REQUEST FOR PROPOSAL

ENTITLED:

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

Official Responses to Offerors' Questions

Question Number	RFP Page #	Section Reference	Question	Response
1	N/A	General Question	Are we able to bid on just the Workers Compensation portion?	No.
2	N/A	General Question	Are you looking for one partner to administer all of these pharmacy programs? We specialize in work comp PBM so we would be appropriate for the NYS Insurance Fund work comp program, but not the others.	See response to Question 1. Upon successful award a single vendor will be selected to enter into separate contracts with DCS and the NYSIF to administer The Empire Plan, Excelsior Plan, Student Employee Health Plan and the New York State Insurance Fund Workers' Compensation Prescription Drug Programs, respectively.
3	N/A	General Question	Will the Department provide specific information relative to NYSIF (workers comp) either with regard to enrollee or member count (if this already provided, please specify the RFP section or Attachment number)?	NYSIF Response: Please see Section 1.5.2 of the RFP.
4	N/A	General Question	Once Offerors are able to determine the Commercial Empire plans, is there an	Please refer to Amended Attachment 86 (Amended Attachment 84 provides the Layout Specifications) which will be provided to all Offerors who submitted a completed Attachment 10 Confidentiality Non-Disclosure Agreement.

			identifier within the supporting documents that notes which Empire Plans follow the Advanced Flexible Formulary vs. the Flexible Formulary?	
5	N/A	General Question	Will the Department be providing a draft contract / agreement between the New York State Department of Civil Services and the Offeror as part of this RFP?	A draft contract will not be included as part of the RFP. Subject to a successful procurement, the tentative awardee will receive a Contract for review and signature between the Department and the Offeror as described in RFP Sec 1.1.1 (Resulting Contracts).
6	N/A	General Question	Can you tell me if the PBM needs to be able to provide both Group Health and Workers' Compensation services or are you allowing separate PBMs to bid for each type of service? We are exclusively a Workers' Compensation PBM and would be interested in responding to just the Workers' Compensation piece if this is acceptable.	See response to Question 1 and Question 2.
7	N/A	General Question	My employer is one of the three NY state owned hospitals located in Syracuse NY. Could you please explain the RFP that was recently released to the NY State Contract Reporter? Is this for specialty pharmacy services or just for PBM services?	The Rx RFP released on August 14, 2023, by the NYS Department of Civil Service seeks a single vendor to enter into separate contracts with DCS and the NYSIF to administer the Pharmacy Benefit Programs under the for The Empire Plan, Excelsior Plan, Student Employee Health Plan and the New York State Insurance Fund Workers' Compensation Program, respectively. The RFP seeks a designated specialty pharmacy as part of this contract.
8	N/A	General Question	Are you looking for one partner to administer all of these pharmacy programs? We specialize in workers'	See response to Question 1 and Question 2.

			compensation PBM's so we would be appropriate for the NYS Insurance Fund work comp prescription program but not the others, as they are not work-comp focused.	
9	N/A	General Question	Day supply – Please confirm that the standard day supply for all plans (SEHP/Excelsior/EGWP/NYSIF) should be 0-30 days for Retail 30 and 31+ for Retail 90. Understanding Retail 30 and Retail 90 will have one guarantee for brands and one guarantee for generics. This clarification is required to ensure accurate pricing of the bid.	Please review Attachment 27, DCS NYSIF Prescription Drug Program Copayment Matrix, for this information. SEHP does not have the option to use Retail Pharmacies to fill prescriptions for more than a 30-Day Supply. Please see Question 174 for response on "Retail 90."
10	N/A	General Question	We understand your goal to receive proposals as soon as possible. However, you've developed a very complex RFP and have only provided a short timeframe to respond. These circumstances may put us and other potential bidders at a competitive disadvantage. Additionally, the current timeline for us to receive responses to questions, claims data and formulary files does not allow sufficient time for data analysis to inform our RFP responses. We're requesting that the Procuring Agencies give serious consideration of a	See Amended RFP, Section 1.9, Timeline of Key Events, for updated Proposal Due Date.

			minimum, two-week extension on the proposal due date. This adjustment to the timeline would help facilitate our ability to complete a higher quality proposal that is in the best interest of the Department of Civil Services and members served.	
11	N/A	General Question	Please confirm that the Modification of Service reservation of rights can be presented by the vendor and includes items outside of laws and regulations that materially impact the Prescription drug program costs and administration to the Program or Vendor. Specifically for example, the introduction of a biosimilar for the specialty drug list, the manufacturer related AMP Cap strategy and recent federal drug negotiations for certain Medicare products once concluded.	Not confirmed. The process and criteria for Modification of Program Services are set forth in Section 8.8 Modification of Program Services.

12	N/A	General Question	In the event that the NYS and the unions representing State Employees enter into collective bargaining agreements, or the State otherwise requires changes in Plan design elements or requirements of the Agreement, please confirm of the negotiated plan designs materially change the ability of the vendor to meet the financial obligations or cause the vendor to have undo administrative burden to implements and support, the vendor can request a review of the contracted administration fee and financial guarantees.	Section 8.8 Modification of Program Services, sets forth the process and criteria for Modification of Program Services including review of Contractor's fees or modification of the financial guarantees.
13	N/A	General Question	Can we please request the to receive the formulary files and the UM criteria before the vendor responses of 9/15? We cannot start the custom process without this information.	Please see New Attachment 100 for August 2023 formularies by NDC. UM criteria is confidential and proprietary and cannot be shared.
14	N/A	General Question	NDC level formulary files are required to do a formulary analysis and disruption please confirm when NDC level formulary files or each program in excel will be available. Can the client provide NDC level formularies, preferably in Excel? (Includes Tiers, PA, and ST) Please include the effective date of each formulary file.	Please see New Attachment 100 for August 2023 formularies by NDC.

15	N/A	General Question	Please provide detailed UM documentation on key classes?	The detailed Utilization Management (UM) documentation on key classes is confidential and proprietary and cannot be shared. Please see New Attachment 100 for detailed formulary information, including NDC, Tier and if Utilization Management (UM) is in place.
16	N/A	General Question	How does the client plan to manage GLP1/weight loss utilization? What is the client's outlook for preferring GLP1/weight loss products? Will there be more or less restriction than what is reflected in the formulary and UM documentation?	The State implemented Prior Authorization review on all GLP-1s on July 1, 2023. Weight-loss medications currently available have Prior Authorization in place; as of October 1, 2023, Prior Authorization will automatically apply to all weight-loss products.
17	N/A	General Question	What is the client's strategy for Immuno biosimilar products? Is the client's objective to follow lowest net cost strategy (covering only low WAC products), rebate maximizing strategy (covering only high WAC products), or something in between?	See Amended RFP Sections 3.14 and 5.15 which provides information on the State's strategy for coverage of rapid-acting insulin and autoimmune biosimilars. The State will pursue a lowest net-cost strategy on rapid-acting insulin and will pursue a blended approach by retaining coverage of Humira while preferring several of the new biosimilar products.
18	N/A	General Question	If a product is not listed on the formulary, should it be considered as "excluded"?	No, Attachment 51, Preferred Drug Lists – January 2023 – provides the most commonly-prescribed medications along with Non-Preferred (Tier 3) medications and provides the list of Excluded Drugs. Comprehensive Drug Lists for the Flexible, Advanced Flexible and Excelsior formularies are provided, by NDC and with details on Tier and Utilization Management as New Attachment 100.
19	N/A	General Question	If there is any misalignment between the formulary and UM documents, which document should we consider as the source of truth?	If the Offeror is asking if a medication appears on Attachment 49, Prior Authorization (PA) Drug Lists, but not on Attachment 51, Preferred Drug Lists (PDL), this is possible as the PDL contains the most utilized products. There is no misalignment between the Comprehensive Formulary (New RFP Attachment 100) and the PA Lists.
20	N/A	General Question	Does the client have any financial arrangements regarding rebates with the states that our organization should take into consideration?	No, the State does not have any financial arrangements regarding rebates with other states.

