PBM Toolkit
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All resources and materials in this toolkit have been developed between January 2013 and March 2014. Production of these materials and the following cumulative electronic toolkit was funded under a cooperative agreement with Human Resources and Services Administration (HRSA).
What is a PBM?
OVERVIEW

Pharmacy Benefits Managers (PBM) and Insurance Benefits Managers (IBM)
OVERVIEW: Pharmacy Benefits Managers and Insurance Benefits Managers

PHARMACY BENEFITS MANAGER (PBM)


What is a PBM?

A pharmacy benefits manager is an organization or system that provides administrative and pharmacy claim adjudication services, and pharmacy benefit coverage programs. PBM services can include:

- Contracting with a network of pharmacies
- Establishing payment levels for provider pharmacies
- Negotiating rebate arrangements
- Developing and managing formularies, preferred drug lists, and prior authorization programs
- Maintaining patient compliance programs
- Performing drug utilization review
- Operating disease management programs

Many PBMs also operate mail order pharmacies or have arrangements to include prescription availability through mail order pharmacies.

Administrative functions typically include:

- Establishing and maintaining a network of providers (recruit and manage a network of pharmacies that fill prescriptions for Ryan White ADAP clients; negotiate prices and payment terms and contract with pharmacies, monitor/audit performance)
- Centrally process claims in real time, claim adjudication, record keeping and reports to clients, payment to providers and fiscal intermediaries (e.g., processing of co-payments, deductibles for medications; track data required to receive rebates; performing electronic split billing at pharmacy point of service, pay pharmacy invoices, and bill ADAP; handle rebates and discounts with pharmaceutical companies; serve as electronic data transfer agent to meet all requirements related to Medicare TrOOP payments [serve as TrOOP coordinator and prepare reports]; paying HIC co-payments and deductibles)
- Assist with benefit design and business rules (covered drugs, exclusions, limits cost-sharing provisions [differential co-payments for generic or preferred drugs], mail-order dispensing)
- Information management (risk assessment, profiling)
- Continuous electronic insurance eligibility checking
- Pharmacoeconomic studies

In addition, PBMs perform a variety of drug utilization functions. These services generally involve “managing” drug utilization to reduce costs and maintain or improve quality. These functions include policies and programs to affect prescribing and dispensing patterns and are targeted towards pharmacists, patients, and prescribers. The range of drug utilization functions that a PBM can offer include:

- Formulary and formulary related activities (provider incentives, patient incentives, rebate management, prior authorization therapeutic interchange)
• Drug use review (retrospective-drug utilization review (DUR), prospective-DUR [some PBMs use the term “concurrent-DUR”]), DUR interventions, “academic detailing,” provider education

• Disease management (therapeutic outcomes management)

• Patient compliance (patient education, e.g., newsletters; phone reminders)

PBMs may charge a per transaction administrative fee, depending on the number and extent of services that they are contracted to perform. The fees charged, if any, are dependent on the contract terms negotiated between the ADAP and PBM. ADAPs that contract with a PBM pay for the cost of the drug, the pharmacy dispensing fee, and an additional per claim administrative fee. In some cases, the administrative fee is rolled into the dispensing fee charged per prescription.

Examples of PBMs
The following directory can be a useful resource for identifying PBMs that operate within your state:
http://www.pbmi.com/pbmdir.asp

INSURANCE BENEFITS MANAGER (IBM) OR THIRD-PARTY ADMINISTRATOR (TPA)

What is an IBM?
An insurance benefits manager or third-party administrator is an organization or system that provides administrative and insurance claim adjudication services. An IBM/TPA is neither the insurer nor the insured; it simply handles the administration of the plan. IBM/TPA functions can include:

• Claims processing/administration
• Claims adjudication
• Negotiation of claims
• Record keeping

• Premium collection/payment
• Enrollment activities
• Access to provider networks
• Utilization review
• Other administrative activities

IBMs/TPAs are prominent players in the managed care industry and have the expertise and capability to administer all or a portion of the claims process.

Examples of IBMs
The following directory can be a useful resource for identifying IBMs/TPAs that operate within your state:

ADAPS AND PBMS/IBMS
As of January 2013, more than 30 states were using a PBM to provide administrative and pharmaceutical claims adjudication services for at least a portion of their traditional ADAP (full payment of medications). Of these states, many were also currently using or exploring the use of a PBM/IBM/TPA to assist in the claims adjudication process for the insurance component of their program, including eligibility screening, enrollment, and payments. ADAPs cite many reasons why they have contracted with a PBM and/or IBM/TPA, including:

• Reduction in administrative costs
• Improvement in the efficiency of services provided to clients
• Assistance in eligibility screening to ensure payer of last resort
• Streamlining of the ADAP prescription and payment delivery system, including inventory control
• Management of rebate processing
WEBINAR

Insurance and PBM Utilization

ADAP AND INSURANCE: PURCHASING

CONTINUING INSURANCE AND
UTILIZING PHARMACY BENEFITS MANAGERS

INSURANCE BENEFITS MANAGERS
The following is the original webinar text. An online recording of this webinar is available at https://hrsa.connectsolutions.com/p5zioxal1s0/?launcher=false&fcsContent=true&pbMode=normal.

ADAPS AND INSURANCE

- The Ryan White Program allows states to use ADAP dollars to purchase health insurance and pay insurance premiums, co-payments and/or deductibles for individuals eligible for ADAP, provided the insurance has comparable formulary benefits to that of the ADAP.

- Per HRSA policy notice 07-05, ADAPs are permitted to purchase or continue an insurance policy for clients. This policy notice serves as an update to the previously issued HRSA policy notice 99-01.

- Prior to the use of ADAP funds for the purchase of health insurance, states must provide HRSA/HAB with notification of intent with the aforementioned assurances to the Grants Management Specialist.

Funds designated to carry out the provisions of Section 2616 of the Public Health Service Act may be used to purchase health insurance whose coverage includes the full range of HIV treatments and access to comprehensive primary care services, subject to the conditions below:

1. Funds must continue to be managed as part of the established ADAP Program.

2. ADAP programs must be able to account for and report on funds used to purchase and maintain insurance policies for eligible clients including covering any costs associated with these policies.

3. Funds may only be used to purchase premiums from health insurance plans that at a minimum provide prescription coverage equivalent to the Ryan White HIV/AIDS Program Part B formulary.

4. The total annual amount spent on insurance premiums cannot be greater than the annual cost of maintaining that same population on the existing ADAP program.

5. Funds may be used to cover any costs associated with the health insurance policy, including co-payments, deductibles, or premiums to purchase or maintain insurance policies.

6. Current client eligibility guidelines, set under Section 2616(b) of the Public Health Service Act, must be followed. The States must maintain their contributions to their HIV/AIDS care programs as required under Section 2617(b)(7)(E).

7. Ryan White HIV/AIDS Program funds must be the payers of last resort for pharmaceuticals.

8. The State must assure that ADAP funds will not be used to purchase health insurance deemed inadequate by the State in its provision of comprehensive primary care services.
• States are increasingly using ADAP funds for this purpose.

  - Forty ADAPs reported using funds for insurance purchasing/continuation in 2012 representing $227 million in estimated expenditures in FY2012.
  
  - ADAPs reported spending over $20.3 million on insurance purchasing/continuation in June 2012.
  
  - In June 2012, 46,653 ADAP clients were covered by such arrangements.
  
  - Spending on insurance purchasing/continuation represented an estimated $434 per capita in June 2012, about 59% of the average monthly cost per client for medications purchased by ADAPs, based on overall drug expenditures, in that month ($1,054).

**INSURANCE PURCHASING AND HEALTH REFORM**

• States are preparing insurance purchasing programs for ACA coverage by:

  - Coordinating ADAP eligibility and application processes with the Marketplace, including aligning ADAP income criteria with Modified Adjusted Gross Income (MAGI).
  
  - Assessing ADAP capacity to help clients afford Marketplace coverage (for clients receiving subsidies as well as those ineligible for federal subsidies).
  
  - Developing relationships with Marketplace plans and pharmacies.
  
  - Assessing scope of coverage and cost of Marketplace plans.
  
  - Ramping up ADAP benefits counseling activities and staff.

**INSURANCE PURCHASING AND CONTINUATION CHECKLIST**

• When considering making any changes, determine if they are economically feasible and administratively manageable for the ADAP in light of current staff capacity and internal administrative processes.

<table>
<thead>
<tr>
<th>2014 ACA Coverage Option</th>
<th>Income Eligibility Threshold</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid Expansion</td>
<td>Income up to 138% FPL</td>
</tr>
<tr>
<td>Advance Premium Tax Credit for purchase of private insurance through exchanges/marketplaces</td>
<td>Income between 100 and 400% FPL (ineligible for Medicaid or affordable employer-based coverage)</td>
</tr>
<tr>
<td>Cost-sharing subsidies to offset out-of-pocket costs of private insurance through exchanges/marketplaces</td>
<td>Income between 100 and 250% FPL (ineligible for Medicaid or affordable employer-based coverage)</td>
</tr>
<tr>
<td>Unsubsidized private insurance coverage through exchanges/marketplaces</td>
<td>Income below 100% FPL (ineligible for Medicaid)</td>
</tr>
</tbody>
</table>
• Train case managers on how to enroll clients in the insurance program.

• Educate clients and case managers about the insurance purchasing and continuation program.

• Verify that ADAP pharmacy network or direct purchase administration can work with the health insurance payers.

• Consider the feasibility of electronic application systems.

• Develop plan assessment tools and procedures.

• Anticipate problems with client participation in the insurance program that may occur with implementation and develop procedures to respond rapidly to address unintended consequences – including waivers.

• Be familiar with state legislation and administrative regulations that may impact your ability to make changes in ADAP.

• Follow the internal state agency process for review and approval of changes to the ADAP.

• Communicate to the community about why and when the ADAP will introduce an insurance purchasing and/or continuation program.

• If Ryan White Part B programs decide to use ADAP funds to purchase health insurance, they must submit a Notification of Intent to HRSA that addresses: the methodology that will be used, an assurance that the pharmaceutical component of the insurance policy includes a formulary equivalent to the ADAP formulary, and assurance that the cost of providing coverage to clients through the insurance program is cost neutral in the aggregate. (See HAB Policy Notice 07-05.)

• Consult other ADAPs that have investigated and/or adopted an insurance program to find out how they approached it, the results and lessons learned.

• Communicate with your HRSA Project Officer and NASTAD when the state is considering implementing an insurance program, when and if significant challenges arise, and when any changes are actually implemented.

ADAPS AND PBMS/IBMS

• ADAPs cite many reasons why they have contracted with a PBM and/or IBM/TPA, including:
  - Reduction in administrative costs
  - Improvement in the efficiency of services provided to clients
  - Assistance in eligibility screening to ensure payer of last resort
  - Streamlining of the ADAP prescription and payment delivery system, including inventory control
  - Management of rebate processing

WHAT IS A PBM?

• A pharmacy benefits manager is an organization or system that provides administrative and pharmacy claim adjudication services, and pharmacy benefit coverage programs.

• Many PBMs also operate mail order pharmacies or have arrangements to include prescription availability through mail order pharmacies.

• Administrative functions typically include:
  - Establishing and maintaining a network of providers Centrally process claims in real
  - Assist with benefit design and business rules
  - Information management
  - Continuous electronic insurance eligibility checking
  - Pharmacoeconomic studies
In addition, PBMs perform a variety of drug utilization functions. The range of drug utilization functions that a PBM can offer include:

- Formulary and formulary related activities
- Drug use review
- Disease management
- Patient compliance

PBMs may charge a per transaction administrative fee, depending on the number and extent of services that they are contracted to perform.

- The fees charged, if any, are dependent on the contract terms negotiated between the ADAP and PBM.
- ADAPs that contract with a PBM pay for the cost of the drug, the pharmacy dispensing fee, and an additional per claim administrative fee.
- In some cases, the administrative fee is rolled into the dispensing fee charged per prescription.

An insurance benefits manager or third-party administrator is an organization or system that provides administrative and insurance claim adjudication services. An IBM/TPA is neither the insurer nor the insured; it simply handles the administration of the plan.

IBM/TPAs are prominent players in the managed care industry and have the expertise and capability to administer all or a portion of the claims process.

ADAPS AND REBATES

REBATES ON DEDUCTIBLES AND CO-PAYMENTS

- Per HRSA program letter dated April 29, 2005, ADAPs are permitted to file for full rebates on partial payments of health insurance policies.
- ADAP grantees that participate in the 340B drug pricing program can claim full rebates on partial pay claims under one of the following circumstances:
  - The ADAP grantee must pay the deductible for the patient’s medication under the insurance policy, whether or not the program also pays the health insurance premium; or
  - The ADAP grantee must pay the co-pay for the patient’s medication under the insurance policy, whether or not the program also pays the health insurance premium.

- In both of the stated circumstances, there is a direct relationship between the ADAP payment and the patient’s medication.

- Drugs that are fully reimbursed by insurance plans, where only the insurance premiums have been funded by ADAPs, are not eligible for rebate.
  - Therefore, payment of the insurance premium alone does not entitle an ADAP to claim a rebate under the 340B drug pricing program.

WHAT IS AN IBM?

- An insurance benefits manager or third-party administrator is an organization or system that provides administrative and insurance claim adjudication services. An IBM/TPA is neither the insurer nor the insured; it simply handles the administration of the plan.

- IBM/TPAs are prominent players in the managed care industry and have the expertise and capability to administer all or a portion of the claims process.
**FILING FOR REBATES**

- ADAPs should bill for units dispensed or other out-lays for prescription costs.

- To file for rebates, ADAPs must bill drug manufacturers for the 340B and ACTF Unit Rebate Amount (URA) for the number of units dispensed.

- To do so, ADAPs should submit a cover letter and claims submission to each pharmaceutical company for which the ADAP is seeking a rebate.

- The cover letter should be sent on ADAP/health department letterhead and include the following information:
  - Date the claims submission is being submitted
  - A statement that the ADAP participates in the 340B drug discount program.
  - Notation about which quarter rebates are being submitted for (i.e., Calendar Year 2013 Quarter 1)
  - Payment remittance information
    - To whom the check should be payable (i.e., Department of Health, ADAP)
    - Federal identification number
    - Contact name
    - Mailing address
  - Phone number in the event of questions

- The claims submission should include:
  - Company specific listing
  - Notation about which quarter rebates are being submitted for (i.e., Calendar Year 2013 Quarter 1)

  - Table for the claims submission, noting:
    - NDC
    - Drug name
    - Quantity dispensed
    - Number of prescriptions
    - Amount paid out in claims

- Rebates should be submitted within 90 days of the close of a given quarter.

**RESOURCES**

- National Alliance of State and Territorial AIDS Directors (NASTAD) – [www.NASTAD.org](http://www.NASTAD.org)


- Public Law No. 104-191, Health Insurance Portability and Accountability Act of 1996

OVERVIEW

ADAPs Contracts With Pharmacy Benefit Managers (PBM), Insurance Benefit Managers (IBM)/Third Party Administrators (TPA), and Medical Benefits Managers (MBM)
OVERVIEW: ADAPs Contracts With Pharmacy Benefit Managers (PBM), Insurance Benefit Managers (IBM)/Third Party Administrators (TPA), and Medical Benefits Managers (MBM)

NASTAD recently surveyed ADAPs about their use of pharmacy benefit managers (PBM), insurance benefit managers (IBM)/third party administrators (TPA), and medical benefits managers (MBM). Forty-two ADAPs responded to the survey. A fact sheet about PBMs, IBMs, and MBMs is available online.

PHARMACY BENEFIT MANAGERS (PBM)

- Seventy-nine percent of ADAPs report their program has a contract in place with a PBM.

- PBM providers used: Ramsell Public Health (7 ADAPs), CVS Caremark (5 ADAPs), ScriptGuide RX (4 ADAPs), Local central pharmacy (3 ADAPs), Catamaran (2 ADAPs), Hewett Packard PBM (2 ADAPs), Magellan Health Services (2 ADAPs), Molina (2 ADAPs), State Medicaid (2 ADAPs), Citizens RX (1 ADAP), Goold Health System (1 ADAP), Xerox (1 ADAP).

- Benefits: created a statewide pharmacy network and claims adjudication system, better facilitation of TrOOP with CMS, facilitation of client-level data reporting to HRSA, increased ability to collect rebates and back-bill, increased eligibility and re-certification screening efficiency, reduced dispensing and distribution costs, increase medication inventory control, and provided adherence counseling services and monitoring of clients.

Example Response: ADAP uses our state’s Medicaid’s interChange system, administered by HP, to electronically process and pay ADAP pharmacy claims. Prior to using this system ADAP processed and paid all claims in a largely manual paper-based system. Using interChange has greatly reduced administrative burden. Pharmacies can now submit ADAP claims electronically rather than on paper, reducing burden for them also. Payments are also generated by HP and can be done through electronic funds transfer or by check. InterChange adjudicates claims and denies payment of ADAP claims if there is a third party payer that wasn’t billed before ADAP, if the drug is not covered by ADAP or if the patient is not ADAP eligible on the date of service.

- Challenges: software training and integration with established data systems is difficult, corporate culture versus public health priorities, and customer service needs versus response times.

INSURANCE BENEFIT MANAGER (IBM)/THIRD PARTY ADMINISTRATOR (TPA)

- Twenty-six percent of ADAPs report their program has a contract in place with a IBM/TPA.

- IBM providers used: Health Management Systems (2 ADAPs), Hewlett Packard (2 ADAPs), NEXTGEN RCM (1 ADAP), Ramsell (1 ADAP).
Five ADAPs use a local community based organizations (CBO) to provide IBM/TPA services.

Benefits: ability to pay and track insurance premium payments and plan changes efficiently, provides administrative tasks that state agencies are not capable of doing (i.e. claims adjudication, service payments, or network development), flexibility to responds to changing needs, and capitalize on efficiencies and cost negotiations that would not otherwise be realized in the state agency (e.g. timely negotiate subcontracts).

Challenges: software and data system integration, lack of communication with patients and providers of program changes, and delays in correcting errors that resulted in clients losing insurance benefits.

Example Response: Contracting with a third party agency in this way has allowed the grantee to focus on the required administrative functions. State governments do not specialize in claims processing, service payments, or network development. In contracting with an IBM/TPA we are able to secure providers who do specialize in the required daily functions and processes. The IBM/TPA structure allows the program greater flexibility in being responsive to the changing needs of the program. Lastly, there is cost savings in choosing an IBM/TPA that can capitalize on efficiencies and cost negotiations that would not otherwise be realized in the state agency.

Medical Benefits Manager (MBM)

Ten percent of ADAPs report their program has a contract in place with a MBM.

MBM providers used: NEXTGEN RCM (1 ADAP) while three are using local CBOs.

Benefits: provides services to monitor and pay medical co-payments and deductibles and processes payments in a timelier manner and ability to address emergency situations more readily then established state procedures.

Example Response: Payments to insurance companies, physicians, laboratories, hospitals, mental health providers, as well as other medical providers, such as dentists in a timely and more efficient manner.

Challenges: integration of data systems, ability to change scope of work as needed, and ensuring that providers invoice medical co-payments and deductible payments correctly.

Contracted Services by Type of Provider

The following table shows services currently being contracted or being adminstered in-house. Many of these services do overlap between the contract provider, local CBOs, and in-house. This overlap demonstrates that there are multiple models of organization to meet client needs and program ability to monitor for quality assurance.
### RANGE OF COSTS FOR CONTRACTED SERVICES

**Prescription Claim Processing:** $0.34 - $6.00 per claim; average is $3.00-3.50. Some have variable fees associated with claim type (e.g., in or out of network, or ADAP versus insurance (i.e., Medicaid, Medicare, or private). Fees may be associated with number of program clients. Fees may be charged as total per month fee with a range of $12,000 to $48,000 per month.

**Insurance Claim Fees:** $6.00-$49.21 per claim

**Client Enrollment Fees:** Currently this fee is not standard, or may be included in other administrative fees.

**Data Reports:** Most program report this cost is included in the claim processing costs or administrative fees. Additional reports outside the previously negotiated contract requirements range from $50 to $200. These costs could be per additional report or per/hour.

**Pharmacy Dispensing Fees:** $1.60-$25.00. Average cost is about $3.00-$6.00 range. Costs can be varied by brand or generic, or claim type (e.g., full ADAP versus insurance). Higher cost dispensing fees, may be inclusive of other related services (i.e., ordering, shipping, provider consultation, etc.)

**Mail Order Dispensing Fees:** These fees could be include in the claim processing fee/administrative fees. Current range is $1.70-$13.55. You may negotiate variable costs associated with brand versus generic drugs.

**Mail Order Shipping Fees:** $0.00-$11; average is roughly $6.00. This cost could be included in dispensing fees or administrative costs.

<table>
<thead>
<tr>
<th>Contracted Services</th>
<th>PBM</th>
<th>IBM/TPA</th>
<th>MBM</th>
<th>IN-HOUSE</th>
<th>CBO</th>
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<tr>
<td>340B inventory management services</td>
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<td>Back-billing associated costs</td>
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<td>Cross match clients eligibility/enrollment with other payer sources (i.e., Medicaid, Medicare, and/or private insurance)</td>
<td>21</td>
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<td>Help desk/customer service</td>
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<td>Payments of insurance premiums and deductibles</td>
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<td>Step therapy/prior authorization</td>
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Selection and Implementation of a PBM
WEBINAR

PBM: From RFP to Implementation
The following is the original webinar text. An online recording of this webinar is available at https://hrsa.connectsolutions.com/p1rg9n9lw67/.

PBM: From RFP to Implementation

WHAT IS A PBM?

- A PBM or pharmacy benefits manager is an organization or system that provides administrative and pharmacy claim adjudication services, pharmacy benefit coverage programs, and drug utilization functions. Some may also have arrangements with mail-order pharmacies.

- PBMs do not adjudicate insurance claims; pay insurance premiums, deductibles, or co-payments; adjudicate medical claims; or pay medical co-payments.

- 79% of ADAPs have a contract with a PBM.

- Benefits of PBM Contract:
  - created a statewide pharmacy network and claims adjudication system
  - better facilitation of TrOOP with CMS
  - facilitation of client-level data reporting to HRSA
  - increased ability to collect rebates and back-bill
  - increased eligibility and re-certification screening efficiency
  - reduced dispensing and distribution costs
  - increased medication inventory control
  - provided adherence counseling services and monitoring of clients.

- Challenges of PBM Contract:
  - software training and integration with established data systems is difficult
  - corporate culture versus public health priorities
  - customer service needs versus response times.

STEP-BY-STEP PBM SELECTION AND IMPLEMENTATION

Why hire a PBM?

- Assist with contract and compliance monitoring of ADAP providers;

- Develop, implement and maintain an online claims processing database that will track and approve medication dispensing claims;

- Create and submit monthly invoices on behalf of the ADAP pharmacies with preapproved ADAP allowable claims;

- Produce bi-weekly client-level data regarding number of clients that picked-up their medications on time. This information will be shared with case managers to contract clients to assist with addressing any mitigating barriers;

- Ensure accurate third-party billing occurs at each dispensing transaction by rejecting medication dispensing claims submitted by pharmacist for clients that have other insurance types;

- Assist the Program with preparing documentation to submit to pharmaceutical companies to begin receiving rebates. The income derived will support the administrative cost of the PBM, as well as provide needed funds that will supplement reduced federal and local funding;
• Assist the program in making more accurate medication purchasing; and
• Assist with oversight of the ADAP formulary and mandated bi-annual updates.

**Request For Proposal (RFP) Process**

- Preparation of Scope of Services;
- Comparison of V.I. Scope of Services with other Ryan White program’s Scope of Services;
- Submission of Scope of Services to local Property & Procurement Department (P&P);
- RFP submitted to local media as well as online media.
- Review of proposals by P&P staff;
- Ensure that all requirements of the RFP were responded too as written and requested;
- Interview & Evaluation process by P&P staff in conjunction with Ryan White staff; and
- Selection of PBM which best met our needs.

**Implementation Process**

**Pre-Implementation Meetings**

- Discovery meeting held with PBM; and
- Scheduled weekly implementation calls with PBM.

**Contract Status**

- Discuss contract strategy with PBM, i.e., who is point of contact, who will manage contract; and
- Finalize and execute contract.

**Eligibility Process**

- Discuss eligibility process, update frequency & type of file;
- Determine method of transmission;
- Determine ID number origin and additional requirements;
- Perform first eligibility test file; and
- Discuss test results with PBM.

**Medicare Part D Data Sharing**

- Determined that PBM will assist with CMS file submission / data sharing;
- PBM initiated contact with CMS to begin data exchange implementation;
- PBM will send first test file to CMS; and
- PBM will send first production file to CMS.

**Finance**

- Determine billing / finance point of contact;
- Determine billing frequency; and
- PBM provided a sample of invoicing reports and billing information.

**ID Card Production**

- Discussed ID card layout with PBM;
- Determined mode of distribution and timeline for delivery of cards;
- Received ID card and welcome letter draft from PBM; and
- Provide approval of ID card and welcome letter.

**System Access**

- Provided staff names for access to PBM system; and
- Implementation of set-up and training by PBM.

**Member Service**

- Set-up services support needs, i.e., business hours, after-hours, weekends, holidays; and
- Implemented dedicated PBM toll free number for pharmacy services.

**Pharmacy Network**

- PBM executed contracts and set-up with pharmacies.

**Reporting**

- Provided PBM with reporting needs and frequency of plan performance reviews.

**Rebate Administration**

- Discussed rebate needs and the need for recoupment services.

**Outcomes of PBM Process**

- Initial savings of 25% on dispensing fees;
• Accuracy of dispensing fees billing is now electronic vs. manual verification;
• Eligibility verification is performed electronically;
• The electronic monthly reports are now assisting with inventory reconciliation; and
• Various reporting requirements are now available electronically.

PHARMACY BENEFIT MANAGER

Experience
• The overall goal of putting out an RFP for new a PBM was to expand services for ADAP clients and provide a more modernized and efficient system.
• Assess the needs and services required for your program (e.g. online adjudication, pharmacy network, COB, electronic reporting, formulary maintenance, eligibility, electronic applications, etc.)

Services
Programmatically, the GA ADAP was seeking to implement a more modernized and efficient system for an electronic eligibility assessment process; electronic ADAP application and recertification process; Clients’ Medicaid status confirmation; Coordination of benefits assessment for Medicare, Medicare Part D and other insurance companies; and a tracking and reporting system for coordination of benefits services. The ADAP was also seeking a faster and more efficient process for paying health insurance premiums.

REQUEST FOR PROPOSAL (RFP)

Process
• Identified deliverables as to what the PBM will do is identified.
• Submission of a Contract Action Request is completed. This form is the initial form that is needed to start the process.
• Procurement meets with the Business Owner, ADAP Manager and Pharmacy Director to discuss the next steps and develop a timeline with the RFP process (project plan). A committee is formed to review and score the proposals once the posting closes (can be persons in the department who have knowledge).
• The RFP for the Pharmacy Benefit Manager (PBM) is posted to the Department of Administrative Services (DOAS) for a minimum of 10 days and a maximum of 30 days.
• Vendors interested in the bid submits their proposals by the date set. Proposals sent after the closing of the bid will NOT be accepted under any circumstances.
• Any questions that the vendors have are to be directed to the Procurement specialist only!
• All vendors must meet the requirements through a series of questions. The category for the questions are (a) mandatory, (b) mandatory scored, and (c) additionally scored.
• The committee meets to score all vendors deemed eligible.
• If the vendor does not meet the criteria for the mandatory requirements, they are automatically disqualified from the bid.
• Once all qualified vendors have been scored one is selected to fulfill the requirement of the PBM.
• Public Notice of the contract identifying the successful bidder is posted.
• The selected vendor finalizes the contract agreement by agreeing to all terms.
• The funding period each is April 1 to March 31. The contract also has four (4) renewals AFTER the initial contract.
**Transition**

- The transition included 3-4 months of data testing and transference for both the pharmacy component and enrollment/eligibility component in preparation for full implementation effective April 1, 2013.

