

WARNING

This unofficial copy of the ITB is for informational purposes only. Before preparing and submitting a response you must receive the official ITB and all required forms from the Alabama Department of Finance, Division of Purchasing. Bid submitted without all forms and attachments required by the Division of Purchasing will be rejected.

For further information, visit the Division of Purchasing website at www.purchasing.alabama.gov.

Invitation to Bid
for
Alabama Medicaid
Pharmacy
Administrative Services



Bid # 09-X-2193471
Alabama Medicaid Agency
May 2008

Section I Introduction to Procurement

1.00.0 General Requirements

The Alabama Medicaid Agency, hereafter called Medicaid, an agency of the State of Alabama, solicits bids to perform the administrative functions of the Pharmacy Program under the provisions of the Code of Alabama, 1975, Section 41-16-20, et seq. as amended, and Section 41-22-1, et seq.

The successful bidder, hereafter called Contractor, shall be responsible for performance of all duties contained within this Invitation to Bid (ITB) for the amount of compensation quoted in bidder's response to this ITB. Bids shall state a firm and fixed administration price.

1.10.0 Introduction

Medicaid will contract with a company to administer certain components of the retrospective and prospective drug utilization review program, prior authorization and override process, as well as education activities. Medicaid will maintain administration responsibilities of the pharmacy program. Additionally, Contractor will not be allowed to restrict the provider network or mandate mail-order services. Contractor will be required by the State to operate under all provisions of the Omnibus Budget Reconciliation Act (OBRA), 1990. State regulatory authority is derived from the Code of Alabama 1975, Alabama Administrative Code and the Social Security Act.

All times stated in this ITB are Central Time. All processing systems implemented must meet standards of systems already in place.

1.20.0 Bidder Qualifications

The successful bidder must demonstrate a high level of expertise in pharmacy benefit management to include extensive experience in drug utilization review. The necessary experience must have been within the last three years.

The successful bidder must meet the following minimum requirements:

1. Licensed company for at least three years
2. Licensed to do business in the state of Alabama
3. Submit the original bid and eight hard copies and one electronic copy of the bid on CD in Word 6.0 or higher format
4. Provide all required documentation as specified by the ITB
5. Submit bid for time period covered by the ITB
6. Accept requirement/submission of a performance guarantee in the amount equal to six months payment
7. Submit bid guarantee for \$5,000
8. Demonstrate the ability to secure and retain professional staff to meet contract requirements to include clerical and administrative personnel, pharmacists, physician and provider representatives

9. Provide staff that are not involved in pharmaceutical detailing activities for any pharmaceutical company and that are dedicated to educate providers with Medicaid approval
10. Submit resume/s for project manager, consulting physician, help desk supervisor, recipient liaison, and account pharmacist
11. Submit price sheet with firm and fixed price including individual component prices; extra-contractual service prices and total evaluated price as specified in Section 5.10
12. Sign and notarize page one of the ITB
13. Submit a brief overview of the history and structure of company, as well as a brief description of the organization's overall capabilities
14. Demonstrate bidder's ability to recommend and apply predetermined standards for drugs or drug classes added to the contract subsequent to the initial drugs identified for prior authorization
15. Submit work plan for educating physicians and pharmacists on preferred drug utilization and appropriate generic utilization
16. Submit work plan for Maximum Allowable Cost (MAC) program responsibilities
17. Provide documented experience and work plans for provider education programs, prior authorization and MAC pricing programs
18. Submit a minimum of 4 references--preferably with at least one from a state Medicaid agency or other government program. Include client name, contact name, title, telephone number, contract type, size and duration
19. Assure through documented work plans the avoidance of real or perceived conflicts of interest
20. Certify that neither it nor its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this contract by any Federal department or agency
21. Maintain a facility within the State of Alabama from which all functions, including the Help Desk, will be operated
22. Supply pre-approved (by Medicaid) Staff Pharmacist and Staff Certified Pharmacy Technician to be based in the Agency full-time as described in Sections 3.91.3 and 3.91.4 of this ITB.

1.20.1 Mandatory Pre-Bid Conference

A mandatory Pre-Bid Conference will be held in Montgomery, Alabama at 10:00 a.m. Central Time on the date as specified in the Schedule of Activities. The location of the conference will be at the *State Department of Finance Division of Purchasing Auditorium in the RSA Union Building, Suite 192, 100 North Union Street, Montgomery, Alabama*. Attendance at the pre-bid conference is mandatory for all entities who plan to submit bids. Failure to attend the pre-bid conference will cause vendor's bid(s) to be rejected. Attendance will be verified based on sign-in logs at the conference. The sign-in sheet must identify the company represented.

The Pre-Bid Conference is intended to be an interactive exchange of information. An opportunity will be given to ask questions to clarify any uncertainties which exist. Since impromptu questions shall be permitted and spontaneous answers may be provided,

bidders should clearly understand that oral answers given at the conference are not binding, but are good faith efforts to give correct useful information. No further questions will be permitted after the date as specified in the Schedule of Activities. All questions with final and binding answers will be distributed to all conference attendees on the date as specified in the Schedule of Activities.

Written questions can be submitted to Medicaid in the following ways:

FAX (334) 353-7014

E-mail: Tiffany.Minnifield@medicaid.alabama.gov

US Mail: Alabama Medicaid Agency

501 Dexter Avenue

P. O. Box 5624

Montgomery, AL 36103-5624

Attention: Tiffany Minnifield, Pharmacy Administrative Services

All questions must be submitted in writing and received by the deadline as specified in the Schedule of Activities. No verbal questions other than those at the Pre-Bid Conference will be accepted. Answers to written questions received by the Contract Administrator by 5:00 p.m. on date specified in Schedule of Activities shall be posted on the Agency website. Prospective bidders will be given at least 1 hour to review the written questions and answers during the Mandatory Pre-Bid Conference.

All amendments and question and answer documents pertaining to this ITB will be distributed in writing via US mail and will be posted on the Agency web-site at www.medicaid.alabama.gov. Bidders may also provide a FAX and E-mail address in addition to a postal mailing address at the Pre-Bid Conference. A bidder's library will be available online for bidders to view any attachments and reference information related to the ITB document.

1.20.2 Disclosure Statement

The following information must be provided by prospective bidders:

1. Are you an independent entity or a subsidiary or division of another company? If not an independent entity, describe the organization linkages and the degree of integration/collaboration between the organizations.
2. List and explain any financial relationships with any pharmaceutical manufacturers or distributors.
3. If not owned by a pharmaceutical manufacturer, is your organization strategically aligned with a pharmaceutical manufacturer? If yes, describe the organization linkages and the degree of integration/collaboration between the organizations.
4. Provide in detail specific processes and procedures by which Contractor will assure the avoidance of any conflict or appearance of conflicts of interest.
5. Disclose all organizations, states, and health plans for which your organization is currently administering or has previously administered pharmacy benefits within the

last three years. Provide organization names, contact persons, address, phone number, and FAX number.

1.20.3 Disclosure of Information

Contractor and Medicaid shall agree that all information, records, and data collected in connection with this contract, shall be protected from unauthorized disclosure. Access to such information shall be limited by Contractor and Medicaid to persons or agencies conducting authorized business relating to the administration of this contract, including, but not limited to, Health and Human Services (HHS) and Center for Medicare and Medicaid Services (CMS). All disclosures are subject to the confidentiality restrictions expressed in this contract, State and Federal law, and regulations.

1.30.0 Background

The Alabama Medicaid Agency is the single state agency responsible for administering the Medicaid program in Alabama. The Medicaid program is partially funded with federal revenues provided through CMS, which establishes rules and regulations for the program and approves the state plan under which the state program operates.

Since the formulary expansion of OBRA 1990, Medicaid expenditures in Alabama for outpatient drugs have escalated from approximately \$60 million in 1990 to over \$700 million in Fiscal Year 2007. This dramatic change is directly related to the broad coverage mandated by OBRA 90, the increase in recipient enrollment and the increase in the costs of covered medications. Medicaid has aggressively sought to address pharmacy issues through the implementation of various programs with an educational focus. In addition to the implementation of cost saving programs such as coverage for over-the-counter (OTC) medication, a prescription brand limit and a state Maximum Allowable Cost (MAC) program, Medicaid has focused on programs that foster safe, appropriate and effective drug therapy. These programs include retrospective Drug Utilization Review (DUR), prospective DUR, the Medicaid Preferred Drug Program, provider education/academic detailing and prior authorization.

The following sections outline the major components of the program and provide a time line for tasks that must be accomplished.

1.40.0 Purpose

The purpose of this Invitation to Bid (ITB) is to competitively procure contractor services to administer certain administrative components of the Pharmacy Program for the State of Alabama Medicaid Agency. The purpose of contracting the administration of these components is to fulfill needs that exist in current staffing levels, technology and provide clinical expertise to the program. The program design reflects the components of programs that are currently operational and are successful in providing quality accessible care.

Contractor shall meet or exceed user needs identified in this ITB and any amendments. Contractor shall meet or exceed defined deliverables and expectations included in this ITB in an acceptable form.

1.50.0 Schedule of Activities

The program is to begin no later than November 1, 2008 on a state-wide basis. In order to implement timely the following milestones must be met:

<i>Activity</i>	<i>Date</i>
Invitation to Bid (ITB) issued	4-14-08
Deadline for questions for pre-bid conference	5-2-08 5:00 p.m.
Responses to questions posted to website	5-9-08
Mandatory ITB Pre-Bid Conference	5-15-08 10:00 a.m.
Answers to Final Bidder's Questions posted to website	5-30-08
ITB Proposals Due	6-9-08 5:00 p.m.
Open bid responses	6-10-08 9:00 a.m.
Contract Award (estimated)	7-11-08
Provider notice mailed by Medicaid	9-29-08
System changes complete and tested	10-10-08
Implementation	11-1-08

1.50.1 Implementation Schedule

Contractor must have the following components operational no later than November 1, 2008, with the exception of staff pharmacist and staff certified pharmacy technician who shall be available no later than September 1, 2008.

- Prospective Drug Utilization Review (DUR) Monitoring Program (see Section 3.10.0)
- Maximum Allowable Cost (MAC) pricing (see Section 3.20.0)
- Prior Authorization (see Section 3.50.0)
- Override Requirements (see Section 3.50.4)
- Retrospective DUR (see Section 3.70.0)
- Drug Interface System (see Section 3.90.0)
- Academic Detailing (see Section 3.80.0)
- Help Desk (see Section 3.90.0)
- Staff Pharmacist (see section 3.91.3)
- Staff Certified Pharmacy Technician (see Section 3.91.4)

1.60.0 Subcontracting

The contract shall not be assigned without written consent of Medicaid. Contractor may

subcontract for the professional services of pharmacists, physicians and statisticians necessary for the completion and maintenance of this contract and for the performance of its duties under this contract with advance written approval of both the subcontracted function and the subcontractor by Medicaid. Subcontractors shall demonstrate the capability to perform the function to be subcontracted at a level equal or superior to the requirements of the contract relevant to the service to be performed. All subcontracts shall be in writing, with the subcontractor functions and duties clearly identified, and shall require the subcontractor to comply with all applicable provisions of this ITB. Contractor shall at all times remain responsible for the performance by subcontractors approved by Medicaid. Contractor's performance bond and Contractor's responsibility for damages shall apply whether performance or nonperformance was by Contractor or one of its subcontractors. Medicaid shall not release Contractor from any claims or defaults of this contract which are predicated upon any action or inaction or default by any subcontractor of Contractor, even if such subcontractor was approved by Medicaid as provided above. Contractor shall give Medicaid notice in writing by registered mail of any action or suit made against Contractor by any subcontractor or vendor, which in the opinion of the Contractor may result in litigation related in any way to this contract with the State of Alabama.

1.70.0 Headings and Titles

Any headings or titles used to help identify any part of this ITB or any contract upon which it is based are for reference purposes only and shall not be deemed as controlling the interpretation or meaning of any provision of this ITB or any contract upon which it shall be based.

1.80.0 Contract Administrator

The individual designated by this ITB to coordinate activities, resolve questions, monitor Contractor performance, ensure that all contract requirements are met, approve payments and be the Alabama Medicaid Agency contact for Contractor is:

Tiffany Minnifield
Alabama Medicaid Agency
Pharmacy Administrative Services
501 Dexter Avenue
P. O. Box 5624
Montgomery, AL 36103-5624
(334) 353-4596 or (334) 242-5050
(334) 353-7014 FAX
Email: Tiffany.Minnifield@medicaid.alabama.gov

Contractor will be notified of any change in Contract Administrator.

1.90.0 Rights of Medicaid

This Invitation to Bid (ITB) does not commit the State to award a contract, or pay any costs incurred in the preparation of a proposal in response to this request. The Alabama Medicaid Agency reserves the right to reject all proposals, and at its discretion may withdraw or amend this ITB at any time.

Deductive Alternatives: Alabama Medicaid reserves the right to eliminate individual work components in line items 3.70.00 Academic Detailing, 3.91.3 Staff Pharmacist, 3.91.4 Certified Pharmacy Technician and Section 3.20.0 State Maximum Allowable Cost as outlined in the scope of work. Elimination of any component will result in deduction of said price component from bidder's firm and fixed bid price.

Alabama Medicaid may by written notice revise and amend the solicitation prior to the due date for the proposal. If, in the opinion of Medicaid, revisions or amendments will require substantive changes in proposals, the due date may be extended.

By submitting a proposal in response to this ITB, the proposing party grants to Medicaid the right to contact or arrange a visit in person with any or all of the bidder's clients. Upon selection of the Contractor, Medicaid will issue a letter of intent to the selected contractor advising that the State intends to make such contacts. Unsuccessful bidders will be notified in writing after the award of the contract.

Section II Alabama Medicaid Agency Overview

2.00.0 Program Outline

The Alabama Medicaid Agency is responsible for administration of the Alabama Medicaid Program under a federally approved State Plan for Medical Assistance. Through teamwork, the Agency strives to enhance and operate a cost efficient system by building an equitable partnership with health care providers, both public and private.

Medicaid's central office is located at 501 Dexter Avenue in Montgomery, Alabama. . The central office personnel are responsible for data processing, program management, financial management, program integrity, general support services, professional services, and recipient eligibility services. For certain recipient categories, eligibility determination is made by Agency personnel located in ten district offices throughout the state and 300 outstationed workers in designated hospitals, health departments and clinics. Medicaid eligibility is also determined by established policies through the Alabama Department of Human Resources and the Social Security Administration. In FY 2007, there was an average of 932,521 Medicaid eligibles and 755,856 that utilized Medicaid services.

Services covered by Medicaid include, but are not limited to, the following:

- Physician Services
- Inpatient and Outpatient Hospital Services
- Rural Health Clinic Services
- Laboratory and X-ray Services
- Nursing Home Services
- Early and Periodic Screening, Diagnosis and Treatment (includes Dental)
- Home Health Care Services and Durable Medical Equipment
- Family Planning Services
- Nurse-Midwife Services
- Federally Qualified Health Services
- Hospice Services
- Prescribed Drugs
- Optometric Services
- Transportation Services
- Hearing Aids
- Intermediate Care Facilities for the Mentally Retarded and Mental Disease Services
- Prosthetic Devices
- Outpatient Surgical Services
- Renal Dialysis Services
- Home and Community Based Waiver Services
- Prenatal Clinic Services
- Mental Health Services
- Coordinated Care Services

Physician services to Medicaid eligibles are based on medical necessity, with physicians themselves determining the need for medical care; with prior authorization by the Agency in selected situations. Physicians provide this care directly and prescribe or arrange for additional health benefits. The majority of licensed physicians in Alabama participate in the Medicaid Program. Physician services may be provided in health departments and health centers, such as Rural Health Clinics and Federally Qualified Health Centers, in addition to private offices, hospitals and nursing homes.

Medicaid covers most prescription drugs as required by OBRA '90. There are approximately 1375 pharmacies enrolled in the Medicaid Program that provide services to Medicaid recipients in Alabama. Claims volume fluctuates from month to month and from year to year. Medicaid makes no guarantee that claims volume from year to year will not go up or down. For more information, please visit the bidder's library on the Alabama Medicaid website at www.medicaid.alabama.gov

All statistical and fiscal information contained in the ITB and amendments reflect the best and most accurate information available to Medicaid at the time of ITB preparation. No inaccuracies in such data shall constitute a basis for change of the payments to Contractor or a basis for legal recovery of damages, either actual, consequential or punitive except to the extent that such inaccuracies are the result of intentional misrepresentation by Medicaid.

Medicaid strives to operate a cost efficient system to meet the health needs of all recipients. The goal for this contract is to continue to improve the quality of care provided to Medicaid recipients while minimizing inappropriate utilization of Medicaid services.

Section III Scope of Work

3.00.0 Scope of Work Overview

The contract support and technical assistance described in this ITB will require a project manager, consulting physician, provider academic detailers, account pharmacist, staff pharmacist, help desk supervisor, recipient liaison, and a staff certified pharmacy technician as well as whatever clinical, administrative and technical support personnel Contractor deems necessary to accomplish the scope of work described herein.

Contractor shall submit resume for each position listed (with the exception of staff pharmacist and staff certified pharmacy technician, for which Contractor shall submit an understanding to supply these resumes/CVs as outlined in Sections 3.91.3 and 3.91.4).

Required components of the program are:

1. The administration of retrospective DUR for outpatient pharmacy services will be provided through a single Contractor who will work with Medicaid to ensure that quality, accessible pharmaceutical products are provided to Medicaid beneficiaries.
2. Contractor will be required to execute Medicaid directives for program and/or policy changes to ensure that quality standards are maintained, services provided are accessible and are appropriate. Areas involved include, but are not limited to, Preferred Drug List product education MAC pricing, Prior Authorization (PA) criteria, Override criteria for Prospective Drug Utilization Review (DUR) hard editing, Academic Detailing and Retrospective DUR criteria.
3. The Medicaid fiscal agent will remain responsible for processing pharmacy claims using an electronic format. Contractor shall be responsible for all costs associated with installing and maintaining system interfaces with the Alabama Medicaid Management Information System (AMMIS). On-line interfaces will be required for prior authorizations to include eligibility and claims information, and prospective DUR edit overrides. Additional information and data transfers can be accomplished through tape transfers/coordination with our fiscal agent.
4. The pharmacy network may not be restricted. Medicaid will maintain the provider enrollment function.
5. The current MAC drug program must be reviewed every six months to validate methodology and pricing algorithms. Recommendations for program changes must be approved by Medicaid.
6. Expansion and maintenance of the current Prior Authorization (PA) Program and selection of high-risk drugs is permitted through recommendation to Medicaid's Pharmacy and Therapeutics (P&T) Committee and approval of Medicaid. Contractor will not have authority over what drugs require prior authorization. All additional drugs to require prior authorization may be recommended to the P&T Committee or Agency for inclusion on the Medicaid Prior Authorization List. The PA program must include a mechanism to allow for a 72 hour emergency supply, 8 hour response time with a mandated 24 hour turnaround and a help desk staffed with appropriate professionals. The turnaround process does not start until all information is received.
7. Promotion of the Medicaid Preferred Drug List (PDL) as approved by the Medicaid P&T Committee and Medicaid.

8. Provider education through academic detailing and other Medicaid approved mechanisms such as distribution of educational materials through notices or newsletters and targeted intervention to selected providers.
9. Provider summary reporting of prescribing and dispensing patterns through claims data analysis.
10. Contractor shall refer to Medicaid's Program Integrity Division Director any instances of suspected fraud or abuse. In this regard, Contractor shall provide all of its employees with specific, written instructions approved by Medicaid on the identification and referral of suspected fraud and abuse.
11. For reviews and recommendations to Medicaid and the DUR Board, Contractor must utilize the most current pharmacological data from the following: AHFS (American Hospital Formulary Services), Hanson's Adverse Drug Reactions, Physicians Desk Reference (PDR), USP DI Pharmacopoeia, ASHP DI, American Medical Association Drug Evaluations, Facts and Comparison, Redbook, Orangebook, and National Formulary.
12. Contractor shall coordinate DUR Board Meetings to update therapeutic criteria, provider education and interventions for retrospective and prospective DUR.
13. Contractor shall maintain an academic detailing program based upon on-going reviews and analysis by Medicaid and Contractor.
14. Contractor shall provide access to Medicaid PA and Override request forms, Medicaid Preferred Drug List (PDL), Medicaid State MAC list and a link to the Medicaid web-site through Contractor web-site.
15. Provide clinical information and respond to questions from Medicaid designated Pharmacy staff within one business day.

