STATE OF CONNECTICUT
OFFICE OF THE STATE COMPTROLLER

Request for Proposal
Pharmacy Benefit Manager

For Contract Beginning July 1, 2019

November 19, 2018

In order to participate in this procurement follow the process below:

Go to http://www.proposaltech.com/home/app.php/register. Enter your email address into the field provided. No registration code is necessary. Click "Begin Registration." If you already have an account with Proposal Tech it will be listed on the registration page, if you do not, you will be asked to provide company information. Once your account has been confirmed, check the appropriate box for the RFP you're registering for and click the "Register" button. An invitation will be mailed to you within fifteen minutes. If you have any questions regarding the registration process, contact Proposal Tech Support at 877-211-8316 x84.

1 Introduction

1.1 Overview and Background

We are soliciting proposals from PBMs to provide prescription drug benefits to the State of Connecticut Employee Benefits Programs for its active employees, non-Medicare eligible retiree participants, State Partnership Plan[i] members, and their covered dependents, effective 7/1/2019. The State Partnership Plan is open to "non-state public employers" and enables these entities to receive the same benefits as the State Employee Plan at comparable cost.

The State has approximately 188,000 covered lives (including dependents), with an annual drug gross cost spend of approximately $340,000,000 on 1.7 million scripts dispensed.

The State seeks best in class pricing terms, aligned and transparent pricing guarantees, comprehensive and responsive member services and state of the art clinical management programs.

Current Plan Design

Full plan design details can be found in the Pharmacy Benefit Plan Document available at: https://www.osc.ct.gov/benefits/docs/State%20of%20CT_2018_Plan%20Document_Pharmacy%20Plan_Final.docx

Member cost shares are illustrated in the table below:

	Retail (up to a 90-day supply)			
	Retired Prior to July 1, 2009	**Retired July 2, 2009 – October 1, 2011**	***Retired October 2, 2011 – October 1, 2017***	**Active Employees and Retired Post October 2, 2017**
Tier 1 (Preferred Generic)	$3	$5	*$5*	$5
Tier 2 (Non-Preferred Generic)	$3	$5	*$5*	$10
Tier 3 (Preferred Brands)	$6	$10	*$20*	$25
Tier 4 (Non-Preferred Brands)	$6	$25	*$35*	$40

	Mail/Maintenance Drug Pharmacy (90-day supply)					
			Retired October 2, 2011 – October 1, 2017		Active Employees and Retired Post October 2, 2017	
	Retired Prior to July 1, 2009	Retired July 2, 2009 – October 1, 2011	General	HEP Chronic Condition*	General	HEP Chronic Condition*
Tier 1 (Preferred Generic)	$0	$0	$5	$0	$5	$0
Tier 2 (Non-Preferred Generic)	$0	$0	$5	$0	$10	$0
Tier 3 (Preferred Brands)	$0	$0	$10	$5	$25	$5
Tier 4 (Non-Preferred Brands)	$0	$0	$25	$12.50	$40	$12.50
Out-of-Pocket Drug Cost Cap		Prescription drugs: $4,600/individual; $9,200/family out of pocket cap				
Out-of-Network Pharmacy (30 day)		20% coinsurance for acute medication refills at non-participating network pharmacy				
*Maintenance Drugs to treat 1) asthma or COPD; 2) diabetes (Type 1 or 2); 3) heart failure/heart disease; 4) hyperlipidemia (high cholesterol); or 5) hypertension (high blood pressure)						

Prescription drugs purchased at retail pharmacy are limited to a maximum 30-day supply; prescription drugs purchased through the State of Connecticut maintenance drug network or mail order pharmacy are limited to a maximum 90-day supply.

After a member obtains one (1) fill for a maintenance medication at any retail pharmacy, the member must fill a 90-day script for the maintenance drug at State of Connecticut maintenance drug network or the mail order facility.

Current Network and Formulary

The State currently has a broad network for 30-day retail and a custom network for 90-day retail. The State has a custom State of Connecticut maintenance drug network where a 90-day supply is available at the State's agreed upon maintenance network for mail pharmacy copay and net prescription plan cost. The proposed offer must reflect a plan design feature for a broad maintenance choice network for greater than 59 days' supply.

The State is currently participating in CVS' Standard Opt-In formulary for active members and those who retired later than 10/2/17 and Opt-Out formulary for those who retired 10/1/17 or earlier with 2 Tier, 3 Tier Non-Qualifying, and 3 Tier Qualifying plan designs for both formularies. For all groups, CVS's Advanced Control Specialty Formulary is available. The State is seeking a proposal with a formulary with exclusions for the actives and post-10/1/17 retirees and a formulary without exclusions for those who retired 10/1/17 or earlier. Certain drugs are subject to prior authorization, quantity duration limits, coverage limits, clinical programs, and safety monitoring.

The State currently has a mail order pharmacy and is seeking a similar program that would allow members to obtain a 90 days' supply fill for mail order copays for its upcoming contract.

The State contracts with its current PBM to provide all specialty drugs. The State would like pricing for the current arrangement (a standard contract that involves both specialty and non-specialty) and pricing if specialty pharmacy is carved out, as the State will also consider proposals for specialty-carve-out coverage.

State of Connecticut PBM RFP

The State currently has a Traditional pricing arrangement with 100% pass through of rebates. The rebate credits are provided on a monthly basis. The State seeks a contract for a full pass through, transparent relationship that includes administrative fees that cover the PBM's cost and reasonable profit targets.

The current PBM is CVS Caremark and the contract will expire on 6/30/2019.

Action/Event	Target Date
Release of RFP	Tuesday, November 20, 2018
Minimum Bid Qualifications Section Due – Assumes Intent to Bid if Submitted	Friday, November 30, 2018
Qualified Bidders Notified	Friday, December 07, 2018
Bidder Questions Due	Wednesday, December 12, 2018
Respond to Bidder Questions	Tuesday, December 18, 2018
Bidder Proposals Due	Tuesday, January 08, 2019
Bid Analysis Report Delivered to State	Friday, February 01, 2019
Finalists Selected and Notified	Week of February 04, 2019
Finalist Interviews and Draft of Contract Due	Week of February 11, 2019
On-line Pricing Auction Opens	Monday, February 18, 2019
On-line Pricing Auction Closed	Friday, February 22, 2019
Final Pricing Analysis from On-line Auction	Thursday, February 28, 2019
Contract Negotiations leading bidder	Friday, March 01, 2019
Contract Award/Start Implementation Process (if applicable)	Friday, March 08, 2019
Effective Date of New Contract	Monday, July 01, 2019

To avoid elimination from the RFP process, all proposals must be returned in the format and dates outlined in the Proposal Instructions section.

The following sections must be completed on BizNet :

Procurement Requirements

The Connecticut Department of Administrative Services ("DAS") has implemented a requirement that all firms seeking to do business with the State create a business profile on the DAS Business Network ("BizNet") system. BizNet eliminates certain redundancies, such as the former requirement to complete and submit forms even though the forms may have been recently submitted in response to another Request for Proposals. In addition to eliminating redundancy, BizNet has automated the completion and submission of required Ethics Affidavits and Non Discrimination forms. Firms must now upload these forms electronically to their BizNet account and update them on an annual basis, rather than submitting paper copies with each proposal. Firms will have the ability to view, verify and update their information by logging in to their BizNet account, prior to submitting responses to an RFP.

Additional required forms as described below must be submitted to or be on file with the BizNet system by the deadline for submission of proposals. Paper or electronic copies need not be provided.

https://www.BizNet.ct.gov/AccountMaint/Login.aspx.Once your firm creates an account, login and select "CT Procurement" and then "Company Information" for access. If you experience difficulty establishing or otherwise managing your firm's account, please call DAS at 860-713-5095.

The following required forms must be completed and uploaded to BizNet in accordance with the following instructions:

Required Forms

Follow instructions for submission of the following:

a) Agency Vendor Form (SP-26NB), available at:

http://das.ct.gov/Purchase/Info/Vendor_Profile_Form_(SP-26NB).pdf

b) W-9 Form, available at: http://www.irs.gov/pub/irs-pdf/fw9.pdf

Ethics Certifications

The following Ethics Forms must be signed, dated, notarized, uploaded or updated on BizNet. To obtain these forms, you must login to BizNet and follow the instructions referenced above.

• OPM Ethics Form 1: Gift & Campaign Contribution Certification;

• OPM Ethics Form 5: Consulting Agreement Affidavit:

• OPM Ethics Form 6: Affirmation of Receipt of State Ethics Laws Summary

• OPM Ethics Form 7: Iran Certification

For information on how to complete these forms, please access the Office of Policy and Management website by using the following link:

http://www.ct.gov/opm/cwp/view.asp?a=2982&q=386038&opmNAV_GID=1806

10. Affirmative Action and Nondiscrimination

Choose one (1) of the forms listed below that applies to your business. Complete and upload or update the form on BizNet annually. To obtain a copy of these forms, you must login to BizNet and follow the instructions referenced above.

• Form A: Representation by Individual (Regardless of Value); or

• Form B: Representation by Entity (Valued at $50,000 or less); or

• Form C: Affidavit by Entity (Valued at $50,000 or more); or

• Form D: New Resolution by Entity; or

• Form E: Prior Resolution by Entity

For information on how to complete these forms, please access the Office of Policy and Management website by using the following link:

http://www.ct.gov/opm/cwp/view.asp?a=2982&q=390928&opmNAV_GID=1806

Commission on Human Rights and Opportunities ("CHRO") Workplace Analysis Affirmative Action Report/Employment Information Form.

The CHRO Workplace Analysis Affirmative Action Report/Employment Information must be completed in BizNet and updated as necessary. You must login to BizNet and follow the Instructions referenced above. For information on how to complete these forms you may contact Diane Comeau at Diane.Comeau@ct.gov for assistance.

For information about how to upload the Ethics Affidavits and Non-Discrimination forms please access the following page. http://das.ct.gov/images/1090/Upload%20Instructions.pdf.

Affirmative Action The proposal must include a summary of the Contractor's experience with affirmative action including a summary of the Contractor's affirmative action plan and the Contractor's affirmative action policy statement.

Regulations of Connecticut State Agencies Section 46a-68j-30(10) require agencies to consider the following factors when awarding a contract that is subject to contract compliance requirements:

a. The Contractor's success in implementing an affirmative action plan;

b. The Contractor's success in developing an apprenticeship program complying with Section 46a-68-1 to 46a-68-17 of the Connecticut General Statutes, inclusive;

c. The Contractor's promise to develop and implement a successful affirmative action plan;

d. The Contractor's submission of employment statistics contained in the "Workforce Analysis Affirmative Action Report," indicating that the composition of its work force is at or near parity when compared to the racial and sexual composition of the work force in the relevant labor market area; and

e. The Contractor's promise to set aside a portion of the contract for legitimate small Contractors and minority business enterprises, where applicable (See C.G.S. §32-9e).

The State of Connecticut's Contract Compliance Forms applicable to State contracts are available at http://www.ct.gov/chro/cwp/view.asp?a=2525&Q=315900, please click on the four forms indicated below to download the pdf files from the CHRO web page:

Notification to Bidders

This document gives notice that the contract to be awarded is subject to the contract compliance

requirements mandated by State statutes and regulations.

Workforce Analysis Affirmative Action Report-State Contractors

This employment information form is used to report the racial and sexual composition of a firm's or corporation's workplace. The form must be completed by the Contractor and submitted with the proposal.

Affidavit for Certification of Subcontractors as Minority Business Enterprises

Upon award of a contract, this form is used to document the good faith efforts of a Contractor to include minority business enterprises as subcontractors (including suppliers) on the State contract

Contract Compliance Notice Poster

This notice concerns the prohibition of discrimination in employment practices. Upon award of a State contract, the notice must be posted by the Contractor in conspicuous places accessible to all employees and applicants for employment. More information about the State of Connecticut's Contract Compliance requirements is available on the Commission on Human Rights and Opportunities' web site at www.state.ct.us/chro under "Contract Compliance."

Your proposal should confirm you have downloaded, completed, and submitted all of the procurement documents listed above to BizNet. If not, please explain.

PBM has completed the required submission of ethics and affirmative action information via BizNet as of date of submission: Yes/No

The following sections from this point be completed through ProposalTech

Create an account on ProposalTech by using the following link:

Go to http://www.proposaltech.com/home/app.php/register. Enter your email address into the field provided. No registration code is necessary. Click "Begin Registration." If you already have an account with Proposal Tech it will be listed on the registration page, if you do not, you will be asked to provide company information. Once your account has been confirmed, check the appropriate box for the RFP you're registering for and click the "Register" button. An invitation will be mailed to you within fifteen minutes. If you have any questions regarding the registration process, contact Proposal Tech Support at 877-211-8316 x84.

Minimum Bidder Qualifications Criteria

Proposals will be reviewed and evaluated for completeness and responsiveness according to the State's selection criteria. Proposals will be deemed responsive only if the bidder responds to and meets all of the requirements of this RFP.

Note to all Bidders – ONLY PBMs that meet the following minimum bid qualifications will be considered. The minimum bidder qualifications are as follows:

PBM Minimum Bidder Qualifications

Minimum Years of Experience	PBM must have at least 3 years in operations as a full service PBM
Minimum Large Group Experience	PBM must have at least 2 clients with 100,000 or more covered lives under contract that would serve as a reference
Minimum Purchasing Scale	PBM must represent at least 5 million covered PBM lives currently under contract
Contracting Terms	PBM must conform to State's Minimum Transparency Pricing Requirements and Pricing Guarantees Exclusions List
Pricing Guarantees	PBM must commit to offer new pricing structure options for the State to consider

Exceptions to these minimum qualifications will be made for specialty carve out only pharmacy options.

