Pharmacy Benefit Services for The Empire Plan, Excelsior Plan, Student Employee Health Plan, and New York State Insurance Fund Workers' Compensation Prescription Drug Programs

REQUEST FOR PROPOSALS

Offeror Questions and Answers

Following are the Procuring Agencies' responses to Offeror questions received regarding the Prescription Drug RFP. Questions and answers are grouped by date of response.

Offerors should note the following:

- The PDF version of the RFP and exhibits posted to the website are deemed to be the controlling documents.
- The responses provided below should not be interpreted in any way to apply to the Procuring Agencies' Prescription Drug Programs as currently administered.

Questions and Answers – As of April 4, 2012

GENERAL		
	Section / Page	Question and Response
Q1	**General**	**Who are the incumbent contractors and are copies of the incumbents contracts and proposals submitted publically available?**
A1		UnitedHealthcare of New York, Inc. (UHC) is the contractor for the DCS Prescription Drug Program. Medco Health Solutions serves as the Pharmacy Benefits Manger through a subcontract with UHC. Express Scripts, Inc. is the current contractor for NYSIF's Workers' Compensation Prescription Drug Program. UHC's redacted contract and submitted proposal is viewable through DCS' public website - http://www.cs.ny.gov/pio/information.cfm. Please contact NYSIF's Public Information Office to request copies of the redacted contract and proposal for the Program's current contractor.
Q2	**General**	**Will the RFP be made available in Microsoft Word format?**
A2		To assist Offerors in preparing their proposals, Microsoft Word versions of Sections III, IV, and V have been posted to the RFP's website. Many of the various RFP exhibits posted on the website are also available in Microsoft Word format. Note, the PDF files posted on the website are deemed to be the controlling documents.
Q3	**General**	**Are the RFP exhibits available in a format that they can be populated electronically, or should they be completed by hand? Specifically, Exhibits I.K., I.P., and I.J.**
A3		Exhibits I.K., I.P., and I.J., as well as many other RFP exhibits have been made available in Microsoft Word format to enable Offerors to populate the forms electronically. Note, the PDF files posted on the website are deemed to be the controlling documents.
Q4	**General**	**Can you confirm if the program is Fully-Insured or Self-Insured?**
A4		The RFP is to secure the services of a qualified Offeror under a Self-Funded arrangement for the DCS Programs and the NYSIF Programs. Currently, the DCS Program is fully insured and the NYSIF Program is Self-Funded.

Q5	**General**	**As the RFP requires that a single offeror respond to all provisions in the RFP, we wish to confirm that NYSIF would [allow] offerors to bid as a sub-contractor (for the provision of workers' compensation pharmacy services) in a Prime Contractor's RFP response. We would appreciate it if you could confirm whether this is acceptable.**
A5		The RFP states that "The Department and NYSIF will only contract with a single Offeror, which will be the sole contact with regard to all provisions of the Agreements. If the Offeror's Proposal includes Key Subcontractors, the Offeror will be considered the Prime Contractor, and the Offeror shall assume full responsibility for the fulfillment of all of the Contractor Responsibilities under the Agreements." As regards the specific question, Offerors are advised that the Offeror (i.e., the Prime Contractor) can propose the use of a Key Subcontractor for the provision of workers' compensation pharmacy services and the Offeror would so note this fact in its Proposal.
Q6	**General**	**My company is a Workers Comp specific Pharmacy Benefits Manager, we are interested in responding to the RFP but would like to know if our proposal would be considered if it only involves Workers Compensation Pharmacy services provided for NYSIF program only.**
A6		No, as per Section IV of the RFP "The Procuring Agencies will accept Proposals only from qualified Offerors and will consider for evaluation and selection purposes only those Offeror Proposals that it determines to meet the Minimum Mandatory Requirements in Section III and are responsive to the duties and responsibilities set forth in Section IV of this RFP."
Q7	**General**	**Aside from the formatting parameters outlined in the instructions, are there any other limitations on formatting our response? Responses typically use the same color and font as the original questions – do you want us to reformat to set off and better differentiate our responses?**
A7		The proposal formatting parameters stipulated by the RFP are set forth in RFP, Section II. A.7.b. Offerors are not mandated to nor prohibited from using the same color and font as the original questions or reformatting to set off its responses.
SECTION I – INTRODUCTION		
	Section / Page	Question and Response
Q8	**I.A (Pg 1-2)**	**Can the State provide the number of pre-65 retirees and the number of post-65 retirees? Are the post-65 retirees currently enrolled in an EGWP program? If not, what does the State currently offer post-65 retirees?**
A8		The following numbers are approximate and provided to Offerors for informational purposes. The numbers should not be viewed as a guarantee: Number of Post-65 retirees – 253,356 Number of Pre-65 retirees – 143,312 Currently the post-65 retirees are in the Active Plan. The DCS Program is transitioning Medicare primary enrollees to an EGWP effective January 1, 2013.
Q9	**I.D (Pg 1-7)**	**NYSIF claimants do not incur copayments or out-of pocket costs when utilizing network or non-network pharmacies, therefore what incentives are there for claimants and physicians to adhere to the formulary placement of the medications?**
A9		There is no incentive.

Q10	**I.D (Pg 1-7)**	**Please provide a process flow for the WC program, including how a claimant opens a case, gets a temporary card and then gets approved for a WC case.**
A10		1-Claimant reports injury to employer and receives information packet from employer. Employer notifies NYSIF of claim and NYSIF creates a claim. PBM is notified of claim eligibility in daily eligibility file. If after investigation, NYSIF decides to deny compensability, claimant is notified via letter and PBM receives notification of denial in daily eligibility file. 2- Claimant reports injury to employer, receives information packet, including policy number, from employer. If after receiving medical attention, claimant requires prescription medication, claimant takes information packet to pharmacy and fills prescription. Pharmacy notifies PBM and fills prescription. PBM notifies NYSIF of the fill in the daily Short Fill file. NYSIF creates a claim and notifies PBM of claim number. **-for additional information about adjudication please go to http://www.wcb.ny.gov/content/main/Workers/Workers.jsp
Q11	**I.D (Pg 1-7)**	**Who determines "med nec and appropriate drugs that are causally related to the loss?" How far is that stretched?**
A11		Whether drugs are medically necessary and appropriate and causally related to the loss is determined by NYSIF nurses, case managers and, if necessary, the NYS Workers' Compensation Board. This determination is not "stretched" if the drug is not causally related to the loss.
Q12	**I.D (Pg 1-7)**	**Is the NYSIF PDL a published document? If it is published, how is it distributed?**
A12		NYSIF's PDL is not a published document.
Q13	**I.D (Pg 1-7)**	**Can the NYSIF PDL have exclusions?**
A13		As the RFP states "All medically necessary and appropriate drugs that are causally related to the loss are covered," therefore there are no drugs that are completely excluded.
Q14	**I.D (Pg 1-8)**	**Can a PDL proposed for the Empire Plan be used for NYSIF; for example could the traditional PDL proposed for the Empire Plan be submitted as the PDL for NYSIF?**
A14		As set forth is Section IV.B.16. of the RFP, the selected Offeror is required to develop and administer separate PDLs for NYSIF's and DCS' Programs.
Q15	**I.E (Pg 1-8)**	**Is it a requirement for the Offeror to determine if the drug is related to the enrollee's accident prior to payment?**
A15		No. But if utilization review by NYSIF determines that a dispensed drug is not causally related, that drug will be blocked and any future fills will not be paid by the NYSIF Program.
Q16	**I.E (Pg 1-9)**	**Please provide DCS and NYSIF interpretation of the NYS Diabetes mandate in regards to coverage of oral and injectable diabetes agents. For example, does the mandate apply to Empire Plan and NYSIF? Do the programs interpret the mandate as rx copays must be at parity with medical copays?**
A16		Coverage of oral and injectable diabetes agents is required for the DCS Programs as a result of the mandate; however, the Department's interpretation of the Law does not require Prescription drug copays to be lesser than or equal to medical copays. The NYS Diabetes mandate does not apply to NYSIF's Program.

Q17	**I.E (Pg 1-10)**	**Insulin is covered under the NYSIF PDL per #4 on page 1-9 yet therapeutic devices are excluded from coverage on page 1-10 under #7. Where are diabetic syringes for the NYSIF program covered? What about other diabetic supplies? Please confirm insulin is an appropriate covered WC drug?**
A17		If the insulin is delivered via individual doses that can be billed with an NDC number, the network pharmacy will bill the PBM in the normal manner. Any other diabetic supplies would be paid for by the claimant and reimbursed directly to the claimant by NYSIF (i.e., not billed through the NYSIF Program).
Q18	**I.E (Pg 1-10)**	**Please confirm under no circumstances are vaccines or immunizations such as Hepatitis vaccines covered on the NYSIF PDL.**
A18		No vaccines or immunizations, such as Hepatitis vaccines, are covered on the NYSIF PDL. The administration of such drugs must be performed by the treating physician.
Q19	**I.E (Pg 1-10)**	**Please explain the obligation of the Offeror to comply with health insurance requirements and DFS regulations and rules since the RFP is being issued as self-insured for the Empire Plan and NYSIF. Please identify all such requirements and rules that the Offeror will be subject to.**
A19		Identification of which health insurance requirements and DFS regulations and rules apply will not be provided by the Procuring Agencies. It is the responsibility of the Contractor to identify and comply with any and all applicable State and/or Federal laws, rules and regulations.
Q20	**I.E (Pg 1-10)**	**Exclusive to DCS, drug for an injury or sickness for which benefits are provided are excluded from coverage under the Empire Plan. Please provide details as to how the Offeror will be able to identify claims related to an injury or sickness for which benefits are provided in order to appropriately exclude from coverage?**
A20		Typically, this occurs retrospectively. If the selected Offeror determines the enrollee's prescription drug(s) should have been covered under another health plan, insurance or Workers' Compensation coverage, it is DCS's expectation that recovery will be pursued where practicable.
Q21	**I.E (Pg 1-10)**	**Please confirm that coverage for drugs where the amount dispensed exceeds the supply limit will be covered upon clinical review and prior authorization. Please confirm that supply limits are proposed by the Offeror and apply to both Empire Plan and NYSIF.**
A21		Confirmed. Under DCS' Program, limited exceptions to exceed supply limits may be granted upon clinical review and prior authorization. For NYSIF's Program, if, after clinical review or prior authorization, a determination is made that the prescribed amount medically necessary and causally related to the compensable injury, then coverage is confirmed. Supply limits are proposed by the Offeror and subject to approval by the Procuring Agencies.
Q22	**I.E (Pg 1-11)**	**Please confirm that coverage for drugs as replacement for a previously dispensed drug should be administered as firm denial of coverage with no override criteria for either program.**
A22		Drug replacement requests are typically considered on a case-by-case basis. It is the expectation of the Procuring Agencies that the evaluation of drug replacement requests would continue as it does today with replacement overrides occurring in limited situations, at the approval of the Procuring Agencies.

