1. Please provide NPI for all your specialty pharmacy members.

   In the claims file.

2. In section 1.1 the total opportunity is outlined as 188K covered lives, $340M and 1.7M prescriptions. Please supply the same information for the stand alone specialty pharmacy including claims data by NDC

   Specialty claims are included in the RFP file. Segal does not include Specialty indicators in the RFP file specification. The bidder should compare the NDCs in the RFP file with their Specialty list for underwriting purposes.

3. Bidder would like to request a specialty medication prescription file pertaining to patients of its affiliated providers. If possible to manipulate available data, the following elements would be most helpful to our analysis: • Fill Date • Drug ID (NDC) • Product Drug Name • Facility Location • Provider Name • Provider NPI • Patient Name • Patient DOB • Quantity Dispensed • Total Rx (fills) • Total Days Supply • Total Gross Cost • Member Rx Cost • Total Net Cost • Any other patient identifier (patient demo. is to remove duplicate scripts seen in e-Rx data)

   Segal provides the following fields in the RFP file:

   - Segal Record ID (internal ID field)
   - Plan/Group Hierarchy Field 1 (These fields are to supply a Carrier/Account/Group or other hierarchical plan structure)
   - Plan/Group Hierarchy Field 2
   - Plan/Group Hierarchy Field 3
   - Blinded Member ID (The blinded Member ID data on the claims file received)
   - Relationship Code
   - Person Code
   - Pharmacy NCPDP/NPI Number
   - Fill Date
   - Fill Number or Refills Authorized
   - Days Supply
   - Metric Quantity
   - Formulary Status
   - Mail/Retail Indicator
   - Claim Status (Paid/Reversed status)
   - NDC
   - DAW

- Claim Counter

These fields should be sufficient for a bidder to use in underwriting. Segal blinds the Member ID numbers received in the claims data, while maintaining the structure of the ID. This allows the bidder to group family units together, if this is supported in the Member ID structure, while not exposing PII or PHI in the file itself. Segal does not provide financial data in the RFP file. The bidder can underwrite the proposal using the claims experience and its own proposed guarantees, network, and MAC and Specialty lists.

4. Please provide the definition of each type of appeal (i.e. First Level Appeals, Second Level Appeals and Medical Review Appeals) currently in place and the number of each type of appeal for the most recent 12 months or the time period of the claim data provided

   Level 1 appeals: 382 (First Level Appeals are submitted within 180 days of adverse benefit determination); Level 2 appeals: 31 (Second Level Appeals are internal reviews of Level 1 Appeal denials; External Appeals: 3 (External Appeals are submitted to the CT Department of Insurance following Level 2 appeals).

5. Please provide a complete list of the current clinical edits including and not limited to, Step Therapy, Age Gender, Quantity Limits, Prior Authorization Edits.

   Attached

6. Please provide a complete list of all additional clinical management programs (for example: Opioid programs, High Cost Generics, Retrospective DUR programs, Member Outreach Programs, Physician outreach programs, Compliance Programs).

   The State participates in CVS' opioid management program which provides for quantity limits, duration limits and step therapy; there is a custom strategy around compound medications, which includes prior authorization and exclusions. We have a Topical Analgesic exclusion for high-cost pain patches. There is also a program for evaluating high cost drugs and targeting them for replacement by lower cost alternatives.

7. Please provide the number of Direct Member Reimbursements for the most recent 12 months or the time period of the claim data provided.

   Direct claims for the most recent 12 months were 196; the total drug spend was $13,721 of which the plan paid $12,028 and the members paid $1693.

8. Please provide the number of Member Customer Service Calls for the most recent 12 months or the time period of the claim data provided.

   32,461 for the first 11 months of 2018.

9. Please provide the number Clinical Prior Authorizations for the most recent 12 months or the time period of the claim data provided

   9453 over the past 12 months. The City of Hartford participates in the State plan for purposes of pricing/claims processing only. The City of Hartford had 663 clinical prior authorizations for the same period.