- In addition to data testing, there were numerous technical conference calls held in preparation for implementation.

- An enrollment site within the local metro area was selected as a pilot site for the initial implementation.

**Challenges**

- Providing a seamless electronic eligibility and enrollment process during the initial implementation stages.

**Lessons Learned**

- Confirm with winning bidder their understanding of contract language

- Assess the specific needs and services required for your program (e.g., Pharmacy services, Program services)

- Design technical evaluation, mandatories and scope of work to allow you to differentiate/score each vendor

- Request “real-time” access to the PBM in order to monitor services at anytime

- Be specific in the Scope of Work regarding methodology, timelines, implementation and execution.

- Work closely with legal team to assure strong language and tangible consequences for non-compliance with deliverables

- Double check/perform QM audits on reports, data deliverables of the PBM services to assure compliance
PBM Proposal Template
PBM Proposal Template

How to use: This is a template for creating a brief description of why it is necessary for an ADAP to contract with a pharmacy benefits manager (PBM) and how it will benefit your program. This template can be tailored to detail the unique needs of your program as some of these points may not apply to your program. Instructions are in italics.

NEED FOR A PHARMACY BENEFIT MANAGER

Briefing Submitted By:

Date:

Issue/Problem Statement  [Adapt this section to be specific to the problems your ADAP is currently facing.]

1  The AIDS Drug Assistance Program (ADAP) is not currently supported by a Pharmacy Benefits Manager (PBM) which would allow for the coordination of benefits for all ADAP clients. With the expansion of the insurance program it has been necessary to complete an increase of back billing for private and public insurances as Ryan White is a payer of last resort. Through contract management, the PBM has systematic capabilities to rotate back and forth between insurance and medication assistance programs seamlesly.

2  Clients do not have access to a network of providers to be able to fill medications and some clients are restricted to various retail and / or mail order pharmacies as a condition of their primary coverage. As a result, agencies that sub-contract through [State DPH] must individually create contracts for submitting payment to particular pharmacies which has been problematic for various agencies. Since PBMs are able to set-up contract with 100% of insurance companies, they are able to create the ADAP Quarterly Report, the ADAP Data Report, and complete rebate claims for 100% of copayments made on behalf of clients.

3  The AIDS Drug Assistance Program is not set-up with its own unique Rx Bin and Processor Claim Number (PCN) that would track ADAP payments made on behalf of Medicare Part D enrollees. HRSA issued the AIDS Drug Assistance Manual 2012 in the late fall of 2012, which states that all ADAPs should participate in electronic claims processing and sign a data sharing agreement with CMS to ensure that ADAP costs are accurately accounted for in the TrOOP calculation. Electronic processing helps ADAP automatically receive refunds due to retroactive adjustments to claims.

Background

To date, approximately 30 states have moved to the Pharmacy Benefit Manager (PBM) model from the previous structure of states utilizing contract pharmacies. The complications that have resulted from working with insurance companies have facilitated this movement to the PBM. PBMs are able to maneuver into the details of various insurance companies where ADAPs have been restricted. [Provide statement about your current ADAP enrollment numbers, including those that may already have insurance. Follow up, with an estimate of the number of clients that may be eligible for further insurance expansion in your state.]

Most recently HRSA has released information on the benefits of utilizing a PBM. “PBM Services can include: contracting with a network of pharmacies; establishing payment levels for provider pharmacies;
negotiating rebate arrangements; developing and managing formularies, preferred drug lists, and prior authorization program; maintaining patient compliance programs; performing drug utilization review; and operating disease management programs. Many PBMs also operate mail order pharmacies or have arrangements to include prescription availability through mail order pharmacy."

Since ADAP is one of the several customers of the PBM, the PBM may be able to secure significant discounts for pharmacy services and drug prices.

**Options**

[Adapt these options to best fit your program’s needs. Provide at least three options, as well as the pro and con for each.]

**Option #1**  **Issue an RFP for a Pharmacy Benefits Manager for both Medication Assistance and Insurance Assistance Programs**

**Pros:**

The PBM is able to rotate back and forth between the insurance assistance and medication assistance programs through a centralized system thus back-billing is more seamless. The PBM is able to set-up contracts for various insurance companies that allows the adjudication of claims that would be restricted at Pharmacy X to allow the PBM to pay the various copayments which eliminates the need for individual agencies to set up individual contracts. The PBM can track Medicare payments made through establishing a unique Rx Bin and Processor Claim Number which would allow any overpayments to be sent directly to the ADAP. The PBM is able to complete various ADAP reports as they have access to all patients who have filled thus this allows for greater integrity of programmatic data. Lastly, PBMs that contract with ADAPs have access to “cutting edge” information and are able to assist ADAPs with complex issues.

**Cons:**

Through additional pharmacy contracts, 340B oversight would need to be monitored more closely as a “virtual” inventory is typically used by most pharmacies and our current contract pharmacy uses a “physical” inventory which is typically more easily monitored.

**Option #2**  **Issue an RFP for a contract with a Pharmacy Benefits Manager only for the Insurance Assistance Program and continue our contract with Pharmacy X for the Medication Assistance Clients**

**Pros:**

Same benefits as listed in Option #1 above with the exception of the PBM rotating back and forth between the insurance assistance and medication assistance programs through a centralized system.

**Cons:**

The PBM would need data sharing agreements in place with Pharmacy X as the PBM couldn’t seamlessly rotate back and forth between the two programs without going through Pharmacy X. This cooperation could be challenging as having a data sharing agreement with a new Pharmacy Benefit Manager represents a loss of business for Pharmacy X. Also, a Pharmacy Benefit Manager would only be able to access partial data for ADAP reports as they would be limited to data on “Insurance Assistance Program” clients only.

**Option #3**  **Continue our current contract with Pharmacy X.**

**Pros:**

We have a long standing established relationship with the pharmacy. We only need to monitor one pharmacy as we only have one contact. The pharmacy is locally based to the ADAP
and this has been a plus. For many years, the processing of applications and sending medications was somewhat seamless up until recently.

**Cons:** Currently, the pharmacy is having a number of challenges keeping up with the increase of ADAP clients. There have been concerns related to clients not receiving medications in a timely manner, back-billing that accumulated that is now being addressed, changes in staffing at the pharmacy and loss of staff that understand the ADAP. Lastly, recently the pharmacy was purchased by Company X, which is a corporation and this has complicated some administrative tasks. Clients are mainly limited to mail order. We are unable to obtain ADAP reports from the pharmacy as the pharmacy doesn’t have contracts with all ADAP “Insurance Assistance Program” clients. Lastly, the pharmacy doesn’t work with other ADAPs and therefore it is difficult for them to be on the “cutting edge” of what is occurring and often ADAP needs to keep them abreast of ADAP issues.

**Recommended Action:** Option #1 *[Provide option choice that is most ideal for your program needs.]*

**Cost:** *[Provide an estimate of cost for the recommended options you have selected.]*

- The projected state cost is based on the example of the State X Pharmacy Benefit Manager contract that is calculated using client utilization. The current cost figures to be around $X per patient per month. Based on current utilization of X clients in MONTH, YEAR, the annualized cost would be approximately $X. As the ADAP continues to grow a more realistic cost calculation would be around $X per year figuring approximately X clients. This figure includes the shared electronic database as well.
Contact list for PBM/IBM/MBMs
Contact list for PBM/IBM/MBMs

PHARMACY BENEFITS MANAGERS

**Catamaran**
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Las Vegas, Nevada 89134
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**CVS Caremark**
*Contact:* Clay Keene
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*Email:* Clay.keene@caremark.com

**ScriptGuideRX (SGRX)**
15400 East Jefferson
Grosse Pointe Park, MI 48230
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*Contact:* Ime Ekpenyong, MBA
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**Goold Health Services**
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Augusta ME 04332-1090
*Contact:* Michael Ouellette, RPh
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(P) 207-622-7153

**Magellan Health Services**
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Glen Allen, VA 23060
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*Contact:* Raquel Holmes
*Email:* RHolmes@magellanhealth.com

**Molina**
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*Contact:* Kathy Wemer

**Ramsell Public Health RX Management**
200 Webster Street, Suite 200
Oakland, CA 94607
888-311-7632
[www.publichealthrx.com](http://www.publichealthrx.com)
*Contact:* Kris Nicklaus
(P) 510-587-2638
*Contact:* Chris Hanson
(P) 510-587-2643

**Xerox State Healthcare, LLC**
1120 N Charles Street
Suite 300, 3rd Floor
Baltimore, MD 21201
(P) 410-230-5451
(F) 410-244-1268

INSURANCE BENEFIT MANAGERS

**Colorado AIDS Project**
2490 W. 26th Ave, Ste. 300A
Denver, CO 80211
303-962-5310
*Contact:* Darrell Vigil
*Email:* Darrell.vigil@coloradohealthnetwork.org

**Dynaxys LLC**
11911 Tech Road
Silver Spring, MD 20904-1961
(P) 301-622-0900, ext. 447
*Contact:* Deborah Himmelheber
*Email:* dhimmelheber@dynaxys.com
**Evergreen Health Insurance Program**
(Insurance Premium Payment)
Lifelong AIDS Alliance
1002 E Seneca St
Seattle, Washington 98122-4214
*Contact:* Mark Baker
(P) 206-957-1694

**Health Management Systems (HMS)**
5615 High Point Dr.
Irving, TX 75038
[www.hms.com](http://www.hms.com)
*Contact:* Bonnie Vaughn
(P) 512-660-9870
Email: bonnie.vaughn@hms.com

**Healthcare Strategic Initiatives (HSI)/ NextGen RCM**
1836 Lackland Hill Parkway
St. Louis, Missouri 63146
(P) 314.872.1435 or Ext. 11435
(F) 314.810.1435
*Contact:* Meg Ebersoldt

**Southern Arizona AIDS Foundation (SAAF)**
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Tucson, AZ 85719
(P) 520.628.7223 / 800.771.9054
(F) 520.628.6222
*Contact:* Luis Ortega
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**MEDICAL BENEFIT MANAGERS**

**Healthcare Strategic Initiatives (HSI)/ NextGen RCM**
1836 Lackland Hill Parkway
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PBM Contract Language Bank and Things to Consider
Part B of the Ryan White HIV/AIDS Treatment Modernization Act (Ryan White Program) established federally funded, state-administered AIDS Drug Assistance Programs (ADAPs) to provide access to HIV medications for low-income, uninsured, and underinsured people living with HIV/AIDS (PLWHA) in the United States. Ryan White Program funds may provide insurance assistance to ADAP-eligible PLWHA through: maintenance of COBRA insurance continuation; State High Risk Health Insurance Pools; state-funded health programs; Pre-existing Condition Insurance Plans (PCIPs); the purchase of individual or group health insurance policies; or through Medicare Part D and Medicaid. ADAPs may provide insurance assistance through payments of premiums, deductibles, co-pays, co-insurance, or True out of Pocket (TrOOP) expenditures for Medicare Part D eligible PLWHA. The Affordable Care Act (ACA) expands access to Medicaid and Marketplace Qualified Health Plans (QHPs) for tens of thousands of people living with HIV. When wrapping around other forms of coverage, ADAPs must ensure that they are the payer of last resort.

In order to ensure ADAPs are the payer of last resort and to supplement the internal ADAP infrastructure, many ADAPs have contracted the services of Pharmacy Benefits Managers (PBM) and/or Insurance Benefit Managers (IBM) to adjudicate the claims and ensure accuracy in payment to the pharmacy and/or insurance company.

There is no one perfect system for contracting with a PBM/IBM and there is no one perfect contract as each program’s needs are unique and should be tailored to address ADAP infrastructure and systems in order to meet client’s needs and ability to access the services.

Below are examples of language from existing PBM/IBM contracts for some of the standard services often requested and provided, as well as language specific to costs and fees related to these services. Contract language can either be very simple or very detailed. These examples are meant to assist your program in writing a request for proposal (RFP) or contract to ensure ADAPs gets the most appropriate PBM/IBM services. Examples of current contracts ADAPs have with PBM/IBMs are available upon request. This is a working document; please share your comments or suggestions with Christopher Cannon at ccannon@nastad.org.

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**PBM Contract Language Bank and Things to Consider**

**THINGS TO CONSIDER**

*Before drafting an RFP or contract with a PBM/IBM:*

- Evaluate the ADAP program to determine current staff and system capacity.
- Determine which services to administer in-house and which to outsource.
- Speak with other programs within your health departments and ADAPs in other states that have established PBM/IBM contracts.
- Use contract language bank to help draft RFP and/or contracts.
- Consult with NASTAD during the review and drafting process for additional technical assistance.
PROVIDED SERVICES

Coordination of Benefits/Claims Processing

Example 1:

The CONTRACTOR shall provide pharmacy benefits management services to the DEPARTMENT and eligible clients starting April 1, 2013. Specifically the CONTRACTOR shall provide pharmacy benefits management services, including claims adjudication, coordination of benefits and point-of-sale processing services to eligible clients with coverage through Medicare Part D, the [State] Comprehensive Health Insurance Pool (HIP[State]), and private insurance, as well as those who are uninsured and receive medication benefits through the [State] ADAP.

1. The CONTRACTOR’s electronic claims processing shall allow pharmacies to do online adjudication and split billing, resulting in pharmacies and/or clients not being required to submit manual claims for secondary payment.

2. The CONTRACTOR shall allow for coordination of primary, secondary and tertiary payers of prescription claims. The CONTRACTOR shall have the ability to transmit primary, secondary, and/or tertiary insurance information to pharmacies.

3. Prescription claims shall pay with the DEPARTMENT as final payer based on other payers’ payment of claim using lesser-of-logic. The DEPARTMENT shall be the payer of last resort.

4. The CONTRACTOR shall coordinate coverage and benefits with insurance providers including Medicare Part D Prescription Drug Plans (PDPs) and shall ensure that applicable expenditures are credited toward meeting clients’ true out-of-pocket (TrOOP) expenditure requirement. The CONTRACTOR shall participate in the electronic data exchange processes as specified by the [State] Medicaid Program for reporting eligible client TrOOP expenses to the [State] Medicaid Program Data Contractor.

5. The CONTRACTOR shall ensure that the DEPARTMENT does not pay for a medication(s) not on the [State] ADAP Formulary or on the formulary for the specific insurance or Medicare Part D plan in which an eligible client is enrolled.

6. The CONTRACTOR shall maintain, for the DEPARTMENT, a unique Prescription Benefit International Number (RXBIN) and a unique Pharmacy Benefit Processor Control Number (PCN) to code for coverage that is supplemental to Medicare Part D.

Example 2:

The Contractor will provide electronic pharmacy claims processing for pharmacies in the network. Point-of-Sale (POS) claims will be transmitted and adjudicated online according to NCPDP standards. The Contractor will provide the capacity for pharmacies to transmit claims via old NCPDP standards as well the most up to date NCPDP standards as they are promulgated.

Pharmacy providers must request prior authorization from the Contractor to process claims for any APDP client with private or other insurance coverage. This will ensure that HD is the payer of last resort while allowing the secondary claim to HD to be transmitted and adjudicated on line.

Pharmacies must bill the other payers prior to billing the Contractor. The pharmacy must fax to the Contractor the label (POS printout) showing the co-pay amount requested by the private insurance...
carrier along with a prior authorization form. The Contractor may also independently verify the status of a HD client’s private insurance benefit with the insurance carrier. Prior authorization (PA) numbers will be issued and returned to the pharmacy. The Contractor will ensure that pharmacies will be paid only the approved co-pay amount for these transactions.

Once the prior authorization is issued, the pharmacy may transmit the claim and receive online claim adjudication. Though the mechanism is in place to allow pharmacies to split bill, there are some pharmacies that are still limited by their pharmacy software system capabilities. Pharmacies that cannot bill two insurance plans (i.e. split bill) through their POS system shall use the Contractor’s prior authorization form to request manual secondary claim processing. In these instances, an approval response is generated for their PA request, with a notation that no further processing is required. The Contractor will process the claim and append that claim information to the individual client’s claim history. The claim will appear on the explanation of benefits and will be billed appropriately to HD just as any claim transacted and adjudicated online.

For those clients with primary payer sources other than HD, the Contractor will assign group numbers that indicate the existence of other insurance coverage. The Contractor’s database will contain fields recording private insurance deductibles and HD co-payments.

The Contractor’s prior authorization process will enforce HD’s formulary guidelines and restrictions on pharmacy claim processing. Prior authorization will be required for exceptional requests such as vacation fills, or early fills due to dosage change or lost medications.

Pharmacies will use the Contractor’s Prior Authorization Request Form to obtain a prior authorization. Pharmacies will submit prior authorization (PA) request forms to the Contractor via the Contractor’s toll-free fax. The form may be completed by the pharmacist or pharmacy technician and can accommodate up to eight separate transactions. There will be a section included on the form requiring the pharmacy to indicate the reason for the PA request. There will also be a section for comments/explanation for pharmacies to notate any additional information. In select situations, pharmacies may be requested to supply additional information before a prior authorization can be approved, such as a copy of the prescription, or completion of an additional form requiring additional clinical information to justify the prescription.

The Contractor pharmacy technician, under the oversight and supervision of one of the Contractor’s pharmacists, will receive, review and process prior authorization requests. After review and processing of the prior authorization request, pharmacies will receive a computer generated fax back form containing a prior authorization number(s) for approval, or explanations for authorization denials. Exceptional requests will not transmit without the Contractor’s prior approval. The Contractor will process prior authorization requests within one business day or faster.

The Contractor will generate quality assurance reports that verify the accuracy of invoices submitted to HD, and to verify the accuracy of reimbursements issued to pharmacy providers. The Contractor will generate the following reports:

- Pharmacy File Errors – i.e. Duplicate NABP codes;
- Drug File Errors – i.e. Duplicate NDC codes;
- Patient File Errors – i.e. Duplicate Patient ID or Federal ID Codes;
- History File Errors – i.e. Duplicate claim reference numbers, duplicate prescriptions;
• Incorrect Claim Prices – i.e. Variances in claim prices in comparison to drug prices from the Contractor’s Drug Pricing Source;

• Claim Back-out Processing – Identifies each pharmacy claim back-out.

• Quality Performance Measures – The Contractor will work to develop a performance measure with HD that monitors client antiretroviral adherence based on prescription refills or other Medication Possession Ratio semi-annually.

These reports identify for further review, transactions that are for unusual quantities and/or dosages, and those that may represent a duplicate transaction.

For online prescription transactions, the Contractor will use an electronic screening procedure to do the following:

• Flag transactions transmitted outside of a client’s eligibility dates with a message indicating, ”Filled after coverage terminated” and for transactions transmitted for invalid clients, with a “Non-matched Cardholder ID” on-line message.

• Flag the day’s supply of a new fill or refill dispensed product, with an “Incorrect Metric Quantity” on-line message to enforce a 30-day minimum supply for maintenance drugs, unless client’s insurance requires more than 30-day fill at a time.

• Flag “Too Soon Refill” when less than 80% of the total quantity in the previous fill has been used. This technique is used to review and process changes in prescription directions, and prevent duplicate claim processing. All too-soon refill rejects cannot be transmitted without prior approval.

• Flag a pharmacy claim at the point of service with a message to the pharmacy alerting the pharmacist to a variety of treatment standards using the Proactive Drug Utilization Reviews (PRODUR). Examples of such standards include low or high doses, drug-drug interactions, therapeutic duplication of products, and allergies to specific products as reported to the pharmacy by the client.

• Flag non-formulary products with a “NDC Not Covered” on-line message, and prompt the pharmacy to inquire by phone for more detail or to initiate a prior authorization request. This prevents the dispensing of non-formulary drugs without Prior Authorization.

• Flag a pharmacy claim when plan limitations are exceeded.

• Flag specific transactions for clients having other primary/secondary coverage, with a message transmitted on-line to the pharmacy that states, “Prior Authorization Required”. This forces the pharmacy to obtain prior approval from the Contractor for clients with other third party prescription benefits.

• Flag specific formulary products, with a “Prior Authorization Required” on-line message. For example, this message would be used to force a pharmacy to obtain prior approval before dispensing a drug with state imposed criteria for use.

The Contractor must achieve HIPAA compliance according to the federal timelines. Pharmacy claims processed through the Contractor’s Point of Sale network will be transmitted and adjudicated through NDC/HealthTrans.
The Contractor will have the capacity and infrastructure to fully implement the data exchange necessary to meet the requirements of the CMS ADAP Data Sharing Agreement. The purpose of the ADAP data sharing agreement process is to coordinate the prescription drug benefits between Medicare Part D plans and ADAPs, as specifically required by the MMA and subsequent law. This collection of all prescription drug related benefits will facilitate the tracking of TrOOP (True Out-of-Pocket) expenses incurred by each Medicare beneficiary. Monthly tasks necessary to complete the requirements of the CMS DSA are:

1. Each month the Contractor (as the ADAP designated partner) submits an electronic input file of all enrollees to the COBC over the Internet using Secure FTP or HTTPS or via an existing T-1 line.

2. The COBC edits the input file for consistency, and attempts to match those enrollees with Medicare Part D enrollment.

3. Where the COBC determines that an enrollee on the ADAP file is a Medicare Part D beneficiary, the COBC updates that record to the CMS Medicare Beneficiary Database (MBD), which holds prescription drug coverage information on all Medicare Part D beneficiaries. The MBD will send daily updates of all prescription drug coverage of Part D beneficiaries to the TrOOP Facilitation Contractor and to the Part D plan that the beneficiaries are enrolled in.

4. The COBC then submits a response file to the Contractor via the same method used to submit the input file. This file contains a response record for each input record the ADAP submitted. The response record shows if the ADAP enrollee is a Part D beneficiary, if the COBC applied the record to the MBD, if the record was not applied to the MBD, and why (e.g., the record contained errors or the record did not provide enough information about the enrollee), in which Part D plan the beneficiary is enrolled in, and other Part D enrollment information.

5. The Contractor then examines the response file to determine whether: The records were applied; the COBC was not able to match the ADAP enrollee in the CMS systems; or the records were not applied because of errors. (The Contractor must correct any records so that from subsequent full replacement input files the corrected records can be applied to the MBD.)

6. The Contractor updates its internal records on the Part D enrollment of its enrollees.

7. When the Contractor submits the next monthly full input file, it also sends corrections of all the errors from the previous submission.

8. The Contractor must obtain and use a unique TrOOP facilitation RxBIN and RxPCN as identifiers to the benefits coordination network.

Pharmacy Network
Example 1:

The CONTRACTOR shall provide an adequate number of Network Pharmacies that will be available to dispense Covered Drugs on behalf of the DEPARTMENT in the various geographical areas where the eligible clients are located. The CONTRACTOR shall audit selected pharmacies as it deems necessary. The CONTRACTOR shall correct any errors detected through such an audit and shall adjust back to the DEPARTMENT.

The CONTRACTOR shall adjudicate electronic claims received from the Network Pharmacies in accordance with the terms of this Contract. Twice a month, the CONTRACTOR shall provide to the
DEPARTMENT an invoice, an Import Report, and a Claims Data Report of pass-through claims as defined in the Contract.

The CONTRACTOR shall pay the Network Pharmacies in a timely manner, according to individual Contracts between the CONTRACTOR and the Network Pharmacies and in accordance with the National Council for Prescription Drug Programs (NCPDP) Guidelines. The DEPARTMENT shall pay the CONTRACTOR for claims submitted by the Network Pharmacies through the Delegation of Limited Purchasing Authority.

Example 2:

The Contractor will establish and maintain a statewide pharmacy network to serve HD clients, which includes the following:

1. Over-the-counter (chain store and independent pharmacies)
2. Institutional (i.e. University based hospitals, county hospitals, Health Maintenance Organizations)
3. Specialty (i.e. HIV targeted services)
4. Mail order

The Contractor will maintain an open enrollment process that will allow additional pharmacies to enter the network that meet the following criteria:

1. Have no licensure encumbrance by any state or federal law;
2. Have a license issued by the residing State; and
3. Be willing to accept reimbursement provided by the Contractor.

In the open enrollment process, pharmacies enter a contractual agreement with the Contractor. The contract will stipulate that pharmacy providers are independent contractors. As independent contractors, the Contractor will not supervise, direct or otherwise intervene in their provision of pharmacy services. The contract shall also state that providers must operate in compliance with service standards, maintain adequate inventory, and fill prescriptions promptly.

If a pharmacy provider does not meet the Contractor’s service, inventory and timeliness standards, the Contractor will notify HD to discuss whether the pharmacy provider should be allowed to enter or stay in the pharmacy network.

The Contractor will inform HD when there are changes in the pharmacy network and notify HD in a timely manner of problems or emergent situations.

The Contractor will routinely communicate with pharmacies in the network to inform them of program issues, such as formulary updates, changes in how HD interacts with insurance companies or other government payers, and other relevant issues. The Contractor will use its Fax-Broadcast System, which allows it to distribute program information to network pharmacies via facsimile. The Fax-Broadcast System will function by faxing text documents to designated recipients overnight. The Contractor will also provide HD with copies of broadcast faxes that go to the entire network.

The Contractor will also provide relevant information on its non-secured web site, which has a
menu option for pharmacies. The web site has a section for non-participating pharmacies as well as pharmacy providers in the network. Pharmacies that have Internet access may use the web site to obtain updated program information. The network pharmacy section of the Contractor’s web site will be password protected and contain the following:

- A list of covered medications, with an option to print the most recent formulary;
- Pharmacy provider forms, with an option to print the selected form(s); and
- Pharmacy provider notices/documents that have been sent via the Contractor’s fax-broadcast system.

The Contractor will also use its Pharmacy Provider Manual as an additional communication tool. The Contractor will provide the Pharmacy Provider Manual to HD by January 1, 2012. The manual will contain the following items regarding the state’s prescription drug program:

- General program information;
- Prescription processing: prior authorization procedures, exceptional prescription processing, supplemental forms used in prescription processing;
- Program administration information;
- Client service information; and
- Master forms for reproduction.

Clinical Management/Formulary Services

Example 1:

1. Clinical management services such as formulary management, step therapy, monitoring prior authorization requests, therapeutic duplication edits, and retrospective and concurrent DUR.

2. Collaborating with the State on an approach for Trend [Cost] Management including strong emphasis on generics.

3. Abide by the State’s formulary list (subject to change).

Example 2:

HD will define the program’s formularies, which includes individual drugs and classes of drugs. The Contractor will provide the following formulary management services:

1. Selection and maintenance of all current data elements for drugs included on each formulary.

2. Notification of pharmacies, and HD staff of formulary changes.

3. Electronic update of formulary prices every week.

4. Provision of secure telephone access for all pharmacies to verify any formulary drug with the use of their NABP number and the National Drug Code.
5. Maintenance of a Contractor web site providing formulary information.

6. Enforcement of prior authorization or code 1 diagnosis requirements for selected formulary items.

HD will direct the Contractor to add or subtract specific drugs or classes of drugs. The Contractor will automatically add drugs to the approved classes when new drugs in those classes are approved by the federal Food and Drug Administration. The Contractor will add or subtract individual drugs identified by HD within 24 hours. The Contractor will notify HD of the need to add or subtract drugs in the approved classes within 2 business days of FDA approval or updates.

For the purpose of adding drugs to approved classes when the FDA adds new drugs to those classes, entire classes of drugs will be linked by a unique identifier code, known as the “therapeutic class code” within the Red Book database, or known as the “HIC3” code within the First DataBank database. The Contractor will flag these classes for notification to and approval from HD for addition to the formulary to ensure that they are added upon FDA approval.