SECTION II – PROCUREMENT AND PROTOCOL PROCESS		
	Section / Page	Question and Response
Q23	**II.A. (Pg 2-1)**	**What is needed to comply with the requirements for requesting the claims and Network Pharmacy data set forth in the RFP? Is there anything due on March 13, 2012 as originally stated prior to the amendment to Section II on March 8, 2012.**
A23		The DCS claims and Network Pharmacy data, as well as the NYSIF claims data will be provided to Offerors that submit a letter requesting the data and a properly executed Exhibit I.Z., as clarified by the March 8, 2012 RFP amendment. Further, the March 8th RFP amendment removed reference to the March 13, 2012 deadline for requesting the data.
Q24	**II.A. (Pg 2-1)**	**The timeline seems to indicate that EGWP would begin on January 1, 2013; however, Section IV.B.5.a states the EGWP will begin on January 1, 2014 (page 4-19). Can the Procuring Agencies please clarify the timeline?**
A24		It is expected that implementation requirements for the EGWP provision of the DCS Program will begin on January 1, 2013. Operation of the EGWP and all other programmatic provisions of the Programs will commence on January 1, 2014.
Q25	**II.A. (Pg 2-1)**	**After reviewing Exhibit I.Z. with our General Counsel, we have a few clarifying questions regarding the non-disclosure agreement. Please provide[s] definitions for the [for the] following noted in Exhibit I.Z.: Respondent (is the Offeror the same as respondent), Network Pharmacy, and Programs. Also, can you please clarify the due date for this form? Prior to the amendment, it was originally due as stated in the RFP on March 13th?**
A25		With regard to Exhibit I.Z., "Respondent" *means* Offeror or Key Subcontractor; the definition of "Network Pharmacy" is set forth in Section VIII of the RFP; and the definition of "Programs" is set forth in Section VIII of the RFP. As a result of the March 8th RFP amendment, the due date for Exhibit I.2 was eliminated from the RFP.
Q26	**II.A.7 (Pg 2-12)**	**Each page of the Proposal/Exhibits are to be labeled and include a page number. Can the State clarify this requirement? If an item, for example an annual report, was pre-numbered in the lower right corner, is it the request of the State that vendors renumber those items and include a label, date, page number, etc. in the upper right? Are only pages that contain content to be numbered? For example, if a sample letter is included that is only printed on one side, would the blank back side need to be numbered?**
A26		Offerors are required to follow the submission and formatting requirements as set forth in Section II.A.7 of the RFP. The submission and formatting requirements are intended to facilitate review by the Programs' evaluators. Please label, date, and number each page with Program content. Blank pages should be labeled "Page Intentionally Left Blank."
Q27	**II.A.7 (Pg 2-13)**	**According to the "Material Deviations section, New York State Law prohibits NYS from awarding a contract based upon material deviations from the specifications, terms, and conditions set forth in the RFP. Consequently, each Offeror's Proposal must conform to the specifications, terms, and conditions set forth in this RFP and prospective Offerors are strongly advised to raise issues and/or concerns relating to this procurement during the question and answer phase rather than taking exceptions within their Proposals. Material deviations from the specifications, terms, and conditions set forth in the RFP may render the Proposal nonresponsive and may result in rejection of the**

		Proposal." **However, due to complexities of the Medicare Part D benefit and the CMS requirements we must follow, there are many differences/ deviations between the Commercial PBM offering and EGWP benefit. Since the majority of the RFP contains questions/topics primarily based upon Commercial PBM business, how would the Procuring Agencies like us to handle these EGWP deviations?** **A) Should we answer the majority of the RFP based upon Commercial PBM responses only, and then note in the EGWP sections any differences between the commercial, business and the EGWP business** **B) Or should we note any difference/ deviations for the EGWP business throughout the whole RFP?** **Also for the EGWP business, the Procuring Agencies would be contracting with our PDP affiliate and the EGWP business would be a separate contract from the Commercial contract. Should we complete all of the Vendor Exhibits forms such as Exhibit I.K. Offeror's Affirmation, etc. for both contracting entities?**
A27		When responding to a specific question in the RFP, the Offeror should address the information required to satisfy the question and, to the extent a particular answer will be different due to the CMS mandates for EGWP, state with specificity the EGWP variance and CMS citation. NOTE: It is the intent of the Procuring Agencies to enter into separate Agreements with the one (1) Offeror selected through the RFP process (RFP Section I.A.). The selected Offeror will be responsible for programmatic duties of the Programs including DCS' EGWP. A separate EGWP contract will not be executed.
Q28	**II.A.7 (Pg 2-13)**	**Can the Procuring Agencies specify which sections of the RFP contain "specifications, terms and conditions", as opposed to those sections that describe preferences?**
A28		All of the sections of the RFP contain various specifications, terms and conditions, some sections of the RFP contain preferences.
Q29	**II.B.2 (Pg 2-20)**	**This subsection refers to a list of jurisdictions in Article 21 of Appendix A. Article 21 of Appendix A was current as of 2002. Can the Procuring Agencies provide an updated list?**
A29		The list referenced in the Appendix A is the current list as of April 2012.
Q30	**II.B.6 (Pg 2-26)**	**The subsection refers to Key Subcontractors, who are defined at various points in the RFP as members of the Offeror's proposed Project Team, but Project Team is not defined in the RFP. We typically utilize subcontractors to perform certain ancillary functions, such as print production, auditing of certain affiliated pharmacies, provision of help-desk services for retail pharmacies and pharmacists, and the provision of medical necessity review in the performance of appeals processing. We would not consider these vendors to be part of our Project Team. Is this consistent with the Procuring Agencies' expectations?**
A30		Section VIII of the RFP contains the following definition of Project Team. "Program Team means the Contractor and those Key Subcontractors, if any, utilized by the Contractor who collectively undertake and perform the Program Services which are the subject of the Agreement."Also, Key Subcontractors are defined as "Key Subcontractor means those vendors with whom the Contractor subcontracts to provide Program Services and incorporates as a part

		of the Contractor's Project Team." And Program Services is defined as "Program Services or Pharmacy Benefit Services means all of the services to be provided by the Contractor as set forth in this RFP." To the extent that the subcontractors listed in the Prospective Offeror's question are providing Program Services, they would be considered Key Subcontractors. Example of possible subcontracted services for which the subcontractor would not, in all likelihood, meet the definition of a Key Subcontractor might include; janitorial services, lawn care, building maintenance services, power and electric services, etc.
Q31	**II.B.8 (Pg 2-29)**	**At the end of the last paragraph on page 2-29, the RFP states that "a copy of the redacted Agreement with the Procuring Agencies may also be posted to the website at that time." As there will be no Agreement with the Procuring Agencies at the time of proposal submission, does this mean that a copy of the "Pharmacy Benefits Services – Redacted Version of Proposal" may be posted to the website after proposal submission or something else? If something else is intended, could the Procuring Agencies please explain?**
A31		The first sentence, of the last paragraph on page 2-29 states in part "*…posting to the procurement website upon completion of the procurement process*." Completion of the procurement process means that an Offeror was selected from the RFP process and the two (2) Agreements were executed and approved by the Office of the State Comptroller (OSC). Once the Agreements are approved by OSC, the redacted proposals and DCS Program Agreement will be posted to the DCS website.
SECTION III – ADMINISTRATIVE PROPOSAL REQUIREMENTS		
	Section / Page	Question and Response
Q32	**III.A (Pg 3-1)**	**This section indicates that we should submit two Original Copies of the Administrative proposal; however, Exhibit I.A indicates that we should submit four Original Copies of the Administrative proposal. Please confirm that you want four Original Copies of the Administrative proposal.**
A32		The correct number of Original/Copies of the Offerors Proposal is stated in RFP Section II. A. 7.a., as follows "…Offerors must submit Sixteen (16) separately bound hard copies (four (4) ORIGINALS and twelve (12) copies) and one (1) electronic copy (CD) **of each of the three (3) parts** of the Offeror's Proposal." Section III.A of the RFP has been amended to reflect the correct number of Original copies.
Q33	**III.A (Pg 3-1)**	**As part of the Formal Offer Letter, we must accept the terms of Section VII – Contract. Does NY State expect that the parties will negotiate and execute a written contract that is mutually agreeable to both parties which would reflect the operational commitments, service and financial guarantees as set forth in the PBM vendor's Response to the Request for Proposal?**
A33		The Department expects that the contracts executed between the parties will be that which is contained in Section VII of the RFP as updated to incorporate the selected the Offeror's Proposal and to fill-in other information relative to the selected Offeror such as its name, address, etc. As such, the contract will reflect the operational commitments, service and financial guarantees as set forth in the selected Offeror's Proposal as deemed acceptable to the State. Prospective Offerors are advised to refer to, at a minimum, RFP, Sections I.A, II.A.7.c, Section II.A.11, and VI.D for further information.
Q34	**III.B.4 (Pg 3-2)**	**Will the State make any exceptions to the "minimum lives" requirement?**
A34		No, the Procuring Agencies will only accept Proposals from Offerors that attest

		and demonstrate through current valid documentation to the satisfaction of the Procuring Agencies that the y meet all of the minimum mandatory requirements in Section III.B.
Q35	**III.B.4 (Pg 3-2)**	**Will any amendments be made to the minimum mandatory requirements found in Section III.B?**
A35		No, the Procuring Agencies will not make any changes to the minimum mandatory requirements in Section III.B.
Q36	**III.B.4 (Pg 3-2)**	**Minimum Mandatory Requirement 2 refers to "Program's Mail Service Pharmacy Process." On page 8-8 of Section VIII, there is a definition of "Mail Service Pharmacy Process" that refers to the method the Contract employs. Please confirm that the Program's Mail Service Pharmacy Process is the Contractor's process, consistent with the requirements stated on page 8-8.**
A36		Confirmed. However, the Offeror's proposed Mail Service Pharmacy process must meet all Mail Service Pharmacy Process requirements contained in the RFP.
Q37	**III.B. (Pg 3-2)**	**Please advise if New York State would accept a Pharmacy Benefit Management (PBM) Partnership Submission between (Vendor #1) and (Vendor #2) who serves as our organization's PBM/Claims processing partner. Below is some information about (Vendor #1) and (Vendor #2) as well as why the partnership is applicable for the 2014 RFP.**
A37		Proposals will only be accepted from Offerors that attest and demonstrate through current valid documentation to the satisfaction of the Procuring Agencies that the Offeror meets all of the minimum mandatory requirements in Section III.B. The Procuring Agencies will execute contracts with the selected Offeror/Prime Contractor only.
Q38	**III.D (Pg 3-6)**	**In the event that a proposer expects to utilize the services of subcontractors in performing the services for the Procuring Agencies, but such subcontractors are not Key Subcontractors, should those subcontractors be identified in the proposal?**
A38		As stated in Section VIII "Glossary of Terms", a Key Subcontractor means those vendors with whom the Contractor subcontracts to provide Program Services and incorporates as a part of the Contractor' s Project Team/Program team. A Subcontractor that does not meet this definition does not need to be identified in the proposal. All subcontracting opportunities should be evaluated by the Offeror for M/WBE applicability.
Q39	**III.G (Pg 3-8)**	**Will NYSIF claims data be made available to interested Offerors?**
A39		Yes, a file of NYSIF Program claims data for the period November 1, 2010 through November 1, 2011 will be provided, along with DCS claims and Network Pharmacy data files, to Offerors that submit a letter requesting the data and a properly executed Exhibit I.Z., Confidentiality Agreement and Certificate of Non-Disclosure. The NYSIF Program claims data is provided for informational purposes only.
Q40	**III.G (Pg 3-8)**	**Is there logic to the 3 repricing files (one has workers' comp scripts, one has Medicaid, etc) or just split due to size?**
A40		The DCS Program claims data is provided in three separate files due to size.