Medicaid will maintain responsibility for administration of the program, provide claims history to perform Retrospective DUR functions, and be responsible for policy decisions and quality oversight. The Agency will monitor and assess the program through the assigned Contract Administrator.

3.10.0 Monitoring Prospective DUR Edits

Prospective Drug Utilization Review (DUR) is a structured program required by the Code of Federal Regulations that screens drug claims on-line against predetermined medical standards and criteria, and promotes clinical safety, therapeutic efficacy and appropriate drug use. Only through the identification of potential drug therapy problems can appropriate interventions be initiated. Contractor will be responsible for monitoring the Prospective DUR program. Additionally, Contractor shall make recommendations to Medicaid and the DUR Board for additions and/or deletions of established prospective DUR criteria.

Contractor is not responsible for adjudicating claims and maintaining the on-line Prospective DUR system. Contractor is responsible for monitoring the prospective DUR program as well as staffing a provider help desk to consider and grant appropriate overrides to hard edits through the prospective DUR system maintained by the fiscal agent (see Section 3.90.4). Contractor shall respond to all requests for on-line editing overrides within 24 hours of receipt of the request. Claims will be flagged by the fiscal

agent for prospective DUR including high-dose, drug/drug interaction, early refill, and excessive quantity. Currently, early refill, maximum units, maximum cost and therapeutic duplication are hard edits that require an override from the Pharmacy Contractor for claims submission. Drug/drug interaction and High Dose are soft edits and can be overridden by the provider at the pharmacy level. Recommendations for other edits may be made by the Contractor to Medicaid for consideration.

Contractor duties regarding prospective DUR include:

1. Monitor frequency of alerts/overrides by pharmacists; determine the average override percentage for the majority of Medicaid pharmacies based on research of Medicaid provider data
2. Monitor and target through Medicaid approved educational plans, pharmacies that consistently override alerts above standards established by Medicaid
3. Provide Medicaid drug utilization information and data, as required to the Alabama Medicaid DUR Board and/or to Alabama Medicaid Agency to support Pro-DUR criteria enhancements
4. Evaluate effectiveness of specific alerts and recommend modifications as needed
5. Recommend use of additional hard, soft, or informational edits to Medicaid for approval
6. Provide ongoing support to providers by maintaining and staffing a help desk (see Help Desk Section 3.90.0)
7. Assist Medicaid in the evaluation of overall on-line system effectiveness
8. Develop in conjunction with the ProDUR contractor, additional ProDUR criteria and present to the DUR Board for approval
9. Coordinate with the DUR Board on specific therapeutic classes to include/exclude in Pro DUR editing
10. Identify additional reporting needs; assist Medicaid in development of additional reports
11. Refer cases to Medicaid's Program Integrity Division including Pharmacy Audit Unit as appropriate
12. Monitor Monthly Provider Summary Reports to identify problem providers; inappropriate prescribing and dispensing patterns
13. Recommend changes to the Alabama Medicaid Provider Manual as appropriate

Contractor deliverables include:

1. Monthly reports that identify pharmacists exceeding the established standard for overrides. These reports shall include, but not limited to, top pharmacies requesting an early refill, total number of early refills, therapeutic duplications, max unit requests and the source of these requests. These reports shall include but not limited to top pharmacies and providers by claim cost.
2. Monthly provider summary reports which identify pharmacists to target through retrospective DUR and education initiatives

3. Quarterly presentations to the Medicaid DUR Board as to the effectiveness of the current prospective DUR system as well as any enhancements that should be considered
4. Pro-DUR training to Medicaid staff and providers as requested by Medicaid

The Alabama Medicaid Agency shall:

1. Establish policies and guidelines to be followed by providers and Contractor in using Pro-DUR
2. Determine the modules and criteria to use for the Pro-DUR functions
3. Specify the Pro-DUR training needs of both State staff and providers
4. Serve as the liaison between the DUR Board, fiscal agent and Contractor
5. Coordinate the development of additional prospective DUR editing with the Fiscal Agent

3.20.0 Maximum Allowable Cost (MAC) Pricing

To continue Medicaid's current MAC program, Contractor must research and make recommendations of drugs to be included in the MAC Program to Medicaid. The following information must be used by Contractor when making recommendation for inclusion of a drug for MAC pricing. Contractor must also use rules as defined by the Food and Drug Administration (FDA).

1. Bioequivalency
 - FDA, therapeutic equivalency ratings as defined by the FDA OrangeBook for bioequivalency
 - Medical literature - review to determine acceptability of generic, concerns of substitution
2. Adequate Availability
 - Must be available from three or more manufacturers, or
 - Must have been on the market long enough to assure accessibility (minimum of 6 months)
3. Utilization and Cost Comparison
 - Products seldom used may not generate significant savings for consideration

Contractor will conduct a review of the MAC program methodology every six months to determine appropriateness of pricing and inclusion of products in MAC program. This review shall consist of a comparison including but not limited to Average Wholesale Price (AWP), Federal Upper Limit (FUL) and Wholesale Acquisition Cost (WAC) prices of a random sampling of MAC products. An adequate sample size must be used for review. Contractor shall make recommendations to Medicaid for changes to the MAC program based upon these reviews.

This section must be listed and priced separately by the contractor, but may be removed by Medicaid dependent upon RFP 2008-SMAC-001 that is currently pending as of the writing of this ITB.

Contractor duties regarding MAC pricing include:

1. Research and recommend drugs monthly to Medicaid for MAC pricing. Drug recommendations should include both generic and brand drugs
2. Receive pricing and/or availability information from all wholesalers within the state of Alabama.
3. Receive and research complaints by providers and Medicaid of unavailability and notify Medicaid within 24 hours of confirmed notice of unavailability. Medicaid will make a determination based on recommendation and documentation and will notify Contractor. Contractor shall respond to requesting provider with outcome within 1 hour of receipt from Medicaid. Contractor will provide a monthly listing of products which have been found to be unavailable. Contractor will recheck availability of these products on a quarterly basis and inform Alabama Medicaid Agency when these products are available.
4. At the request of providers and/or the Alabama Medicaid Agency, Contractor will verify drugs are available/unavailable at or below established price. Verification should be completed within 24 hours of request from Medicaid or provider
5. Distribute a MAC drug list, to include product names that are in the MAC program to enrolled providers upon request
6. Identify and provide a list to Alabama Medicaid Agency on a monthly basis of pharmacy providers overriding the MAC price through use of Dispense As Written (DAW) code 1
7. Maintain MAC exclusion list and verify monthly that these drugs should remain excluded from MAC pricing
8. Report any findings of incorrect MAC prices to Medicaid within 24 hours of discovery
9. Review MAC program methodology every six months to determine appropriateness
10. Make recommendations to Medicaid for changes to MAC pricing algorithm as requested.
11. Provide a monthly listing of all new generically available products in the marketplace.

Contractor deliverables include:

1. Monthly report of recommendations with supporting documentation to Medicaid regarding additions for MAC pricing as well as a list of drugs included in the MAC program.
2. Quarterly report on cost savings associated with the MAC pricing system
3. Monthly reports identifying pharmacy providers overriding the MAC price through use of Dispense As Written (DAW) code 1
4. Quarterly list of all MAC drug additions from the previous quarter
5. Quarterly report of MAC drug discrepancies discovered/reviewed within prior quarter to include all MAC actions taken and recommendations made during previous quarter
6. Biannual report of MAC program review to include products included in sample, outcomes and recommendations.

7. Monthly report of all new generically available products in the marketplace.
8. Monthly report of all pharmacy providers overriding the MAC price through use of DAW code of 1.
9. Monthly report of all product shortages

The Alabama Medicaid Agency shall:

1. Provide established policy to Contractor regarding the review and expansion of the MAC program
2. Review drugs recommended by Contractor to be added to the MAC Program. Medicaid shall review recommendations and notify Contractor of determination
3. Make necessary pricing file changes to accommodate additions/exclusions to the MAC Program as recommended by Contractor and approved by Medicaid
4. Review Contractor recommendations for changes to MAC program methodology and coordinate the implementation of such changes

3.30.0 Together For Quality

Together for Quality is an Alabama Medicaid Agency-led initiative to transform the state's fragmented claims and process-oriented system into one that is coordinated, patient-centered and cost efficient. The goals for TFQ include:

- 1) Medicaid Transformation: To change the way Medicaid does business by simplifying provider access and use of information at the point of care by developing a real-time, claims-based electronic health record for provider use to improve patient health outcomes. A clinical support tool using care management data will also be developed to enable providers to improve care choices and better manage their patients, especially those with chronic illnesses.
- 2) Statewide health information system development: To create a system that allows state agencies and providers to share information electronically to improve patient health and control costs.

More detailed information regarding TFQ can be found on Medicaid's website www.medicaid.alabama.gov under the "Transformation Grant" link.

Medicaid has obtained services through a RFP process (unrelated to this ITB) for a vendor to assist the implementation of TFQ. At the time of writing this ITB, the TFQ project is deep in the development stage, preparing to roll out the pilot project stage. The Contractor will be expected to supply the needed daily interfacing with the TFQ vendor, as well as any proposed interfacing to ensure online/electronic prior authorization/override capabilities as it relates to the electronic clinical support tool. Contractor will also be expected to coordinate in a timely manner (within one business day) with the TFQ vendor (courtesy copying the Medicaid Contract Administrator) on needed requests for coding, interfacing, etc.

Contractor Responsibilities related to TFQ include:

- 1) Daily interfacing with TFQ vendor. The interface is over a secure sftp connection or https connection between Contractor and the TFQ vendor. The interface is a

batch process program that will run every hour that sends approval prior authorizations in an ascii text file format to a certain location where the TFQ vendor can pick up the data file. Contractor shall also create a batch process program that runs once a day to send 24 hour old denial prior authorizations in an ascii text file format to a certain location where the TFQ vendor can pick up the data file. The location of the data files are on the TFQ vendor's site.

- 2) Proposed interfacing with TFQ vendor/fiscal agent to allow for online/electronic prior authorization/override checks, approvals, and denials as it relates to the electronic clinical support tool. At the time of writing this ITB, this component is early in the development stage and capabilities of web service interfacing may be necessary, but Contractor will be responsible for working with all parties involved to ensure a successful outcome and product.

Medicaid Responsibilities related to TFQ include:

- 1) Provide needed support and coordination efforts between Contractor, TFQ vendor, fiscal agent, and any other needed parties

3.40.0 Preferred Drug Program

In accordance with Alabama Act No. 2003-297, Alabama Medicaid implemented a mandatory Preferred Drug Program in November 2003. Prior to November 2003, the preferred drug program was voluntary.

The Preferred Drug Program operates with three basic goals. The primary goal of the program is to foster safe, appropriate and effective drug therapy. Clinical considerations and patient care and safety take precedence over all other deliberations and decisions. The program provides Medicaid with a fundamental and foundational drug management system through a quality of care supported by evidence-based medicine driven approach.

Secondly, the Preferred Drug Program is designed to serve as an educational system for both prescribing physicians and dispensing pharmacies. The Preferred Drug Program does not override the prescribing prerogatives of physicians. A physician has and maintains the ability to prescribe any medically necessary medication. Use of a preferred drug is required unless the prescriber obtains prior approval.

Additionally, the Preferred Drug Program offers a mechanism to control the increasing costs associated with medical care. Properly employed drug therapy in managing disease contributes substantially to improved health outcomes and lower overall health care costs. Also, the Preferred Drug Program fosters appropriate generic and over-the-counter (OTC) drug utilization.

The pertinent components of the Preferred Drug Program include the Preferred Drug List (PDL) and the Pharmacy and Therapeutics (P&T) Committee. These components are outlined in the following sections.

Preferred Drug List (PDL)

Alabama Medicaid utilizes a preferred drug list (PDL) for determination of drugs available for reimbursement under the Medicaid Program without prior authorization. The PDL is composed of preferred brands, generics and covered over-the-counter (OTC) products of targeted and reviewed classes of drugs. Non-preferred agents for the classes reviewed remain covered but require prior authorization. For reimbursement under the Medicaid Program, use of the Preferred Drug list is mandatory. Drugs will be considered for the preferred drug list based on the following:

- (a) clinical efficacy
- (b) side effect profiles
- (c) appropriate usage
- (d) cost

OTC drugs covered by Medicaid will be considered preferred drugs for Alabama Medicaid's Preferred Drug Program. However, OTC drugs will not appear on the preferred drug lists.

Also, brand name drugs not included on the preferred drug lists may be available through the prior authorization process. Medicaid shall strive to ensure any restriction on pharmaceutical use does not increase overall health care costs to Medicaid.

As of the writing of this ITB, the following AHFS drug classes have been implemented into the PDL: ADHD Agents, Alzheimer Agents, Antidepressants, Antiemetics, Antihyperlipidemics, Antihypertensives, Antiinfective Agents, Anxiolytics/Sedatives/Hypnotics, Cardiac Agents, Diabetic Agents, Diuretics, Estrogens, Eye/Ear/Nose/Throat Agents(with certain exceptions), Intranasal Corticosteroids, Narcotic Platelet Aggregation Inhibitors, Proton Pump Inhibitors, Respiratory Agents, Skeletal Muscle Relaxants, Skin and Mucous Membrane Agents and Triptans.

Pharmacy and Therapeutics (P&T) Committee

Alabama Legislation mandates that Medicaid is to develop the PDL in coordination with the Pharmacy and Therapeutics (P&T) Committee. The P&T Committee functions include advising Medicaid on prior authorization, PDL reviews and coverage determinations. For purposes of the PDL, the Committee performs in-depth clinical reviews of targeted classes of drugs. The P&T Committee serves as an advisory panel and makes recommendations to Medicaid utilizing reviews provided by a Clinical (not the Administrative) Contractor.

The Alabama Medicaid Agency will utilize the P&T Committee to review and recommend drugs for the Preferred Drug List. The Committee will consist of three clinical pharmacists licensed to practice in the state of Alabama including at least one independent pharmacist and one long term care pharmacist, and at least five physicians licensed to practice medicine in the state of Alabama. More information regarding our Preferred Drug Program can be found on the Agency website, www.medicaid.alabama.gov.

Drugs may be added from time to time upon request to P&T, however Contractor shall not have authority over drugs that go on the Prior Authorization List, nor shall Contractor be responsible for selecting products for the PDL. Contractor may make recommendations for additional drugs to be added. Contractor account and staff pharmacists will be required to attend all P&T Committee meetings.

Contractor Responsibilities shall include:

- 1) Account and Staff pharmacists attend all P&T Committee meetings
- 2) Review, implement, and recommend modifications regarding any criteria related to prior authorization, override, and/or DUR as outlined in this ITB

Medicaid responsibilities shall include:

- 1) Provide needed support and coordination efforts between Contractor, Clinical Contractor, fiscal agent, and any other needed parties

3.50.0 Prior Authorization (PA)

The primary goal of the PA program is to promote the most appropriate utilization of select drugs. Medicaid and the P&T Committee will approve prior authorization requirements to target a chosen drug or group of drugs. Additional drugs to require prior authorization may be presented for review by the Medicaid P&T Committee and approved by Medicaid in accordance with State of Alabama Administrative Code Rule No. 560-X-16-.09.

Contractor shall review proposed prior authorization criteria and make recommendations for change to Medicaid based on clinical review of current medical literature. Medicaid will provide Contractor with approved PA criteria and forms in hard copy and electronic format. In FY 2007 113,827 manual prior authorizations and 283,234 electronic requests were processed by the PA contractor. Of the manual requests, there were 108 appeals, 2,443 sent in online, 111,127 by fax, 4 by mail and 145 by phone.

3.50.1 PA Requirements

Contractor shall receive requests, hereinafter referred to as PA Requests from physicians or pharmacists for Medicaid coverage of drugs that require prior authorization. Drugs requiring prior authorization outside the scope of the PDL include brand name Non-Steroidal Anti-Inflammatory Agents (NSAIDS), Second Generation Antihistamines, Sustained Release Oral Opioid Agonists, Biological Injectables, Erectile Dysfunction, Growth Hormones, H-2 Antagonists, nutritional supplements and certain miscellaneous/noncovered drug/ EPSDT medications. Non-preferred agents for the classes reviewed under the PDL are covered but require prior authorization as well. For medications currently requiring prior authorization, please visit the bidder's library located on the Alabama Medicaid website at www.medicaid.alabama.gov. Other requirements may be added by Medicaid at any point in the future. Medicaid shall give at least two weeks written notice to Contractor before implementing a new prior authorization requirement.

Contractor shall accept written, electronic or telephone requests from either the prescribing physician or the dispensing pharmacist, or their authorized representative. Written requests may be submitted by mail, fax, or online. Toll free phones shall be provided 24 hours a day, 7 days a week with an automated voice message system to record calls after hours and give on-call contact information. Toll-free FAX lines shall be provided 24 hours a day, seven days a week. A help desk shall be available to providers 8:00 a.m. - 7:00 p.m. Monday through Friday with Saturday coverage from 10:00 a.m. until 2:00 p.m. Contractor will provide a clinical representative on call to accept prior authorization and issue prior authorization numbers on Sundays, after hours and on help-desk holidays.

Contractor shall respond to a minimum of 75 percent of total prior authorization requests each month within 8 hours of receipt of completed request but in no event shall response time exceed 24 hours. Responses to requests must be issued within 24 hours of receipt of the completed request. Upon receipt of an incomplete request, Contractor is to make a good faith effort to obtain missing information. This may be accomplished through system inquiry, calling or faxing form to provider for completion of required information.

Additionally, a mechanism must be in place to provide a 72 hour supply of medication in emergency situations. Medicaid has established a generic PA number to be used in these situations. Utilization of this generic PA number will be monitored closely by Medicaid.

Contractor shall respond to the requesting practitioner by telephone or other telecommunications device with approval/denial within twenty-four hours of receipt of a phoned, faxed, electronic or mailed complete PA. Telephone responses shall be during the normal business hours of the providers. Contractor shall document unsuccessful attempts to respond which occur more than fifteen minutes apart. Attempts made more frequently than these fifteen minute intervals are at Contractor's discretion. Documentation must include the date, time, method used, and the result of each attempt. Contractor shall respond by mail to a request only when the documentation on the Drug Prior Authorization Response establishes that three unsuccessful attempts were made no closer than fifteen minutes apart. Contractor shall receive and respond to electronic requests in the NCPDP HIPAA Standard format. Additional responses to electronic requests by telephone, fax and mail are allowed but are not required.

Contractor shall utilize drug usage criteria approved by Medicaid to approve/deny PA requests. Current criteria to be applied to specific drugs requiring prior authorization can be found in the bidder's library on the Medicaid website. Medicaid will provide Contractor with more detailed criteria during implementation phase. Criteria may be added or revised by Medicaid based on clinical review or recommendation of the P&T Committee. Contractor shall ensure that review criteria are applied in a uniform manner to all requests. If staff cannot determine whether to approve or deny a request, it shall be referred to a pharmacist or physician consultant for approval/denial. If Contractor has questions regarding criteria, clarification should be requested from Medicaid. (See Attachment G for a workflow diagram of the review process). Contractor shall implement daily quality control checks on prior authorization and override requests and

monthly prior authorization and override audits shall be conducted to ensure requests are being reviewed approved accurately. Prior authorization denials that contain additional medical justification shall be reviewed by clinical personnel before a denial letter is sent to a provider.