21	N/A	General Question	Is one formulary to be used on both Commercial and EGWP, or does EGWP have its own formulary? If it does and its custom, please provide, if not please confirm that you want the PBM standard.	EGWP follows a custom, CMS-approved, Medicare Part D formulary that has supplemental coverage under what the State refers to as “supplemental coverage” or a “Wrap” and such coverage is provided under the Advanced Flexible Formulary. Please see New Attachment 101, September 2023 EGWP Formulary.
22	N/A	General Question	If there are separate custom formularies, please provide the indicators in the claim file to map these accordingly.	Comprehensive Drug Lists for the Flexible, Advanced Flexible and Excelsior formularies are provided, by NDC and with details on Tier and Utilization Management as New Attachment 100.
23	N/A	General Question	Is the Department willing providing the requested documents in questions # 23 and 22 (reference two questions above) before 9/15?	See Amended RFP, Section 1.9, Timeline of Key Events, for updated Proposal Due Date.
24	N/A	General Question	Can you advise if the Excelsior Plan will require an EGWP component and formulary.	No, the Excelsior Plan does not currently include Medicare Part D prescription drug coverage, so Medicare-primary enrollees and dependents receive the same drug coverage as those who are Plan primary. However, as noted in the Amendment to Section 1.5.1.d., of this RFP, effective January 1, 2024, a large group within a Participating Agency will move from The Empire Plan to the Excelsior Plan and the Department will explore the option of adding EGWP coverage to the Excelsior Plan in Calendar Year 2025.
25	N/A	General Question	Does the Department allow for the same subcontractors to be listed on multiple proposals from different offerors?	Subject to any conditions that may be noted in the RFP regarding the use of Subcontractors, there is no prohibition regarding subcontractors to be listed on multiple proposals from different Offerors.
26	N/A	General Question	Does the Department allow for DMRs and if so, what is the volume?	Yes, the Department allows for paper claims. See New RFP Attachment 98 for data on paper claims.
27	N/A	General Question	Can the Department confirm there are EGWP lives and if so, what is the total?	Confirmed. Please see Amended Attachments 25 and 26 for more refined splits of the Commercial versus EGWP population
28	N/A	General Question	Are all current pharmacy programs required to remain in place with the new PBM?	Offeror should review requirements in Section 3 Project Services for all required elements.

29	N/A	General Question	Please provide clarification on the formularies in place for the DCS commercial and EGWP programs. Does the EGWP program utilize the same formulary as the commercial plans, or is there a Medicare Part D formulary in place for the EGWP programs? Is it the Agencies' expectation that Offerors are required to bid based on adapting to the incumbent PBM's current formularies in place today?	The formularies currently in place are described in Section 1.5.1. The Flexible and Advanced Flexible Formularies are in place for the Commercial Program. EGWP is covered by a custom, CMS-approved, Medicare Part D formulary that has supplemental coverage under what the State refers to as "supplemental coverage" or a "Wrap" and such coverage is provided under the Advanced Flexible Formulary. No, the Agencies' expectation is that the Offerors bid proposed formularies which meet the requirements of the RFP, including Sections 3.14 and 5.15, which requires custom formularies subject to the Department's approval. These formularies do not need to adapt to the incumbent PBM's current formularies, but DCS asks Offerors to inform DCS as to how the Offeror's proposed excluded drugs compare to those currently excluded (See Section 5.15.3.c).
30	8	1.1.1.6 Resulting Contracts	Subsection 1 (Resulting Contracts) of Section 1.1 lists six groups of documents for DCS, and nine for NYSHIP in order of precedence for purposes of resolving conflicts among the listed documents. The last item in each list is "Selected Contractor's Bid or Proposal, including and clarifications resulting from Management Interviews or Department Requests for Clarifications and Contractor's responses." This item appears to contain a typographical error: please advise whether the word "and" should be read as "all", or, alternatively, whether there is a word or phrase missing from the item.	See amended RFP which will reflect the following changes to Section 1.1.1 Under DCS #6 and under NYSIF #9: "Selected Contractor's Bid or Proposal, including ~~and~~ any clarifications resulting from Management Interviews or Department Requests for Clarifications and Contractor's responses."

31	9	1.1 Purpose	Given all of the workers' compensation changes within the State of New York over the past 18-24 months (NY OnBoard process, prior authorization, utilization review, state reporting requirements, formulary changes, etc.) would the Department consider carving out NYSIF as a separate contract, whereas a more specialized workers' compensation PBM would be able to bid solely on NYSIF and better serve the needs of NYSIF for the future?	No.
32	15	1.5.2 Overview of the DCS and NYSIF Prescription Drug Programs	The RFP states, “NYSIF services over 40,000 Workers’ Compensation Claimants who fill roughly 525,000 prescriptions annually. Of this number, about 75% are dispensed through the services of a Pharmacy Benefits Management (PBM) provider.” Do the remaining prescriptions process through the bill review program? Are these prescriptions processed as paper bills? Is NYSIF interested in an alternative solution to increase the percentage of prescriptions processed through the PBM?	NYSIF processes non-PBM billing through an internal workflow, which are generally through paper bills or e-billing. No, NYSIF is not soliciting proposals to increase the percentage of prescriptions processed through the PBM.

