Contract Number:
4400007944 Amendment #1

PENNSYLVANIA DEPARTMENT OF AGING AGREEMENT

PURPOSE OF CONTRACT: Administrative Services for the PACE, PACENET, and Other Ancillary Programs

AWARDED TO: Magellan Medicaid Administration
4300 Cox Road
Glen Allen, VA 23060-3358

CONTRACTOR EIN: 54-0849793

VENDOR #: 167379

EFFECTIVE PERIOD: APRIL 18, 2012
through June 30, 2017

Copy Identification (PDA Use Only)

[ ] DFM&SS [ ] Comptroller [ ] Treasury [ ] Program [ ] Vendor

AMENDMENT NUMBER 1
TO
AGREEMENT NUMBER 4400007944

This Amendment is made between the Commonwealth of Pennsylvania, Department of Aging (hereinafter referred to as "Department") and Magellan Medicaid Administration, Inc., 4000 Crums Mil Road Suite 301, Harrisburg, Pennsylvania 17112 (hereinafter referred to as "Contractor").

WHEREAS, Act 134 of 1996 (hereinafter referred to as "Act"), amending Act 63 of 1983, continued a program of limited pharmaceutical assistance for elderly Pennsylvanians referred to as the Pharmaceutical Assistance Contract for the Elderly Program (PACE) and established the Pharmaceutical Assistance Contract for the Elderly Program Needs Enhancement Tier Program (PACENET) and its Ancillary Programs (hereinafter these programs shall collectively be referred to as the "PACE Program"); and

WHEREAS, the Department, through a competitive Request for Proposal (RFP – Number 6100015782) process entered into a six year Agreement with Contractor known as Agreement Number 4400007944, hereinafter referred to as the "Contract" for the provision of administration services for the PACE Program for the period of July 1, 2011 through June 30, 2017; and

WHEREAS, the parties now intend that the Contractor will undertake those additional services for the Department as described in Statement of Understanding for PACE Application Wizard Enhancements dated March 21, 2012, Statement of Understanding for SPBP1 Enrollment Processing Changes dated March 21, 2012, and Statement of Understanding for SPBP1 Reports Enhancements dated March 21, 2012 (the "Statements of Understanding") for a total of $891,352.99; and

WHEREAS, the parties desire to incorporate the terms of the Statements of Understanding into the Contract;

NOW, THEREFORE, for and in consideration of the foregoing premises and the mutual promises hereinafter set forth, the Department and the Contractor, with the intention of being legally bound, hereby agree as follows:

1. In accordance with the terms of Attachment A, Statement of Understanding for PACE Application Wizard Enhancements dated March 21, 2012, the Contractor shall make changes to the current HTML version of the cardholder enrollment application wizard in order to accommodate the significant changes to the PACE enrollment application forms. The Department shall reimburse Contractor for Web Application Developer labor costs at a rate of $150 per hour, not to exceed 230 hours, plus overhead charges of 11.87% and profit of 12.27%, as more fully explained in the SOU. The total amount to be billed for the PACE Application Wizard Enhancements will not exceed $43,330.77.

2. In accordance with the terms of Attachment B, Statement of Understanding for SPBP1 Enrollment Processing Changes dated March 21, 2012, the Contractor shall make changes to the existing enrollment processing system for the SPBP1 Program to accommodate a second cycle of enrollments during each calendar year. The Department shall reimburse the Contractor $610,299.80, as more fully explained in the SOU.

3. In accordance with the terms of Attachment C, Statement of Understanding for SPBP1 Reports Enhancements dated March 21, 2012, the Contractor shall modify the existing SPBP1 reporting package to meet the requirements for the new HRSA report and deliver the enhanced report to the SPBP1 staff. The Department shall reimburse the Contractor $219,758.62, as more fully explained in the SOU.

4. At the request of the Department of Aging, the Contractor shall procure up to 50,000 pieces of SPBP1 ID Card Stock at the rate specified in Attachment D, SPBP1 ID Card Stock, and Attachment E, Summary of Charges.

5. Term of the Contract: This Amendment Number 1 to Agreement Number 4400009744 shall be effective when it has been fully executed by the Contractor and by the Commonwealth, and all required approvals have been obtained and it shall end on the last day of each respective fiscal year.

6. All terms and conditions of the Contract that are not consistent with this Amendment Number 1 shall remain in full force and effect.

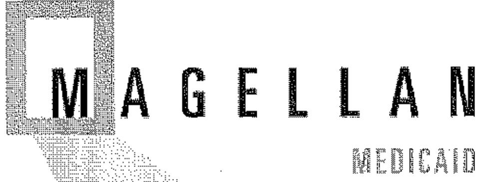
IN WITNESS WHEREOF, the parties have caused this Amendment for additional services to the Pharmaceutical Assistance Contract for the Elderly to be executed by their duly authorized officials.

CONTRACTOR: MAGELLAN MEDICAID ADMINISTRATION, INC.
SAP VENDOR NUMBER: 167379

FEDERAL I.D. NUMBER: 54-0849793

____
Authorized Signature Date

Print Name: Timothy P. Nolan
Title: President



AMENDMENT NUMBER 1 TO AGREEMENT NUMBER 4400007944

APPENDIX A

Statement of Understanding (SOU) for PACE Application Wizard Enhancements

March 21, 2012

Confidential and Proprietary
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Privacy Rules

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

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

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

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Approvals Signature Page

Magellan Medicaid Administration will deliver the requested change outlined in this Statement of Understanding by June 30, 2012, if Client signature approval is received by April 30, 2012.

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

[signature]	Timothy P. Nolan
Signature	**Printed Name**
President	4/3/2012
Title	**Date**
Signature	**Printed Name**
Title	**Date**

1.0 Overview

Magellan Medicaid Administration, Inc. (MMA) has developed and maintains a cardholder enrollment application wizard to support the Pennsylvania Department of Aging's (PDA) PACE Program. The application wizard guides the user through the process of applying for the Program, prompting the user for the information needed to build and enrollment record and determine eligibility. As modifications are made to the enrollment form each year, MMA updates the wizard to accommodate the changes.

For 2012, the PACE enrollment application forms package was significantly changed, necessitating major changes to the application wizard. This Statement of Understanding (SOU) presents the scope of work needed to enhance the current HTML version of the application wizard to accommodate those changes.

2.0 Requirements

The effort for the PACE Application Wizard Enhancements project includes the following:

- Identify the changes from the 2011 PACE new enrollment application form to the 2012 version.
- Change the PACE enrollment application wizard Internet application to capture the information needed on the 2012 enrollment form, making adjustments to follow the correct information flow, prompts and editing.
- Test the enrollment wizard application changes.
- Promote the accepted enrollment application wizard to the production environment.
- Securely capture, store and transmit the information received through the application wizard to fulfill the application process.
- Evaluate the finished application wizard and submit recommendations to PDA for improving the product.

3.0 Assumptions

Workload and pricing estimates are based on the following assumptions:

- Development will follow the 2012 PACE new enrollment application, included as Attachment A, *2012 PACE New Enrollment Application*, to this Statement of Understanding.
- The application wizard will continued to be hosted by MMA.
- No changes to the application forms or process will occur during the development of the proposed application wizard enhancements.