10. Please provide the number of Administrative Prior Authorizations for the most recent 12 months or the time period of the claim data provided
    120 over the past 12 months for the State and Partnership Plans

    City of Hartford had 2.

11. Please provide the current Retail 90 pharmacy listing with NAPB numbers
    Attached

12. Please explain the purpose of the large Rx claims data file posted to ProposalTech on 12/11/18? Is this informational only? Claims repricing being requested? a. Also, can you confirm the difference between the two claims files received?

    The large claim file is provided to bidders to give the claims distribution so that you can generate proposed discounts, rebate offers and alternative pricing.

13. Does the state use any contracted pharmacies? If yes, what are the NPI(s) numbers for the pharmacy(ies)?

    No, not presently

14. What are the questions that will be utilized for the stand alone Specialty Pharmacy services criteria?

    All specialty carve-out bidders should answer clinical, financial and operational questions that would be relevant to running the specialty pharmacy portion of the State program. If a question is not germane please leave blank (ex. Retail network access).

15. What is the pricing methodology for the stand alone specialty pharmacy? Will it be PBM dependent on therapeutic category?

    The pricing methodology should be minimum guaranteed ingredient cost discounts and minimum rebate guarantees per specialty drug dispensed plus any dispensing or clinical management fees.

16. Which sections within Phase 2 of the PBM RFP must be completed for a stand-alone specialty pharmacy proposal? Specifically, Section 9.8 references stand-alone specialty pharmacy proposals; however, several questions appear to reference PBM specific elements.

    All specialty carve-out bidders should answer clinical, financial and operational questions that would be relevant to running the specialty pharmacy portion of the State program. If a question is not germane please leave blank (ex. Retail network access).

17. Is the State of Connecticut looking for a rate schedule as part of a stand-alone specialty pharmacy proposal? Yes the State is seeking a drug specific pricing schedule for specialty drugs on both an exclusive and non-exclusive basis. If so, does a stand-alone specialty pharmacy proposal have to include proposed rates for both exclusive and non-exclusive arrangements; and should the proposed AWP-based pricing rate be submitted as a percent of AWP versus a dollar amount?

    The State prefers an aggregate overall effective discount for specialty drugs with a maximum ceiling dollar amount by drug.

18. In sections 9.8.4 you request exclusive and non exclusive specialty pharmacy stand-alone pricing and the chart is just for non-exclusive. Please clarify what specialty pharmacy pricing is required. Thanks

    Pricing should be provided on both exclusive and non-exclusive bases.

19. We will clarify in the chart. For the 9.83 pricing table, should the new to market and new to market limited distribution drugs be on separate lines like 9.84?

    Yes

20. For Section 2.3.1 This portion is not currently activated. When will this be activated?

    This was applicable to phase one only; the section requires no further input.

21. Pertaining to 9.8 'Stand-alone Specialty Pharmacy' applicants, is the pricing for Specialty Drugs at the GPI-4 level? Thanks very much

    9.8 is by NDC 11 for each drug and in aggregate

22. Is there any additional information, beyond what is listed in the PBM RFP that a stand-alone specialty pharmacy proposal should include in its Phase 2 submission?

    No please be clear and specific regarding integration of benefits and clinical programs with the non-specialty PBM program.

23. Please provide the States' detailed requirements for a specialty pharmacy carve out.

    Address all relevant pricing, clinical and operational questions as they relate to specialty pharmacy.

    The pharmacy specialty carve-out offer must stand alone from non-specialty.

?

24. Please confirm the number of records on your claims file. Please provide details on the specialty pharmacy benefit design including member copay/co-insurance in regards to question 2.4.6:

    There is no specialty tier, specialty drug plan design is the same as all others (generic, brand, etc.)