Q41	**III.H.2 (Pg 3-11)**	**Can the state clearly define what distribution records must be provided to the Procuring Agencies?**
A41		Offeror should provide copies of documentation provided by Pharmaceutical Manufacturers that accompany payment of rebates to the Offeror. This documentation should show rebates received by the Offeror and support appropriate distribution of rebates to the Procuring Agencies.
Q42	**III.H.2 (Pg 3-11)**	**Please clarify the calculation used to determine "(as a percentage of claims)."**
A42		When calculating the "percentage of claims," claims may be represented by AWP. AWP should be consistently used when utilizing this calculation. Example: If AWP is $100 and rebate is $3.00, the rebate as a percentage of claims is 3%.
Q43	**III.H.3 (Pg 3-16)**	**Is NYSIF open to having a Workers' Compensation retail network specifically contracted to process Workers' Compensation scripts and add compliance requirements to avoid third-party biller intervention?**
A43		The Procuring Agencies intend to have one Retail Network for the Empire Plan, Excelsior Plan, Student Health Plan and the New York State Insurance Fund Drug Programs.
Q44	**III.H.4 (Pg 3-17)**	**Drug Pricing: We would like to confirm your intentions here; are DCS and NYSIF asking for a single MAC list to be applied to both the DCS and NYSIF program across retail and mail, or are you indicating there could be a MAC list for DCS and a separate MAC list for NYSIF, but regardless they must both apply the MAC list to claims across retail and mail within each program.**
A44		As set forth in Section V.C.5 of the RFP, the selected Offeror is required to create and maintain a single, Programs specific Maximum Allowable Cost (MAC) List called the Programs MAC List for Retail and Mail Service Pharmacies setting the price the Programs will be charged, and the amount the dispensing Network and Mail Service Pharmacies will be paid, for the Ingredient Cost for the drugs required to be included on the Programs MAC List.
Q45	**III.H.4 (Pg 3-19)**	**Question 12 asks if Offeror's pricing is equal to or better than all other clients of Offeror. Does this question refer to only retail pharmacy pricing terms, or retail, mail and specialty pharmacies, and rebates? In this question, do the Procuring Agencies mean equal to or better than all other clients of a roughly equal or smaller size to the Procuring Agencies?**
A45		The question in Section III.H.4.a(13) refers to all prescription drug pricing terms, including rebates, for the Programs. Pricing terms should be compared to clients that are of comparable size and benefit structure to the Programs as outlined in the RFP.
SECTION IV – TECHNICAL PROPOSAL REQUIREMENTS		
	Section / Page	Question and Response
Q46	**IV.B.2 (Pg 4-7)**	**Will there be any requirement to include shared communication expenses in the premium buildup? Please detail which communications will be the responsibility of the PBM to produce and include in the claims admin fee?**
A46		Shared communication expenses will be included in the premium buildup. The Department will provide the selected Offeror with the shared communication amount prior to the annual rate renewals. The Department will retain responsibility for distributing DCS Program certificates, SPDs and SBCs to Program Enrollees. Please refer to Section IV.B.6 "Enrollee Communication

		Support" for the communication requirements in the RFP covered by the Offeror's proposed Claim Administrative Fees for the Programs.
Q47	**IV.B.3 – (Pg 4-9)**	**Subsection (2)(a) stipulates that Proposers Retail Pharmacy Network implemented on January 1, 2014 must include all chain pharmacies with more than 20 locations and all groups of 20 or more independent pharmacies utilizing the same third party organization to collectively negotiate network participation. This Subsection includes a similar requirement for smaller chains and smaller groups of (or individual) independents, however, a number of exceptions are listed for these smaller groups, including a pharmacy's violation of law, breach of network contracts and failure to meet credentialing requirements. Please confirm that it is the Procuring Agencies intention that these exceptions (e.g., violation of law, failure to meet credentialing requirements, etc.) should apply to all categories of pharmacies and pharmacy chains, regardless of size.**
A47		Confirmed. It is the intent of the Procuring Agencies that the acceptable reasons for Pharmacy non-participation stated in Section IV.B.3 a.(2) (a) would apply to all categories of pharmacies and pharmacy chains, regardless of size.
Q48	**IV.B.3 (Pg 4-11)**	**Subsection (2) refers to the percentage at risk for failure to meet the Implementation and Start-Up requirements as being prorated on a daily basis. Can the Procuring Agencies provide guidance as to the time period over which it would anticipate such proration to occur?**
A48		In accordance with Section IV.B.3.b.(2) of the RFP, the Offeror shall forfeit its proposed percentage of 2014 Claims Administration Fees (prorated on a daily basis) starting January 1, 2014 until all Implementation and Start Up requirements in Section IV.B.3.a.(2) are in place. For example, if the 2014 Claims Administrative Fee was $3,650,000, the Offeror proposed a 50% credit, and the Offeror fully implemented the Program on January 11, 2014, the implementation credit would equal 50% multiplied by $3,650,000, then multiplied by 10/365, or $50,000.
Q49	**IV.B.4 - (Pg 4-12)**	**Please provide call center statistics for the NYSIF program. Please provide web statistics for the NYSIF program.**
A49		The Call Center statistics are not available for the NYSIF Program. The NYSIF Program does not require a customized website.
Q50	**IV.B.4 - (Pg 4-12)**	**Are both call centers routed off the NYSHIP number? Or is NYSIF a separate toll free number not affiliated with the NYSHIP line?**
A50		The NYSIF Prescription Drug Program will have a separate toll free phone number which will not be routed off the NYSHIP toll free phone number.
Q51	**IV.B.4 - (Pg 4-13)**	**Define dedicated call center.**
A51		As stated in Section VIII "Glossary of Terms," Dedicated Call Center means a group of Customer Service Representatives trained and capable of responding to a wide range of questions, complaints, and inquiries specific to the Programs. The Customer Service Representatives are dedicated to the Programs and do not work on any other accounts.
Q52a	**IV.B.4 - (Pg 4-13)**	**Can an[d] Offeror propose a dedicated call center for the peak hours 7-7pm est and then a designated call center for after hours when the call volume is low?**
Q52b	**IV.B.4 - (Pg 4-13)**	**Can an Offeror propose dedicated call center (s) during core peak volume business hours and rollover to a designated call center (s) for after core hours that would be equally trained in the Program's benefits?**

A52 (a-b)		Yes, this is acceptable. During high volume call hours of 7:00 am – 7:00 pm ET calls must be handled by separate Dedicated Call Centers for NYSIF's and DCS' Programs. During the low volume call hours, calls may be handled by a designated call center(s) for the Programs. The designated call center(s) must be located in the United States and calls must be routed to customers service representatives with Program specific training. Section IV.B.4 has been amended.
Q53a	**IV.B.4 - (Pg 4-13)**	**Is the requirement that there be 2 call centers separate and distinct from each other without rollover of calls between the two centers?**
Q53b	**IV.B.4 - (Pg 4-13)**	**If the call centers are separate, is there a requirement that callers be transferred between call centers if they have both NYSHIP and NYSIF business to attend to[o]?**
A53 (a-b)		The RFP requires the selected Offeror to maintain separate call centers for the DCS' and NYSIF's Programs. As such, rollover of calls will not be required.
Q54	**IV.B.4 - (Pg 4-13)**	**Please confirm if under the EGWP, a third CMS approved process for handling Medicare calls can be proposed.**
A54		Not confirmed. See answer Q&A 52 (a-b). The DCS Program Dedicated Call Center and any designated call center(s) used for the EGWP must be CMS approved facilities. Separate designated call centers may be used for the EGWP and active DCS Program as long as each has program specific training.
Q55	**IV.B.4 - (Pg 4-13)**	**Can an Offeror propose a dedicated call center unit within a larger call center for each of the programs?**
A55		Yes, the Offeror may propose a Dedicated Call Center unit within a larger call center for each of the Programs as long as it meets the definition of a Dedicated Call Center contained in Section VIII "Glossary of Terms."
Q56	**IV.B.4 - (Page 4-13)**	**Is there a requirement for enrollees to have access to a customized website for NYSIF claims and transactions?**
A56		No – As the RFP states, this requirement is excusive to DCS.
Q57	**IV.B.4 – (Pg 4-13)**	**As long as pharmacists are available 24/7/365, are CSRs and Supervisors also required to be available 365 days per year, or would 363 suffice?**
A57		In addition to pharmacists, customer service representatives, and supervisors must be available 24 hours a day 365 Days a year as stated in Section IV.B.a.3 "Customer Service."
Q58	**IV.B.4 – (Pg 4-13)**	**Will the Programs' Med D members be serviced by the Dedicated Customer Service team? Or can the vendor service your Med D members with CSRs who are specially trained in and dedicated to Med D plans?**
A58		The DCS Program Dedicated Call Center is required to service calls for all Enrollees, including those enrolled in the EGWP+Wrap program. Dedicated customer Services Representatives are expected to be trained and capable of handling enrollee issues related to both the EGWP+Wrap program and the benefits for active enrollees.
Q59	**IV.B.4 – (Pg 4-15)**	**Subsection (2) refers to a shared service agreement with the Empire Plan Medical Insurer and AT&T. Do the Procuring Agencies intend the shared service agreement to be in a specific form? If so, can a copy be provided?**
A59		A copy of the most current agreement is attached
Q60	**IV.B.5 (Pg 4-19)**	**After reviewing the data available by the DCS for the RFP, there is no evident way to identify Enrollees who will be eligible for the EGWP Portion**

<table>
<tr><td></td><td></td><td>of the Programs. We are respectively requesting census data and claims spend for the EGWP eligible enrollees.</td></tr>
<tr><td>A60</td><td></td><td>Exhibit II.B.2 of the RFP provides the number of Enrollees with Medicare Primary coverage as of December 2011. The DCS claims file provided to interested Offerors for the RFP's repricing exercise includes a Medicare Part B indicator to assist Offerors with projecting EGWP enrollment and claim spend.</td></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td>Q61</td><td>IV.B.5. (Pg 4-19)</td><td>Under the Duties and Responsibilities for the EGWP there is no specific requirement stated to develop a pharmacy network that is CMS compliant and meets the obligation of "Any Willing Provider". Is it the intent of the DCS to use the commercial and WC network for the EGWP and if so the network must include an "Any Willing Provider" provision which may dilute the discount effectiveness of the commercial network. How will the DCS address this CMS regulation?</td></tr>
<tr><td>A61</td><td></td><td>The RFP requires the selected Offeror to have one network for all DCS Programs (which includes the EGWP+Wrap program) and the NYSIF Program. Pertaining to the CMS regulation of "Any Willing Provider," any pharmacy will be allowed to join the Programs' pharmacy network contingent on meeting all of the Network Pharmacy requirements set forth in the RFP and the acceptance of the selected Offerors contractual terms and conditions.</td></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td>Q62</td><td>IV.B.5 – (Pg 4-22)</td><td>So that we may provide a formulary disruption for all lines of business, please provide a formulary listing for each proposed formulary in Excel format with the NDCs and drug names at a minimum.</td></tr>
<tr><td>A62</td><td></td><td>Drug lists are not available in the requested Excel format. For DCS Program drug lists, refer to Exhibit II.I.1 (2012 Preferred Drug List), Exhibit II.I.3 (2012 Flexible Formulary) and Exhibit II.I.4 (2012 Excelsior Preferred Drug List). NYSIF's PDL is not a published document.</td></tr>
<tr><td>Q63</td><td>IV.B.6. (Pg 4-23)</td><td>Please provide the volumes per type of enrollee communication materials for both the Empire Plan and the NYSIF programs. Specifically:
1) PDL's
2) SPD's
3) ID Cards for NYSIF both temporary and permanent</td></tr>
<tr><td>A63</td><td></td><td><table><tr><th></th><th>NYSIF Program</th><th>DCS Program</th></tr><tr><td>PDLs</td><td>0</td><td>Approx 650,000 per year</td></tr><tr><td>SPDs</td><td>0</td><td>N/A</td></tr><tr><td>ID Cards</td><td>7,000 to 10,000 per month</td><td>For EGWP Enrollees only, if proposed by Offeror</td></tr></table>
Note: The contractor is NOT responsible for issuing temporary ID cards to NYSIF Claimants. The Contractor is responsible only for providing permanent ID cards.</td></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td>Q64</td><td>IV.B.7. (Pg 4-23)</td><td>Can the Offeror propose a standard card already developed within our organization for the NYSIF Program?</td></tr>
<tr><td>A64</td><td></td><td>Yes – provided it contains the necessary information</td></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td>Q65</td><td>IV.B.7 – (Pg 4-28)</td><td>Subsection (7) refers to Offeror's staff being available to access enrollment information through NYBEAS. What are the Procuring Agencies' expectations as to the Offeror's obligations for enrollment information that is</td></tr>
</table>