4.0 Constraints

Workload and pricing estimates are based on the following constraints:

- Work can begin upon approval of this Statement of Understanding.
- Implementation of the final product will occur after user testing and customer acceptance have been demonstrated.

5.0 Issues and Concerns

There are no issues or concerns for the PACE Application Wizard Enhancements Project.

6.0 Scope of Work

The Scope of Work for the PACE Application Wizard Enhancements Project is described in Section 2.0, Requirements. Work will begin upon approval of this Statement of Understanding and continue until the enhancements have been tested and accepted by the Department of Aging and moved into production by MMA.

7.0 Test Plan

Quality assurance testing will be performed by the QA department for the enhancements prior to implementation. MMA's Cardholder Services staff and the PDA staff will be provided an opportunity to conduct user acceptance testing prior to putting the resulting enrollment application wizard product into production.

8.0 Operational Impact

This project will change the look and functioning of the PACE new enrollment application wizard. Changes will also need to be made to accommodate the new fields being captured in the enrollment process.

9.0 Estimates and Costing

Pricing for the PACE Application Wizard Project appears on the page following.

The pricing for Labor includes 230 hours of Web Application Developer time at a cost of $150.00 per hour. Overhead charges of 11.87% will be applied to the direct cost. Profit charges of 12.27% will be applied to the direct cost plus the overhead charges. The final billing will be for actual number of hours worked, up to the 230 hour maximum. There are no materials charges for this development project.

Web Application Developer Hours	230	hours
Web Application Developer Hourly Rate	$150.00	per hour
Direct Cost	$34,500.00	
Overhead Charges at 11.87%	$4,095.15	
Profit Charges at 12.27%	$4,735.62	
Total Charges	$43,330.77	

PACE APPLICATION WIZARD
PRICING SUMMARY BY CONTRACT YEAR

Y E A R E N D I N G

		June 30, 2012	June 30, 2013	June 30, 2014	June 30, 2015	June 30, 2016	June 30, 2017
Summary:							
Licenses		$	$	$	$	$	$
Materials		$	$	$	$	$	$
Mailing services		$	$	$	$	$	$
Postage		$	$	$	$	$	$
IT Charges		$	$	$	$	$	$
Labor		$ 34,500.00	$	$	$	$	$
Programming		$	$	$	$	$	$
Total Direct Expense		$ 34,500.00	$	$	$	$	$
Overhead	11.87%	$ 4,095.15	$	$	$	$	$
Profit	12.27%	$ 4,735.62	$	$	$	$	$
Total Price		$ 43,330.77	$	$	$	$	$

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

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

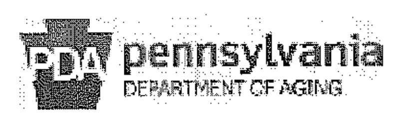
APPENDIX A

2012 PACE NEW ENROLLMENT APPLICATION

AGE 65 AND OLDER?
NEED PRESCRIPTION HELP?
APPLY ANYTIME
★ APPLICATION ENCLOSED ★

Need Assistance?

CALL
1-800-225-7223

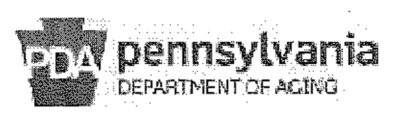


PACE AND PACENET

WORKS TOGETHER WITH:

- MEDICARE PART D PLANS
- RETIREE/UNION COVERAGE
- EMPLOYER PLANS
- VETERANS' BENEFITS

WE OFFER LOW PRESCRIPTION COPAYS



1-800-225-7223

PACE AND PACENET

- 65 years of age or older
- Pennsylvania resident for at least 90 consecutive days
- Must meet income requirements as listed below

HOW YOU CAN APPLY

- FILL OUT THE ENCLOSED APPLICATION
  - MAIL TO PACE/PACENET, PO Box 8806, Harrisburg, PA 17105-8806
  - FAX TO PACE/PACENET – 717-651-3608
  - EMAIL THE APPLICATION TO papace@magellanhealth.com
- APPLY ONLINE AT https://pacecares.magellanhealth.com/
- CALL US AT 1-800-225-7223

PACE FACTS

- A single person's total income from last year must be $14,500 or less.
- A married couple's total combined income from last year must be $17,700 or less.
- Covered drugs (based on 30-day supply):
  $6 Generic co-pay $9 Brand co-pay

PACENET FACTS

- A single person's total income from last year must be between $14,501 and $23,500.
- A married couple's total combined income from last year must be between $17,701 and $31,500.
- Covered drugs (based on 30-day supply):
  $8 Generic co-pay $15 Brand co-pay

(PACENET members may have a monthly premium to pay at the pharmacy.)

IT'S EASY TO APPLY!
FOLLOW OUR HANDY CHECKLIST:

- Complete both sides of the application form
- Complete the section marked for spouse even if you are not applying for your spouse to have coverage
- Complete your Health Survey
- Make sure your application contains a signature in Section E
- Make sure to include complete POA documentation if you are requesting your POA to receive all correspondence
- Complete the TPL information sheet and return it with the application

CERTIFICATION AND AUTHORIZATION STATEMENTS

Please Read this Information Carefully

I understand that my signature on the application indicates my agreement to the following provisions:

A. I authorize the Department of Aging, within its discretion, to release any and all information in my PACE file as deemed appropriate by the Department. I authorize such release of information.

B. I understand that PACE may provide general information of PACE participants to outside sources for research purposes, as deemed appropriate by the Department.

C. I hereby assign to the Commonwealth of Pennsylvania, in the event of duplicate or overpayment, any right to drug benefits to which I may be entitled under any other plan of government assistance or insurance from any for-profit third party insurer.

D. I hereby waive the confidentiality of any health care information found in any Medicare Advantage plan (HMO), third party insurer's file or any other information from any health care source about my medications as witnessed by my signature on this application. I authorize such release of information for use consistent with this application. I understand that PACE may contact my physician for relevant medical history and information related to my prescription drugs paid for by PACE. I waive the confidentiality of such medical records and authorize their release to the PACE program.

E. I agree to forgo any payment from any insurance company for any amount which has been paid by PACE on my behalf.

F. I authorize the Internal Revenue Service, the Social Security Administration, the US Railroad Retirement Board, the Pennsylvania Department of Revenue, the Pennsylvania Department of Transportation, the Public School Employees' Retirement System, the State Employees' Retirement System, any other federal or state agency, and any other financial or other institution or entity with information on my income or resources to release information to the PACE program that will verify my eligibility for the PACE program or for the low income subsidy of the federal Medicare prescription drug benefit. All information released to the Department of Aging shall remain confidential in accordance with 72 P.S. § 3761-517(b).

G. I authorize the Department of Aging or its designee to act as my representative for determining my eligibility and applying for the low income subsidy of the Medicare prescription drug benefit, enrolling me in the Medicare prescription drug plan that best fits my prescription needs, handling any and all aspects of Part D on my behalf consistent with federal law, and, if I am a PACE enrollee, paying the premium of the selected Medicare prescription drug plan that is less than or equal to the regional benchmark premium.

Where the applicant(s) executed a Power of Attorney or is adjudicated incapacitated, the Department of Aging shall accept the Attorney-In-Fact or court-appointed Guardian as an authorized agent for the purpose of documenting enrollment. Power of Attorney or Guardianship documentation must be provided.