25. Due to the upcoming holidays and scheduled time off, will the State consider a 1-week extension? No

26. If not a week, will the State consider an extension to January 11th? No

27. 2.1.2 General Proposal Requirements; Minimum Contractual Requirements: Is a signature required with the RFP submission?

    Yes I

28. If so, please let us know where to provide the signature or if a signature document will be provided

    You may submit a cover letter or e-mail with signature.

29. 2.3.1.8: Will the State accept a contract template with the RFP submittal with a signature ready draft contract provided as stipulated in the timeline "Finalist Interviews and Draft Contract Due" provided on the week of February 11, 2019? Yes

    In Section 2.1.2 of the RFP, there is a paragraph stating that both a network AND formulary disruption are required; however, there is only a RFP question asked about the formulary disruption only (question 2.7.4). Are we required to submit a network disruption with our RFP response? If so, which question should we attach our response to?

    Please provide an excel spreadsheet indicating pharmacy network status with a yes or no (y or n) attached to 2.12. Segal will perform the network analysis.

30. Please explain the purpose of the large Rx claims data file posted to ProposalTech on 12/11/18? Is this informational only? Claims repricing being requested? a. Also, can you confirm the difference between the two claims files received?
    The large claim file is provided to bidders to give the claims distribution so that you can generate proposed discounts, rebate offers and alternative pricing.

Segal provides the de-identified, claim-level RFP file for the bidder to use in underwriting their proposal. I am aware of one RFP file , called "StateOfCT_RFP_File_20181031.txt".

31. . What is the State's current formulary management strategy?

    a. Does the current formulary (aka "drug list") cover the majority FDA approved medications? Yes.

    See https://www.caremark.com/portal/asset/Value_Formulary.pdf and https://www.caremark.com/portal/asset/Formulary_Exclusion_Drug_List.pdf

    What drugs are not covered?

    The State aligns with the CVS/Caremark Standard Formulary exclusions (see above).

    b. How often are changes made to the current formulary?

    Tier changes are made quarterly and exclusions/ additions are made every calendar year (confirming with CVS)

    c. What is the member notification process when changes are made to covered drugs?

    Affected members are contacted directly by mail.

32. Does the State's current pharmacy benefit employ utilization management programs such as Step Therapy, Prior Authorization, and/or Quantity Limits where clinically applicable?

    The State employs some prior authorization, quantity limits, safety edits, etc. There is no step therapy.

33. . Can you describe any other clinical management strategies/programs that the pharmacy benefit has in place today (for example opioid management)?

    The State participates in CVS' opioid management program, which provides for quantity and duration limits; there is a custom strategy around compound medications, which includes prior authorization and exclusions. We have a Topical Analgesic exclusion for high-cost pain patches. There is also a program in place for evaluating high cost drugs and targeting them for replacement by lower cost alternatives.

34. . Upon migration to a new pharmacy vendor, what is the State's expectation to minimize member disruption?

    The State would expect to work with its new PBM partner to minimize member disruption through member and provider communication and education. The new PBM will also be required to do implementation testing before the plan goes into effect.

35. The RFP states: "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."

    a. Please confirm how these lives are broken out on the claims file. Segal blinds the Member ID numbers received in the claims data, while maintaining the structure of the ID. This allows the bidder to group family units together, if this is supported in the Member ID structure, while not exposing PII or PHI in the file itself.

    b. Do you have multiple formularies or are you seeking different rebate guarantees for these groups based on tiers 2 & 3? Yes, pre October 2017 retirees have a broad formulary without exclusions.

36. The RFP States: "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."

    a. Please confirm this information. The data we received indicates 2.7 million scripts.

The RFP file contains 3,279,101 rows, consisting of 2,754,575 Net Paid claims processed between 10/1/2017 and 9/30/2018. This is consistent with the claims detail provided by the incumbent PBM for this project.

The claims file previously provided included Medicare-eligible members; that data will be eliminated from an updated file to be provided.