		loaded in NYBEAS that has not yet been transmitted to the Offeror in an updated eligibility file?
A65		The intent of DCS providing read-only NYBEAS access is to allow the Offeror's customer service representatives to resolve questions of enrollee eligibility without having to contact DCS. If it is discovered that the Offeror's enrollment file is incorrect for an individual, the DCS would expect the Offeror to adjudicate escalated claims, on a case-by-case basis, to reflect the Enrollee's real time information as it resides in NYBEAS. The daily transaction file submitted by DCS to the Offeror reflects the daily NYBEAS enrollment transactions. These daily enrollment transactions should be applied to the Offeror's file and utilized for claims processing.
Q66	**IV.B.7. (Pg 4-29)**	**Would NYSIF provide a separate patient eligibility file and accept and submit an electronic billing file?**
A66		NYSIF will provide a daily eligibility file with new claims and/or changes to established claims. NYSIF will accept an electronic billing file.
Q67	**IV.B.7. (Pg 4-29)**	**Please describe the short fill procedure? Does the process exist within the adjudication system or through the pharmacy network manual with an identified list of drugs and guaranteed payment? Please provide the volume of "instant enrollments" as experienced under the NYSIF short fill program. THE RFP is unclear as to the Program's expectation.**
A67		Claimant reports injury to employer, receives information packet, including policy number, from employer. If after receiving medical attention, claimant requires prescription medication, claimant takes information packet to pharmacy and fills prescription. Pharmacy notifies PBM and fills prescription. PBM notifies NYSIF of the fill in the daily Short Fill file. NYSIF creates a claim and notifies PBM of claim number. There is an identified list of drugs available through the short fill procedures. For drugs not on the List, the claimant must pay cash for the drug and submit a claim directly to NYSIF, outside of the NYSIF drug Program.
Q68	**IV.B.7. (Pg 4-30)**	**You state the Offeror needs to be able to administer three ID numbers; a social security number, alternate id number and employee ID number; do we need to be able to adjudicate a POS claim off of any of these three numbers? Is the social security number, the alternate identification number for the Empire Plan and the Employee Identification Number for NYSIF eligibility only? Are the eligibility files to be coordinated?**
A68		The selected Offeror's claims processing system must have the capacity to adjudicate POS claims utilizing any of the three (3) identification numbers: Social security number, alternate identification number, and carrier case number. DCS' Program utilizes social security and alternate identification numbers. NYSIF assigns claim numbers (carrier case numbers) to each claimant/date of accident. This is the number the claimant uses to fill the prescription and the number used for claim processing. The exception to this is the short fill program. Claimants use the employer information and policy number on the temporary ID card to obtain prescriptions. DCS and NYSIF will each send separate daily enrollment files to the Offeror. DCS' eligibility file will include Enrollee social security number, alternate identification number, and employee identification number, which is used to link family members. NYSIF's eligibility file includes the Claimants carrier case number, policy number, and social security number.
Q69	**IV.B.7. (Pg 4-31)**	**Please confirm that eligibility related to the EGWP Program will be exempt from the 24 hour turnaround time guarantee since loading eligibility under the EGWP is dependent on CMS approval.**
A69		Confirmed. Enrollment records for EWGP participants will be exempt from the

		Enrollment Management Guarantee. However, the Offeror is required to meet all CMS enrollment requirements including any mandated turnaround times.
Q70	**IV.B.8. (DCS Reporting - Pg 4-34)**	**The Annual Rate Renewal Report must include PDL changes related to the various programs, please confirm that the various program's PDLs must be locked down and approved by the NYS agencies prior to the release of the report.**
A70		Flexible Formulary and PDL changes for the upcoming year are typically developed and presented to the DCS by the September 1st Annual Rate Renewal Report due date, but may not necessarily have been formally approved by the Department. The Annual Rate Renewal Report should be developed based on the best information available at the time regarding DCS acceptance of Flexible Formulary and PDL changes.
Q71	**IV.B.8. (DCS Reporting - Pg 4-35)**	**Please cite the reference to the "weekly pharmacy billing file". Is this another report not listed in the reporting section? Is this referencing the Detailed Claim File Data required in a bi-weekly basis?**
A71		The reference to the "weekly pharmacy billing file" in the paragraph describing the annual Rebate True-Up File, has been amended to change "weekly" to "bi-weekly" to coincide with the Detailed Claim file.
Q72	**IV.B.8. (DCS Reporting - Pg 4-37)**	**Please define what is the "assessment of DCS Program costs?"**
A72		The "assessment of DCS Program cost" refers to a narrative of the Offeror's projections of current plan costs and its assessment as to why those projections are different from both the costs of the prior plan year as well as the costs projected at rate renewal and prior quarterly reports.
Q73	**IV.B.8. (NYSIF Reporting - Pg 4-44)**	**Is the encryption methodology for NYSIF the same as for the DCS?**
A73		The Procuring Agencies will work with the selected Offeror to establish a standard encryption/decryption methodology for the secure delivery of data at the time of implementation.
Q74	**IV.B.8. (NYSIF Reporting – Pg 4-44)**	**Capturing and providing NYSIF with electronic files of eligibility and authorization on the GC3, or similar code level. The Offeror should have the capability to capture drug denials on the GCN and NDC code levels; Since (the Offeror) adjudicates claims using Medi-Span, we can provide a formulary file that contains the NDC, GPI and a therapeutic class description as GPI6 level. Please confirm that GPI will meet the obligation under the requirement.**
A74		Offerors may use GCN or GPI, consistent with their claims adjudication platform.
Q75	**IV.B.11 (Network Management – Pg 4-55)**	**Are Offerors required to propose a single pharmacy network for the DCS and NYSIF Programs?**
A75		Yes, Offerors must propose a single pharmacy network to be utilized for all Programs.
Q76	**Section IV.B.11: Retail Pharmacy Network (Pg 4-57)**	**The selected Offeror shall include in its Retail Pharmacy Network any Pharmacy(ies) upon the Department's or NYSIF's request, where such inclusion is deemed necessary by the Procuring Agencies to meet the needs of Enrollees even if not otherwise necessary to meet the minimum access guarantees outlined below. Please confirm that for any pharmacy added to the Offeror's retail pharmacy network at the request of the DCS or NYSIF, claims processed at these pharmacies will be excluded**

		from the calculation of the guaranteed minimum discounts for brands, generics and specialty drugs.
A76		Confirmed.
Q77	**IV.B.11 (Network Management – Pg 4-58)**	**Please clarify the meaning of "actual distance" i.e., driving distance or 'as the crow flies.'**
A77		Actual distance means driving distance from Enrollees' residences.
Q78	**IV.B.11 (Pg 4-63)**	**Without a Workers' Compensation-specific retail contract a participating pharmacy can circumvent the all-Payor group health contract and direct scripts to 3rd parties; will NYSIF allow for the network to be modified or contracted to include compliance provisions for the participating pharmacies?**
A78		Yes, if network contracts must be revised, the Offeror should do so to ensure program compliance.
Q79	**Section IV.B.11: Pharmacy Contracting (Pg 4-64)**	**If the Offeror does not currently contract with all the HCAP Program Pharmacies and the Offeror recruits said pharmacy to participate, will claims processed at said pharmacy be excluded from the calculation of the guaranteed minimum discounts for brands, generics and specialty drugs?**
A79		No, The HCAP Program pharmacies must also be included in the calculation of the guaranteed minimum discounts for brand, generic, and Specialty Pharmacy Program drugs.
Q80	**IV.B.11 (Mail Service Pharmacy Process – (Pg 4-68)**	**Are the Procuring Agencies open to discussion regarding Mail Service Pharmacy processes that are slightly different than what you have outlined in this section? For example, in item a.(1), the RFP states "must be capable of dispensing all covered, FDA approved medications." However, some medications are not dispensed (e.g., those that are flammable).**
A80		Facilities involved in the Offeror's Mail Service Pharmacy Process are expected to comply with all applicable State and/or Federal laws, rules and regulations. If a facility is prohibited under the laws of the state in which it is located from filling a prescription as presented, the Programs expect the Selected Offeror to either route the prescription to another mail service facility that can fill the prescription or contact the prescribing provider to have an acceptable prescription issued. If neither approach corrects the problem, the Selected Offeror must promptly inform the enrollee of the problem and provide assistance, as necessary, to facilitate the enrollee receiving needed medications in a timely manner.
Q81	**IV.B.11 (Mail Service Pharmacy Process – (Pg 4-72)**	**Subsection (15) refers to establishment of a payment plan for Enrollees, upon request. Do the Procuring Agencies have any objections to the Proposer arranging for this through a partnership with an unaffiliated third party, based on a review of Enrollee credit-worthiness? If this is not permitted, may the successful proposer invoice the Procuring Agencies for any Copayments remaining unpaid after a reasonable collection effort?**
A81		There are no copayments under the NYSIF Program. In accordance with Section IV.B.11.(a)(15), (Mail Service Pharmacy Process), the DCS Program expects the selected Offeror to assist Enrollees, upon request, in establishing a payment plan, based on their prior payment history, to ensure prescriptions essential to the Enrollee's health continue to ship when the outstanding amount temporarily exceeds the Offeror's proposed maximum limits. Enrollees are expected to make regular and full payments. The DCS Program will not permit referral to a third