Additionally, Contractor shall review the Alabama Drug Information Reference subsystem panels to ensure that the drug being prior authorized is covered by Medicaid and the Alabama Recipient panels to ensure that the recipient is eligible for Medicaid drug coverage at the time of the PA request. Requests for QMB-only, otherwise ineligible recipients, and recipients covered under Part D (for Part D covered drugs) shall be denied. Contractor shall verify that the designated pharmacy is currently enrolled in the Medicaid program. Contractor shall also ensure that the appropriate pharmacy is indicated when the recipient is locked-in to a certain pharmacy. This information is provided through the Recipient Lock-in File.

Contractor shall assign a ten digit numeric PA number for approved PA requests which meet the approval criteria for Medicaid coverage. Contractor shall document the assigned PA number and supporting documentation on the request form. Contractor shall update Medicaid's on-line Prior Authorization File within twenty-four hours of receipt of request.

Contractor shall deny PA requests that fail to meet Medicaid approved guidelines. Contractor shall notify the prescribing physician and dispensing pharmacy in writing and include the denial reason using codes established by Contractor and approved by Medicaid. This information shall be faxed to the prescribing physician and dispensing pharmacist within 24 hours of receipt. Contractor must respond to electronic requests via NCPDP HIPAA Standard format.

Contractor shall establish and maintain a database of PA requests. Data shall include, but is not limited to, date and time of receipt; name of recipient; Medicaid number; pharmacy name and provider number; date of PA approval or denial, drug name, NDC number, requester, whether medical justification was submitted and prescribing physician license number. Provider may appeal a PA decision and supply additional medical justification for consideration. (See Clinical Appeals section 3.50.6).

3.50.2 Electronic Prior Authorization

Contractor shall develop and maintain a system for the electronic prior authorization (EPA) of pharmacy claims that require PA. The (EPA) system shall check pharmacy and medical claims history to determine if prior authorization requirements are met when a pharmacy claim is submitted. If it is determined that all criteria are met, the request is approved, the claim will pay and no manual PA request will be required. Contractor must be able to monitor EPA system for rejected claims that do not meet criteria and will need to be completed manually. Contractor must be able to accept batch transactions. Contractor shall establish a dedicated circuit (512kb) and maintain interface capabilities between contractor and Medicaid's fiscal agent to ensure a less than 3 second response

time to the provider. Contractor shall establish any VAN lines needed to complete EPA process. Contractor shall respond to provider regarding the outcome of prior authorization request (if the EPA is denied, the provider must be guided that a manual PA is needed). Contractor must be able to accept and respond to requests in NCPDP P4 format. At the time of the writing of this ITB, there are 21 drug classes implemented into EPA. Other classes will be phased in as they are reviewed. The electronic PA process is automated and checks the system electronically within seconds of the PA submission. For all PA requests including electronic, contractor shall send approval letters to physician and pharmacists. Contractor will be responsible for ensuring computer connections are compatible with fiscal agent connectivity requirements already in place. Any additional lines needed by contractor will be at the expense of the contractor to ensure that system is operational from the contractor's end of the connectivity lines.

3.50.3 Prior Authorization Online Submission

Contractor shall develop, and maintain an online submission system for prior authorizations. The online system shall meet minimum standards of what is currently in place. Currently, this is done via an email request utilizing HTML and SSL encryption to provide a secure interface. The online submission of prior authorization will allow a provider to complete the prior authorization form via a fillable form online and send it directly to the pharmacy PA help desk via an email account for review by the PA contractor. The prescribing physician and the dispensing pharmacy will receive a faxed approval or denial response for documenting purposes. Contractor shall establish a link from its website for online PA submission and make available a link to Medicaid's website. Contractor plans and procedures shall be submitted to Medicaid for approval. Contractor shall establish and maintain an HTML page for data entry of EPA claim. Online html page must maintain fillable form and programming to require certain fields before submission. Online system shall prompt provider to enter required fields before submission will occur. Creating the online fillable version of the form will be the responsibility of the contractor.

Additional Contractor responsibilities regarding prior authorizations include:

1. Make recommendations for prior authorization to Medicaid based on clinical data
2. Make recommendations for and conduct provider education
3. Monitor effectiveness of prior authorization requirements for specified drug; dollars saved and clinical outcome cost savings
4. Identify and monitor areas where cost shifting could occur as a result of a prior authorization requirement
5. Contractor shall maintain a turnaround time not to exceed three seconds on electronic PA claims.

Contractor deliverables include:

1. Make presentations including documentation to Medicaid regarding recommendations for additions/deletions of prior authorization requirements

2. Provide monthly prior authorization report by drug group to include number of requests, approvals, denials; number of requests initiated by pharmacists and physicians; number of requests by fax, phone, mail, electronic and online; percentage of total requests responded to within eight hours of receipt of completed request
3. Provide weekly toll-free phone line usage studies to include number of calls per day, average wait time, average response time, longest wait time, longest response time, number of aborted calls, number of Help Desk personnel for each day
4. Provide monthly reports identifying cost savings associated with prior authorization requirements
5. Provide monthly report of prior authorization appeals to include decisions rendered
6. Contractor shall monitor and report monthly on statistics of online submissions.
7. A monthly report of electronic prior authorization submission totals of EPA implemented drug classes, to include number of denials, total rejected for manual completion, total unique approvals
8. Contractor will provide plans and procedures on development and maintenance of EPA system to Medicaid for approval.

The Alabama Medicaid Agency shall:

1. Ensure that the P&T Committee reviews drugs recommended for PA inclusion by the Contractor. Medicaid shall consider recommendations for additional review categories for approval
2. Supply Contractor with PA number range for assignment of approved PA Requests
3. Review and approve any changes in form letters, report formats and new forms or reports prior to use by Contractor
4. Provide for administrative review by a licensed physician for requests when medical documentation has been submitted and denied after administrative and clinical remedies have been exhausted at Contractor level. Requests for review must be made by the prescribing physician or dispensing pharmacist and be received within sixty days of the date of the adverse decision. Medicaid shall obtain the necessary documentation required from Contractor for the Medicaid physician to determine whether or not Contractor's denial was justified. Medicaid will review samples of prior authorizations approved by Contractor on appeal
5. Provide for administrative hearings. All adverse administrative review decisions made by Medicaid shall be subject to a formal administrative hearing. The prescribing physician, dispensing pharmacist, or recipient may request such a hearing. Requests must be in writing and received by Medicaid within sixty days of the date of the denial and shall be addressed to the Pharmacy Program, Alabama Medicaid Agency, P.O. Box 5624, Montgomery, Alabama 36103-5624. After receipt of a request for a hearing, Medicaid shall notify Contractor of the time, date and place of the hearing
6. Initiate and distribute public notice of drugs requiring prior authorization, to include recipient and provider notices
7. Notify Contractor in writing in advance of any additional prior authorization requirements
8. Review samples of prior authorization requests and determinations made by the Contractor for accuracy and timeliness

3.50.4 Overrides

The primary goal of an override is to encourage appropriate dosing as indicated by the Food and Drug Administration (FDA) and appropriate dispensing. For claims requesting more than recommended by the FDA or requesting to be filled for amounts outside of required Medicaid criteria, an override will be required. Currently Medicaid has the following overrides/hard edits available: Early Refill, Maximum Allowable Cost, Maximum Unit, Brand Limit Switchover and Therapeutic Duplication. These are hard edits that must be overridden/approved by the contractor. Medicaid shall give at least two weeks written notice to Contractor before implementing a new override requirement. Contractor shall utilize drug usage criteria and appropriate medical justification approved by Medicaid to approve/deny Override requests. Medicaid may review contractor's overrides for appropriate accepted medical justification upon request.

3.50.5 Override Requirements

Contractor shall receive requests, hereinafter referred to as Override Requests from pharmacists, or their authorized representative for Medicaid coverage of claims that require an override. Currently, Medicaid has the following edits that require an override: Early Refill, Maximum unit, maximum cost, therapeutic duplication and brand limit switchover. Other requirements may be added by Medicaid at any point in the future. Medicaid shall give at least two weeks written notice to Contractor before implementing a new edit/override requirement.

Contractor shall accept written, electronic, telephone and some verbal requests from either the prescribing physician or the dispensing pharmacist. Written requests may be submitted by mail, fax, or online. Toll free phones shall be provided 24 hours a day, 7 days a week with an automated voice message system to record calls after hours and give on-call contact information. Toll-free FAX lines shall be provided 24 hours a day, seven days a week. A help desk shall be available to providers 8:00 a.m. - 7:00 p.m. Monday through Friday with Saturday coverage from 10:00 a.m. until 2:00 p.m. Contractor will provide a clinical representative on call to accept override and issue override numbers on Sundays, after hours and on help-desk holidays mentioned in Section 3.90.4.

Contractor shall respond to a minimum of 75 percent of total override requests each month within eight hours of receipt of completed request but in no event shall response time exceed 24 hours. Responses to requests must be issued within 24 hours of receipt of the completed request. Upon receipt of an incomplete request, Contractor is to make a good faith effort to obtain missing information. This may be accomplished through system inquiry or by faxing form to provider for completion of required information.

Contractor shall respond to the requesting practitioner by telephone or other telecommunications device with approval/denial within twenty-four hours of receipt of a phoned, faxed, electronic or mailed complete override request. Telephone responses shall be during the normal business hours of the providers. Contractor shall document unsuccessful attempts to respond which occur more than fifteen minutes apart. Attempts made more frequently than these fifteen minute intervals are at Contractor's discretion.

Documentation must include the date, time, method used, and the result of each attempt. Contractor shall respond by mail to a request only when the documentation on the Override Response establishes that three unsuccessful attempts were made no closer than fifteen minutes apart. Contractor shall receive and respond to electronic requests in the NCPDP HIPAA Standard format. Additional responses to electronic requests by telephone, fax and mail are allowed but are not required.

Contractor shall utilize drug usage criteria approved by Medicaid to approve/deny Override requests. Current criteria to be applied to claims requesting an override can be located in the bidder's library on the Medicaid website. Medicaid will provide Contractor with more detailed criteria during implementation phase. Criteria may be added or revised by Medicaid based on clinical review or recommendation of the P&T Committee. Contractor shall ensure that review criteria are applied in a uniform manner to all requests. If contractor staff cannot determine whether to approve or deny a request, it shall be referred to a pharmacist or physician consultant for approval/denial. If Contractor has questions regarding criteria, clarification should be requested from Medicaid.

Additionally, Contractor shall review claim history to check prior therapy information. Contractor shall review the Alabama Drug Reference panels to ensure that the drug being prior authorized is covered by Medicaid and the Alabama Recipient panels to ensure that the recipient is eligible for Medicaid drug coverage at the time of the override request. Requests for ineligible recipients shall be denied. Contractor shall verify that the designated pharmacy is currently enrolled in the Medicaid program. Contractor shall also ensure that the appropriate pharmacy is indicated when the recipient is locked-in to a certain pharmacy. This information is provided through the Recipient Lock-in File.

Contractor shall assign a ten digit numeric number for approved override requests which meet the approval criteria for Medicaid coverage. Contractor shall document the assigned number and supporting documentation on the request form. Contractor shall update Medicaid's on-line override file within twenty-four hours of receipt of request. This applies to updating/transferring data for claims processing to the EDS system with approved prior authorizations and overrides information.

Contractor shall deny override requests that fail to meet Medicaid approved guidelines. Contractor shall notify the prescribing physician and dispensing pharmacy in writing and include the denial reason using codes established by Contractor and approved by Medicaid. This information shall be faxed to the prescribing physician and dispensing pharmacist within twenty-four hours of receipt. Contractor must respond to electronic requests via NCPDP HIPAA Standard format.

Contractor shall establish and maintain a database of override requests. Data shall include, but is not limited to, date and time of receipt, name of recipient, Medicaid number, pharmacy name and provider number, date of override approval or denial, drug name, NDC number, requester, whether medical justification was submitted and prescribing physician license number.

Additional Contractor responsibilities regarding overrides include:

1. Make recommendations for overrides to Medicaid
2. Make recommendations for and conduct provider education
3. Monitor effectiveness of override requirements for specified drug; dollars saved and clinical outcome cost savings
4. Identify and monitor areas where cost shifting could occur as a result of an override requirement

Contractor deliverables include:

1. Make presentations including documentation to Medicaid regarding recommendations for additions/deletions of override requirements
2. Provide monthly override report by drug group to include number of requests, approvals, denials; number of requests initiated by pharmacists and physicians; number of requests by fax, phone, mail, electronic and online; percentage of total requests responded to within 8 hours of receipt of completed request
3. Provide weekly toll-free phone line usage studies to include number of calls per day, average wait time, average response time, longest wait time, longest response time, number of aborted calls, number of Help Desk personnel for each day
4. Provide monthly reports identifying cost savings associated with override requirements

The Alabama Medicaid Agency shall:

1. Medicaid shall consider recommendations for additional review categories for approval
2. Review and approve any changes in form letters, report formats and new forms or reports prior to use by Contractor
3. Provide for administrative review by a licensed physician for requests when medical documentation has been submitted and denied after administrative remedies have been exhausted at Contractor level. Requests for review must be made by the prescribing physician or dispensing pharmacist and be received within sixty days of the date of the adverse decision. Medicaid shall obtain the necessary documentation required from Contractor for the Medicaid physician to determine whether or not Contractor's denial was justified. Medicaid will review samples of prior authorizations, overrides and appeals approved by Contractor.
4. Provide for administrative hearings. All adverse administrative review decisions made by Medicaid shall be subject to a formal administrative hearing. The prescribing physician, dispensing pharmacist, or recipient may request such a hearing. Requests must be in writing and received by Medicaid within sixty days of the date of the denial and shall be addressed to the Pharmacy Program, Alabama Medicaid Agency, P.O. Box 5624, Montgomery, Alabama 36103-5624. After receipt of a request for a hearing, Medicaid shall notify Contractor of the time, date and place of the hearing

5. Initiate and distribute public notice of drugs requiring an override, to include recipient and provider notices
6. Notify Contractor in writing in advance of any additional override requirements
7. Review samples of override requests and determinations made by the Contractor for accuracy and timeliness

3.50.6 Clinical Appeal

Providers may request to appeal a PA denial or Override denial and supply additional medical justification for consideration to the contractor. Upon receipt of an appeal, Contractor's consulting physician shall review the documentation and render a decision based on Medicaid approved PA or Override criteria or medical justification within one business day of receipt of complete appeal request. If Contractor's physician denies the appeal, the request and supporting documentation and Contractor's physician's notes are to be sent to Medicaid for review and final determination within one business day of receipt of complete appeal request. Medicaid will review the documentation and will send written notification to Contractor of final appeal decision within one Medicaid business day of receipt of appeal request from Contractor. Contractor is responsible for notifying the requesting provider of the outcome within four hours of receipt of response from Medicaid. If Contractor's physician approves the appeal, the requesting provider is to be notified within four hours. Contractor shall also be responsible for receiving appeals related to the Early Periodic Screening Diagnostic Treatment (EPSDT) screenings. Providers may request to appeal a denial for a noncovered product when the drug has been shown to be medically necessary through the clinical appeal process using an EPSDT referral form and additional peer reviewed literature.

Contractor deliverables include:

1. Contractor shall send any denied clinical appeal claims to the agency for review
2. Contractor shall submit a monthly report of all Clinical Appeals.

3.60.0 Administrative Duties

Contractor shall maintain and staff a Help Desk as specified in Section 3.90.0. Contractor Help Desk staff shall answer inquiries, written, electronic and telephonic, from providers and Medicaid. Help desk hours of operation are 8:00 a.m. through 7:00 p.m. Central Time, Monday through Friday, and 10:00 a.m. - 2:00 p.m. Saturday. Contractor holidays are Easter, Independence Day, Thanksgiving, Christmas, and New Year. Contractor shall provide a clinical representative on call on Sundays, holidays and after hours, to respond to prior authorization and override requests within the federally mandated 24 hour response period. Help Desk Staff must be capable of reviewing requests and making a determination based on medical criteria within a 24 hour time frame. All staff mentioned in this ITB must be approved by Medicaid. Contractor is responsible for 24 hour response to all requests regardless of holidays and weekends.

Contractor shall utilize clerical and administrative personnel, licensed pharmacists, pharmacy technicians, nurses, and physicians to perform the duties outlined in this ITB. Contractor shall ensure that staff is trained in current Alabama Medicaid policy relevant to drug prior authorization activity, contract requirements, telephone etiquette, and professional conduct. Contractor shall respond in writing, with identity of responding staff person, to written provider inquiries within one working day of the date of receipt. Date and time of receipt shall be stamped on all correspondence and requests. Contractor shall retain copies of written inquiries and responses and make such correspondence available to Medicaid upon request. All form letters must be approved by Medicaid prior to use.

Contractor shall draft and distribute a quarterly newsletter to all enrolled pharmacists and physicians and a small number of Medicaid staff and association leaders. The newsletter should consist of a minimum of six pages and may be duplexed. It is estimated that approximately 9,000 newsletters are currently generated and mailed each quarter. This number is subject to change based on provider enrollment fluctuations. The content of the newsletter should reflect pharmacy program updates, trends, prior authorization and override information, etc. It is to be drafted by Contractor for Medicaid approval. Electronic versions of the newsletter are to be posted on Contractor's web-site and made available to Medicaid for posting to the Medicaid web-site.

Monthly meetings will be held for Medicaid and Contractor staff to address such items as status of assigned projects, performance issues, report reviews, compliance with contract requirements, and any Medicaid or Contractor concerns as they relate to this ITB. Weekly conference calls will be held for Medicaid and Contractor to address such items as status of assigned projects, performance issues, report reviews, compliance with contract requirements, and any Medicaid or Contractor concerns as they relate to this ITB. A toll-free conferencing number shall be provided by Contractor for these weekly meetings. Additional meetings may be requested and scheduled to address specific issues such as proposed contract amendments, appropriate application of prior authorization criteria, and the change or addition of contract requirements.

Contractor deliverables include:

1. Quarterly newsletter to be drafted and mailed to all enrolled pharmacists and physicians

Alabama Medicaid shall:

1. Review and approve quarterly newsletters
2. Provide Contractor with provider mailing tapes

3.60.0 Operational Requirements

Contractor shall have installed and provide for maintenance of a minimum of a dedicated 512 kbps communication line from Medicaid's fiscal agent to the Contractor's facility. Contractor shall be responsible for all cabling within their facilities. In addition, Contractor shall be financially responsible for a CSU/DSU and IP router that will be required at each end of the line. Contractor shall be required to have workstations and adapter cards to support TCP/IP protocol. Contractor shall have IE 6.0 and TCP/IP stack for each work-station accessing the Medicaid fiscal agent network.

Contractor shall purchase or develop and install the software necessary to receive and reply to drug prior authorization and override requests in the NCPDP HIPAA Standard Format.

Contractor shall be responsible for maintaining a minimum of twenty toll-free lines for direct access by callers for telephone inquiry and a minimum of eight dedicated FAX lines for written provider inquiries. A telephone message shall be provided for physicians and pharmacists to leave messages. It must also notify callers during off-hours of the established business hours along with the number for on-call staff.

AMMIS System passwords will be made available by Medicaid's fiscal agent prior to implementation for Contractor employees. Passwords are not to be shared among employees. Additional passwords for contractor are to be requested via the contract administrator.

Medicaid implemented a new AMMIS (interChange) on February 25, 2008 which may require a higher level of operational requirements. The system is a web based system. Medicaid will provide more information on this before implementation of contract.