The Contractor will take the following steps when HD requests a formulary change:

1. Drug activation will be initiated within the Contractor system and at the claims adjudicator. The drug selection may be National Drug Code (NDC#) specific, generic formulation code (GFC#) or generic code sequence number (GCN#) specific, or drug class specific. A start date and any dispensing restrictions will be posted. Reimbursement rates for state invoicing and pharmacy reimbursement will be entered.

2. Preparation of a fax broadcast within 24 hours that will notify all pharmacies within the dispensing network of the planned change. HD will also receive a copy of this fax broadcast.

Example 3:

The DEPARTMENT shall provide the [State] ADAP Formulary to the CONTRACTOR prior to the start date of this Contract. The DEPARTMENT shall provide written notice to the CONTRACTOR of any modifications of the [State] ADAP Formulary within at least thirty (30) days of the DEPARTMENT’s notification of such modification. If such modifications are not unreasonably burdensome and are without additional costs to the CONTRACTOR, modifications shall be implemented within a mutually agreed upon time frame.

The CONTRACTOR shall provide management and administrative services for a [State] ADAP Formulary to Ryan White Part B eligible clients as determined by the DEPARTMENT.

Drug Benefit/Identification Card

Example 1:

The Contractor will produce prescription drug cards for use when clients go to the pharmacies to get their prescriptions filled. The Contractor will mail eligibility cards to HD within seven business days of being notified by HD that the client is eligible for the program. Any items mailed to HD will be sent in corporate envelopes and identified as confidential and without any reference to HIV or AIDS on the outside of the envelope. HD will mail the cards to clients.

The prescription drug cards will contain patient identification information that pharmacy providers use to identify eligible clients. Fields of information will be limited to client name, date of birth, gender, member ID number, eligibility begin and end date, EIP and identifiers for other insurance coverage. The Contractor may include other fields of information with HD approval. The cards will also have the Contractor’s toll free phone number and logo preprinted on the cards. Information will be typed or
printed on the cards. For confidentiality purposes, they must not include HIV or AIDS anywhere on the cards.

The Contractor must have procedures for pharmacies to verify the eligibility of a client when there is no eligibility card available. Providers may call the Contractor’s toll free line and speak to any of the Contractor’s help desk staff during regular business hours or they can use the Contractor’s touch tone operated automated system 24 hours a day to verify a client’s eligibility status.

The Contractor must be in compliance with HIPAA’s Privacy Standard for Individually Identifiable Health Information.

**Payment of Claims and Other Related Insurance Costs and Reimbursement**

**THINGS TO CONSIDER**

- How often will you be able to pay/reimburse the contractor for insurance related costs?
- Is the ADAP planning to use a local community based organization (CBO) to make payments? If so, will up-front payments to the CBO be necessary?

**Example 1:**

Paying pharmacies for insurance co-pay and deductible costs and passing on those costs, without markup or fees, to the State for reimbursement.

**Example 2:**

The Contractor will pay pharmacies and submit invoices to HD for reimbursement on a weekly basis. Prior to submitting the weekly invoice, the Contractor will verify and correct each claim identified in its claim error reports. Once all transactions are complete, the Contractor will process a weekly invoice to HD in a format specified by HD. The invoice shall include all fees and costs and be accompanied by a cover page that includes miscellaneous charges or credits to HD. The Contractor will pay pharmacies on a weekly basis. The three-week waiting period from the start date of the contract is necessary to allow time to cycle through pharmacy claim reversals, back-outs and suspensions.

Once per month, the Contractor will provide a data file in a suitable electronic format specified by HD that contains all of the previous month’s claims-level detail and any necessary adjustments from prior transactions. HD will reconcile the monthly data with the invoices that the Contractor submitted for the month prior to paying the final claim for the month. The Contractor will also provide paper backup documentation on a monthly basis that includes claims-level detail that is organized by client group number.

To pay pharmacies, the Contractor will generate a weekly Pharmacy Payment Report. The Contractor’s Pharmacy Payment Report will list all pharmacies eligible for pharmacy payment within the invoicing period. This report will be generated within five days of the end of the invoicing period. Once the Pharmacy Payment Report has been generated, payments are sent to the providers either by check or electronic funds transfer, within ten days from the date the Pharmacy Payment Report was generated. The Contractor will send with each payment, a remittance advice giving the provider a line item detail of the claims submitted and the corresponding payment. The remittance advice will include...
information regarding paid claims, pharmacy back-out claims, and claims that have been suspended as a result of our claims processing quality assurance protocols. The remittance advice will not include client names.

**Example 3:**

The CONTRACTOR shall submit claims to the DEPARTMENT twice a month for payment of pharmacy billing services. The DEPARTMENT shall pay the CONTRACTOR for administrative costs as set forth in the Fee Schedule, Attachment C.

The CONTRACTOR shall submit a separate invoice for each group described in the Fee Schedule (Attachment C) for the defined and pass-through cost of prescription drugs and dispensing fees. This invoice shall consist of a Billing Statement, an Import Report and Claims Data Report. The DEPARTMENT shall pay the CONTRACTOR within 30 days of receiving undisputed invoices.

The Network Pharmacies on behalf of the DEPARTMENT shall charge or bill the CONTRACTOR for eligible clients’ co-payments as provided in the Prescription Drug Benefit Plan. The DEPARTMENT shall pay the CONTRACTOR for the pass-through co-payments.

1. Eligible clients shall not pay co-payments up front and then seek reimbursement from the DEPARTMENT. The Pharmacy shall bill the CONTRACTOR for co-payments on behalf of insured eligible clients; the DEPARTMENT shall then pay the CONTRACTOR for co-payment claims.

2. The DEPARTMENT shall not pay the dispensing fee associated with the co-payment; the fee shall be charged to the eligible client’s primary insurance.

3. The CONTRACTOR shall have a detailed, mapped recoupment process for instances where other prescription coverage has been identified, so that claims can be reversed and re-billed to other payers.

**Drug Pricing/Rebate Claims**

**THINGS TO CONSIDER**

- Rebate claims and drug pricing verification can be done by the contractor, but having regular audits and reviews are important to ensure accuracy.
- Will the PBM/IBM take a portion of the rebate that is recouped?
- What is the administrative fee associated with the PBM/IBM processing rebate claims?

**Example 1:**

Work with the State to audit wholesale costs to ensure accurate reflection of ADAP negotiated supplemental rebates from the drug manufacturers. The Contractor will additionally access rebates from the drug manufacturing companies for insured client co-pay costs. The Contractors rebate percentage fee is listed in Section XX.

**Example 2:**

The DEPARTMENT shall provide, in a format mutually agreed to by the CONTRACTOR and the DEPARTMENT, quarterly pricing loads for 340B Drug Prices.
The DEPARTMENT shall provide updated 340B drug prices for new drugs and 340B price changes as available. The same six (6) business day time frame as described in Section IV.G shall apply for implementation.

Within 24 hours after receiving the quarterly 340B pricing file, the CONTRACTOR shall submit the request to benefit coding for completion. Coding shall be given six (6) business days to code and input into production. Should the CONTRACTOR not have the coding completed within the allotted six (6) business day time frame, the CONTRACTOR shall be required to audit the National Drug Codes (NDC’s) to determine the financial impact to the DEPARTMENT. The CONTRACTOR shall make corrections and rebill the DEPARTMENT.

**Back-billing**

**Example 1:**

Recoupment services (e.g. assistance with back-billing insurances such as Medicaid, when coverage was retroactive).

**Data and Processing System**

**THINGS TO CONSIDER**

- Determine if the PBM/IBM data system is independent or integrated into existing data systems.
- Evaluate the costs of integrating with systems versus using a new independent system.
- Is the data system secure? How does pertinent staff gain access?
- Who will run required and specialty data reports (i.e., the PBM/IBM or ADAP staff)? Does ADAP staff have the ability to query information at any time, or will requests for data have to be formally made?

**Example 1:**

Provide the State a secure, unlimited remote access to a password-protected electronic pharmacy claims processing and reporting system accessible to the PBM, the State, and the designated ADAP pharmacies. The electronic claims system must allow for confidential communications of claims, product cost, individual prescription history, and client demographics. The Contractor will work with the State to accomplish any necessary data transfers.

- The minimum data set includes full name, date of birth, ID and Social Security numbers, case management area, gender, federal poverty level and race. Full drug utilization and prescription data is also required.
- Access to this system is to be determined by the State and administered by the contractor (i.e. training, user setup, password reset, technical support, etc.).
- The Contractor shall provide notification via on-line claims adjudication system to applicable Participating Pharmacies regarding Terminated Members.
Example 2:
The Contractor will receive updated client demographic and eligibility information from HD via facsimile, Internet-based ADAP Enrollment Application, and/or other electronic data transfer means such as secure transfer file. Once received, the Contractor’s Client Support Services Representatives will update client information simultaneously in the Contractor and HealthTrans client databases. The update process will take approximately three to twenty-four hours, during office hours seven days a week. During emergency enrollment situations during the Contractor’s business hours, HD staff may call the Contractor to enroll a client within 30 minutes after the call. Only authorized HD personnel, including HD Client Service Representatives and their supervisor, may enroll clients.

On a weekly basis, the Contractor will archive on CDROM all faxes received through the Contractor’s fax system. The Contractor will use these archives as part of its Quality Assurance process to make sure that enrollments are processed within the required timeframes.

The Contractor’s database will track information required for prescription invoicing, demographic reporting and other data elements as requested by HD for use in obtaining drug manufacturer rebates. Client prescription transaction information is downloaded on a daily basis from NDC/HealthTrans. This information will be posted to the Contractor database within two hours of the download.

- **NDC/HealthTrans:** The Contractor will submit client, drug formulary and pharmacy provider files electronically to NDC for Point-of-sale (POS) reference. The Contractor will also configure within the NDC mainframe, dispensing controls, reimbursements, and client eligibility status that trigger POS responses to the pharmacies. The Contractor and NDC/HealthTrans systems will operate twenty-four hours, seven days a week.

- **Contractor’s In-house Data Processing:** The Contractor’s data systems will be scalable and accommodate increases in the client database and claims processing that will result from services provided to HD.

- **Contractor’s Fax Servers:** The Contractor’s fax servers will receive client enrollment and re-certification applications twenty-four hours, seven days a week. These fax documents will be processed by the Contractor’s Client Support Services Representatives during business hours and shredded for purposes of confidentiality. All faxes received will be stored electronically and can be reproduced or viewed if necessary.

**Data Management and Reporting**

Example 1:
Expertise in data analysis and AIDS Drug Assistance Program-specific reporting requirements. Client/patient-level demographic data must be collected in a format usable by the State for quarterly federal reporting.

Example 2:
Contractor will provide HD staff with training and technical assistance on their online reporting system and on other ways we can use this site to generate our own reports and monitor/improve work processes. Contractor will provide reports to HD via their online system for weekly data files on prescription utilization with the necessary data elements to effectively submit pharmaceutical rebate requests and reports on agreed upon quality performance measures. HD expects all Contractor reports to be checked for accuracy and quality assurance before being sent to HD, such as no “0” identification.
numbers, when client Identification number is not known.

Examples of reports:

*Drug Usage by Manufacturer* (Quarterly)
This data should match the invoice weekly files for the quarter.

- Name of Manufacturer
- NDC Number
- Drug Name
- Quantity (or units)
- Rx Count (or # of claims/prescriptions)
- Total Cost
- Average Cost

*Antiretroviral Adherence Performance Measure* (Semi-annually)
The Contractor is to provide semi-annual reports to HD on the number of times their adjudication system with pharmacies identifies and rejects an inappropriately prescribed antiretroviral drug dosage, so that HD can use this information in our quality management reports.

HD also anticipates brainstorming with Contractor staff to develop a stronger process and possible additional Contractor reporting on client antiretroviral adherence and utilization.

The reporting formats and processes will be determined at a later date.

The Contractor will also maintain the capacity to provide ad hoc reports to HD. The cost of the reports will depend on the complexity and desired turnaround time, and will be negotiated between the Contractor and HD at the time HD requests the reports. Once the Contractor receives a written request for information from HD, the Contractor will review the specifications. If any clarification is needed, the Contractor will seek clarification in writing. At the completion of the data request assessment, the Contractor will notify HD of the date when the requested reports will be available. This time frame can be anywhere from 48 hours to 10 days.

**Technical and Customer Support**

**Example 1:**

- Customize and freely adapt to the specific needs of the ADAP program. The Contractor must offer a hands-on approach provided by dedicated account management and clinical support staff.

- In addition to interaction with the State and ADAP-specific pharmacies, the Contractor is expected to advise and/or cooperate with case managers at multiple sites, a formulary advisory committee, a public planning body, the State, and federal grant officials.

- Shall communicate various types of claims, eligibility, and other information related to the claims services to and from the State, members, participating pharmacies, and other authorized third persons for purposes of PBM administration.
• Respond to inquiries and complaints from participating pharmacies with regard to the contractor services under the subsequent contract.

• Staff a help desk to provide information to members and participating pharmacies regarding the PBM.

• Assign an account team to assist the State to answer and resolve questions and issues that arise with respect to the contractor’s administration of the PBM.

Example 2:

The Contractor will provide technical support to HD staff, pharmacies, and clients. The Contractor will maintain a staff that includes licensed pharmacists, pharmacy technicians, and additional staff that assist in the enrollment and eligibility process. The Contractor’s Client Support Representatives will provide support to clients and HD staff. The Contractor’s Provider Support Representatives consist of pharmacy technicians that provide technical support to pharmacy providers, clients, and HD staff.

The Contractor will maintain business hours of Monday through Friday 9am-7pm, Saturday 9am-5pm and Sunday 11am-4pm Pacific Time. The Contractor will provide direct telephone access to its staff during business hours and to a Contractor supervisor Monday – Friday and on-call during weekend hours. Pharmacy providers, clients, and/or HD staff who call the Contractor to speak to a live person will have a maximum hold time of 3 minutes.

The Contractor will also provide a secure telephony system (Electronic Eligibility Verification System (EEVS)) for pharmacy providers and HD staff to access 24 hours a day. To use the Contractor’s EEVS, pharmacy providers and/or HD staff may call the Contractor toll-free and select the appropriate phone menu option. By entering an assigned password, pharmacy providers may use the Contractor’s EEVS to verify client eligibility status and program formulary status. HD staff may use the Contractor’s EEVS to verify client eligibility status.

Web Site Availability

Example 1:

The Contractor will provide an Internet web site that will be available 24-hours a day. The Contractor’s web site will contain secure and non-secure web sites. The non-secure web site will be available to anyone with Internet access and feature the following:

• Updated program information (i.e. program eligibility requirements);

• A search tool used to identify participating pharmacy providers by city, zip code, or county;

• The formulary, with an option to print the latest version.

The Contractor’s non-secured web site will have a menu option for pharmacies. This portion of the web site will have a section for non-participating pharmacies as well as pharmacy providers in the network. Pharmacies that have Internet access may access the Contractor’s non-secured web site to obtain information on how to become a participating pharmacy. The participating pharmacy section of the Contractor’s web site will be password protected and will contain the following:

• The HD formulary, with an option to print the latest version;

• The Contractor pharmacy provider forms, with an option to print the selected form(s); and
• Pharmacy provider notices/documents that have been sent via our fax-broadcast system.

**Overpayment or Payment of Invalid Claim**

**Example 1:**

In the event the contractor pays an Invalid Claim or makes an Overpayment, the contractor, at the State’s option and discretion, will undertake one or more of the following actions unless the payment of the Invalid Claim or Overpayment is the result of inaccurate or untimely information provided by the State:

- Contact the recipient of the improper payment and request a refund from the recipient. If the recipient fails to refund the amount of the improper payment, the contractor will offset the amount of the improper payment against future payments for Claims submitted by the same recipient.
- In the event of an overpayment as a result of the contractor’s failure to require the dispensing pharmacy to collect the correct amount of co-pay(s) and/or deductible(s), then the contractor will refund the amount of the overpayment to the State provided that the contractor is not precluded by the State from recovering past and/or present Members’ non-payment or underpayment of copayments, and the State provides all available address and similar information with respect to past and present Members who benefited from the Member nonpayment or underpayment of the copayment; and/or
- Reimburse the State

**Example 2:**

A. Beginning on June 1, 2010, Contractor shall implement its comprehensive plan, as described in the Proposal, including automated systems, to detect and prevent internal and external fraud, malfeasance, criminal and improper activity and other similar abuses and improprieties, including, but not limited to intentionally perpetrated fraud, theft, embezzlement, misappropriation of funds, commingling, misuse of ADAP, overcharges, overpayments, wrongful and incorrect payments, deceptive, and duplicate or suspicious billings, and the failure to disclose material information in connection with ADAP (hereinafter collectively “Improprieties”) by Contractor, as that term is defined in this Contract and including, but not limited to Contractor’s officers, employees, affiliates, subsidiaries, agents, independent contractors, and subcontractors; ADAP members; and ADAP clinical sites. Whether or not an impropriety exists or may have been committed, includes, but is not limited to, by way of example, the following circumstances and/or factors:

i. If a person or entity, either intentionally or negligently, presents or causes to be presented to Contractor, the State or a Provider, a claim for benefits, services, coverages, equipment, supplies or products or for any other manner of payment or reimbursement that (a) contains any statement or representation that the person or entity knows or reasonably should have known was false, and/or (b) fails to disclose material information; or

ii. If an ADAP clinical site fails to provide an individual with any benefits, services, coverages, equipment, supplies or products that are required to be provided under this Contract or applicable laws and regulations in connection with the ADAP; or

iii. If an ADAP clinical providing prescription drugs, services, equipment, supplies, coverages or products for clients, in relation to ADAP, either intentionally or negligently, provides a materially false or misleading representation, or fails or refuses to provide information required to be provided to the State or Contractor by law or this Contract in order to obtain payment, reimbursement, or restock of medication inventory or to establish the legitimacy of a claim, charge
or billing or to avoid any damages or penalties otherwise payable in connection with the Contract; or
iv. If any person or entity misappropriates from or commits any malfeasance in connection with the State’s account, or any ADAP member information; or
v. If a ADAP clinical site engages in actions that indicate a pattern of wrongful denial of services, benefits, equipment, supplies, coverages or products that are required to be provided under this Contract or applicable laws and regulations, or that indicate a pattern of wrongful requests for payment for services, benefits, equipment, supplies, coverages or products not performed, delivered, or provided or improperly billed or that are not medically/pharmaceutically necessary.

B. Contractor shall enforce and implement all aspects of its comprehensive plan and the requirements of this Contract in order to prevent, detect, investigate and eliminate improprieties. Contractor shall conduct investigations on its own, in cooperation with ADAP clinical sites and other carriers or administering firms, when directed by the State or as Contractor otherwise deems in good faith to be appropriate in the exercise of reasonable due diligence, with regard to improprieties, and as further provided in the RFP.

C. Contractor shall notify the State immediately whenever it reasonably believes that any of the improprieties described herein by way of example, or other similar improprieties not so specifically identified, have occurred in connection with ADAP and in connection with Contractor’s performance under the Contract.

D. Contractor shall also provide reports to the State regarding such improprieties immediately upon their detection by Contractor and also as may be requested by the State.

E. Contractor shall comply with all future additional the State policies or directives, as they are developed by the State and provided to Contractor, in connection with the prevention, detection, investigation and elimination of fraud, abuse and other improprieties in connection with ADAP and as they may apply to Contractor.

F. Contractor shall further maintain all the State and ADAP-related information and claims records as required by the Contract, and Contractor acknowledges and agrees that the State or its designated representatives shall have reasonable and timely access to all such information related to the State, ADAP, and its members.

G. Contractor warrants and represents that it shall fully assist and cooperate with the State, the Office of the Attorney General, any other applicable state or federal agency and law enforcement authorities in the prosecution of administrative and civil actions and/or criminal prosecution of those individuals or entities who have engaged in the commission of improprieties.

**Grievance Procedures**

**Example 1:**

The Contractor will provide grievance procedures for clients and pharmacy providers to address grievances regarding the provisions of the services or related to a Contractor contract or administration issue.

Grievance procedures for pharmacy providers will be as follows:

1. Disagreement or disputes related to specific prior authorization requests should be resolved
with the Contractor pharmacy technician concerned whenever possible or the pharmacy provider should request assistance from the pharmacy technician supervisor.

2. All other issues and disputes should be directed to one of the members of the Contractor’s executive staff. Pharmacy providers should include any documentation with as much information as possible to support the grievance. Grievances will be reviewed objectively and fairly considering information provided by all sides. A response will be conveyed to the involved parties within 72 hours.

3. If the grievance is not resolvable by the Contractor, the pharmacy provider will have the right to contact the HD contract monitor who oversees the contract performance of the Contractor.

4. Written grievances that pharmacy providers forward to HD require supporting documentation. The Contractor will forward to HD copies of the Contractor actions taken to resolve the grievance upon notification by HD.

5. Both the pharmacy provider and the Contractor will be obliged to work towards a resolution as stated in the Pharmacy Provider Contract.

Grievance procedures for clients are as follows:

1. Disagreement or disputes should be resolved with the Contractor staff person concerned whenever possible.

2. If the disagreement or dispute is not resolvable at the staff level, the client may request a meeting with the immediate supervisor of the staff person.

3. If the disagreement or dispute still is unresolved at the first level supervisor or with the pharmacy manager, the client should be instructed to contact the Contractor executive staff to document the grievance and/or forward it by fax or mail to the Contractor executive staff.

4. The situation will be investigated considering information provided by all sides. The client must provide necessary documentation when applicable to support the grievance being reviewed. The facts and documentation will be reviewed objectively and fairly. All parties involved in the grievance will be interviewed and a resolution determined.

5. If the grievance is not resolvable by the Contractor, clients may then complete the Contractor grievance form and forward it to HD.

The Contractor will maintain records of all documented pharmacy provider and client grievances. As part of the Contractor’s Quality Assurance Plan, the Contractor will document all grievances and review them for the effectiveness of the process and appropriateness of the response. The Contractor will share its findings with HD.

Performance Reviews and Audits

THINGS TO CONSIDER

- Ensure language in the contract stresses the PBM/IBM, and all sub-contractors/pharmacies, are acting as an agent on behalf of the ADAP and therefore must maintain compliance with Ryan White Program legislation, additional HRSA/HAB policies, and state and federal law.
Example 1:

Performance reviews and audit participating pharmacies as it deems necessary or as reasonably requested by the State. The Contractor shall report to the State any errors or improper activity detected through such an audit and shall take such corrective action as appropriate to prevent future errors or improper activity.

Example 2:

The Contractor shall provide right of access to its facilities to DOH, or any of its officers, or to any other authorized agent or official of the state or the federal government, at all reasonable times, in order to monitor and evaluate performance, compliance, and/or quality assurance under this contract. The Contractor shall make available information necessary for DOH to comply with the client’s right to access, amend, and receive an accounting of disclosures of their Personal Information according to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) or any regulations enacted or revised pursuant to the HIPAA provisions and applicable provisions of State law. The Contractor's internal policies and procedures, books, and records relating to the safeguarding, use, and disclosure of personal information obtained or used as a result of this contract shall be made available to DOH and the U.S. Secretary of the Department of Health & Human Services, upon request.

Example 3:

The Contractor shall permit the State, any other governmental agency authorized by law, or an authorized designee thereof, in its sole discretion, to monitor all activities conducted by the Contractor pursuant to the terms of this contract. Monitoring may consist of internal evaluation procedures, reexamination of program data, special analyses, on-site verification, formal audit examinations, or any other procedures as deemed reasonable and relevant. All such monitoring shall be performed in a manner that will not unduly interfere with contract work.

Contract Costs

**THINGS TO CONSIDER**

- Confer with other ADAPs about existing negotiated costs in contracts to ensure you are getting a fair and reasonable price.
- Determine if you will have one flat fee or variable fees (i.e., monthly, per claim, percentage of expenditure).
- Factors to consider in negotiations:
  - Direct ADAP versus insurance client
  - Brand name versus generic
  - Antiretrovirals (ARVs) versus non-ARVs
  - In-network pharmacy versus out-of-network pharmacy
  - Pharmacy pick versus mail-order delivery (may include shipping costs)
- Determine all reporting needs prior to contract signing. Data reports are commonly included in the service fees, but additional costs may be associated with new data requests.
Service Fees

Example 1:

The Department shall pay the service fee of $XX.XX per claim. Contractor will bill the Department twice a month electronically or by mail. Contractor shall also make claims detail available as of the date of the invoice. The Department's obligation to pay invoices from contractor is not in any way contingent on The Department's receipt of payment from other sources. The Department will pay in full, via electronic funds transfer, all invoices submitted by contractor within 10 days of the date of receipt of the invoice. Invoices that are not paid within 10 days of the date of receipt of the invoice shall be deemed late.

Example 2:

HD will pay a processing fee of $X.XX for every approved prescription submitted by any participating pharmacy provider. HD will pay this in addition to the net reimbursable amount eligible for payment to any participating pharmacy provider for any processed and approved prescription (Drug ingredient plus dispensing fee).

When Contractor issues a credit to HD for any reversed transaction that has been invoiced and paid by HD, the credit will equal the net amount paid, excluding the $X.XX claims processing fee paid to Contractor. Contractor will issue credits to HD for any reversed transaction that has been invoiced and paid by HD on or before the final invoice cycle within each quarter.

Example 3:

A. Contractor's administrative fees, if any, and compensation structure for the services, coverages, benefits, equipment, supplies and products that Contractor is required to perform, deliver or provide in connection with, arising out of or related to its performance of this Contract shall be only those specifically agreed to and accepted by the State and the Board and that are reflected in the Budget attached hereto and fully incorporated herein as Exhibit X. Administrative fees, if any, and compensation shall remain unchanged for the Contract Term unless in accordance with provisions in this Contract. Notwithstanding the foregoing, the parties acknowledge that the pricing terms in the Contract are based on the Plan design and program specifications set forth in the RFP. The State must approve in writing any material modification of the Plan design or program specifications prior to any implementation thereof. If such modifications, including modifications to the formulary, as that term is defined in Article 2 herein, are material and are initiated or approved by the State, the State shall notify Contractor of the required modifications, and Contractor and the State understand and agree that such material Plan modifications may result in a corresponding increase or decrease in Contractor's pricing or compensation terms as reasonably necessary to reflect such material modification of the Plan design or specifications. Any Plan changes or program specification modifications that are not considered material shall be communicated to Contractor and implemented in a timely manner by Contractor.