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INSTRUCTIONS FOR COMPLETING APPLICATION

Need Assistance? 1-800-225-7223

SECTION A – APPLICANT INFORMATION

Please complete all fields on this section of the application.

- *Helpful Hints:*
  - Applicant Pennsylvania Address ..... The Pennsylvania address where you reside.
  - Mailing Address.................................. If your mail goes to a different address than your residential address, please fill this out.
  - Emergency Contact Name................ The name of a person we can contact to help reach you should the information on our file not be valid.

SECTION B – SPOUSE INFORMATION

If you are married, your spouse's information must be completed even if your spouse is not applying for coverage.
Please complete all fields on this section of the application.

- *Helpful Hints:*
  - Applicant Pennsylvania Address ..... The Pennsylvania address where you reside.
  - Mailing Address.................................. If your mail goes to a different address than your residential address, please fill this out.
  - Emergency Contact Name................ The name of a person we can contact to help reach you should the information on our file not be valid.

SECTION C – INCOME VERIFICATION

UNDERSTANDING AGE, INCOME, AND RESIDENCY VERIFICATION & YOUR RESPONSIBILITY

It is important to carefully review the age, income and residency information that you report on your application. Be sure to include all income that you and your spouse (if married) received during the previous year. Do not include this year's income. The Program may request you to provide photocopies of your age, income, and residency documents to verify the information you reported on your application at any time.

If it is determined that you incorrectly reported your age, income, or residency status and that you are ineligible to receive these benefits, you may be required to repay the Program for any benefits it paid on your behalf.

IMPORTANT INFORMATION REGARDING THE SALE OF A HOME/PROPERTY

If you sold your home, all capital gains must be declared as income within two (2) years of the sale date even if you did not file a State or Federal tax return. If you sold your home to pay for nursing home costs or used these proceeds to purchase another residence deeded in your name, it is not considered income.

PACE/PACENET INCOME REQUIREMENTS— INCOME INCLUDES, BUT IS NOT LIMITED TO, THE FOLLOWING:

- Gross Social Security & SSI (including Medicare Premiums)
- Railroad Retirement (RRB1099 & RRB1099R)
- Gross Pensions
- Salaries/Wages/Commissions
- Self-Employment or partnership income
- Alimony and Spousal Support Money
- Taxable Amount of Annuities and IRAs
- Unemployment
- Veterans' Disability Payments
- Cash Public Assistance
- Interest/Dividends/Capital Gains
- Net Rental Income
- Royalties
- Workers' Compensation
- Life Insurance Benefits (death benefits over $10,000)
- Gifts and inheritance of cash or property over $300
- Any amount of money or the fair market value of a prize, such as a car or trip won in a lottery, contest, or gambling winnings

PACE/PACENET INCOME NOT COUNTED

- Aid & Attendance payments from VA
- Certain AmeriCorps*VISTA payments may be excluded
- Property Tax/Rent Rebates
- Other people's income living with you other than your spouse
- Damages received in a civil suit/settlement agreement
- Benefits granted under 306c of Workers' Comp Act
- Food Stamps
- LIHEAP payments
- Black or White Lung Benefits
- Assets

SECTION D – SPECIAL STATUS INDICATOR	SECTION E	SECTION F	SECTION G
Provide the requested information if you have been diagnosed with end-stage renal disease.	This section is required. Please sign your name.	Complete this section if you have a Power of Attorney. If you want all correspondence sent to your Power of Attorney, be sure to check the box.	If someone else completed the application other than yourself, their signature is required on the application.

MEDICARE PART D & OTHER PRESCRIPTION COVERAGE

We work with all Part D plans. PACE/PACENET may help pay your premium directly to your Part D plan. Contact us at 1-800-225-7223 for more details.

You can be enrolled in PACE/PACENET and other prescription drug plans such as Retiree, Union, Employer, Medicare Advantage (HMO, PPO) and Veterans' (VA).

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PO Box 8806
Harrisburg, PA 17105-8806

SECTION A – APPLICANT INFORMATION

Applicant Name	Gender (Circle) MALE FEMALE	Applicant Social Security Number
Applicant Pennsylvania Residential Address		Applicant Mailing Address (If different than residential)
Applicant Date of Birth	Applicant PA Driver's License/Photo ID Number	Applicant Primary Phone Number ( )
Emergency Contact Name	Emergency Contact Phone	Marital Status: 1. Single/Widowed 2. Married 3. Divorced 4. Married Living Separately

Please fill in the information below (located on your Medicare Card):

MEDICARE CLAIM NUMBER

____

MEDICARE PART A DATE ______-______-______

MEDICARE PART B DATE ______-______-______

Residence Type (optional)

1. Own
2. Rent
3. Nursing Home
4. Personal Care Home
5. Living with Relative
6. Other

Ethnic Origin (optional)

What is your race? (circle one or more)

1. White
2. Black or African American
3. American Indian or Alaska Native
4. Hispanic
5. Asian
6. Other

NOTE: IF YOU ARE MARRIED, YOU MUST FILL OUT SPOUSE INFORMATION

SECTION B – SPOUSE INFORMATION APPLYING? ☐ YES ☐ NO

Spouse Name	Gender (Circle) MALE FEMALE	Spouse Social Security Number
Spouse Pennsylvania Residential Address		Spouse Mailing Address (If different than residential)
Spouse Date of Birth	Spouse PA Driver's License/Photo ID Number	Spouse Primary Phone Number ( )
Emergency Contact Name	Emergency Contact Phone	Marital Status: 1. Single/Widowed 2. Married 3. Divorced 4. Married Living Separately

Please fill in the information below (located on your Medicare Card):

MEDICARE CLAIM NUMBER

____

MEDICARE PART A DATE ______-______-______

MEDICARE PART B DATE ______-______-______

Residence Type (optional)

1. Own
2. Rent
3. Nursing Home
4. Personal Care Home
5. Living with Relative
6. Other

Ethnic Origin (optional)

What is your race? (circle one or more)

1. White
2. Black or African American
3. American Indian or Alaska Native
4. Hispanic
5. Asian
6. Other

MUST COMPLETE OTHER SIDE.

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SECTION C – INCOME VERIFICATION

If you (or your spouse, if married and living together) receive income from any of the sources listed below, please enter the **GROSS INCOME FROM PREVIOUS YEAR** in the appropriate boxes. If you (or your spouse) do not have income from the previous year, please provide a statement of validation of zero income. If widowed, include only your previous year's income (do not include your deceased spouse's income).