Contractor responsibilities include:

1. Submission of requests for employee passwords for the AMMIS Interchange system to Medicaid
2. Notifying Medicaid when an issued password is no longer needed due to termination of employment or change in duties
3. Ensuring that its employees are informed of importance of system security and confidentiality
4. Documenting and notifying Medicaid of system problems to include type of problem, action(s) taken by Contractor to resolve problem and length of system down-time
5. Coordinate with Fiscal Agent and take action as necessary to ensure all aspects of the contract are carried out timely and appropriately. All coordination with fiscal agent shall include a courtesy copy to Medicaid

Alabama Medicaid shall:

1. Obtain security passwords from the Fiscal Agent upon Contractor request
2. Serve as liaison between Contractor and Fiscal Agent

3.70.0 Retrospective Drug Utilization Review (DUR)

Contractor will be responsible for performing retrospective DUR functions as outlined in 42 CFR 456.709. See bidder's library on the Medicaid website for code of federal regulations (CFR) requirements. Paid claims data will be used to develop reports which identify patterns of fraud, abuse, gross overuse, or inappropriate medically unnecessary care among physicians, pharmacists, and Medicaid recipients, associated with specific drugs or groups of drugs. This examination must involve pattern analysis using predetermined standards of physician prescribing practices, drug use by individual patients, and where appropriate, dispensing pharmacies. Retrospective DUR includes, but is not limited to, using predetermined standards to monitor the following: therapeutic appropriateness, over-utilization and under-utilization, appropriate use of generic products, therapeutic duplication, drug-disease contraindications, drug/drug interaction, incorrect drug dosage, incorrect duration of drug treatment, and clinical abuse and misuse.

Contractor will be responsible for the development and distribution of DUR Board meeting agendas and meeting packets. Contractor pharmacist will present appropriate materials to the DUR Board at quarterly meetings. Contractor will also be responsible for drafting and finalizing minutes of the DUR Board meetings to include discussions held, and motions and recommendations made.

Contractor responsibilities shall include:

1. Coordinating with Medicaid provider education activities
2. Marketing of the Medicaid PDL and instructing in its usage
3. Generating provider specific prescribing data of Medicaid's top 200 prescribing physicians and top 200 dispensing pharmacists on a quarterly basis to Medicaid
4. Generating and distributing educational letters on specific intervention criteria as directed by the DUR Board and Medicaid. A minimum of 300 recipients are to be targeted each quarter and all involved providers for each recipient must be contacted for intervention. Letters shall be reviewed by a licensed pharmacist and should offer the provider an opportunity for feedback. Any such feedback should be summarized and provided to Medicaid and the DUR Board
5. Referring provider concerns regarding inappropriate prescribing and dispensing patterns to Medicaid
6. Maintain a database to support retrospective DUR
7. Develop, in conjunction with the DUR Board, therapeutically based criteria by which patient specific profiles, physician and pharmacy profiles will be generated

8. Input into the retrospective DUR database the therapeutic criteria, approved by the DUR Board, within four weeks of DUR Board and Medicaid approval to ensure that the most current criteria have been used to generate profiles.
9. Provide within seven business days, upon request of Medicaid, a hard copy listing of all DUR criteria in computer system
10. Develop and monitor the retrospective DUR program according to Federal guidelines to ensure compliance
11. Annually review current criteria for recommended DUR Board revision and approval
12. Provide ongoing evaluation of appropriateness of dispensing and prescribing patterns for DUR Board review
13. Compile analysis from DUR annually to meet CMS requirements for annual DUR reporting. Prepare and submit to Medicaid for approval the CMS DUR Report a minimum of four weeks prior to CMS due date
14. Provide professional guidance on DUR issues upon request
15. Develop and distribute Medicaid approved DUR Board agenda and meeting packets to include ballots to board members for DUR Board meetings. Packets must be received by DUR Board members a minimum of two weeks prior to scheduled meetings. Eight copies of the finalized packets should be sent to Medicaid Contract Administrator two weeks prior to meeting.
16. Act as the recording secretary of all DUR Board meetings and provide formal record of DUR Board meeting in the form of minutes to be approved by Medicaid. Proposed draft of minutes shall be provided to Medicaid within two weeks of DUR Board meetings. Once approved by Medicaid, the finalized version shall be provided to Medicaid within one week for posting to the web.
17. Notify members of DUR Board of meetings in coordination with Medicaid
18. Send written notification to DUR members whose terms are expiring.
19. Send written notification to new members selected for the DUR Board.
20. Maintain a listing of committee members and send an electronic version to Medicaid annually or upon update to include contact information.
21. Maintain an operational procedures manual for DUR Board to include meeting policies, election of officers, conflict of interest policy, etc.
22. Conduct a meeting with all new members prior to first meeting to provide an orientation to the committee. These meetings are to be conducted with a designated staff member from Medicaid.
23. Make recommendations to Medicaid regarding operational policy and procedures for the DUR and pharmacy program policy and procedures as they relate to the scope of work of this ITB. Contractor is expected to utilize its expertise in the scope of this ITB to identify procedures that may improve current Medicaid policy.

Contractor deliverables include:

1. Quarterly report of providers targeted through retro DUR initiatives to include the total number of letters sent, number of recipients and providers targeted, DUR criteria used for interventions, and summary of feedback received
2. Quarterly report of PDL usage to monitor effectiveness of program and program dollars saved as a result of PDL usage

3. Quarterly report consisting of, at a minimum, tabulation by percent of generic, single source and multi-source prescriptions by dollars, claim count, unduplicated count of recipients and number of prescribing physicians
4. Annual CMS DUR Report for Medicaid approval as specified in 42 CFR 456.712
5. Formal minutes of DUR Board meetings
6. Finalized DUR Board meeting agendas, ballots and meeting packets
7. Formal internal timeline of each quarterly DUR meeting action items to be pre-approved by Medicaid

The Alabama Medicaid Agency shall:

1. Approve retro DUR educational activities of Contractor
2. Provide Contractor with a current Medicaid Preferred Drug List and notify timely of updates
3. Provide clinical data for the P&T Committee to review regarding drugs for preferred status
4. Schedule P&T Committee and DUR Board meetings
5. Submit DUR Annual Report to CMS
6. Review and approve DUR Board meeting agendas and packets and annual reports
7. Review and approve DUR Board meeting minutes and notify Contractor of recommendation decisions
8. Maintain responsibility for nominations and approval of DUR Board member positions
9. Notify Contractor of any changes in DUR Board membership in a timely manner
10. Provide Contractor with monthly eligibility and claims tapes

3.80.00 Academic Detailing

Contractor shall provide, at a minimum, seven full time equivalent (FTE) provider representatives dedicated to Medicaid to educate providers on appropriate and cost-effective utilization of medications, Pharmacy ALERTS and other Medicaid-approved topics through academic detailing. Provider representatives must possess, at a minimum, an undergraduate degree and excellent communication and organizational skills. They must be capable of developing an in-depth understanding of Medicaid prescribing patterns and working closely with Medicaid staff to educate providers on appropriate prescribing and dispensing patterns. They must live and work in designated regions throughout the state in order to be able to quickly and efficiently respond to requests for academic detailing visits. The Contractor shall provide each representative with the following: laptop PC; color copier/scanner/printer with paper; ink and other supplies; and document shredder to be located at home site of each representative. Contractor shall also furnish internet connection/service; hand-held PDA device capable of ePocrates, InfoSolutions, TFQ, etc demonstration; dependable, late modeled vehicle equipped with GPS for location tracking; and access to detailed scheduling database. In addition, the Contractor shall also provide for two schedulers to schedule the visits for the provider

representatives. Contractor must also provide for one manager to supervise provider representatives.

Contractor must conduct a minimum of 1,800 interventions/visits to targeted providers per quarter. Interventions/Visits are to be completed by well-trained provider representatives and must meet the following minimum requirements:

- Must be pre-scheduled. No cold-calls are permitted
- Must include a face-to-face meeting with the physician, prescribing nurse/physician assistant, or pharmacy
- The makeup of the 1800 visits should be approximately 1000 prescribers and 800 pharmacy providers each quarter
- An intervention contact form must be completed by provider representative
- Provider representative should supply PDL Reference Tool, and any recent Pharmacy Alerts or Notices to provider at intervention/visit

Contractor must conduct a minimum of one education program/seminar for providers per quarter. Contractor is to make application for Continuing Education units for participating providers. Each seminar must have a clinical aspect with 2.0 continuing education hours approved separately by the Boards of Pharmacy, Social Workers and Nursing for CE credit and by the Board of Medicine for CME credit. Continuing Education units must be acceptable for pharmacists, pharmacy technicians, nurses, and clinical social workers. A minimum of 100 physicians and 100 pharmacists within the region of the CE seminar are to be invited to each seminar. A Medicaid Agency representative, the account pharmacist, and the regional academic detailer(s) shall be present at all seminars. Such programs are to be held at locations throughout the state and at times that will encourage attendance and a meal is to be offered for lunch and dinner time programs. Encounters at seminars are not to be applied to the requirement for 1,800 provider interventions/visits per quarter. Contractor is responsible for brochure promoting each seminar to be sent out at minimum one month prior to seminar. Contractor shall make available to speaker an honorarium amount per presentation approved by Medicaid. Contractor shall cover all expenses for seminars and shall pay all expenses incurred by Agency staff in attendance at seminar (if overnight stay is warranted).

Academic detailers of that region of the state shall attend any Medicaid-related meetings or initiatives, including but not limited to outreach programs such as Town Hall meetings, district pharmacy association meetings, etc. These outreach meetings shall not count toward the 1800 visits per quarter.

Contractor shall provide quarterly meetings/trainings for provider representatives and Medicaid staff and others as requested by Medicaid. Contractor will be responsible for developing and recommending educational materials to promote appropriate utilization of drugs and use of the PDL and shall incorporate, telephone interventions, targeted mailings, and quarterly newsletters. Emphasis shall be placed on appropriate generic and OTC utilization. Educational materials shall include:

- Current and appropriate Medicaid Alerts,
- Prior Authorization forms and Override forms and instructions for the proper use of each,
- On an as needed basis – Maximum Unit list, PDL (in color), PDL reference tools, cough and cold list, OTC list and Nutritional list, and current newsletters.
- ePocrates information – information on how to obtain and use such information on a Palm PDA, and
- Any other documents that Medicaid requests to be provided during Academic Detailing visits.

Physician provider summary reports shall be utilized to compare individual physicians to peers in their specialty, geographic area, and state-wide. The reports shall utilize graphics and charts as well as verbiage to provide the following information:

- Overall Utilization Rate – generic, preferred brand, and non-preferred brand,
- Prior Authorization Analysis – count per MD, approval and denial percentage rates,
- Recipients and Claims – recipients per MD per month, claims per MD per month, and claims per recipient per month,
- Data in chart format regarding Claims for Providers - top drugs prescribed, top most costly drugs, top denial classes, and top denial reasons,
- Total amount of Medicaid dollars spent as a result of their prescribing, and
- Suggestions on how they could assist in saving Medicaid dollars while maintaining quality of care by more aggressively utilizing the PDL.

Pharmacy provider summary reports shall be utilized to compare individual pharmacies to peers state-wide. The reports shall utilize graphics and charts as well as verbiage to provide the following information:

- Prior Authorization Analysis – count per pharmacy (store), approval and denial percentage rates,
- Overall Utilization Rate – generic, preferred brand, and non-preferred brand,
- Recipients and Claims – recipients per pharmacy (store) per month, claims per pharmacy (store) per month, and claims per recipient per month,
- Early Refill Analysis,
- DAW-1 Analysis,
- Pharmacy Originated PA Requests as a percentage of total manually processed requests for the pharmacy (store), and

PAs processed by electronic versus manual requests as a percentage of total PAs originated by the pharmacy (store).

For an example of current pharmacy provider summary report, please see the bidder's library located on the Medicaid website.

Contractor shall host quarterly meetings for all detailing staff, interested Medicaid staff and others as requested by Medicaid. Such meetings will last at least one-half day with lunch provided by the contractor to all attendees.

Contractor shall provide the following evaluations and reports to Medicaid quarterly and annually:

- Total visits made and total visits attempted but not completed (detailer is not allowed to see the prescriber or pharmacy representative)
- Visits made and visits attempted but not completed to prescribers or pharmacies (stores) with high PA denial rates
- List of Providers that are unresponsive to visit requests, including providers with high denial rates and other requested by Medicaid and documentation of attempts to perform visits
- Visit summary report by
 - Specialist
 - Geographical area
 - City
 - Title of entity visited – MD, DO, Nurse Practitioner, Physician Assistant, Nursing Home, and Pharmacy Store)
- Visit detail report by provider
- Specialist Survey Response Report
- Provider Survey Response Report
- Provider Survey Response Comment Report
- Seminar evaluation results and attendance by title of attendee

Detailing Effectiveness Report – statistically valid analysis of PA denial rates pre and post visit for prescribers and pharmacies (based only on PAs initiated by the pharmacy) with comparisons against state averages.

Contractor responsibilities include:

1. Conducting a minimum of 1,800 academic detailing interventions/visits per quarter
2. Supplying necessary staff outlined in this section
3. Completing an intervention summary report of all provider contacts
4. Conducting a minimum of one education program/seminar for providers per quarter.
5. Make recommendations to Medicaid for improvements to the academic detailing initiative
6. Develop an intervention contact form for Medicaid approval to be used by provider representatives to record interventions/visits
7. Identify providers to be targeted for intervention based on Medicaid approved criteria
8. Make available completed intervention contact forms for Medicaid review upon request
9. Make recommendations to Medicaid for program/seminar presentation topics and develop program materials

Contractor Deliverables include:

1. Quarterly reports separated by provider representative of academic detailing interventions/visits conducted to include name of provider, location of provider, title of individual(s) involved in intervention/visit, and date of intervention/visit
2. Annual summary reports of total number of interventions/visits and programs conducted by Contractor and any cost savings accredited to interventions
3. Quarterly reports of academic detailing seminars/programs conducted to include number of physicians and pharmacists in attendance, total number invited, location and date of programs, names of speakers and topic of presentations
4. Supply provider representatives with color copies of the Medicaid Preferred Drug Quicklists and Medicaid notices for interventions/visits

Alabama Medicaid shall:

1. Work with Contractor to identify providers for intervention
2. Review and approve education materials to be used by provider representatives
3. Provide Contractor with quarterly updates to Preferred Drug List and Quicklists
4. Conduct periodic follow-up with targeted providers to verify program requirements are being met
5. Approve presentation topics for quarterly programs/seminars
6. Coordinate all education activities with the Medicaid Outreach and Education Director

3.90.0 Drug Interface

The following section details Contractor responsibilities for On-Line Inquiry, Reporting Requirements and Data Entry.

3.90.1 On-Line Inquiry

Contractor will be responsible for having direct interfacing capabilities with Medicaid and the Medicaid fiscal agent for on-line access. Contractor shall utilize for eligibility verification, prior authorizations and prospective DUR overrides, the following AMMIS on-line files:

- a. Prior Authorization File
- b. Drug Pricing File
- c. Recipient Lock-in File
- d. Physician License File
- e. Provider File
- e. Recipient Eligibility File

These files are currently maintained by Medicaid's fiscal agent and access will be allowed for inquiry and updating purposed only as required by this ITB using existing Interchange web portal software. Contractor will not be subject to transaction user fees, but will be responsible for the telecommunication charges. Contractor is responsible for

supplying a software license for adequate or comparable hardware to support the scope of work. Phone lines shall have the capacity for a supervisor to routinely monitor calls, record calls, and to monitor incoming and outgoing calls.

3.90.2 Reporting Requirements

Contractor shall produce and submit to the Medicaid Pharmacy Program, in formats approved by Medicaid, monthly reports as described below. Unless otherwise stated, reports should be delivered to Medicaid by the tenth of each month. Management reports shall be provided in hard copy and electronic version on CD (Word 6.0 or higher format) to Medicaid.

Contractor deliverables include:

1. Prior authorization and Override activity by drug, including, but not limited to, the number of denied and approved requests by drug classification, number of appeals referred to consulting physician, number of requests received by fax, mail, electronic or telephone, number of requests by source such as pharmacy or physician, and number of requests received daily. Contractor shall submit a monthly ranking report of the 25 physicians submitting the most PA Requests and Override Requests. Contractor shall produce statistical reports as reasonably requested and approved by Medicaid
2. Prospective DUR override activity, including but not limited to, the number of requests for each edit, number of denied, approved, as well as the top 50 pharmacists requesting overrides
3. Weekly Toll free phone line usage studies performed to determine the capability of all lines and potential need for additional lines. Results of these studies shall be provided to Medicaid's Contract Administrator
4. Top 30 non-preferred drugs (single source brand) by dollar and claims
5. Top 30 non-preferred drugs (multi-source brand and generic) by dollar and claims
6. Physician analysis report (Top 200 prescribers) by dollar and claims
7. Top 200 pharmacies report by dollar and claims
8. Claims analysis by major therapeutic class

Contractor is also responsible for other reports required in all sections of this ITB.

3.90.3 Data Entry

Contractor shall perform on-line updates using CICS transactions to Medicaid's Prior Authorization Panel for use by the claims processing system to edit drug claims requiring a PA number. Contractor shall key the following data fields for updating:

- a. 13-digit Medicaid number
- b. 10 digit pharmacy NPI number
- c. 9-digit pharmacy provider license number
- d. Date and length of approval
- e. 11-digit National Drug Code (NDC number)
- f. 10-character prior authorization number

g. Authorized number of units

Contractor will have access to panels needed to perform duties in Interchange system after clearing network security and entering appropriate password.

Medicaid will work with Fiscal Agent to provide training to Contractor staff on the use of system panels and fields during implementation phase and prior to contract begin date.

3.90.4 Help Desk

Contractor shall provide the services of a toll free help desk for Alabama Medicaid physicians and pharmacy providers. The Contractor operated help desk shall be physically located in Alabama within a 100 mile radius of the Medicaid Montgomery Central Office and function as the first resort for providers inquiring into matters of drug prior authorization, prospective DUR overrides and MAC pricing. Help Desk staff shall consist of pharmacists, nurses, pharmacy technicians, physician and/or data entry staff. Help Desk reviewers shall consist of certified pharmacy technician reviewers, nurses, and/or pharmacists. Contractor shall conduct weekly training meetings with pharmacy technician reviewers and data entry personnel for educational purposes, discussion of audits, quality control and feedback. Contractor shall keep record of these meetings and provide to agency staff as requested. Contractor shall provide a minimum of twenty dedicated toll free phone lines for instate calls and bordering states and eight dedicated toll-free FAX lines to Medicaid providers for the requirements listed below. These are the minimum requirements of this ITB. Please refer to Attachment H for the number of phone and FAX lines utilized in the current contract. Average weekly wait time for Help Desk calls is not to exceed twenty seconds. Consideration will be given for circumstances outside of Contractor's control such as system failure or natural disaster. Medicaid will monitor this requirement through the weekly toll-free phone line studies. If as a result of weekly toll-free phone line studies, additional lines and staff are necessary, the costs associated with additional lines and staff shall be considered extra contractual services to Medicaid. Medicaid shall have approval for additional lines and staffing to include number of lines and qualifications of additional staff. Extra contractual services will only be considered if Medicaid has imposed one of the following policy changes that have resulted in the increased workload:

1. Prospective DUR overrides: Overrides are necessary for excessive quantities and early refills. Early refills are defined as prescriptions with greater than 25% of the prescription remaining (see Section 3.10.0).
2. Prior authorization requests (see Section 3.50.0)
3. Substantial system changes by Medicaid or the Fiscal Agent

Contractor responsibilities regarding a help desk include:

1. Staff help desk with appropriate personnel capable of responding to programmatic questions and prior authorization requests within 24 hours. Help desk staff must be trained to recognize basic medical terminology as it relates to their duties. Help Desk

Staff shall demonstrate the professionalism, patience, and respect while coordinating with providers, recipients, Agency staff, etc.