33	17	1.6.9 Covered Drugs under the DCS and NYSIF Prescription Drug Programs	How would formulary and UM rules manage paper claims for “on-premises” pharmacies, as it is a retrospective review of coverage?	Utilization Management (UM) is applied like any claim, including a claim at Point-of-Sale. The UM in place at the time of fill will be applied to the paper claim. For example, if a Prior Authorization (PA) is required and the member does not have a PA in place for the claim on Date of Fill, then the claim will be denied for payment. NYSIF reviews paper bills outside of PBM.
34	17	1.6.9 Covered Drugs under the DCS and NYSIF Prescription Drug Programs	Please confirm if these claims refer to member-submitted paper claims and if so how many annually have been submitted historically?	DCS Response: Confirmed. See New Attachment 98, *Paper Claims*. NYSIF Response: NYSIF reviews paper bills outside of PBM - counts are not material to RFP.
35	17	1.6.10 1.6 Covered Drugs under the DCS and NYSIF Prescription Drug Programs	Does NYSIF require Offerors to be able to process medications that are dispensed outside of the United States?	No.
36	18	1.7.7 DCS and NYSIF Prescription Drug Program Exclusions and Limitations	The RFP notes, in part, that drug exclusions include “Therapeutic devices or appliances (e.g., hypodermic needles, syringes, support garments, or other non-medicinal substances), with the exception of certain diabetic supplies, regardless of their intended use.” Please confirm the plan design allows for coverage of syringes used to administer insulin as part of “certain diabetic supplies”.	DCS Response: Confirmed. The Plan design allows for coverage of syringes used to administer insulin as part of “certain diabetic supplies.” Additionally, the Department covers needles, alcohol swabs and 2x2” gauze pads and dressings as part of “certain diabetic supplies.” Finally, due to manufacturer preferences on dispensing through retail pharmacies, the Department covers the Omnipod 5 and Dexcom G6 through plan design. NYSIF Response: NYSIF would allow coverage if related to claim.
37	19	1.7.19 DCS and NYSIF Prescription Drug Program Exclusions and Limitations	The RFP requires coverage for drugs as a replacement for a previously dispensed drug. Does this imply replacement of lost/stolen prescriptions is not a covered option for members? Is	DCS Response: Current DCS Plan Design allows for replacement of lost/stolen medications subject to PBM and DCS approval. NYSIF Response: Claimant must file police report and NYSIF would release one time.

			this correct and if so, is this the case for all plans (DCS and NYSIF)?	
38	21	1.8.6 Offeror Eligibility	If the PBM has lives well over 5,000,000 do all clients and their respective lives need to be listed? Alternatively stated, could multiple clients be listed with their associated lives until PBM has demonstrated they have over 5M lives?	It is not necessary to provide a list of all Offeror's clients, an Offeror is only required to provide a list of clients to substantiate that, as of the Proposal Due Date, the Offeror provides Point of Service prescription claims adjudication and pharmacy benefit management services for a minimum of five million (5,000,000) lives.
39	22	1.8.8.b Offeror Eligibility	The RFP requests that the Offeror provide Geo Access network Reports based on Attachment 22, Enrollment by ZIP Code & Geo Access Network Report File. Please provide guidance for breaking out the DCS file to separate Commercial and EGWP enrollees. Alternatively, will the Agencies provide updated census files that include zip codes for Commercial only and EGWP only? \Additional question on this Section 1.8: Please confirm that the Retail Pharmacy Network offered to each of the three components (DCS Commercial, DCS EGWP, and NYSIF) may differ in composition and in contract rates.	Attachment 22 contains a Medicare Primacy indicator: "M" denotes Medicare-primacy; "N" denotes Plan-primary. Offerors can capture Commercial enrollment with the "N" indicator and EGWP enrollment with the "M" indicator. Confirmed; Offerors may, but are not required to, propose a single Retail Pharmacy Network that covers all three components of the program (DCS Commercial, DCS EGWP and NYSIF workers' compensation). Offerors must meet the minimum access guarantees specified in the RFP. All three programs will be evaluated to ensure these guarantees are met independently. NYSIF requires a broad network and requires that Claimants use a pharmacy within the network. The DCS and NYSIF Enrollment by Zip Code & Geo Access Network Report Files will be shared via IBM Aspera SendVault and Offerors need to have the latest version of the IBM Aspera Web Plugin (Aspera Connect) to use the application. Requests for these files should be made directly to DCSProcurement@cs.ny.gov.

40	33	2.1.8 Notification of Tentative Contract Award	Are the Procuring Agencies able to provide any additional detail around the anticipated contract negotiation process and timeline? For example, will the bidder tentatively awarded the contract be presented with a contract document to review, and to which the bidder may offer proposed modifications in keeping with the RFP requirements? If so, are the12 agencies able to share approximately how long the bidder will be given to provide such proposed modifications, and whether there will be other stages or key dates during the negotiation process that bidders should anticipate?	A) Subject to a successful procurement, the tentative awardee will receive a Contract for review and signature between the Procuring Agencies and the Offeror as described in RFP Sec 1.1.1 (Resulting Contracts). The Procuring Agencies will not entertain material modifications to the Contract terms and conditions. All non-material deviations to the terms and conditions of the RFP requirements should be submitted with the Offeror's proposal (See RFP Section 2.1.7 B) As set forth under Amended RFP Section 1.9 Timeline of Key Events, the contract negotiation period is not defined; there are no Key Events scheduled between the Anticipated Tentative Contract Award date, December 28, 2023, and the Anticipated OSC Approval of Contract Award date, May 22, 2024.
41	33	2.1.7.e Bid Deviations	The RFP notes that the Offeror should submit non-material bid deviations using the Non-Material Deviations Template (Attachment 8). Please provide an example or category of non-material deviations that can be submitted that will not result in rejection or disqualification.	See Section 2.1.7.c which provides guidance as to what is a material and substantive bid deviation. An example or category of deviation that would be material is a deviation that would substantially shift liability (risk) or financial responsibility from the Offeror to NYS. A bid deviation that does not meet the above criteria may be considered non-material, but it is still at the discretion of the Agency as to whether it is acceptable.
42	41	2.2.5 MWBE Goals	Since the MWBE goals are exclusive to the NYSIF program, please confirm that there are no MWBE participation requirements for the DCS programs. Although Offeror intends to use MWBE	NYSIF requires the Amended Appendix D to be submitted with all proposals

			vendors when possible, are Offerors required to submit Appendix D with their submission if they are not proposing the use of specific MWBE vendors for non-NYSIF programs?	
43	46	3.2.1.d.viii Implementation Plan	When the member is submitted on the EGWP enrollment file if the member is enrolled in another DCS plan the member will reject on the file. If member is enrolled in another plan the Offeror may delete the member out of the other plan. Therefore a report cannot be provided in advance. Please confirm if this is acceptable.	Not confirmed. During the testing phase, the Department needs a report of members who may be eligible for a Low-Income Subsidy and who may have dual NYSHIP coverages. The Department does not need the LEP report and the RFP is amended for this change in Section 3.2.1.d.viii.
44	48	3.3.1.c Customer Service	Please confirm whether a vendor is required to staff and manage two individual dedicated call centers for the NYSIF and DCS programs, or can one dedicated call center service both NYSIF and DCS if we can manage to measure and report on separate performance guarantees for each program?	Confirmed; the vendor is required to staff and manage two individual dedicated call centers; one for the NYSIF and one for the DCS Programs. Per Sections 3.3.1.c and Section 5.4.3, Offerors are required to maintain separate call centers for each Program. Amended Attachment 15, *Glossary of Defined Terms,* defines these terms as: "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." "Program(s)/ Plan(s) means The Empire Plan Prescription Drug Program, the Excelsior Plan Prescription Drug Program, and Student Employee Health Plan (SEHP) Prescription Drug Program administered by the New York State Department of Civil Service, AND the Workers' Compensation Pharmacy Benefits Management Program administered by the New York State Insurance Fund." DCS & NYSIF confirm that these can be co-located, so long as all functions and metrics can be separated.