Please do not subtract losses from income	Applicant	Spouse	Total
1. Gross Social Security and Gross SSI			
2. Railroad Retirement (RRB1099 and RRB1099R)			
3a. Pennsylvania State Employees' Retirement System Pension (SERS)			
3b. Pennsylvania Public School Employees' Retirement System Pension (PSERS)			
4. Other Gross Pensions and Taxable Amounts of Annuities, 401k's and IRA's not listed in 3a or 3b			
5. Interest, Dividends, Capital Gains, Prizes			
6. Wages, Salary, Bonuses, Commissions, Self-Employment, Partnerships, Net Rental, Net Business, Cash Public Assistance, Unemployment, Workers' Comp., Alimony, Support, Gambling, Gifts & Inheritance (only if over $300), Death Benefits (only if over $10,000)			

SECTION D – SPECIAL STATUS INDICATOR

Please check if you or your spouse have been diagnosed with End Stage Renal Disease: ☐ You ☐ Spouse

Applicant: Dialysis Start Date ____-____-____ Spouse: Dialysis Start Date ____-____-____

Transplant Date: ____-____-____ Transplant Date: ____-____-____

SECTION E – SIGNATURE

Applicant Signature or Power of Attorney (POA) Signature	Spouse Signature or Power of Attorney (POA) Signature
________________ Date __-__-__	________________ Date __-__-__

SECTION F – POWER OF ATTORNEY

☐ **Check box if you want all correspondence sent to your POA; complete POA documents are required if box is checked.**	☐ **Check box if you want all correspondence sent to your POA; complete POA documents are required if box is checked.**
Name	Name
Address	Address
City / State / ZIP	City / State / ZIP
Phone #	Phone #

SECTION G – WITNESS/PREPARER

Witness/Preparer's Name (If not the Applicant)	Witness/Preparer's Name (If not the Applicant)
Name	Name
Phone #	Phone #

6

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Your Survey on Health and Well-Being

Social Security Number

Gender: ____Male ____Female

We would appreciate it if you would answer the following questions about your current health and well-being. (Even if you have completed a similar survey in the past, it is important to complete the present survey because many of the questions have changed.) However, you are under no obligation to complete the survey, nor will your decision in any way affect your eligibility for enrollment in PACE/PACENET. All information is confidential and will be used only for research about the health needs of people who enroll in PACE/PACENET. Your answers are important in helping us to improve upon the delivery of health services and benefits for older Pennsylvanians.

1. Would you say that in general your health is:
   ☐ 1. Excellent ☐ 2. Very good ☐ 3. Good ☐ 4. Fair ☐ 5. Poor

2. Now thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?
   ______ days (If none, enter zero on the line.)

3. Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?
   ______ days (If none, enter zero on the line.)

4. During the past 30 days, for about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation?
   ______ days (If none, enter zero on the line.)

5. During the past 30 days, for about how many days did PAIN make it hard for you to do your usual activities, such as self-care, work, or recreation?
   ______ days (If none, enter zero on the line.)

6. Do you have any problems reading or understanding instructions about your medications that you receive from your physician or pharmacist?
   ☐ 1. No, I have no problems reading and understanding instructions about my medications.
   ☐ 2. Yes, sometimes I do have problems.

   If yes, what kind of problems do you have? Please check all that apply.
   ☐ a. Vision problems (for example, reading small print).
   ☐ b. Problems in reading (for example, understanding words).
   ☐ c. Problems because English is not my native language.
   ☐ d. Other problems (please describe briefly) ______________________

7. Is there a friend or family member that could help you read and understand labels on medicine containers, and the instructions from the physician or pharmacist, if needed?
   ☐ 1. Yes ☐ 2. No ☐ 3. Not Sure

8. During the last 12 months, how many times did you decide not to fill a prescription because it was too expensive?

☐ a. None ☐ b. 1 time ☐ c. 2 times ☐ d. 3-5 times ☐ e. 6-9 times ☐ f. 10 or more times

PLEASE TURN THE PAGE OVER AND CONTINUE

9. During the last 12 months, have you done any of the following:

a. Skipped doses of a medicine to make the prescription last longer? ☐ 1. Yes, often ☐ 2. Yes, sometimes ☐ 3. No, never

b. Spent less on food, heat, or other basic needs so that you would have enough money for your medicines? ☐ 1. Yes, often ☐ 2. Yes, sometimes ☐ 3. No, never

c. Had a family member or friend who helped pay for your medicine? ☐ 1. Yes, often ☐ 2. Yes, sometimes ☐ 3. No, never

d. Gotten samples of a prescription for free from a doctor? ☐ 1. Yes, often ☐ 2. Yes, sometimes ☐ 3. No, never

10. During the last 12 months, was there any time you avoided seeing a doctor because of concerns about the cost of prescription drugs? ☐ 1. Yes ☐ 2. No ☐ 3. Not Sure

11. Are you LIMITED in any way in any activities because of any impairment or health problem?
☐ 1. Yes ☐ 2. No.

12. Because of any impairment or health problem, do you need the help of other persons with your PERSONAL CARE needs, such as eating, bathing, dressing, or getting around the house?
☐ 1. Yes ☐ 2. No

13. Because of any impairment or health problem, do you need the help of other persons in handling your ROUTINE needs, such as everyday household chores, doing necessary business, shopping, or getting around for other purposes? ☐ 1. Yes ☐ 2. No

14. What is your approximate height and weight? Height: ___ ft ____ in Weight: ______ pounds

15. What is your educational level? Please give highest grade completed. ______________________

The next few questions ask about experiences you may have had with a Medicare prescription drug plan. You can be enrolled in a Medicare prescription drug plan and also be enrolled in PACE/PACENET. (Your answers will not affect either your Medicare benefit or your PACE/PACENET benefit in any way.)

16. Have you ever been enrolled in a Medicare prescription drug plan? ☐ 1. Yes ☐ 2. No

If yes, are you still enrolled? ☐ 1. Yes ☐ 2. No ☐ 3. Not Sure

The following are some statements that may or may not describe your feelings about the Medicare prescription drug plan you are (or were) most recently enrolled in. For each statement, please indicate how strongly you agree or disagree with the statement.

	Strongly Agree	Somewhat Agree	Somewhat Disagree	Strongly Disagree
a. My monthly plan premium was affordable	☐	☐	☐	☐
b. My annual deductible was reasonable	☐	☐	☐	☐
c. My co-pays were affordable	☐	☐	☐	☐
d. My total out-of-pocket costs were reasonable	☐	☐	☐	☐
e. My plan covered all the medicines my doctor prescribed	☐	☐	☐	☐
f. My plan was convenient to use	☐	☐	☐	☐
g. I understood how my plan worked and how to use it	☐	☐	☐	☐

THANK YOU. YOUR ANSWERS WILL HELP US TO IMPROVE THE DELIVERY OF HEALTH CARE SERVICES AND BENEFITS FOR OLDER PENNSYLVANIANS.

8

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Spouse's Survey on Health and Well-Being
If Spouse is Also Applying for PACE/PACENET

Social Security Number

Gender: ____Male ____Female

We would appreciate it if you would answer the following questions about your current health and well-being. (Even if you have completed a similar survey in the past, it is important to complete the present survey because many of the questions have changed.) However, you are under no obligation to complete the survey, nor will your decision in any way affect your eligibility for enrollment in PACE/PACENET. All information is confidential and will be used only for research about the health needs of people who enroll in PACE/PACENET. Your answers are important in helping us to improve upon the delivery of health services and benefits for older Pennsylvanians.

1. Would you say that in general your health is:

   ☐ 1. Excellent ☐ 2. Very good ☐ 3. Good ☐ 4. Fair ☐ 5. Poor

2. Now thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?

   ______ days (If none, enter zero on the line.)

3. Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?

   ______ days (If none, enter zero on the line.)

4. During the past 30 days, for about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation?

   ______ days (If none, enter zero on the line.)

5. During the past 30 days, for about how many days did PAIN make it hard for you to do your usual activities, such as self-care, work, or recreation?

   ______ days (If none, enter zero on the line.)

6. Do you have any problems reading or understanding instructions about your medications that you receive from your physician or pharmacist?