Minimum Bidder Qualifications Phase

This Initial Minimum Bidder Qualifications Request is required to be submitted within 10 business days after release to determine which PBMs meet **Minimum State Bidder Requirements**. Information provided in response to this request will be legally binding and considered part of each bidder's proposal. Bidder responses to the Minimum State Bidder Requirements will be evaluated to determine which bidders qualify to submit formal proposals in Phase 2 or will be eliminated from future consideration.

Minimum State Bidder Criteria include the following information:

1. Minimum PBM experience
2. Minimum Scale of PBM Client volume
3. Conformity with the State's Minimum Transparency Pricing Requirements
4. Agreement with the State Acceptable Pricing Guarantee Exclusions List
5. Commitment to quote alternative pricing guarantees as outlined by the State

Phase 1 -Please complete the attached Minimum Bidder Requirement document and return by November 30, 2018.

Minimum Bidder Requirements

The following are the State's Minimum Bidder Requirements. Please include your responses within this form. Indicate “yes” or “no” as to your organization's ability to comply.

- **Minimum PBM experience** (Complete the following}:
  - Number of Years PBM has been in operation servicing large group plan sponsors
  - Average number of years of group policies in force
  - Complete Account Team Table for team assigned to this account

	Years of PBM Experience	Number of Assigned Accounts	Location
Lead Account Manager	*Unlimited.*	*Unlimited.*	*Unlimited.*
Manager Member Services	*Unlimited.*	*Unlimited.*	*Unlimited.*
Implementation Manager	*Unlimited.*	*Unlimited.*	*Unlimited.*
Clinical Pharmacists	*Unlimited.*	*Unlimited.*	*Unlimited.*

- **Minimum Scale of PBM Client volume (Provide Separately for Retail, Mail Service and Specialty)**

  Please provide the following information regarding your organization:

Complete all	As of 1/1/2018
Total Number of Covered PBM Lives under management	*Integer.*
Total Number of Scripts Dispensed	*Integer.*
Total AWP Dollars Processed	*Integer.*
Total Number of Direct Employer Group Plan Sponsor Client Accounts with at least 100,000 covered lives	*Integer.*
Do you have the capacity to take on the State of Connecticut as of 7/1/2019?	*Yes/No*

- **Conformity with the State’s Minimum Transparency AND Pricing Requirements**
  - The PBM agrees to a three-year Initial Term effective, July 1, 2019.
    Yes/No
  - The State reserves the right to terminate with or without cause at any time with 60 days' notice.
    Yes/No
  - 100% of paid claims will be available to third party audits at no cost to the state for up to three years after the fiscal plan year end
    Yes/No

- PBM shall provide bi-weekly detailed claims data to the State and its delegates.
  Yes/No

- PBM may use data for clinical research purposes only and shall not use data for any marketing purposes.
  Yes/No

- PBM shall make available all manufacturer rebate contracts, without restriction, to audit all rebate revenue earned by the State.
  Yes/No

- PBM shall guarantee that all paid claims will be adjudicated using the PBM's lowest MAC list with any network pharmacy annual audits to confirm PBM is meeting this requirement.
  Yes/No

- PBM agrees to apply rebate credits and rebate reporting on a monthly basis
  Yes/No

- All rebate revenue earned by the State will be paid to the State regardless of its termination status as a client. Lag rebates on claims incurred prior to the termination date will continue to be paid to the State after termination until 100% of earned rebates are paid.
  Yes/No

- The PBM shall indemnify, defend and hold harmless the State, its officers, directors, employees and agents from and against any and all claims, actions, demands, costs, and expenses, including reasonable attorney fees and disbursements, as a result of a breach by the PBM of any of its obligations under the Agreement or arising out of the negligent act or omission or willful misconduct of the PBM or its employees or agents.
  Yes/No

The PBM acknowledges that it is compliant with the Electronic Data Interchange ("EDI"), Privacy and Security Rules of the Health Insurance Portability and Accountability Act ("HIPAA") and will execute the appropriate Business Associate Addendum ("BAA") as provided by the State. PBM also agrees that in the event of a privacy violation or data breach, the PBM will notify the State and the impacted members of a breach and provide any required remedies. Remedies shall at a minimum conform to the provisions in PA 15-142 as passed by the Connecticut General Assembly.

Yes/No

Confirm you agree to the following contract definitions and terms: Complete all items in table	Response
a. "100% Pass Through of Formulary Rebates" – The PBM agrees to pass through 100% of ALL rebate revenue earned and will not charge an administrative fee for this arrangement.	*Yes/No*
b. "Payment Disclosure " - The PBM also agrees to disclose details of all other programs and services generating financial remuneration from outside entities, including manufacturers and retailers.	*Yes/No*
c. "Formulary Rebates" - Rebates include any fees that PBM receives from a pharmaceutical manufacturer for administrative costs, formulary placement, and/or access, as well as all revenue from price protection or price predictability provisions. All rebates associated with therapeutic drug switching activities or other promotional activities are to be shared with the plan for both retail and mail order scripts. Rebates shall be inclusive of preferred biosimilar.	*Yes/No*
d. "AWP" (Average Wholesale Price) is based on date sensitive, 11-digit NDC as supplied by Medi-Span, a single nationally-recognized pricing source	*Yes/No*
e. "Members" - All eligible employees and their eligible dependents enrolled under the State's prescription benefit program.	*Yes/No*
f. Member Copay - Members will pay the lowest of the following: plan copay/coinsurance, plan-negotiated discounted price plus dispensing fee, usual and customary (U&C), MAC (maximum allowable cost) or retail cash price.	*Yes/No*
g. Paid Claims - Defined as all transactions made on eligible members that result in a payment from the State or from the State member copays to the pharmacies or to the members (Does not include reversals, rejected claims and adjustments.) Each unique prescription that results in payment shall be calculated separately as a paid claim.	Yes/No
h. Client eligibility and claim data - All eligibility and claims records are the sole property of the State and must be made available upon request to the State and its representatives. This is to include but is not limited to: health benefits administrators and the State's healthcare consultant and actuary, data manager and wellness plan coordinator. Selling or providing of the State's data to ANY outside entities must be approved in advance, reported on a monthly basis, and all income derived must be disclosed and shared per agreement with the State. Even if PBM has not "sold" the data, it is NOT free to use the data for analyses that it publishes or provides to outside industries.	Yes/No
i. Direct and Indirect Remuneration - Compensation or remuneration of any kind received or recovered whether directly or indirectly from a pharmaceutical manufacturer or retail pharmacy attributable to the purchase or utilization of covered drugs by eligible persons, including, but not limited to, incentive rebates categorized as mail order purchase discounts; credits; rebates, regardless of how categorized; market share incentives; promotional allowances; commissions; educational grants; market share of utilization; drug pull-through programs; implementation allowances; clinical detailing; rebate submission fees; and administrative or management fees.	Yes/No

Member Eligibility Enrollment and Maintenance	**Response**
a. Eligibility Maintenance - Vendor must agree to accept and provide electronic data feeds in the appropriate HIPAA or State defined format on a schedule determined by the State. Currently for active employees and retirees, enrollment data is sent via the HIPAA 834 format. All carriers will receive the identical format and data structure as defined by the	*Yes/No*

	State. Vendor must agree to accept the eligibility structure as defined by the State.	
b.	Enrollment Data Maintenance - Enrollment data that does not pass carrier system edits must either be corrected or bypassed by the carrier. The remaining data must be posted without delay. Issues related to errant data must be addressed with the employing agency's benefit staff or the Healthcare Policy and Benefit Services Division as appropriate.	*Yes/No*
c.	Eligibility Periods - Vendor must agree to the State-defined Eligibility Periods; award of this contract means that any eligible employee and their dependents will be eligible for coverage. Open enrollment shall be the period announced by the State to allow eligible subscribers to join the plan, change coverage, or add eligible dependents. The open enrollment periods are generally from May 1st to June 1st each year for active employees and retirees. Members may add, drop, or make changes as appropriate if an allowable qualifying event occurs.	*Yes/No*
d.	Eligibility File Processing - The vendor must agree to process active and retiree enrollment additions, changes and deletions correctly within seven (7) days of the creation date of the file or information provided by the State. The State will provide a weekly file to report any changes within their enrollment data (to be known as the Change File). This file will include additions, terminations, coverage class changes, changes in dependent enrollment, etc. Towards the end of each month, the State will provide a monthly file to report a snapshot of all current live enrollment data (to be known as the Full File). The Full File is typically not loaded and used for comparative purposes only. After receipt of the monthly Full File, the vendor must reconcile all active employee and retiree enrollment data and report any discrepancies, in a format defined by the State, by the 15th of the next month to the appropriate State agency personnel; aggregate information must be sent to the Healthcare Policy and Benefit Services Division. The State will review the discrepancies and provide feedback appropriate to the condition being reported and make any necessary corrections to State enrollment information.	*Yes/No*
e.	Group Numbers – Department ID, as defined by the State, will substitute for any arbitrary vendor group number that might otherwise be assigned to a State agency or location. More specifically, enrollment and remittance information from the State will include the Department ID as the sole identifier of an employee's location. The vendor may translate the data to accommodate its own systems, however; all communications to and from the State and its data warehouse vendor, whether electronic or otherwise, will refer to the Department ID.	*Yes/No*
f.	Employee ID – The vendor will capture and report the State provided Employee ID (EMPLID) in data stores and data transfers with the State and other state vendors. The member's EMPLID must also be connected to all associated dependents.	*Yes/No*
g.	Data Access – The vendor will provide the State with online access to their enrollment information in real time.	*Yes/No*
h.	File Exchange Protocol – There are currently three methods for exchanging files with the State's Core-CT system: 1. The carrier logs into the secure Core-CT Production Supplier Portal via https to download or upload files. The URL is https://coreps.ct.gov/PSPRD/signon.html -or- 2. The carrier logs into the secure CT Axway Server. The URL is https://sft.ct.gov This Secure Transport service supports a broad set of file transfer clients and protocols including web browser access, SFTP and SSH client connectivity.	*Yes/No*

-or- 3. The State's Core-CT system uploads or collects files from the interfacing partner's system using the SFTP protocol. Testing Requirements At least one test cycle must be completed successfully prior to going live employing one of the previously mentioned file transports. Vendors must report in their response to this RFP whether they were able to successfully reach the portal sign on page at: https://coreps.ct.gov/PSPRD/signon.html or have connected to: https://sft.ct.gov/ For testing purposes, the link to the TEST supplier portal is: https://corepstpr.ct.gov/PSTPR/signon.html and the link to the test CT Axway Server is https://sft.stg.ct.gov/ Additional information for all parties that exchange data with State's Core-CT system is available at: http://www.core-ct.state.ct.us/hrint/	

Brand and Generic Minimum Discount Guarantees for both mail and retail shall be defined as follows: (1-Aggregate Ingredient Cost/Aggregate AWP)	**Response**
a. Aggregate Ingredient Cost Discounts are guaranteed dollar for dollar by individual component guarantees without offsets from other surpluses in other financial guarantees.	*Yes/No*
b. Aggregate Ingredient Cost will not be reduced by penalty amounts or member copays during the annual financial reconciliation process.	*Yes/No*
c. Aggregate AWP will be from a single, nationally recognized price source for all claims.	*Yes/No*
d. Please indicate source based on previous question.	*Unlimited*
e. Dispensing Fees are not included in the Aggregate Ingredient Cost.	*Yes/No*
f. Zero balance or zero amount claims paid by the State will be included in the guaranteed measurement for AWP, ingredient cost, achieved discounts or dispensing fee calculations at the discounted cost before copay.	*Yes/No*
g. All guarantee measurements shall be calculated prior to all member copayments being applied.	*Yes/No*
h. Both the Aggregate Ingredient Cost and Aggregate AWP from the actual date of claim adjudication will be used.	*Yes/No*
i. Aggregate AWP will be the date sensitive, 11-digit NDC of the actual product dispensed.	*Yes/No*
j. Both non-MAC, MAC, single-source and multiple source generic products are to be included in the generic guarantee measurement.	*Yes/No*
k. Discount guarantees include member eligible claims even when members pay 100% of cost because of deductibles or copays.	*Yes/No*
l. Measurement will be performed and provided quarterly by PBM to State and audited annually via independent audit utilizing date-sensitive AWP derived from a single, nationally recognized price source for all claims.	*Yes/No*

Agreement with the State Acceptable Pricing Guarantee Exclusions List

Acceptable Pricing Exclusions (Do you agree to exclude only the following items from all discount and rebate guarantees?) • Compound Drugs • Non-Network pharmacy claims • 340B pharmacy claims • Paper submitted claims by participants • Secondary Payor Claims (where the State is secondary to COB or Subrogation) • The guarantee measurement must exclude the savings impact from DUR programs, formulary programs, utilization management programs, and/or other therapeutic interventions. • Supplies that are billed separately to administer drugs, except blood glucose test strips	*Yes/No (Please list any that are only in partial agreement)*

Commitment to quote alternative pricing guarantees as outlined by the State

In addition to providing financial quotes in a traditional format as detailed below, the state requires bidders to provide alternative pricing guarantees for their consideration.