		party credit agency nor will the Program compensate the Offeror for unpaid copays.
Q82a	**IV.B.11 (Retail Pharmacy Network – Pg 4-57)**	**Please clarify how Limited Distribution Specialty drugs dispensed at Retail are to be handled.**
Q82b	**IV.B.11 (Mail Service Pharmacy Process – (Pg 4-59, 4-68, and 4-80)**	**Will Limited Distribution Drugs submitted through the Mail Service Pharmacy Process be charged to the Programs based on the Offeror's Retail Network pricing terms?**
Q82c	**IV.B.11 (Mail Service Pharmacy Process – (Pg 4-68, 4,69, 4-80, and 4-82)**	**Please clarify how Limited Distribution specialty drugs dispensed at Mail are to be handled. Appears to be a conflict between Mail Service Duties and responsibilities outlined on page 4-59 and Specialty Drugs duties and responsibilities outlined on page 4-80.**
Q82d	**IV.B.11 (Retail Pharmacy Network – Pg 4-69)**	**Limited Distribution Drugs submitted through the Mail Service Pharmacy Process shall be charged to the Program based on the Offeror's Retail Network pricing terms and dispensing fees (if any) applicable to Brand Name, Generic and Compound Drug claims as set forth in Exhibit V.A." this is in conflict with page 4-80 a. duties and responsibilities (b) The Offeror must facilitate the Enrollee's receipt of the Limited Distribution Drug by obtaining the drug from an authorized distributor and billing the Programs consistent with its Guaranteed Discounts applicable to Brand Drugs for the mail service pharmacy. This also seems conflicting to page 4-83 a. duties and responsibilities (3) The Offeror must establish a process to provide Enrollees with access to Limited Distribution Drugs not available through the Designated Specialty Pharmacy(ies), which places no additional steps or burdens on the Enrollee. The Offeror must bill the Programs for these Prescriptions consistent with the Offeror's Minimum overall Guaranteed Discount applicable to Prescriptions dispensed at Network Pharmacies. Please clarify the requirement.**
A82 (a-d)		For the purpose of the RFP, Limited Distribution Drugs are defined as those prescription drugs whose distribution is limited by the manufacturer and which are NOT available at the Offeror's Designated Specialty Pharmacy and/or Mail Service Pharmacy. As such, these drugs would NOT be part of the Offeror's Specialty Pharmacy Program. The Procuring Agencies require that the Offeror will help facilitate receipt of these drugs from a limited distribution supplier, placing no additional steps or burdens on the enrollee. Pricing is dependent on whether the Enrollee is eligible for the Specialty Pharmacy Program, whether the script was sent to a retail or mail order pharmacy, and whether the Offeror has a retail network agreement with the limited distribution supplier. It is expected that the Offeror arrange for coverage for Limited Distribution Drugs through a participating Retail Network Pharmacy or cover these drugs under the Specialty Pharmacy Program in order to have minimal impact on Enrollees. Section IV - Pages 4-80, 4-81, and 4-84 of the RFP have been amended to clarify pricing requirements for Limited Distribution Drugs.
Q83	**IV.B.11 (Specialty Drugs / Medications – Pg 4-79)**	**Please provide a specialty drug list specific to NYSIF?**
A83		NYSIF will provide this information to the company that is awarded the contract. Specialty Drugs/Medications dispensed under the NYSIF Program for the period November 1, 2010 through November 1, 2011 may be obtained in the NYSIF Program claims data file.

Q84	**IV.B.11 (Specialty Drugs / Medications – Pg 4-79)**	**Does NYSIF cover specialty drugs dispensed and billed by a physician's office or in a hospital setting?**
A84		Specialty drugs dispensed and billed by a physician or a hospital are not covered through the NYSIF Drug Program. These providers bill NYSIF directly.
Q85a	**IV.B.11 (Specialty Drugs / Medications – Pg 4-79)**	**Are all Specialty Drugs/Medications required to have the same pricing discounts?**
Q85b	**IV.11 (Specialty Drugs / Medications -Pg 4-79 – 4-80)**	**This reads: Specialty Drugs/Medications Received Through the Retail Pharmacy Network or the Mail Service Pharmacy Process For those groups that receive Specialty Drugs/Medications through the Retail Pharmacy Network or the Mail Service Pharmacy Process, the Programs make no distinction for Specialty Drugs/Medications for pricing purposes and the Offeror is strictly prohibited from proposing an alternative pricing arrangement for any FDA approved drug or class of drugs. All drugs shall be classified as either brand name, generic, or compound for pricing purposes based on the methodologies set forth in Section V of this RFP. Proposals that exclude Specialty Drugs/Medications from proposed pricing for brand name, generic and Compound Drugs, whether by omission or by the submission of an alternate pricing proposal will be removed from consideration. The Programs shall be entitled to all manufacturer revenue derived from Specialty Drugs/Medications.** **We read this as requiring that no separate specialty discount is allowed. However, Exhibit V.A has a section for Specialty Pharmacy Program.** **Please confirm that Specialty drugs dispensed through the PBM's Specialty Pharmacy are not required to have the same discount as non-Specialty retail or mail drugs.**
Q85c	**IV.11 (Specialty Drugs / Medications -Pg 4-79 – 4-80)**	**Also, our mail service pharmacy does not dispense specialty drugs. Please confirm that non-retail specialty drugs for all groups, whether they have an open or exclusive specialty drug benefit, will be dispensed from the PBM's specialty pharmacy at specialty discounts, and not at mail pharmacy discounts.**
Q85d	**IV.B.11 (Specialty Drugs / Medications – Pg 4-80)**	**Confirm that Specialty Price List with Variable AWP based Discounts will be acceptable for the proposal?**
A85 (a-d)		Not confirmed. The pricing for Specialty Drugs/Medications is dependent first on whether the Enrollee participates in the Specialty Pharmacy Program and second, where the drug is dispensed. Offerors must propose a single Guaranteed Discount off AWP for all Specialty Drugs/Medications dispensed through the Specialty Pharmacy Program. Offerors may propose guaranteed dispensing fees, on an NDC basis, for each drug proposed to be included in the Specialty Pharmacy Program in Exhibit V.D. Pricing for Specialty Drugs/ Medications not dispensed through the Specialty Pharmacy Program is dependent on whether the script is sent to a retail or mail order pharmacy.
Q86	**IV.B.11 (Specialty Drugs / Medications – Pg 4-80)**	**When presenting a new specialty pharmacy drug for consideration to the Specialty Pharmacy Program, the Offeror must proposed a discount that cannot exceed the guaranteed discount on specialty pharmacy drugs, will the Offeror have any requirements when submitting the dispensing fee for the particular drug?**
A86		As set forth in Section V.C.9.a.(1) of the RFP, dispensing fees for claims filled at the Designated Specialty Pharmacy(ies) may be variable, commensurate with the level of clinical services offered through the Specialty Pharmacy Program. The Procuring Agencies must approve the selected Offeror's proposed dispensing fee before the drug is added to the Specialty Pharmacy Program.

Q87	**IV.B.11 (Specialty Pharmacy Program – Pg 4-87)**	**Will Offerors be required to use the criteria established by NYS for the addition/inclusion of medications on the specialty drug list or will NYS allow the Offeror to propose criteria for use in determining the addition/inclusion of new specialty medications on the specialty drug list as they are launched onto the market? If NYS mandates the use of its own criteria, please provide additional details regarding the criteria for specialty drugs.**
A87		The criteria set forth in Section IV.B.11 (Specialty Pharmacy Program), represents the Procuring Agencies' minimum established criteria for the addition/inclusion of medications on the Specialty Pharmacy Program drug list. In accordance with Section IV.B.11.b.(1)(7), Offerors may propose additional criteria for the Procuring Agencies' consideration. The Procuring Agencies have final approval over new drugs proposed to be added to the Specialty Pharmacy Program.
Q88	**IV.B.11 (Specialty Pharmacy Program – Pg 4-87)**	**Subsection (23) states that newly introduced Specialty Drugs may not be priced at a rate higher than the Guaranteed Discount on Specialty Drugs. It is not uncommon for a new Specialty Drug in a new drug class to be priced in a manner that is inconsistent with the pricing for other Specialty Drugs and Proposer has found that it may not always be able to obtain and provide such new Specialty Drugs at pricing levels consistent with other Specialty ~~Dugs~~ [Drugs]. In such circumstances, is it the Procuring Agencies' preference to not cover the Specialty Drug through the Specialty Drug Program, but rather just through the retail pharmacy network (if available) or through physicians' offices via the medical benefit?**
A88		The Offeror is required to propose newly launched Specialty Drugs/Medications for the Specialty Pharmacy Program if they are clinically appropriate for the program. Specialty Drugs/medications that are not included in the Specialty Pharmacy Program must be available to Enrollees through the Retail Network and Mail Service Pharmacy. Prescription drugs dispensed in a physician's office are not covered under the DCS and NYSIF Drug Programs.
Q89	**IV.B.11 (Specialty Pharmacy Program – Pg 4-87)**	**Recommending newly launched Specialty Drugs/Medications for inclusion in the Specialty Pharmacy Program based on the established criteria/definition of Specialty Drug/Medications, in a format to be approved by the Procuring Agencies. Prior to inclusion in the Programs, or if not accepted by the Procuring Agencies to be included in the Programs, the Offeror must bill the Programs for these Prescriptions consistent with the Offeror's contracted discount off of AWP at the dispensing Network Pharmacies or the Guaranteed Discount at the Mail Service Pharmacy Process, based on where each Prescription was actually dispensed. Inclusion of new Specialty Drugs/Medications shall have a cost- neutral or positive financial impact on the Program, and in no case shall the Ingredient Cost of a newly added Specialty Drug/Medication charged to the Program exceed the Guaranteed Discount on Specialty Pharmacy Drugs. What is the typical turn around time for the Programs to approve the addition of a new drug to the Specialty Program? How shall the Offeror process the claim in the interim while waiting approval from the Programs to add the drug to the Specialty Pharmacy Process. Can the claim be retroactively adjusted to the Specialty Pharmacy guaranteed discount?**
A89		Each Specialty Drug/Medication proposed for inclusion in the Specialty Pharmacy Program is considered on a case by case basis. Typically, approval/disapproval of a drug is made within a week of the date all clinical and financial information necessary for a determination is received. However, the turnaround time can vary. Prior to inclusion in the Specialty Pharmacy Program, or if not accepted by the