   ☐ 1. No, I have no problems reading and understanding instructions about my medications.

   ☐ 2. Yes, sometimes I do have problems.

   If yes, what kind of problems do you have? Please check all that apply.

   ☐ a. Vision problems (for example, reading small print).

   ☐ b. Problems in reading (for example, understanding words).

   ☐ c. Problems because English is not my native language.

   ☐ d. Other problems (please describe briefly) ______________________

7. Is there a friend or family member that could help you read and understand labels on medicine containers, and the instructions from the physician or pharmacist, if needed?

   ☐ 1. Yes ☐ 2. No ☐ 3. Not Sure

8. During the last 12 months, how many times did you decide not to fill a prescription because it was too expensive?

   ☐ a. None ☐ b. 1 time ☐ c. 2 times ☐ d. 3-5 times ☐ e. 6-9 times ☐ f. 10 or more times

PLEASE TURN THE PAGE OVER AND CONTINUE

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9. During the last 12 months, have you done any of the following:

   a. Skipped doses of a medicine to make the prescription last longer? ☐ 1. Yes, often ☐ 2. Yes, sometimes ☐ 3. No, never

   b. Spent less on food, heat, or other basic needs so that you would have enough money for your medicines? ☐ 1. Yes, often ☐ 2. Yes, sometimes ☐ 3. No, never

   c. Had a family member or friend who helped pay for your medicine? ☐ 1. Yes, often ☐ 2. Yes, sometimes ☐ 3. No, never

   d. Gotten samples of a prescription for free from a doctor? ☐ 1. Yes, often ☐ 2. Yes, sometimes ☐ 3. No, never

10. During the last 12 months, was there any time you avoided seeing a doctor because of concerns about the cost of prescription drugs? ☐ 1. Yes ☐ 2. No ☐ 3. Not Sure

11. Are you LIMITED in any way in any activities because of any impairment or health problem?
    ☐ 1. Yes ☐ 2. No.

12. Because of any impairment or health problem, do you need the help of other persons with your PERSONAL CARE needs, such as eating, bathing, dressing, or getting around the house?
    ☐ 1. Yes ☐ 2. No

13. Because of any impairment or health problem, do you need the help of other persons in handling your ROUTINE needs, such as everyday household chores, doing necessary business, shopping, or getting around for other purposes? ☐ 1. Yes ☐ 2. No

14. What is your approximate height and weight? Height: ___ ft ____ in Weight: ______ pounds

15. What is your educational level? Please give highest grade completed. ______________________

The next few questions ask about experiences you may have had with a Medicare prescription drug plan. You can be enrolled in a Medicare prescription drug plan and also be enrolled in PACE/PACENET. (Your answers will not affect either your Medicare benefit or your PACE/PACENET benefit in any way.)

16. Have you ever been enrolled in a Medicare prescription drug plan? ☐ 1. Yes ☐ 2. No

    If yes, are you still enrolled? ☐ 1. Yes ☐ 2. No ☐ 3. Not Sure

    The following are some statements that may or may not describe your feelings about the Medicare prescription drug plan you are (or were) most recently enrolled in. For each statement, please indicate how strongly you agree or disagree with the statement.

	Strongly Agree	Somewhat Agree	Somewhat Disagree	Strongly Disagree
a. My monthly plan premium was affordable	☐	☐	☐	☐
b. My annual deductible was reasonable	☐	☐	☐	☐
c. My co-pays were affordable	☐	☐	☐	☐
d. My total out-of-pocket costs were reasonable	☐	☐	☐	☐
e. My plan covered all the medicines my doctor prescribed	☐	☐	☐	☐
f. My plan was convenient to use	☐	☐	☐	☐
g. I understood how my plan worked and how to use it	☐	☐	☐	☐

THANK YOU. YOUR ANSWERS WILL HELP US TO IMPROVE THE DELIVERY OF HEALTH CARE SERVICES AND BENEFITS FOR OLDER PENNSYLVANIANS.

10

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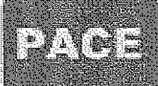


PACE/PACENET OTHER COVERAGE FORM

Please return this completed form along with your PACE/PACENET application.
If you are applying for the PACE/PACENET benefit for:
☐ YOU only, complete section A
☐ YOU and your SPOUSE, complete sections A and B

YOUR NAME:

PHONE:

ADDRESS:

SECTION A

YOUR OTHER DRUG COVERAGE

Do You Have Any Other Drug Coverage? ☐ Yes ☐ No
Is this Retiree/Employer/Union Coverage? ☐ Yes ☐ No

Does Your Card Say Any of the Following:
☐ Medicare Rx ☐ PDP ☐ Access Card
☐ Discount Card ☐ PPO ☐ SNP ☐ Veterans'
☐ HMO ☐ PFFS ☐ TRICARE

DRUG COVERAGE INFORMATION

ID # ____________________
RXPCN# ____________________
RXBIN# ____________________
RXGRP# ____________________
ISSUER# ____________________
CMS # ____________________
Name of Plan ____________________

Do You Have Any Other Health Insurance? ☐ Yes ☐ No

ID # ____________________
Eff Date ____________________
Name of Plan ____________________

SECTION B

SPOUSE OTHER DRUG COVERAGE

Do You Have Any Other Drug Coverage? ☐ Yes ☐ No
Is this Retiree/Employer/Union Coverage? ☐ Yes ☐ No

Does Your Card Say Any of the Following:
☐ Medicare Rx ☐ PDP ☐ Access Card
☐ Discount Card ☐ PPO ☐ SNP ☐ Veterans'
☐ HMO ☐ PFFS ☐ TRICARE

DRUG COVERAGE INFORMATION

ID # ____________________
RXPCN# ____________________
RXBIN# ____________________
RXGRP# ____________________
ISSUER# ____________________
CMS # ____________________
Name of Plan ____________________

Do You Have Any Other Health Insurance? ☐ Yes ☐ No

ID # ____________________
Eff Date ____________________
Name of Plan ____________________

11

QUESTIONS?

CALL CARDHOLDER SERVICES
1-800-225-7223

Hearing Impaired Callers Using TTY/TDD should call:
1-800-222-9004

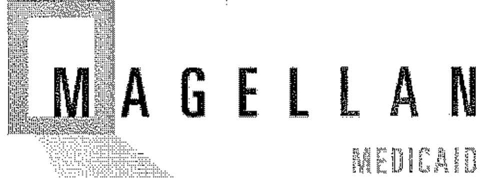
24 HOUR FAX NUMBER
717-651-3608

EMAIL ADDRESS
papace@magellanhealth.com

Visit our website at:
https://pacecares.magellanhealth.com/

Brian Duke
SECRETARY OF AGING

Tom Corbett
GOVERNOR



AMENDMENT NUMBER 1 TO AGREEMENT NUMBER 4400007944

APPENDIX B

Statement of Understanding (SOU) for SPBP1 Reports Enhancements

March 21, 2012

Confidential and Proprietary
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Privacy Rules

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

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

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

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6.0 Scope of Work 10
7.0 Test Plan 11
8.0 Operational Impact 12
9.0 Estimates and Costing 13
APPENDIX A 15

Approvals Signature Page

Magellan Medicaid Administration will deliver the requested change outlined in this Statement of Understanding by June 30, 2012, if Client signature approval is received by April 30, 2012.