All finalists will be subject to rounds of on-line best and final financial offers. This reverse auction will be conducted on-line through a secure website where each finalist will be able to submit revised pricing guarantees. Finalists will be provided their relative bid rank based on overall projected cost savings, compared to their competitors in the finalist stage. No specific pricing terms or detailed quotes provided by each finalist will be identified. Only the relative overall financial ranking of the PBM will be shared with each PBM. No changes in exclusions or other pricing caveats will be permitted during this phase. The reverse auction will be open for a defined period (e.g. 5 to 10 business days). PBMs will be provided instructions on the submission process and will be given relative bid rankings after a period of analysis. The State will reserve the right to conduct multiple rounds of the reverse auction.

Pass-Through Prescription Drug Pricing

AWP Reimbursement Basis - Complete the following tables using the drug reimbursement that your organization is willing to guarantee on a dollar-for-dollar basis for each year of the contract. Columns marked "AWP Discount" are to be completed using a discount from 100% AWP and dispensing fee logic. All guarantees must be based on the AWP unit cost dispensed at the point of sale, and post September 26, 2009 AWP rollback.

Please verify that all retail guarantees are for a Full Pass through Retail contract ___Yes/No____

Bids must be 100% Rebate Pass-through quotes

Brand Discounts must include both single source and multi-source brands

Both non-MAC, MAC, single-source and multiple source generic products are to be included in the generic guarantee measurement.

Specialty Pharmacy Program Pricing

Please provide your organization's definition and qualification criteria of a “specialty drug product.”

Unlimited.

Provide current specialty drug list and indicate which are Limited Distribution Drugs in a supplemental attachment.

NOTE: The State will accept quotes for stand-alone specialty pharmacy fulfillment services.

Alternative Prescription Drug Pricing Arrangements [Do not submit actual Pricing]

PBM may be eliminated if they do NOT agree to provide pricing guarantees in the arrangements presented below. For each pricing request below, please indicate if you will quote on pricing feature described. A yes answer will serve as a commitment by the PBM to provide quotes in such formats during the formal RFP process for qualified bidders.

1. PBM agrees to report rebates on a drug specific basis for all drugs dispensed?
   Yes/No

2. All pricing and rebate guarantees for each of the first three years of the contract are based on the first year of formulary exclusions. The State has the right to opt in or opt out of any additional formulary drug exclusions without financial penalty. Future year changes to the formulary can be offered with financial incentives.
   Yes/No

3. Prospective Unit Cost Pricing Guarantees – Generic Drugs

   Each PBM will be given claims history by generic drug class in order to quote a **Maximum Ceiling Price Per Unit of Generic Drug**. Guarantees will be based on the PBM paying 100% of the surplus of costs (before member copays) in the full year of the contract. Each subsequent contract year, PBMs will set a maximum generic drug price inflation rate to be applied to the first year quoted ceiling price. The table below provides an illustration.

PBM Prospective Unit Cost Pricing Methodology

➢ **Prospective Unit Cost Price Ceilings for Generic Drugs** - Illustration

PBM Generic Drug Guarantee	Generic Drug Maximum Cost Per Unit of Therapy					
	Retail Year One Guaranteed Cost Per Unit			Mail Service Year One Guaranteed Cost Per Unit		
Generic Cost Per Unit	**PBM 1**	**PBM 2**	**PBM 3**	**PBM 1**	**PBM 2**	**PBM 3**
Atorvastatin	.65	.77	.62	.65	.77	.62
Metformin	.10	.15	.18	.10	.17	.18
Duloxetine	3.53	4.12	3.50	3.53	4.35	3.50
Metoprolol	.52	.60	.49	.52	.80	.49
Raloxitine	4.45	4.79	4.42	4.45	4.89	4.42

- PBM required to pay 100% of any excess price per unit above quoted maximum price per unit guarantee times actual units dispensed.
- Bid would also require maximum annual inflation factor for second and third year generic ceiling price.

	Response
Do you agree to bid on the Maximum Ceiling Unit Price format above for all GCNs paid in the plan year? Describe Underwriting Requirements.	*Yes/No.*

4. Price Inflation Guarantees

Do you agree to offer average price per Rx price inflation guarantees by channel, adjusted for days' supply? What restrictions would you require to accept at least 50% of the risk above the target rate?

Illustration

Avg Cost/Rx	Target Annual Trend Rate	PBM Excess Risk Share	PBM Savings Risk Share
Retail Formulary Brand	8%	50%	50%
Retail Generic	2%	50%	50%
Mail Formulary Brand	8%	50%	50%
Mail Generic	2%	50%	50%
Specialty Brand	10%	50%	50%

	Response
Do you agree to offer cost per Rx price inflation guarantees? Describe Underwriting requirements	*Yes/No.*

5. Lowest Net Cost by therapy class guarantees Illustration

Therapy PBM 1	Current Yr. Allowed Per Patient/Yr	Maximum First Year Allowed Cost Per Patient/Yr	Minimum Rebates credited per Patient/Yr	Maximum Dispensing Fees per patient/Yr	Maximum Allowed Per Patient Per Year*
Anti-diabetes	$4,522	$5,000	$1,500	$150	$3,650
RA	$44,766	$48,347	$9,750	$78	$38,675
Dermatologicals	$1,055	$1,140	$300	$100	$940
Asthma	$1,248	$1,310	$400	$150	$1,060
Pysch-Neuro Agents	$12,332	$12,950	$2,500	$150	$10,600

- Set average ceiling price per patient per month or year or Rx by specific treatment
- Ceiling price shall serve as stop loss attachment points. PBM pays the excess
- Pricing by Therapy class must be based on National Standard Formulary with standard drug exclusions. PBM cannot have open ended ability to remove formulary drugs to meet its therapy guarantees.
- *Max Ceiling Price Per Year Example, PBM pays 100% of excess by therapy class: (can be Monthly or Quarterly)
- Please describe the clinical programs you will utilize in order to achieve the guarantees provided. All guarantees should assume PBMs national standard formulary.

	Response
Do you agree to bid on the Net cost by therapy class? Describe Underwriting requirements	*Yes/No.*

Clinical performance guarantees

The State Employee Health Plan is committed to improving the health outcomes of its members, through the use of a value based benefit design; the State has successfully improved health outcomes while reducing overall costs to the plan. The State Employee Health Plan is interested in partnering with its PBM to reduce costs by improving clinical measures and health outcomes. To that end please list the clinical guarantees you are willing to commit to achieve. Clinical guarantees that are outcome based are preferred to process measures though a combination is acceptable. Please describe the clinical programs you will use to achieve such guarantees. Please provide the amount of the administration fee you willing to put at risk relative to achieving such clinical outcomes.

End of Phase 1 – Complete and submit to ProposalTech by November 30, 2018.

NOTE: All bidders that participate in Phase 1 will be notified by December7, 2018 if they have been qualified to complete Phase 2 (the full proposal) that follows. PBMs eliminated from consideration as a result of not passing the Minimum Bidder Qualifications Phase will also be notified and should not complete the full proposal. Please note that the entire questionnaire is visible to all bidders; however, only qualified PBMs will be able to access ProposalTech to enter responses during Phase 2..

Proposal Tech will open up access to Phase 2 for all qualified PBMs.

Phase 2

The State will score/evaluate each proposal based on the following categories:

Category	Weight	Score
A. Overall Cost and Trend Guarantees		
B. Degree of Contracting Transparency		
C. Member Services		
D. Account Services/Reporting		
E. Strength of New Financial Guarantee Arrangements		
F. Quality of Clinical Programs		
G. Value of Formulary and Drug Mix Offering		
H. e-Prescribing Price Transparency Tool		

2 Proposal Instructions

2.1 Please note that failure to follow these instructions may result in rejection of a proposal offer for non-responsiveness or cancellation of contract if already awarded.

General Proposal Conditions

1. **Award or Rejection:** The contract award will be made to the bidder whose proposal is deemed to be in the best interest of the State. The State reserves the right to reject any or all proposals. Proposals will not be returned.

2. **Costs for Proposal Preparation:** All costs incurred by bidders in preparing and submitting proposals are the bidders' sole responsibility.
3. **No Commissions** are to be included and all proposals must be submitted directly from the contracting company, without any intermediary.
4. **Time for Acceptance:** The bidder agrees to be bound by its proposal for a period of at least 180 days, during which time the State and/or Segal may request clarification or correction of the proposal for the purpose of evaluation. Amendments or clarifications shall not affect the remainder of the proposal, but only the portion so amended or clarified.
5. **Eligibility Rules:** The bidder agrees to the specified eligibility rules established by the State for covered parties.
6. **General Compliance**: All bidder services must adhere to relevant Federal and state laws and regulations.

7. **HIPAA Compliance:** All bidder systems and services must be in compliance with the HIPAA EDI, Privacy, and Security regulations on the appropriate dates established by the Department of Health & Human Services.
8. **Oral Explanations:** The State will not be bound by oral explanations or instructions given during the competitive process or after the award of the contract.
9. **Exceptions:** Any exceptions to terms, conditions, or other requirements in any part of these specifications must be clearly and fully documented in the appropriate section of the proposal. Otherwise, it will be considered that all items offered are in strict compliance with the specifications.
10. **Rights to Claims Data:** All claims data is the property of the State and must be returned upon request.
11. **Right to Audit:** All bidders agree to extend audit rights to the State.
12. **Contract Terms and Conditions:** The contract between the State and bidder will follow the format specified by the State. However, the State reserves the right to negotiate provisions in addition to those contained in this RFP with the successful bidder. The contents of this RFP, as revised and/or supplemented, and the successful bidder's proposal will be incorporated into and become part of the contract.
13. **Notice of Supplier Change**: The bidders must agree to 90-day advance notice of any changes in suppliers such as specialty pharmacy, mail-order facility and/or other products and services.
14. **Full Disclosure:** The bidders must fully disclose any and all sub-contracted work and off-shoring services (e.g., Member services, Call Centers, etc.)
15. **Confidentiality:** All responses will be held in strict confidence. Once the successful bidder has entered into a contract with the State all proposals submitted in response to this RFP are subject to requirements of the Freedom of Information Act, Conn. Gen. Stat. Sections 1-200 et seq. Any proposer that submits matter that it in good faith determines to contain trade secrets or confidential commercial or financial information must identify such materials as exempt in the course of responding to the RFP. In such case a copy of the proposer's response from which exempt materials have been redacted will be subject to disclosure in the event that the State receives a FOIA request for its proposal. Segal Consulting will keep all responses strictly confidential and will use them only for evaluation of the stated project.

All proposals submitted must adhere to these conditions, unless otherwise noted in the proposal. Failure to meet any Client terms or conditions may result in disqualification of the proposal. This RFP and your responses, as well as RFP Addendums, will become part of the conformed contract with the State.

2.2 **General Proposal Requirements**

This bid will only accept pricing proposal with 100% pass through of ALL manufacturer formulary rebates. The pricing arrangements will be evaluated based on guaranteed discounts, fees, and minimum rebates.

In order for your proposal to be considered and accepted, your organization must provide answers to the questions presented in this RFP. Each question must be answered specifically and in detail. Reference should not be made to a prior response, or to your contract, unless the question involved specifically provides such an option. Be sure to review this entire RFP before responding to any of the questions, so that you have a complete understanding of all of the State's requirements with respect to the proposal.

*****DO NOT ALTER THE QUESTIONS OR QUESTION NUMBERING*****

1. Provide answers to all questions in the electronic RFP (eRFP) online system.
2. Provide an answer to each question even if the answer is "not applicable" or "unknown."
3. Answer the question as directly as possible.

- If the question asks “How many…” provide a number.
- If the question asks, “Do you…” indicate Yes or No followed by any additional narrative explanation.

4. Where you desire to provide additional information to assist the reader in more fully understanding a response, refer the reader of your RFP response to your appendix/attachments. However, direct responses to all of the RFP questions must be provided and will be looked upon favorably.
5. Bidder will be held accountable for accuracy/validity of all answers.

If your proposal is different in any way (whether more or less favorable) from that indicated in this RFP, clearly indicate where and explain the difference. If you do not, the submission of your proposal will be deemed a certification that you will comply in every respect (including, but not limited to, coverage provided, funding method requested, benefit exclusions and limitations, underwriting provisions, etc.) with the requirements set forth in this RFP.

If you are unable to perform any required service, indicate clearly: a) what you are currently unable to do, and, b) what steps will be taken (if any) to meet the requirement, the timetable for that process and who will be responsible for the implementation, along with that person's qualifications.

Financial Section: When displaying your proposed fees, the tables in the Financial Section included in this RFP must be used. Footnotes to the form(s) may be used to provide supplemental explanations, if necessary**.**

Network & Formulary Disruption: Both a network disruption based on the zip codes of the utilized retail pharmacies in the claims data file and a formulary disruption analysis are necessary in order to award a final contract. In order to be considered, your organization must provide data regarding your network and contracted pharmacies. **The basis of this evaluation will include your organization’s broadest, national network offering and formulary with drug coverage exclusions, unless otherwise requested by the State or Segal**. The PBM’s proposed formulary and formulary exclusion list will not be materially different from the actual formulary implemented.

Minimum Contractual Requirements: The Minimum Contractual Requirement section will become part of the actual contract document. Agreement to the terms and language in this section will be a critical factor in bidder evaluation and selection and an authorized binding signature will be required.