B. The State and Contractor agree that Contractor shall not receive or charge any administrative fees or any other costs, expenses or fees in connection with the Contract unless it is included in the administrative fees, if any, accepted by the State. If applicable, the parties also agree that the State may select one or more of Contractor's additional management programs identified in Contractor's Proposal for the fees agreed to by the parties as reflected in the Budget.
The “claim processing fee” includes the following services, which will be provided at no additional cost to the State, ADAP members, or ADAP clinical sites:

a. Access to/use of the Contractor ADAP data management system, as described further in this Attachment

b. Processing of paper claims

c. ID cards issued at enrollment or renewal

d. Electronic eligibility management

e. Electronic claims adjudication

f. Coordination of benefits

g. CMS data exchange file processing

h. Member help desk

i. Pharmacy help desk

j. Toll free telephone number

k. Pharmacy network administration

l. Pharmacy reimbursement

m. Provider management and education

n. Drug utilization review (prospective/concurrent)

o. Basic formulary management

p. Plan analysis, design, and setup

q. Standard reports

r. Online reports or queries

s. Prior authorizations

t. Step therapy

u. Account management services (including quarterly face-to-face meetings)

v. 3408 inventory management services

w. Training for State staff, ADAP clinical sites, and mail order provider

The “claim processing fee” also includes the following functions of the Contractor web site. Additional web site capabilities, with associated additional fees, are described under “Additional Fees” in this Attachment.
a. Member services
   i. Locate a participating pharmacy based on specific geographic requirements.
   ii. View formulary
   iii. View health education materials
   iv. Submit appeals

b. Services available to State ADAP staff
   i. Real time access to claims data, including all data elements consistent with the National Council of Prescription Drug Program’s (NCPDP) 5.1 standards or any updates to these standards
   ii. Real time ability to enter, access, and edit eligibility and enrollment data
   iii. Create reports online

c. Services available to staff at ADAP clinical sites and the mail order provider
   i. On-line pre-certification
   ii. Point of service adjudication
   iii. Access PHR (with member’s written permission)
   iv. View formulary

**Rebate Processing**

**Example 1:**
Contractor will assess a XX% fee on all rebated acquired on behalf of the State.

**Example 2:**
The State asserts its right to receive all rebates from drug manufacturers related to the ADAP. No portion of drug manufacturer rebates will be retained by the Contractor in any circumstances. The term “Rebates” is intended to include all revenues, monies and payments received by Contractor from drug manufacturers or their affiliates as a result of the utilization of each such manufacturer’s products by ADAP members, whether or not such revenues, monies and payments are described as “rebates” by and between any such drug manufacturers and Contractor.

i. Formulary - The State has furnished a list of prescription drugs to be administered by Contractor for inclusion on the ADAP formulary. As provided in the RFP, the drugs included on the ADAP formulary may be modified by Contractor, with prior approval by the State’s authorized representatives, from time-to-time as a result of factors including, but not limited to medical appropriateness, manufacturer rebate arrangements and patent expirations. Upon the State’s review and approval, Contractor shall implement a formulary management program, which may include cost containment initiatives, communications with ADAP members, participating pharmacies and/or physicians (including communications regarding generic substitution programs).
ii. Rebates and Rebate Payment Timing - Contractor may receive rebate revenue from certain drug manufacturers as a result of the utilization of each such manufacturer’s products by ADAP members (“Rebates”). Contractor shall pay Rebates to the State based on each manufacturer’s Formulary drugs dispensed to ADAP members. Such Rebate payments shall be paid to the State by Contractor no later than 90 days following their receipt by the Contractor.

**Pharmacy Rx Charges**

**Example 1:**

Contractor will charge a $0.XX data transmission fee to participating pharmacy providers per approved transaction. When pharmacies cannot “split bill” through point of service due to limitations of their ‘turnkey’ pharmacy system, Contractor will deduct $0.XX per line item from the calculated pharmacy reimbursement to process the claim within the Contractor manual claim processing system. The Contractor will not pass either of these charges on to HD.

**Mail-order Pharmacy fees**

**Example 1:**

The “mail order dispensing fees” include the following services, which will be provided at no additional cost to the State, ADAP members, or ADAP clinical sites:

a. Adherence counseling

b. Pharmacist consultation

c. Involvement of pharmacists suitably trained in HIV-specific issues

d. Involvement of support staff with specialized training in HIV and providing a welcoming patient experience

e. HIV side effect management

f. Refill and medication management so all fills can be complete the same day

g. A 7-day pill container and a magnet with pharmacy hours, location, and phone number (provided on the first fill)

h. Refill reminder calls, non-compliant calls, and drug assessment for new medications

i. Patient assistance specific to State, including assistance regarding insurance, reduction of copayments through “co-pay cards,” and State’s HIV system

The “mailing order shipping fees” include prescription delivery services, assessed per package delivery (not per claim).

**Late fees**

**Example 1:**

Payment for invoices deemed late will accrue interest from the invoice date at a rate of (1.5%) per month, or prorated portion of a month, on the outstanding balance.
**Other Fees**

**Example 1:**

Any fees and charges for services not specifically listed in this Schedule or in the body of this Agreement will be mutually agreed upon by contractor and the Department prior to performance of the service. Upon request by the Department, contractor will submit a written estimate of the fees and charges for the service in question, and the Department will notify contractor in writing, whether or not it will accept or reject contractor’s offer for performing the services in question.

**Example 2:**

A. If the State exercises its option to require one annual financial or process audit of the Contractor, the additional fee will be $X,XXX in each year in which such an audit is conducted.

B. The following web based member services may be developed and implemented by the Contractor, at the option of the State. Before commencing with the development of these services, the Contractor shall submit a budget to the State for approval, at the rate of $XXX per hour. Such services include, but are not limited to, member ability to:

   i. Submit an initial ADAP application and ADAP member eligibility renewals

   ii. Place a refill order and track the status of a mail order prescription.

   iii. View claims data and other protected health information

C. The State may request system enhancements. Before commencing with the development of such enhancements, the Contractor shall submit a budget to the State for approval, at the rate of $XXX per hour.

D. The State may request additional consulting services. Before commencing with the delivery of such consulting services, the Contractor shall submit a budget to the State for approval, at the rate of $XXX per hour.

E. The State may request ad hoc reports beyond the standard reports currently available. Before commencing with the development of such ad hoc reports, the Contractor shall submit a budget to the State for approval, at the rate of $XXX per hour.

F. In regard to mail order services, the mail order dispensing fees do not include Medication Therapy Management services, including service in regard to appropriateness of therapy (up to two interventions per year), poly pharmacy, and inappropriate medications for the elderly. If the State decides to add these Medication Therapy Management services, a contract amendment (with associated budget) will be initiated.
PBM Request for Proposal Example
REQUEST FOR PROPOSAL

PHARMACY BENEFITS MANAGER / POINT OF SALE PROCESSOR
FOR LOUISIANA AIDS DRUG ASSISTANCE PROGRAM (ADAP)

OFFICE OF PUBLIC HEALTH
STD/HIV PROGRAM
DEPARTMENT OF HEALTH AND HOSPITALS

RFP # 305PUR-DHHRFP-PBM-II-OPH
Proposal Due Date/Time: June 20, 2012
4:00 P.M. CDT

Release Date: May 18, 2012
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# Glossary

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<tr>
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<tr>
<td>340B:</td>
<td>Federal drug discount program that was established in 1992</td>
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<td>ADAP:</td>
<td>AIDS Drug Assistance Program (national)</td>
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<tr>
<td>ADR:</td>
<td>ADAP Data Report</td>
</tr>
<tr>
<td>ANSI:</td>
<td>American National Standards Institute</td>
</tr>
<tr>
<td>AWP:</td>
<td>Average Wholesale Price</td>
</tr>
<tr>
<td>CAREWare:</td>
<td>Free, scalable software for managing and monitoring Ryan White Services</td>
</tr>
<tr>
<td>CBO:</td>
<td>Community Based Organization</td>
</tr>
<tr>
<td>CDAP:</td>
<td>Copayment and Deductible Assistance Program</td>
</tr>
<tr>
<td>CMS:</td>
<td>Centers for Medicare and Medicaid Services</td>
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<tr>
<td>COB:</td>
<td>Coordination of Benefits</td>
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<tr>
<td>CQI:</td>
<td>Continuous Quality Improvement</td>
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<td>CDT:</td>
<td>Central Daylight Time</td>
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<tr>
<td>Dispense Fee:</td>
<td>Cost to fill a prescription</td>
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<tr>
<td>DHH:</td>
<td>Department of Health and Hospitals</td>
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<tr>
<td>DMR:</td>
<td>Direct Member Reimbursement</td>
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<tr>
<td>EDI:</td>
<td>Electronic Data Interface</td>
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<td>FPL:</td>
<td>Federal Poverty Level</td>
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<tr>
<td>HIP:</td>
<td>Health Insurance Program</td>
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<tr>
<td>HiTECH:</td>
<td>Health Information Technology for Economic and Clinical Health</td>
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<tr>
<td>HIV:</td>
<td>Human Immunodeficiency Virus</td>
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<td>HRSA:</td>
<td>Health Resources and Services Administration</td>
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<td>LA ADAP:</td>
<td>Louisiana AIDS Drug Assistance Program (local)</td>
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<td>LIS:</td>
<td>Low Income Subsidy</td>
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<tr>
<td>Must:</td>
<td>Denotes a mandatory requirement</td>
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<tr>
<td>NDC:</td>
<td>National Drug Code</td>
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<td>NCPDP:</td>
<td>National Council for Prescription Drug Programs</td>
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<td>Original:</td>
<td>Denotes must be signed in ink</td>
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<td>OPH:</td>
<td>Office of Public Health</td>
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<tr>
<td>PBM:</td>
<td>Pharmacy Benefits Manager</td>
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<td>PCIP:</td>
<td>Pre-existing Condition Insurance Plan</td>
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<td>PCN:</td>
<td>Processor Control Number</td>
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<tr>
<td>PDP:</td>
<td>Prescription Drug Plans</td>
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<td>POS:</td>
<td>Point of Sale</td>
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<tr>
<td>Redacted Proposal:</td>
<td>The removal of alleged confidential and/or proprietary information from one copy of the proposal for public records purposes.</td>
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<tr>
<td>RxBIN:</td>
<td>Benefits Identification Number</td>
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<tr>
<td>Shall, Will:</td>
<td>Denote a mandatory requirement</td>
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<tr>
<td>SHP:</td>
<td>STD/HIV Program</td>
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<tr>
<td>Should, Can, May:</td>
<td>Denote a preference, but not a mandatory requirement</td>
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<td>STD:</td>
<td>Sexually Transmitted Disease</td>
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<td>TAB Coordinator:</td>
<td>Treatment Access and Benefits Coordinator</td>
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<td>Transaction Fee:</td>
<td>Cost to execute a pharmacy claim</td>
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<td>TrOOP:</td>
<td>True Out Of Pocket</td>
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I. GENERAL INFORMATION

A. Background

1. The mission of the Department of Health and Hospitals (DHH) is to protect and promote health and to ensure access to medical, preventive, and rehabilitative services for all citizens of the State of Louisiana. The Department of Health and Hospitals is dedicated to fulfilling its mission through direct provision of quality services, the development and stimulation of services of others, and the utilization of available resources in the most effective manner.

2. DHH is comprised of Medical Vendor Administration (Medicaid), Office for Citizens with Developmental Disabilities, Office of Behavioral Health, Office of Aging and Adult Services, and the Office of Public Health. Under the general supervision of the Secretary, these principal offices perform the primary functions and duties assigned to DHH.

3. DHH, in addition to encompassing the program offices, has an administrative office known as the Office of the Secretary, a financial office known as the Office of Management and Finance, and various bureaus and boards. The Office of the Secretary is responsible for establishing policy and administering operations, programs, and affairs.

4. The STD/HIV Program (SHP), located within the Office of Public Health (OPH), is responsible for coordinating the state's response to the STD/HIV epidemics. The program conducts activities to: 1) provide medical and social services to persons with HIV infection and treat persons diagnosed with an STD, 2) prevent new cases of HIV and STD infection, and 3) collect data and compile, analyze and distribute information about the progression of the HIV and STD epidemics in the state.

Louisiana AIDS Drug Assistance Program (LA ADAP) helps low-income Louisiana residents who are living with HIV disease gain access to medications prescribed by a licensed clinician. To be eligible for these services, clients must have a household income less than or equal to 300% of the federal poverty level (FPL), be a Louisiana resident, enroll in Medicare Part D and Low Income Subsidy (LIS) if eligible, and have a prescription for LA ADAP formulary medications written by a licensed Louisiana clinician.

LA ADAP currently has approximately 2,900 clients and pays for about 6,500 pharmaceutical claims per month.

B. Purpose of RFP

1. The purpose of this RFP is to solicit proposals from qualified proposers that provide pharmacy benefits management services, including claims adjudication, coordination of benefits and point-of-sale processing for its clients. The contract will begin August 15, 2012, and run through August 14, 2015, contingent upon the availability of federal funding.

2. A contract is necessary to provide pharmacy benefits management services to all eligible clients with coverage through third party providers including individual/group insurance, COBRA, Louisiana Health Plan, Medicare Part D, and Pre-existing Condition Insurance Plan (PCIP), as well as uninsured clients. The successful proposer will implement an efficient and cost-effective program with a comprehensive distribution network of pharmacies that provides services to eligible clients residing in all 64 parishes in Louisiana.
C. Invitation to Propose
DHH Office of Public Health, STD/HIV Program (SHP) is inviting qualified proposers to submit proposals for services to provide pharmacy benefits management services through managed care organizations, self-insured companies, retail pharmacies and government programs to manage certain prescription drug benefits for clients eligible for LA ADAP in accordance with the specifications and conditions set forth herein.

D. RFP Coordinator
1. Requests for copies of the RFP and written questions or inquiries must be directed to the RFP coordinator listed below:

   Heather Weaver, LCSW  
   Treatment Access and Benefits Coordinator  
   STD/HIV Program  
   Department of Health and Hospitals  
   1450 Poydras St, Suite 2136  
   504-568-7474  
   504-568-3157 (fax)  
   heather.weaver@la.gov

2. This RFP is available in PDF format at the following weblinks:

   http://wwwprd.doa.louisiana.gov/OSP/LaPAC/bidlist.asp?department=4  
   http://new.dhh.louisiana.gov/index.cfm/newsroom/category/47

3. All communications relating to this RFP must be directed to the DHH RFP contact person named above. All communications between Proposers and other DHH staff members concerning this RFP are strictly prohibited. Failure to comply with these requirements may result in proposal disqualification.

E. Proposer Inquiries
1. The Department will consider written inquiries regarding the RFP or Scope of Services which are received on or before the date specified in the Schedule of Events. To be considered, written inquiries and requests for clarification of the content of this RFP must be received at the above address or via the above fax number or email address by the date specified in the Schedule of Events. Any and all questions directed to the RFP coordinator will be deemed to require an official response and a copy of all questions and answers will be posted by the date specified in the Schedule of Events to the following web link:

   http://wwwprd.doa.louisiana.gov/OSP/LaPAC/bidlist.asp?department=4  
   and may also be posted at:  
   http://new.dhh.louisiana.gov/index.cfm/newsroom/category/47

2. Action taken as a result of verbal discussion shall not be binding on the Department. Only written communication and clarification from the RFP Coordinator shall be considered binding.
**F. Schedule of Events**

DHH reserves the right to deviate from this Schedule of Events

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<td>May 25, 2012</td>
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<td>Response to Written Questions</td>
<td>June 1, 2012</td>
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<td>Deadline for Receipt of Written Proposals</td>
<td>June 20, 2012 4:00 P.M. CDT</td>
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<td>Proposal Evaluation</td>
<td>June 22-July 10, 2012</td>
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<td>On Site Presentations/Demonstrations</td>
<td>July 10, 2012 9:00am-5:00pm CDT</td>
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<td>Proposers susceptible of being awarded the contract will be invited to provide up to a one hour On Site presentation or demonstration of services and/or products.</td>
<td>Benson Tower/ SHP Office 1450 Poydras St., Ste. 2136 New Orleans, LA</td>
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<td>Contract Award Announced</td>
<td>July 19, 2012</td>
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<td>Contract Negotiations Begin</td>
<td>July 20, 2012</td>
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<td>Contract Begins</td>
<td>August 15, 2012</td>
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**G. RFP Addenda**

In the event it becomes necessary to revise any portion of the RFP for any reason, the Department shall post addenda, supplements, and/or amendments to all potential proposers known to have received the RFP. Additionally, all such supplements shall be posted at the following web address:

- http://wwwprd.doa.louisiana.gov/OSP/LaPAC/bidlist.asp?department=4
- and may also be posted at:

It is the responsibility of the proposer to check the DOA website for addenda to the RFP, if any.

**II. SCOPE OF WORK**

**A. Project Overview**

The result of this contract will be for the Contractor to meet the medication needs of eligible clients living with HIV disease in all 64 parishes in Louisiana in an effective and efficient manner. The Contractor will provide pharmacy benefits management services, including claims adjudication, coordination of benefits and point-of-sale processing services to eligible clients with coverage through Medicare Part D, Pre-existing Condition Insurance Plan (PCIP) and private insurance, as well as those who are uninsured; maintain a comprehensive distribution network of pharmacies; and provide reporting that meets client level data requirements of LA ADAP and the Ryan White HIV/AIDS Treatment Extension Act of 2009 (Public Law 111-87, October 30, 2009). Eligibility determination services for all of the persons applying to LA ADAP will be performed by a separate entity. The Contractor must have or be able to develop a mechanism to electronically receive and provide eligibility information that matches the data requirements of SHP and HRSA. SHP will retain authority in the development and management of the LA ADAP formulary.
B. Deliverables

Pharmacy Network: Contractor shall create, maintain and/or expand a pharmacy distribution network within Louisiana and provide LA ADAP with an established and operational single source mail order distribution system capable of serving the needs of eligible clients in all 64 parishes of the state. The Contractor shall:

1. Establish and maintain a network of pharmacy locations capable of providing walk-in service to 100 percent of LA ADAP clients, ensuring communication of billing procedures, access to eligibility, claims adjudication and coordination of benefits.

2. Communicate with the pharmacy network any program updates or changes via broadcast fax, email or mail and provide copies of all pharmacy and client correspondence to the TAB Coordinator.

3. Provide payment to retail network pharmacies on a regular basis in accordance with NCPDP Guidelines. The Contractor must also provide detailed invoice information to SHP staff on all reimbursable charges incurred for each invoice period, such as the cost of medication, applicable copayments and deductible charges, dispensing fees, etc.

4. Not receive payment from LA ADAP for ineligible charges, and any payments made for such will be recouped by SHP.

5. Have an established mail order pharmacy as an option to clients that:
   a. Ensures that all eligible clients receive mail order prescriptions less than five (5) working days from the time the prescription is submitted by the client to the Contractor.
   b. Addresses special shipping needs of homeless and transient LA ADAP clients by ensuring mail order pharmacies ship prescriptions to client’s preferred address.
   c. Confirms delivery of medications to LA ADAP client’s preferred address, assumes responsibility for costs associated with repeat delivery events and works with SHP on loss reduction activities.

6. Have a documented and routinely tested emergency response/preparedness plan that, once implemented, has operations of retail claims network and/or mail order pharmacy back to 95 percent within 48 hours of the conclusion of the emergency. On an annual basis, the Contractor must provide the TAB Coordinator with documentation of this plan and frequency of testing, as well as any contingency plans.

7. Transition clients to either mail order and/or the retail walk-in pharmacy network within 48 hours if there is an interruption of service in either distribution system that requires implementation of the emergency response/preparedness plan.

8. Enter all data into or prepare data for import into CAREWare, a HRSA-developed, web-based data management system. Software will be provided by SHP.

Claims Processing: Contractor shall provide an efficient electronic point-of-sale (POS), claims adjudication and coordination of benefits system, make payments to network pharmacies, coordinate with other third-party payers and provide data management and member support services. Electronic claims processing capacity must be sufficient to allow pharmacies to do online adjudication and split billing, which will mean that pharmacies or clients will not need to submit manual claims for secondary payment. The Contractor shall:
1. Allow for coordination of primary, secondary and tertiary payers of prescription claims. Prescription claims must always pay with LA ADAP as final payer based on other payers’ payment of claim using “lesser of” logic. LA ADAP will always be the payer of last resort.

2. Retain the primary payer status of an insurance or Medicare Part D PDP so that LA ADAP will always be considered a secondary payer.

3. Have the ability to transmit primary and/or secondary insurance information to the pharmacy.

4. Provide remote access to the Contractor’s claim system to include:
   a. Pharmacy locator
   b. Real-time claim tracking/history to include retail, mail order and direct client reimbursement claims history
   c. Drug formulary and pricing information
   d. Client benefit level information
   e. Client prescription history
   f. Prior Authorization

5. Identify and report the LA ADAP clients’ enrollment in and eligibility for other third party payers, including but not limited to private insurance, PCIP, Medicaid and Medicare.

6. Provide an automated process of ongoing screening for other prescription benefits for LA ADAP clients.

7. Have a detailed, mapped recoupment process for instances where other prescription coverage has been identified, so that claims can be reversed and rebilled to other payers. Facilitate and report to SHP staff the recoupment process. Use outside vendors and software programs as necessary to communicate with LA ADAP and/or the pharmacy.

8. Coordinate coverage and benefits with insurance providers including individual/group insurance, COBRA, Louisiana Health Plan, PCIP and direct member reimbursement plans, and ensure that applicable expenditures are credited toward meeting the client’s minimum/maximum out of pocket expenditure requirements.
   a. Oversee the payment of medication deductibles, coinsurance, co-payments and costs of medications during any gaps in coverage for clients enrolled in third party insurance providers.
   b. Ensure that the LA ADAP does not pay for a medication that is not on the formulary for the specific insurance plan in which an individual client is enrolled.
   c. Establish a network of pharmacies that will be able to split the billing of prescription drug costs between third party insurance plans including and LA ADAP. The network of pharmacies must be geographically dispersed throughout the state of Louisiana and have at least one mail order pharmacy option available to all eligible LA ADAP clients.

9. Coordinate coverage and benefits with Medicare Part D Prescription Drug Plans (PDPs) and ensure that applicable expenditures are credited toward meeting the client’s TrOOP expenditure requirement.
   a. Oversee the payment of medication deductibles, coinsurance, co-payments and costs of medications during any gaps in coverage for clients enrolled in Medicare Part D PDPs;
   b. Coordinate benefits with all Medicare Part D PDPs in the state of Louisiana, without discrimination, based upon the Medicare Part D PDP in which the individual is enrolled, as
clarified by the CMS Coordination of Benefits (COB) guidelines dated July 1, 2005, and any subsequent updates to these guidelines that are available at: http://cms.hhs.gov/PrescriptionDrugCovContra/02_RxContracting_COB.asp.

c. Ensure that the LA ADAP does not pay for a medication that is not on the formulary for the specific Medicare Part D PDP in which an individual client is enrolled.

d. Establish a network of pharmacies that will be able to split the billing of prescription drug costs between third party insurance plans including Medicare Part D PDPs and LA ADAP. The network of pharmacies must be geographically dispersed throughout the state of Louisiana and have at least one mail order pharmacy option available to all eligible LA ADAP clients.

10. Participate in data share with CMS to ensure that paid claim data is captured by the CMS TrOOP Facilitation Contractor in the claim response from the payer to the pharmacy provider.

   a. Coordinate coverage and benefits with CMS and the Medicare Part D PDP and ensure that applicable expenditures are credited toward meeting the enrollee’s true out-of-pocket expenditure requirement. As part of this duty, the Contractor shall participate in the electronic data exchange processes as specified by CMS for reporting enrollee true out-of-pocket expenses to the CMS data Contractor.

   b. Maintain for LA ADAP a unique Prescription Benefit International Number (Rx BIN) and a unique Pharmacy Benefit Processor Control Number (PCN) to code for coverage that is supplemental to Medicare Part D. The Input and Response Files used by the CMS Data Sharing Agreement program include data fields for both Rx BIN and PCN reporting. This unique coding will assure that the supplemental paid claim is captured by the CMS TrOOP Facilitation Contractor in the claim response from the payer to the pharmacy provider. The TrOOP Facilitation Rx BIN(s) or PCN(s) will be separate and distinct from a PBM’s standard Rx BIN and PCN. Rx BIN(s) and/or PCN(s) may be obtained from the American National Standards Institute (ANSI) located at http://www.ansi.org/ or the National Coalition for Prescription Drug Programs (NCPDP) located at http://www.ncpdp.org/.

**Drug Pricing:** Contractor shall continuously maximize the cost effectiveness of LA ADAP through drug pricing negotiation. The Contractor must:

1. Provide monthly reporting of up-to-date drug pricing to include Average Wholesale Price (AWP) and contracted AWP discounted rate.

2. Agree to biannual renegotiation of contracted AWP discount rate as well as dispensing and transaction fees to pass along further saving to the program when applicable; and to remain competitive and to ensure that the ADAP program is able to serve a growing population. At a minimum, AWP discounted rate must increase by one-half (½) of one percent for every year the Contract remains in place for a total of three (3) years or one and one-half (1½) of one percent discount.

3. Ensure that discounted rate for mail order prescriptions must be at least three and one-half (3½) of one percent higher than retail rate with biannual renegotiation of mail order AWP discount based on increase in number of patients utilizing mail order as method of accessing medication.

**Technical/Customer support:** Contractor shall provide knowledgeable staff who are readily available to answer calls from SHP staff, CBO staff, clinicians, providers, pharmacists and clients. The Contractor shall:
1. Provide technical assistance to SHP staff and pharmacy service providers on inquiries including but not limited to coordinator of benefits, claims processing and billing.

2. Provide technical assistance, based on needs and requests, related to accessing LA ADAP to CBOs, clinicians, and providers throughout the state. Depending on the scope of the requests, technical assistance may be provided via telephone, webinars or during scheduled provider trainings which occur an average of five times each year.

3. Maintain current contact information on CBOs, clinicians, network pharmacies, and insurance companies.

4. Assign a contact person with a designated phone number to respond to client inquiries. This individual must have customer service experience, be trained and knowledgeable of the program’s services, and have access to client-level information to respond to participants’ inquiries regarding program enrollment and coverage information. This person must also have a designated back up.

5. Maintain a toll-free client support number, which will be staffed 24 hours a day, 7 days a week including weekends as well as state and federal holidays. The toll-free client support number must also be available in the event of SHP staff furlough, government shut downs, emergency evacuation or other unforeseen events.

6. Maintain a help desk that will provide technical assistance to pharmacies and the LA ADAP for billing and claims system issues. 24 hour access is preferred; however, at a minimum, the help desk staff must be readily available between the hours of 7:00 a.m. – 7:00 p.m. Central Time (CT), Monday through Friday. In place of 24 hour access, an automated phone system must be maintained for telephone calls received after hours with response to messages occurring on the next business day.

7. Maintain, at minimum, monthly contact via in person meeting or phone call with SHP staff to review and discuss contract objectives and program performance. A designated staff member shall be identified to communicate with SHP staff.

8. Participate in relevant SHP meetings, including but not limited to, the Continuous Quality Improvement (CQI) Medications Access Committee meeting, monthly monitoring meetings, SHP Services staff meetings, and other appropriate SHP planning meetings.

9. Participate in an average of five statewide trainings and/or meetings per year at SHP’s direction, to assist in presenting program information to contracted CBOs, case management agencies and other service providers.

10. Prepare a monthly call log that documents problem calls, and include, at a minimum: date, caller, type of problem, how the problem was resolved, and when it was resolved.

**Data system:** Contractor shall maintain a data system that is capable of receiving and managing client eligibility information to use for claims processing, monthly invoicing, reports and billing. The Contractor shall:

1. Provide and manage a data system to collect client level data on each person for whom payment was provided on behalf of LA ADAP. This information will be provided to SHP no later than the 10th of each month, following the month in which services were provided. SHP will specify the format for the download;
2. Maintain a data system capable of implementing and monitoring cost containment measures (such as annual expenditure caps on client services, client or medication prior authorizations, etc.) established by SHP;

3. Provide SHP with access to a web-based system that will allow LA ADAP staff to view live claims adjudication, and provide training for LA ADAP staff on the use of the system. The system must be compatible with Internet Explorer 8.0.

4. Provide SHP on-demand access to downloadable real-time client and service data in one of the following formats: XML, CSV, XLSX, or ACCDB.

