbal consent, written consent shall be obtained at the next office visit or within thirty days, whichever comes sooner. Required information will include:

1. Names of the people about whom information may be shared.
2. A checklist of the kinds of information to be shared.
3. A checklist of the departments within the Agency to receive the information.
4. A statement or date covering expiration of consent.
5. A statement about procedures for revoking consent.
6. Signature of individuals covered by the consent, or their parents or guardians.
7. Signature of the individual explaining the consent process with their position and job title.
8. A space to provide individualized instructions.

A copy of the consent form shall be provided to all signatories.

Client Access to Records

Unless prohibited by federal or state law or regulation, clients shall be permitted to view and obtain copies of their records. Each department within the Agency shall have written procedures which permit clients to verify personal information they have provided for accuracy and completeness and for placing amendments to the information in their files. Employees shall take reasonable steps to present records in a form accessible to the client, including but not limited to large type format or verbal review. A fee not to exceed the actual cost of copying may be charged for records exceeding 10 pages. This fee shall be waived if it would prohibit access.

AHS Rule 96-23

Procedures to Protect Confidentiality

Staff Training

All AHS employees and all AHS volunteers and interns, shall be instructed in these rules. AHS shall train their Contractors and grantees who shall, in turn, provide the same instruction for their employees, interns, and volunteers.

Response to Requests for Information

An employee shall not respond to requests from outside the Agency for information about clients even to acknowledge that the person is a client, unless authorized. If a client has consented to or requests that information be released, the employee shall comply with the request.

Designated Individual

Each agency or department shall appoint one or more trained staff members to be responsible for responding to all requests for client information when there is no written consent to release, and no statutory or administrative authority permitting release of the requested information. These individuals shall be specially trained in maintaining confidentiality. A list of the designated individuals for each department and office shall be maintained in the Attorney General's Office, Human Services Division.

Affirmation of Understanding

Employees shall sign an affirmation that they will comply with these rules. This affirmation shall be part of their personnel files. Supervisors shall review this affirmation during annual evaluations. Violation of these rules shall result in disciplinary action.

Written Agreements with Grantees or Contractors

The following assurance, or one similar to it, will be included in all AHS grants/contracts signed after these rules have been approved:

[Grantee/Contractor] agrees to comply with the requirements of AHS Rule No. 96-23 concerning access to information. The Contractor shall require all of its employees to sign the AHS Affirmation of Understanding or an equivalent statement.

Client Referrals

When referring a client to another agency for services, if the referral does not meet the criteria for permissible disclosures under Section 3.4, the initial agency shall obtain the consent of the client for the referral and alert the receiving agency that confidential client information accompanies the referral.

Documentation of Disclosure

Requests for disclosures of client information shall be maintained in the client's file if the request does not meet the definition of a permissible disclosure under Section 3.4. Employees shall document in writing any information actually disclosed, along with the name of the person/agency to whom it was disclosed and the date of the disclosure. When permissible disclosures are made under Section 3.4, documentation may be limited to the name of the department/agency/program to whom the disclosure was made.

Information Systems

Computerized Information

When developing a computerized data system, the Agency shall:

1. Develop security procedures consistent with the rule;
2. Instruct staff in the security procedures;
3. Inform clients if a computerized system is being used;
4. Establish written agreements with participating agencies outlining procedures for sharing and protecting information.
5. Develop security procedures in relation to the transmission of information.

Security Procedures

The Agency shall develop a protocol which is consistent with the requirements of this rule to safeguard confidential client information. Contractors and grantees shall also develop a protocol or shall adopt the protocol of the Agency. The protocol shall be designed to safeguard written information, data in computer systems, and verbal exchange of information. The protocol shall prohibit unauthorized access to records and include an appropriate disciplinary process for violations of the security rules.

Procedures

Written procedures for implementing these rules shall be used as the basis for employee Instruction and shall be available for review in the Agency Central Office.

AGENCY OF HUMAN SERVICES
103 South Main Street
Waterbury, Vermont 05676

AFFIRMATION OF UNDERSTANDING STATEMENT

As a Contractor for the State of Vermont, I affirm that I have read the Agency of Human Services (AHS) Rule No. 96-23 concerning Access to Information, and that I agree to comply with the requirements of AHS Rule No. 96-23.

