



## PROCUREMENT JUSTIFICATION FORM (PJF)

This form must accompany all contract requests and sole source requisitions (RQS) over \$5,000 submitted to the Division of Procurement Services.

*INSTRUCTIONS: Please provide the requested information in the white spaces below. All responses (except signatures) must be typed; no hand-written forms will be accepted. See the guidance document posted with this form on the Division of Procurement Services intranet site (Forms page) for additional instructions.*

## PART I: OVERVIEW

Department Office/Division/Program:		DHSS/Office of MaineCare Services	
Department Contract Administrator or Grant Coordinator:		CM / Melinda Farrell	
(If applicable) Department Reference #:		OMS-24-300	
Amount: (Contract/Amendment/Grant)	\$469,159.56	Advantage CT / RQS #:	CT 10A 20230317000000002356
CONTRACT	Proposed Start Date:	7/1/2023	Proposed End Date: 6/30/2024
AMENDMENT	Original Start Date:		Effective Date:
	Previous End Date:		New End Date:
GRANT	Project Start Date:		Grant Start Date:
	Project End Date:		Grant End Date:
Vendor/Provider/Grantee Name, City, State:		Change Healthcare Pharmacy Solutions, Inc. Murray, UT	
Brief Description of Goods/Services/Grant:		Staff Augmentation Services	

## PART II: JUSTIFICATION FOR VENDOR SELECTION

Check the box below for the justification(s) that applies to this request. (Check all that apply.)

<input type="checkbox"/>	A. Competitive Process	<input type="checkbox"/>	G. Grant
<input type="checkbox"/>	B. Amendment	<input type="checkbox"/>	H. State Statute/Agency Directed
<input checked="" type="checkbox"/>	C. Single Source/Unique Vendor	<input type="checkbox"/>	I. Federal Agency Directed
<input type="checkbox"/>	D. Proprietary/Copyright/Patents	<input type="checkbox"/>	J. Willing and Qualified
<input type="checkbox"/>	E. Emergency	<input type="checkbox"/>	K. Client Choice
<input type="checkbox"/>	F. University Cooperative Project	<input type="checkbox"/>	L. Other Authorization

Please respond to ALL of the questions in the following sections.

**PART III: SUPPLEMENTAL INFORMATION**

1. Provide a more detailed description and explain the need for the goods, services or grant to supplement the response in Part I.

The purpose of this agreement is to procure a highly skilled, experienced, and qualified agency to provide recruitment of Resources and payroll functions for several Units at the Department's Office of MaineCare Services (OMS) and Office of Aging and Disability Services (OADS).

The Provider shall provide staff augmentation services in support of the Department. Work duties of the supplied staff are related to prior authorization, care management, provider enrollment, Value-Based Purchasing, Pharmacy Helpdesk, HIV Waiver Services, classification updates, clinical review, policy and legislative research, transportation and claims adjustment services.

2. Provide a brief justification for the selected vendor to supplement the response in Part II. Reference the RFP number, if applicable.

The staff provided under this Agreement have specific knowledge of OMS systems and operations. Loss of these resources would result in significant compliance and issues affecting services to Medicaid members. As vacancies occur, the Department will use existing staffing contracts to fill those vacancies.

3. Explain how the negotiated costs or rates are fair and reasonable; or how the funding was allocated to grantee.

This is an ongoing service contract, and rates are the same as previous contracts.

4. Describe the plan for future competition for the goods or services.

As vacancies occur, the Department will use existing staffing contracts to fill those vacancies. The Department will review this Agreement prior to the end date to determine the need to continued services.

**PART IV: AMERICAN RESCUE PLAN ACT (ARPA) / MAINE JOBS & RECOVERY PLAN (MJRP)**

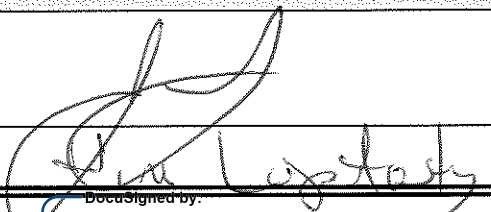
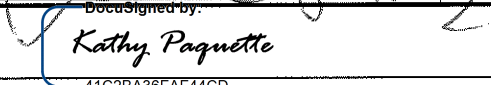
Does this request utilize ARPA/MJRP funds?

Yes – If Yes, please attach the approved Business Case(s).

No – If No, proceed to Part V.

**PART V: APPROVALS**

The signatures below indicate approval of this procurement request.

Signature of requesting Department's Commissioner (or designee):		
Typed Name:		Date: 23-Aug-23
Signature of DAFS Procurement Official:		
Typed Name:	Kathy Paquette	Date: 1/29/2024