37. Can you provide more details regarding your custom retail maintenance network, such as total number of pharmacies and major chains included? Does this network have mail order pricing for 90-day supplies?

    All major chains (except Rite Aid and Walgreens) and some independent pharmacies are in the current custom retail maintenance network. The network has mail order pricing for 90-day supplies.

38. Please confirm the number of records on your claims file.

    The RFP file contains 3,279,101 rows, consisting of 2,754,575 Net Paid claims processed between 10/1/2017 and 9/30/2018. This is consistent with the claims detail provided by the incumbent PBM for this project.

    The claims file previously provided included Medicare-eligible members; that data will be eliminated from an updated file to be provided.

39. Please provide details on the specialty pharmacy benefit design including member copay/co-insurance in regards to question 2.4.6: 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.

    The State would not expect generic reference pricing for Specialty

40. The RFP documents provided state that the plan covers 188,000 lives, but the data shows 260,000 unique patients. Can you confirm that the data aligns with the plans current members.

    Current enrollment in the State of CT plan is as follows: Active lives: 118,747; under-65 retirees and dependents: 33,375, Partnership Plan: 48,019.

    Claims data previously supplied inadvertently included the Medicare-eligible lives covered under the EGWP in prior years. It will be removed from the file.

41. We have located the list of pharmacies on the maintenance network via www.osc.ct.gov. Is it possible to provide these lists in Excel format?

    Excel file has been provided.

42. . Please confirm if the retiree population are RDS or EGWP lives.

    The retirees are non-Medicare eligible and mainly under-65; any over-65 retirees are non-Medicare eligible.

43. The Hierarchy field provided on the data lists 4 identifiers (3345, 4750, 4833, 9433). Can you provide a crosswalk of each identifier to the specific plan population? Confirm that we are bidding on all 4 plan types.

    We do not apply a naming convention as noted in this question to our plan structure. If you wish to apply this naming convention the plans should be defined as follows:

    Plan A – Active Employees

    Plan C1 – Retirees Retired Before 7/1/2009

Plan C2 – Retirees Retired Between 7/1/2009 and 10/1/2011

Plan C3 – Retirees Retired Between 10/2/2011 and 10/1/2017

Plan C4 – Retirees After 10/2/2017

44. . The phase II pricing documents request rebate guarantees for Three Tier Plans (Plan A, Plan C1, Plan C2 & Plan C3) and CDH Plans (Plan C4) separately, confirm the hierarchy in the data that aligns with each grouping.

    See above.

45. Please provide the current Retail 90 pharmacy listing with NAPB numbers
    Attached

46. . Per 1.2.10 "All finalists will be subject to round of on-line best and final financial offers" Please confirm that the online auction will be limited to the Alternative Pricing offers.

    No, the auction will apply to all pricing offers.

47. In regards to the Alternative Pricing Quotes. We are able to provide pricing on a Gross Net Cost basis. Is the State willing to accept this pricing structure as the Alternative Pricing Quote in lieu of guarantees by therapy class, guaranteed generic MAC pricing and price inflation guarantees by channel?

    The State may consider this; however, please also provide the requested pricing.

48. In regards to 2.3.1.8. "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." Given that pricing and terms often change in subsequent rounds of best and final offers, can a signature ready contract be provided at that time to capture all final negotiated terms?

    Yes

49. . Please confirm that grandfathered retirees that are not on the formulary with exclusions would not be quoted in the alternative pricing quote.

    Confirmed

50. . Will the State be providing additional detail on the Weight and Scoring associated with each category?

    No

51. Please confirm whether the State is requesting rebates on a per brand or on a per Rx basis across channels. 2.3.2.8 States: "Guaranteed rebates per prescription will be based (whether by therapy or in aggregate by channel) on all brand prescriptions dispensed. 2.8.6.5 States: "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.

    Each guaranteed rebate should be based on a per specialty brand Rx within channel, no offset.