Segal Contacts: Please direct any questions to the contacts noted in this RFP and within the eRFP tool.

Bidder questions: All questions will be made via ProposalTech. Please submit your RFP related questions by the close of business,**11:59 P.M. EST, *Wednesday, December 12, , 2018, with a copy to OSC.rfp@ct.gov.***

Submission of proposals: Proposals are to be submitted electronically via ProposalTech system.

All decisions and evaluations will be determined from the proposals submitted electronically via the eRFP system.

Your proposal should be submitted in the following format:

- Minimum Contractual Requirements: electronic copy required
- Contractual Expectations: electronic copy required
- Operational Service Capabilities: electronic copy required
- Financial Section: electronic copy required
- Required attachments

2.4 . **Claims data will not be released with the Minimum Bid Qualifications Section. A census file will not be released for this bid.**

3 PBM Services to be Provided

3.1 A number of factors will be considered in the selection process. The primary factors include pricing, pharmacy network access, formulary management and formulary disruption, contractual compliance, account management services, reporting capabilities, financial stability, performance guarantees, flexibility, references, clinical programs, and Member service.

All bidders are required, at a minimum, to duplicate the plan design features and levels of coverage presently offered to the State.

Prospective vendors are to offer comprehensive PBM services including but not limited to the following:

- Claims Adjudication
- Ability to Integrate PBM services with other vendors (e.g. Disease Management, Medical), if applicable
- Eligibility Maintenance
- Patient and Provider Education
- Systematic Prospective, Concurrent, and Retrospective Drug Utilization Review
- Network Pharmacy Management
- Formulary Management and Rebate Sharing
- Data Reporting (standard and ad-hoc reporting)
- Distribution of ID Cards and Pharmacy Directories
- Mail Service Pharmacy
- Specialty Pharmacy Program
- Complete Availability of IT services, including Online/Real Time Availability to the State and/or its designee(s)
- Pricing Administration
- Member Services
- Ad Hoc Reporting
- Website with Membership Portal
- Clinical Programs
- Vaccinations

4 Contractual Terms and Requirements

Bidders' responses to this section will be heavily weighted in the selection process. Please include your responses within this form. Indicate “yes” or “no” as to your organization's ability to comply.

4.1 Term/ Termination

4.1.1 The PBM agrees to a three-year Initial Term effective July 1, 2019.

Yes/No.

4.1.2 The State reserves the right to terminate with cause at any time with 60 days' notice if an effective remedy is not provided to the satisfaction of the State.

Yes/No.

4.1.3 The State will have the right to terminate the PBM without cause given a 60-day notice period without penalty to the State.

Yes/No.

4.1.4 PBM agrees to an annual market check, that may start as soon as the first quarter of the second contract year, conducted by an independent third party to ensure the State is receiving appropriate current pricing terms competitive with the industry (as compared to other PBMs and contracts the PBM may have with other clients) based on its volume and membership, and will improve pricing in the event that the State's contract terms are less than market best pricing. The State will have the right to terminate without penalty if the pricing terms are not industry best for similar sized groups.

Yes/No.

4.1.5 PBM agrees to implement new pricing within 90 days of completion of the market check or signature of contract. Acceptance of the new pricing will apply for the remainder of the Initial Term and will NOT result in extension of the contract, unless requested by the State. The financial guarantees for any partial contractual year that results from the implementation of new pricing will still be guaranteed, reconciled and the PBM will still make payments for any shortfalls for those partial contractual years with less than 12 months and those contractual years with over 12 months.

Yes/No.

4.1.6 The PBM contract will not include automatic renewal language.

Yes/No.

4.1.7 All rebate revenue earned by the State will be paid to the State regardless of its termination status as a client. Lag rebates on claims incurred prior to the termination date, will continue to be paid to the State after termination until 100% of earned rebates are paid.

Yes/No.

4.1.8 The PBM will provide a signature ready contract incorporating all agreed upon provisions within this RFP. Contract document will be submitted along with proposal response.

Yes/No.

4.2 Financial

4.2.1 Each distinct pricing guarantee (including discounts, dispensing fees and rebates) will be measured and reconciled on a standalone basis (e.g. retail brand, retail generic, maintenance supply brand, maintenance supply generic, mail order brand, mail order generic, specialty drugs at participating retail pharmacies, and specialty drugs at the PBM's Specialty Pharmacy) and guaranteed on a dollar-for-dollar basis with 100% of any shortfalls recouped by the State. **Surpluses in one component may not be utilized to offset deficits in another component.**

Yes/No.

4.2.2 The PBM will provide a financial reconciliation report within 90 days after the end of each contractual year, and the report will include the contractual and actual discounts and dispensing fees for each component (e.g., retail brands, retail generics, mail brands, mail generics, specialty drugs via Participating Retail Pharmacies, specialty drugs via the PBM's Specialty Pharmacy).

Yes/No.

4.2.3 The PBM agrees that any shortfall between the actual result and the guarantee will be paid, dollar-for-dollar, to the State within 90 days of the end of each contractual year.

Yes/No.

4.2.4 The PBM's financial reconciliation that occurs after the end of the contract year will use the lower of the AWP pricing at the point of adjudication or the retroactive AWP pricing, if the pricing source the PBM uses issues retroactive AWP pricing for that annual reconciliation time period.

Yes/No.

4.2.5 All pricing submitted, other than clinical performance guarantees, will **NOT** be contingent on participation in any proposed clinical management programs, group medical or behavioral health programs proposed by you or any other vendor other than programs that are requested by the State.

Yes/No

4.2.6 Pricing guaranteed in the Financial Section of this RFP reflects the PBM's standard national preferred formulary drug listing with drug coverage exclusions unless otherwise authorized or requested by the State.

Yes/No.

4.2.7 Mail order pricing and rebates will apply to all claims that adjudicate at mail regardless of days' supply.

Yes/No.

4.2.8 Guaranteed rebates per prescription will be based (whether by therapy or in aggregate by channel) on **all brand prescriptions dispensed**, not on formulary prescriptions dispensed.

Yes/No.

4.2.9 Rebates are guaranteed on a minimum (i.e., not fixed) basis, and the PBM will pass through 100% of the rebates to the State.

Yes/No.

4.2.10 The PBM agrees to disclose details of all programs and services generating financial remuneration from outside entities that are based on the plan sponsor’s drug claim experience and that 100% of any such direct or indirect manufacturer remuneration will be passed through to the State.

Yes/No.

4.2.11 PBM agrees that Rebates will be paid upon signature of any of the following documents: 1) the Letter of Agreement/Intent, OR 2) Pricing Implementation Document, OR 3) Contract.

Yes/No.

4.2.12 The PBM will reconcile rebate guarantees to verify that the State is receiving the guaranteed rebates and provide rebate payments and reports listing detailed rebate utilization and calculations to the State quarterly, within sixty (60) days of the quarter's close, without a request being made by the State.

Yes/No.

4.2.13 The PBM will provide the annual rebate report within 90 days of the end of each contract year. Confirm that any shortfall between the actual result and the minimum rebate guarantees will be paid, dollar-for-dollar,

to the State within 90 days of the end of the contract year. Please confirm that lag rebates will continue to be paid to the State until 100% of earned rebates are paid.

Yes/No.

4.2.14 The PBM agrees to produce a date-sensitive comparison report showing unit costs charged to the State at a GCN-level and reimburse the State on a dollar-for-dollar basis for all instances where mail order unit costs exceed retail unit's costs for generic drugs dispensed. Report and reconciliation will be provided on a quarterly basis, without a request being made by the State.

Yes/No.

4.2.15 The State will be notified of any switch to the source of the aggregate AWP with at least a 180-day notice. In the event that a switch is made it must be price neutral and acceptable to the State.

Yes/No.

4.2.16 The PBM will be responsible for collecting any outstanding member cost shares for prescriptions dispensed through the mail order facility. The PBM will not invoice the State for any uncollected member cost shares even if there is a debit threshold in place.

Yes/No.

4.2.17 The PBM will not withhold any financial recoveries from audits performed on the contracted pharmacy network including mail order and specialty pharmacies. Any recoveries will be disclosed and credited to the State, with 100% pass through of all recovery amounts.

Yes/No.

4.2.18 The PBM will invoice the State twice monthly for claims and administrative services.

Yes/No.

4.2.19. All fees, including clinical and formulary program fees, must be clearly outlined in the Financial Section.

Yes/No.

4.2.20 Confirm the PBM will provide run-out claims processing for the State after contract termination at no additional costs to the State.

Yes/No.

4.2.21 The PBM agrees to adjudicate prescription claims for compound medications with the same dispensing fees and logic (such as UM edits) associated with traditional claims.

Yes/No.

4.2.22 The PBM agrees to no additional charges for any retroactive claims reprocessing and member reimbursements due to retroactive plan design adjustments.

Yes/No.

4.2.23 All pricing will be effective and guaranteed for the term of the agreement and will not include adjustments for claims volume changes or claims volume shifts amongst the various provider channels (e.g., mail utilization rates decline or 90-day retail utilization increases).

Yes/No.

4.2.24 Confirm all pricing will be guaranteed for the term of the agreement so long as the State's covered lives exceed 100,000.

Yes/No.

4.2.25 Confirm pricing and fees quoted will not be subject to change by the PBM due to any contingency, such as but not limited to:

a. Participation in any supplemental programs.

b. Direct communication with patient population.

c. Use of member data by the PBM for any purpose not specifically authorized by the State

d. Changes in laws or the industry (such as change in Average Wholesale Price (AWP) source or new generic launches).

e. Actions by drug manufacturers, wholesalers, or pharmacies.

f. Drug recalls or withdrawals.

g. Patent expirations or brands moving off-patent to generic status.

h. Benefit design changes.

Yes/No.

4.2.26 Confirm all pricing will be effective and guaranteed for the term of the agreement and will not be modified or amended if the State adds an additional plan design, such as a high deductible health plan/consumer-driven health plan option, or if the population under that plan increases.

Yes/No.

4.2.27 The State will have the ability to annually renegotiate and/or “carve-out” specialty drug pricing and service terms without penalty or changes to the financial guarantees quoted.

Yes/No.

4.2.28 The PBM mail order service must notify the individual member, the State or its designee prior to substituting products that will result in higher member co-pays or higher total costs to the plan.

Yes/No.

4.2.29 All applicable administrative fees will be on a per paid claim basis as defined in in this RFP.

Yes/No.

4.3 Formulary Management

4.3.1 With the exception of FDA recalls or other safety issues, the PBM agrees not to remove any additional drug products, brand or generic, from the State's formulary or preferred drug listing without notification and prior approval from the State.

Yes/No.

4.3.2 The PBM agrees to notify the State or its designee in advance of 90 days when a drug is targeted to be moved to the preferred drug list and thus be covered or removed from the preferred drug list and thus become excluded from coverage. The PBM must provide a detailed member disruption and financial impact analysis at the same time.

Yes/No.

4.3.3 The PBM agrees to notify the State or its designee in advance of 90 days when a drug is targeted to be moved to or from a preferred or non-preferred formulary tier. The PBM must provide a detailed disruption and financial impact analysis at the same time.

Yes/No.

4.3.4 The PBM agrees to remove drugs from coverage or the formulary (other than FDA recalls and other safety reasons) no more frequently than once per year and that any disruption due to formulary changes shall be limited to no greater than two percent (2%) of total unique plan utilizers.

Yes/No.

4.3.5 The State has the right to opt in or opt out of any formulary drug exclusions without penalty.

Yes/No.

4.4 Retail Network Management

4.4.1 The PBM agrees that it will not remove any participating network pharmacies that impact greater than 2% of the State's prescriptions without communicating to the State at least sixty (60) days in advance of the scheduled change. If the change is not agreeable to the State, the State will have the right to terminate the agreement without penalty with 30 days' notice.

Yes/No.

4.4.2 The PBM agrees to offer improved pricing terms to the State if greater than 2% of members are impacted by proposed changes to the participating pharmacy network.

Yes/No.

4.4.3 The State has implemented a mandatory 90 day supply for maintenance drugs. When a covered person begins to take a maintenance medication, the first fill must be for 30 days and can be obtained at any participating pharmacy. The copay for the first 30-day fill of a maintenance drug must be prorated as a single fill. After that, the member must receive 90-day fills of the maintenance medication, which will process for a single copay. The member has two choices for obtaining 90-day fills of maintenance medications; they are:

- Receive the medication through the mail-order pharmacy, or
- Fill the medication at a pharmacy that participates in the state's custom Maintenance Drug Network

A list of the pharmacies that currently participate in the Maintenance Drug Network can be found on the Comptroller's website at www.osc.ct.gov. The PBM agrees to develop and maintain a similar Maintenance Drug Network.

Yes/No.

4.4.4 The State's medical benefit plan includes coverage for adult or childhood immunizations as recommended by the U.S. Department of Health and Human Services, or as required for foreign travel if, administered in a physician's office. Whenever available or applicable (i.e. flu vaccination, shingles vaccinations) members may also utilize their PBM benefits to have vaccinations administered at a participating pharmacy. The PBM agrees to cover immunization claims under the pharmacy benefit.

Yes/No.