		Procuring Agencies to be included in the Specialty Pharmacy Program, the Offeror must bill the Programs for these Prescriptions consistent with the Offeror's contracted discount off of AWP at the dispensing Network Pharmacies or the Guaranteed Discount at the Mail Service Pharmacy, based on where each Prescription was actually dispensed. Specialty Pharmacy Program pricing will be effective on the date the drug is approved, in writing, by the Procuring Agencies for inclusion in the Specialty Pharmacy Program.
Q90	**IV.B.11 (Specialty Pharmacy Program – Pg 4-88)**	**Can the Procuring Agencies please provide some details regarding the successful proposer's obligations with respect to processing foreign claims under the Program?**
A90		In instances where the Offeror's designated Specialty Pharmacy is unable to ship a medication to an Enrollee's foreign address, the Enrollee will be granted a Specialty Pharmacy Program override so that he/she may seek a local supply of the medication and submit a paper claim (Enrollee Submitted Claim) to the Offeror for processing/reimbursement in accordance with the respective Procuring Agencies' benefit designs.
Q91	**IV.B.12 (Pg 4-88)**	**Please clarify the situations in which HCAP providers would not supply medications.**
A91		In limited instances, an HCAP provider may not be affiliated with a participating Retail Pharmacy, for example, a rural provider that provides infusion services.
Q92	**IV.B.12 (Pg 4-90)**	**Subsection a(1)(i) specifies that all claims data is the property of the Procuring Agencies and it will be shared with the carriers and consultants specified by the Department. Is it the Procuring Agencies expectation that the successful proposer will be permitted to require third party recipients to execute an appropriate confidentiality agreement and to otherwise reasonably protect the confidentiality of the claims data, including the proposer's interests in the pricing data contained in the claims records, which constitutes the proposer's protectable trade secret information?**
A92		The Procuring Agencies will work with the selected Offeror in establishing reasonable protections, including the use of confidentiality agreements, for sensitive data that is shared with consultants and other carriers.
Q93	**IV.B.12 (Pg 4-90)**	**Please distinguish between or define a claim submitted or processed due to fraud and a claim submitted to processed due to abuse and provide an example of each. Who has the final say in determining whether the claim submitted or processed was due to fraud or abuse? If the claim was submitted and processed with valid eligibility and in accordance with the plan design established by the Program under what circumstances would the Offeror be obligated to refund the DCS/NYSIF?**
A93		For purposes of this RFP and the draft Contracts, "**fraud**" is defined as an intentional deception or misrepresentation made by a party(ies) or person(s) with knowledge that the deception could result in some unauthorized benefit to a party(ies) or person(s). For purposes of this RFP and the draft Contracts, "**abuse**" is defined as an action(s) by a party(ies) or person(s) that is/are inconsistent with accepted, sound medical, business, or fiscal practices resulting in an otherwise inappropriate and/or unnecessary cost to the DCS/NYSIF Program. The Department has the final say in determining whether the claim submitted or processed was due to fraud or abuse. Any dispute regarding

		the determination of fraud or abuse shall be resolved in accordance with the "Dispute Resolution" provisions of Appendix B.
Q94	**IV.B.12 (Pg 4-90)**	**Please define "over-dispensing".**
A94		In the context of RFP section IV.B.12: Claims Processing, over-dispensing means the Offeror's utilization edits and controls over prescription refills are inadequate to prevent excessive dispensing and/or stockpiling of drugs, resulting in increased costs to the Programs.
Q95	**IV.B.12 (Pg 4-99)**	**Please clarify your expectations in regards to the adjudication system interacting with the debit card program. Do you expect copays for eligible flexible spending claims to be automatically reimbursed for those enrollees with a flexible spending account?**
A95		The Procuring Agencies have no expectations at this time regarding a flexible spending account debit card program other than learning whether an Offeror's claims processing system has the ability to interact with a debit card program for flexible spending accounts. The current flexible spending account program does not utilize a debit card.
Q96	**IV.B.13 (Pg 4-101)**	**Retrospective Coordination of Benefits: How many retrospective COB claims and the $ that were recovered in 2011?**
A96		In 2011 a total of $500,105 was recovered from 1,022 claims under the DCS Programs.
Q97	**IV.B.13 (Pg 4-101)**	**Retrospective Coordination of Benefits: What are the expectations and/or requirements of the Offeror to survey the DCS population to determine if there is alternative coverage (once per year ?)**
A97		In accordance with Section IV.B.13, Offerors are required to provide a detailed description of the process they will employ to conduct the DCS Program's retrospective coordination of benefits (COB) requirement. The RFP's requirements do not specify the mailing frequency for Enrollee surveys and questionnaires to confirm other prescription drug coverage. DCS will work with the selected Offeror in developing a retrospective COB process, including mailing frequencies, during the implementation phase. The current process does not employ the use of annual surveys. See Q&A 98.
Q98	**IV.B.13 (Pg 4-102)**	**Please provide additional detail on DCS's Retrospective Coordination of Benefits. How is this administered today?. What vendor currently provides retrospective COB services for DCS?**
A98		DCS' Retrospective Coordination of Benefits (COB) Program is currently administered by the Rawlings Group, a third party vendor. The vendor mails COB questionnaires to Enrollees suspected of having other coverage. If other coverage is confirmed, the vendor corresponds with Enrollees and other payers to secure recovery of amounts overpaid.
Q99	**IV.B.14 (Pg 4-108)**	**Under NYSIF, if a pharmacy submits a claim for a brand name drug that has an A-rated generic or authorized generic, what will the reimbursement to the pharmacy be, brand or generic? Will MAC pricing apply and if so, the MAC list cannot mirror the Empire Plan MAC list as the brand name drug must be exempt from mandatory generic substitution. Can DAW-0 claims be rejected under the NYSIF program as well, please clarify the requirement.**
A99		The difference between the DCS Program NYSIF Program is that the DCS

		Program charges copays and ancillary charges to the Enrollee. There should be no difference between DCS and NYSIF in the total amount paid to the pharmacy. The difference is who pays – DCS has the different levels of copays, NYSIF pays the entire amount. If a pharmacy submits a claim for a brand name drug that has a A-rated generic or authorized generic, the reimbursement to the pharmacy should be generic, unless the prescription is DAW-1. As stated in the RFP, DAW-0 claims should be rejected by the offeror for further clarification of why the substitution was not made.
Q100	**IV.B.14 (Pg 4-109)**	**Please confirm if the GAP Process must be offered for Excelsior enrollees?**
A100		The Excelsior Plan benefit design should mirror the Offeror's book of business plan. If the Offeror's book of business benefit design includes a generic appeal process, it should be proposed for the Excelsior Plan. Otherwise, a generic appeal process is not required for the Excelsior Plan.
Q101	**IV.B.14 (Mandatory Generic Substitution – Pg 4-110)**	**Is the development of actual form (i.e., "Appeal Form") required?**
A101		Yes. In accordance with Section IV.B.14.a.(1), the selected Offeror is required to develop an appeal form as part of administering the Mandatory Generic Substitution Appeal Process.
Q102	**IV.B.14 (Mandatory Generic Substitution – Pg 4-110)**	**Please clarify: Does the "five (5) Business Days" allowed for preparing communications to notify Enrollees of the outcome of appeals pertain to Urgent or Non-Urgent appeals?**
A102		The five (5) Business Day notification turnaround time requirement set forth in Section IV.B.14.a.(1), pertains to all mandatory generic substitution appeals. Note that the Offeror is responsible for reimbursing Ancillary charges paid up to 30 days prior to receipt of the approved appeal.
Q103	**IV.B.14 (Mandatory Generic Substitution – Pg 4-110)**	**Please clarify the term "Interfacing".**
A103		In the context of IV.B.14.a.(5), "Interfacing" means responding to questions and requests from the New York State Department of Financial Services regarding External Appeals filed by DCS Program Enrollees.
Q104	**IV.B.15 (Pg 4-113)**	**Please provide a list of drugs that require PA under NYSIF. What message should be sent back at the POS? Where does the claimant call to get PA approval? How is it handled today? What is the volume of calls expected for these medications and the volume of claims for these medications? Does the Claimant have the right to external appeal upon denial by NYSIF? Where do we direct the claimant? Is there any requirement of the Offeror to develop clinical criteria for Prior Authorization drugs?**
A104		A list of drugs that require PA is part of the current formulary. NYSIF will work with the winning bidder to develop a list of drugs that will require PA. The claimant does not request PA, PA is requested by the dispensing pharmacy. The Offeror should have a process in place with the network pharmacies to obtain PA via telephone or internet. There are between 100 - 150 requests per day. If PA is denied, the Claimant would need to adjudicate the denial through the Workers' Compensation Board.

Q105	**IV.B.14 (Clinical Mgt/Retrospective DUR Pg 4-120)**	**The RFP states "Offerors may propose a voluntary Half Tablet Program"... This wording suggests this may be an optional program. Is this a minimum requirement to the RFP or a Patient Education program that is viewed as optional should we choose to propose an alternative approach?**
A105		The submission of a proposal for a voluntary Half Tablet Program under the RFP is optional.
Q106	**IV.B.15 (Clinical Mgt/Drug Utilization Review – Pg 4-121)**	**Based on our P&T Committee's clinical review and analysis, would the Procuring Agencies be willing to discuss changes to the list of drugs currently included in Half Tablet Program (Exhibit II.M)?**
A106		Yes, in accordance with Section IV.B.15 (Patient Education).a.(2)a, Offerors that propose a voluntary Half Tablet Program are required to establish a listing of drugs that are appropriate for inclusion in the Half Tablet Program.
Q107	**IV.B.15 (Clinical Mgt/Retrospective DUR – Pg 4-121)**	**Would the Programs be open to providing Enrollees with tablet splitters?**
A107		If a Half Tablet Program is proposed by the Offeror, Section IV.B.15.a.(2).c. requires the selected Offeror to provide each Enrollee newly participating in the Half Tablet Program with one tablet splitter, at no charge to the Enrollee.
Q108	**IV.B.15 (Clinical Mgt/Retrospective DUR – Pg 4-122)**	**How many enrollees have volunteered for this (Half Tablet Program) program and currently have tablet splitters today? How many new enrollees volunteer on a yearly basis?**
A108		Approximately 28,000 DCS Program Enrollees currently participate in the Half Tablet Program. Annual enrollment counts and the number of tablet splitters that have been issued to Enrollees are unavailable
Q109	**IV.B.16 (Pg 129)**	**The RFP states that the successful proposer "must assist the Department in collecting monies from recalled products." Can the Procuring Agencies provide additional detail regarding the scope of assistance expected? Typically, Proposer would provide appropriate reports showing the recalled products recently dispensed to members and paid for by the plans.**
A109		DCS expects the selected Offeror to keep them informed of any Drug recalls including any impact on Enrollees. The Programs seek to be financially protected from paying for a drug twice due to a manufacturer's recall. To the extent credits or recoveries are available, the Programs expect the Offeror to pursue and credit the Programs.
Q110	**IV.B.16 (Pg 130)**	**Subsection B.16.a(14) asks the Offeror to be responsible for taking appropriate steps to control Prescription Drug AWP increases. Please confirm the Procuring Agencies' understanding that AWP is published by and independent source that the proposer cannot control.**
A110		The Procuring Agencies understand that AWP is published by an independent source outside the control of the Offeror. However, the Offeror is responsible for managing the Programs' formularies, which includes pharma revenue and other cost related negotiations. If an Offeror negotiates a rebate with a pharmacy manufacturer in exchange for placement of the drug on the formulary, and the pharmacy manufacturer subsequently increases the price of the drug, the Programs may not be charged the lowest possible cost. The Procuring Agencies expect the Offerors to take steps to ensure that formulary placement and management achieves the desired financial objectives, including possible use of AWP caps, as described in the response to Q121.