5. Provide SHP on-demand access to ad hoc reporting tools through the Contractor's PBM data system.

**Reporting:** Contractor shall provide all required annual, semi-annual, quarterly, and monthly reports and exchange of data. The Contractor shall:

1. Submit required program data by the deadlines set forth in the final, approved contract.

2. Provide the following deliverables within the specified timeframes:

<table>
<thead>
<tr>
<th>REPORT</th>
<th>SCHEDULE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug Pricing Summary</td>
<td>Quarterly: due to SHP last day of the month following the end of calendar year quarter.</td>
<td>Summary of all drug prices and drug price changes. Fields &amp; format to be determined during contract negotiation.</td>
</tr>
<tr>
<td>ADAP &amp; Insurance Enrollment Status Summary</td>
<td>Quarterly: due to SHP last day of the month following the end of calendar year quarter.</td>
<td>Individual &amp; aggregate report on client enrollment/ disenrollment for each service type. Fields &amp; format to be determined during contract negotiation.</td>
</tr>
<tr>
<td>ADAP &amp; Insurance Program Aggregate Utilization</td>
<td>Monthly: Due to SHP by 15th of following month.</td>
<td>Summary report on service utilization. Fields &amp; format to be determined during contract negotiation.</td>
</tr>
<tr>
<td>ADAP Adherence Summary</td>
<td>Due with monthly invoice</td>
<td>List of clients who were late or missed picking up refills. Fields &amp; format to be determined during contract negotiation.</td>
</tr>
</tbody>
</table>

3. Capture the required information for payment and analysis of program statistics including HRSA ADAP reporting requirements and drug manufacturer rebate requests.

4. Generate the two required HRSA ADAP reports listed below:

<table>
<thead>
<tr>
<th>REPORT</th>
<th>SCHEDULE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADAP Quarterly Report</td>
<td>Due to SHP the 20th of the month following the end of the calendar year quarter.</td>
<td>Aggregate report using HRSA's required format (see attachment VIII for report and instructions)</td>
</tr>
<tr>
<td>ADAP Client Data Report</td>
<td>Due to SHP 20 days prior to the HRSA deadline (HRSA deadline is TBD)</td>
<td>Client-level data report using HRSA's required fields and XML format. (see attachment VII for current field list)</td>
</tr>
</tbody>
</table>
5. Provide additional required monthly and quarterly reports as requested that describe various aspects of program activity. Attachments VII – IX provide examples of current reports, including lists of data fields. Additional reporting requirements shall be identified as state and federal legislation is updated.

6. Ensure network pharmacies resolve payment errors made to third party insurance and Medicare Part D PDPs within 90 days.

7. Report LA ADAP client out-of-pocket payments to the CMS TrOOP facilitator by the 5th of each month, following the month in which payments were provided.

8. Schedule, organize and conduct, at least quarterly, a SHP/Contractor conference call to discuss programmatic issues that occurred during the previous quarter. The Contractor shall submit a written summary of each call to SHP within ten (10) business days of the call.

9. SHP may request an action plan from the Contractor regarding programmatic issues or deficiencies that are identified. Such action plans must be submitted to SHP within ten (10) business days of the date they are requested. Contractor must take actions directed by SHP staff following the review of the plan submitted, and must do so within the timeframes directed by SHP.

**Monthly Payment:** The Contractor must provide monthly services, employ staff, pay claims, and perform all other required work prior to receiving payment from SHP. The Contractor shall:

1. Reimburse the network pharmacies in accordance with NCPDP Guideline timeframe for prescriptions filled for eligible clients. Submit an invoice for payment to SHP by the 10th of each month, following the month in which services were provided.

2. Provide invoices that include all costs for claims processed.

3. Provide by the 10th of each month, following the month in which services were provided, a data file that contains all of the previous month’s claims in client level detail and in an electronic format that can be entered or imported into CAREWare (or the data system selected for use by SHP).

4. Add or remove specific drugs to the formulary as directed by SHP staff. SHP defines the LA ADAP formulary. The formulary includes individual drugs and whole classes of drugs.

**Client Confidentiality:** The Contractor must be compliant with all DHH and HIPAA Guidelines and the federal HiTECH Act of 2009. Confidential information shall include not only sensitive health and risk-related information, but also client personal identifiers, potentially identifying information, and any other information provided to the Contractor for which confidentiality was assured when the individual or establishment provided the information. Extremely stringent standards of client confidentiality must be maintained. The use of client information for commercial purposes shall be prohibited. Likewise, the Contractor shall not publish any information about program participants, even in the aggregate, without SHP review and prior written permission.

**Conflict of Interest:** Neither contractor nor its subcontractors shall have ownership or any interest in any pharmacies in Louisiana which will participate in the provider network created or utilized under the contract awarded through this RFP.

Contractor and any sub-contractors must divulge relationships with drug companies. These relationships must be fully disclosed to SHP prior to the effective date of the contract and updated as appropriate.
Staffing and Organization Plan: Contractor shall provide a Staffing and Organization Plan to complete all aspects of the proposed work.

Quality Assurance/Monitoring Requirements:
1. Contractor shall produce monthly, quarterly, and annual reports to monitor service utilization and expenditures, and to ensure that the program is being implemented and delivered as required

2. Prior to delivering services, the Contractor shall be required to establish and submit to SHP for approval a quality assurance and monitoring protocol. This protocol must include, at a minimum, a plan to internally review 5% of all active client records on a quarterly basis. For each of the client records reviewed, the Contractor must verify the accuracy of information entered into, or imported into CAREWare (or the data system selected for use by SHP). The minimal data elements to verify shall include:
   a. Client profile and health insurance information;
   b. Number of services provided;
   c. Total expenditures from the beginning of each grant year and the total expenditures for each quarter; and
   d. Number of payments.

3. The Contractor shall be subject to an external review of a minimum of 10% of all active client files on an annual basis, to be conducted by the Treatment Access and Benefits Coordinator and/or a member(s) of the SHP Evaluation and/or Business Units.

4. Contractor shall collaborate with SHP staff to conduct annual client and provider satisfaction surveys.

5. Prior to delivering services, the Contractor must have a policy or protocol that outlines clients’ “Rights and Responsibilities” and have a detailed client grievance policy in effect.

Transition Plan: Contractor must have a task-specific and time-limited transition plan that will successfully implement Contractor responsibilities upon initiation of the contract, and transfer Contractor activities upon termination of the contract without interrupting services to clients.

C. Liquidated Damages
1. In the event the Contractor fails to meet the performance standards specified within the contract, the liquidated damages defined below may be assessed. If assessed, the liquidated damages will be used to reduce the Department’s payments to the Contractor, or if the liquidated damages exceed amounts due from the Department, the Contractor will be required to make cash payments for the amount in excess.
   a. Late submission of a required report beginning 5 business days after the stated due date - $50 per working day, per report.
   b. Late submission of a required HRSA related report beginning 5 business days after the stated due date – additional $50 per working day, per report.
   c. Failure to maintain all client files and perform all file updates according to the requirements in the contract, as evidenced in client files when reviewed during monitoring site visit - $100 per client file.
   d. Late submission of invoices beginning 10 business days after the stated due date - $50 per working day per invoice.
   e. Failure to address client grievance within a 30 day period - $50 per working day, per documented grievance.
f. Failure to provide prescriptions resulting in treatment interruption - $100 per day, per incident.
g. Failure to transmit monthly CMS data share file beginning 10 business days after the stated due date - $50 per working day.

2. The decision to impose liquidated damages shall include consideration of some or all of the following factors:
   a. The duration of the violation;
   b. Whether the violation (or one that is substantially similar) has previously occurred;
   c. The Contractor’s history of compliance;
   d. The severity of the violation and whether it imposes an immediate threat to the health or safety of the consumers;
   e. The “good faith” exercised by the Contractor in attempting to stay in compliance.

D. Fraud and Abuse
1. The Contractor shall have internal controls and policies and procedures in place that are designed to prevent, detect, and report known or suspected fraud and abuse activities.

2. Such policies and procedures must be in accordance with state and federal regulations. Contractor shall have adequate staffing and resources to investigate unusual incidents and develop and implement corrective action plans to assist the Contractor in preventing and detecting potential fraud and abuse activities.

E. Technical Requirements
The Contractor must maintain hardware and software compatible with current DHH requirements which are as follows:

- IBM compatible PC
- Intel Core i5 or equivalent (or compatible successors)
- 4 Gig of RAM memory (minimum)
- Enough spare USB ports to accommodate thumb drives, etc.
- 250GB Hard Drive (minimum)
- Ethernet LAN interface for laptop and desktop PCs
- 19” WXGA Digital Flat Panel LCD monitor with DVI (minimum)
- Printer compatible with hardware and software required
- High speed internet with email
- DVD/CD ROM
- Windows XP, SP3 or later version of operating system (minimum)
- Windows Internet Explorer 8.0 (or later)
- Microsoft Office 2007 or later
- Appropriate firewalls for internet security
- Compliant with industry-standard physical and procedural safeguards for confidential information (NIST 800-53A, ISO 17788, etc.).

F. Subcontracting
The contractor shall not contract with any other party for furnishing any of the work and professional services required by the contract without the express prior written approval of the Department. The contractor shall not substitute any subcontractor without the prior written approval of the Department. For subcontractor(s), before commencing work, the contractor will provide letters of
agreement, contracts or other forms of commitment which demonstrates that all requirements pertaining to the contractor will be satisfied by all subcontractors through the following:
1. The subcontractor(s) will provide a written commitment to accept all contract provisions.
2. The subcontractor(s) will provide a written commitment to adhere to an established system of accounting and financial controls adequate to permit the effective administration of the contract.

G. Insurance Requirements

Insurance shall be placed with insurers with an A.M. Best’s rating of no less than A-:VI. This rating requirement shall be waived for Worker’s Compensation coverage only.

1. Contractor’s Insurance
The Contractor shall not commence work under this contract until it has obtained all insurance required herein. Certificates of Insurance, fully executed by officers of the Insurance Company shall be filed with the Department for approval. The Contractor shall not allow any subcontractor to commence work on subcontract until all similar insurance required for the subcontractor has been obtained and approved. If so requested, the Contractor shall also submit copies of insurance policies for inspection and approval of the Department before work is commenced. Said policies shall not be canceled, permitted to expire, or be changed without thirty (30) days notice in advance to the Department and consented to by the Department in writing and the policies shall so provide.

2. Compensation Insurance
Before any work is commenced, the Contractor shall obtain and maintain during the life of the contract, Workers’ Compensation Insurance for all of the Contractor’s employees employed to provide services under the contract. In case any work is sublet, the Contractor shall require the subcontractor similarly to provide Workers’ Compensation Insurance for all the latter’s employees, unless such employees are covered by the protection afforded by the Contractor. In case any class of employees engaged in work under the contract at the site of the project is not protected under the Workers’ Compensation Statute, the Contractor shall provide for any such employees, and shall further provide or cause any and all subcontractors to provide Employer’s Liability Insurance for the protection of such employees not protected by the Workers’ Compensation Statute.

3. Commercial General Liability Insurance
The Contractor shall maintain during the life of the contract such Commercial General Liability Insurance which shall protect Contractor, the Department, and any subcontractor during the performance of work covered by the contract from claims or damages for personal injury, including accidental death, as well as for claims for property damages, which may arise from operations under the contract, whether such operations be by the Contractor or by a subcontractor, or by anyone directly or indirectly employed by either of them, or in such a manner as to impose liability to the Department. Such insurance shall name the Department as additional insured for claims arising from or as the result of the operations of the Contractor or its subcontractors. In the absence of specific regulations, the amount of coverage shall be as follows: Commercial General Liability Insurance, including bodily injury, property damage and contractual liability, with combined single limits of $1,000,000.

4. Insurance Covering Special Hazards
Special hazards as determined by the Department shall be covered by rider or riders in the Commercial General Liability Insurance Policy or policies herein elsewhere required to be furnished by the Contractor, or by separate policies of insurance in the amounts as defined in any Special Conditions of the contract included therewith.
5. **Licensed and Non-Licensed Motor Vehicles**
   The Contractor shall maintain during the life of the contract, Automobile Liability Insurance in an amount not less than combined single limits of $1,000,000 per occurrence for bodily injury/property damage. Such insurance shall cover the use of any non-licensed motor vehicles engaged in operations within the terms of the contract on the site of the work to be performed thereunder, unless such coverage is included in insurance elsewhere specified.

6. **Subcontractor’s Insurance**
   The Contractor shall require that any and all subcontractors, which are not protected under the Contractor’s own insurance policies, take and maintain insurance of the same nature and in the same amounts as required of the Contractor.

H. **Resources Available to Contractor**
   The Office of Public Health STD/HIV Program will have an assigned staff member who will be responsible for primary oversight of the contract. This individual will schedule meetings to discuss progress of activities and problems identified.

   Utilization data provided by SHP for the purpose of this RFP are estimates based on previous claims. Variation in future services, funding and utilization trends in any of the three years will be based on the result of litigation regarding the Patient Protection and Affordable Care Act, the availability of federal funds, as well as guidance requirements from federal funders and should be considered in the proposer’s calculation. Fees proposed will not be negotiated based on volume.

I. **Contact Personnel**
   All work performed by the Contractor will be monitored by the contract monitor:

   Heather Weaver
   Treatment Access and Benefits Coordinator
   Department of Health and Hospitals
   Office of Public Health
   STD/HIV Program
   1450 Poydras St, Suite 2136
   504-568-7474
   504-568-7044 (fax)
   heather.weaver@la.gov

J. **Term of Contract**
   The contract shall commence on or near the date approximated in the Schedule of Events. The term of this contract shall be for a period of 36 months. The continuation of this contract is contingent upon the appropriation of funds by the legislature to fulfill the requirements of the contract.

K. **Payment**
   The contractor shall submit deliverables in accordance with established timelines and shall submit itemized invoices monthly or as defined in the contract terms. Payment of invoices is subject to approval of STD/HIV Program Administrative Director.
III. PROPOSALS

A. General Information
This section outlines the provisions which govern determination of compliance of each proposer’s response to the RFP. The Department shall determine, at its sole discretion, whether or not the requirements have been reasonably met. Omissions of required information shall be grounds for rejection of the proposal by the Department.

B. Contact After Solicitation Deadline
After the date for receipt of proposals, no proposer-initiated contact relative to the solicitation will be allowed between the proposers and DHH until an award is made.

C. Code of Ethics
Proposers are responsible for determining that there will be no conflict or violation of the Ethics Code if their company is awarded the contract. The Louisiana Board of Ethics is the only entity which can officially rule on ethics issues.

D. Rejection and Cancellation
Issuance of this solicitation does not constitute a commitment by DHH to award a contract or contracts. The Department reserves the right to reject all proposals received in response to this solicitation.

In accordance with the provisions of LA R.S. 39:2182, in awarding contracts after August 15, 2010, any public entity is authorized to reject a proposal or bid from, or not award the contract to, a business in which any individual with an ownership interest of five percent or more, has been convicted of, or has entered a plea of guilty or nolo contendere to any state felony or equivalent federal felony crime committed in the solicitation or execution of a contract or bid awarded under the laws governing public contracts under the provisions of Chapter 10 of Title 38 of the Louisiana Revised Statutes of 1950, professional, personal, consulting, and social services procurement under the provisions of Chapter 16 of this Title, or the Louisiana Procurement Code under the provisions of Chapter 17 of this Title.

E. Award Without Discussion
The Secretary of DHH reserves the right to make an award without presentations by proposers or further discussion of proposals received.

F. Assignments
Any assignment, pledge, joint venture, hypothecation of right or responsibility to any person, firm or corporation should be fully explained and detailed in the proposal. Information as to the experience and qualifications of proposed subcontractors or joint ventures should be included in the proposal. In addition, written commitments from any subcontractors or joint ventures should be included as part of the proposal.

G. Proposal Cost
The proposer assumes sole responsibility for any and all costs associated with the preparation and
reproduction of any proposal submitted in response to this RFP, and shall not include this cost or any portion thereof in the proposed contract price

H. Errors and Omissions
The State reserves the right to make corrections due to minor errors of proposer identified in proposals by State or the proposer. The State, at its option, has the right to request clarification or additional information from proposer.

I. Ownership of Proposal
All proposals become the property of the Department and will not be returned to the proposer. The Department retains the right to use any and all ideas or adaptations of ideas contained in any proposal received in response to this solicitation. Selection or rejection of the offer will not affect this right. Once a contract is awarded, all proposals will become subject to the Louisiana Public Records Act.

J. Procurement Library/Resources Available To Proposer
Relevant material related to this RFP will be posted at the following web address: www.hiv.dhh.la.gov

K. Proposal Submission
1. All proposals must be received by the due date and time indicated on the Schedule of Events. Proposals received after the due date and time will not be considered. It is the sole responsibility of each proposer to assure that its proposal is delivered at the specified location prior to the deadline. Proposals which, for any reason, are not so delivered will not be considered.

2. Proposer shall submit one (1) original hard copy (The Certification Statement must have original signature signed in ink) and should submit one (1) electronic copy (cd or flash drive) of the entire proposal and ten (10) hard copies of each proposal. Proposer may additionally submit one redacted copy of the proposal on cd or flash drive. No facsimile or emailed proposals will be accepted. The cost proposal and financial statements should be submitted separately from the technical proposal; however, for mailing purposes, all packages may be shipped in one container.

3. Proposals must be submitted via U.S. mail, courier or hand delivered to:
   If courier mail or hand delivered:
   Mary Fuentes
   Department of Health and Hospitals
   Division of Contracts and Procurement Support
   628 N 4th Street, 5th Floor
   Baton Rouge, LA 70802

   If delivered via US Mail:
   Mary Fuentes
   Department of Health and Hospitals
   Division of Contracts and Procurement Support
   P.O. Box 1526
   Baton Rouge, LA 70821-1526
L. **Proprietary and/or Confidential Information**

Pursuant to the Louisiana Public Records Act (La. R.S. 44.1 et. seq.), all public proceedings, records, contracts, and other public documents relating to this RFP shall be open to public inspection. Proposers should refer to the Louisiana Public Records Act for further clarification.

M. **Proposal Format**

1. An item-by-item response to the Request for Proposals is requested.

2. There is no intent to limit the content of the proposals, and proposers may include any additional information deemed pertinent. Emphasis should be on simple, straightforward and concise statements of the proposer’s ability to satisfy the requirements of the RFP.

N. **Requested Proposal Outline:**

- Introduction/Administrative Data
- Work Plan/Project Execution
- Relevant Corporate Experience
- Personnel Qualifications
- Additional Information
- Corporate Financial Condition
- Cost and Pricing Analysis

O. **Proposal Content**

1. Proposals should include information that will assist the Department in determining the level of quality and timeliness that may be expected. The Department shall determine, at its sole discretion, whether or not the RFP provisions have been reasonably met. The proposal should describe the background and capabilities of the proposer, give details on how the services will be provided, and shall include a breakdown of proposed costs. It should also include information that will assist the Department in determining the level of quality and timeliness that may be expected. Work samples may be included as part of the proposal.

2. Proposals should address how the proposer intends to assume complete responsibility for timely performance of all contractual responsibilities in accordance with federal and state laws, regulations, policies, and procedures.

3. Proposals should define proposer’s functional approach in providing services and identify the tasks necessary to meet the RFP requirements of the provision of services, as outlined in Section II.

4. **Introduction/Administrative Data**

   a. The introductory section should contain summary information about the proposer’s organization. This section should state proposer’s knowledge and understanding of the needs and objectives of DHH Office of Public Health STD/HIV Program as related to the scope of this RFP. It should further cite its ability to satisfy provisions of the Request for Proposal.

   b. This introductory section should include a description of how the proposer’s organizational components communicate and work together in both an administrative
and functional capacity from the top down. This section should contain a brief summary setting out the proposer’s management philosophy including, but not limited to, the role of Quality Control, Professional Practices, Supervision, Distribution of Work and Communication Systems. This section should include an organizational chart displaying the proposer’s overall structure.

c. This section should also include the following information:
   i. Location of Active Office with Full Time Personnel, include all office locations (address) with full time personnel.
   ii. Name and address of principal officer;
   iii. Name and address for purpose of issuing checks and/or drafts;
   iv. For corporations, a statement listing name(s) and address(es) of principal owners who hold five percent interest or more in the corporation.
   v. If out-of-state proposer, give name and address of local representative; if none, so state;
   vi. If any of the proposer’s personnel named is a current or former Louisiana state employee, indicate the Agency where employed, position, title, termination date, and social security number;
   vii. If the proposer was engaged by DHH within the past twenty-four (24) months, indicate the contract number and/or any other information available to identify the engagement; if not, so state; and
   viii. Proposer’s state and federal tax identification numbers.
   ix. Veteran/Hudson Initiative: Proposer should demonstrate participation in Veteran Initiative and Hudson Initiative Small Entrepreneurships or explanation if not applicable. (See Attachment I)

d. The following information must be included in the proposal:
   i. Certification Statement: The proposer must sign and submit an original Certification Statement (See Attachment II).

5. Work Plan/Project Execution

The proposer should articulate an understanding of, and ability to effectively implement, services as outlined within Section II of the RFP. In this section the proposer should state the approach it intends to use in achieving each objective of the project as outlined, including a project work plan and schedule for implementation. In particular, the proposer should describe the plan for implementing pharmacy benefits management services, including claims adjudication, coordination of benefits and point-of-sale processing for LA ADAP consistent with this RFP. Please note that client eligibility determination services for LA ADAP clients are not included in this RFP.

The work plan should include narrative addressing the following:

- Describe the proposer’s existing pharmacy network in Louisiana or the proposer’s ability and experience in developing other statewide pharmacy networks. If the proposer currently has a network of pharmacies in Louisiana, please include the complete list of pharmacies.
- Describe the ability to provide a mail order option for clients. Also, include a description of the mechanism by which communication with pharmacies in the network occurs to inform of significant events.
- Provide documentation of the emergency response/preparedness plan and describe how all clients will be transitioned to available services in the event of an emergency.
Claims Processing

Describe how the proposer will provide an electronic point-of-sale (POS) claims adjudication system, make payments to pharmacies and coordinate with other payers. Provide a plan for achieving accurate client level data management and providing client support services.

Provide a detailed description of how the recoupment process will be performed to include type(s) of software used, third party vendor(s) used (if any), frequency at which tasks are performed, and how information will be communicated to LA ADAP and/or the network pharmacies.

Describe how the proposer will monitor billings to assure non-duplication and the proper split between primary, secondary and (if applicable) tertiary payers. Include an explanation of recoupment and reimbursement procedures.

Describe the proposer’s ability and experience in coordinating and communicating with insurance plans, including but not limited to private insurance, COBRA, PCIP, Medicare Part D and state insurance pool plans.

Describe in detail the workflow process between SHP, network pharmacies, third party insurance plans (including but not limited to Medicare Part D PDPs, CMS and private insurance), clients, SHP staff and the proposer. The description should include timelines for accomplishments, as well as flowcharts or other visual presentations of the process.

a. Include how expenditures for LA ADAP Medicare Part D clients will be reported to the True Out of Pocket (TrOOP) facilitator to ensure applicable expenditures are credited toward the client’s TrOOP.

b. Provide information regarding the capability to split bill and track multiple third-party payer sources including, but not limited to, Medicare Part D PDPs, PCIP, private insurance plans, and LA ADAP.

c. Describe how the process identified in item (b) above will prevent LA ADAP from making erroneous payments. Include how the proposer will ensure that LA ADAP does not pay for medications that are not on a client’s insurance formulary or that of the Medicare Part D PDPs.

d. Describe the process for resolving issues surrounding client billing and prescription fulfillment that occur at the point of sale between the retail pharmacy, LA ADAP and the insurance or Medicare Part D PDP.

e. Describe the process for obtaining credits and adjustments on behalf of LA ADAP for any possible overpayments that have been made; include the timeframes or other parameters in which such adjustments and credits will be allowed and recorded.

f. Describe how the system will be able to effectively monitor an annual benefits cap for each client.

g. Provide information on the capability to pay incurred expenses on behalf of LA ADAP clients at the point of service and bill LA ADAP afterwards.

Technical support

Describe the proposer’s ability and experience in providing technical support to program staff, pharmacies and clients. Include a description of the levels of service that are provided at various
times during the day. For example, describe the level of service available during business hours versus the type of support provided during non-business hours, including holiday and weekend hours. Also include a description of how the proposer ensures that there is adequate staff who are trained to provide coverage during transition times, such as when key staff position becomes vacant. Describe the ability to document problem resolution.

Explain the ability to participate in relevant SHP meetings, including but not limited to, the CQI Medications Access Committee meeting, monthly monitoring meetings, SHP Services staff meetings, and other relevant HIV Services planning meetings.

Describe the proposer’s ability to participate in an average of five statewide trainings and/or meetings per year at SHP’s direction, to assist in presenting program information to contracted CBOs, case management agencies and other service providers. Include examples of training tools and resources the proposer can make available to clients, case managers and other caregivers.

**Data system**
Maintain a data system that is capable of receiving and managing client eligibility information to use for claims processing, monthly invoicing, reports and billing.

Describe the proposer’s ability and experience to create and manage data systems that receive detailed client eligibility information from SHP and provide it for payment information with pharmacies. Include a description of how the proposer ensures that client eligibility information is accessible to the network pharmacies the same day in which it is received. Include information about tools available to SHP through the proposer’s systems, including but not limited to remote access, report builders and claims data review.

Describe the ability to submit a monthly electronic data file of all transactions provided to individual eligible clients, to include: the medication dispensed; amount paid for each medication; and the location where the medication was dispensed or delivered. Include a description of the type of data file that will be provided and how it will be transmitted to SHP.

Describe in detail any initial, and subsequent, network/hardware/software/system requirements that SHP would need to have in order to electronically interface with the proposer’s program/system. Include any special software or hardware that would need to be installed on SHP computers. If the interface is web-based, specify if it will be fully compatible with Windows Internet Explorer Version 8.0 or above. Include description of how the interface provide secure/encrypted data transmission in compliance with all DHH and HIPAA Guidelines and the federal HiTECH Act of 2009.

Describe the proposer’s ability and experience to create reports that describe monthly user activity and prescription drug costs. Include a description of standard reports, if any, and the ability to create custom reports.

Describe the ability to provide standardized monthly utilization and expenditure reports. Include how will this report be submitted to SHP staff and in what format (i.e., PDF, Excel, Word).

**Monthly Payment**
Describe the proposer’s ability and experience in providing payment upfront to the network pharmacies for the duration of a month while preparing an invoice to SHP at the end of each month. Include a description of how the proposer ensures that payment is only requested for valid claims; include details about the claims checking processes that eliminate duplicate or invalid claims.
Describe the ability to create and provide to SHP staff a monthly, claim-level detail file in electronic format.

Describe how the proposer would manage a closed formulary that includes specific drugs and drug classes. Include a description of how the proposer would ensure that routine FDA decisions and NDC changes that affect approved formulary drugs would be noted and applied in a timely manner.

Treatment Adherence
Treatment adherence is defined as services provided to encourage, support, and enhance adherence to and compliance with treatment regimens, including related medical monitoring.

Describe your current experience or ability to provide treatment adherence activities to improve access to medications, increase and support adherence to medication regimens and/or assist clients monitor their progress in taking HIV-related medications.

Client Confidentiality
Client confidentiality is extremely important. The Contractor must be compliant with all DHH HIPAA Guidelines and the federal HiTECH Act of 2009. Confidential information shall include not only sensitive health and risk-related information, but also client personal identifiers, potentially identifying information, and any other information provided to the Contractor for which confidentiality was assured when the individual or establishment provided the information. Extremely stringent standards of client confidentiality must be maintained and the use of client information for commercial purposes is not allowed. Likewise, the Contractor may not publish any information about program participants, even in the aggregate, without SHP review and written permission.

Describe the proposer’s ability and experience in assuring client confidentiality. Describe in detail any security or confidentiality breaches experienced by the company in the past five years. Also, describe how the proposer protects client information from being used for commercial purposes or published, even in the aggregate, without SHP review and written permission.

Provide a detailed description of how secure data will be transmitted between the different parties involved in pharmacy service coordination (CMS, SHP, insurance plans, Medicare Part D plans, and pharmacies), to comply with DHH HIPAA Guidelines, federal HiTECH Act of 2009 as well as satisfying industry standards and practices.

Conflict of interest
Describe any potential conflicts of interest related to the provision of HIV treatment that the proposer, and/or any proposed sub-vendors may have.