4.5 Audit Rights

4.5.1 The State or its designee will have the right to audit annually, with an auditor of its choice, (for both claims and rebate audits), with full cooperation of the selected PBM, the claims, services and pricing and/or rebates, including the manufacturer rebate contracts held by the PBM, to verify compliance with all program requirements and contractual guarantees with no additional charge from the PBM.

Yes/No.

4.5.2 The State or its designee will have the right to audit (separately) up to the last three complete plan years at no additional charge from the PBM.

Yes/No.

4.5.3 The State or its designee will have the right to conduct an audit at any time during the year, at any point during the contract term, and the selected PBM will provide all documentation necessary to perform the audit.

Yes/No.

4.5.4 The PBM will provide complete claim files and documentation (i.e., full claim files, financial reconciliation reports, inclusion files, and plan documentation) to the auditor within 30 days of receipt of the audit data request as long as a non-disclosure agreement is in place between the auditor and the PBM.

Yes/No.

4.5.5 The PBM agrees to a 30-day turnaround time to provide the full responses to all of the sample claims and claims audit findings.

Yes/No.

4.5.6 The State or its designee will have the right to audit any and all pharmaceutical manufacturer contracts during an on-site rebate audit

Yes/No.

4.5.7 The audit provision shall survive the termination of the agreement between the parties for a period equivalent to the Initial Term of the contract.

Yes/No.

4.5.8 The State will not be held responsible for time or miscellaneous costs incurred by the PBM in association with any audit process including, all costs associated with provision of data, audit finding response reports, or systems access, provided to the State or its designee by the PBM during the life of the contract. Note: This includes any data required to transfer the business to another vendor and money collected from lawsuits and internal audits.

Yes/No.

4.5.9 Confirm the PBM will correct any valid errors that the State brings up to the PBM's attention whether identified by an audit or otherwise. Describe the process that the PBM will undergo to correct the error and make the appropriate payments to the member and/or the State, if applicable.

Unlimited.

4.6 Legal Responsibilities

4.6.1 PBM agrees to hold the State harmless for any HIPAA Violations made by the PBM or its Network Pharmacies.

Yes/No.

4.6.2 The PBM will agree to be claims fiduciary for clinical based determinations.

Yes/No.

4.6.3 The PBM will agree to defend claims litigation based on its decisions to deny coverage for clinical reasons.

Yes/No

4.6.4 The PBM shall indemnify, defend and hold harmless the State, its officers, directors, employees and agents from and against any and all claims, actions, demands, costs, and expenses, including reasonable attorney's fees and disbursements, as a result of a breach by the PBM of any of its obligations under the Agreement or arising out of the negligent act or omission or willful misconduct of the PBM or its employees or agents.

Yes/No.

4.6.5 The PBM acknowledges that it is compliant with the Electronic Data Interchange ("EDI"), Privacy and Security Rules of the Health Insurance Portability and Accountability Act ("HIPAA") and will execute the appropriate Business Associate Addendum ("BAA") as provided by the State. PBM also agrees that in the event of a privacy violation or data breach, that the PBM will notify the State and the impacted members of a breach and provide any required remedies.

Yes/No.

4.6.6 The PBM agrees that none of the functions to be performed hereunder shall be assigned by either party, absent advance notice to the other party, and written consent to said assignment, which consent shall not be unreasonably withheld. In the event either party does not consent to assignment by the other party, then this agreement shall terminate upon the effective date of said assignment.

Yes/No.

4.6.7 The PBM must agree that in the event of a dispute between the parties, about the payment or entitlement to receive payment, or any administrative fees hereunder, the PBM and the State shall endeavor to meet and negotiate a reasonable outcome of said dispute. In NO event shall PBM undertake unilateral offset against any monies due and owed the State, whether from manufacturer rebates, credit adjustment or otherwise.

Yes/No.

4.6.8 The PBM will respond to and incorporate future Health Care Reform changes in full compliance with the law and at no additional cost to the State.

Yes/No.

4.6.9 The PBM will agree to handle claims/appeals processing in accordance with the Patient Protection and Affordable Act (PPACA).

Yes/No.

4.6.10 The PBM will agree to be responsible for selecting and contracting with external review organizations sufficient to allow the State to comply with the PPACA.

Yes/No.

4.6.11 The PBM agrees to assume fiduciary relationship with the State plan in which the PBM formulary, network and administrative decisions are in the best financial interests of the State and or the interests of the health of participants.

4.7 Implementation

4.7.1 The PBM agrees to provide an Implementation Credit to the State on a Per Member basis.

Yes/No.

4.7.2 The PBM will agree to provide an allowance for a Pre-Implementation Audit to be conducted at least 60 days prior to the start of claims adjudication and a post implementation Audit to be conducted within the first 90 days of implementation. The PBM will work with the auditor to run test claims in a test environment utilizing the State's actual plan parameters.

Yes/No.

4.7.3 The PBM will provide draft language to the State for any clinical programs that are recommended as amendments to the State’s Summary Plan Documents.

Yes/No.

4.7.4 The PBM agrees to load all current prior authorizations, open mail order refills, specialty transfer files, claim history files, and accumulator files that exist for current members from the existing PBM at NO charge to the State (without deduction from the implementation allowance for file loading or IT).

Yes/No.

4.7.5 The PBM agrees to send at least 12 months of claims history data, all current prior authorizations, open mail order refills, specialty transfer files, and accumulator files that exist for the State participants to the next/successor PBM at NO charge if the State terminates the contract with or without cause.

Yes/No.

4.7.6 The PBM agrees to provide weekly and/or monthly data transmissions (may include feeds to data warehouses) to at least 10 chosen vendors at no charge and two full, annual electronic claims files, in NCPDP format, at no charge, as needed. PBM will also interact/exchange data with all vendors as needed at no additional charge.

Yes/No.

4.7.7 PBM agrees to waive any charges to the State or its medical plan claims administrators, such as a set-up fee or a programming fee, for establishing a connection with a Third Party Administrator/Claims processor for real-time, bidirectional data integration, including non-standard data integration formats.
Yes/No.

4.7.8 PBM agrees to absorb any programming or other administrative costs to meet any existing or future requirements of the Affordable Care Act.
Yes/No.

4.8 Reporting and Administration

4.8.1 The PBM agrees to provide a claims feed to each of the state's data warehouse vendors every two weeks.

4.8.2 The PBM agrees to provide the State with network pharmacy invoice details of all Rxs dispensed on behalf of the plan participants by retail pharmacies. Such details will be provided as an additional field or fields in the standard claims feed provided to the State.

4.8.3 The PBM commits to working with the State to provide prescription cost information, net of rebate, to prescribers along with patient copay impact, through their EHR or e-prescribing platforms. Please provide a high level description of a project plan and timeframe for implementing this requirement.

4.8.4 The PBM agrees to provide the State with net cost of all brand name prescription drugs that are eligible for rebate through manufacturer contracts and agreements with the PBM. The net cost should be provided as an additional field added to the standard claims feed.

4.8.5 The PBM agrees to quote rebates at the point of sale before member copays are adjudicated.

4.8.6 PBM agrees to work with Comptroller's Office to create a prescription savings card program that allows state residents to leverage the state employee plan pricing when filling prescriptions. The creation of any such program would be within the Comptroller's discretion.

4.8.7 PBM agrees to display the net cost of all prescription drugs (along with more cost-effective alternatives) to providers via eprescribing platforms and tools in order to facilitate more effective monitoring of total cost of care.

4.8.8 PBM agrees to advise State of class actions settlements concerning prescription drugs that are utilized by the Plan and will provide State with data to support submission of claims in connection with such settlements.

5 Formulary Management and Utilization Management

5.1 Provide the name of the Formulary you are proposing to the State. If applicable, provide the number of drug exclusions as well as a list of the excluded drugs and the therapeutic alternatives.
Unlimited.

5.2 Does the PBM use an external organization for rebate aggregation? If so, which one?
Unlimited.

5.3 Confirm a member is able to obtain an excluded prescription through a Prior Authorization without impact to the guaranteed rebates.
Unlimited.

5.4 The PBM agrees to grandfather the State's current formulary for up to 90 days following the contract effective date.
Yes/No.

5.5 List all Formulary Options you support. Include a basic description of the objective of each formulary and the potential plan savings over the broad national formulary.

a. The state has a tiered generic benefit design. Currently, the generic tiering is based upon a standard reference price of $50 across all therapeutic classes. The PBM will commit to creating a custom generic reference price by therapeutic class to incentivize members to use lower cost generic alternatives when price variation within the therapeutic class is greater than the generic copay differential.

b. The PBM will not apply the 90-day maintenance drug requirement to controlled substances or psychotropic drugs.

c. The PBM will describe its efforts to control waste, avoid unnecessary fills related to 90-day supply requirements and auto-refills.

d. What is the process the PBM uses for selecting drug placement on the proposed standard formulary? How does the PBM limit the inclusion of high cost/low value drugs on the proposed formulary, including high cost/low value drugs with significant rebate offerings?

e. How does the PBM monitor for potentially abusive practices including but not limited to: captive pharmacies, coupon schemes that direct members toward higher cost lower value prescriptions and other forms of fraud, waste and abuse?

f. Please describe your current and future plans for entering into alternative payment models with manufacturers including value based contracts, indication based contracts and outcome based contracts. The PBM will make such contracts available to the State of Connecticut, should the State choose to participate.

g. Confirm the PBM agrees to provide a Coverage Exception process in which a member may obtain a non-formulary drug or a non-preferred drug at a lower tier co-pay if medically necessary.

h. Confirm the PBM agrees to continue State’s existing appeal process pursuant to the SEBAC 2017 Agreement, which allows the State Comptroller, as the plan administrator, to override appeal decisions, including those presented to the Connecticut Department of Insurance based on denial of coverage due to

non-formulary status. (Note: this process is very rarely invoked but is required under the State's current labor agreement).

i. Describe any additional programs available that are not included in the proposal and the fees associated with those programs.

5.6 The state is aware of several third party vendors who offer products that review pharmacy claims data to determine opportunities for participants to lower their out of pocket costs and the costs to the plan by switching to lower cost therapeutically-equivalent alternatives, often times generic to generic changes. Do you currently have or are you developing similar programs that proactively identify lower cost therapeutically equivalent options for plan participants and pro-actively outreach to plan participants to inform them of cost saving opportunities for themselves and the plan? If yes, please quantify the savings opportunity of such a program for the state employee plan. If not, would you be willing to work with a third party vendor to institute such a program?
Unlimited.

5.7 The State employee health plan places a high priority on promoting the health of its members; the plan utilizes a value based insurance design that reduces member costs for preventive care. Investments in preventive care have helped improve health outcomes for plan members and reduce total costs. The State is looking for a PBM partner that utilizes a similar philosophy in making formulary decisions. It is expected that formulary decisions will prioritize the health outcomes of plan members and the total cost of care, including medical costs. Please describe the process used by your pharmacy and therapeutics committee to make formulary decisions. Does your formulary take into account efficacy and total cost of care, including medical? Please provide examples
Unlimited.

5.8 Do you offer any programs that help manage specialty drugs under the medical benefit? What clinical benefit and cost value benefit, if any do these programs provide, specifically blocking specialty drugs under the medical benefit and steering towards pharmacy benefit and site of care opportunities for these specialty drugs? Do you also provide utilization management programs under the medical benefit so that the utilization management offering is in line with the pharmacy benefit? What other programs do you offer in this arena?
Unlimited.

5.9 Will you agree to measure and report the medication adherence rates for the following conditions? What is your book of business average adherence levels for each of these areas? Will you put performance guarantees on adherence rates that meet or exceed national guidelines?

- Adherence for diabetes medications
- Adherence for hypertension (RAS antagonist)
- Adherence for cholesterol
- % of patients with diabetes between the ages of 40-75 that receive statin therapy (not adherence)

Unlimited.

6 Specialty Drug Management

6.1 PBM agrees to notify the State and its members at least 60 days prior to the addition of a drug to the specialty drug list and at least 90 days prior to a deletion of a drug from the specialty drug list.

Yes/No.

6.2 The State reserves the right to approve any addition to the specialty drug list.
Yes/No.

6.3 Describe your most effective Prior Authorization Programs for specialty drugs. Be specific as to any variations by therapy class.

6.4 Describe your most effective utilization management programs for specialty drugs. Be specific as to any variations by therapy class.

6.5 Describe your most common quantity limit rules currently applied to large plan sponsors.

6.6 What processes are in place to capture and return specialty Rx's that are not picked up by the participants? How do you monitor unfulfilled Rx's and return to stock credits back to the plan sponsor?

6.7 If you sub-contract specialty services to a third party, describe the services sub-contracted and the steps you take to monitor performance?

6.8 What is the average speed to answer calls to the specialty pharmacy per month in the last 4 completed quarters?

6.9 What is the average abandonment rate of calls to the specialty pharmacy per month in the last 4 completed quarters?

6.10 List all quality accreditations your specialty pharmacy has earned?

6.11 The PBM commits to acquisition based pricing for prescriptions filled through any mail order and specialty pharmacy, that is wholly owned by or affiliated with the responding PBM.

7 Member and Account Service

7.1 The PBM agrees to obtain the State's approval for all member communication materials before distribution to members. The PBM will not automatically enroll the State in any programs that involve any type of communications with members or alterations of members' medications, without express written consent from the State.
Yes/No.

7.2 The State reserves the right to review, edit, or customize any communication from the PBM to its membership.
Yes/No.

7.3 The PBM agrees that upon any formulary update it will provide proactive direct member communication to all members having recently filled a 90-day drug prescription that will experience a negative formulary change.
Yes/No.