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

[signature]	Timothy P. Nolan
Signature	**Printed Name**
President	4/3/2012
Title	**Date**
Signature	**Printed Name**
Title	**Date**

1.0 Overview

The Special Pharmaceutical Benefits Program 1 currently is responsible for submitting all required grantee monitoring reports to the federal Health Resources and Services Administration (HRSA.) HRSA is proposing changes to the required reports which will necessitate change in data capture, storage and presentation.

Magellan Medicaid Administration, Inc., is proposing to enhance the current reporting for SPBP1 to accommodate the new HRSA requirements.

2.0 Requirements

The effort for the SPBP1 Reports Enhancements includes the following:

- Modify the existing SPBP1 reporting package to conform with the requirements for the new HRSA report. These reports are identified in Appendix A, *AIDS Drug Assistance Program Grantee Report Proposed Grantee-Level Variables*, of this Statement of Understanding.
- Capture and store additional data elements necessary to complete the HRSA *AIDS Drug Assistance Program Grantee Report* (Appendix A.)
- Produce and deliver the enhanced report to the SPBP1 staff, following the delivery schedule established by HRSA. The draft version of the report requirements anticipates reports prepared for the six-month periods ending March 31 and September 30 of each year.

3.0 Assumptions

Workload and pricing estimates are based on the following assumptions:

- Final requirements will be established no later than April 30, 2012, so that work can begin by that date.
- The data capture modifications can be completed in time to begin data capture by April 30, 2012.
- The first report using the new information will be for the quarter ending September 30, 2012.
- Reports will be delivered to the SPBP1 staff no later than thirty days after the end of the reporting period.
- The data capture, storage and reporting requirements for the final reports will not differ significantly from the draft set available from HRSA on February 15, 2012.

4.0 Constraints

Workload and pricing estimates are based on the following constraints:

- Work to develop and test these enhancements can begin no later than April 30, 2012.
- Final requirements are available to the developer by no later than April 30, 2012.

5.0 Issues and Concerns

There are no issues or concerns for the SPBP1 Reports Enhancement Project.

6.0 Scope of Work

The Scope of Work for the SPBP1 Reports Enhancements Project is described in Section 2.0, Requirements. This project will result in modifications being made to the information being captured and reported to SPBP. Work will begin on April 30, 2012, and the first report to be produced with the enhanced reporting requirements will be for the period ending September 30, 2012, which will be delivered by no later than October 30, 2012.

7.0 Test Plan

Quality assurance testing will be performed by the QA department for the enhancements prior to implementation. The SPBP1 staff will be provided an opportunity to conduct user acceptance testing prior to putting the resulting reports into production.

8.0 Operational Impact

This project will add a new report to the report production cycle.

9.0 Estimates and Costing

Pricing for the SPBP1 Reports Enhancement project appears on the page following.

The pricing for Labor includes 840 hours of COBOL Developer time at a cost of $150.00 per hour.

The pricing for IT Charges includes a charge of $2,332.00 per business day for 21 business days to extend the availability of mainframe computing services needed to complete the development of this project. Only incurred cost, including overhead and profit, will be billed.

SPBP1 REPORTS ENHANCEMENT
PRICING SUMMARY BY CONTRACT YEAR

		YEAR ENDING					
		June 30, 2012	June 30, 2013	June 30, 2014	June 30, 2015	June 30, 2016	June 30, 2017
Summary:							
Licenses		$	$	$	$	$	$
Materials		$	$	$	$	$	$
Mailing services		$	$	$	$	$	$
Postage		$	$	$	$	$	$
IT Charges		$ 48,972.00	$	$	$	$	$
Labor		$ 126,000.00	$	$	$	$	$
Programming		$	$	$	$	$	$
Total Direct Expense		$ 174,972.00	$	$	$	$	$
Overhead	11.87%	$ 20,769.18	$	$	$	$	$
Profit	12.27%	$ 24,017.44	$	$	$	$	$
Total Price		$ 219,758.62	$	$	$	$	$

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

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

APPENDIX A

AIDS Drug Assistance Program
ADAP Grantee Report
Proposed Grantee-Level Variables

06/29/2011

Page 1

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

06/29/2011 Page 2

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"):

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

C. EXPENDITURES

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

	Expenditure Category	Total Cost
a.	Pharmaceuticals	$
b.	Dispensing and other administrative costs	$
c.	Insurance coverage (including co-pays, deductibles, and premiums)	$
d.	Under the ADAP Flexibility Policy - **Adherence**	$
e.	Under the ADAP Flexibility Policy - **Access**	$
f.	Under the ADAP Flexibility Policy - **Monitoring**	$
	Total ADAP expenditures this quarter	**$**

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

Included in Formulary	GENERIC NAME	BRAND NAME	Category	Added to Formulary this Reporting Period	
				Med Added?	Date Added
☐	abacavir	Ziagen	NRTIs	☐	MM/DD/YYYY
☐	abacavir, zidovudine, and lamivudine	Trizivir	NRTIs	☐	MM/DD/YYYY
☐	abacavir/lamivudine	Epzicom	NRTIs	☐	MM/DD/YYYY
☐	didanosine, ddI, dideoxyinosine	Videx	NRTIs	☐	MM/DD/YYYY
☐	efavirenz, emtricitabine, tenofovir disoproxil fumarate	Atripla	NRTIs	☐	MM/DD/YYYY
☐	FTC, emtricitabine	Emtriva	NRTIs	☐	MM/DD/YYYY
☐	lamivudine and zidovudine	Combivir	NRTIs	☐	MM/DD/YYYY
☐	lamivudine, 3TC	Epvir	NRTIs	☐	MM/DD/YYYY
☐	stavudine, d4T	Zerit	NRTIs	☐	MM/DD/YYYY
☐	tenofovir disoproxil fumarate	Viread	NRTIs	☐	MM/DD/YYYY
☐	tenofovir disoproxil/emtricitabine	Truvada	NRTIs	☐	MM/DD/YYYY
☐	zalcitabine, ddC, dideoxycytidine	Hivid	NRTIs	☐	MM/DD/YYYY
☐	zidovudine, AZT, azidothymidine, ZDV	Retrovir	NRTIs	☐	MM/DD/YYYY
☐	delavirdine, DLV	Rescriptor	NNRTIs	☐	MM/DD/YYYY
☐	efavirenz	Sustiva	NNRTIs	☐	MM/DD/YYYY
☐	Etravirine (TMC-125)	Intelence	NNRTIs	☐	MM/DD/YYYY
☐	nevirapine, BI-RG-587	Viramune	NNRTIs	☐	MM/DD/YYYY