Quality Assurance/Monitoring Requirements
Describe current quality assurance activities and measures, including the ability and timeline required to produce utilization and expenditure reports.

Describe the experience or ability to conduct client satisfaction and provider surveys. Include example of previous survey tools and outcomes as an attachment.

Provide documentation of the policy or protocol that outlines clients’ “Rights and Responsibilities” as an attachment and provide a copy of the current client grievance policy as an attachment.
Transition Plan
Describe in detail the plan and the proposed timeline to successfully transition clients from the current LA ADAP service provision model to a PBM model.

Explain how Contractor activities would be transitioned upon on termination of the contract without interrupting services to clients.

Fraud and Abuse
Describe the fiscal controls and accounting practices that assure against fraud or abuse of funds, including the fiscal accountability of any proposed sub-vendors. Include a description of how you would take corrective/disciplinary action upon detection of fraud or abuse, and describe how you would notify SHP.

1. Relevant Corporate Experience
   a. The proposal should indicate the firm has a record of prior successful experience in the design and implementation of the services sought through this RFP. Proposers should include statements specifying the extent of responsibility on prior projects and a description of the projects scope and similarity to the projects outlined in this RFP. All experience under this section should be in sufficient detail to allow an adequate evaluation by the Department. The proposer should have, within the last 24 months completed a similar type project. Proposers should give at least two customer references for projects completed in at least the last 24 months. References should include the name, email address and telephone number of each contact person.

   b. In this section, a statement of the proposer’s involvement in litigation that could affect this work should be included. If no such litigation exists, proposer should so state.

2. Personnel Qualifications
   a. The purpose of this section is to evaluate the relevant experience, resources, and qualifications of the proposed staff to be assigned to this project. The experience of proposer’s personnel in implementing similar services to those to be provided under this RFP will be evaluated. The adequacy of personnel for the proposed project team will be evaluated on the basis of project tasks assigned, allocation of staff, professional skill mix, and level of involvement of personnel.

   b. Proposers should state job responsibilities, workload and lines of supervision. An organizational chart identifying individuals and their job titles and major job duties should be included. The organizational chart should show lines of responsibility and authority.

Proposer should:
   a. Provide a Staffing and Organization Plan required to complete the proposed work.

   b. Provide a list and overview of staffing positions needed to successfully meet the program objectives. Include business hours of operation and primary methods of contact.

   c. Describe the responsibilities and qualifications of key staff. Note: any staff replaced during the period of performance of any resulting contract must be replaced with staff with equivalent or superior qualifications.

   d. Describe the responsibilities and qualifications of as any sub-Contractor who would likely be assigned to this contract.
e. Describe how the proposer ensures that functions of the contract will be maintained in the absence of key staff. For example, if a staff member leaves unexpectedly, describe who would assume his/her duties and how quickly that would happen. The proposer should have an emergency preparedness plan in place and included in the proposal as an attachment.

f. Describe how implementation of the Staffing and Organization Plan will be consistent with the designated contract start date and services start date, as listed in this RFP.

g. Job descriptions, including the percentage of time allocated to the project and the number of personnel should be included and should indicate minimum education, training, experience, special skills and other qualifications for each staff position as well as specific job duties identified in the proposal. Job descriptions should indicate if the position will be filled by a sub-Contractor.

h. Key personnel and the percentage of time directly assigned to the project should be identified.

i. Résumés of all known personnel should be included. Resumes of proposed personnel should include, but not be limited to:
   • Experience with proposer,
   • Previous experience in projects of similar scope and size.
   • Educational background, certifications, licenses, special skills, etc.

j. If subcontractor personnel will be used, the proposer should clearly identify these persons, if known, and provide the same information requested for the proposer’s personnel.

3. Additional Information
   As an appendix to its proposal, if available, proposers should provide copies of any policies and procedures manuals applicable to this contract, inclusive of organizational standards or ethical standards. This appendix should also include a copy of proposer’s All Hazards Response Plan, if available.

4. Corporate Financial Condition
   a. The organization's financial solvency will be evaluated. The proposer’s ability to demonstrate adequate financial resources for performance of the contract or the ability to obtain such resources as required during performance under this contract will be considered.

   b. Proposal should include for each of the last three (3) years, copies of financial statements, preferably audited, including at least a balance sheet and profit and loss statement, or other appropriate documentation which would demonstrate to the Department the proposer’s financial resources sufficient to conduct the project.

5. Cost and Pricing Analysis
   a. Proposer shall specify costs for performance of tasks for each year of the contract. Proposal shall include all anticipated costs of successful implementation of all deliverables outlined in attachment Va. An item by item breakdown of costs shall be included in the proposal.

   b. Proposers shall submit the per transaction and per dispensing fee for each item in attachment Vb for the first year of the contract.
c. Proposer shall specify AWP discount rates for both generic and brand name drugs for both retail and mail order dispensing. Proposer shall submit the rates in a similar format, and are strongly encouraged to use the same format, as the chart below.

<table>
<thead>
<tr>
<th>SERVICES</th>
<th>PERCENT</th>
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<tbody>
<tr>
<td>1. Discounts from AWP for generic drugs</td>
<td>%</td>
</tr>
<tr>
<td>2. Discounts from AWP for brand drugs</td>
<td>%</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>SERVICES</th>
<th>PERCENT</th>
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<tr>
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<td>%</td>
</tr>
<tr>
<td>2. Discounts from AWP for brand drugs</td>
<td>%</td>
</tr>
</tbody>
</table>

P. Evaluation Criteria

The following criteria will be used to evaluate proposals:

1. Evaluations will be conducted by a Proposal Review Committee.

2. Evaluations of the financial statements will be conducted by a member of the DHH Fiscal Division.

3. Scoring will be based on a possible total of 110, and the proposal with the highest total score will be recommended for award.

4. Cost Evaluation:
   a. The proposer with the lowest total three-year cost (from Attachment Va) shall receive 15 points. Other proposers shall receive points for cost based upon the following formula:

   **Annual Fee Schedules** (Attachment Va)
   
   \[ CPS = \left( \frac{LPC}{PC} \right) \times 15 \]

   CPS = Cost Proposal Score  
   LPC = Lowest Proposal Cost of all proposers  
   PC = Individual Proposal Cost

   b. The proposer with the lowest proposed fees (from Attachment Vb) shall receive 10 points. Other proposers shall receive points for cost based upon the following formula:

   **Claims Table** (Attachment Vb)
   
   \[ CPS = \left( \frac{LPC}{PC} \right) \times 10 \]

   CPS = Cost Proposal Score  
   LPC = Lowest Proposal Cost of all proposers  
   PC = Individual Proposal Cost

Proposers are strongly encouraged to use the same formats provided in Attachment Va and Vb.
c. The assignment of the 25 points based on the above formula will be calculated by a member of the DHH Contracts Office staff.

5. Evaluation Criteria and Assigned Weights:

<table>
<thead>
<tr>
<th>EVALUATION CRITERIA</th>
<th>ASSIGNED WEIGHT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction/Understanding of RFP</td>
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<tr>
<td>Work Plan/Project Execution</td>
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</tr>
<tr>
<td>Corporate Experience</td>
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<tr>
<td>Qualification of Personnel</td>
<td>10</td>
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<tr>
<td>Financial Statements</td>
<td>5</td>
</tr>
<tr>
<td>Cost</td>
<td>25</td>
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<tr>
<td>Veterans/Hudson Initiatives</td>
<td>10</td>
</tr>
<tr>
<td>On Site Presentation/Demonstration, if applicable</td>
<td>10</td>
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<tr>
<td>TOTAL</td>
<td>110</td>
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Q. On-Site Presentations/Demonstrations

1. The Department may select the proposers susceptible of being awarded the contract for an on-site presentation and/or demonstration for final determination of contract award. On-site presentations/demonstrations will allow proposers to demonstrate their unique capability to provide the services requested in the RFP.

2. Proposers selected for on-site presentations/demonstrations should:
   • Provide a strategic overview of services to be provided,
   • Summarize major strengths,
   • Demonstrate flexibility and adaptability to handle both anticipated and unanticipated changes,
   • If possible, have the project manager and key personnel in attendance to provide their view of the partnership envisioned with LA ADAP.

3. Up to an additional 10 points may be awarded for the bullet points in #2 above as a result of the on-site presentation/demonstration.

R. Announcement of Award

The Department will award the contract to the proposer with the highest graded proposal and deemed to be in the best interest of the Department. All proposers will be notified of the contract award. The Department will notify the successful proposer and proceed to negotiate contract terms.

IV. CONTRACTUAL INFORMATION

A. The contract between DHH and the Contractor shall include the standard DHH contract form (CF-1/attached) including a negotiated scope of work, the RFP and its amendments and addenda, and the Contractor’s proposal. The attached CF-1 contains basic information and general terms and conditions of the contract to be awarded.

B. Mutual Obligations and Responsibilities: The state requires that the mutual obligations and responsibilities of DHH and the successful proposer be recorded in a written contract. While final
wording will be resolved at contract time, the intent of the provisions will not be altered and will include all provisions as specified in the attached CF-1.

C. Retainage-The Department, shall secure a retainage of 10% from all billings under the contract as surety for performance. On successful completion of contract deliverables, the retainage amount may be released on an annual basis.

D. In addition, to terms of the CF-1 and supplements, the following will be incorporated into the contract awarded through this RFP:

1. Personnel Assignments: The Contractor’s key personnel assigned to this contract may not be replaced without the written consent of the Department. Such consent shall not be unreasonably withheld or delayed provided an equally qualified replacement is offered. Key personnel for these purposes will be determined during contract negotiation.

2. Force Majeure: The contractor and the Department are excused from performance under contract for any period they may be prevented from performance by an Act of God, strike, war, civil disturbance, epidemic or court order.

3. Order of Precedence: The contract shall, to the extent possible, be construed to give effect to all provisions contained therein; however, where provisions conflict, the intent of the parties shall be determined by giving a first priority to provisions of the contract excluding the RFP and the proposal; second priority to the provisions of the RFP; and third priority to the provisions of the proposal.

4. Entire Agreement: This contract, together with the RFP and addenda issued thereto by the Department, the proposal submitted by the contractor in response to the Department’s RFP, and any exhibits specifically incorporated herein by reference constitute the entire agreement between the parties with respect to the subject matter.

5. Board Resolution/Signature Authority: The contractor, if a corporation, shall secure and attach to the contract a formal Board Resolution indicating the signatory to the contract is a corporate representative and authorized to sign said contract.

6. Warranty to Comply with State and Federal Regulations: The contractor shall warrant that it shall comply with all state and federal regulations as they exist at the time of the contract or as subsequently amended.

7. Warranty of Removal of Conflict of Interest: The contractor shall warrant that it, its officers, and employees have no interest and shall not acquire any interest, direct or indirect, which conflicts in any manner or degree with the performance of services hereunder. The contractor shall periodically inquire of its officers and employees concerning such conflicts, and shall inform the Department promptly of any potential conflict. The contractor shall warrant that it shall remove any conflict of interest prior to signing the contract.

8. If the contractor is a corporation, the following requirement must be met prior to execution of the contract:
   a. If a for-profit corporation whose stock is not publicly traded-the contractor must file a Disclosure of Ownership form with the Louisiana Secretary of State.
   b. If the contractor is a corporation not incorporated under the laws of the State of Louisiana-the contractor must obtain a Certificate of Authority pursuant to R.S. 12:301-302 from the Louisiana Secretary of State.
c. The contractor must provide written assurance to the agency from contractor’s legal
counsel that the contractor is not prohibited by its articles of incorporation, bylaws or
the laws under which it is incorporated from performing the services required under the
contract.

Attachments:
I. Veteran and Hudson Initiatives
II. Certification Statement
III. DHH Standard Contract Form (CF-1)
IV. HIPAA
Va. Cost Template – Annual Fee Schedule
Vb. Cost Template – Claims Table
VI. ADR Proposed Client Level Variables
VII. ADR Proposed Grantee Level Variables
VIII. Minimum Required Data Fields/Variables
Minimum Required Language - Request For Proposal (RFP)
Veteran-Owned and Service-Connected Small Entrepreneurships (Veteran Initiative) and Louisiana Initiative for Small Entrepreneurships (Hudson Initiative) Programs

Participation of Veteran Initiative and Hudson Initiative small entrepreneurships will be scored as part of the technical evaluation.

The State of Louisiana Veteran and Hudson Initiatives are designed to provide additional opportunities for Louisiana-based small entrepreneurships (sometimes referred to as LaVet's and SE's respectively) to participate in contracting and procurement with the state. A certified Veteran-Owned and Service-Connected Disabled Veteran-Owned small entrepreneurship (LaVet) and a Louisiana Initiative for Small Entrepreneurships (Hudson Initiative) small entrepreneurship are businesses that have been certified by the Louisiana Department of Economic Development. All eligible vendors are encouraged to become certified. Qualification requirements and online certification are available at https://smallbiz.louisianaforward.com/index_2.asp.

Ten percent (10%) of the total evaluation points on this RFP are reserved for proposers who are themselves a certified Veteran or Hudson Initiative small entrepreneurship or who will engage the participation of one or more certified Veteran or Hudson Initiatives small entrepreneurships as subcontractors.

Reserved points shall be added to the applicable proposers' evaluation score as follows:

Proposer Status and Reserved Points

- Proposer is a certified small entrepreneurship: Full amount of the reserved points
- Proposer is not a certified small entrepreneurship but has engaged one or more certified small entrepreneurships to participate as subcontractors or distributors. Points will be allocated based on the following criteria:
  - the number of certified small entrepreneurships to be utilized
  - the experience and qualifications of the certified small entrepreneurship(s)
  - the anticipated earnings to accrue to the certified small entrepreneurship(s)

If a proposer is not a certified small entrepreneurship as described herein, but plans to use certified small entrepreneurship(s), proposer shall include in their proposal the names of their certified Veteran Initiative or Hudson Initiative small entrepreneurship subcontractor(s), a description of the work each will perform, and the dollar value of each subcontract.

During the term of the contract and at expiration, the Contractor will also be required to report Veteran-Owned and Service-Connected Disabled Veteran-Owned and Hudson Initiative small entrepreneurship subcontractor or distributor participation and the dollar amount of each.


A current list of certified Veteran-Owned and Service-Connected Disabled Veteran-Owned and Hudson Initiative small entrepreneurships may be obtained from the Louisiana Economic Development
Certification System at https://smallbiz.louisianaforward.com/index_2.asp. Additionally, a list of Hudson and Veteran Initiative small entrepreneurship, which have been certified by the Louisiana Department of Economic Development and who have opted to register in the State of Louisiana LaGov Supplier Portal https://lagoverpvendor.doa.louisiana.gov/irj/portal/anonymous?guest_user=self_reg may be accessed from the State of Louisiana Procurement and Contract (LaPAC) Network http://wwwprd.doa.louisiana.gov/osp/lapac/vendor/srchven.asp. When using this site, determine the search criteria (i.e. alphabetized list of all certified vendors, by commodities, etc.) and select SmallE, VSE, or DVSE.

Rev. 12/1/11
**CERTIFICATION STATEMENT**

The undersigned hereby acknowledges she/he has read and understands all requirements and specifications of the Request for Proposals (RFP), including attachments.

**OFFICIAL CONTACT.** The State requests that the Proposer designate one person to receive all documents and the method in which the documents are best delivered. Identify the Contact name and fill in the information below: (Print Clearly)

<table>
<thead>
<tr>
<th>Date</th>
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<tbody>
<tr>
<td>Official Contact Name</td>
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<tr>
<td>Email Address</td>
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<td>Fax Number with Area Code</td>
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<td>Telephone Number</td>
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<td>Street Address</td>
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<tr>
<td>City, State, and Zip</td>
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</table>

Proposer certifies that the above information is true and grants permission to the Department to contact the above named person or otherwise verify the information I have provided.

By its submission of this proposal and authorized signature below, proposer certifies that:

1. The information contained in its response to this RFP is accurate;
2. Proposer accepts the procedures, evaluation criteria, contract terms and conditions, and all other administrative requirements set forth in this RFP.
3. Proposer accepts the procedures, evaluation criteria, mandatory contract terms and conditions, and all other administrative requirements set forth in this RFP.
4. Proposer’s quote is valid for at least 120 days from the date of proposal’s signature below;
5. Proposer understands that if selected as the successful Proposer, he/she will have 10 business days from the date of delivery of initial contract in which to complete contract negotiations, if any, and execute the final contract document. The Department has the option to waive this deadline if actions or inactions by the Department cause the delay.
6. Proposer certifies, by signing and submitting a proposal for $25,000 or more, that their company, any subcontractors, or principals are not suspended or debarred by the General Services Administration (GSA) in accordance with the requirements in OMB Circular A-133. (A list of parties who have been suspended or debarred can be viewed via the internet at www.epls.gov.

Authorized Signature: __________________________________________

(Original signature only. Photocopy or electronic not accepted.)

Typed or Printed Name: __________________________________________

Title: _________________________________________________________

Company Name: ________________________________________________
# CONTRACT BETWEEN STATE OF LOUISIANA

## DEPARTMENT OF HEALTH AND HOSPITAL

AND

FOR

- [ ] Personal Services
- [ ] Professional Services
- [ ] Consulting Services
- [ ] Social Services

1. **Contractor (Legal Name if Corporation)**
2. **Street Address**
3. **Telephone Number**
4. **Mailing Address** (if different)
5. **Federal Employer Tax ID# or Social Security#** (11 digits)
6. **Parish(es) Served**
7. **License or Certification#**
8. **Contractor Status**
   - Subrecipient: [ ] Yes [ ] No
   - Corporation: [ ] Yes [ ] No
   - For Profit: [ ] Yes [ ] No
   - Publicly Traded: [ ] Yes [ ] No
8a. **CFDA#** (Federal Grant#)
9. **Brief Description Of Services To Be Provided:**
   Include description of work to be performed and objectives to be met; description of reports or other deliverables and dates to be received (when applicable). In a consulting service, a resume of key contract personnel performing duties under the terms of the contract and amount of effort each will provide under terms of contract should be attached.
10. **Effective Date**
11. **Termination Date**
12. This contract may be terminated by either party upon giving thirty (30) days advance written notice to the other party with or without cause but in no case shall continue beyond the specified termination date.
13. **Maximum Contract Amount**
14. **Terms of Payment**
   If progress and/or completion of services are provided to the satisfaction of the initiating Office/Facility, payments are to be made as follows: (stipulate rate or standard of payment, billing intervals, invoicing provisions, etc.). Contractor obligated to submit final invoices to Agency within fifteen (15) days after termination of contract.

**PAYMENT WILL BE MADE ONLY UPON APPROVAL OF:**

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Phone Number</th>
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15. **Special or Additional Provisions which are incorporated herein, if any (IF NECESSARY, ATTACH SEPARATE SHEET AND REFERENCE):**
During the performance of this agreement, the Contractor hereby agrees to the following terms and conditions:

1. Contractor hereby agrees to adhere as applicable to the mandates dictated by Titles VI and VII of the Civil Rights Act of 1964, as amended; the Vietnam Era Veterans' Readjustment Assistance Act of 1974; Americans with Disabilities Act of 1990 as amended; the Rehabilitation Act of 1973 as amended; Sec. 202 of Executive Order 11246 as amended, and all applicable requirements imposed by or pursuant to the regulations of the U.S. Department of Health and Human Services. Contractor agrees not to discriminate in the rendering of services to and/or employment of individuals because of race, color, religion, sex, age, national origin, handicap, political beliefs, disabled veteran, veteran status, or any other non-merit factor.

2. Contractor shall abide by the laws and regulations concerning confidentiality which safeguard information and the patient/client confidentiality. Information obtained shall not be used in any manner except as necessary for the proper discharge of Contractor's obligations. (The Contractor shall establish, subject to review and approval of the Department, confidentiality rules and facility access procedures.)

3. The State Legislative Auditor, Office of the Governor, Division of Administration, and Department Auditors or those designated by the Department shall have the option of auditing all accounts pertaining to this contract during the contract and for a three year period following final payment. Contractor grants to the State of Louisiana, through the Office of the Legislative Auditor, Department of Health and Hospitals, and Inspector General's Office, Federal Government and/or other such officially designated body the right to inspect and review all books and records pertaining to services rendered under this contract, and further agrees to guidelines for fiscal administration as may be promulgated by the Department. Records will be made available during normal working hours.

Contractor shall comply with federal and state laws and/or DHH Policy requiring an audit of the Contractor's operation as a whole or of specific program activities. Audit reports shall be sent within thirty (30) days after the completion of the audit, but no later than six (6) months after the end of the audit period. If an audit is performed within the contract period, for any period, four (4) copies of the audit report shall be sent to the Department of Health and Hospitals, Attention: Division of Fiscal Management, P.O. Box 91117, Baton Rouge, LA 70821-3797 and one (1) copy of the audit shall be sent to the originating DHH Office.

4. Contractor agrees to retain all books, records and other documents relevant to the contract and funds expended thereunder for at least four (4) years after final payment or as prescribed in 45 CFR 74:53 (b) whichever is longer. Contractor shall make available to the Department such records within thirty (30) days of the Department's written request and shall deliver such records to the Department's central office in Baton Rouge, Louisiana, all without expense to the Department. Contractor shall allow the Department to inspect, audit or copy records at the contractor's site, without expense to the Department.

5. Contractor shall not assign any interest in this contract and shall not transfer any interest in the same (whether by assignment or novation), without written consent of the Department thereto, provided, however, that claims for money due or to become due to Contractor from the Department under this contract may be assigned to a bank, trust company or other financial institution without advanced approval. Notice of any such assignment or transfer shall be promptly furnished to the Department and the Division of Administration, Office of Contractual Review.

6. Contractor hereby agrees that the responsibility for payment of taxes from the funds received under this contract shall be Contractor's. The contractor assumes responsibility for its personnel
providing services hereunder and shall make all deductions for withholding taxes, and contributions for unemployment compensation funds, and shall maintain, at Contractor’s expense, all necessary insurance for its employees, including but not limited to automobile insurance, workers’ compensation and general liability insurance.

7. Contractor shall obtain and maintain during the contract term all necessary insurance including automobile insurance, workers’ compensation insurance, and general liability insurance. The required insurances shall protect the Contractor, the Department of Health and Hospitals, and the State of Louisiana from all claims related to Contractor’s performance of this contract. Certificates of Insurance shall be filed with the Department for approval. Said policies shall not be canceled, permitted to expire, or be changed without thirty (30) days advance written notice to the Department. Commercial General Liability Insurance shall provide protection during the performance of work covered by the contract from claims or damages for personal injury, including accidental death, as well as claims for property damages, with combined single limits prescribed by the Department.

8. In cases where travel and related expenses are required to be identified separate from the fee for services, such costs shall be in accordance with State Travel Regulations. The contract contains a maximum compensation which shall be inclusive of all charges including fees and travel expenses.

9. No funds provided herein shall be used to urge any elector to vote for or against any candidate or proposition on an election ballot nor shall such funds be used to lobby for or against any proposition or matter having the effect of law being considered by the legislature or any local governing authority. This provision shall not prevent the normal dissemination of factual information relative to a proposition or any election ballot or a proposition or matter having the effect of law being considered by the legislature or any local governing authority. Contracts with individuals shall be exempt from this provision.

10. Should contractor become an employee of the classified or unclassified service of the State of Louisiana during the effective period of the contract, Contractor must notify his/her appointing authority of any existing contract with State of Louisiana and notify the contracting office of any additional state employment. This is applicable only to contracts with individuals.

11. All non-third party software and source code, records, reports, documents and other material delivered or transmitted to Contractor by State shall remain the property of State, and shall be returned by Contractor to State, at Contractor’s expense, at termination or expiration of this contract. All non-third party software and source code, records, reports, documents, or other material related to this contract and/or obtained or prepared by Contractor in connection with the performance of the services contracted for herein shall become the property of State, and shall be returned by Contractor to State, at Contractor’s expense, at termination or expiration of this contract.

12. Contractor shall not enter into any subcontract for work or services contemplated under this contract without obtaining prior written approval of the Department. Any subcontracts approved by the Department shall be subject to conditions and provisions as the Department may deem necessary; provided, however, that notwithstanding the foregoing, unless otherwise provided in this contract, such prior written approval shall not be required for the purchase by the contractor of supplies and services which are incidental but necessary for the performance of the work required under this contract. No subcontract shall relieve the Contractor of the responsibility for the performance of contractual obligations described herein.

13. No person and no entity providing services pursuant to this contract on behalf of contractor or any subcontractor is prohibited from providing such services by the provisions of R.S. 1113 as amended in the 2008 Regular Session of the Louisiana Legislature.
14. No claim for services furnished or requested for reimbursement by Contractor, not provided for in this contract, shall be allowed by the Department. In the event the Department determines that certain costs which have been reimbursed to Contractor pursuant to this or previous contracts are not allowable, the Department shall have the right to set off and withhold said amounts from any amount due the Contractor under this contract for costs that are allowable.

15. This contract is subject to and conditioned upon the availability and appropriation of Federal and/or State funds; and no liability or obligation for payment will develop between the parties until the contract has been approved by required authorities of the Department; and, if contract exceeds $20,000, the Director of the Office of Contractual Review, Division of Administration in accordance with La. R.S. 39:1502.

16. The continuation of this contract is contingent upon the appropriation of funds from the legislature to fulfill the requirements of the contract. If the Legislature fails to appropriate sufficient monies to provide for the continuation of the contract, or if such appropriation is reduced by the veto of the Governor or by any means provided in the appropriations act to prevent the total appropriation for the year from exceeding revenues for that year, or for any other lawful purpose, and the effect of such reduction is to provide insufficient monies for the continuation of the contract, the contract shall terminate on the date of the beginning of the first fiscal year for which funds are not appropriated.

17. Any alteration, variation, modification, or waiver of provisions of this contract shall be valid only when reduced to writing, as an amendment duly signed, and approved by required authorities of the Department; and, if contract exceeds $20,000, approved by the Director of the Office of Contractual Review, Division of Administration. Budget revisions approved by both parties in fee for service contracts do not require an amendment if the revision only involves the realignment of monies between originally approved cost categories.

18. Any contract disputes will be interpreted under applicable Louisiana laws and regulations in Louisiana administrative tribunals or district courts as appropriate.

19. Contractor will warrant all materials, products and/or services produced hereunder will not infringe upon or violate any patent, copyright, trade secret, or other proprietary right of any third party. In the event of any such claim by any third party against DHH, the Department shall promptly notify Contractor in writing and Contractor shall defend such claim in DHH’s name, but at Contractor’s expense and shall indemnify and hold harmless DHH against any loss, expense or liability arising out of such claim, whether or not such claim is successful. This provision is not applicable to contracts with physicians, psychiatrists, psychologists or other allied health providers solely for medical services.

20. Any equipment purchased under this contract remains the property of the Contractor for the period of this contract and future continuing contracts for the provision of the same services. Contractor must submit vendor invoice with reimbursement request. For the purpose of this contract, equipment is defined as any tangible, durable property having a useful life of at least (1) year and acquisition cost of $1000.00 or more. The contractor has the responsibility to submit to the Contract Monitor an inventory list of DHH equipment items when acquired under the contract and any additions to the listing as they occur. Contractor will submit an updated, complete inventory list on a quarterly basis to the Contract Monitor. Contractor agrees that upon termination of contracted services, the equipment purchased under this contract reverts to the Department. Contractor agrees to deliver any such equipment to the Department within 30 days of termination of services.

21. Contractor agrees to protect, indemnify and hold harmless the State of Louisiana, DHH, from all claims for damages, costs, expenses and attorney fees arising in contract or tort from this contract or from
any acts or omissions of Contractor’s agents, employees, officers or clients, including premises liability and including any claim based on any theory of strict liability. This provision does not apply to actions or omissions for which LA R.S. 40:1299.39 provides malpractice coverage to the contractor, nor claims related to treatment and performance of evaluations of persons when such persons cause harm to third parties (R.S. 13:5108.1(E)). Further it does not apply to premises liability when the services are being performed on premises owned and operated by DHH.