2. Provide a licensed pharmacist and licensed physician for consultation and review of prospective DUR and prior authorization requests
3. Provide toll-free FAX lines and toll free phones to be available to providers and Medicaid staff 24 hours a day, seven days a week
4. Staff toll-free phones from 8:00 a.m. - 7:00 p.m. Monday - Friday with an automated voice message system to record calls after 7:00 p.m. Phones shall be staffed from 10:00 a.m. - 2:00 p.m. Saturdays. Sundays, help desk holidays and after hours, a clinical representative must be available to respond to requests to comply with the twenty-four hour prior authorization response requirement
5. Maintain average weekly call wait times of 20 seconds or less for Help Desk phone lines

Contractor deliverables include:

1. Weekly toll-free phone and fax line usage study to Medicaid
2. Monthly summary report of number of calls by call type, to include referrals

The Alabama Medicaid Agency shall:

1. Communicate to the Contractor help desk any changes in State policy regarding prior authorization, prospective DUR overrides, MAC pricing
2. Develop policy protocol to be utilized by the Contractor's help desk concerning prospective DUR overrides, prior authorization requests
3. Monitor toll-free phone line usage studies and Help Desk reports

3.91.0 Key Personnel

3.91.1 Project Manager

Contractor shall assign a Project Manager with a minimum of an Undergraduate Degree to the Alabama Medicaid Agency contract. The Project Manager shall be the person assigned under this contract, who is responsible for operation of contract duties including the PA review process, MAC pricing, help desk functions, Prospective and Retrospective DUR, Academic Detailing and correspondence. Contractor shall make good faith effort to use the Project Manager for not less than 12 months to ensure successful contract performance. Contractor shall notify Medicaid in writing of any proposed change in Project Manager at least 30 days prior to the change, if possible. Contractor shall furnish with its response to the ITB a resume for the proposed Project Manager which shall include the individual's name, current address, current title and position, experience with Contractor, experience in implementing or performing prior authorization functions, experience with provider relations, experience with drug utilization review, relevant education and training, and management experience. Three work references shall also be included.

Contractor's Project Manager shall serve as liaison and shall be available and responsible, as the need arises, for consultation and assistance with Medicaid personnel; he/she shall attend, upon request, Medicaid meetings, administrative hearings, meetings and hearings of Legislative Committees and interested governmental bodies, agencies, and officers; and he/she shall provide timely and informed responses when operational and administrative issues arise in administration of the Alabama Medicaid Program. Whenever the Project Manager is not reasonably available, Contractor shall provide a designated alternate fully capable of meeting the requirements of this section.

Additional responsibilities of the Project Manager include but are not limited to:

- Research the need for and implementation of special projects that would benefit management of the pharmacy program
- Assure timely compliance with all contract responsibilities and deliverables
- Attend DUR Board meetings as a contractor representative
- Serve as liaison between Contractor and Medicaid for matters involving contract requirements
- Attend monthly contract status meetings with Medicaid
- Notify Medicaid's Contract Administrator of any proposed changes in personnel; organizational changes; any system problems; etc.
- Attend Medicaid meetings upon request

3.91.2 Account Pharmacist

Contractor shall also assign an FTE account pharmacist to work with the program. The account pharmacist assigned to work with Alabama Medicaid must possess superior clinical competence, demonstrate proficiency in drug therapy management, hold a minimum of a Doctor of Pharmacy degree, must be licensed in the State of Alabama, and must be in good standing with the Alabama Board of Pharmacy. Contractor shall furnish with its response to the ITB a CV or resume for the proposed account pharmacist which shall include the individual's name, current address, current title and position, experience with Contractor, experience in implementing or performing prior authorization functions, experience with provider relations, experience with drug utilization review, relevant education and training, and management experience. Three work references shall also be included. The account pharmacist shall be the person assigned under this contract, who is responsible for clinical functions, contract duties including the PA review process, MAC pricing, Preferred Drug List Management, help desk functions, Prospective and Retrospective DUR and correspondence. Contractor shall make good faith effort to use the account pharmacist for not less than twelve months to ensure successful contract performance. The account pharmacist will be responsible for (at minimum) biweekly quality assurance checks and report findings during monthly meetings. Contractor shall notify Medicaid in writing of any proposed change in account pharmacist at least 30 days prior to the change, if possible.

Whenever account pharmacist is not reasonably available, Contractor shall provide a designated alternate fully capable of meeting the requirements of this section.

Responsibilities of the account pharmacist will include, but are not limited to:

- Conduct clinical research and development, with the DUR Board, of the therapeutically based criteria by which patient and provider profiles for the program will be generated
- Provide clinical support and administrative oversight to the Help Desk
- Coordinate review of prior authorization and override appeal requests with account physician
- Coordinate DUR Board meetings to update therapeutic criteria, provider education and interventions for retrospective and prospective DUR
- Perform drug utilization reviews. A drug utilization review shall be performed by an analysis of claims paid and/or denied to providers on behalf of Medicaid recipients
- Conduct research relating to drug therapy and advising providers of the significance of information obtained from the DUR program
- Provide recommendations on additional areas of improvement and/or disease management
- Attend DUR Board meetings and P&T meetings
- Attend monthly contract status meetings with Medicaid
- Attend Medicaid meetings upon request
- Attend and participate in quarterly programs/seminars required through the academic detailing component upon request
- Coordinate, oversee and present DUR Board meeting materials at such meetings

3.91.3 Staff Pharmacist

Contractor shall also assign a FTE staff pharmacist to work with the program. The staff pharmacist assigned to work with Alabama Medicaid must possess superior clinical competence, demonstrate proficiency in drug therapy management, have at minimum two years experience in outpatient/community pharmacy, must be licensed in the State of Alabama and hold a current preceptor license, and must be in good standing with the Alabama Board of Pharmacy.

Upon award of the contract, the Contractor shall furnish a CV/resume for the proposed staff pharmacist which shall include the individual's name, current address, current title and position, experience with Contractor, experience as it relates to the duties described in this ITB, and relevant education and training. Three work references shall also be included. Before beginning work for the contract, the staff pharmacist will interview with the Director of Pharmacy program and any additional Agency staff necessary, and must be pre-approved by Medicaid. Contractor shall, in its bid response, demonstrate an understanding of this section's requirements.

Contractor shall make a good faith effort to use the staff pharmacist for the entire length of the contract to ensure successful contract performance. Contractor shall notify Medicaid in writing of any proposed change in staff pharmacist at least 30 days prior to the change, if possible. Any replacements made will be subject to Medicaid approval.

The staff pharmacist will work at the Medicaid office in Montgomery, AL on a full-time basis; work schedule will be at the discretion of the Alabama Medicaid Agency Director of Pharmacy to best serve the Agency. The majority of his/her time will be spent providing clinical support to Medicaid's Pharmacy Program staff. He/she will report to the Pharmacy Program Director for work assignments and scheduling requests.

It will be at Contractor's discretion as to work requirements for this individual on State holidays that are not Contractor holidays since the Medicaid office will be closed. The staff pharmacist will be required to attend various off-site meetings; at the time of the writing of this ITB it is common to have the staff pharmacist to attend pharmacy associations' yearly conferences (1-2 in/out of state meeting(s)/year), the Annual Drug Utilization Review meeting (1 out of state meeting/year), the quarterly academic detailing CEs (4 in-state meetings/year), and the quarterly academic detailing in-house meeting (4 meetings/year to be held at a location determined by the Contractor). The Contractor will be responsible for the staff pharmacist travel costs.

Medicaid will not be responsible for costs that result from staff pharmacist's work on other Contractor projects outside of this ITB such as costs for long-distance telephone calls; postage and copying/printing.

Medicaid will provide a suitable work-station for this individual at the Medicaid office to include a desktop computer. Reference materials and software needed to perform the responsibilities outlined below will be at the cost of Contractor unless already maintained by Medicaid such as Redbook, AHFS, Interchange, DSS (Decision Support System), and PDR (Physician Desk Reference). The staff pharmacist's current membership with the appropriate state/national pharmacy association(s) is required. The use of personal notebook computer, personal digital assistant (PDA), etc, (to be supplied by Contractor) is required; the Contractor shall supply the staff pharmacist with any additional technology/membership(s) to support the pharmacist to ensure successful contract performance. Prior to beginning at the Medicaid Agency, the staff pharmacist shall be experienced in Microsoft Office 2007. Staff pharmacist shall be available to begin work at the Agency no later than September 1, 2008.

Responsibilities of the staff pharmacist include, but are not limited to:

- Provide recommendations on additional areas of program improvement such as disease management, DUR interventions, etc.
- Attend and participate in DUR Board meetings and P&T Committee meetings

- Coordinate and manage Comprehensive NeuroScience (CNS) contract to include collection of data, review of physician feedback, and resolution of outcomes
- Assist PDL coordinator by review and revision of drug lists for P&T meetings, review of clinical packet for meetings, and coordination of appropriate lists once clinical review is complete
- Attend weekly teleconferences and any additional meetings between Medicaid and Clinical Contractor
- Must hold a current preceptor license in the state of Alabama. Accept pharmacy students from one or more school(s) of pharmacy in the state of Alabama. Coordinate and oversee all student activities, prepare and grade assignments in accordance with School of Pharmacy guidelines, and ensure student receives well-rounded rotation that reflects all aspects of Medicaid pharmacy and current policies
- Conduct product research for weekly drug tape reviews and provide recommendations for coverage and restrictions by applying Medicaid guidelines
- Conduct clinical reviews on drug classes and/or individual products upon Medicaid's request
- Organize and conduct quarterly Pharmacy Advisory Board Meetings in order to provide an open forum between pharmacy associations, pharmacists and Medicaid with the intent to address current issues in pharmacy and new policies established by Medicaid
- Attend and participate in Medicaid related meetings upon request
- Provide clinical support to Medicaid's Pharmacy Program
- Provide clinical support to Medicaid's Medical Director and Associate Medical Director
- Review, maintain, and revise internal/external criteria for use in the prior authorization process, and coordinate any updates/changes with pertinent personnel
- Make recommendations and maintain maximum units list for providers
- Review, maintain, and revise information for classes pertaining to electronic prior authorization
- Attend weekly teleconferences and monthly contract status meetings with Medicaid and Contractor
- Attend quarterly programs/seminars required through the academic detailing component
- Respond to provider/recipient inquiries via written, verbal, or electronic means upon Medicaid's request
- Review and make recommendations as it relates to information regarding the drug reference file, pharmacy billing, etc. for the Agency MMIS system

3.91.4 Staff Certified Pharmacy Technician

Contractor shall also assign a full time equivalent (FTE) certified pharmacy technician to work with the program. The pharmacy technician shall be nationally certified, be registered with the Alabama Board of Pharmacy, possess a minimum of two years experience in outpatient/community pharmacy and must be in good standing with the Alabama Board of Pharmacy.

Upon award of the contract, the Contractor shall furnish a CV/resume for the proposed staff certified pharmacy technician which shall include the individual's name, current address, current title and position, experience with Contractor, experience as it relates to the duties described in this ITB, and relevant education and training. Three work references shall also be included. Before staff certified pharmacy technician begins work for the contract, he/she will interview with the Director of Pharmacy program, and any additional Agency staff necessary, and must be pre-approved by Medicaid. Contractor shall, in its bid response, demonstrate an understanding of this section's requirements.

Contractor shall make a good faith effort to use the staff certified pharmacy technician for the entire length of the contract to ensure successful contract performance. Contractor shall notify Medicaid in writing of any proposed change in staff certified pharmacy technician at least 30 calendar days prior to the change, if possible. Any replacements made will be subject to Medicaid approval.

The staff certified pharmacy technician will work at the Medicaid office in Montgomery, Alabama on a full time basis; work schedule will be at the discretion of the Pharmacy Director to best serve the agency. The majority of his/her time will be spent maintaining the Alabama Medicaid drug file and providing administrative support to the Pharmacy program.

It will be at contractor's discretion as to work requirements for this individual on State holidays that are not Contractor holidays since the Medicaid office will be closed. The technician will be required to maintain certification. The staff certified pharmacy technician's current membership with the appropriate state/national pharmacy association(s) is required. Contractor shall be responsible for technician's travel costs.

Medicaid will provide a suitable work station for this individual at the Medicaid office to include a desktop computer. Reference materials and software needed to perform the responsibilities outlined below will be at the cost of the Contractor unless already maintained by Medicaid. The contractor shall supply the staff pharmacy technician with any additional technology to support the technician to ensure successful contract performance. Prior to beginning at the Medicaid Agency, the staff certified pharmacy technician shall be experienced in Microsoft Office 2007. Staff certified pharmacy technician shall be available to begin work at the Agency no later than September 1, 2008.

Responsibilities of the pharmacy technician include, but are not limited to:

- Monitor the drug pricing file including but not limited to receiving and disseminating weekly drug tape, making updates based on weekly updates, communicating both orally and written with contractors
- Attend weekly teleconferences and any additional meetings between Medicaid and Administrative Services Contractor
- Conduct pricing reviews on individual products
- Attend and participate in Medicaid related meetings upon request
- Maintain updates to cough and cold list and post on the web for providers
- Respond to provider/recipient inquiries via written, verbal, or electronic means
- Monitor ePocrates contract and make ePocrates updates and maintain up to date Medicaid information
- Monitor infoSolutions agreement so that renewals are performed, updates are made, and meetings are conducted.
- Conduct various queries and system testing
- Provide clinical support to the staff pharmacist as needed
- Receive and respond to provider requests
- Represent Pharmacy in weekly coverage and procedures meeting
- Research proposed cost savings as needed
- Review monthly contractor status report
- Additional ad-hoc projects as requested by Medicaid

3.91.5 Consulting Physician

Contractor shall furnish with its response to the ITB a CV/resume for the proposed consulting physician which shall include the individual's name, current address, current title and position, experience with Contractor, experience as it relates to the duties described in this ITB, and relevant education and training. Three work references shall also be included. Consulting physician duties do not constitute a FTE.

Contractor shall make good faith effort to use the consulting physician for not less than 12 months to ensure successful contract performance. Contractor shall notify Medicaid in writing of any proposed change in consulting physician at least 30 days prior to the change, if possible.

Responsibilities of the consulting physician will include, but are not limited to:

- Work with Account Pharmacist to conduct clinical research and development, with the DUR Board, of the therapeutically based criteria by which patient and provider profiles for the program will be generated
- Provide recommendations on additional areas of program improvement such as disease management, DUR interventions, etc.
- Review prior authorization and override appeal requests and make a decision for approval or denial based on Medicaid approved criteria and supporting evidence-based medicine documentation from provider

- Provide clinical support to Help Desk and Account Pharmacist when needed
- Meet with Medicaid staff upon request
- Attend quarterly programs/seminars required through the academic detailing component

3.91.6 Help Desk Supervisor

Contractor shall supply a Help Desk Supervisor. Upon award of the Contract, a resume/CV shall be submitted which shall include the individual's name, current address, current title and position, experience with Contractor, experience as it relates to the duties described in this ITB, and relevant education and training, and must be pre-approved by Medicaid. Three work references shall also be included. The Help Desk Supervisor shall be a certified pharmacy technician, nurse, pharmacist, or physician.

Contractor shall make good faith effort to use the Help Desk Supervisor for not less than twelve months to ensure successful contract performance. Contractor shall notify Medicaid in writing of any proposed change in Help Desk Supervisor at least thirty days prior to the change, if possible.

Responsibilities of the Help Desk Supervisor will include, but are not limited to:

- Oversee the Help Desk to ensure criteria is followed appropriately and help desk staff are responding timely and professionally to providers and recipients
- Provide clinical support and administrative oversight to the Help Desk
- Coordinate review of prior authorization and override appeal requests with account physician
- Review prior authorization and override appeal requests and make a decision for approval or denial based on Medicaid approved criteria and supporting evidence-based medicine documentation from provider
- Provide clinical support to Help Desk and Account Pharmacist when needed
- Meet with Medicaid staff upon request
- Attend quarterly programs/seminars required through the academic detailing component

3.91.7 Recipient Liaison

Contractor shall provide a Recipient Liaison. Upon award of the Contract, a resume/CV shall be submitted which shall include the individual's name, current address, current title and position, experience with Contractor, experience as it relates to the duties described in this ITB, and relevant education and training and must be pre-approved by Medicaid. Three work references shall also be included. The Recipient Liaison shall be a certified

pharmacy technician, nurse, pharmacist, or social worker. The Recipient Liaison shall demonstrate the utmost professionalism, patience, and respect while conducting duties listed in this section.

Contractor shall make good faith effort to use the Recipient Liaison for not less than 12 months to ensure successful contract performance. Contractor shall notify Medicaid in writing of any proposed change in Recipient Liaison at least 30 days prior to the change, if possible.

As the Help Desk focuses primarily on calls, requests, and issues with providers, the Recipient Liaison will accept calls from recipients with questions regarding PA and Override requests, approvals, and denials. The Recipient Liaison shall be given his/her own extension of the toll-free help desk number, and will take recipient calls referred from the Agency and the help desk. The Recipient Liaison will assist recipients with PA and Override issues, and will coordinate with providers to ensure recipients receive medically necessary medication covered by Medicaid. The Recipient Liaison may be a Help Desk Staff and review requests/data entry while not taking recipient calls, but recipient assistance shall be his/her first priority. Base hours Recipient Liaison shall be available are 8:30am – 5:30pm Central Time Monday – Friday. Other times the Help Desk is open, the Help Desk Supervisor (or designated representative) shall take recipient calls as described above.

Responsibilities of the Recipient Liaison will include, but are not limited to:

- Assist recipients with PA and Override issues, and coordinate with providers to ensure recipients receive medically necessary medication covered by Medicaid
- Return messages left by providers and/or recipients within three hours
- Review prior authorization and override appeal requests and make a decision for approval or denial based on Medicaid approved criteria and supporting evidence-based medicine documentation from provider
- Provide support to Help Desk and Account Pharmacist when needed
- Meet with Medicaid staff upon request

3.91.8 Other Personnel

Contractor shall demonstrate the ability to secure and retain professional staff to meet contract requirements. This shall include staff member with financial-based education (accounting, statistics, business degree, etc.) for projected cost savings data and other clinical and administrative personnel to carry out the requirements of this contract, and shall not be limited to clerical and administrative personnel, pharmacists, physicians and provider representatives.

Medicaid shall have the absolute right to approve or disapprove Contractor's and any subcontractor's staff assigned to the contract, to approve or disapprove any proposed changes in this personnel, or to require the removal or reassignment of any personnel

found by Medicaid to be unwilling or unable to perform under the terms of the contract. Contractor shall upon request provide Medicaid with a resume of any member(s) of its staff or a subcontractor's staff assigned to or proposed to be assigned to any aspect of the performance of this contract. Personnel commitments made on Contractor's response shall not be changed except as herein above provided or due to the resignation of any named individual.

3.92.0 Organizational Plan

Contractor must submit an organizational chart to Medicaid for approval prior to contract implementation. This plan shall include a breakdown of job duties and responsibilities of management staff.

It is permitted by Medicaid to have one individual assigned by Contractor for Project Manager and Account Pharmacist as long as the individual is qualified to perform duties outlined for these positions. It is permitted to have one individual assigned by Contractor for Account Pharmacist and Help Desk Supervisor as long as the individual is qualified to perform duties outlined for these positions. It is not permitted to have the same individual as Project Manager, Account Pharmacist, and Help Desk Supervisor.

It will not be permitted by Medicaid to have one individual assigned to perform the duties of Account Pharmacist and Staff Pharmacist.

It will not be permitted by Medicaid to have one individual assigned to perform the duties of Staff Certified Pharmacy Technician and have that person serve on the help desk or any other areas other than described in Section 3.91.4.

Contractor may not combine the FTE provider representatives required for the academic detailing component with other required positions.

Any subsequent changes to the organizational plan must be approved by Medicaid.

Section IV General Terms and Conditions

4.00.0 General

This ITB and Contractor's response thereto shall be incorporated into a contract by the execution of a formal agreement. No alteration or variation of the terms of the contract shall be valid unless made in writing and duly signed by the parties thereto. The contract may be amended by written agreement duly executed by the parties. Every such amendment shall specify the date its provisions shall be effective as agreed to by the parties. The contract and amendments, if any, are subject to approval by the Governor of the State of Alabama and CMS.

4.00.1 Compliance with State and Federal Regulations

Contractor shall perform all services under the contract in accordance with applicable federal and state statutes and regulations. Medicaid retains full operational and administrative authority and responsibility over the Alabama Medicaid Program in accordance with the requirements of the federal statutes and regulations as the same may be amended from time to time.