45	48	3.3.1.b Customer Service	Specific to sub-question (b), please provide a copy of the shared service agreement Offeror is required to sign with the Empire Plan's Medical Program vendor.	See Amended Section 3.3.1.b. The Selected Offeror will be referred to AT&T, who will then work with AT&T to enter into a shared service agreement and establish a connection. AT&T then bills the Selected Offeror directly.
46	49	3.31.b Customer Service	If the Offeror maintains one TTY line across its client base that is available 24/7/365, please confirm this meets DCS' needs for TTY services,	Not Confirmed. The TTY number must provide the same level of access to customer service as required by Section 3 of the RFP, which requires separate Dedicated Call Centers for the Programs between the hours of 7:00 a.m. and 7:00 p.m. ET.
47	47-48	3.3.1.c Customer Service	Please clarify what are the separate programs that each require separate call centers.	Please see response to Question 44. The vendor is required to staff and manage two individual dedicated call centers for the NYSIF and DCS Programs.
48	49	3.3.1.g Customer Service	Specific to sub-question (g), please clarify this requirement. Is the request that a link provided to Offeror be put on the Offeror's website?	The requirement is for the Offeror to create a dedicated secure online customized website that can be linked to from the Department's website with content subject to the approval of the Department and limited to information that pertains to the DCS Program. Links bringing a viewer back to the Department website must be provided. No other links or non-Program related information is permitted without the written approval of the Department. Current dedicated link is available here: https://www.cs.ny.gov/empireplanrxprogram/
49	49	3.3.1.g Customer Service	Specific to sub-question (g), it states that the member website must be operational and available to enrollees thirty (30) days prior to the Implementation Date. As Program members will not be covered by the Offeror's program prior to the Implementation Date, access to functions such as eligibility, claim status, order status, and drug history would not be available until the Implementation Date. Please confirm that Offeror may	Confirmed.

			provide open enrollment website access for members 30 days' prior to the Implementation Date, with live access to full information beginning on the Implementation Date.	
50	50	3.3.1.i-iv Call Center Telephone Guarantees; Telephone Blockage Rate Guarantee	Offeror requests modification/deviation to the requested Telephone Blockage Rate Guarantee to remove the request for weekly reporting for the first month of the program and include monthly reporting only. At this time, Offeror's phone vendor does not have the ability to support weekly reporting.	Modification request rejected, weekly reporting as specified in Section 3.3.1.i.iv. is required for the first month of the program.
51	51	3.3.j.i.j Secure Online Customized Website Guarantee; Website Accuracy Guarantee	The Website accuracy Guarantee requires inaccurate information identified by DCS to be corrected within 3 business days. Please provide examples of inaccuracies that have been identified for correction that would incur this timing. Will DCS allow Offeror to propose alternative language within the proposed performance guarantees in Attachment 6 to allow for mutual agreement on timing to correct complex issues that may require more than 3 business days to correct? Additionally, please confirm that potential inaccurate information provided to Offeror by DCS that	Examples of inaccurate information identified by DCS includes issues such as, but not limited to, incorrect copays listed for drug tiers, incorrect formularies posted (e.g., Flexible Formulary posted instead of Advanced Flexible Formulary posted). The Department views the request for the Offeror to propose alternative language on timing to correct complex issues and to exclude corrections to information supplied by the Department within the proposed Performance Guarantees in Attachment 6 as non-material deviations. The Department has a separate process for the consideration of non-material deviations. If an Offeror wishes to propose a modification to the timing to correct complex issues and to exclude corrections to information supplied by the Department within the proposed Performance Guarantees in Attachment 6, it should provide the information as part of the justification for the non-material deviation using the Non-Material Deviations Template (Attachment 8).

			has been posted to the website and requires correction will be excluded from this performance standard. Since Attachment 6 allows Offeror to include alternative proposed guarantee language, please confirm DCS will not consider our explanations tied to this requirement in Section 3.3 and Section 5.4 to be considered deviations.	
52	52	3.4.1.b.ii Empire Plan Medicare Rx	Offeror requests modification to the requirement; we are unable to support temporary coverage for members while waiting for members to be enrolled in EGWP. Please confirm if the State's intent is to add the member to a commercial plan to provide coverage.	Confirmed. The State's intent is for enrollees and/or dependents who are pending enrollment by Medicare to have temporary Empire Plan Commercial coverage. The Department considers this request for a modification/deviation to be material and is not approved.
53	54	3.5 Member Communication Support	Will NYSIF provide claimant email addresses and/or mobile phone numbers to facilitate digital communications with injured workers?	Unknown at this time.
54	55	3.5.1.d Member Communication Support	The RFP states, "Offeror must work with the Procuring Agencies to develop appropriate customized forms and letters for the Programs, including but not limited to mail order forms, enrollee claim forms, prior authorization letters, specialty guideline management letters, grace fill	See Amended RFP Section 3.5.1.d., to exclude CMS-required communications from the customization requirement.

			letters, generic appeal letters, disruption letters, etc. All such communications must be customized as needed, sent on a timeline acceptable to the Procuring Agencies and the forms and letters must be approved by the Procuring Agencies." Offeror requests modification to exempt CMS required communications from customization requirements where we are required to follow the CMS required templates.	
55	56	3.5.f Member Communication Support	The RFP states, "The fully functioning, customized Prescription Drug Program Benefits website, approved and accepted by the Department, must be available a minimum of 30 calendar days prior to commencement of the Project Services Start Date." Does this requirement apply to both Programs? If this requirement applies to the NYSIF Program, please provide the acceptance criteria of the fully functional NYSIF Prescription Drug Program Benefits website.	This requirement is Exclusive to the DCS Program. See Amended Section 3.5.f and 5.6.8 of the RFP and Amended Attachment 97, *Program Services Matrix*.
56	56	3.5.f Member Communication Support	The RFP states, "The fully functioning, customized Prescription Drug Program Benefits website, approved and accepted by the Department, must be available a minimum of 30 calendar days prior to	This requirement is Exclusive to the DCS Program. See Amended Section 3.5.f and Section 5.6.8 of the RFP and Amended Attachment 97, *Program Services Matrix*.