7.4 The PBM agrees to document 100% of the State's member service calls through call recordings and call notes. PBM will forward written transcripts of calls at the State's request within two business days of the request being made.

Yes/No.

7.5 The PBM agrees to allow the State access to its member website with a dummy login prior to the go-live date.

Yes/No.

7.6 The PBM will provide the State with a virtual tour of its CSR system and any custom messaging system.

Yes/No.

7.7 The PBM agrees to, at minimum, quarterly calls to review member service issues. The PBM agrees to allow the State to review member service quality issues to the resolution endpoint.

Yes/No.

7.8 The PBM agrees to a minimum of one annual meeting with call center executives to discuss services regarding enrollment and member issues.

Yes/No.

7.9 The PBM agrees to provide online, real time, claim system access to the State or its designee, including access to historical claims data for up to three (3) years following termination of the agreement.

Yes/No.

7.10 The PBM agrees that all future edits required because of plan design changes implemented by the State shall be completed, after testing, by the PBM within 30 days of request/advisory by the State.

Yes/No.

7.11 What is the average speed to answer calls to the call center by a live agent per month in the last 4 completed quarters? What percentage of call were answered by a live agent within 30 seconds?

7.12 What is the average abandonment rate of calls to the call center per month in the last 4 completed quarters?

8 Operational Service Capabilities

8.1 Please provide the following information regarding your organization:

	CY 2018
Total Number of Covered Lives	*Integer.*
Total Number of Scripts Dispensed	*Integer.*

Total AWP Dollars Processed	*Integer.*
Total Number of Group Plan Sponsor Client Accounts with at least 100,000 Covered lives	*Integer.*
Most Recent Financial Solvency or Credit Ratings from Major Ratings Agency List Agency	*Integer.*
List All Key Owners and Subsidiaries of the Organization	*Unlimited.*

8.2 Please provide the following information regarding the **proposed call center**:

	CY 2018
Location	*Unlimited.*
Days of Operation	*Unlimited.*
Hours of Operation	*Unlimited.*
Percent of Calls Abandoned (on Average)	*Percent.*
Average Number of Seconds to Reach Representative	*Decimal.*

8.3 Please provide the following information regarding the **proposed mail order facility**:

	CY 2018
Location	*Unlimited.*
Days of Operation	*Unlimited.*

Hours of Operation	*Unlimited.*
Total Scripts Filled	*Integer.*
Utilization as Percent of Capacity	*Percent.*
Average Turnaround (No Intervention)	*Unlimited.*
Average Turnaround (Intervention Required)	*Unlimited.*

8.4 As a reminder, all bidders must complete and submit a formulary disruption analysis based on the claims data provided and your proposed formulary with drug exclusions. Results to be included are the number of members that will require a change as well as the number of prescriptions associated with the formulary change. An Excel file that lists the specific drugs that will be negatively impacted (excluded or higher-cost tier) along with the total number of scripts and members impacted for each of these drugs should also be provided. Please provide a summary of your formulary disruption analysis using the table below:

Type of Change	**Number of Members Impacted**	**% of Total Members**	**Number of Scripts Impacted**	**% of Total Scripts (including all brands and generics)**
No Change	*Unlimited.*	*Percent.*	*Integer.*	*Percent.*
Negative (lower tier to higher-cost tier)	*Unlimited.*	*Percent.*	*Integer.*	*Percent.*
Positive (higher-cost tier to lower tier)	*Unlimited.*	*Percent.*	*Integer.*	*Percent.*
Moving from covered to not covered/Excluded	*Unlimited.*	*Percent.*	*Integer.*	*Percent.*
Total		100.0%		100.0%

8.5 PBM agrees to provide designated/dedicated account resources including, but not limited to, an implementation manager, strategic account executive, clinical director - pharmacist, account manager, claims advocate and an underwriter/financial analyst. Please include biographies in attachments.

Yes/No.

8.6 Indicate if the following resources will be designated (have other clients) or dedicated (have no other clients other than the State).

	Response
Strategic Account Executive	*Single, Pull-down list.* 1: Dedicated, 2: Designated
Account Manager	*Single, Pull-down list.* 1: Dedicated, 2: Designated
Implementation Manager	*Single, Pull-down list.* 1: Dedicated, 2: Designated
Clinical Pharmacist	*Single, Pull-down list.* 1: Dedicated, 2: Designated
Financial Analyst	*Single, Pull-down list.* 1: Dedicated, 2: Designated
Call Center Service Representatives	*Single, Pull-down list.* 1: Dedicated, 2: Designated

8.7 Please provide the following information regarding the proposed account team:

	Years of PBM Experience	Number of Assigned Accounts	Location
Strategic Account Executive	*Unlimited.*	*Unlimited.*	*Unlimited.*
Account Manager	*Unlimited.*	*Unlimited.*	*Unlimited.*
Implementation Manager	*Unlimited.*	*Unlimited.*	*Unlimited.*
Clinical Pharmacists	*Unlimited.*	*Unlimited.*	*Unlimited.*

8.8 Please provide the PBM's Book-of-Business Turnover Rate for the following divisions:

	CY 2018
Overall Book-of-Business	*Percent.*
Call Center Representatives	*Percent.*
Strategic Account Executives	*Percent.*
Account Managers	*Percent.*
Client-Facing Clinical Pharmacists	*Percent.*

8.9 How do you track member complaints? List the top 5 member complaints related to your retail, mail order, and the specialty pharmacy program. What processes/ remedies have been put into effect to resolve these complaints?

Unlimited.

8.10 Do you maintain statistics with respect to customer and member service telephone response time? Inquiries made? If so, provide results for the last calendar year.

Unlimited.

8.11 How are disabled (e.g., hearing-impaired) member calls facilitated through your member services area?

Unlimited.

9 Financial Section

Bidders are required to complete all financial forms as instructed. Bidders should provide proposed fees and minimum guarantees separately for each year of the three-year contract, so that the State's pricing terms keep pace with expected market trends. Transparency in Pricing Contracts are preferred by the State. Bidders are instructed to quote one traditional pricing arrangement and the alternative pricing format.

We ask all bidders to provide

A) RETAIL PASS THROUGH PRICING WITH 100% PASS THROUGH OF ALL FORMULARY REBATES). Note: PBM must guarantee that it will provide the state with the lowest MAC pricing it has with each network pharmacy for each pharmaceutical drug dispensed.

B) ALTERNATIVE PRICING FORMAT (FAILURE TO OFFER ALTERNATIVE PRICING OPTIONS MAY RESULT IN REJECTION OF BIDS)

A) Verify Retail Pricing Offer is based on Full Retail Passthrough: _____

Administrative fees and dispensing fees are requested on a per-prescription paid basis. Note that fees must be based on prescriptions dispensed (not adjustments, errors, or redo's) and include, but not be limited to, the following services:

- Claims Adjudication
- Ability to Integrate PBM services with Current Vendors, as applicable
- Providing ID cards (initial, duplicate, additional and replacement cards), pharmacy directories, and formulary lists
- Standard systems edit (must include “refill-too-soon” edit)
- Network Pharmacy Management
- Formulary Management and Rebate Sharing
- Eligibility Verification and Maintenance
- Customer Service, including dedicated Toll-free Telephone and Website with Membership Portal
- Patient and Provider education
- Complete Availability of IT services, including Online/Real Time Availability to the State and/or its designee(s)
- Ad-hoc reporting
- Systematic Prospective, Concurrent, and Retrospective Drug Utilization Review
- Data Reporting & Data File Requests
- Mail Service Pharmacy
- Specialty Pharmacy Program
- Customer Services
- Clinical Programs

All services covered under the Basic administrative fees should be listed. However, some services may be offered as optional or ancillary and be covered by separate add-on fees. For example, separate fees for providing PAs, EOBs, COB, integration for the consumer driven health (“CDH”) plans, appeals and subrogation or for providing duplicate ID cards can be offered and/or excluded from the base fees. These fees should be listed separately as an option.

All fees must be binding until the assumed implementation date specified in this proposal and must be guaranteed for a minimum of the initial July 1, 2019 to June 30, 2022 contract period.

9.1 Administrative Fees

9.1.1 Complete the following Administrative Fee Table:

Broad Retail Network/100% Rebate Pass through	7/1/2019-6/30/2020	7/1/2020-6/30/2021	7/1/2021-6/30/2022
Indicate which of these services are included for no additional cost:			
Toll Free Phone Lines	*Yes/No.*	*Yes/No.*	*Yes/No.*
Monthly Data Feeds to the State or Designee(s)	*Yes/No.*	*Yes/No.*	*Yes/No.*

Prospective /Concurrent/Retro DUR	*Yes/No.*	*Yes/No.*	*Yes/No.*
Standard Reports	*Yes/No.*	*Yes/No.*	*Yes/No.*
Ad Hoc Reports	*Yes/No.*	*Yes/No.*	*Yes/No.*
COB Program	*Yes/No.*	*Yes/No.*	*Yes/No.*
Mandatory Mail Program	*Yes/No.*	*Yes/No.*	*Yes/No.*
Dose Optimization Program	*Yes/No.*	*Yes/No.*	*Yes/No.*
Prior Authorization Program	*Yes/No.*	*Yes/No.*	*Yes/No.*
Step Therapy Program	*Yes/No.*	*Yes/No.*	*Yes/No.*
Quantity Limitations	*Yes/No.*	*Yes/No.*	*Yes/No.*
Custom System Overrides	*Yes/No.*	*Yes/No.*	*Yes/No.*
Annual EOB Statements	*Yes/No.*	*Yes/No.*	*Yes/No.*
Retro Termination Letters	*Yes/No.*	*Yes/No.*	*Yes/No.*
Group Coding	*Yes/No.*	*Yes/No.*	*Yes/No.*
Drug Notification Letters	*Yes/No.*	*Yes/No.*	*Yes/No.*
Formulary Administration/Management	*Yes/No.*	*Yes/No.*	*Yes/No.*
ID Cards	*Yes/No.*	*Yes/No.*	*Yes/No.*
Pharmacy Directories and other member materials	*Yes/No.*	*Yes/No.*	*Yes/No.*
Standard 1st level appeals processing	*Yes/No.*	*Yes/No.*	*Yes/No.*
Standard 2nd level appeals processing	*Yes/No.*	*Yes/No.*	*Yes/No.*
Urgent appeals processing	*Yes/No.*	*Yes/No.*	*Yes/No.*
Overrides	*Yes/No.*	*Yes/No.*	*Yes/No.*
Audit Recovery Fees	*Yes/No.*	*Yes/No.*	*Yes/No.*
Compound Drug Management	*Yes/No.*	*Yes/No.*	*Yes/No.*
Services above that have additional costs (i.e., services marked "N" above) (show fees separately):	*Unlimited.*	*Unlimited.*	*Unlimited.*
·	*Unlimited.*	*Unlimited.*	*Unlimited.*
·	*Unlimited.*	*Unlimited.*	*Unlimited.*
·	*Unlimited.*	*Unlimited.*	*Unlimited.*

9.1.2 Detail all services and supplies to be provided under your basic fees that are not included in your response to question one.

Unlimited.

9.1.3 Confirm there are no additional fees to coordinate the deductible and the maximum out of pocket with the medical carrier.

Unlimited.

9.1.4 Describe the PBM's clinical programs that are available to the State. Please note that that all pricing submitted must **NOT** be contingent on participation in any of these optional clinical programs.

Unlimited.

9.1.5 Will there be any additional charges if plans/benefits are restructured or new classes of eligible members are added? If so, how are these charges determined and state amount of charges?

1: Yes, please explain: [Unlimited],
2: No

9.1.6 Confirm that postage is included in all mail order prescriptions and any mailings.

Unlimited.

9.1.7 Confirm that quoted fees include postage paid mail order envelopes for member prescription submission.

Unlimited.

9.1.8 Confirm that mail order and specialty drug dispensing fees will remain constant throughout the contract term and will not be increased for any increases in postage charges.

Unlimited.

9.1.9 Detail all data-related services included under the base administrative fees, including ad hoc reporting, electronic claims files, plan design options, custom mailings, etc. In addition, detail any data-related service fees not included in the base administrative fees.

Unlimited.

9.1.10 Confirm that multi-language communication phone line support is included in the base administrative fee. List the languages available to the State members speaking to your customer service representatives.

Unlimited.

9.2 Prescription Drug Pricing

AWP Reimbursement Basis - Complete the following tables using the drug reimbursement that your organization is willing to guarantee on a dollar-for-dollar basis for each year of the contract. Columns marked "AWP Discount" are to be completed using a discount from 100% AWP and dispensing fee logic. All guarantees must be based on the AWP unit cost dispensed at the point of sale, and post September 26, 2009 AWP rollback. Note: Quotes should be RETAIL PASS THROUGH PRICING WITH 100% PASS THROUGH OF ALL FORMULARY REBATES

Verify the pricing is for a Full Pass through Retail contract? _____Yes/No_____

Bids must be 100% Rebate Pass-through quotes

Maintenance Drug Supply pricing should be uniform for both retail maintenance choice and mail order scripts.