4.00.2 Confidentiality

Contractor shall treat all information, and in particular information relating to enrollees that is obtained by or through its performance under the contract, as confidential information to the extent confidential treatment is provided under State and Federal laws including 45 CFR §160.101 – 164.534. Contractor shall not use any information so obtained in any manner except as necessary for the proper discharge of its obligations and rights under this contract. All information as to personal facts and circumstances concerning enrollees obtained by Contractor shall be treated as privileged communications, shall be held confidential, and shall not be divulged to anyone other than the agencies already specified without written consent of Medicaid or the enrollee, provided that nothing stated herein shall prohibit the disclosure of information in summary, statistical, or other form that does not identify particular individuals. The use or disclosure of information concerning enrollees shall be limited to purposes directly connected with the administration of the State Plan. Upon signing of this contract by all parties, the terms of the contract become available to the public pursuant to Alabama law. Contractor agrees to allow public access to all documents, papers, letters, or other materials subject to the current Alabama law on disclosure. It is expressly understood that substantial evidence of Contractor's refusal to comply with this provision shall constitute a material breach of contract.

Contractor shall insure safeguards that restrict the use or disclosure of information concerning applicants and recipients to purpose directly connected with the administration of the Plan in accordance with 42 CFR Part 431, Subpart F, as specified in 42 CFR § 434.6(a)(8). Purposes directly related to the Plan administration include:

- (a) Establishing eligibility;

- (b) Determining the amount of medical assistance;
- (c) Providing services for recipients; and
- (d) Conducting or assisting an investigation, prosecution, or civil or criminal proceeding related to the administration of the Plan.

Pursuant to requirements of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 (Public Law 104-191), Contractor will be required to sign a business associate agreement. (See Attachment E)

4.00.3 Term of Contract

It is understood and agreed by the parties that every effort will be made to ensure the successful completion of this contract. The initial contract shall be for twelve months commencing November 1, 2008, through October 31, 2009. Medicaid shall have four one-year options for extending this contract. At the end of each contract year Medicaid may at its discretion, exercise the extension option and allow the period of performance to be extended for an additional contract year. The payment rate during the period prior to execution of the succeeding contract extension year shall be the same as the rate paid during the preceding contract year. In no event shall the term of the original contract plus the four extension year options exceed a total of five contract years.

The contract for administrative services shall include the following:

1. Executed contract,
2. ITB, and any amendments thereto,
3. Contractor's response to the ITB, and shall be construed in accordance with and in the order of the applicable provisions of:
 - Title XIX of the Social Security Act, as amended and regulations promulgated thereunder by HHS and any other applicable federal statutes and regulations
 - The statutory and case law of the State of Alabama
 - The Alabama State Plan for Medical Assistance under Title XIX of the Social Security Act, as amended
 - The Alabama Medicaid Agency Administrative Code
 - Medicaid's written response to prospective bidder's questions

4.00.4 Contract Amendments

The contract shall be deemed to include all applicable provisions of the State Plan and of all state and federal laws and regulations applicable to the Alabama Medicaid Program, as they may be amended. In the event of any substantial change in such Plan, laws, or regulations, that materially affects the operation of the Alabama Medicaid Program or the costs of administering such Program, either party, after written notice and before performance of any related work, may apply in writing to the other for an equitable adjustment in compensation caused by such substantial change. In the event of any such substantial change that decreases Contractor's cost of performance, Medicaid shall be entitled to a decrease in Contractor reimbursement commensurate with such substantiated change. In the event of any substantial change mandated by Medicaid which increases

Contractor's cost of performance, Contractor may, in the sole discretion of Medicaid, be entitled to an increase in reimbursement commensurate with such substantiated increased cost. Such payment shall not exceed the lesser of documented cost or approved estimated cost, based on cost specified in Pricing Schedule B.

4.10.0 Termination of Contract

4.10.1 Termination for Bankruptcy

The filing of a petition for voluntary or involuntary bankruptcy or a company or corporate reorganization pursuant to the Bankruptcy Act shall, at the option of Medicaid, constitute default by Contractor effective the date of such filing. Contractor shall inform Medicaid of any such action(s) immediately upon occurrence by the most expeditious means possible.

4.10.2 Termination for Default

Medicaid may, by written notice, terminate performance under the contract, in whole or in part, for failure of Contractor to perform any of the contract provisions. In the event, Contractor defaults in the performance of any of Contractor's material duties and obligations, written notice shall be given to Contractor specifying default. A copy of the written notice shall be sent to the Surety for Contractor's Performance Bond. Contractor shall have 30 calendar days, or such additional time as agreed to in writing by Medicaid, after the mailing of such notice to cure any default. In the event Contractor does not cure a default within 30 calendar days, or such additional time allowed by Medicaid, Medicaid may, at its option, notify Contractor in writing that performance under the contract is terminated and proceed to seek appropriate relief from Contractor and Surety.

4.10.3 Termination for Unavailability of Funds

Performance by the State of Alabama of any of its obligations under the contract is subject to and contingent upon the availability of state and federal monies lawfully applicable for such purposes. If Medicaid, in its sole discretion, deems at any time during the term of the contract that monies lawfully applicable to this agreement shall not be available for the remainder of the term, Medicaid shall promptly notify Contractor to that effect, whereupon the obligations of the parties hereto shall end as of the date of the receipt of such notice and the contract shall at such time be cancelled without penalty to Medicaid, State or Federal Government.

4.10.4 Force Majeure

Contractor shall be excused from performance hereunder for any period Contractor is prevented from performing any services pursuant hereto in whole or in part as a result of an act of God, war, civil disturbance, epidemic, or court order; such nonperformance shall not be a ground for termination for default.

4.20.0 Contractor's Duties Upon Expiration/Termination

4.20.1 Transfer of Documents

At Medicaid's discretion, but no later than three working days following expiration or termination of the contract, Contractor, at its expense, shall box, label, and deliver to Medicaid, the following items:

- All unprocessed and pending original PA requests
- All PA Request supporting documentation and correspondence regarding PA Requests
- Any information, data, manuals, or other documentation which shall permit Medicaid to continue contract performance or contract for further performance by others.

4.20.2 Change of Address

Contractor shall no later than the last postal business day of the contract submit to the United States Postal Service a standard change of address form indicating the new mailing address supplied to it by the successor Contractor. A change of address shall be turned in for each street address, post office box, or post office drawer used for receiving delivery of Medicaid drug PA requests and correspondence.

4.20.3 Dialogue

Contractor shall at any time during the transition period and up to 30 calendar days after expiration of the contract answer all questions and provide all dialogue and training that Medicaid deems necessary to enable the successor Contractor to take over the prior authorization function. All such communications shall be with or through Medicaid's Administrator for this contract.

4.30.0 Employment Practices

4.30.1 Nondiscriminatory Compliance

Contractor shall comply with Title VII of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, Executive Order No. 11246, as amended by Executive Order No. 11375, both issued by the President of the United States, the Americans with Disabilities Act of 1990, and with all applicable federal and state laws, rules and regulations implementing the foregoing statutes with respect to nondiscrimination in employment.

4.30.2 Small and Minority Business Enterprise Utilization

In accordance with the provisions of 45 CFR Part 74 and Attachment O, paragraph 9 of OMB Circular A-102, affirmative steps shall be taken to assure that small and minority businesses are utilized when possible as sources of supplies, equipment, construction, and services.

4.30.3 Worker's Compensation

Contractor shall take out and maintain, during the life of this contract, Worker's Compensation Insurance for all of its employees under the contract or any subcontract thereof, if required by state law.

4.30.4 Employment of State Staff

Contractor shall not knowingly engage on a full-time, part-time, or other basis during the period of the contract any professional or technical personnel, who are or have been in the employment of Medicaid during the previous 12 months, except retired employees or contractual consultants, without the written consent of Medicaid.

4.40.0 Guarantees, Warranties, and Certifications

4.40.1 Security and Release of Information

Contractor shall take all reasonable precautions to ensure the safety and security of all information, data, procedures, methods, and funds involved in the performance under the contract, and shall require the same from all employees so involved. In compliance with 42 CFR §431.300 et seq. Contractor shall conform to the requirements of federal and state regulations regarding confidentiality of information about eligible recipients. Contractor shall not release any data or other information relating to the Alabama Medicaid Program without prior written consent of Medicaid. This provision covers both general summary data as well as detailed, specific data. Contractor shall not be entitled to use of Alabama Medicaid Program data in its other business dealings without prior written consent of Medicaid. All requests for program data shall be referred to Medicaid for response by the Commissioner only.

4.40.2 Share of Contract

No official or employee of the State of Alabama shall be admitted to any share of the contract or to any benefit that may arise therefrom.

4.40.3 Conflict of Interest

A conflict of interest exists where the Contractor will receive direct or indirect financial gain as a result of the prior authorization of a Medicaid prescription. A conflict of interest also exists where Contractor has a contract, business arrangement or other professional association with, or acts as the personal or professional representative of a physician, pharmacist, or other Medicaid provider affected by the decision made on a prior authorization request. Contractor cannot possess or be awarded any additional contract with Medicaid which would impact the pharmacy prior approval program.

Medicaid reserves the right to determine in its sole discretion what constitutes a conflict of interest.

4.40.4 Performance Guarantee

Contractor shall post a performance bond guarantee with a corporate bonding company licensed by the Alabama Department of Insurance as surety upon execution of the contract to be effective no later than the first day of the first month in which capitation payments are made in accordance with the provisions of Code of Alabama, 1975, Section 41-16-28. The performance guarantee shall be in the amount equal to six months payments. This bond shall be in force from that date through the term of the contract and 180 calendar days beyond and shall be conditioned on faithful performance of all contractual obligations. Failure of Contractor to perform satisfactorily, breach of contract, or termination of the contract shall cause the performance bond to become due and payable to the State of Alabama to the extent necessary to cover the cost incurred by Medicaid as a result of Contractor's failure to perform its contractual obligations. These costs include, but are not limited to, costs to correct any Medicaid program errors caused by Contractor's default and costs incurred by Medicaid for completion of the contracted work, including any costs associated with the preparation, solicitation, and award of a competitive bid for these contract services and any federal state or other penalties, sanctions, disallowance's, or other such costs incurred by Medicaid as a result of Contractor's default and legal, administrative, and delay costs incurred as a result of Contractor's default and any liquidated damages necessary as a result of Contractor's default. The Commissioner of Medicaid shall be custodian of the performance bond. Said bond shall be extended in the event Medicaid exercises its option to extend the contract.

4.40.5 Indemnification

Contractor shall hold harmless and indemnify Medicaid as to any penalties or federal recoupment and any interest incurred by reason of any Title XIX noncompliance due to the fault of Contractor and/or any subcontractors. The term "Title XIX noncompliance" shall be construed to mean any failure or inability of Medicaid to meet the requirements of Title XIX of the Social Security Act, due to an act or omission of Contractor or subcontractor and/or any regulations promulgated by the federal government in connection therewith.

Contractor shall be liable and agrees to be liable for and shall indemnify, defend, and hold the State and Medicaid and their officers, employees and agent harmless from all claims, suits, judgments or damages, including court costs and attorney fees, arising out of or in connection with this contract due to negligent or intentional acts of omissions of the Contractor and/or any subcontractors. Contractor shall hold the State and Medicaid harmless from all subcontractor liabilities under the terms of this contract.

Contractor agrees to indemnify, defend, and hold harmless Medicaid, its officers, agents, and employees from:

1. Any claims or losses attributable to a service rendered by Contractor or any subcontractor, person, or firm performing or supplying services, materials, or supplies in connection with the performance of the contract regardless of whether Medicaid knew or should have known of such improper service, performance, materials or supplies unless otherwise specifically approved by Medicaid in writing in advance.
2. Any claims or losses attributable to any person or firm injured or damaged by the erroneous or negligent acts, including without limitation, disregard of Federal or State Medicaid regulations or statutes, of Contractor, its officers, employees, or subcontractors in the performance of the contract, regardless of whether Medicaid knew or should have known of such erroneous or negligent acts.
3. Any failure of Contractor, its officers, employees, or subcontractors to observe Alabama Laws, including, but not limited to, labor laws and minimum wage laws, regardless of whether Medicaid knew or should have known of such failure.
4. If at any time during the operation of this contract, Medicaid gains actual knowledge of any erroneous, negligent, or otherwise wrongful acts by Contractor, its Officers, employees, or subcontractors, Medicaid agrees to give Contractor written notice thereof. Failure by Medicaid to give said notice does not operate as a waiver of Contractor's obligations to Medicaid, or a release of any claims Medicaid may have against Contractor.

4.40.6 Waivers

No covenant, condition, duty, obligation, or undertaking contained in or made a part of the contract shall be waived except by written agreement of the parties.

4.40.7 Warranties Against Broker's Fees

Contractor warrants that no person or selling agency has been employed or retained to solicit or secure the contract upon an agreement or understanding for a commission percentage, brokerage, or contingent fee excepting bona fide employees. For breach of this warranty, Medicaid shall have the right to terminate the contract without liability.

4.40.8 Novation

In the event of a change in the corporate or company ownership of Contractor, Medicaid shall retain the right to continue the contract with the new owner or terminate the contract. The new corporate or company entity must agree to the terms of the original contract and any amendments thereto. During the interim between legal recognition of the new entity and Medicaid execution of the novation agreement, a valid contract shall continue to exist between Medicaid and the original Contractor. When, to Medicaid's satisfaction, sufficient evidence has been presented of the new owner's ability to perform under the terms of the contract, Medicaid may approve the new owner and a novation agreement will be executed.

4.40.9 Employment Basis

It is expressly understood and agreed that Medicaid enters into this agreement with Contractor and any subcontractor as authorized under the provisions of this contract as an independent Contractor on a purchase or service basis and not on an employer-employee basis and not subject to State Merit System law.

4.50.0 Disputes and Litigation

Except in those cases where the bid response exceeds the requirements of the ITB, any conflict between the bid response of Contractor and the ITB shall be controlled by the provisions of the ITB. Any dispute concerning a question of fact arising under the contract which is not disposed of by agreement shall be decided by the Commissioner of Medicaid.

Any litigation brought by Medicaid or Contractor to enforce any provision of the contract shall be brought in either the Circuit Court of Montgomery County, Alabama, or the United States District Court for the Middle District of Alabama, Northern Division, according to the jurisdictions of these courts. This provision shall not be deemed an attempt to confer any jurisdiction on these courts which they do not by law have, but is a stipulation and agreement as to forum and venue only.

4.60.0 Records

4.60.1 Records Retention and Storage

In accordance with 45 CFR §74.164, Contractor shall maintain financial records, supporting documents, statistical records, and all other records pertinent to the Alabama Medicaid Program for a period of three years from the date of the final payment made by Medicaid to Contractor under the contract. However, if audit, litigation, or other legal action by or on behalf of the State or Federal Government has begun but is not completed at the end of the three year period, or if audit findings, litigation, or other legal action have not been resolved at the end of the three year period, the records shall be retained until resolution. Subsequent to the contract term, documents shall be returned to

Medicaid within three working days following expiration or termination of the contract. Micromedia copies of source documents for storage may be used in lieu of paper source documents subject to Medicaid approval.

4.60.2 Inspection of Records

Contractor agrees that representatives of the Comptroller General, HHS, the General Accounting Office, the Alabama Department of Examiners of Public Accounts, and Medicaid and their authorized representative shall have the right during business hours to inspect and copy Contractor's books and records pertaining to contract performance and costs thereof. Contractor shall cooperate fully with requests from any of the agencies listed above and shall furnish free of charge copies of all requested records. Contractor may require that a receipt be given for any original record removed from Contractor's premises.

4.70.0 Method of Payment and Invoices

4.70.1 Use of Federal Cost Principles

For any terms of the contract which allow reimbursement for the cost of procuring goods, materials, supplies, equipment, or services, such procurement shall be made on a competitive basis (including the use of competitive bidding procedures) where practicable, and reimbursement for such cost under the contract shall be in accordance with 48 CFR, Chapter 1, Part 31. Further, if such reimbursement is to be made with funds derived wholly or partially from federal sources, such reimbursement shall be subject to Contractor's compliance with applicable federal procurement requirements, and the determination of costs shall be governed by federal cost principles.

4.70.2 Invoice Submission

Contractor shall submit to Medicaid monthly a detailed invoice for compensation for the previous month's services. Each invoice shall state at a minimum, the total number of prior authorization reviews completed (approved, denied), total number of prospective DUR overrides completed (approved, denied), number of academic detailing interventions completed, and the administrative fee due. Any subsequent charges through contract amendments should be detailed individually.

4.70.3 Payment

Alabama Medicaid will make payments for successful completion of deliverables/requirements received and accepted as specified in the Scope of Work. Payments will be withheld until reports, deliverables, and task completion schedules by the ITB during the applicable period are received as acceptable by Alabama Medicaid. Payments are dependent upon successful completion and acceptance of described work and delivery of required documentation. Payment for Contractor services shall be made according to the following provisions:

- Firm and Fixed Price to be paid in 12 equal payments
- Extra contractual services in accordance with any contract amendment and calculated using reimbursement base reflected on Pricing Schedule B
- Usual Payment Practices: Contractor compensation shall be issued through the Comptroller of the State of Alabama in accordance with the usual payment practices of Medicaid
- Recoupments: Payments made for services performed which fail to comply with the terms and conditions of the contract are subject to recovery by Medicaid through applicable administrative and legal proceedings

4.80.0 Other Requirements

4.80.1 Notice to Parties

Any notice to Medicaid under the contract shall be sufficient when mailed to Alabama Medicaid Agency, Attention Associate Director, Pharmacy Program, 501 Dexter Avenue, P.O. Box 5624, Montgomery, Alabama 36103-5624. Any notice to Contractor shall be sufficient when mailed to Contractor at the address given on the return receipt from this ITB or on the contract after signing. Notice shall be given by certified mail, return receipt requested.

4.80.2 Disaster Recovery Plan

Contractor shall provide to Medicaid not later than October 1, 2008, a written implementation plan addressing back-up arrangements for data processing equipment and files to provide continued contract performance in the event of machine failure or loss of records, as well as a contingency plan in the event of inclement weather that only affects a certain portion of the state (ie hurricane/tornado). Medicaid must approve both plans prior to implementation. The implementation plan must provide detailed back up procedures that will ensure the Contractor's capability to meet ITB specifications in the event of equipment failure to include all network equipment systems as they relate to the contract. In the event of equipment failure or loss of records due to a disaster, Contractor is to provide an uninterrupted power system shutdown and completion of current transactions. Data backup tapes are to be stored at an offsite location to be provided by Contractor. Restoration of data should occur within 24 hours of system failure. System downtime due to hardware failure must not exceed eight business hours.

4.80.3 Cooperation

Effective operation of the Alabama Medicaid Program shall require close cooperation between Medicaid and Contractor. To this end, the parties agree to work mutually in solving operational problems. Contractor shall make known and fully describe to Medicaid, in writing, any difficulties encountered that threaten required performance or when such a potential exists. Such difficulties may include, but not be limited to, system "down" times, scheduling problems, meeting reporting requirements, accuracy of data, issues with fiscal agent, etc. If Contractor determines that Medicaid's input or direction

is required to resolve the difficulties, such an explanation describing the desired input along with any applicable timetables and projected corrections shall be included in a report. Contractor shall notify the Medicaid Contract Administrator by telephone within one working day of discovery of any problem which has already occurred, or within one working day of the identification of potential problems that threaten required performance. All telephone notices shall be followed up in writing, including any action taken. Any correspondence between Contractor and the Medicaid fiscal agent shall be courtesy copied to the Medicaid Contract Administrator.

4.90.0 Liquidated Damages

Contractor shall be liable for any penalties and late deliverables or disallowance of Federal Financial Participation incurred by Medicaid due to Contractor's failure to comply with the terms of the contract. Imposition of liquidated damages may be in addition to other contract remedies, and does not waive Medicaid's right to terminate the contract.