			commencement of the Project Services Start Date." Will there be a requirement that the website's URL be masked with wcb.ny.gov?	
57	58	3.6.1.b Enrollment Management	Offeror updates enrollment based upon the file from CMS and not the client. Eligibility on the EGWP files is updated after receipt of approval from CMS rather than the client's file. Please confirm this is acceptable.	DCS determines eligibility for NYSHIP coverage. The Department understands that CMS is the governing body of Medicare Part D enrollments. However, if the member is not eligible for NYSHIP coverage, they should not be enrolled in EGWP; in addition, if the member is newly eligible for NYSHIP coverage, the member should be enrolled in the EGWP as soon as possible. Offeror needs to be able to receive data from NYBEAS and process enrollments/disenrollments based on information in there. The Department understands CMS has rules and regulations the Department must follow, but the Department needs to ensure that the member is eligible under NYSHIP rules.
58	59	3.6.1.c Enrollment Management	What is secondary 1, 2 and 3 on EGWP enrollment layout and is the Offeror expected to store or report on that information? What EGWP report is alternate ID expected to be listed on?	The Department is responding to this question presuming the Offeror is referring to the Secondary Hierarchy Level 1, 2 and 3. These are the Carrier, Account and Group codes used by the plan to ensure members are covered under the correct prescription drug coverage. Yes, the selected Offeror is expected to store and report on this information when processing enrollments/disenrollments/changes, etc. and when conducting reconciliations. The Alternate ID is expected to be listed on all reports from the selected Offeror to the Department; this is how the Department links it to the enrollee's file in NYBEAS.
59	59	3.6.1.c.ii. Enrollment Management	The RFP requires Offeror to: Report the Empire Plan Alternate ID number (beginning with 890 or 891) in addition to the EGWP issued ID number when reporting information for EGWP members. Please clarify what EGWP report the Alternate ID is expected to be listed on.	The Department expects the Alternate ID to be on every report received from the Offeror. This is how the Department links an enrollee's EGWP account to their NYBEAS account.
60	59	Section 3.6.1.d Enrollment Management	The RFP states, "Coordinate enrollments, disenrollments, and cancellations of the EGWP using the EGWP eligibility file, including if a member has multiple alternate IDs (i.e.,	The Department expects the Offeror to store the Alternate ID in the Offeror's system. A portion of enrollees have dual coverage – coverage under themselves and as a dependent of another NYSHIP enrollee. The Alternate ID is unique to each account, so if a person has multiple coverages, they will have multiple Alternate IDs. Coordination of benefits should be done with Alternate IDs. This is how the Department links the member's EGWP account to their NYBEAS account.

			Dependent Survivors' coverage). Please provide clarification on this requirement, providing the Agencies' expectation for Offerors in relation to alternate IDs.	
61	59	3.6.1.e.i Enrollment Management	The RFP states that the Offeror is responsible for providing temporary Commercial Coverage to those Medicare Rx Enrollees in the event automatic enrollment into Empire Plan Medicare Rx is unavailable. Will the State be sending Offeror a Commercial record for the temporary coverage, or is this expectation that this is built by the Offeror?	Currently, the Department processes a manual Commercial enrollment request through the EP Rx Manual Action Page in NYBEAS. The Department also emails the vendor if temporary coverage is needed immediately for a member.
62	59-60	3.6.1.f Enrollment Management	Without documentation and CMS approval, Offeror is unable to support enrolling the member for a CAT 3 date. Additionally, Offeror is unable to support commercial temporary coverage until the member is enrolled in the EGWP. Would the State allow modification where we are required to follow CMS guidelines, for example CMS does not allow retroactive dates more than two months plus the current month? Additionally, is it expected that the Offeror is to provide eligibility data to third parties?	A) The Department is not requesting the Offeror to enroll a member for a CAT 3 date. B) The Department requires that enrollees and/or dependents who are pending enrollment by Medicare have temporary Empire Plan Commercial coverage. C) Modification Request is rejected. The Department understands CMS's guidelines and the requirement is that the Selected Offeror enroll for the earliest date possible based on CMS's rules and regulations. D) No, it is not expected that the Offeror provide eligibility data files to third parties. Civil Service handles dissemination of eligibility information to third parties.

63	60	3.6.1.h Enrollment Management	The RFP states, “Process disenrollments for the EGWP using the EGWP eligibility file when a member is retroactively terminated from EGWP coverage (including ending Empire Plan coverage in its entirety or Medicare primacy). The Contractor will accept the disenrollment or cancellation on the EGWP eligibility file and use it to either disenroll or cancel an enrollment into the EGWP plan with the earliest date CMS allows if the effective date of the termination cannot be processed and submit the appropriate transaction to CMS.” Offeror requests modification to this requirement as we cannot support disenrolling the member for a CAT 3 date without documentation and CMS approval.	Modification request is rejected. The Department is not requesting Offeror to enroll a member for a CAT 3 date. The Department understands CMS’s guidelines and requests that the Selected Offeror enroll for the earliest date possible based on CMS’s rules and regulations.
64	61	3.6.1.I.ii-iii Enrollment Management	Offeror requests modification on the noted requirements to provide weekly feedback since our system does currently not support daily feedback, only weekly.	Modification request is not approved; the Department requires daily feedback files to meet this requirement.
65	61	3.6.1.I.ii-iii Enrollment Management	The RFP requires “Transmitting all TRC codes received for a given member (enrollee or Dependent) with ordered sequencing so all TRC codes may be processed in order.”	See Amended RFP Section 3.6.1.I.i, removing the requirement for Low Income amount.

			Offeror requests modification; we can provide the Low Income Copay Category or Low Income percentage but not the amount because that is not a reliable field on the TRC.	
66	62	3.6.1.s Enrollment Management	The RFP states, “Ability to manually load/correct an enrollment record and to contact the Pharmacy to allow the adjudication of a Prescription in an urgent or emergency situation.” Please provide clarification on this requirement. What communication method is expected to contact pharmacies (phone, email, etc.)? Please confirm Offeror can use its preferred communication mechanisms to contact pharmacies.	Confirmed. Offeror can use its preferred communication mechanism to contact pharmacies. Such mechanism must ensure that PHI is protected.
67	62	3.6.1.v Enrollment Management	The RFP states, “Agreeing to the State defined eligibility periods as they relate to waiting periods and duration of coverage as a member (See General Information Books referenced in Section 1.5 for additional information on State defined eligibility periods). Please provide clarification on this requirement. Will the State be providing the eligibility date periods or is the Offeror expected to derive it?	Effective October 1, 2023, the 42- or 56-day waiting period is changed to 28 days for Medical, Dental, and Vision for all NY groups with the exception of SEHP. SEHP benefits begin on the date enrollment is requested by an enrollee, provided the request is made within the first 45 days of their appointment date. This information will be provided in the 2023 General Information Book, which will be available on the Department’s website soon.