22. Any provision of this contract is severable if that provision is in violation of the laws of the State of Louisiana or the United States, or becomes inoperative due to changes in State and Federal law, or applicable State or Federal regulations.

23. Contractor agrees that the current contract supersedes all previous contracts, negotiations, and all other communications between the parties with respect to the subject matter of the current contract.

THIS CONTRACT CONTAINS OR HAS ATTACHED HERETO ALL THE TERMS AND CONDITIONS AGREED UPON BY THE CONTRACTING PARTIES. IN WITNESS THEREOF, THIS CONTRACT IS SIGNED ON THE DATE INDICATED BELOW.

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

SIGNATURE DATE SIGNATURE DATE

NAME NAME

TITLE Secretary, Department of Health and Hospitals or Designee

TITLE

SIGNATURE DATE SIGNATURE DATE

NAME

TITLE

SIGNATURE DATE

NAME

TITLE
HIPAA Business Associate Addendum

This Business Associate Addendum is hereby made a part of this contract in its entirety as Attachment __ to the contract.

1. The U.S. Department of Health and Human Services has issued final regulations, pursuant to the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), governing the privacy of individually identifiable health information. See 45 CFR Parts 160 and 164 (the “HIPAA Privacy Rule”). The Department of Health and Hospitals, (“DHH”), as a “Covered Entity” as defined by HIPAA, is a provider of health care, a health plan, or otherwise has possession, custody or control of health care information or records.

2. “Protected health information” (“PHI”) means individually identifiable health information including all information, data, documentation and records, including but not limited to demographic, medical and financial information that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual or payment for health care provided to an individual; and that identifies the individual or which DHH believes could be used to identify the individual.
   
   “Electronic protected health information” means PHI that is transmitted by electronic media or maintained in electronic media.
   
   “Security incident” means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

3. Contractor is considered a Business Associate of DHH, as contractor either: (A) performs certain functions on behalf of or for DHH involving the use or disclosure of protected individually identifiable health information by DHH to contractor, or the creation or receipt of PHI by contractor on behalf of DHH; or (B) provides legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, financial or social services for DHH involving the disclosure of PHI.

4. Contractor agrees that all PHI obtained as a result of this contractual agreement shall be kept confidential by contractor, its agents, employees, successors and assigns as required by HIPAA law and regulations and by this contract and addendum.

5. Contractor agrees to use or disclose PHI solely (A) for meeting its obligations under this contract, or (B) as required by law, rule or regulation or as otherwise permitted under this contract or the HIPAA Privacy Rule.

6. Contractor agrees that at termination of the contract, or upon request of DHH, whichever occurs first, contractor will return or destroy (at the option of DHH) all PHI received or created by contractor that contractor still maintains in any form and retain no copies of such information; or if such return or destruction is not feasible, contractor will extend the confidentiality protections of the contract to the information and limit further uses and disclosure to those purposes that make the return or destruction of the information infeasible.

7. Contractor will ensure that its agents, employees, subcontractors or others to whom it provides PHI received by or created by contractor on behalf of DHH agree to the same restrictions and conditions that apply to contractor with respect to such information. Contractor also agrees to take all reasonable steps to ensure that its employees’, agents’ or subcontractors’ actions or omissions do not cause contractor to breach the terms of this Addendum. Contractor will use all appropriate safeguards to prevent the use or disclosure of PHI other than pursuant to the terms and conditions of this contract and Addendum.

8. Contractor shall, within 3 days of becoming aware of any use or disclosure of PHI, other than as permitted by this contract and Addendum, report such disclosure in writing to the person(s) named in section 14 (Terms of Payment), page 1 of the CF-1.
9. Contractor shall make available such information in its possession which is required for DHH to provide an accounting of disclosures in accordance with 45 CFR 164.528. In the event that a request for accounting is made directly to contractor, contractor shall forward such request to DHH within two (2) days of such receipt. Contractor shall implement an appropriate record keeping process to enable it to comply with the requirements of this provision. Contractor shall maintain data on all disclosures of PHI for which accounting is required by 45 CFR 164.528 for at least six (6) years after the date of the last such disclosure.

10. Contractor shall make PHI available to DHH upon request in accordance with 45 CFR 164.524.

11. Contractor shall make PHI available to DHH upon request for amendment and shall incorporate any amendments to PHI in accordance with 45 CFR 164.526.

12. Contractor shall make its internal practices, books, and records relating to the use and disclosure of PHI received from or created or received by contractor on behalf of DHH available to the Secretary of the U.S. DHHS for purposes of determining DHH's compliance with the HIPAA Privacy Rule.

13. Compliance with Security Regulations:

   In addition to the other provisions of this Addendum, if Contractor creates, receives, maintains, or transmits electronic PHI on DHH’s behalf, Contractor shall, no later than April 20, 2005:

   (A) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of DHH;

   (B) Ensure that any agent, including a subcontractor, to whom it provides such information agrees to implement reasonable and appropriate safeguards to protect it; and

   (C) Report to DHH any security incident of which it becomes aware.

14. Contractor agrees to indemnify and hold DHH harmless from and against all liability and costs, including attorneys’ fees, created by a breach of this Addendum by contractor, its agents, employees or subcontractors, without regard to any limitation or exclusion of damages provision otherwise set forth in the contract.

15. Notwithstanding any other provision of the contract, DHH shall have the right to terminate the contract immediately if DHH determines that contractor has violated any material term of this Addendum.
# Annual Fee Schedules

## Year One

<table>
<thead>
<tr>
<th>Services</th>
<th>Price</th>
<th>Estimated Transactions per Year</th>
<th>Yearly Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Implementation Fee – Onetime costs associated with initial implementation of services.</td>
<td>$1</td>
<td>1 (first year only)</td>
<td>$</td>
</tr>
<tr>
<td>2. Monthly Administrative Fees* – Costs associated with execution of services.</td>
<td>$12</td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>3. Training Fees – Costs associated with participating in and/or providing annual trainings.</td>
<td>$5</td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>4. Reporting Fees – Monthly cost associated with generating required reports.</td>
<td>$12</td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>5. Recoupment Fee - Monthly costs associated with claims recoupment.</td>
<td>$12</td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>6. Third Party Match Fee – Monthly costs associated with third party enrollment identification and reporting</td>
<td>$12</td>
<td></td>
<td>$</td>
</tr>
</tbody>
</table>

Estimated Year One Fee Total: $\

## Year Two

<table>
<thead>
<tr>
<th>Services</th>
<th>Price</th>
<th>Estimated Transactions per Year</th>
<th>Yearly Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Monthly Administrative Fees*</td>
<td>$12</td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>2. Training Fees</td>
<td>$5</td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>3. Reporting Fees</td>
<td>$12</td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>4. Recoupment Fee</td>
<td>$12</td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>5. Third Party Enrollment Match Fee</td>
<td>$12</td>
<td></td>
<td>$</td>
</tr>
</tbody>
</table>

Estimated Year Two Fee Total: $\

## Year Three

<table>
<thead>
<tr>
<th>Services</th>
<th>Price</th>
<th>Estimated Transactions per Year</th>
<th>Yearly Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Monthly Administrative Fees*</td>
<td>$12</td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>2. Training Fees</td>
<td>$5</td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>3. Reporting Fees</td>
<td>$12</td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>4. Recoupment Fee</td>
<td>$12</td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>5. Third Party Enrollment Match Fee</td>
<td>$12</td>
<td></td>
<td>$</td>
</tr>
</tbody>
</table>

Estimated Year Three Fee Total: $\

Estimated Total Three (3) Year Fee Total: $\

Proposers are strongly encouraged to use the template provided.

*Administrative Costs may include:
- Usual and recognized overhead activities, including rent, utilities, and facility costs
- Costs of management oversight of specific programs funded under this title, including program coordination; clerical, financial, and management staff not directly related to patient care; program evaluation; liability insurance; audits; computer hardware/software not directly related to patient care.

However, in accordance with the legislative mandates of the Ryan White HIV/AIDS Treatment Extension Act of 2009, and the Monitoring Standards for Ryan White Part A and B Grantees, Administrative Costs must be documented and shall not exceed 10% of the total resources contracted for direct client services.
### Cost Template - Claims Table

Fees proposed in this table will be valid for the first year of the contract with discounts in subsequent years as reflected in II.A.Drug Pricing. Proposers are strongly encouraged to use the template provided.

<table>
<thead>
<tr>
<th>Services</th>
<th>Price</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Third Party Claims</strong></td>
<td></td>
</tr>
<tr>
<td>Dispensing fee per claim</td>
<td>$</td>
</tr>
<tr>
<td>Transaction fee per claim</td>
<td>$</td>
</tr>
<tr>
<td><strong>340B Claims</strong></td>
<td></td>
</tr>
<tr>
<td>Dispensing fee per claim</td>
<td>$</td>
</tr>
<tr>
<td>Transaction fee per claim</td>
<td>$</td>
</tr>
<tr>
<td><strong>Mail Order Claims</strong></td>
<td></td>
</tr>
<tr>
<td>Shipping fee per claim</td>
<td>$</td>
</tr>
<tr>
<td>Transaction fee per claim</td>
<td>$</td>
</tr>
<tr>
<td><strong>Manual / Direct Member Reimbursement Third Party Claims</strong></td>
<td></td>
</tr>
<tr>
<td>Transaction fee per claim</td>
<td>$</td>
</tr>
</tbody>
</table>

SHP estimates 100,000 medication claims for calendar year 2012

Utilization data provided by SHP for the purpose of this RFP are estimates based on previous claims. Variation in future services, funding and utilization trends in any of the three years will be based on the result of litigation regarding the Patient Protection and Affordable Care Act, the availability of federal funds, as well as guidance requirements from federal funders and should be considered in the proposer's calculation. Fees proposed will not be negotiated based on volume.
## ADAP Data Report / Proposed Client-Level Data Variables

<table>
<thead>
<tr>
<th>Field #</th>
<th>Variable Description</th>
<th>Variable Definition</th>
<th>Allowed Values</th>
<th>Rationale</th>
</tr>
</thead>
</table>
| 1.      | Reporting period     | The report period identifier. | 2012P1= 04/01/2012 – 09/30/2012  
2012P2= 10/01/2012 – 03/31/2012  
Note that values will continue and be sequential i.e. 2013P1, 2013P2 |  |
| 2.      | Encrypted UCI        | The encrypted, unique client identifier generated by the HAB UCI generation utilities. | 41-character string |  |
| 3.      | ADAP number          | The unique provider organization identifier assigned through the ADR Web Application. | State ADAP number |  |

### Client Demographics: To describe the socio-demographic characteristics of all clients enrolled in the ADAP, whether or not they received services

<table>
<thead>
<tr>
<th>Field #</th>
<th>Variable Description</th>
<th>Variable Definition</th>
<th>Allowed Values</th>
<th>Rationale</th>
</tr>
</thead>
</table>
| 4.      | Ethnicity            | Client’s ethnicity. OMB-approved categories are used. | • Hispanic/Latino(a)  
• Non-Hispanic  
• Unknown | Description of clients served |
| 5.      | Race                 | Client’s race. Select all that apply. OMB-approved categories are used. | • White  
• Black or African American  
• Asian  
• Native Hawaiian/Pacific Islander  
• American Indian or Alaska Native  
• Unknown | Description of clients served |
| 6.      | Gender               | Client’s current gender | • Male  
• Female  
• Transgender  
• Unknown | Description of clients served |
| 7.      | Transgender          | Client’s current transgender status. To be completed only if the response is “Transgender” in Q6. | • Male-to-Female  
• Female-to-Male  
• Unknown | Description of clients served |
<table>
<thead>
<tr>
<th>Field #</th>
<th>Variable Description</th>
<th>Variable definition</th>
<th>Allowed Values</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Client Demographics:</strong> To describe the socio-demographic characteristics of all clients enrolled in the ADAP, whether or not they received services</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| 8.     | Pregnancy status     | Value indicating whether the client was pregnant at any time during the reporting period. This should be completed for HIV+ women only. | • No (skip to #10)  
• Yes  
• Not applicable (skip to #10)  
• Unknown (skip to #10) | Description of clients served |
| 9.     | Pregnancy outcome    | Value indicating whether this pregnancy resulted in a live birth. This should be completed for HIV+ women who reported being pregnant in item #8. | • Yes  
• No  
• Don’t know | Description of clients served |
| 10.    | Client’s year of birth | The year in which the client was born | YYYY | Description of clients served |
| 11.    | HIV/AIDS status      | Client’s HIV/AIDS status as of the end of the reporting period | • HIV positive, not-AIDS  
• HIV positive, AIDS status unknown  
• CDC-defined AIDS  
• Unknown | Description of clients served |
| 12.    | Poverty level        | Client’s annual household income as a percent of the Federal Poverty Level (FPL) at the end of the reporting period. | • Equal to or below the FPL  
• 101-200% of the FPL  
• 201-300% of the FPL  
• 301% - 400% of the FPL  
• 401% - 500% of the FPL  
• Over 500% of the FPL  
• Unknown/ unreported | Description of clients served |
| 13.    | High Risk Insurance  | Was this client in a High Risk Insurance Pool at any time during the reporting period? | • No  
• Yes  
• Don’t know | Description of clients served |
| 14.    | Client’s health insurance coverage during the reporting period | Indicate all sources of client’s health insurance during the reporting period.  
Report all that apply. | • Medicare Part A/B  
• Medicare Part D  
• Medicaid  
• Private  
• Other public  
• No insurance  
• Other | Description of clients served |
**ADAP Data Report / Proposed Client-Level Data Variables**

<table>
<thead>
<tr>
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<th>Allowed Values</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>15.</td>
<td>Report the date of the most recent CD4 count for this client during this reporting period</td>
<td>Value indicating the date of the most recent CD4 count for this client during this report period</td>
<td>MM/DD/YYYY</td>
<td>To determine the impact of ADAP-funded medications</td>
</tr>
<tr>
<td>16.</td>
<td>Report the value of the most recent CD4 count for this client during this reporting period</td>
<td>Value indicating the value of the most recent CD4 count for this client during this report period</td>
<td>Value: ###</td>
<td>To determine the impact of ADAP-funded medications</td>
</tr>
<tr>
<td>17.</td>
<td>Report the date for the most recent Viral load count for this client during the reporting period</td>
<td>Value indicating the date of the most recent Viral load count for this client during this report period</td>
<td>MM/DD/YYYY</td>
<td>To determine the impact of ADAP-funded medications</td>
</tr>
<tr>
<td>18.</td>
<td>Report the value of the most recent Viral load count for this client during the reporting period</td>
<td>Value indicating the value of the most recent Viral load count for this client during this report period</td>
<td>Value: ###</td>
<td>To determine the impact of ADAP-funded medications</td>
</tr>
</tbody>
</table>
### ADAP Data Report / Proposed Client-Level Data Variables

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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Enrollment and Certification: To describe client enrollment patterns and certification processes</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| 19.     | Was the individual a new or existing client? | Newly enrolled clients in ADAP this reporting period refers to individuals who meet all of the following criteria:  
• applied to ADAP for the first time ever;  
• met the financial and medical eligibility criteria of the ADAP during the period for which you are reporting data.  
Examples of clients who should NOT be included in this number are the following:  
• Clients who have been recertified as eligible or clients who have been re-enrolled after a period of having been decertified/disenrolled.  
• Clients who have moved out of the State and then returned, and  
• Clients who move on and off ADAP because of fluctuations in eligibility for a Medicaid/ Medically Needy program, based on whether they met spend-down requirements.  
An existing ADAP client is a client who met the following criteria:  
• enrolled in ADAP in a previous reporting period and;  
• continues to be enrolled in the current reporting period, regardless of whether they used ADAP services in either reporting period.  
Note: An individual enrolled in ADAP (new or existing client) may | • Newly enrolled client  
• Existing Client (skip to question #23) | HAB ADAP Performance Measures |

|             |                       |                     |                |           |
# ADAP Data Report / Proposed Client-Level Data Variables

<table>
<thead>
<tr>
<th>Field #</th>
<th>Variable Description</th>
<th>Variable definition</th>
<th>Allowed Values</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>20.</td>
<td>What was the date of receipt of the completed client ADAP application?</td>
<td>The date that the completed application was received by the ADAP program.</td>
<td>MM/DD/YYYY</td>
<td>HAB ADAP Performance Measures</td>
</tr>
<tr>
<td>21.</td>
<td>What was the date of approval of this client’s ADAP application?</td>
<td>The date that the client was approved to begin to receive ADAP services. This is when the client was first enrolled in the ADAP program.</td>
<td>MM/DD/YYYY</td>
<td>HAB ADAP Performance Measures</td>
</tr>
<tr>
<td>22.</td>
<td>What was the date this client first received an ADAP-funded service?</td>
<td>The date that the client first received any ADAP-funded service. An ADAP-funded service includes medications and insurance assistance (co-pays, deductibles or premiums).</td>
<td>MM/DD/YYYY</td>
<td>HAB ADAP Performance Measures</td>
</tr>
</tbody>
</table>
| 23.     | What was this client’s recertification date during this reporting period? | The date on which a client was determined to be eligible to continue to receive ADAP services.  

Note: All individuals enrolled in ADAP, regardless of whether or not they receive services, must be recertified every six months. This includes clients on a waiting list. The minimum activities for recertification include:  
1) Financial Eligibility determination.  
2) Ensuring that ADAP is the Payer of Last Resort.  
3) Appropriate documentation (ie: financial/insurance –or lack thereof/ denial of coverage) | MM/DD/YYYY | HAB ADAP Performance Measures |
| 24.     | What was the client’s enrollment status as of the end of the reporting period? | The status of an individual in the ADAP program as of the end of the reporting period. There are four possible options which are:  
• The individual is enrolled in ADAP but did not need/request any services  
• The individual is enrolled in ADAP but is on a waiting list  
• The individual is enrolled in ADAP and received either ADAP-funded medications or insurance services during the reporting period  
• The individual was disenrolled from ADAP | • Enrolled, receiving services  
• (skip to question #26)  
• Enrolled, on waiting list (skip to question #26)  
• Enrolled, services not requested (skip to question #26)  
• Disenrolled | Description of clients served |
# ADAP Data Report / Proposed Client-Level Data Variables

<table>
<thead>
<tr>
<th>Field #</th>
<th>Variable Description</th>
<th>Variable definition</th>
<th>Allowed Values</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Enrollment and Certification: To describe client enrollment patterns and certification processes</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| 25.     | What was/were the reason(s) for disenrollment? | Please note the reasons for disenrollment/discharge. Select all that apply. If the reason is unknown, please report under “other”. | • Ineligible, change in ADAP program FPL requirements  
• Ineligible for ADAP, now eligible for Medicaid  
• Ineligible, other reason  
• Did not recertify  
• Did not fill prescription  
• Deceased  
• Dropped out, no reason given  
• Other/Unknown | To determine service utilization |

**ADAP Insurance Services Received: To describe ADAP-funded insurance assistance services and expenditures. ADAP-funded insurance assistance includes premiums, co-pays and deductibles. Co-pays and deductibles for medications should be reported in this section.**

<table>
<thead>
<tr>
<th>Field #</th>
<th>Variable Description</th>
<th>Variable definition</th>
<th>Allowed Values</th>
<th>Rationale</th>
</tr>
</thead>
</table>
| 26.     | Did this client receive any ADAP-funded insurance assistance during this reporting period, including Medicare Part D premiums? | This includes premiums, deductibles and co-payments for which ADAP funds were used. [If response to question #26 is no, go to #31] | • No  
• Yes | To describe service utilization |
| 27.     | Total amount of insurance Premium paid on behalf of this client during the reporting period [not including Medicare Part D]. | The total amount of insurance premium paid on behalf of the client. This pertains to any premium paid during the reporting period, regardless of the time frame that it covers (i.e. if it extends outside the reporting period) | $$$ | To describe service utilization and to determine annualized costs by type of insurance assistance |
| 28.     | For how many months of coverage was this insurance Premium during the reporting period? | The total number of months of coverage for which insurance premium in item #26 was paid. Please report all months even if they fall outside of the reporting period. | ## | To describe service utilization and to determine annualized costs by medication type |
# ADAP Data Report / Proposed Client-Level Data Variables

<table>
<thead>
<tr>
<th>Field #</th>
<th>Variable Description</th>
<th>Variable definition</th>
<th>Allowed Values</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>29.</td>
<td>Total amount of deductible and co-pays paid on behalf of this client during the reporting period.</td>
<td>The total amount of insurance deductibles and co-pays paid on behalf of the client, not including Medicare Part D. The amount reported should be based on the date that the deductible or co-pay was paid.</td>
<td>$$$</td>
<td>To describe service utilization and to determine annualized costs by medication type</td>
</tr>
<tr>
<td>30.</td>
<td>Total amount of Medicare Part D Co-Insurance, Co-Payment or donut hole coverage (true out of pocket expenses) paid on behalf of this client during the reporting period.</td>
<td>The total amount of Medicare Part D Co-Insurance, Co-Payment or donut hole coverage (true out of pocket expenses) paid on behalf of the client during this reporting period. The amount reported should be based on the date that the co-insurance, co-payment or donut hole coverage amount was paid.</td>
<td>$$$</td>
<td>To describe service utilization and to determine annualized costs by medication type</td>
</tr>
</tbody>
</table>
## ADAP Data Report / Proposed Client-Level Data Variables

<table>
<thead>
<tr>
<th>Field #</th>
<th>Variable Description</th>
<th>Variable Definition</th>
<th>Allowed Values</th>
<th>Rationale</th>
</tr>
</thead>
</table>
| 31.     | Were any ADAP-funded medications dispensed to this client during this reporting period? | Whether or not ADAP-funded medications were dispensed to this client during this reporting period? ADAP-funded medications include any medication on your ADAP formulary which was paid for in full by ADAP funds. | • No (skip to end)  
• Yes | To describe service utilization |
| 32.     | Please list the ADAP-funded medication dispensed to the client during this reporting period. | The specific list of ADAP funded medications that were dispensed to the client during the reporting period. Please use the five-digit drug code (d-xxxx) of the medication. Variables 32-35 will be reported for each ADAP-funded medication. | d#### | To describe service utilization and to determine annualized costs by medication type |
| 33.     | What is the start date of the ADAP-funded medication dispensed to the client during this reporting period? | List the start date for each ADAP funded medication listed in question #32. | MM/DD/YYYY | To describe service utilization and to determine annualized costs by medication type |
| 34.     | For how many days was the ADAP-funded medication dispensed? | The number of days for which the medication was dispensed for each ADAP funded medication listed in question #32. Number of days should be reported in 30-day increments (i.e. 30, 60, 90). Anything less than 30 days should be reported as 30 days. | ## | To describe service utilization and to determine annualized costs by medication type |
| 35.     | What was the total cost of the ADAP-funded medication dispensed to the client during the reporting period? | The total cost of each ADAP-funded medication dispensed during the reporting period. Include total costs of each ADAP-funded medication paid during the reporting period, even if the medication prescription period extended beyond the reporting period. | $$ | To describe service utilization and to determine annualized costs by medication type |
| 36.     | Dispensing fees collected separately | Do you pay dispensing fees for medications separate from other fees such other administrative? (If yes, go to question 37) | • No  
• Yes | To describe service utilization and to determine annualized costs by medication type |
## ADAP Data Report / Proposed Client-Level Data Variables

<table>
<thead>
<tr>
<th>Field #</th>
<th>Variable Description</th>
<th>Variable definition</th>
<th>Allowed Values</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>37.</td>
<td>What is the total cost of all Dispensing Fees for medications paid on behalf of this client during the reporting period?</td>
<td>The total cost of all dispensing fees for medications paid on behalf of the client during the reporting period. Include all costs paid during the reporting period, even if the medication period extended beyond the reporting period.</td>
<td>$$</td>
<td>To describe service utilization and to determine annualized costs by medication type.</td>
</tr>
</tbody>
</table>
AIDS DRUG ASSISTANCE PROGRAM

ADAP GRANTEE REPORT

PROPOSED GRANTEE-LEVEL VARIABLES

COVER PAGE

Grantee Contact Information

1. Grantee name: ________________________________________________________________
2. Grant number: ____________________________________________________________
3. ADAP number: ____________________________________________________________
4. D-U-N-S number: __________________________________________________________
5. Grantee address:
   a. Street: ___________________________________________________________________
   b. City: ___________________________________ State: _______________________
   c. ZIP Code: __________________________________________________________________
6. Contact information for the ADAP Coordinator/Administrator:
   a. Name: _____________________________________________________________________
   b. Title: _____________________________________________________________________
   c. Phone #: ( ) ________________________________
   d. Fax #: ( ) _________________________________
   e. E-mail: _____________________________________________________________________
7. Indicate the six month reporting period for which you are submitting data:
   ☐ April 1 – September 30
   ☐ October 1 – March 31
**Section 1: Programmatic Summary Submission**

Section 1 (Items 1–7) should be completed for each six month period. Please review the Instructions for Completing the ADAP Grantee Report to ensure that you respond to each item appropriately.

**A. PROGRAM ADMINISTRATION**

1. Please indicate which of the following limits applied to your ADAP during the reporting period. For each item that applied, complete the blank with the information requested on that limit. (Check all that apply)

   - Waiting list anytime during the reporting period
   - Enrollment cap Max number of enrollees___________
   - Capped expenditure Monetary cap $__________ per client
   - Drug-specific enrollment caps for ARVs or Hepatitis C medications - Please specify below for each medication that has an enrollment cap:
     - Medication______________________________ Max number of enrollees___________

2. Indicate which of the following developments or changes occurred in your program during this reporting period: (Check all that apply)

   - Project budget deficit
   - Change in income eligibility criteria (please specify:___________________________________)
   - Change in medical eligibility criteria (please specify:___________________________________)
   - Added medications to the formulary
   - Deleted medications from the formulary

3. Please indicate the maximum ADAP eligibility requirements as a percentage of Federal Poverty Level (FPL):__________ %

4. Please indicate which of the following activities your ADAP uses to coordinate with Medicaid or a State-only Pharmacy Assistance Program: (Check all that apply)

   - Online interface
   - Dual application
   - Coordinated benefits
   - Retroactive billing
   - Other (please specify:_____________________________________________________________)
   - We have no coordination with Medicaid or State-only ADAP
### B. FUNDING

5. Please enter the funding received during this reporting period from each of the following sources (if no funding was received enter “0”):

<table>
<thead>
<tr>
<th>Funding Source</th>
<th>Amount Received (to nearest dollar)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Total contributions from Part A EMA(s)/TGAs</td>
<td>$</td>
</tr>
<tr>
<td>b. Total contributions from Part B Base Funding</td>
<td>$</td>
</tr>
<tr>
<td>c. Total contributions from Part B Supplemental Funding</td>
<td>$</td>
</tr>
<tr>
<td>d. State contributions (other than Ryan White or Required State Match Funds)</td>
<td>$</td>
</tr>
<tr>
<td>e. Carry-over of Ryan White funds from previous year</td>
<td>$</td>
</tr>
<tr>
<td>f. Manufacturer Rebates</td>
<td>$</td>
</tr>
<tr>
<td>g. Other Negotiated Rebates</td>
<td>$</td>
</tr>
<tr>
<td>h. All Insurance Reimbursements, including Medicaid</td>
<td>$</td>
</tr>
<tr>
<td>Resources received this reporting period (Total of a through h)</td>
<td>$</td>
</tr>
</tbody>
</table>

### C. EXPENDITURES

6. For each of the following categories, please enter total expenditures for this reporting period:

<table>
<thead>
<tr>
<th>Expenditure Category</th>
<th>Total Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Pharmaceuticals</td>
<td>$</td>
</tr>
<tr>
<td>b. Dispensing and other administrative costs</td>
<td>$</td>
</tr>
<tr>
<td>c. Insurance coverage (including co-pays, deductibles, and premiums)</td>
<td>$</td>
</tr>
<tr>
<td>d. Under the ADAP Flexibility Policy - <strong>Adherence</strong></td>
<td>$</td>
</tr>
<tr>
<td>e. Under the ADAP Flexibility Policy - <strong>Access</strong></td>
<td>$</td>
</tr>
<tr>
<td>f. Under the ADAP Flexibility Policy - <strong>Monitoring</strong></td>
<td>$</td>
</tr>
<tr>
<td><strong>Total ADAP expenditures this quarter</strong></td>
<td>$</td>
</tr>
</tbody>
</table>
### D. ADAP MEDICATION FORMULARY

7. Please provide information on Antiretroviral (ARV), hepatitis B, hepatitis C and 'A1'-OI medications currently on your ADAP formulary. If you added an ARV medication to your ADAP formulary during this reporting period, please note that and provide the date that it was added.