Brand Discounts must include both single source and multi-source brands

Both non-MAC, MAC, single-source and multiple source generic products are to be included in the generic guarantee measurement

9.2.1 **Year 1 (7/01/2019 – 6/30/2020)**

Broadest Retail Network (List any Major Retail Chains Excluded)	AWP Discount Retail Supply Up to 59 days	AWP Discount Retail Maintenance Supply Over 59 days	AWP Discount Mail Supply 1-90 days
Brand Drugs[1]			
Discount from AWP[2] for all brands	*Percent.*	*Percent.*	*Percent.*
Dispensing Fee Per Rx	*Dollars.*	*Dollars.*	*Dollars.*
Generic Drugs[3]			
Discount from AWP[2] for all generics (composite single source and multisource generic discount of MAC and Non-MAC prices, discounted AWP, or usual and customary retail price)	*Percent.*	*Percent.*	*Percent.*
Dispensing Fee Per Rx	*Dollars.*	*Dollars.*	*Dollars.*
Rebates			
Three Tier Plans (Plan A, Plan C1, Plan C2 & Plan C3) – Per Brand Rx	*Dollars.*	*Dollars.*	*Dollars.*
CDH Plans (Plan C4) – Per Brand Rx	*Dollars.*	*Dollars.*	*Dollars.*

1. Including both single source and multi-source brands.
2. Post September 26, 2009 AWP rollback
3. Including single-source generics.

9.2.2 **Year 2 (7/01/2020 – 6/30/2021)**

Broadest Retail Network (List any Major Retail Chains Excluded)	AWP Discount Retail Supply Up to 59 days	AWP Discount Retail Maintenance Supply Over 59 days	AWP Discount Mail Supply 1-90 days
Brand Drugs[1]			
Discount from AWP[2] for all brands	*Percent.*	*Percent.*	*Percent.*
Dispensing Fee Per Rx	*Dollars.*	*Dollars.*	*Dollars.*
Generic Drugs[3]			
Discount from AWP[2] for all generics (composite discount of MAC and Non-MAC prices, discounted AWP, or usual and customary retail price)	*Percent.*	*Percent.*	*Percent.*
Dispensing Fee Per Rx	*Dollars.*	*Dollars.*	*Dollars.*
Rebates			
Three Tier Plans (Plan A, Plan C1, Plan C2 & Plan C3) – Per Brand Rx	*Dollars.*	*Dollars.*	*Dollars.*
CDH Plans (Plan C4) – Per Brand Rx	*Dollars.*	*Dollars.*	*Dollars.*

Notes:

1. Including both single source and multi-source brands.
2. Post September 26, 2009 AWP rollback
3. Including single-source generics.

9.3 **Year 3 (7/01/2021 – 6/30/2022)**

Broadest Retail Network (List any Major Retail Chains Excluded)	AWP Discount Retail Supply Up to 59 days	AWP Discount Retail Maintenance Supply Over 59 days	AWP Discount Mail Supply 1-90 days
Brand Drugs[1]			
Discount from AWP[2] for all brands	*Percent.*	*Percent.*	*Percent.*
Dispensing Fee Per Rx	*Dollars.*	*Dollars.*	*Dollars.*
Generic Drugs[3]			
Discount from AWP[2] for all generics (composite discount of MAC and Non-MAC prices, discounted AWP, or usual and customary retail price)	*Percent.*	*Percent.*	*Percent.*
Dispensing Fee Per Rx	*Dollars.*	*Dollars.*	*Dollars.*
Rebates			
Three Tier Plans (Plan A, Plan C1, Plan C2 & Plan C3) – Per Brand Rx	*Dollars.*	*Dollars.*	*Dollars.*
CDH Plans (Plan C4) – Per Brand Rx	*Dollars.*	*Dollars.*	*Dollars.*

Notes:

1. Including both single source and multi-source brands.
2. Post September 26, 2009 AWP rollback
3. Including single-source generics.

9.4 Confirm the pricing listed in the tables above reflects:

Assumptions	Response
All guarantees are calculated using the date-sensitive AWP based on the 11-digit NDC of the actual product dispensed	*Yes/No.*
All-in generic guarantee is inclusive of single-source generics	*Yes/No.*
Drugs with an "Insufficient Supply" are included in the guarantees	*Yes/No.*
Select, sole source or authorized generics from at least one FDA-approved generic manufacturer with exclusivity, limited supply, limited availability, or limited competition will be included in the generic pricing guarantees and excluded from the brand pricing guarantees.	*Yes/No.*
No single-source generic or generic drug will be included in the brand drug component for the annual discount guarantee reconciliation.	*Yes/No.*
Member Cost Share at the point-of-sale (for retail and mail) is based on the lowest of the plan copay/coinsurance, usual and customary charges, negotiated discounted ingredient cost plus dispensing fee, or retail cash price	*Yes/No.*
All guarantees are calculated before the application of member cost share	*Yes/No.*
All guarantees (including Rebates) are stand-alone with no offsetting (within or across channels)	*Yes/No.*
Any guarantee shortfalls are paid on a dollar-for-dollar basis	*Yes/No.*

9.4.1 Please confirm your proposed drug type designation or classification (e.g. brand, generic) source will be Medi-Span.

Yes/No.

9.4.2 Do you agree to apply rebates at the point of sale as separate credit/discount by drug and report drug specific rebates in monthly claims file provided to the State with annual guarantee reconciliations?

Yes/No

9.4.3 PBM agrees that changes in the number of manufacturers of a Generic Drug as a result of a merger and/or acquisition activity will not permit the PBM to reclassify a Generic Drug as a Brand Drug or to modify pricing guarantees. PBM agrees that the following will not trigger a change in brand/generic classifications: manufacturer mergers and acquisitions, manufacturers manufacturing or marketing both brand and generic products, raw material shortages, dramatic price changes, and repackaged products.

Yes/No

9.5 ALTERNATIVE PRICING QUOTES (9.5 Pricing Quotes MUST BE BASED ON YOUR NATIONAL PREFERRED FORMULARY WITH STANDARD DRUG EXCLUSIONS)

9.5.1 Guarantees by Therapy Class

Complete the table below for the first fiscal year of the contract. PBMs will be required to set annual PMPY dollar limits in each renewal year of the initial term (guaranteed renewal).

Therapy Class (By GPI-4 code)	Maximum Allowed Charges patient/Yr 1 (a)	Minimum Rebate Per Patient/Yr 1 (b)	Average Dispensing fees Patient/Year 1 (c)	Maximum Net Charge/Patient (before copays) (a-b+c)	PBM Agrees to Reimburse 100% of Excess (yes/no)
6627 (e.g. Anti-TNF)					
2710 (insulin)					

NOTES:

- Therapy Class shall use the Generic Product Identifier (GPI-4) –therapy level
- Provide quotes for no less than the top 50 GPI-4 classes (by dollar volume).
- New to market drugs may be excluded for 6 months. Members can appeal for medical necessity
- All Underwriting Limits must be disclosed
- Clinical PAs/Step Therapy Rules must be disclosed
- Quantity Limits must match current plan quantity limit rules
- Maximum Allowed Charges must reflect discounts, drug mix, generic dispensing rates, etc.
- PBM shall provide all Rx adjudication rates including rebates earned by therapy class
- PBM agrees to reimburse the State 100% of excess cost per patient on annual basis
- PBM will be required to provide year 2 and year 3 price caps to underwriting each year

9.5.2 **Guaranteed Generic MAC Pricing by GPI-14**

Maximum Price Per Unit by GPI-14(before copays)	Max Unit Cost Retail Generic Drugs Dispensed Year 1	Max Unit Cost Mail Service Generic Drugs Dispensed Year 1
GPI 1		
GPI 2		

NOTES:

- All GPIs should be quoted using the GPI14 (drug and dosage specific)
- The **Generic Product Identifier** (**GPI**) is a 14-character hierarchical classification system that identifies drugs from their primary therapeutic use down to the unique interchangeable product regardless of

manufacturer or package size. The code consists of seven subsets, each providing increasingly more specific information about a drug available with a prescription in the United States.

- New to market generic drugs may be excluded for 6 months
- MAC pricing changes must be limited to once per month for individual products
- All Underwriting Limits must be disclosed
- PBM agrees to reimburse the State of 100% of excess cost above guaranteed MAC unit
- PBM will be required to provide year 2 and year 3 price caps to underwriting each year

9.6 Allowances

9.6 Please complete the following table:

Allowance	Description	Response
Implementation	Place the $ (dollar) Per Member amount or the flat dollar ($) amount you are offering the State.	*Unlimited.*
Pre-Implementation Audit	Place the flat dollar ($) amount you are offering the State to be used to conduct a pre-implementation audit	*Unlimited.*
Post-Implementation Audit	Place the flat dollar ($) amount you are offering the State to be used to conduct a post-implementation audit within the first 90 days of the contract	
Audit	Place the dollar ($) Per Member amount or the flat dollar ($) amount you are offering the State to be used annually to verify the State is receiving discounted costs and major services as contracted as well as 100% of rebates.	*Unlimited.*
General Pharmacy Program Management	Place the $ (dollar) Per Member amount or the flat dollar ($) amount you are offering the Plan for general expenses related to the management of the pharmacy benefits program such as pharmacy claim and rebate audits, communication expenses, clinical programs, consulting fees, or to be used as a credit against claim invoices.	*Unlimited.*

9.7 Generic Drugs - Dispensing Rate Guarantees

9.7.1 Complete the table below for contract Years 1, 2, and 3. Note that generic dispensing rate includes only true instances of generic dispensing (i.e., exclude multi-source brand drugs dispensed under member-pay-difference plan designs).

Guaranteed GDR	**Retail ≤ 59 days**	**Retail Maintenance Supply Over 59 days**	**Mail Order**

Year 1	*Percent.*	*Percent.*	*Percent.*
Year 2	*Percent.*	*Percent.*	*Percent.*
Year 3	*Percent.*	*Percent.*	*Percent.*

9.7.2 What dollar amount are you prepared to put at risk for failure to meet your GDR guarantee?
Unlimited.

9.7.3 Confirm the PBM's Generic Dispensing Rate Guarantee will be measured and reconciled on a stand-alone basis and a shortfall in one delivery channel will not be used to offset a shortfall in another delivery channel or any other financial component guarantee.
Unlimited.

9.8 Specialty Pharmacy Program Pricing

The State will accept stand-alone specialty pharmacy proposals.

9.8.1 Please provide your organization's definition and qualification criteria of a “specialty drug product.”
Unlimited.

9.8.2 Provide an AWP-based pricing adjudication rate list of all specialty pharmaceuticals that your company dispenses and distributes to providers and patients. Your pricing must include adequate supplies of ancillaries such as needles, swabs, syringes, and containers. The following items must be included in your list:
a. Product Name
b. Therapeutic Group/Therapeutic Category
c. Guaranteed Minimum AWP Discount for all specialty pharmacy program prescriptions for the Exclusive specialty arrangement.
d. LDD indicator
e. GPI
Unlimited.

9.8.3 Complete the following table under the proposed Non Exclusive specialty arrangement:

Specialty Drugs Dispensed at Participating Retail Pharmacies under the Non Exclusive Specialty Arrangement	**7/01/2019 – 6/30/2020**	**7/01/2020 – 6/30/2021**	**7/01/2021 – 6/30/2022**
Overall Effective Discount (OED) Guarantee	*Percent.*	*Percent.*	*Percent.*
Confirm New to Market Specialty Drugs and New to Market Limited Distribution Specialty Drugs will be included in the above OED guarantee	*Unlimited.*	*Unlimited.*	*Unlimited.*
Dispensing Fee	Prefix: "" Suffix: "per Rx" *Dollars.*	Prefix: "" Suffix: "per Rx" *Dollars.*	Prefix: "" Suffix: "per Rx" *Dollars.*
Administrative Fee	Prefix: "" Suffix: "per Rx"	Prefix: "" Suffix: "per Rx"	Prefix: "" Suffix: "per Rx"

	Dollars.	*Dollars.*	*Dollars.*
Minimum Rebate Guarantee	Prefix: "" Suffix: "per Rx" *Dollars.*	Prefix: "" Suffix: "per Rx" *Dollars.*	Prefix: "" Suffix: "per Rx" *Dollars.*

9.8.4 Complete the following table for your proposed specialty pharmacy (quote both exclusive and non-exclusive arrangements):

Specialty Drugs Dispensed at the PBM's Specialty Pharmacy Under the Non Exclusive Arrangement	**7/01/2019 – 6/30/2020**	**7/01/2020 – 6/30/2021**	**7/01/2021 – 6/30/2022**
Overall Effective Discount (OED) Guarantee	*Percent.*	*Percent.*	*Percent.*
New to Market Specialty Discount Guarantee	*Percent.*	*Percent.*	*Percent.*
New to Market Limited Distribution Specialty Discount Guarantee	*Percent.*	*Percent.*	*Percent.*
Dispensing Fee	Prefix: "" Suffix: "per Rx" *Dollars.*	Prefix: "" Suffix: "per Rx" *Dollars.*	Prefix: "" Suffix: "per Rx" *Dollars.*
Administrative Fee	Prefix: "" Suffix: "per Rx" *Dollars.*	Prefix: "" Suffix: "per Rx" *Dollars.*	Prefix: "" Suffix: "per Rx" *Dollars.*
Minimum Rebate Guarantee	Prefix: "" Suffix: "per Rx" *Dollars.*	Prefix: "" Suffix: "per Rx" *Dollars.*	Prefix: "" Suffix: "per Rx" *Dollars.*

9.8.5 Please confirm the proposed "Minimum Rebate Guarantee" for Specialty Drugs is based on a "per specialty drug" basis and not on a "per specialty brand" basis.