68	64	3.7.1.a.i Financial Reports	The RFP requests that financial reports including claim reports are generated from amounts billed to the Programs, and tie to the amounts reported in quarterly and annual financial experience reports and Rebate reports. Offeror requests modification to allow standalone reporting for claims/billing from financial and rebate reports, as claims and rebates occur on different cycles (i.e., Offeror will provide requested claims, financial, and rebate reports, but weekly/biweekly claims reports do not tie to quarterly rebate reports). Would the State allow this modification without it being viewed as a deviation?	The State rejects the requested modification to this section.
69	64	3.7 Reporting Services	The RFP states, “Offeror may on occasion be requested to provide ad-hoc reporting and analysis upon twenty-four (24) hour written notice from NYSIF.” Although many ad-hoc reports can be provided within 24 hours, development time is dependent upon the complexity of the request. For complex report development and analysis that may take additional time, is it acceptable to NYSIF for the Offeror to acknowledge receipt of the request and determine a mutually agreeable timeline	Yes.

			within 24 hours of written notice?	
70	74	3.9.A Retail Pharmacy Network	Section A states that Offerors may not exclude Chain Pharmacies in their Retail Pharmacy Network. Please define chain pharmacy. Is this applicable to large, nationwide chains only? Does this apply to smaller local and/or regional chain pharmacies, even those with fewer than 10 stores?	See Amended Attachment 15, *Glossary of Defined Terms*, where Chain Pharmacy is defined as: **Chain Pharmacy** means any national chain, or local and/or regional chain with ten or more pharmacy locations in New York State.
71	74	3.9.A Retail Pharmacy Network	Section A states that Offerors may not exclude Chain Pharmacies in their Retail Pharmacy Network. Will the State accept network offerings that exclude a regional chain if it has no DCS member utilization?	No, the State will not accept network offerings that exclude a regional chain even if the regional chain has no DCS member utilization.
72	74	3.9.A Retail Pharmacy Network	Section A states that Offerors may not exclude Chain Pharmacies in their Retail Pharmacy Network. Please also confirm that this requirement does not apply if a chain pharmacy has elected to withdraw from PBM's retail network prior to the release of RFP.	An Offeror may not exclude Chain Pharmacies in their Retail Pharmacy Network. At the time of bid submission, an Offeror whose Retail Pharmacy Network does not include a Chain Pharmacy (even if such Chain Pharmacy elected to withdraw from the PBM's retail network prior to the release of the RFP) would not meet this requirement.

73	74	3.9.A Retail Pharmacy Network	Section A states that Offerors may not exclude Chain Pharmacies in their Retail Pharmacy Network. Are Offerors required to provide only one, single Retail Pharmacy Network that covers all three components of the program (DCS Commercial, DCS EGWP, and NYSIF Workers' Compensation) and that the one network must have identical composition for all three components? We understand that New York does not allow for direction of care for Workers' Compensation programs. Would this require a separate, completely open network for the NYSIF program?	Offerors may, but are not required to, propose a single Retail Pharmacy Network that covers all three components of the program (DCS Commercial, DCS EGWP and NYSIF workers' compensation). Offerors must meet the minimum access guarantees specified in the RFP. All three programs will be evaluated to ensure these guarantees are met independently. NYSIF requires a broad network and requires that Claimants use a pharmacy within the network.
74	74-75	3.9.A.1.d Retail Pharmacy Network	This provision requires the selected Offeror to 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 in the RFP. Please confirm that for any pharmacy so added to the Offeror's retail pharmacy	Confirmed.

			network at the request of 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 if the pharmacy will not agree to the terms proposed to the other pharmacies in the network.	
75	78	3.9.C Pharmacy Contracting	Please advise how the State's requirements in this section will be adjusted in response to the DFS's proposed Insurance Regulations 219, 224, 226-29.	DCS Response: Offerors should submit their bids based on the status of the regulations as they exist on the Proposal Due Date. NYSIF Response: NYSIF's current understanding of the proposed regulations are that they apply to "health" plans and not workers' compensation.
76	79	3.9.C Pharmacy Contracting	Offeror is agreeable to the requirement, but reserves the right to redact information concerning other clients and information that is not required to confirm compliance with the terms of the agreement and applicable law. Please confirm this is acceptable.	The State is agreeable to the redaction of information concerning other client's information related to Section 3.9.C Pharmacy Contracting to the extent the information can be redacted without impeding the intent of the section.
77	79	3.9.C.c Pharmacy Contracting	The RFP states, "(Exclusive to DCS) Recruiting licensed Pharmacies affiliated with home care agencies that are participating providers under The Empire Plan's Home Care Advocacy Program (HCAP) administered by The Empire Plan's medical carrier. These licensed pharmacies are provided in Attachment 32,	Amended Attachment 32 provides NPI and Tax ID (when available) for each listed HCAP provider. The Department understands that NABP is an identifier that is no longer used and cannot be provided. Upon receipt of a signed, notarized Confidentiality and Non-Disclosure Agreement (RFP Attachment 10), the Department will release to an Offeror the Amended Attachment 32 HCAP Providers for the NYS Empire Plan.

			HCAP Providers for the NYS Empire Plan, of this RFP." Please provide a revised Attachment 32 that includes NABP numbers for each provider.	
78	80	3.9.D.1.f Pharmacy and Program Audit	The RFP states, in part: "The capability and contractual right to effectively audit the Programs' Retail Pharmacy Network, including the use of statistical sampling audit techniques and the extrapolation of errors." and "Use of statistical sampling of claims and extrapolation of findings resulting from such samples shall be acceptable techniques for identifying claims errors." Offeror requests modification to remove the requirement to extrapolate errors; the ability to extrapolate errors can vary greatly and if the network providers will be located outside of the state of New York, extrapolation in most cases is a violation of state audit regulations.	For clarification, this response to the language noted in RFP Section 3.9.D.1.e, not Section 3.9.D.1.f as indicated in the question. RFP Section 3.9.D.1.e requires the Offeror to have the capability and contractual right to use statistical sampling and extrapolation. If a network provider is located outside New York State and it would be a violation of that's State's laws or regulations to perform extrapolation, the Procuring Agencies would not require the Contractor to use extrapolation of errors. See Amended RFP, Section 3.9.D.1.e, "The capability and contractual right to effectively audit the Programs' Retail Pharmacy Network, including the use of statistical sampling audit techniques, and the extrapolation of errors, unless the use of extrapolation of errors is prohibited by State law or regulation."
79	81	3.9.D.1.e Pharmacy and Program Audit	Offeror does not extrapolate errors; appropriate determination of errors can vary greatly and if the network providers will be located outside of the state of NY, extrapolation in most cases is a violation of state audit regulations	See Response to Question 78.