#### a. Grantee-level Formulary Information - Antiretroviral Medications

<table>
<thead>
<tr>
<th>Included In Formulary</th>
<th>GENERIC NAME</th>
<th>BRAND NAME</th>
<th>Category</th>
<th>Added to Formulary this Reporting Period</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>abacavir</td>
<td>Ziagen</td>
<td>NRTIs</td>
<td>[ ]</td>
</tr>
<tr>
<td></td>
<td>abacavir, zidovudine, and</td>
<td>Trizivir</td>
<td>NRTIs</td>
<td>[ ] MM/DD/YYYY</td>
</tr>
<tr>
<td></td>
<td>abacavir/lamivudine</td>
<td>Epzicom</td>
<td>NRTIs</td>
<td>[ ] MM/DD/YYYY</td>
</tr>
<tr>
<td></td>
<td>didanosine, ddl, dideoxyinosine</td>
<td>Videx</td>
<td>NRTIs</td>
<td>[ ] MM/DD/YYYY</td>
</tr>
<tr>
<td></td>
<td>efavirenz,emtricitabine, tenofovir disoproxil fumarate</td>
<td>Atripla</td>
<td>NRTIs</td>
<td>[ ] MM/DD/YYYY</td>
</tr>
<tr>
<td></td>
<td>FTC, emtricitabine</td>
<td>Emtriva</td>
<td>NRTIs</td>
<td>[ ] MM/DD/YYYY</td>
</tr>
<tr>
<td></td>
<td>lamivudine and zidovudine</td>
<td>Combivir</td>
<td>NRTIs</td>
<td>[ ] MM/DD/YYYY</td>
</tr>
<tr>
<td></td>
<td>lamivudine, 3TC</td>
<td>Epvir</td>
<td>NRTIs</td>
<td>[ ] MM/DD/YYYY</td>
</tr>
<tr>
<td></td>
<td>stavudine, d4T</td>
<td>Zerit</td>
<td>NRTIs</td>
<td>[ ] MM/DD/YYYY</td>
</tr>
<tr>
<td></td>
<td>tenofovir disoproxil fumarate</td>
<td>Viread</td>
<td>NRTIs</td>
<td>[ ] MM/DD/YYYY</td>
</tr>
<tr>
<td></td>
<td>tenofovir disoproxil/emtricitabine</td>
<td>Truvada</td>
<td>NRTIs</td>
<td>[ ] MM/DD/YYYY</td>
</tr>
<tr>
<td></td>
<td>zalcitabine, ddC, dideoxyctudine</td>
<td>Hivid</td>
<td>NRTIs</td>
<td>[ ] MM/DD/YYYY</td>
</tr>
<tr>
<td></td>
<td>zidovudine, AZT, azidothymidine, ZDV</td>
<td>Retrovir</td>
<td>NRTIs</td>
<td>[ ] MM/DD/YYYY</td>
</tr>
<tr>
<td></td>
<td>delavirdine, DLV</td>
<td>Rescriptor</td>
<td>NNRTIs</td>
<td>[ ] MM/DD/YYYY</td>
</tr>
<tr>
<td></td>
<td>efavirenz</td>
<td>Sustiva</td>
<td>NNRTIs</td>
<td>[ ] MM/DD/YYYY</td>
</tr>
<tr>
<td></td>
<td>Etravirine (TMC-125)</td>
<td>Intelence</td>
<td>NNRTIs</td>
<td>[ ] MM/DD/YYYY</td>
</tr>
<tr>
<td></td>
<td>nevirapine, BI-RG-587</td>
<td>Viramune</td>
<td>NNRTIs</td>
<td>[ ] MM/DD/YYYY</td>
</tr>
<tr>
<td>Included In Formulary</td>
<td>GENERIC NAME</td>
<td>BRAND NAME</td>
<td>Category</td>
<td>Added to Formulary this Reporting Period</td>
</tr>
<tr>
<td>-----------------------</td>
<td>--------------</td>
<td>------------</td>
<td>----------</td>
<td>------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>amprenavir</td>
<td>Agenerase</td>
<td>PIs</td>
<td>Med Added? MM/DD/YYYY</td>
</tr>
<tr>
<td></td>
<td>atazanavir sulfate</td>
<td>Reyataz</td>
<td>PIs</td>
<td>Med Added? MM/DD/YYYY</td>
</tr>
<tr>
<td></td>
<td>darunavir</td>
<td>Prezista</td>
<td>PIs</td>
<td>Med Added? MM/DD/YYYY</td>
</tr>
<tr>
<td></td>
<td>Fosamprenavir Calcium</td>
<td>Lexiva</td>
<td>PIs</td>
<td>Med Added? MM/DD/YYYY</td>
</tr>
<tr>
<td></td>
<td>indinavir, IDV, MK-639</td>
<td>Crixivan</td>
<td>PIs</td>
<td>Med Added? MM/DD/YYYY</td>
</tr>
<tr>
<td></td>
<td>lopinavir and ritonavir</td>
<td>Kaletra</td>
<td>PIs</td>
<td>Med Added? MM/DD/YYYY</td>
</tr>
<tr>
<td></td>
<td>nelfinavir mesylate, NFV</td>
<td>Viracept</td>
<td>PIs</td>
<td>Med Added? MM/DD/YYYY</td>
</tr>
<tr>
<td></td>
<td>ritonavir, ABT-538 r</td>
<td>Norvi</td>
<td>PIs</td>
<td>Med Added? MM/DD/YYYY</td>
</tr>
<tr>
<td></td>
<td>saquinavir</td>
<td>Fortovase</td>
<td>PIs</td>
<td>Med Added? MM/DD/YYYY</td>
</tr>
<tr>
<td></td>
<td>saquinavir mesylate, SQV</td>
<td>Invirase</td>
<td>PIs</td>
<td>Med Added? MM/DD/YYYY</td>
</tr>
<tr>
<td></td>
<td>tipranavir</td>
<td>Aptivus</td>
<td>PIs</td>
<td>Med Added? MM/DD/YYYY</td>
</tr>
<tr>
<td></td>
<td>enfuvirtide, T-20</td>
<td>Fuzeon</td>
<td>Fls</td>
<td>Med Added? MM/DD/YYYY</td>
</tr>
<tr>
<td></td>
<td>Raltegravir (RGV or MK-0518)</td>
<td>Isentress</td>
<td>Integrase Inhibitors</td>
<td>Med Added? MM/DD/YYYY</td>
</tr>
<tr>
<td></td>
<td>maraviroc</td>
<td>Selzentry or Celsentri</td>
<td>CCR5 Antagonists</td>
<td>Med Added? MM/DD/YYYY</td>
</tr>
</tbody>
</table>

**References:**
- RGV or MK-0518
- CCR5 Antagonists

**Categories:**
- PIs
- Fls
- Integrase Inhibitors
### b. Grantee-level Formulary Information – A1-OI Medications

<table>
<thead>
<tr>
<th>Included in Formulary</th>
<th>GENERIC NAME</th>
<th>BRAND NAME</th>
</tr>
</thead>
<tbody>
<tr>
<td>□</td>
<td>acyclovir</td>
<td>Zovirax</td>
</tr>
<tr>
<td>□</td>
<td>amphotericin B</td>
<td>Fungizone</td>
</tr>
<tr>
<td>□</td>
<td>azithromycin</td>
<td>Zithromax</td>
</tr>
<tr>
<td>□</td>
<td>cidofovir</td>
<td>Vistide</td>
</tr>
<tr>
<td>□</td>
<td>clarithromycin</td>
<td>Biaxin</td>
</tr>
<tr>
<td>□</td>
<td>clindamycin</td>
<td>Cleocin</td>
</tr>
<tr>
<td>□</td>
<td>famciclovir</td>
<td>Famvir</td>
</tr>
<tr>
<td>□</td>
<td>fluconazole</td>
<td>Diflucan</td>
</tr>
<tr>
<td>□</td>
<td>flucytosine</td>
<td>Ancobon</td>
</tr>
<tr>
<td>□</td>
<td>fomivirsen</td>
<td>Vitravene</td>
</tr>
<tr>
<td>□</td>
<td>foscarnet</td>
<td>Foscavir</td>
</tr>
<tr>
<td>□</td>
<td>anciclovir</td>
<td>Cytovene</td>
</tr>
<tr>
<td>□</td>
<td>Isoniazid (INH)</td>
<td>Lanizid, Nydrazid</td>
</tr>
<tr>
<td>□</td>
<td>itraconazole</td>
<td>Sporonox</td>
</tr>
<tr>
<td>□</td>
<td>leucovorin calcium</td>
<td>Wellcovorin</td>
</tr>
<tr>
<td>□</td>
<td>peginterferon alfa-2a</td>
<td>PEG-Intron</td>
</tr>
<tr>
<td>□</td>
<td>pentamidine</td>
<td>Nebupent</td>
</tr>
<tr>
<td>□</td>
<td>pentavalent antimony</td>
<td>—</td>
</tr>
<tr>
<td>□</td>
<td>prednisone</td>
<td>Deltasone, Liquid Pred, Metocorten, Orasone, Panasol, Prednicen-M, Sterapred</td>
</tr>
<tr>
<td>□</td>
<td>probenecid</td>
<td>—</td>
</tr>
<tr>
<td>Included in Formulary</td>
<td>GENERIC NAME</td>
<td>BRAND NAME</td>
</tr>
<tr>
<td>----------------------</td>
<td>--------------------------------</td>
<td>------------------------------</td>
</tr>
<tr>
<td>☐</td>
<td>pyrazinamide (PZA)</td>
<td>—</td>
</tr>
<tr>
<td>☐</td>
<td>pyrimethamine</td>
<td>Daraprim, Fansidar</td>
</tr>
<tr>
<td>☐</td>
<td>ribavirin (TMP/SMX)</td>
<td>Virazole, Rebetol, Copegus</td>
</tr>
<tr>
<td>☐</td>
<td>rifabutin</td>
<td>Mycobutin</td>
</tr>
<tr>
<td>☐</td>
<td>rifampin (RIF)</td>
<td>Rifadin, Rimactane</td>
</tr>
<tr>
<td>☐</td>
<td>sulfadiazine (oral generic)</td>
<td>Microsulfon</td>
</tr>
<tr>
<td>☐</td>
<td>trimethoprim-sulfamethoxazole (TMP/SNX)</td>
<td>Bactrim, Septra</td>
</tr>
<tr>
<td>☐</td>
<td>valacyclovir</td>
<td>Valtrex</td>
</tr>
<tr>
<td>☐</td>
<td>valganciclovir</td>
<td>Valcyte</td>
</tr>
</tbody>
</table>

“A1” Opportunistic Infection Medications*

**A – Both strong evidence for efficacy and substantial clinical benefit support recommendation for use; should always be offered

1 – Evidence from ≥1 correctly randomized, controlled trials.

Source:

Guidelines for Preventing Opportunistic Infections Among HIV-Infected Persons – 2002; Recommendations of the U.S. Public Health Service and the Infectious Diseases Society of America”.
### c. Grantee-level Formulary Information – Hepatitis B Medications

<table>
<thead>
<tr>
<th>Included in Formulary</th>
<th>GENERIC NAME</th>
<th>BRAND NAME</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>entecavir</td>
<td>Baraclude</td>
</tr>
<tr>
<td></td>
<td>lamivudine</td>
<td>Epivir-HBV</td>
</tr>
<tr>
<td></td>
<td>interferon alfa-2b</td>
<td>Intron A</td>
</tr>
<tr>
<td></td>
<td>adefovir dipivoxil</td>
<td>Hepsera</td>
</tr>
<tr>
<td></td>
<td>peginterferon alfa-2a</td>
<td>Pegasys</td>
</tr>
<tr>
<td></td>
<td>telbivudine</td>
<td>Tyzeka</td>
</tr>
</tbody>
</table>

### d. Grantee-level Formulary Information – Hepatitis C Medications

<table>
<thead>
<tr>
<th>Included in Formulary</th>
<th>GENERIC NAME</th>
<th>BRAND NAME</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>interferon alfa-2b</td>
<td>Intron A</td>
</tr>
<tr>
<td></td>
<td>recombinant interferon alfa-2a</td>
<td>Roferon-A</td>
</tr>
<tr>
<td></td>
<td>consensus interferon or interferon alfacon-1</td>
<td>Infergen</td>
</tr>
<tr>
<td></td>
<td>peginterferon alfa-2a</td>
<td>Pegasys</td>
</tr>
<tr>
<td></td>
<td>peginterferon alfa-2b</td>
<td>PEG-Intron</td>
</tr>
<tr>
<td></td>
<td>peginterferon alfa-2a + ribavin</td>
<td>Copegus and Pegasys</td>
</tr>
<tr>
<td></td>
<td>peginterferon alfa-2b and ribavin</td>
<td>PEG-Intron and Rebetol</td>
</tr>
<tr>
<td></td>
<td>interferon alfa-2b and ribavin</td>
<td>Intron A and Rebetol</td>
</tr>
<tr>
<td></td>
<td>recombinant interferon alfa-2a and ribavin</td>
<td>Roferon and Ribavirin</td>
</tr>
</tbody>
</table>
Section 2: Annual Submission

Section 2 (Items 8-11) should be completed only once each year for the previous 12-month period

A. PROGRAM ADMINISTRATION

8. Please indicate the frequency of re-certification of client eligibility:
   - [ ] Annual
   - [ ] Semiannual (every 6 months)
   - [ ] Other (please specify: ____________________________________________)

9. Please indicate the clinical eligibility criteria required to enroll in the ADAP in your State/Territory: (Check all that apply)
   - [ ] HIV+
   - [ ] CD4 (what is your CD4 count requirement?________________________________________)
   - [ ] Viral load (what is your VL count requirement?________________________________________)
   - [ ] Other (please specify: ____________________________________________)

B. COST SAVING STRATEGIES

10. Please check all that apply to your Drug Pricing Program: (Check all that apply)
    - [ ] 340B Rebate
    - [ ] Direct purchase
    - [ ] Prime vendor
    - [ ] Alternative Method Demonstration Project
    - [ ] Other drug discount program (not 340B) (please specify:_______________________________)

C. SOURCES AND AMOUNTS OF ADAP FUNDING – THIS WILL BE PREPOPULATED BY HAB AND IS FOR REVIEW PURPOSES ONLY.

11. ADAP funding received for this fiscal year from each of the following Ryan White HIV/AIDS program sources:

<table>
<thead>
<tr>
<th>Funding Source</th>
<th>Amount Received (to nearest dollar)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. ADAP earmark</td>
<td>$</td>
</tr>
<tr>
<td>b. ADAP Supplemental Drug Treatment Grant Award</td>
<td>$</td>
</tr>
<tr>
<td>c. State Match for Supplemental Drug Treatment Award</td>
<td>$</td>
</tr>
<tr>
<td>ADAP resources received (total of a through c)</td>
<td>$</td>
</tr>
</tbody>
</table>
Minimum Required Data Fields/Variables
This document combines the required fields/variables for the proposed HRSA ADAP Data Report (ADR) and fields required by SHP. This list does not explicitly include fields required for the CMS data share.

Additional fields/variables may be added/removed as identified during the contracting process.

Many of these variables may be calculated based on other fields or variables.

<table>
<thead>
<tr>
<th>Field #</th>
<th>Variable Description</th>
<th>Variable Definition</th>
<th>Coding or Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Longitudinal Client Level Data</td>
<td>Last name</td>
<td>Client’s legal last name</td>
<td>Text</td>
</tr>
<tr>
<td></td>
<td>First name</td>
<td>Client’s legal first name</td>
<td>Text</td>
</tr>
<tr>
<td></td>
<td>Date of birth</td>
<td>Client’s legal date of birth</td>
<td>Date</td>
</tr>
<tr>
<td></td>
<td>URN</td>
<td>Unique Record Number (Federal ID string)</td>
<td>11 character code: 1st &amp; 3rd characters of last name + 1st &amp; 3rd characters of first name + DOB MMDDYY + Gender Code</td>
</tr>
<tr>
<td></td>
<td>Unique Provider ID</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td></td>
<td>Ethnicity</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td></td>
<td>Race</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td></td>
<td>Gender</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td></td>
<td>Transgender</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td></td>
<td>Primary Language</td>
<td>Client’s primary language</td>
<td>Text</td>
</tr>
<tr>
<td></td>
<td>Secondary Language</td>
<td>Client’s secondary language</td>
<td>Text</td>
</tr>
<tr>
<td></td>
<td>Social Security Number</td>
<td>Client’s verified SSN</td>
<td>Text</td>
</tr>
<tr>
<td></td>
<td>Street address</td>
<td>Client’s residential street address</td>
<td>Text</td>
</tr>
<tr>
<td></td>
<td>City</td>
<td>Client’s residential city</td>
<td>Text</td>
</tr>
<tr>
<td></td>
<td>State</td>
<td>Client’s residential state</td>
<td>Text</td>
</tr>
<tr>
<td></td>
<td>Zip Code</td>
<td>Client’s residential zip code</td>
<td>Text</td>
</tr>
<tr>
<td></td>
<td>Parish/County</td>
<td>Client’s residential parish/county</td>
<td>Text</td>
</tr>
<tr>
<td></td>
<td>Primary Phone Number</td>
<td>Client’s primary phone number</td>
<td>Text</td>
</tr>
<tr>
<td></td>
<td>Secondary Phone Number</td>
<td>Client’s secondary phone number</td>
<td>Text</td>
</tr>
<tr>
<td></td>
<td>Mailing Street address</td>
<td>Client’s mailing street address</td>
<td>Text</td>
</tr>
<tr>
<td></td>
<td>Mailing City</td>
<td>Client’s mailing city</td>
<td>Text</td>
</tr>
<tr>
<td></td>
<td>Mailing State</td>
<td>Client’s mailing state</td>
<td>Text</td>
</tr>
<tr>
<td></td>
<td>Mailing Zip Code</td>
<td>Client’s mailing zip code</td>
<td>Text</td>
</tr>
<tr>
<td></td>
<td>Client’s case manager contact</td>
<td>Name of client’s case manager</td>
<td>Text</td>
</tr>
<tr>
<td></td>
<td>Client’s case management agency</td>
<td>Name of agency where client receives case management services</td>
<td>Text</td>
</tr>
<tr>
<td></td>
<td>Veteran status</td>
<td>Client is a U.S. military veteran</td>
<td>Yes/No</td>
</tr>
<tr>
<td></td>
<td>Clinical Provider</td>
<td>Client’s prescribing clinical provider</td>
<td>Text</td>
</tr>
<tr>
<td></td>
<td>Clinical provider street address</td>
<td>Clinical Provider mailing street address</td>
<td>Text</td>
</tr>
<tr>
<td></td>
<td>Clinical provider City</td>
<td>Clinical Provider mailing city</td>
<td>Text</td>
</tr>
<tr>
<td></td>
<td>Clinical provider State</td>
<td>Clinical Provider mailing state</td>
<td>Text</td>
</tr>
<tr>
<td>Clinical provider Zip Code</td>
<td>Clinical Provider mailing zip code</td>
<td>Text</td>
<td></td>
</tr>
<tr>
<td>---------------------------</td>
<td>----------------------------------</td>
<td>------</td>
<td></td>
</tr>
<tr>
<td>Clinical provider phone number</td>
<td>Clinical Provider phone number</td>
<td>Text</td>
<td></td>
</tr>
<tr>
<td>Clinical provider fax number</td>
<td>Clinical provider fax number</td>
<td>Text</td>
<td></td>
</tr>
<tr>
<td>Veteran status</td>
<td>Client is a U.S. military veteran</td>
<td>Yes/No</td>
<td></td>
</tr>
</tbody>
</table>

### Longitudinal Client-Level Data

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
<th>Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual household income</td>
<td>Total annual household income for client and spouse/dependents in household</td>
<td>Currency</td>
</tr>
<tr>
<td>Annual household size</td>
<td>Total annual household size, to include client and spouse/dependents</td>
<td>Number</td>
</tr>
<tr>
<td>Annual Federal Poverty Level</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Health insurance coverage (all sources)</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>HIV/AIDS status</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>HIV/AIDS status date</td>
<td>Date of HIV/AIDS status</td>
<td>Date</td>
</tr>
<tr>
<td>Client pregnancy status</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Date of client’s pregnancy status</td>
<td>Date of client’s pregnancy status</td>
<td>Date</td>
</tr>
<tr>
<td>Date of receipt of completed client ADAP application</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Date of initial approval of client’s ADAP application</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Date ADAP application submitted to ADAP Medical Reviewer</td>
<td>Date ADAP application submitted to ADAP Medical Reviewer</td>
<td>Date</td>
</tr>
<tr>
<td>Date ADAP application submitted to ADAP Medical Consultant</td>
<td>Date ADAP application submitted to ADAP Medical Consultant</td>
<td>Date</td>
</tr>
<tr>
<td>Date ADAP card sent to client</td>
<td>Date ADAP card mailed</td>
<td>Date</td>
</tr>
<tr>
<td>ADAP enrollment status</td>
<td>Client’s current ADAP enrollment status (tied to enrollment status date)</td>
<td>Text</td>
</tr>
<tr>
<td>Reason for ADAP disenrollment</td>
<td>Reason for disenrollment if enrollment status is disenrolled</td>
<td>Text</td>
</tr>
<tr>
<td>ADAP enrollment status date</td>
<td>Date current enrollment status effective</td>
<td>Date</td>
</tr>
<tr>
<td>Client consented to receive services</td>
<td>Verification that client has consented to receive ADAP services</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Date client consented to receive services</td>
<td>Date client consented to receive services</td>
<td>Date</td>
</tr>
</tbody>
</table>

### Drug Service Fields (to be captured for each non-insurance drug service)

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
<th>Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dispense date</td>
<td>Date client received service/drug</td>
<td>Date</td>
</tr>
<tr>
<td>Invoice date</td>
<td>Date prescription invoiced to ADAP</td>
<td>Date</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>Name or ID for pharmacy providing service</td>
<td>TBD</td>
</tr>
<tr>
<td>NDC</td>
<td>Drug NDC</td>
<td>Text</td>
</tr>
<tr>
<td>Drug Name</td>
<td>Drug Name</td>
<td>Text</td>
</tr>
<tr>
<td>Drug strength</td>
<td>Drug strength/dose</td>
<td>Text</td>
</tr>
<tr>
<td>Drug quantity</td>
<td>Number of drug units billed</td>
<td>Number</td>
</tr>
<tr>
<td>Days</td>
<td>Prescription days supply</td>
<td>Number</td>
</tr>
<tr>
<td>Dispense fee</td>
<td>Dispense fee billed to ADAP</td>
<td>Currency</td>
</tr>
</tbody>
</table>
### Drug Cost and Total Transaction Cost

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
<th>Currency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug cost</td>
<td>Cost of drug, without dispense fee</td>
<td></td>
</tr>
<tr>
<td>Total transaction cost</td>
<td>Total of drug cost and dispense fee</td>
<td></td>
</tr>
</tbody>
</table>

### Claim Number and Drug Manufacturer

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
<th>TBD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claim Number</td>
<td>Uniquely assigned claim number</td>
<td>TBD</td>
</tr>
<tr>
<td>Drug manufacturer</td>
<td>Drug manufacturer</td>
<td>TBD</td>
</tr>
</tbody>
</table>

### Insurance Service Fields (to be captured for each insurance drug service)

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
<th>TBD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dispense date</td>
<td>Date client received service/drug</td>
<td></td>
</tr>
<tr>
<td>Invoice date</td>
<td>Date invoiced to ADAP</td>
<td></td>
</tr>
<tr>
<td>Pharmacy</td>
<td>Name or ID for pharmacy providing service</td>
<td>TBD</td>
</tr>
<tr>
<td>NDC</td>
<td>Drug NDC</td>
<td>Text</td>
</tr>
<tr>
<td>Drug Name</td>
<td>Drug Name</td>
<td>Text</td>
</tr>
<tr>
<td>Drug strength</td>
<td>Drug strength/dose</td>
<td>Text</td>
</tr>
<tr>
<td>Drug quantity</td>
<td>Number of drug units billed</td>
<td>Number</td>
</tr>
<tr>
<td>Days</td>
<td>Prescription days supply</td>
<td>Number</td>
</tr>
<tr>
<td>Co-Pay Amount</td>
<td>Amount of co-pay made on client’s behalf</td>
<td>Currency</td>
</tr>
<tr>
<td>Deductible Amount Paid</td>
<td>Amount paid toward deductible on client’s behalf for this transaction</td>
<td>Currency</td>
</tr>
<tr>
<td>Deductible Amount Remaining</td>
<td>Amount remaining to be paid toward client’s deductible after this transaction</td>
<td>Currency</td>
</tr>
<tr>
<td>Claim Number</td>
<td>Uniquely assigned claim number</td>
<td>TBD</td>
</tr>
<tr>
<td>Drug manufacturer</td>
<td>Drug manufacturer</td>
<td>TBD</td>
</tr>
</tbody>
</table>

### Calculated ADR fields

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
<th>TBD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Encrypted UCI</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Did this client receive any ADAP funded medications during the reporting period (yes/no)</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Did this client receive any ADAP funded insurance assistance during the reporting period (yes/no)</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Total amount of insurance deductible paid on behalf of the client during the reporting period (not including Medicare Part D)</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Total amount of insurance co-pays paid on behalf of the client during the reporting period (not including Medicare Part D)</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Total amount of Medicare Part D co-insurance, co-payment, or donut hole coverage paid on behalf of the client during the reporting period</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Client was prescribed any ADAP-funded ARV medications during the reporting period</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Number of months client received ADAP-funded ARVs</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td><strong>Total cost of all ADAP-funded ARV medications dispensed to client during the reporting period</strong></td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td><strong>Total dispensing cost for medications paid on behalf of client during the reporting period</strong></td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td><strong>Client was disenrolled at any time during the reporting period (yes/no)</strong></td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td><strong>Most recent CD4 count</strong></td>
<td><em>(This data may be provided by SHP)</em></td>
<td>*</td>
</tr>
<tr>
<td><strong>Most recent Viral Load count</strong></td>
<td><em>(This data may be provided by SHP)</em></td>
<td>*</td>
</tr>
<tr>
<td><strong>Client was newly enrolled or re-enrolled during ADR reporting period (yes/no)</strong></td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td><strong>Client was newly enrolled or re-enrolled during ADR reporting period (specify newly or re-enrolled)</strong></td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td><strong>Date of client’s first ADAP-funded service</strong></td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td><strong>Client’s certification/re-certification dates during reporting period</strong></td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td><strong>Client was disenrolled at any time during the reporting period (dates of disenrollment)</strong></td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td><strong>Reasons for client’s disenrollment</strong></td>
<td>*</td>
<td>*</td>
</tr>
</tbody>
</table>

*See ADAP Data Report Proposed Client-Level Variables*