Unlimited.

9.8.6 Will you provide specialty rebate guarantees **by therapy class as a minimum percentage of gross allowed cost dispensed within that therapy class?**

Unlimited.

9.8.7 Do you agree to apply specialty rebates at the point of sale as separate credit/discount by drug and report drug specific rebates in monthly claims file provided to the State with annual guarantee reconciliations?

Yes/No

9.8.8 Confirm that your proposed guarantees for your retail/mail quotes are not contingent upon the State's purchase of your specialty drug program?

Unlimited.

9.8.9 If you are only bidding the specialty drug fulfillment contract, explain how you will coordinate with the PBM administrator on member, billing; clinical and claim issues?

Unlimited

9.8.10 Confirm that discount guarantees include limited distribution drugs

Unlimited

9.9 Price Inflation Guarantees

9.9.1 Do you agree to offer average annual price per Rx price inflation guarantees by channel, adjusted for day supply for all drugs that have been available in the market for at least 12 months? Provide separately for each year of the initial contract term.

Average Discounted Cost Per Rx	Target Annual Max Trend Rate (%)	Excess above Trend Rate Reimbursed
Retail Brand		
Retail Generic		
Retail/Mail Brand 90 day		
Retail/Mail Generic 90 day		
Specialty		

9.9.2 In regard to the previous question, what underwriting restrictions would you require to accept at least 50% of the risk above the target rate?

Unlimited

10 Performance Guarantees

The State will require specific performance guarantees. All guarantees shall be set and measured quarterly (with a few exceptions) and must be measured on a State-specific basis. Measurement of performance guarantees may be based on internal self-reporting, subject to independent audit.

10.1 Confirm the PBM will pay any amount owed to the State and/or its members if the PBM fails to properly administer claims.

Unlimited.

10.2 The State is looking for a flat dollar ($) performance guarantee amount and the ability to select the weighting for each metric. In addition, the PBM may provide other guarantees designed to differentiate the PBM's program.

	Standard	**Measurement Criteria (BOB or Client specific)**	**Penalty Dollars at Risk**	**Timing of Payments**
Implementation	Indicate the Total Implementation Performance Guarantees Amount you are proposing to the State.	N/A	*Dollars.*	*Unlimited.*
Ongoing	Indicate the Total Ongoing Annual Performance Guarantees Amount you are proposing to the State.	N/A	*Dollars.*	*Unlimited.*
Ongoing Allocation	Confirm the State may determine the weighting (e.g., 0% to 30%) for the total amount of Performance Guarantees below prior to the start of each Contractual Year.	*Unlimited.*		
Implementation Performance Guarantees				
Clean Implementation	No systems errors, ID card delays, and the State's online access to all tools prior to effective date	*Unlimited.*	*Unlimited.*	*Unlimited.*
Implementation Timeline	Implementation team will be assigned and introduced to the State at least 3 months in advance of effective date	*Unlimited.*	*Unlimited.*	*Unlimited.*

Implementation Team	Implementation team members will not change and will be responsible for the accurate installation of all administrative, clinical and financial parameters for the State's program	*Unlimited.*	*Unlimited.*	*Unlimited.*
Implementation Satisfaction Scorecard	Assigned Account Executive will work with the State prior to the start of implementation to agree on terms of a satisfaction scorecard to be issued to the State after effective date for completion	*Unlimited.*	*Unlimited.*	*Unlimited.*
Ongoing Performance Guarantees				
Payment Accuracy & System Performance				
Protected Health Information	PBM guarantees no incidents in violation of HIPAA Security Rules which results in a transmission of electronic PHI of the State's covered members. This is measured and reported on a quarterly basis and on a State-specific basis.	*Unlimited.*	*Unlimited.*	*Unlimited.*
Plan Administration Accuracy	Implementation of all plan design changes will be 100% accurate. This is measured and reported on a quarterly basis and on a State-specific basis.	*Unlimited.*	*Unlimited.*	*Unlimited.*
Pricing Change Accuracy	Implementation of all pricing changes will be 100% accurate. This is measured and reported on a quarterly basis and on a State-specific basis.	*Unlimited.*	*Unlimited.*	*Unlimited.*
Financial accuracy (electronic and paper claims)	Percentage of claim payments made without error relative to the total dollars paid will be at least 99%. This is measured and reported on a quarterly	*Unlimited.*	*Unlimited.*	*Unlimited.*

	basis and on a State-specific basis.			
Mail Service Non-Financial Accuracy	The mail service pharmacy shall guarantee dispensing accuracy of at least 99.996% (correct participant name, correct participant address, correct drug, correct dosage form, and correct strength). This is measured and reported on a quarterly basis and on a State-specific basis.	*Unlimited.*	*Unlimited.*	*Unlimited.*
System Downtime	At least 99.5% access to its systems by all the retail pharmacies in PBM's network 24 hours a day, 7 days a week, 365 days a year. This is measured and reported on a quarterly basis and on a State-specific basis.	*Unlimited.*	*Unlimited.*	*Unlimited.*
Invoicing Errors	All invoicing errors will be credits back to the State by next billing cycle or PBM will pay interest. This is measured and reported on a quarterly basis and on a State-specific basis.	*Unlimited.*	*Unlimited.*	*Unlimited.*
Claims Eligibility Data	Eligibility loads not to exceed 24-hours after receipt. This is measured and reported on a quarterly basis and on a State-specific basis.	*Unlimited.*	*Unlimited.*	*Unlimited.*
Eligibility Data Error Reporting	Eligibility file error reporting on all eligibility file updates will be provided to the State within 2 business days. This is measured and reported on a quarterly basis and on a State-specific basis.	*Unlimited.*	*Unlimited.*	*Unlimited.*
Eligibility Error Rate Audits	Error rate identified through quarterly audits shall not exceed, on an average basis, 2%. This is measured and reported on a quarterly basis and on a State-specific basis.	*Unlimited.*	*Unlimited.*	*Unlimited.*
Retail Pharmacy	100% of participating retail pharmacies	*Unlimited.*	*Unlimited.*	*Unlimited.*

Audit	will be subject to automated review audits and 20% of participating pharmacies will be subject to further investigation (e.g., desk audits, on-site audits, etc.) as a result of the automated review audits. This is measured and reported on a quarterly basis and on a State-specific basis.			
Retail Pharmacy Turnover	Less than 5% of retail pharmacies will leave the retail network. This is measured and reported on a quarterly basis and on a State-specific basis.	*Unlimited.*	*Unlimited.*	*Unlimited.*
Claims Detail File	All claims detail files sent to external vendors will be provided within 8 days of request or scheduled delivery date. This is measured and reported on a quarterly basis and on a State-specific basis.	*Unlimited.*	*Unlimited.*	*Unlimited.*
Account Management				
Contracting Cooperation	Response to recommended contract language changes within 10 business days. This is measured and reported on a quarterly basis.	*Unlimited.*	*Unlimited.*	*Unlimited.*
Client Approval of Member Communications	100% of all member communications will be approved by the State - exceptions for drug recalls and urgent patient safety communications.	*Unlimited.*	*Unlimited.*	*Unlimited.*
Online Reporting Data Availability	Online reporting data will be available within an annual average of fifteen (15) business days after the billing cycle that contains the last day of the month. This is measured and reported on annual basis and on a State-specific basis.	*Unlimited.*	*Unlimited.*	*Unlimited.*
Delivery of Standard Reports	Within 30 days of end of reporting quarter.	*Unlimited.*	*Unlimited.*	*Unlimited.*

Accuracy of Standard Reports	All standard reports provided will be 100% accurate. This is measured and reported on a quarterly basis and on a State-specific basis.	*Unlimited.*	*Unlimited.*	*Unlimited.*
Pharmacy Audit Resolution	48 hours after receipt of findings. This is measured and reported on a quarterly basis and on a State-specific basis.	*Unlimited.*	*Unlimited.*	*Unlimited.*
PBM Account Team's Performance	The PBM account team's performance for each Contract Year will receive an average of 3 or better on a scale of 1 to 5 (5 being the best based on a range of performance criteria agreed to between the State and the PBM at the beginning of such Contract Year) from the State's benefits staff. This is measured and reported on an annual basis and on a State-specific basis.	*Unlimited.*	*Unlimited.*	*Unlimited.*
Account Management Turnover	Account team members will remain constant for at least the first 18 months of the contract period, unless a change in account management staff is requested by the State. This is measured and reported on a quarterly basis and on a State-specific basis.	*Unlimited.*	*Unlimited.*	*Unlimited.*
Issue Resolution: The State Staff Involvement / Escalation	PBM will resolve member issues within 48 business hours for any case that required the involvement of the State's staff due to incorrect or incomplete information being provided by the PBM. If not resolved within 48 hours, a penalty will be applied per case, up to an annual maximum. This is measured and reported on a quarterly basis and on a State-specific basis.	*Unlimited.*	*Unlimited.*	*Unlimited.*
Member Services				

Mail Turnaround – Prescriptions not requiring intervention	95% of prescriptions dispensed within average of 2 business days and 100% within average of 3 business days. This is measured and reported on a quarterly basis and on a State-specific basis.	*Unlimited.*	*Unlimited.*	*Unlimited.*
Mail Turnaround – Prescriptions requiring intervention	95% of prescriptions dispensed within average of 4 business days and 100% within average of 5 business days. This is measured and reported on a quarterly basis and on a State-specific basis.	*Unlimited.*	*Unlimited.*	*Unlimited.*
Paper Claims Turnaround	95% of prescriptions reimbursed within average of 10 business days and 100% within average of 14 business days. This is measured and reported on a quarterly basis and on a State-specific basis.	*Unlimited.*	*Unlimited.*	*Unlimited.*
ID Cards Mailing	98% of all ID cards are sent within 5 business days of receipt of eligibility. 100% mailed within 10 business days. This is measured and reported on a quarterly basis and on a State-specific basis.	*Unlimited.*	*Unlimited.*	*Unlimited.*
Replacement ID Card Mailing	Standard replacement ID cards will be produced within an annual average of five (5) business days of the request. This is measured and reported on a quarterly basis and on a State-specific basis.	*Unlimited.*	*Unlimited.*	*Unlimited.*
Mailing Member Materials	All applicable member materials (for example, mail order forms) will be mailed at least 10 days prior to the effective date and will be 100% accurate (provided that eligibility file was received at least 30 days prior to the effective date). This is measured and reported on a quarterly basis and on a State-specific basis.	*Unlimited.*	*Unlimited.*	*Unlimited.*

Phone Average Speed of Answer	100% of calls to the State-specific toll free line shall be answered within 20 seconds (excluding IVR). This is measured and reported on a quarterly basis and on a State-specific basis.	*Unlimited.*	*Unlimited.*	*Unlimited.*
Phone Abandonment Rate	All calls to the State-specific toll free line shall be answered with an abandonment rate of 3% or less. This is measured and reported on a quarterly basis and on a State-specific basis.	*Unlimited.*	*Unlimited.*	*Unlimited.*
Written Inquiry Answer Time	95% of inquiries responded to in 5 business days - 100% in 20 business days. This is measured and reported on a quarterly basis and on a State-specific basis.	*Unlimited.*	*Unlimited.*	*Unlimited.*
Member Satisfaction Survey	The PBM agrees to conduct a Member Satisfaction Survey for each contract year and that the Satisfaction Rate will be 90% or greater. A penalty of **$100,000** per Contract Year may be assessed against the PBM for failure to meet this standard. "Member Satisfaction Rate" means (i) the number of Eligible Persons responding to PBM annual standard Patient Satisfaction Survey as being satisfied with the overall performance under the Integrated Program divided by (ii) the number of Eligible Persons responding to such annual Patient Satisfaction Survey; the State must provide timely approvals and responses, and a minimum of 20% of surveys must be returned for the Performance standard to be applicable. This is measured and reported on a quarterly basis and on a State-specific basis.	*Unlimited.*	*Unlimited.*	*Unlimited.*
Issue Resolution: Verbal Inquiries	PBM will resolve 99% of all telephone issues at the first point of contact (the number of telephone inquiries completely resolved at the time of initial contact divided by the total number of	*Unlimited.*	*Unlimited.*	*Unlimited.*

	calls). This is measured and reported on a quarterly basis and on a State-specific basis.			
Issue Resolution: Written Inquiries	PBM will resolve 98% of all written inquiries (including those received via email, text message or the PBM's App) within 10 business days of receipt of inquiry. This is measured and reported on a quarterly basis and on a State-specific basis.	*Unlimited.*	*Unlimited.*	*Unlimited.*
Other (describe)	*Unlimited.* Nothing required	*Unlimited.* Nothing required	*Unlimited.* Nothing required	*Unlimited.* Nothing required
Other (describe)	*Unlimited.* Nothing required	*Unlimited.* Nothing required	*Unlimited.* Nothing required	*Unlimited.* Nothing required
Other (describe)	*Unlimited.* Nothing required	*Unlimited.* Nothing required	*Unlimited.* Nothing required	*Unlimited.* Nothing required
Other (describe)	*Unlimited.* Nothing required	*Unlimited.* Nothing required	*Unlimited.* Nothing required	*Unlimited.* Nothing required

Reference Documents

All reference documentation is located on the Manage Documents page. A link has been provided in the left-hand side menu.

[iii]