Q111	**IV.16 (Pg 4-130)**	**Please confirm provider refers to physician.**
A111		Section IV.16.a.(12) of the RFP references newsletters sent to participating providers under the Empire Plan's Medical and Mental Health/Substance Abuse Programs. Under these Empire Plan programs, provider means physicians as well as other medical and behavioral health providers. Please see Exhibit II.D.2 (Empire Plan Certificate of Insurance) for detailed definitions of "provider."
SECTION V – COST PROPOSAL REQUIREMENTS		
	Section / Page	Question and Response
Q112	**V.B.1. (Pg 5-1)**	**Analysis of the impact of proposed Guaranteed Discounts and dispensing fees, and the Offeror's per final paid claim Pharma Revenue Guarantee on combined Program claim costs; and Will guaranteed discounts be weighted more heavily in the evaluation than claims admin fee since the value of the discount may be more valuable as the impact of inflation puts pressure on overall ingredient cost and claims spend?**
A112		Section IV.B.1 presents the cost evaluation. There is no preset weighting between claim costs and administrative fees in the evaluation of Offeror Cost Proposals. The weighting for each Offeror will be based on the calculated dollar amount for claims (net of discounts/dispensing fees), as well as the calculated dollar amount of administrative cost and pharma revenue. As the claim costs will vastly exceed the amount of administrative costs, they will have more weight than administrative costs.
Q113	**V.C.1 (Pg 5-2)**	**Explain how the claim repricing exercise will be evaluated?**
A113		Offerors' submitted claim repricing exercises will be used to verify the Offerors' understanding and agreement to the requirements contained in Section V. The repricing, in and of itself, will not receive a cost score. Cost scores will be developed as specified in Section VI.B of the RFP.
Q114	**V.C.3 (Pg 5-5)**	**Subsection a(6) instructs proposers to utilize Brand and Generic Drug classifications consistent with the definitions contained in Article I of Section VII (Contract Provision), however, Subsection a(7) provides a method of classification that is much more detailed than that contained in Section VII. Additionally, the definitions in the two Section VIIs are not identical. Should proposers expect that all Brand/Generic classifications under the contract(s) resulting from this procurement will be made consistently as specified in Subsection a(7)?**
A114		Offerors should utilize the more detailed methodology set forth in Section V.C.3.a.(7) of the RFP. See Q&A 115.
Q115	**V.C.3 (Pg 5-8)**	**Can the Procuring Agencies please confirm that, if the proposers adhere to the guidelines in Section V.C.3.a.(7) of the RFP, is it the Procuring Agencies expectation that the re-pricing specified in Subsection V.C.3.b.(1).(f) would match the Procuring Agencies' classification?**
A115		Yes, if the Offeror uses the brand/generic classification referenced in Section V.C.3.a(7) of the RFP, it will meet the Programs' classification requirements. If the Offeror uses a different brand/generic classification from that referenced in Section V.C.3.a.(7) of the RFP and agrees to all parts of Section V.C.3.b.(1)(f) of the RFP, then the Offeror would comply with this requirement.
Q116a	**V.B.5. (Pg 5-15,16)**	**The calculations must be completed by July 1st of the following year. The Contractor shall pay/credit each Program the applicable amount, if any, within 30 Days following the February 15th calculations. Please Clarify the dates, they seem to conflict.**

Q116b	**V.B.5 (Pg 5-15,16)**	**Can the Procuring Agencies please confirm the accuracy and relationship of the July 1, February 15 and July 31 dates stated in the first full paragraph on page 5-16? The referenced time periods do not appear to fit together with the dates clearly.**
A116 (a-b)		Section V.B.5 (Retail Pharmacy Network Brand Name Drug Pricing)a.(3) of the RFP has been amended.
Q117a	**V.C.5. (Pg 5-17)**	**Please clarify "The MAC price assigned shall not exceed the Discounted Ingredient Cost."**
Q117b	**V.C.5. (Pg 5-17)**	**The MAC price assigned shall not exceed the Discounted Ingredient Cost to the Programs achieved through Pharmacy submitted pricing or pricing achieved by using the Contractor's Retail and Mail Service Pharmacy Guaranteed Minimum Discount off of AWP applied to the AWP of the dispensed Generic Drug as proposed by the Contractor in its Proposal. Please confirm if this is correct or if it should have been written The MAC price assigned shall not exceed the Discounted Ingredient Cost to the Programs achieved through Pharmacy submitted pricing or pricing achieved by using the Contractor's Retail Brand Pharmacy Guaranteed Minimum Discount off of AWP applied to the AWP of the dispensed Generic Drug as proposed by the Contractor in its Proposal.**
A117 (a-b)		Section V.C.5. (Retail Pharmacy Generic Pricing)a.(2)(a) has been amended to clarify the MAC pricing.
Q118	**V.B.5. (Pg 5-21)**	**Claims submitted for secondary payer consideration, Compound Drug claims, NYSIF Program non- network claims and claims submitted by governmental entities must be excluded from the aggregate discount calculation. In addition, claims with a calculated AWP discount greater than 90% and a total AWP greater than $500 will be excluded pending receipt of supporting documentation- If claims for these NDC's are included in the Offeror's proposed MAC for the Program's is that sufficient supporting documentation to allow the claims be counted in the guaranteed minimum discount for generics? Additionally, if these NDC's and their corresponding MAC prices are included on the proposed MAC list can they be used in the re-pricing exercise?**
A118		The claims referenced in the question are included in the calculation made each year to determine if the guaranteed minimum discount was achieved. These claims, with the exception of claims with a calculated AWP discount greater than 90% and a total AWP greater than $500, have been removed from the repricing exercise as the results would generally skew the calculated discounts. The Procuring Agencies require that all NDCs of all Generic drugs be MAC'd, as detailed in sections V.C.5 and V.C.6 of the RFP. For the purpose of the repricing exercise, the proposed MAC price(s) should be included for each generic NDC listed.
Q119	**V.C.5 (Pg 5-22)**	**In Subsections b(2) and b(3) on page 5-22, the RFP asks the proposer to agree that it has an obligation to maximize the discounts achieved on Generic for the Program at Retail and at Mail Service Pharmacies. This obligation appears in a section describing the pricing of Generic Drugs at retail pharmacies only, not mail pharmacies. In addition, it appears to conflict with the confirmations required in relation to mail service pharmacy pricing on pages 5-29 and 5-30 of the RFP. Please confirm that the requirements in Subsections b(2) and b(3) should refer to the pricing of Generic Drugs at retail only and the requirements regarding Generics at mail appear on pages 5-28 to 5-30.**

A119		The Offeror must propose one Guaranteed Minimum Discount for Generic Drugs dispensed at both Retail and Mail Service Pharmacies. Additionally, the Offeror must create and maintain a single, Programs-specific MAC list for Retail and Mail Service Pharmacies. Offerors are required to confirm under V.C.5.b(2) and (3) that they have an obligation to maximize the discount achieved on behalf of the Program for Generic Drugs dispensed by Retail and Mail Service Pharmacies, and they agree to develop a Program's MAC List for Retail and Mail Service Pharmacies in order to maximize the discount achieved on behalf of the Programs for Generic Drugs. Therefore, the requirement to maximize the discount achieved on Generic Drugs dispensed by Retail and Mail Service Pharmacies applies to both, on a combined basis. Maximizing the discount is through the development and ongoing management of the MAC list.
Q120a	**V.B.10. (Pg 5-37)**	**Propose a fixed contracted Guaranteed Discount off of Average Wholesale Price (AWP) that will be utilized to determine the Ingredient Cost of the Prescription to charge the Programs. The Offeror's Guaranteed Discount shall be applicable to all individual Prescriptions for Brand Drugs and Generic Drugs dispensed to Enrollees/Claimants through the Specialty Pharmacy Process. Will the Program's consider a guaranteed minimum discount for specialty drugs vs a fixed discounts for all specialty drug claims?**
Q120b	**V.B.10.(Pg 5-37)**	**Would the Programs consider alternative pricing for specialty pharmacy claims? By limiting the discount applied to a guaranteed discount per claim for specialty drugs for the life of the contract, the Programs would have a fixed discount that would not keep pace with inflation and may cause increases in paid specialty claims. The conservatiism needed may result in a lower aggregate discount that will result in higher claim costs to the Programs than a discount set at a drug by drug basis.**
A120 (a-b)		No. In accordance with the RFP requirements, Offerors must propose a single Guaranteed Discount off of AWP for Specialty Drugs/Medications dispensed through the Specialty Pharmacy Program. The fixed discount keeps pace with inflation since when the AWP increases, the amount paid increases proportionately. If a new specialty drug is proposed to be added to the list after implementation of the Specialty Pharmacy Program, the Procuring Agencies will agree to review the adequacy of the Guaranteed Discount, and if warranted, amend the Agreement. The determination to amend the Guaranteed Discount shall be made at the sole discretion of the Procuring Agencies.
Q121	**V.B.11.(Pg 5-39)**	**Please define what an "AWP Cap" is.**
A121		AWP caps are contractual provisions that a Pharmacy Benefit Manager (PBM) may use to help control the rate of AWP increase for a specific drug that has been placed in a preferred status on the PBM's formulary. For example, the PBM may negotiate with a pharmacy manufacturer that if the AWP of brand drug A increases by more than x% during the period covered by the agreement, the rebates for drug A would increase commensurately.
Q122	**V.C.11 (Pg 5-41)**	**Would the Program be amenable to a pharma revenue guarantee quote that was used "per final retail paid claim" and "per final mail paid claim" as the basis for payment, as opposed to the "per final paid claim" basis?**
A122		No. In accordance with Section V.C.11, Offerors must propose a minimum pharma revenue guarantee on a per final paid claim basis (all combined claims).
Q123	**V.B.12. (Pg 5-44)**	**Please confirm that the Offeror must implement any changes necessary to accommodate Program modifications resulting from collective bargaining or legislation within 60 days even if that change requires technical build out and a completion timeline of greater than 60 days.**

A123		Section V.B.12 of the RFP has been amended to clarify the implementation requirements.
Q124	**V.B.13. (Pg 5-47)**	**Will the Programs allow bi-weekly billing for the NYSIF Program as is allowed for the DCS Programs?**
A124		NYSIF prefers a weekly billing cycle and will work with the selected offeror to develop a billing system that meets NYSIF's needs.
Q125	**V.B.13. (Pg 5-47)**	**Any credit amounts due from the Contractor to the Procuring Agencies for failure of the Contractor to meet the performance guarantees set forth in the Agreements shall be applied as a credit against the Claims Administration Fees charged separately to the Programs in the next invoice(s). Can the Offeror propose the following; Any credit amounts due from the Contractor to the Procuring Agencies for failure to meet the performance guarantees set forth in the Agreements shall be applied as a credit against the Claims Administration Fees charged separately to the Programs in the 1st invoice following 30 business days after the quarter closes and the performance guarantee is calculated?**
A125		No. In accordance with Section V.B.13.a.(2), any credit amounts due from the Contractor to the Procuring Agencies for failure of the Contractor to meet the performance guarantees set forth in the Agreements shall be applied as credit against the Claims Administration Fees charged separately to the Programs in the first invoice(s) processed after the performance guarantee has been calculated and agreed to by the Program(s). Section V.B.13 has been amended to clarify this requirement.
SECTION VI – EVALUATION AND SELECTION CRITERIA		
	Section / Page	Question and Response
Q126	**VI.B.1 (Pg 6-8)**	**Will weighted percentages be applied to proposed claim costs and administrative fees in the evaluation of Offeror cost proposals?**
A126		Section IV.B.1 presents the cost evaluation. There is no preset weighting between claim costs and administrative fees in the evaluation of Offeror Cost Proposals. See Q&A 124
Q127	**VI.B.1 (Pg 6-8)**	**As the Procuring Agencies may adjust the aggregated AWP amount for each Offeror, will you review the rationale with each Offeror to allow each to provide insight to support or refute any assumed shifts in the utilization? What drug therapeutic categories will you focus your evaluation on?**
A127		During the evaluation of proposals, the Department will not review with each Offeror the formularies analysis nor its rationale for any shifts in utilization. The Department may seek clarifying information from Offerors, if necessary. As noted on page 6-8 of the RFP, any adjustment to an Offeror's AWP will be based on an analysis of the Program's most significant drug therapeutic categories. The Program's primary therapeutic categories may be derived from the claims data.
SECTION VII - DRAFT CONTRACT (DCS VERSION)		
	Section / Page	Question and Response
Q128	**VII A - Article VI: Program Services/Network Mgmt-Pharmacy Audit (Pg 7-31)**	**Conducting routine and targeted on-site audits of Network Pharmacies, the Mail Service Pharmacy and the Specialty Pharmacy(ies). Pharmacies that deviate significantly from patterns of dispensing in terms of cost, drug selection, overrides, Days supply or utilization are to be identified and targeted for on-site and desk audits in accordance with established selection and screening criteria. On-site audits must also be conducted upon request by the Department, or when information is received by the Contractor that indicates a pattern of conduct by a Pharmacy that is not consistent with the**