52. 7. 2.3.2.12 suggests quarterly reconciliation of rebates, but 2.3.2.13 & 2.8.27 indicate annual reconciliation. Please confirm the following rebate arrangement satisfies the State's intent: With Point-of-Service rebates, we provide quarterly invoice letters that compares rebate distribution at the point of service to pharma invoiced for the quarter. We provide annual reconciliation to client guarantees.

    Yes

53. 8. 2.8.6.2 (c) Asks for an Overall effective discount on an Exclusive Specialty arrangement. But 2.8.6.3 asks for an OED on the Non Exclusive specialty pricing. Is the State seeking an OED on both Open and Exclusive specialty?

    Yes

54. 2.8.6.2 Requests pricing for "Specialty Drugs Dispensed at Participating Retail Pharmacies under the Non Exclusive Specialty Arrangement. 2.8.6.4 Asks PBM's to "quote both exclusive and non-exclusive arrangements." However, the pricing grid under 2.8.6.4 only lists Non Exclusive (similar to the grid in 2.8.62). Please update 2.8.6.4 to reflect your request for an Exclusive Specialty arrangement since the Non-Exclusive arrangement is already covered under 2.8.6.2.

    Pricing should be provided on both exclusive and non-exclusive bases.

55. . Drugs that are commonly classified as Specialty Drugs are generally priced and procured under different terms than non-specialty drugs due to significant variations in the competition within a given therapeutic class, lower levels of utilization, manufacturer-imposed restrictions on which pharmacies may dispense certain Specialty Drugs, and/or other characteristics and factors not typically associated with drugs not commonly considered to be Specialty Drugs. Accordingly, through inclusion or exclusion of certain drugs in its proposed Specialty Drug list, a Bidder can materially impact the overall effective Specialty Drug discount it can propose. Because of the disproportionate impact of Specialty Drug spend on a pharmacy benefit program, it is very important for Bidders to understand the scoring of the Specialty Drug component of their offers. Accordingly, please provide a more detailed description of the calculations that will be used to evaluate Bidder's Specialty Drug Lists and compare them to other Bidders.

    Using CMS definition of specialty claims we will evaluate each bidder's proposed volume of specialty drugs compared to current volume. Any material deviation from the current volume will be investigated.

56. . We have seen cases where indirect value (such as the value of copay assistance programs, copay offset programs, or drug card/member reimbursement programs from the manufacturer) appear to be included in the rebate/discount guarantee calculations even though the plan sponsor derives a financial benefit only from copay offset programs and not from copay assistance programs. Please confirm manufacturer coupons or copay card programs cannot be used or included in the calculation of the ANY guarantees.

    Confirmed.

57. Please confirm that the State will not permit guarantees to include terms that allow for the proration of claims. For example, claims meeting the minimum days' supply agreed upon for a specific channel will receive the same guarantee as claims with a higher days' supply within that channel.

    Confimed.

58. Please confirm that CDH or Zero Balance due claims must be included in the calculation of the minimum rebate guarantees.

    Confirmed.

59. Please confirm if the Affidavit for Certification of Subcontractors or the DAS 26-CT Economic Impact form are to be submitted with the proposal.

    These forms do not need to be submitted with the proposal.

60. Per RFP question 2.3.8.5, the RFP refers to rebates in several other areas indicating that rebates should be paid post claim processing and indicating that they should be or are currently are not paid at POS. For example, questions 1.2.5, 2.3.2.11 and 1.1.12. Please confirm if rebates are currently paid at POS or paid/credited after rebate reporting periods. If rebates are paid at point of service currently, please provide bidders details to ensure there is an equal understanding of the current arrangement and the desired arrangement that vendors should respond to.

State receives a rebate payment monthly based on estimated amounts, with true-ups quarterly and annually.

61. Per RFP question 2.3.6.2, PBMs commonly accept fiduciary responsibilities where clinical determinations are made for medical necessity appeals. Is this the State's expectation in this request? Please provide details, definition and requirements of the State's expectation of 'clinical based requirements to ensure bidders respond based on the same understanding of the request.