Included In Formulary	GENERIC NAME	BRAND NAME	Category	Added to Formulary this Reporting Period	
				Med Added?	Date Added
☐	amprenavir	Agenerase	PIs	☐	MM/DD/YYYY
☐	atazanavir sulfate	Reyataz	PIs	☐	MM/DD/YYYY
☐	darunavir	Prezista	PIs	☐	MM/DD/YYYY
☐	Fosamprenavir Calcium	Lexiva	PIs	☐	MM/DD/YYYY
☐	indinavir, IDV, MK-639	Crixivan	PIs	☐	MM/DD/YYYY
☐	lopinavir and ritonavir	Kaletra	PIs	☐	MM/DD/YYYY
☐	nelfinavir mesylate, NFV	Viracept	PIs	☐	MM/DD/YYYY
☐	ritonavir, ABT-538 r	Norvi	PIs	☐	MM/DD/YYYY
☐	saquinavir	Fortovase	PIs	☐	MM/DD/YYYY
☐	saquinavir mesylate, SQV	Invirase	PIs	☐	MM/DD/YYYY
☐	tipranavir	Aptivus	PIs	☐	MM/DD/YYYY
☐	enfuvirtide, T-20	Fuzeon	FIs	☐	MM/DD/YYYY
☐	Raltegravir (RGV or MK-0518)	Isentress	Integrase Inhibitors	☐	MM/DD/YYYY
☐	maraviroc	Selzentry or Celsentri	CCR5 Antagonists	☐	MM/DD/YYYY

b. Grantee-level Formulary Information – A1-OI Medications

Included in Formulary	GENERIC NAME	BRAND NAME
☐	acyclovir	Zovirax
☐	amphotericin B	Fungizone
☐	azithromycin	Zithromax
☐	cidofovir	Vistide
☐	clarithromycin	Biaxin
☐	clindamycin	Cleocin
☐	famciclovir	Famvir
☐	fluconazole	Diflucan
☐	flucytosine	Ancobon
☐	fomivirsen	Vitravene
☐	foscarnet	Foscavir
☐	ganciclovir	Cytovene
☐	Isoniazid (INH)	Lanizid, Nydrazid
☐	itraconazole	Sporonox
☐	leucovorin calcium	Wellcovorin
☐	peginterferon alfa-2a	PEG-Intron
☐	pentamidine	Nebupent
☐	pentavalent antimony	—
☐	prednisone	Deltasone, Liquid Pred, Metocorten, Orasone, Panasol, Prednicen-M, Sterapred
☐	probenecid	—

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Included in Formulary	GENERIC NAME	BRAND NAME
☐	pyrazinamide (PZA)	—
☐	pyrimethamine	Daraprim, Fansidar
☐	ribavirin	Virazole, Rebetol, Copegus
☐	rifabutin	Mycobutin
☐	rifampin (RIF)	Rifadin, Rimactane
☐	sulfadiazine (oral generic)	Microsulfon
☐	trimethoprim-sulfamethoxazole (TMP/SMX)	Bactrim, Septra
☐	valacyclovir	Valtrex
☐	valganciclovir	Valcyte

"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 ≥1correctly 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".

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c. Grantee-level Formulary Information – Hepatitis B Medications

Included in Formulary	GENERIC NAME	BRAND NAME
☐	entecavir	Baraclude
☐	lamivudine	Epivir-HBV
☐	interferon alfa-2b	Intron A
☐	adefovir dipivoxil	Hepsera
☐	peginterferon alfa-2a	Pegasys
☐	telbivudine	Tyzeka

d. Grantee-level Formulary Information – Hepatitis C Medications

Included in Formulary	GENERIC NAME	BRAND NAME
☐	interferon alfa-2b	Intron A
☐	recombinant interferon alfa-2a	Roferon-A
☐	consensus interferon or interferon alfacon-1	Infergen
☐	peginterferon alfa-2a	Pegasys
☐	peginterferon alfa-2b	PEG-Intron
☐	peginterferon alfa-2a + ribavirin	Copegus and Pegasys
☐	peginterferon alfa-2b and ribavirin	PEG-Intron and Rebetol
☐	interferon alfa-2b and ribavirin	Intron A and Rebetol
☐	recombinant interferon alfa-2a and ribavirin	Roferon and Ribavirin

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:

Funding Source		Amount Received (to nearest dollar)
a.	ADAP earmark	$
b.	ADAP Supplemental Drug Treatment Grant Award	$
c.	State Match for Supplemental Drug Treatment Award	$
	ADAP resources received (total of a through c)	$

01/27/2011

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AMENDMENT NUMBER 1 TO AGREEMENT NUMBER 4400007944

APPENDIX C

Statement of Understanding (SOU) for SPBP1 Enrollment Processing Changes

March 21, 2012

Confidential and Proprietary
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Privacy Rules

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

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

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

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Approvals Signature Page

Magellan Medicaid Administration will deliver the requested change outlined in this Statement of Understanding by June 30, 2012, if Client signature approval is received by April 30, 2012.

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

[signature]	Timothy P. Nolan
Signature	**Printed Name**
President	4/3/2012
Title	**Date**
Signature	**Printed Name**
Title	**Date**

1.0 Overview

The Special Pharmaceutical Benefits Program 1 currently performs an initial eligibility determination for newly enrolling individuals and annually recertifies continued eligibility each year prior to Medicare Part D plan assignment.

The federal Health Resources and Services Administration (HRSA) requires all clients receiving SPBP1 benefits be recertified every six (6) months. To eliminate duplication of the recertification process and to streamline the existing process, the SPBP1 Program has requested that a six-month cycle be instituted for all persons receiving SPBP1 benefits. Newly-enrolled individuals will be enrolled and receive benefits for six months. In order to continue receiving benefits, the individual would need to be redetermined eligible before the end of the six months. Current SPBP1 cardholders will be assigned an end date distributed over a six-month period in the year the change is implemented. These members will need to re-apply and be determined eligible in order to continue receiving benefits. Members who fail to re-apply within thirty (30) days of their assigned ending enrollment date will lose their extended SPBP1 benefits.

Both newly applying and re-applying individuals will need to submit the same completed forms and required documents in order to be determined eligible. A new enrollment form will be created and used for both programs. All current members will be notified by mail in advance of these changes and the effective date. Enrollment processing will be automated to the extent practical, to include the printing and mailing of re-application packets, reminders letters, pend letters, and benefit cards.

2.0 Requirements

The effort for the SPBP1 Enrollment Processing Changes Project will include the following tasks:

- Upon approval of this SOU and prior to the mailing of any enrollment documents, print and mail a notice to all current SPBP1 cardholders advising them that the process to apply for continued benefits is changing and they will be receiving enrollment materials from the Program.
- Create new SPBP1 enrollment forms and documents to meet the needs of both initial enrollment and subsequent continuing enrollment. A complete enrollment package (letters, instructions, inserts, envelopes, etc.) will only be included with the first mailing for each enrollment cycle. Succeeding mailings will not include the enrollment forms unless requested by the individual.
- All forms will be produced and stocked in both English and Spanish language versions.
- Receive and image-capture incoming enrollment forms and accompanying documents. Make document images available for viewing on the existing imaging system. Provide imaging software and licenses to the SPBP1 staff, allowing them to retrieve and view document images on their workstations.
- Enhance and maintain the SPBP1 enrollment processing applications to support the changes needed to conduct initial and continuing enrollment on an ongoing basis.
- Enhance and maintain the SPBP1 enrollment processing applications to support the capture and display of the cardholder's caseworker name, address, and telephone number. Suspend the processing of applications which indicate there is a caseworker but for whom incomplete caseworker identifying information is provided.
- Enhance and maintain the SPBP1 enrollment processing applications to support the capture and display of the cardholder's attending physician name, address, and telephone number. Suspend the processing of applications which include any but not all of these data elements.
- Enhance the SPBP1 enrollment software applications to reset the ending coverage dates so that cardholder enrollments do not all expire in the same month. As part of this task:
    - Reassign coverage end dates for SPBP1 cardholders in such a way that these end dates are evenly distributed over a range of months.