80	82	3.9.E Mail Service Pharmacy Process	There may be situations where the home delivery pharmacy does not fill all covered drugs; for example, some specific acute medications. Please confirm this exception.	Not confirmed; exception rejected. As stated in the RFP, “The Mail Service Pharmacy Process must be capable of dispensing all covered, FDA-approved medications including any drug that could be classified as Specialty Drugs or requires special preparation or handling for up to a 90-Day supply.” It is noted in 1.6.5 that, “Specialty Drugs identified as being for short-term therapy, for which a delay in starting therapy would not affect clinical outcome (e.g., drugs needed for the treatment of Hepatitis C), do not have a grace fill” and therefore need to be available through the Mail Service Pharmacy Process.
81	84	3.9.E.1.e Mail Service Pharmacy Process	Will the Agencies consider removing the requirement for providing postage-paid mail service envelopes to Enrollees? In our experience, the majority of prescriptions are submitted via ePrescribing, fax, and online submission; therefore, eliminating this portion of the requirement would help reduce overall costs for the Agencies.	No, the Procuring Agencies will not remove the requirement for providing postage-paid mail service envelopes to Enrollees.
82	85	3.9.E.1.l Mail Service Pharmacy Process	The RFP states, “the Offeror shall call the Enrollee first to obtain permission to contact their Physician to offer alternative medications, or to offer to return the prescription.” Will the Agencies allow revision to note Offeror can “contact” the enrollee and physicians via email rather than only by phone? Please confirm.	See Amended RFP Section 3.9.E.1.l to allow “contact” and not require this contact to be a call.
83	85	3.9.E.1.m Mail Service Pharmacy Process	Offeror requests approval to “contact” the patient via email and/or call instead of only via call. Please confirm.	DCS Response: See Amended RFP Section 3.9.E.1.l to allow “contact,” which includes call, email, or other secure means. NYSIF Response: NYSIF has no preference over contact method.

84	85	3.9.E.1.n Mail Service Pharmacy Process	The RFP states, in part, “Informing the Enrollee prior to shipping if the total amount for a new Prescription order submitted through the Mail Service Pharmacy Process exceeds $100 and Enrollee has payment information (e.g., credit card) on file or Enrollee’s total balance is over $100 and Enrollee has no payment information (e.g., credit card) on file.” Offeror requests modification to remove requirement to contact patients on every order that exceeds $100. Offeror’s standard process is to contact a patient if the floor limit is exceeded.	DCS Response: The Department is unsure what the reference to “floor limit” means and declines the request to modify the requirement. NYSIF Response: NYSIF does not apply copays and this question does not apply to the workers' compensation program.
85	86	3.9.E.1.r Mail Service Pharmacy Process	The RFP states, “Ensuring that the consent of the Enrollee is obtained prior to calling the prescribing Physician with the exception of calls made for purposes of clarification, verification, settlement of other intervention claim issues or DAW-1 confirmations.” Offeror outreaches to Enrollees are done post conversion not prior to. Please confirm this change.	Not confirmed, the request for modification of this requirement is declined.
86	90	3.9.G Specialty Pharmacy Program	What is the time allowed for grace fill on Specialty drugs that are not long-term therapy?	Grace Fills are for a 30-Day supply.

87	94	3.9.G.1.y Specialty Pharmacy Program	This section includes the following statement: “Offeror’s Guaranteed Minimum Discount off of Aggregate AWP for all Specialty Drugs dispensed via specialty pharmacies or Mail Service Pharmacies shall be greater than the Offeror’s Guaranteed Minimum Discount off of Aggregate AWP and Guaranteed Maximum Dispensing Fee.” Please clarify to which pricing or cost component all Specialty Drugs dispensed via specialty pharmacies or Mail Service Pharmacies shall be greater than.	See Amended RFP, Section 3.9.G.1.y, clarifying this requirement to read: “Offeror’s Guaranteed Minimum Discount off of Aggregate AWP for all Specialty Drugs dispensed via specialty pharmacies or Mail Service Pharmacies shall be greater than the Offeror’s Guaranteed Minimum Discount off of Aggregate AWP **of Brand Name Drugs dispensed through the Retail Pharmacy Network** and Guaranteed Maximum Dispensing Fee.”
88	96	3.10 Claims Processing	The RFP states that Enrollee Submitted Claims (DCS Only) are required to be submitted to the Offeror no later than one hundred twenty (120) Days after the end of the Calendar Year in which the drugs were dispensed, or one hundred twenty (120) Days after another plan processes the claim, unless it was not reasonably possible for the Enrollee to meet this deadline. Would the State consider modifying this to exclude the EGWP plan? CMS regulations require 36 months from the Date of Service for direct claims to be submitted.	See Amended RFP Section 3.10, to address this distinction to allow enrollee submitted claims within 36 months from the Date of Service.

89	98	3.10.1.a.ix Claims Processing	This Subsection specifies that all claims data is the property of the State 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 PHI contained in the claims records and the proposer's interests in the pricing data contained in the claims records, which constitutes the proposer's protectable trade secret information?	A) Department Response: DCS believes this question specifically pertains to Section 3.10.1.a.ix, Claims Processing and is responding as such: The expectation is that the successful Offeror will require all third-party recipients of the State's claims data to execute an appropriate confidentiality agreement to protect the confidentiality of the claims data, including the PHI contained in the claims records. It is also expected that the successful Offeror will not unreasonably deny access to such data. DCS reserves the right to determine if a confidentiality agreement is appropriate, which will not be unreasonably withheld. Note that while pricing data is not a listed field in Amended Attachment 84 or Attachment 85, the successful Offeror is required to share a larger file that contains pricing information for the claims records with the Department's Decision Support System (DSS) vendor. To the extent that the successful Offeror already has agreements in place with DCS' third-party vendors which are acceptable to DCS, DCS will not require the execution of separate, new agreements. Any assertions for trade secret protection or request for exemption from the NYS Freedom of Information Law must be made in accordance with RFP Section 2.2.1 and Attachment 11. No determination regarding the trade secret protection or FOIL exemption is made within the context of the questions and answers. B) NYSIF Response: Yes.
90	100-101	3.10.1.a.xx Claims Processing	Requirement xx notes the Offeror shall credit the Programs the amount of any overpayment regardless of whether any overpayments are recovered. Will the Agencies modify the request to allow Offeror to pass back 100% of recovered Fraud Waste and Abuse (FWA) overpayments?	Modification request rejected.
91	102	3.10.1.b.iii Claims Processing Guarantees	The RFP requests a Turnaround Time for Claims Adjudication Guarantee of 99.5% within 10 business days. Will the Agencies modify the	No, this modification request is not granted. Expectation is for vendor to meet 99.5% within 10 business days, including EGWP.

			requirement for the EGWP plan to allow reimbursement or response within fourteen (14) calendar days, in alignment with CMS standards?	
92	114	3.13.C Retrospective DUR Program	This duty indicates Medicare Retrospective DUR needs to be offered to the Commercial plans. The Medicare Retrospective DUR can include concerns applicable to EGWP population that may not apply to commercial plan members. While Offeror can implement Retrospective DUR for EGWP and Commercial plans, there are unique nuances and rules required by CMS for Medicare lives that are not required for non-Medicare lives. Please confirm Offeror can provide segment-specific RDUR support to meet this requirement.	See Amended RFP Sections 3.13.C.1.a, and 5.14.C.1.f allowing Offerors to provide segment-specific Retrospective DUR support to meet this requirement.
93	127	4.3 Subcontractors or Affiliates	Please define Project Services as related to this RFP, so that Offeror may understand the types of subcontractors specifically related to Project Services in this RFP.	Project Services are services which the resulting Contractor will provide to the State as described in Section 3 of the RFP, Project Services.
94	128	4.5 New York State Tax Law Section 5-a	Offeror requests modification to the language in this section to include the following: Any applicable sales, use or other similarly assessed and administered tax imposed on items dispensed, or services	Modification request is rejected. The resulting Contractor is required to comply with NYS Tax Law § 5-a, any concerns with compliance with NYS Tax Law § 5-a should be addressed with the New York State Department of Taxation and Finance (DTF).