The following liquidated damages shall be assessed against contractor for:

- Failure to produce required report or any contractor deliverable - \$100 per day per report.
- Failure to respond to a prior authorization request within twenty-four hours - \$1,000 per hour for each request up to time request is complete. Penalty assessed in full hour increments. No partial penalties will be allowed.
- Use of educational materials and newsletter without prior review and approval by Medicaid - \$1,000 per instance.
- Failure to follow Medicaid criteria and/or directives in approval/denial of PA requests or Override requests - \$500 per instance or cost to Medicaid, whichever is greater.
- Failure to include Medicaid requested changes/corrections/revisions in reports, minutes of DUR Board meetings, newsletters or any other contractor deliverable - \$100 per change/correction/revision per document.
- Failure of designated contractor staff to be punctual for DUR Board meetings - \$100 per minute past scheduled start time.
- Presentations to groups/associations or others regarding this contract and work thereunder without prior approval of Medicaid - \$1,000 per instance.
- Failure to safeguard confidential information of providers, recipients or the Medicaid program - \$2,500 per instance plus any penalties incurred by Medicaid for said infractions.
- Failure to maintain average call wait times of 20 seconds or less for Help Desk phone lines - \$500 per week that performance standard is exceeded.
- Failure to make required academic detailing provider visits per quarter - \$100 per visit under requirement.
- Failure to meet equipment, technical or personnel requirements - \$100 per day that requirement is not met.

- Failure to input DUR criteria into the retrospective DUR database within 4 weeks of DUR Board and Medicaid approval - \$100 per business day until criteria have been implemented to the satisfaction of Medicaid.
- Failure to respond to an appeal request within 12 hours of receipt of completed appeal or failure to respond to provider within four hours of receipt of response from Medicaid - \$1,000 per hour for each appeal request up to time appeal request is complete. Penalty/ assessed in full hour increments. No partial penalties allowed.
- Failure to respond to 75% of monthly total of prior authorization and override requests within 8 hours of receipt of completed requests will result in penalty of \$1,000 per percentage point below 75%. In no event shall response time exceed 24 hours.
- Failure to respond to recipient within three hours of message: \$100 per instance

Section V Bid Procedures

5.00.0 General Response Requirements

Each bid shall be submitted with 1 original and 6 original-quality copies under sealed cover, along with 1 electronic copy (CD using MS Word 6.0 or higher format), and shall be received no later than 5:00 p.m. Central Time on June 9, 2008. Sealed bid packages shall be delivered or sent by mail to:

State of Alabama
Division of Purchasing
RSA Union Building
100 N. Union Street
Suite 192
Montgomery, AL 36130-2401

Attention: Bernie Arant

The outside cover of the package containing the response shall be marked:

Alabama Medicaid Pharmacy Administration Services
BID # 09-X-2193471
Opening Date: June 10, 2008, 9:00 a.m.

Bids submitted in whole or part by modem or fax will be rejected. Late responses will not be accepted. It is the responsibility of the bidder to ensure the bid is delivered by the time specified. Bids received after that time will not be considered. Bidders must submit the following documents to the Division of Purchasing:

5.10.0 Format of Response

5.10.1 Transmittal Letter

The Transmittal Letter shall include:

- a. Identification of all materials and enclosures being submitted collectively as a response to this ITB
- b. A statement identifying each addendum to this ITB that has been received; if no addenda have been received, a statement to that effect shall be included. The bidder shall list each ITB addendum acknowledged and received, by addendum number
- c. Identification of the bidder that will be the prime contractor and the name of the corporation or other legal entity submitting the proposal. It shall also include a statement identifying any and all subcontractors, if any, that are needed in order to satisfy the requirements of this ITB. The percentage of

work, as measured by percentage of total contract price, to be performed by the prime contractor shall be provided. Subcontracted work shall not, collectively, exceed forty percent of the total contract price. The bidder will assume sole and exclusive responsibility for all of contractor responsibilities and work indicated in the ITB (including any and all addenda)

- d. A statement certifying that, if a foreign corporation, the bidder has a current Certificate of Authority to do business in Alabama issued from the Alabama Secretary of State
- e. A statement of compliance with Affirmative Action and Equal Employment Opportunity regulations that confirms that the bidder does not discriminate in its employment practices with regard to race, color, religion, age (except as provided by law), sex, marital status, developmental disability, political affiliation, national origin, or handicap, and complies with all applicable provisions of Public Law 101-336, Americans with Disabilities Act
- f. A statement that the system proposed will 1) meet the specifications set forth in the ITB, 2) meet CMS certification requirements and 3) meet all performance standards and expectations set forth in this ITB
- g. A statement acknowledging and agreeing to all of the rights of the Alabama Medicaid Agency contained in the provisions of this ITB
- h. A statement that the response is valid for a minimum of nine months from the bid submission date
- i. A statement that the prices proposed have been arrived at independently without consultation, communication, or agreement with any other bidder or competitor for this procurement
- j. A statement that the bidder, through its duly authorized representatives, has in no way entered into any arrangement or agreement with any other bidder or competitor which could lessen or destroy free competition in awarding the contract sought by the attached proposal
- k. A statement that, unless otherwise required by law, the prices quoted shall not be knowingly disclosed by the bidder, directly or indirectly, prior to award of the contract, to any other bidder or to any competitor
- l. A statement that the bidder has not and will not make any attempt to induce any other person or firm to withhold or submit a proposal for the purposes of restricting competition
- m. A statement that the person signing this bid is authorized to make decisions on behalf of the bidder's organization as to the prices quoted

- n. A statement that the bidder has not employed anyone, other than a bona fide employee working solely for the bidder, in soliciting or securing this contract
- o. A statement that no person or agency has been employed or retained to solicit or secure the proposed contract based on an agreement or understanding for a commission, percentage, brokerage, or contingent fee
- p. A statement that the bidder, and any subcontractors, will maintain a drug-free workplace

If the use of subcontractors is proposed, a statement from each subcontractor, on official letterhead, shall be attached to the Transmittal Letter, signed by an individual authorized to legally bind the subcontractor to perform the scope of work as assigned, stating:

- a. The general scope of work to be performed by the subcontractor
- b. The subcontractor's willingness to perform the work indicated
- c. The names and titles of individuals who will be responsible for the subcontractor's efforts
- d. That the subcontractor's firm does not discriminate in its employment practices with regard to race, color, religion, age (except as provided by law), sex, marital status, developmental disability, political affiliation, national origin, or handicap, and complies with all applicable provisions of Public Law 101-336, Americans With Disabilities Act

If the bidders' response deviates, in any way whatsoever, from the detailed specifications and requirements in the ITB, the Transmittal Letter shall explicitly identify and explain these deviations. The Alabama Medicaid Agency reserves the right, at its sole discretion, to reject any proposal containing such deviations or to require modifications and/or clarifications before acceptance.

Bidders may not place any conditions, reservations, limitations, or substitutions in their response with regard to the contract terms and conditions. The bidder selected under this ITB may request non-substantive changes to the contract language, but the State reserves the sole right to accept or reject any requested changes.

5.10.2 Bid Response

The bid response must present a complete and detailed description of the bidder's qualifications to perform, and its approach to carry out the requirements in Section III, Scope of Work, of this ITB. Any deviations in the bidder's response from the outline described below could disqualify that bid due to evaluation considerations. The name and number of this ITB shall be included on the title page of each volume.

The response shall include 12 separate sections (with named and numbered tabs) presented in the following order:

1. Transmittal Letter
2. Table of Contents and ITB Cross-Reference
3. Executive Summary
4. Audited Financial statements for the last three completed fiscal years to include:
 - Income statements
 - Balance sheets
 - Statements of financial position
5. Work plan for various required components
6. Approach to Administrative Responsibilities
7. Corporate Capabilities and Commitment
8. Interfacing Capabilities
9. Bidder's Understanding of Alabama Requirements
10. Four references, at a minimum for both Contractor and Subcontractors
11. Submission of Pricing Schedules for firm and fixed bid price including Individual Components, Extra-contractual Service Rates and Total Evaluated Bid Price
12. Appendices

Each response (including all copies thereof) shall be 1) clearly page-numbered on the bottom (center or right) of each page, 2) submitted in three- (3-) ring binders, and 3) use 8.5 x 11-inch paper and two-sided copies. A font size of eleven points or larger shall be used.

The pricing schedules may be reproduced by the bidder, however, no deviations in the format or content of the pricing schedule is permitted. The Bid response pricing schedules are included in Attachment A. Instructions for completing each schedule are given in the following sections.

Brochures or other presentations, beyond that sufficient to present a complete and effective response, are not desired. Audio and/or videotapes are not allowed. Elaborate artwork or expensive paper is not necessary or desired.

The Division of Purchasing desires and encourages that bids be submitted on recycled paper, printed on both sides. While the appearance of proposals and professional presentation is important, the use of non-recyclable or non-recycled glossy paper is discouraged.

5.10.3 Individual Bid Components – Pricing Schedule A

In addition to the total Fixed Bid Price, bidders should submit firm costs required to develop and operate the individual components of bid requirements. The total of Pricing Schedule A will be the firm and fixed base price.

The response will include the bidder's total Fixed Base Price representing the fixed, not estimated, costs that bidder requires in order to complete this project according to the requirements of the ITB. Payments will be based upon contracted services actually performed in accordance with the proposed Fixed Price.

5.10.4 Extra-Contractual Services – Pricing Schedule B

The response will include the bidder's monthly rates for personnel, furniture and equipment for the purpose of making payment due to an increase in Contractor's cost of performance.

5.10.5 Total Evaluated Price – Pricing Schedule C

The Firm and Fixed Base Price (Pricing Schedule A) will be combined with the total of the Extra Contractual Services (Pricing Schedule B) to obtain the Total Evaluated Price. This is the Bid Price upon which the contract award will be based.

5.20.0 Bid Guarantee

Each sealed response shall be accompanied by a bid guarantee consisting of a bid bond issued by a company authorized to do business in the State of Alabama. The guarantee shall be payable to the State of Alabama in the amount of \$5,000, as a guarantee of good faith and to ensure a firm bid for contracting purposes for 90 calendar days after bid due date. Bid guarantees provided by unsuccessful bidders shall be returned after 90 calendar days.

5.30.0 Bid Opening

Bid responses shall be opened on June 10, 2008 at 9:00 a.m. Central Time at the office of the State Department of Finance, Division of Purchasing, Suite 192, RSA Union Building, 100 N. Union Street, Montgomery, Alabama. This process is open to the public.

5.40.0 Acceptable Bid Responses

All bids become the property of the State of Alabama, and none shall be returned to the bidder. Only bids that conform to the requirements of this solicitation shall be acceptable. The state reserves the right to reject any or all bids. There is no guarantee

that a contract shall result from this solicitation. The State accepts no obligation for costs incurred by any bidder in the preparation of a bid in response to this ITB.

5.50.0 Protest Guarantee

Any protest filed after the award of the bids shall be accompanied by a bond issued by a company authorized to do business in the State of Alabama. The guarantee shall be payable to the State of Alabama and shall be in an amount that will be an adequate guarantee of good faith in the filing of such protest and in an amount that will allow the Alabama Medicaid Agency to recover the costs incurred as a result of the filing of an unsuccessful bid protest. This bond will be returned to the protester shall such protest be well founded. The amount of the bond shall be \$10,000.

5.60.0 Evaluation of Bids

The State of Alabama will conduct a comprehensive, fair, and impartial evaluation of bids received in response to the ITB.

The evaluation will be conducted in two phases, which include:

- Phase 1 - Evaluation of Mandatory Requirements
- Phase 2 - Contract award

5.60.1 Evaluation Participants

A Selection Committee composed of the Alabama Medicaid Agency management and staff will be responsible for reviewing the bids for responsiveness to the bid requirements.

5.60.2 Evaluation of Mandatory Requirements

The purpose of this phase is to determine whether each bid has met the response submission requirements, and conforms with the rules of the procurement. Bids will be evaluated on a pass/fail basis for each requirement.

Any response that fails to comply with response submission instructions or meet the mandatory requirements listed in Attachment F of the ITB will be deemed “non-responsive” and the bid will be rejected by the Selection Committee. The State reserves the right to reject any and all bids.

5.60.3 Contract Award

Only those responses passing the mandatory requirements will be considered in the final response evaluation. After the determination of whether a bid is considered responsive and responsible, the contract award will be based on the low bid price.

Section VI Attachments

6.00.0 Attachments

Attachments to this ITB are outlined below:

- Attachment A – Bid Pricing Schedule
- Attachment B - Definitions
- Attachment C - Example of Formal Agreement
- Attachment D– Relationship Disclosure Statement
- Attachment E - HIPAA Business Associate Agreement
- Attachment F - Mandatory Bid Requirements Checklist
- Attachment G - PA Workflow Diagram
- Attachment H - Current Contractor Specifications

For additional information and references regarding the Pharmacy Administrative Services ITB, please visit the Bidder's library located on the Alabama Medicaid website at

www.medicaid.alabama.gov

Attachment A

Bid Pricing Schedule

Pricing Schedule A
Bid Components

Bid Component	Price
Prospective DUR Monitoring Program	\$
Maximum Allowable Cost Pricing	\$
Prior Authorization Requirements	\$
Drug Interface System	\$
Retrospective DUR	\$
Academic Detailing	\$
Help Desk	\$
Staff Pharmacist	\$
Staff Certified Pharmacy Technician	\$
Total	\$

Pricing Schedule B
Extra Contractual Services

Contract Item	Monthly Rate	Units*	Price
Help Desk Clerk Salary and Benefits	\$	120	\$
Help Desk Phone Line	\$	120	\$
FAX Line	\$	24	\$
Help Desk Furniture and Equipment	\$	120	\$
Total			\$

*for evaluation purposes only

Pricing Schedule C
Evaluated Price

Contract Item	Price
Firm and Fixed Annual Base Price (from Schedule A)	\$
Extra Contractual Services Total (from Schedule B)	\$
Total Evaluated Price (Enter on ITB Form)	\$

Signature _____ Date _____

Definitions

Administrative Hearing: a formal face-to-face hearing by an impartial State Hearing Officer attended by the complainant or an authorized representative(s).

Administrative Review: a thorough review by Medicaid allowing providers an opportunity to submit additional written documentation.

Adverse Reaction: the development of undesired side effects or toxicity caused by prescription drugs.

AHFS Code: Therapeutic Class of the American Hospital Formulary Service code.

Alabama Medicaid Agency: the single State Agency designated to administer the medical program under Title XIX of the Social Security Act.

Alabama Medicaid Agency Administrative Code: publication containing information about the administration of the Medicaid program and the extent of the covered services available for eligible categorically needy recipients when medically prescribed.

AMMIS: the Alabama Medicaid Management Information System that consists of all subsystems of the AMMIS maintained by Medicaid's fiscal agent.

CMS: Center for Medicare and Medicaid Services

Dispensing Pharmacist: state licensed pharmacist, enrolled in the Alabama Medicaid Agency, authorized to dispense prescription medication to Medicaid recipients.

Drug Class: those drugs with the same therapeutic classification.

Drug Usage Review Criteria: predetermined standards of indications for medical necessity for certain drug classes which are compared to medical documentation submitted by physicians.

Drug Utilization Review (DUR): a structured and continuing program that reviews, analyzes and interprets patterns of drug usage in a given health care environment against predetermined criteria and standards.

DUR Board: advisory board regarding matters of drug utilization review. The group consists of Medicaid enrolled practicing physicians and dispensing pharmacists and meets a minimum of four times per year to advise Medicaid on drug utilization issues.

Duplicate Request: a PA Request which contains identical or similar information submitted in a previous request which was approved or denied within the past thirty days.

Enterals: Nutritional products which may be administered orally or via nasogastric tube, feeding gastrostomy, or needle-catheter jejunostomy.

Fiscal Agent: a Contractor that processes or pays provider claims on behalf of Medicaid.

GCN (Generic Code Number): A five digit code number that represents a generic formulation specific to generic ingredients, drug strength, dosage form and route of administration.

GSN (Generic Sequence Number): The Generic Sequence Number is a unique number representing a generic formulation. It is specific to the generic ingredient(s), route of administration and drug strength. It is the same across manufacturers.

HIPAA: Health Insurance Portability and Accountability Act.

HHS: Department of Health and Human Services is a cabinet level department which administers all federal health care services, including Medicare, Medicaid, and federal employees insurance.

Lock-in: a recipient who has failed to comply with Medicaid program requirements may be restricted, or “locked-in,” to a specified physician and pharmacy. The recipient’s eligibility record will indicate when the recipient is restricted.

MAC Program: State Maximum Allowable Cost Program

Material change in Scope of Work: This term is defined as a material decrease in the scope or level of duties as required by the ITB. Material change will result in reduction in bid price as agreed upon by parties in a contract amendment.

Medical Justification: documentation to support medical necessity of the drug or procedure being requested. Documentation must include, at minimum, peer reviewed literature, evidence based medicine, national guidelines, or patient specific medical records.

Medical Necessity: the need or condition documented on submitted information compared to established criteria which indicates appropriateness of the use of prescription drugs necessary to treat certain medical conditions.

MLIF: Medicaid for Low Income Families

Multiple Source Brand Name: drugs marketed or sold by two or more drug manufacturers or sold by the same manufacturer or labeler under two or more different proprietary names or both under a proprietary name and without such a name.

NDC (National Drug Code): a nationally recognized 11-digit number used to identify a drug. The first five digits identify the company that manufactures the drug, the next four digits identify the drug and its strength, and the last two digits indicate the package size.

Nonsteroidal Anti-Inflammatory Drugs (NSAIDs) : drugs which have analgesic and antipyretic activities. Most NSAIDs are primarily used for their anti-inflammatory effects and are effective analgesics useful for relief of mild to moderate pain. These agents do not alter the course of the underlying disease.

Override: a review and determination of a prescription's appropriateness identified by certain edits such as maximum cost, maximum quantity, therapeutic duplication and early refill prior to reimbursement from Medicaid.

Override Request, approved: a request that meets criteria for an allowance above/outside that which is recommended and screened for within a ProDUR edit.

Override Request, denied: a request not meeting criteria to overrule an allowance above/outside that which is recommended and screened within a ProDUR edit.

PA List: list of drugs that require authorization prior to payment

PA Request, Approved: a request that meets the review criteria for Medicaid coverage and assigned a PA number.

PA Request, Denied: a request that does not meet the review criteria for Medicaid coverage.

Pass Through Expense: (also referred to as Extra-contractual services) Those expenses of Contractor which are to be reimbursed at cost by Medicaid. Includes reimbursement only for costs incurred as a result of additional requirements by Medicaid which increase the volume or scope of work to be performed by Contractor above the ITB requirements.

Pharmacy and Therapeutics (P&T) Committee: Expert panel of Medicaid enrolled physicians and pharmacists with well developed medical and pharmacological backgrounds that review drugs for preferred drug status, review drugs for prior authorizations and make program recommendations to Medicaid.

Physician: a doctor of medicine, osteopathy, or dentistry or another individual who is authorized under State or Federal law to practice medicine and surgery or osteopathy.

Preferred Drug List: List of drugs recognized by the P&T Committee as superior drugs within their class that are recommended for usage to the Medicaid provider community. PDL Quicklists are summary sheets of preferred products by category such as geriatric, pediatric, women's health, over-the-counter, etc.

Prior Authorization (PA): a review and determination of the medical necessity and appropriateness of certain drug classes prescribed for treatment of medical conditions prior to reimbursement from Medicaid.

Professional Staff: licensed pharmacist(s) and physician(s) employed by Contractor to review PA Request(s) for Medicaid coverage.

Prospective DUR: On-line drug screening system that alerts pharmacists to certain drug concerns such as early refill, therapeutic duplication, drug/drug interactions and high dose.

Provider: a physician or pharmacy that is enrolled by Medicaid to provide services.

QMB (Qualified Medicare Beneficiary): part A Medicare beneficiary whose verified income and resources do not exceed certain levels.

QMB Only: category of recipients eligible only for services included in Medicare coverage. Coverage for prescription drugs is not a benefit for this category.