  - Develop, test and implement processing changes to assign an initial ending enrollment date to SPBP1 cardholders being approved for enrollment the first time. (Once the cardholder has been approved, coverage will always be extended to six months from the date that coverage is conferred.)
  - Develop, test and implement changes to scheduling which will accommodate the schedule for SPBP1 recertification activities.

- If requested, print and mail notices to clients who have not had a prescription filled by the Program during the past six months that their benefits will be discontinued. Cardholders who do not respond to the notice will not receive enrollment materials and their coverage will end on their Ending Coverage Date.
- Six weeks prior to the cardholder's Ending Coverage Date, print and mail a notice of the need to re-apply to the cardholder, requesting that they complete and return the enclosed application forms and requested documentation within thirty days or risk losing their SPBP1 benefits.
- Two weeks after the first mailing, print and mail a cancel notice to all SPBP1 clients not responding to the initial mailing informing them their benefits will end in 30 days. This correspondence will include a notice informing the cardholder of their appeal rights.
- If all of the requested information and documents are not provided, print and mail notices to clients indicating their application cannot be processed and advising them how to resolve the issue. Clients with expanded benefits who do not apply successfully before their Ending Coverage Date may reapply at a later day but will not be eligible to receive expanded benefits.
- Create an electronic file and conduct telephone outreach to current utilizers who have not responded, asking them to apply.
- Receive and respond to telephone inquiries about recertification from clients. Record the call and capture in Verint.
- Personalize all correspondence and enclosed forms with the client's name, address, and other personalizing information.
- Test all changes before placing into production.
- Perform regular ongoing quality assurance testing for all work products of the enrollment process.

3.0 Assumptions

Workload and pricing estimates are based on the following assumptions:

- The first additional recertification cycle will be for SPBP1 cardholders whose eligibility ends on March 31, 2012. Enrollment materials will be mailed to these cardholders approximately six weeks before their eligibility ends.
- No additional letter inserts will be required.
- Identification cards will be produced and distributed each time a cardholder's Ending Coverage Date changes. The ID card mailing will include the ID card and carrier, a HIPAA informing notice and a creditable coverage letter.

4.0 Constraints

Workload and pricing estimates are based on the following constraints:

- Work to develop and test these changes can begin no later than the date that this Statement of Understanding is executed.
- Additional changes to the SPBP1 eligibility and enrollment system will not need to be implemented prior to March 31, 2012.

5.0 Issues and Concerns

There are no issues or concerns for the SPBP1 Enrollment Processing Changes Project.

6.0 Scope of Work

The Scope of Work for the SPBP1 Enrollment Processing Changes Project is as described in Section 2.0, Requirements. This project will result in cardholders receiving 6 months of eligibility upon successful application to the SPBP1 Program. The first cardholders to be affected will be those whose coverage was extended to March 31, 2012.

Modifications will be made to the existing SPBP1 enrollment processing system which affect lettering and notices, application forms, enrollment processing and eligibility determination, ID card production and mailing, and reporting.

7.0 Test Plan

Quality assurance testing will be performed by the QA department for the enhancements prior to implementation and also for the work products of the recertification activity. User acceptance testing will be performed by the application processing staff of the Cardholder Services department.

8.0 Operational Impact

The SPBP1 Enrollment Processing Changes Project will change the recertification process. Ending eligibility dates for the program will be staggered and a second round of recertifications will be performed each year.

The existing processes and procedures for SPBP1 recertification will be modified to incorporate staggered recertifications and the addition of a second recertification cycle each year. One FTE application reviewer will be added to the staff to handle the additional workload created by the second renewal cycle.

9.0 Estimates and Costing

Pricing for the SPBP1 Enrollment Processing Changes Project appear on the page following.

SPBP1 ENROLLMENT PROCESSING CHANGES
PRICING SUMMARY BY CONTRACT YEAR

		YEAR ENDING					
		June 30, 2012	June 30, 2013	June 30, 2014	June 30, 2015	June 30, 2016	June 30, 2017
Summary:							
Licenses		$ 3,281.58	$ 3,380.03	$ 3,481.43	$ 3,585.87	$ 3,693.45	$ 3,804.25
Materials		$ 8,216.88	$ 7,501.89	$ 7,726.99	$ 7,958.81	$ 8,197.58	$ 8,443.59
Mailing services		$ 3,026.53	$ 2,926.57	$ 3,014.37	$ 3,104.74	$ 3,197.80	$ 3,293.72
Postage		$ 20,002.29	$ 16,125.59	$ 16,609.36	$ 17,107.60	$ 17,620.82	$ 18,149.41
IT Charges		$ 9,804.58	$ 3,914.00	$ 4,031.40	$ 4,152.40	$ 4,277.00	$ 4,405.40
Labor		$ 31,387.20	$ 32,328.82	$ 33,298.68	$ 34,297.64	$ 35,326.57	$ 36,386.37
Programming		$ 58,860.00	$ **0.00**	$ **0.00**	$ **0.00**	$ **0.00**	$ **0.00**
Total Direct Expense		**$134,579.06**	$ 66,176.90	$ 68,162.23	$ 70,207.06	$ 72,313.22	$ 74,482.74
Overhead	11.87%	$ 15,974.53	$ 7,855.20	$ 8,090.86	$ 8,333.58	$ 8,583.58	$ 8,841.10
Profit	12.27%	$ 18,472.93	$ 9,083.74	$ 9,356.25	$ 9,636.94	$ 9,926.04	$ 10,223.84
Total Price		**$169,026.52**	**$ 83,115.84**	**$ 85,609.34**	**$ 88,177.58**	**$ 90,822.84**	**$ 93,547.68**

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

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

APPENDIX D

SPBP1 ID Card Stock Purchase

March 31, 2012

Quote for ID Cards

50,000 ID Plastic 30 mill cards Two color two sides polished FOB 4000 Crums Mill Road Harrisburg, PA.
Inside delivery

Price per 1,000	**$286.06**
Total Card Cost	**$14,303.00**

AMENDMENT NUMBER 1 TO AGREEMENT NUMBER 4400007944

Appendix E

AMENDMENT 1: SUMMARY OF CHARGES

CHARGE BY ACTIVITY	Year Ending 30-Jun-12	Year Ending 30-Jun-13	Year Ending 30-Jun-14	Year Ending 30-Jun-15	Year Ending 30-Jun-16	Year Ending 30-Jun-17	Total
AMENDMENT 1 CONTRACTED SERVICES							
SPBP1 Enrollment Processing Changes	$169,026.52	$83,115.84	$85,609.34	$88,177.58	$90,822.84	$93,547.68	$610,299.80
SPBP1 Reports Enhancements	$219,758.62	$0.00	$0.00	$0.00	$0.00	$0.00	$219,758.62
PACE Application Wizard Enhancements	$43,330.77	$0.00	$0.00	$0.00	$0.00	$0.00	$43,330.77
SPBP1 ID Card Stock Purchase	$17,963.80	$0.00	$0.00	$0.00	$0.00	$0.00	$17,963.80
Total Amendment 1 Charges	$450,079.71	$83,115.84	$85,609.34	$88,177.58	$90,822.84	$93,547.68	$891,352.99