		DCS Program's design and objectives. Periodic, on-site audits must be conducted at least once during the course of the five (5) year resultant Agreement for Pharmacies that fall into the top fifty (50) in terms of total dollar spend for the DCS Program. Any modifications to the proposed Pharmacy audit programs must receive prior approval by the Department; Please define "in accordance with established selection and screening criteria"
A128		The Department requires the selected Offeror to develop and utilize selection and screening criteria for conducting pharmacy audits under the Program. The criteria must detail the methodology the selected Offeror will employ in selecting pharmacies for audit. The selection and screening criteria must be reviewed and approved by the Department in advance of the Offeror's audit program implementation.
Q129	**VII A – Art.VII (Performance Guarantees – Pg 7-66-7-74)**	**Due to the requirements of the EGWP, deviations may also apply to the Performance guarantees listed in Article VII. How would the Procuring Agencies like us to note any deviations to these PGs for the EGWP business?**
A129		The Department recognizes that CMS requirements for an EGWP may differ from certain performance standards listed in the RFP. It is the Department's expectation that the selected Offeror will comply with any and all applicable State and/or Federal laws and regulations for the administration of the Department's EGWP. Offerors may submit proposals noting any required deviations; however, material deviations will not be allowed.
Q130	**VII A - Article VII: Performance Guarantees (Pg 7-67)**	***Guarantee:*** **The Contractor guarantees that all Implementation and Start-up activities will be completed no later than December 31, 2013 so that, effective January 1, 2014, the Contractor can assume full operational responsibility for the DCS Program. For the purpose of this guarantee, the Contractor must, on January 1, 2014, have in place and operational: Will the Programs agree to waive or recalculate the guarantee if the Offeror cannot complete implementation tasks due to a delay in the Programs providing information necessary to implement?**
A130		Prior to the contract start date, the selected Offeror will develop a detailed implementation Plan, including duties and responsibilities of the Offeror and Procuring Agencies, as well as key dates. There will be regular communication between the selected Offeror and the Procuring Agencies regarding the status of implementation duties and responsibilities as set forth in the RFP and presented in the Offeror's proposal. Any implementation tasks that cannot be completed timely solely due to a delay in the Program providing information necessary to implement will be discussed and considered by the Procuring Agencies during the implementation phase.
Q131	**VII A - Article VII: Performance Guarantees (Pg 7-71)**	**Measurement of compliance with each access guarantee in Section 7.4 of this Agreement will be based on a "snapshot" of the Retail Pharmacy Network taken on the last Day of each quarter within the current Plan Year. The results must be provided in the format specified by DCS in Exhibit B, the Request for Proposals entitled "Pharmacy Benefit Services for The Empire Plan, Excelsior Plan, Student Employee Health Plan and the New York State Insurance Fund Workers" Compensation Prescription Drug Programs RFP," unless otherwise specified by DCS. The report is due thirty (30) Days after the end of the quarter. Is the performance guarantee reported quarterly and measured annually for penalty or reported quarterly and measured quarterly for penalty.**

A131		In accordance with the RFP and Article 7.4.0 of the draft contract, the Retail Pharmacy Network Access Guarantee is reported quarterly and measured quarterly for the purpose of determining any penalty.
Q132	**VII A (Pg 7-1 – 7-133 and VII B (Pg 7-1 – 7-96)**	**Some of the provisions of Sections VIIA and VIIB appear to be oriented towards a health plan proposer and not a stand-alone PBM proposer. Proposer understands that the successful proposer will be required to enter into two separate agreements with DCS and NYSIF composed substantially of the terms and conditions contained in Sections VIIA and VIIB (as specified in Exhibit I.S, the form of Formal Offer Letter) and that the terms and conditions stated in Appendices A, B, C and D are non-negotiable. Should a proposer wish to propose provisions for the agreements with DCS and/or NYSIF to better align with industry practices, legal requirements or Proposer's operations as specified in its Proposal, and provided the proposed provisions do not contradict Appendices A, B, C, or D, how should a proposer incorporate such proposals into its submission?**
A132		The Department expects that the contracts executed between the parties will be that which is contained in Section VII of the RFP as updated to incorporate the selected the Offeror's Proposal and to fill-in other information relative to the selected Offeror such as its name, address, etc. As such, the contract will reflect the operational commitments, service and financial guarantees as set forth in the selected Offeror's Proposal as deemed acceptable to the State. Prospective Offerors are advised to refer to, at a minimum, RFP, Sections I.A, II.A.7.c, Section II.A.11, and VI.D for further information.
SECTION VIII – GLOSSARY OF TERMS		
	Section / Page	Question and Response
Q133	**VIII (Pg 8-5)**	**The definition of "GCN" expressly refers to First Data Bank. Please confirm that this would refer equally to GCN codes as assigned by Medi-Span if Proposer utilizes Med-Span as its pricing and classification source.**
A133		Offerors may substitute GPI for GCN if they utilize MediSpan as an adjudication platform.
EXHIBITS		
	Section / Page	Question and Response
Q134	**Exhibit I.O**	**When and how will we receive the application receipt from the Empire State Development (ESD)?**
A134		Exhibit I.O, makes no reference to an application or its receipt by ESD. If the asking party is referring to an initial application for minority- or woman-owned business enterprise status, prospective Offerors are advised that such question is outside the scope of the procurement and the prospective Offerors should contact the Division of Minority and Woman Business Development ((518) 292-5250; (212) 803-2414; or (716) 846-8200) for further assistance.
Q135	**Exhibit I.O**	**Does NYS allow reporting of indirect MWBE spend to support or completely fulfill the 20% goal?**
A135		The facts of each specific situation would be a determining factor and as such, a blanket "Yes" or "No" response is not possible.
Q136	**Exhibit I.Q**	**What non-NYS certification agencies does NY ESD recognize in making a Good Faith Effort?**
A136		Offerors are directed to RFP, Section II, Page 2-21 which states "For guidance on how the Procuring Agencies will determine the Contractor's 'good faith efforts,' refer to 5 NYCRR §142.8."

Q137	**Exhibit II.C (SEHP Non Network Claims)**	**Should we expect SUNY Pharmacy claims to be submitted on paper since they are non-participating pharmacies.**
A137		Upon Program implementation, the Department will provide the selected Offeror with a complete listing of SUNY pharmacies that will submit drug claims. The Offeror is expected to work with the SUNY Pharmacies to set-up electronic claims adjudication, if feasible. Currently, the SUNY Stony Brook Pharmacy submits claims electronically. No other SUNY pharmacies currently participate in the DCS Program.
Q138	**Exhibit III.I and III.J**	**Can you provide annual pharmacy spend in $ dollars for the NYSIF Program**
A138		Exhibit III.I and III.J provides NYSIF annual pharmacy spend for the years 2008-2010.
Q139	**Cost Proposal Exhibits (V.A., V.B., V.B.1., V.B.2., V.C., V.C.1., V.D., V.E., V.E.1)**	**Should the following Cost proposal exhibits (V.A, V.B, V.B.1, V.B2, V.C., V.C.1, V.D, V.E, V.E.1,) also be completed for the EGWP business?**
A139		Offerors are required to complete the Cost Proposal exhibits per the RFP's instructions. Separate pricing for the EGWP component of the Program is not permitted.
Q140	**Cost Proposal Exhibits (V.F)**	**Are the Procuring Agencies looking for a Self-funded EGWP +Wrap pricing offer? If so where should we provide the EGWP Pricing (retail/mail and Non-retail networks brand and Mail discounts)? It appears that Exhibit V.F only asks for the EGWP per claim fee for retail/mail and Non-retail networks brand and Mail discounts. Should we provide the EGWP pricing in a separate attachment?**
A140		The self-funded EGWP+Wrap program requirements in the RFP pertain only to DCS Program. With the exception of the claims administration fee, Offerors are required to propose combined drug pricing and dispensing fees that will apply to NYSIF's and DCS' Programs as well as DCS' EGWP+Wrap program.
Q141	**Exhibit V.B.1**	**Looking at the data, I believe we need the legend of the Benefit program's in order to reprice them per plan type (e.g. Workers' Comp, Medicare, Medicaid, Commercial). Examples are benefit plans are: PR7, A01, A05. Once we have that data indicator, I can at least get started on the Workers' Comp repricing.**
A141		Exhibit II.C (RFP Copay and Benefit Maximum Matrix) lists the Benefit Program codes associated with for the DCS Programs (Empire Plan, Excelsior Plan and SEHP). The separate NYSIF workers' compensation file provided to Offerors is for informational purposes and should not be re-priced.
Q142a	**Exhibit V.B.1**	**We are reviewing the NYSIF claims data and the NPI field is populated with the same NPI number for each paid claim 0000003858. Please confirm that all NYSIF claims were filled at this one identified NPI? For purposes of re-pricing these claims, how do we apply our network discounts for each individual pharmacy if the pharmacy NPI is not identified.**
Q142b	**Exhibit V.B.1**	**Please confirm, the Programs provided a single NPI for all WC claims even though such claims were not all filled under the NPI provided in the Programs' data? if so, we have concerns about how the data is provided and the lack of information available to the Offeror. NPI specific information is critical to developing a pricing and network strategy for the Programs. Without have the dispensing information pertaining to the network and the NPI associated with the claims our ability to negotiate a network that will include WC claims and the ability to anticipate at which network pharmacies**

		those WC claims will be process (including mail service) will disadvantage all Offerors. Additionally, there will be no available information to determine claims processed or submitted by a third party biller.
A142 (a-b)		As stated in Section III.G and Exhibit V.B.1 of the RFP, a data file of NYSIF Program claims for the period November 1, 2010 through November 1, 2011 is provided to Offerors for informational purposes. Offerors are not required to submit a re-priced claims for the NYSIF Program claims data. Further, Offerors should disregard the NPI field since the pharmacy identifiers are not valid. NYSIF claims were NOT all filled under the NPI number identified in the data. Should the correct NPI (or NAPB) data be available in the future, it will be posted to the RFP procurement website.
Q143	**Exhibit V.B.2**	**Since the test file we are creating is relatively small (500 records), will we will be allowed to submit the re-pricing test file via e-mail secured delivery.**
A143		If the Offeror intends to submit the final Re-Priced Claim Files (Exhibit V.B.2) without utilizing the FTP connection, then the use of secure email would be acceptable for the submission of the "Optional Re-Priced Claims Test File." The purpose of the "Optional Re-Priced Claims Test File" is that the FTP connection between the Potential Offeror and DCS needs to be tested to ensure that the final Re-Priced Claim Files (Exhibit V.B.2) is received on or before the Proposal Due Date of May 8, 2012, 3:00pm ET. The Procuring Agencies will not be able to accept the Re-Priced Claim Files after the stated Proposal Due Date.