    We are not aware of any question numbered 2.3.6.2 within the RFP. The expectation is that the State's PBM has a medical and clinical staff to administer the benefits in accordance of the plan document.

62. In Section 1.1.1, it states "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 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)." Please provide details regarding the retiree lives associated with this RFP to ensure all bidders have the same understanding, such as are the retirees pre-56 retirees only? Do the retirees include post 65 retirees. If yes, please provide the most current breakdown of retiree membership counts. If there are post 65 retirees included, what type of plan are the covered under? If there are not post 65 retirees, describe the plan under which they may be covered (i.e. EGWP) and the Office that oversees that plan.

    All retirees included in this RFP are not Medicare eligible. Any over-65s included in this RFP are not Medicare eligible. Medicare eligible retirees are covered by the MA-PD Plan overseen by the Office of the State Comptroller.

63. Please confirm that this RFP is for the lives administered by the CVS/Caremark only. Confirmed If yes to the above, please confirm if there are any retirees included, the current number of retirees lives and if they are pre or post 65 retirees. If there are post 65 retirees under the Prescription Benefit Plan administered by CVS/Caremark, please confirm the type of plan and if the State's intent is to keep those members in the same plan for the period of the new contract term represented under the RFP.

    All retirees included in this RFP are not Medicare eligible. Any over-65s included in this RFP are not Medicare eligible. Medicare eligible retirees are covered by the MAPD overseen by the Office of the State Comptroller.

64. Please confirm if the Prescription drug coverage for MEDICARE-eligible retirees and their Medicare-eligible dependents available under the UnitedHealthcare Group Medicare Advantage (PPO) plan is included in in this RFP. No, they are not included If yes to the above, please confirm the type of plan they are under and if it's the State's intent to keep those members in the same type of plan for the period of the new contract term represented under the RFP.

65. Please provide clarification on the reverse auction outlined in 1.2.10. Please provide any possible or applicable "alternative" pricing guarantees that bidders need to be aware of during this Phase of the RFP.

    The reverse auction will be run through Proposal Tech's secure website. All bidders will see their rank relative to other finalists. Bidders will not have access to other finalists' specific pricing.

66. RFP Question 2.3.1.8 states "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." PBM requests the State consider accepting a sample contract as an Executable Contract will not capture information provided via Amendments, Proposal Clarification Question Responses from PBMs, Finalist Meeting follow-up items or any applicable Best and Final Pricing.

Submit a signature ready contract with the exception of final pricing.

67. Noting that the State has requested pricing for our broadest retail maintenance network, do PBMs also need to propose pricing for the current custom maintenance network in place with the State? Or, will the custom network be replaced with the winning bidder's broadest maintenance network?

    The State would be willing to accept the winning bidder's broadest maintenance network.

68. Per Section 2.8.2 - the requested rebate guarantees indicate a Plan A, Plan C1, Plan C2, Plan C3, and Plan C4. Can the State provide a Key that assists in mapping these plan codes to the plan designs detailed in the Plan Document TBD

    We do not apply a naming convention as noted in this question to our plan structure. If you wish to apply this naming convention the plans should be defined as follows:

    Plan A – Active Employees

    Plan C1 – Retirees Retired Before 7/1/2009

    Plan C2 – Retirees Retired Between 7/1/2009 and 10/1/2011

    Plan C3 – Retirees Retired Between 10/2/2011 and 10/1/2017

    Plan C4 – Retirees After 10/2/2017

69. Regarding the request for retail network pricing with a days supply break at 59 days - Is there a pending or anticipated benefit change for maintenance medications? Please confirm the current day supply required for retail pricing and day supply requirement of maintenance medications.

    There is no benefit change pending. 30-days at retail, 31-90 for retail maintenance and mail-order for plan adjudication purposes.