Recipient: a person who has been certified as eligible for medical assistance under the State Plan and has been assigned a Medicaid identification number.

Retroactive Eligibility: category of recipients that have been determined to have been eligible three months prior to application for Medicaid eligibility.

SLIMB (Specified Low Income Medicare Beneficiaries): patients for which Medicaid pays Part B premiums only; these patients are not eligible for drug benefits through Medicaid.

SOBRA (Sixth Omnibus Budget Reconciliation Act of 1986): A Medicaid program for pregnant women and children at or below required Federal Poverty Levels.

State Plan: the State Plan for Medical Assistance of the State of Alabama, as amended, is a comprehensive written commitment for administration of the Medicaid program approved by HHS for federal financial participation under Title XIX of the Social Security Act.

Therapeutic Classification Code: a six-digit number arrangement which groups drugs with similar activities. This numbering scheme is copyrighted as the American Hospital Formulary Services Pharmacologic-Therapeutic Classification.

Title XIX: that part of the Social Security Act which established the Medicaid program.

Sample Formal Agreement

State of Alabama
Montgomery County

KNOW ALL MEN BY THESE PRESENTS, that the Alabama Medicaid Agency, an Agency of the State of Alabama, and the undersigned Contractor agree as follows:

Contractor shall furnish all labor, equipment, and materials and perform all of the work required under the Invitation to Bid, No. 09-X-2193471, dated June 9, 2008, strictly in accordance with the requirements thereof and Contractor’s bid response thereto.

Contractor shall be compensated for performance under this contract in accordance with the provisions of Section 4.70.0 and the Pricing Schedule provided for within ITB.

This contract specifically incorporates by reference the said Invitation to Bid, any amendments thereto, and Contractor’s bid response, including all attachments.

EXECUTED THIS ____ DAY OF _____, 2008.

Contractor

Alabama Medicaid Agency
This contract has been reviewed for
and is approved as to content.

Printed Name _____

Commissioner

Title _____

This contract has been reviewed for legal form and complies with all applicable laws, rules, and regulations of the State of Alabama governing these matters.

Medicaid Legal Counsel

APPROVED

Governor, State of Alabama



State of Alabama Disclosure Statement

(Required by Act 2001-955)

ENTITY COMPLETING FORM

ADDRESS

CITY, STATE, ZIP

TELEPHONE NUMBER

()

STATE AGENCY/DEPARTMENT THAT WILL RECEIVE GOODS, SERVICES, OR IS RESPONSIBLE FOR GRANT AWARD

ADDRESS

CITY, STATE, ZIP

This form is provided with:

Contract
 Proposal
 Request for Proposal
 Invitation to Bid
 Grant Proposal

Have you or any of your partners, divisions, or any related business units previously performed work or provided goods to any State Agency/Department in the current or last fiscal year?

Yes
 No

If yes, identify below the State Agency/Department that received the goods or services, the type(s) of goods or services previously provided, and the amount received for the provision of such goods or services.

STATE AGENCY/DEPARTMENT	TYPE OF GOODS/SERVICES	AMOUNT RECEIVED

Have you or any of your partners, divisions, or any related business units previously applied and received any grants from any State Agency/Department in the current or last fiscal year?

Yes
 No

If yes, identify the State Agency/Department that awarded the grant, the date such grant was awarded, and the amount of the grant.

STATE AGENCY/DEPARTMENT	DATE GRANT AWARDED	AMOUNT OF GRANT

1. List below the name(s) and address(es) of all public officials/public employees with whom you, members of your immediate family, or any of your employees have a family relationship and who may directly personally benefit financially from the proposed transaction. Identify the State Department/Agency for which the public officials/public employees work. (Attach additional sheets if necessary.)
- 2.

NAME OF PUBLIC OFFICIAL/EMPLOYEE	ADDRESS	STATE DEPARTMENT/AGENCY

2. List below the name(s) and address(es) of all family members of public officials/public employees with whom you, members of your immediate family, or any of your employees have a family relationship and who may directly personally benefit financially from the proposed transaction. Identify the public officials/public employees and State Department/Agency for which the public officials/public employees work. (Attach additional sheets if necessary.)

NAME OF FAMILY MEMBER	ADDRESS	NAME OF PUBLIC OFFICIAL/ PUBLIC EMPLOYEE	STATE DEPARTMENT/ AGENCY WHERE EMPLOYED
-----------------------	---------	---	--

If you identified individuals in items one and/or two above, describe in detail below the direct financial benefit to be gained by the public officials, public employees, and/or their family members as the result of the contract, proposal, request for proposal, invitation to bid, or grant proposal. (Attach additional sheets if necessary.)

Describe in detail below any indirect financial benefits to be gained by any public official, public employee, and/or family members of the public official or public employee as the result of the contract, proposal, request for proposal, invitation to bid, or grant proposal. (Attach additional sheets if necessary.)

List below the name(s) and address(es) of all paid consultants and/or lobbyists utilized to obtain the contract, proposal, request for proposal, invitation to bid, or grant proposal:

NAME OF PAID CONSULTANT/LOBBYIST	ADDRESS
----------------------------------	---------

By signing below, I certify under oath and penalty of perjury that all statements on or attached to this form are true and correct to the best of my knowledge. I further understand that a civil penalty of ten percent (10%) of the amount of the transaction, not to exceed \$10,000.00, is applied for knowingly providing incorrect or misleading information.

Signature _____ Date _____

Notary's Signature _____ Date _____ Date Notary Expires _____

Act 2001-955 requires the disclosure statement to be completed and filed with all proposals, bids, contracts, or grant proposals to the State of Alabama in excess of \$5,000.

**ALABAMA MEDICAID AGENCY
BUSINESS ASSOCIATE ADDENDUM**

This Business Associate Addendum (this "Agreement") is made effective the _____ day of _____, 20____, by and between the Alabama Medicaid Agency ("Covered Entity"), an agency of the State of Alabama, and _____ ("Business Associate") (collectively the "Parties").

1. BACKGROUND

- a. Covered Entity and Business Associate are parties to a contract entitled _____ (the "Contract"), whereby Business Associate agrees to perform certain services for or on behalf of Covered Entity.
- b. The relationship between Covered Entity and Business Associate is such that the Parties believe Business Associate is or may be a "business associate" within the meaning of the HIPAA Privacy Rule (as defined below).
- c. The Parties enter into this Business Associate Addendum to the Contract with the intention of complying with the HIPAA Privacy Rule provision that a covered entity may disclose protected health information to a business associate, and may allow a business associate to create or receive protected health information on its behalf, if the covered entity obtains satisfactory assurances that the business associate will appropriately safeguard the information.

2. DEFINITIONS

Unless otherwise clearly indicated by the context, the following terms shall have the following meaning in this Agreement:

- a. "HIPAA" means the Administrative Simplification Provisions, Sections 261 through 264, of the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191.
- b. "Individual" shall have the same meaning as the term "individual" in 45 CFR 164.501 and shall include a person who qualifies as a personal representative in accordance with 45 CFR 164.502(g).
- c. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR part 160 and part 164, subparts A and E.
- d. "Protected Health Information" (PHI) shall have the same meaning as the term "protected health information" in 45 CFR 164.501, limited to the information created or received by Business Associate from or on behalf of Covered Entity.
- e. "Required By Law" shall have the same meaning as the term "required by law" in 45 CFR 164.501.
- f. "Secretary" shall mean the Secretary of the United States Department of Health and Human Services or his designee.
- g. Unless otherwise defined in this Agreement, capitalized terms used herein shall have the same meaning as those terms have in the Privacy Rule.

3. OBLIGATIONS OF BUSINESS ASSOCIATE

- a. Use and Disclosure of PHI. Business Associate agrees to not use or disclose PHI other than as permitted or required by this Agreement or as Required By Law.
- b. Appropriate Safeguards. Business Associate agrees to use appropriate safeguards to prevent use or disclosure of the PHI other than as provided for by this Agreement. The Business Associate agrees to take steps to safeguard, implement and maintain PHI in accordance with the HIPAA Privacy Rule.
- c. Mitigation. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI by Business Associate in violation of the requirements of this Agreement.
- d. Report Unauthorized Use or Disclosure. Business Associate agrees to promptly report to Covered Entity any use or disclosure of PHI not provided for by this Agreement of which it becomes aware.
- e. Applicability to Business Associate's Agents. Business Associate agrees to ensure that any agent, including a subcontractor, to whom it provides PHI received from, or created or received by the Business Associate on behalf of, Covered Entity agrees to the same restrictions and conditions that apply through this Agreement to Business Associate with respect to such information. The Business Associate agrees to have HIPAA-compliant Business Associate Agreements or equivalent contractual agreements with agents to whom the Business Associate discloses Covered Entity PHI.
- f. Access. Upon receipt of a written request from Covered Entity, Business Associate agrees to provide Covered Entity, in order to allow Covered Entity to meet its requirements under 45 CFR 164.524, access to PHI maintained by Business Associate in a Designated Record Set within thirty (30) business days.
- g. Amendments to PHI. Business Associate agrees to make any amendment(s) to PHI maintained by Business Associate in a Designated Record Set that Covered Entity directs or agrees to, pursuant to 45 CFR 164.526 at the request of Covered Entity, within thirty (30) calendar days after receiving a written request for amendment from Covered Entity.
- h. Availability of Documents. Business Associate agrees to make 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 the Business Associate on behalf of, Covered Entity, available to Covered Entity or to the Secretary for purposes of the Secretary determining Covered Entity's compliance with the Privacy Rule, within five business days' after receipt of written notice.
- i. Documentation of PHI Disclosures. Business Associate agrees to keep records of disclosures of PHI and information related to such disclosures as would be required for Covered Entity to respond to a request by an individual for an accounting of disclosures of PHI in accordance with 45 CFR 164.528.
- j. Accounting of Disclosures. The Business Associate agrees to provide to Covered Entity, within 30 days of receipt of a written request from Covered Entity, information collected in accordance with the documentation of PHI disclosure of this Agreement, to permit Covered Entity to respond to a request by an Individual or an authorized representative for an accounting of disclosures of PHI in accordance with 45 CFR 164.528.

4. PERMITTED USES AND DISCLOSURES

Except as otherwise limited in this Agreement, if the Contract permits, Business Associate may use or disclose PHI to perform functions, activities, or services for, or on behalf of, Covered Entity as specified in the Contract, provided that such use or disclosure would not violate the Privacy Rule if done by Covered Entity;

- a. Except as otherwise limited in this Agreement, if the Contract permits, Business Associate may use PHI for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate.
- b. Except as otherwise limited in this Agreement, if the Contract permits, Business Associate may disclose PHI for the proper management and administration of the Business Associate, provided that:
 - 1) disclosures are Required By Law; or
 - 2) Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as Required By Law or for the purpose for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.
- c. Except as otherwise limited in this Agreement, if the Contract permits, Business Associate may use PHI to provide data aggregation services to Covered Entity as permitted by 42 CFR 164.504(e)(2)(i)(B).
- d. Notwithstanding the foregoing provisions, Business Associate may not use or disclose PHI if the use or disclosure would violate any term of the Contract.

5. OBLIGATIONS OF COVERED ENTITY

- a. Covered Entity shall notify the Business Associate of any limitation(s) in its notice of privacy practices in accordance with 45 CFR 164.520, to the extent that such limitation may affect Alabama Medicaid's use or disclosure of PHI.
- b. Covered Entity shall notify the Business Associate of any changes in, or revocation of, permission by an Individual to use or disclose PHI, to the extent that such changes may affect the Business Associate's use or disclosure of PHI.
- c. Covered Entity shall notify the Business Associate of any restriction to the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 CFR 164.522, to the extent that such restriction may affect the Business Associate's use or disclosure of PHI.
- d. Covered Entity shall not request Business Associate to use or disclose PHI in any manner that would not be permissible under the Privacy Rule if done by Covered Entity.
- e. Covered Entity shall provide Business Associate with only that PHI which is minimally necessary for Business Associate to provide the services.

6. TERM AND TERMINATION

- a. **Term.** The Term of this Agreement shall be effective as of the effective date stated above and shall terminate when the Contract terminates.
- b. **Termination for Cause.** Upon Covered Entity's knowledge of a material breach by Business Associate, Covered Entity may, at its option:

- 1) Provide an opportunity for Business Associate to cure the breach or end the violation, and terminate this Agreement if Business Associate does not cure the breach or end the violation within the time specified by Covered Entity;
- 2) Immediately terminate this Agreement; or
- 3) If neither termination nor cure is feasible, report the violation to the Secretary as provided in the Privacy Rule.

c. Effect of Termination.

- 1) Except as provided in paragraph (2) of this section or in the Contract, upon termination of this Agreement, for any reason, Business Associate shall return or destroy all PHI received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity. This provision shall apply to PHI that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the PHI.
- 2) In the event that Business Associate determines that returning or destroying the PHI is not feasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction not feasible. 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.

7. GENERAL TERMS AND CONDITIONS

- a. This Agreement amends and is part of the Contract.
- b. Except as provided in this Agreement, all terms and conditions of the Contract shall remain in force and shall apply to this Agreement as if set forth fully herein.
- c. In the event of a conflict in terms between this Agreement and the Contract, the interpretation that is in accordance with the Privacy Rule shall prevail. Any ambiguity in this Agreement shall be resolved to permit Covered Entity to comply with the Privacy Rule.
- d. A breach of this Agreement by Business Associate shall be considered sufficient basis for Covered Entity to terminate the Contract for cause.
- e. The Parties agree to take such action as is necessary to amend this Agreement from time to time for Covered Entity to comply with the requirements of the Privacy Rule and HIPAA.

IN WITNESS WHEREOF, Covered Entity and Business Associate have executed this Agreement effective on the date as stated above.

ALABAMA MEDICAID AGENCY

Signature: _____

Printed Name: Paul Brannan

Title: Privacy Officer

Date: _____

BUSINESS ASSOCIATE

Signature: _____

Printed Name: _____

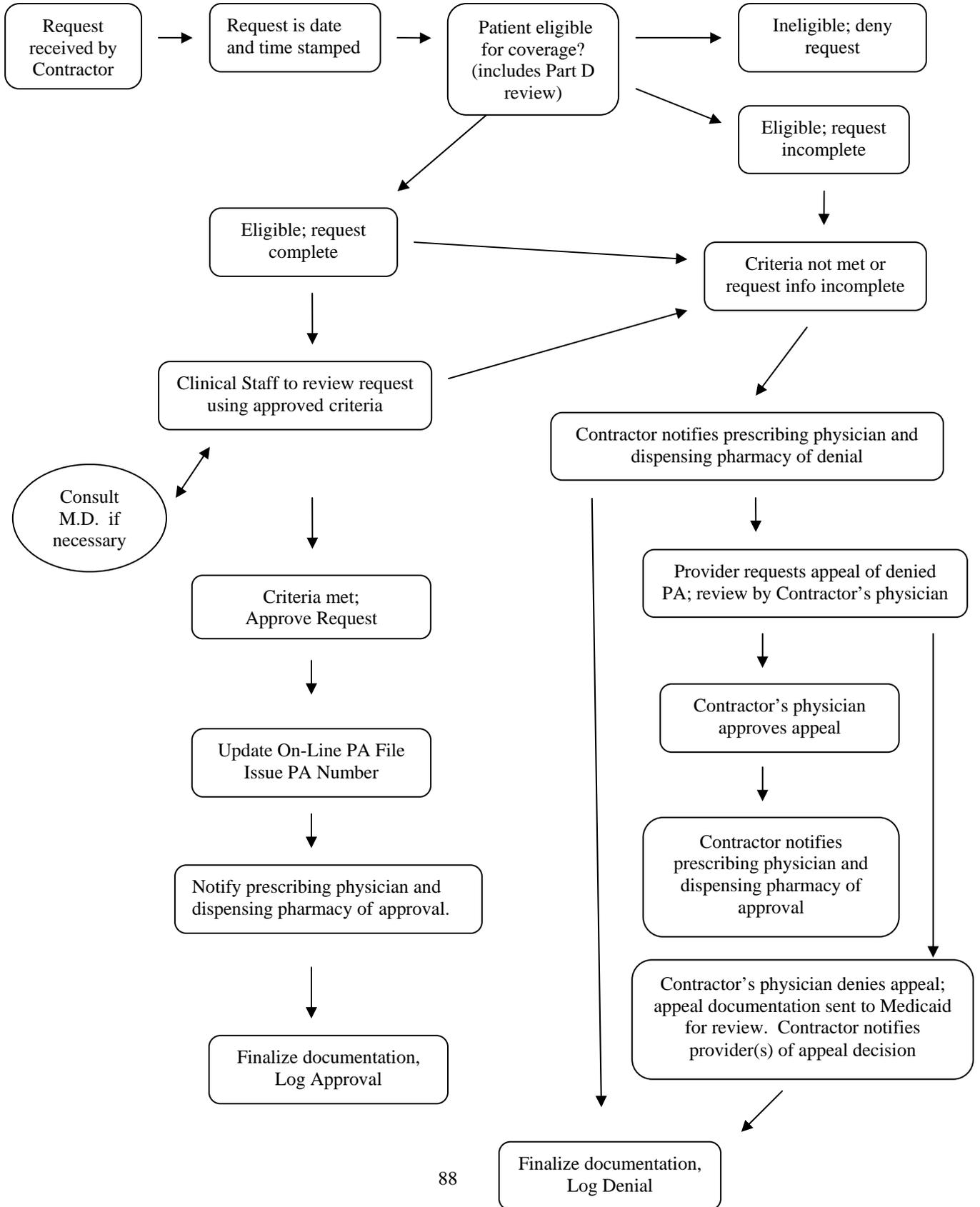
Title: _____

Date: _____

Mandatory Bid Requirements Checklist

1. Has company had business license for minimum of three years?
2. Is company licensed to do business in Alabama?
3. Did bidder submit original and six (6) hard copies and one (1) electronic copy of bid on CD in Word 6.0 or higher format?
4. Were all requirements specified by the ITB provided?
5. Does the bid cover the time period specified?
6. Does the bid accept the requirement for a performance bond?
7. Is the bid accompanied by a bid guarantee for five thousand dollars (\$5,000)?
8. Does the price sheet state a total evaluated price for implementation of a program as described in the ITB?
9. Have Pricing schedules A, B and C been filled out completely and signed?
10. Is page 1 of ITB signed and notarized?
11. Was overview of company history and structure provided, as well as a description of the organization's overall capabilities?
12. Does the bid demonstrate bidder's ability to develop and apply predetermined standards for drugs or drug classes identified for review?
13. Does the bid demonstrate bidder's ability to develop and apply predetermined standards for drugs or drug classes added to the contract subsequent to the initial drugs identified for review?
14. Did the bidder include a work plan for educating physicians and pharmacists of appropriate utilization?
15. Did the bidder submit plan outlining provider education and academic detailing capabilities?
16. Did the bidder submit work plan for MAC program responsibilities?
17. Did the bidder provide documented experience and work plans for provider education programs, prior authorization and MAC pricing?
18. Does the bid demonstrate the ability to secure and retain professional staff to meet contract requirements to include administrative personnel, pharmacists, physicians and provider representatives?
19. Are resume/s included for the project manager, account physician and account pharmacist with the bid?
20. Were a minimum of four references provided? Was client name, contact name, title, telephone number, contract type, size and duration provided?
21. Does the bid demonstrate, upon award of the contract, the ability of contractor to implement all aspects of this ITB (help desk, electronic prior authorization, staff, DUR, Academic Detailing, etc.), in a manner that meets (at minimum) the current standard program in place, by November 1, 2008?

Manual Prior Authorization and Override Workflow Diagram



Current Contractor Specifications

Current Contractor specifications for the Help Desk component are as follows:

Twenty-two (22) FTE Help Desk Attendees

One (1) LPN

One (1) RN

One (1) Account Pharmacist

One (1) Consulting Physician

Twenty telephone lines for the toll-free Help Desk phone number

Eight FAX lines for the toll-free Help Desk FAX number

Twenty-five computers