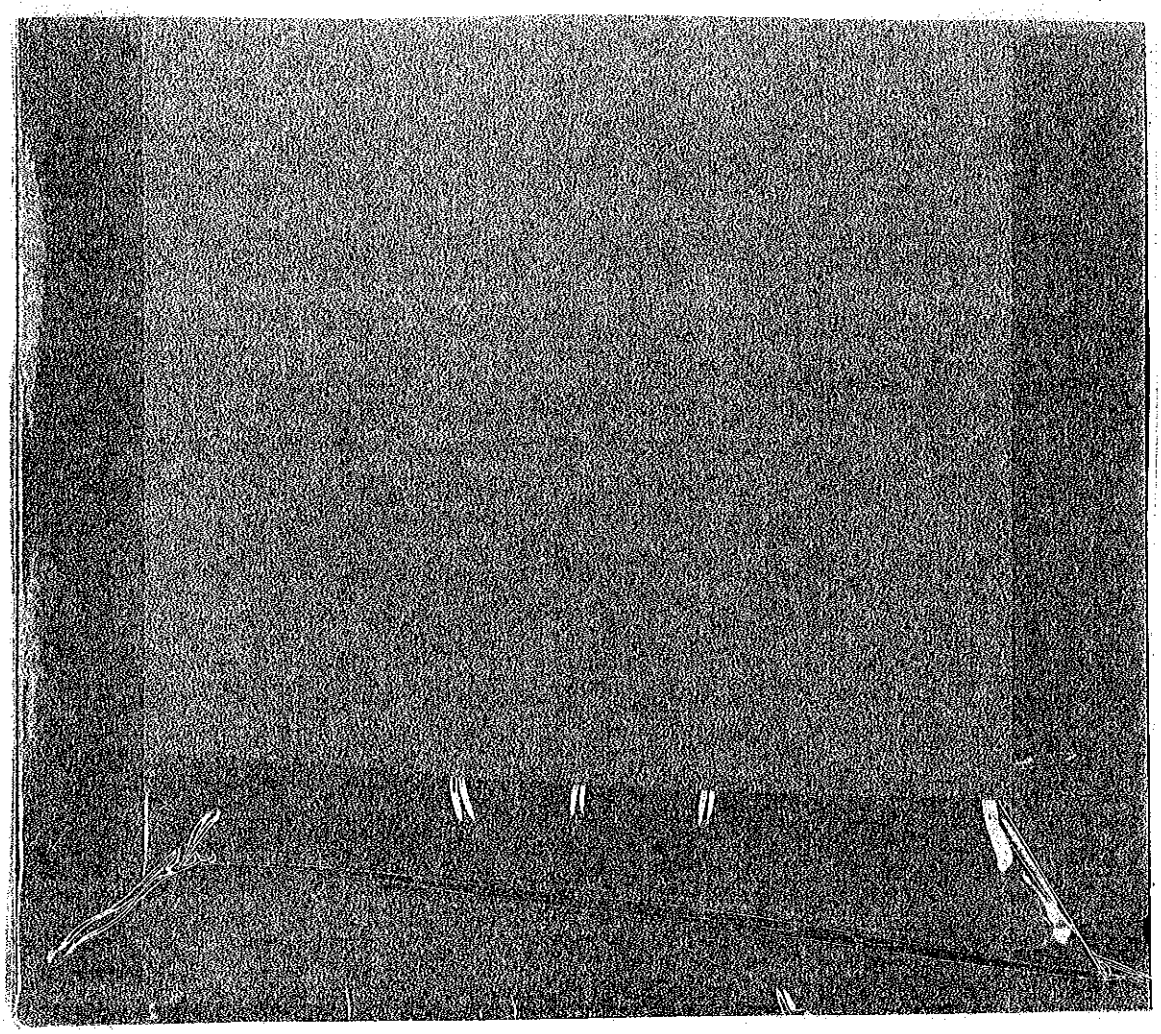
I shall require all of my employees performing services under this contract, to sign an affirmation of understanding statement. Employee statements need not be sent to the State. However, they shall remain in Contractor's personnel records. The State can request copies of such documents if necessary.

MedMetrics Health Partners, Inc.
Name of Company (Print or type)

10/28/2005
Date

Authorized Signature

Chairman
Title

Attachment G – CD with pdf files

Folder	File #	Name Document on File
RFP	1	Request for Proposal for Pharmacy Benefits Management Services March 18, 2005
	2	Reponses to Bidders Questions, April 29, 2005
Technical	3	Medmetrics Health Partners Proposal, May 20, 2005 - VT Table of Contents
	4	Medmetrics Health Partners Proposal, May 20, 2005 - VT Executive Summary
	5	Medmetrics Health Partners Proposal, May 20, 2005 - VT Section II
	6	Medmetrics Health Partners Proposal, May 20, 2005 - VT Section III
	7	Medmetrics Health Partners Proposal, May 20, 2005 - VT Implementation Plan
	8	Medmetrics Health Partners Proposal, May 20, 2005 - VT Disclosure Statement
	9	Medmetrics Health Partners Proposal, May 20, 2005 - VT Service Performance Standards
Cost	10	Medmetrics Health Partners Proposal, May 20, 2005 - VT Budget Narrative
	11	Medmetrics Health Partners Proposal, May 20, 2005 - VT Uninsured Table A
	12	Medmetrics Health Partners Proposal, May 20, 2005 - VT Uninsured Table B
	13	Medmetrics Health Partners Proposal, May 20, 2005 - VT Pricing
	14	Medmetrics Health Partners Proposal - VT Pricing Revised 8/10/05 with Part D
	15	Medmetrics Health Partners Proposal, May 20, 2005 - Specialty Pharmacy Drug List