			provided hereunder will be the sole responsibility of the Member and/or Payor and the Member and/or Payor shall pay such amount to Provider in addition to the payment amounts set forth in this Agreement. If Provider is legally obligated to collect and remit sales, use or other similarly assessed and administered tax in a particular jurisdiction, such tax will be reflected on the applicable claim or subsequently invoiced to Payor at such time when Provider adjudicates claim, and Member and/or Payor agrees to pay Provider such amount in a manner consistent with terms within.	
95	129	4.6 Insurance Requirements	Offeror requests the following modification to the first paragraph: “Prior to the start of work the Offeror shall procure, at its sole cost and expense, and shall maintain in force at all times during the term of any Contract resulting from this RFP, policies of insurance as required by this section, written by companies that have an A.M. Best Company rating of “A-,” Class “VII” or better at the inception of each policy.”	The State does not agree to any modification of this language. Per Section 4.6 Insurance Requirements: If, during the term of a policy, the carrier’s A.M. Best rating falls below “A-,” Class “VII,” the insurance must be replaced, on or before the renewal date of the policy, with insurance that meets the requirements above.

96	130	4.6.1.a.ii Specific Coverage and Limits	Offeror requests the following be struck: “ii. Independent contractors/subcontractors;”	The State does not agree to any modification or removal of this language removing or modifying subsection (ii). Independent contractors/subcontractors.
97	130	4.6.1.b.ii General Conditions	The RFP states: “Disclose any deductible, self-insured retention, aggregate limit, or any exclusion to the policy that materially changes the coverage required by this Solicitation or any Contract resulting from this Solicitation;” Offeror requests the following modification: “Disclose any deductible, self-insured retention, aggregate limit”	The State does not agree to any modification of this language to remove the disclosure of any exclusion to the policy that materially changes the coverage required by this Solicitation or any Contract resulting from this Solicitation. This would expose the State to more risk.
98	130-131	4.6.1.c General Conditions	Offeror requests the following modification: “Only original documents (Certificates of Insurance and any endorsements and other attachments) or electronic versions of the same that can be directly traced back to the insurer, agent or broker via e-mail distribution or similar means will be accepted. The Department generally requires an Offeror to submit only certificates of insurance and additional insured endorsements.” We can comply with the language above except for agreeing to seek approval for any deductibles/retentions in excess of $100,000. Given the financial size of our organization, we maintain	The State rejects the requested modification to this section.

			deductibles and self-insured retentions when financially prudent to do so and as such, we are unable to contractually agree to restrictions regarding notification, limitations or requirements to seek approval from third parties on our ability to assume risk.	
99	131-132	4.6.1.g General Conditions	Offeror requests the following modification: “Additional Insured: The Offeror shall cause to be included in each of the liability policies required below (excluding Professional Liability Insurance and Workers Compensation/Employers Liability) coverage for ongoing work and operation naming as additional insureds) the Department and their officers, agents, and employees. An Additional Insured Endorsement evidencing such coverage shall be provided to the Department pursuant to the timelines set forth in Section 4.6(1)(m) of this RFP. A blanket Additional Insured Endorsement evidencing such coverage is also acceptable. For Offerors who are self-insured, the Offeror shall be obligated to defend and indemnify the above-named additional insureds with respect to Commercial General Liability	See Amendment to RFP Section 4.6.1.i adding "and Workers Compensation/Employers Liability" below. The State rejects any other request for modification to this provision as it exposes NY State to risk in the event of a claim: “The Offeror shall cause to be included in each of the liability policies required below (excluding Professional Liability Insurance and Workers' Compensation/Employers Liability) coverage for on-going work and operations naming as additional insureds (via ISO coverage forms CG 20 10 04 13 or 20 38 04 13 and form CA 20 48 10 13, or a form or forms that provide equivalent coverage) the Department and their officers, agents, and employees. An Additional Insured Endorsement evidencing such coverage shall be provided to the Department pursuant to the timelines set forth in Section 4.6(1)(m) of this RFP. A blanket Additional Insured Endorsement evidencing such coverage is also acceptable. For Offerors who are self-insured, the Offeror shall be obligated to defend and indemnify the above-named additional insureds with respect to Commercial General Liability and Business Automobile Liability, in the same manner that the Offeror would have been required to pursuant to this RFP had the Contractor obtained such insurance policies.”

			and Business Automobile Liability, in the same manner that the Offeror would have been required to pursuant to this RFP had the Contractor obtained such insurance policies. ”Explanation: With the exception of the Workers Compensation/Employers Liability policy, we can gladly provide additional insured status via the use of an industry standard blanket additional insured endorsement. Due to the tens of thousands of contractual obligations that include insurance obligation requiring additional insured status, we are unable to agree to specific endorsement forms on a contact by contract basis. Offeror requests the following modification: “Subcontractors: Prior to the commencement of any work by a Subcontractor, the Offeror shall require such Subcontractor to procure policies of insurance as appropriate for the services that they are providing ”Offeror agrees to ensure that all subcontractors are required to maintain appropriate levels of insurance as applicable for the specific services that they're providing. Given our thousands of contractual obligations that	

			include insurance requirements, Offeror is unable to provide insurance documentation for our subcontracted vendors. In addition, as a standard insurance industry practice, Offeror requires our subcontractors to maintain reasonable and customary types and limits of insurance based on the specific services that they are providing which can vary based upon factors such as contract value, coverages applicable to the scope of services being performed, and financial exposure to us so given this, we are unable to agree to specific insurance requirements to fit all subcontractors. Please note too that in most cases, the indemnification obligations in the final executed copy of the underlying agreement will require Offeror to indemnify the Department for any negligence on our part in retaining subcontractors or damages to the Department arising out of our subcontractors' negligence.	

100	133	4.6.1.k General Conditions	Offeror requests the following modification: “Notice of Cancellation or Non-Renewal: Policies shall be written so as to include the requirements of notice of cancellation or non-renewal in accordance with the New York State Insurance Law. Offeror shall provide the Department a 30-day notice of cancellation of any of the required insurance programs if any insurance policy(ies) is(are) cancelled or non-renewed and not immediately replaced by a substantially similar insurance program without a disruption in coverage while continuing to meet the requirements herein.”	The State rejects the requested modification to this section.
101	134-135	4.6.2.a Specific Coverage and Limits	Offeror requests the following modification: “a. Commercial General Liability: Commercial General Liability Insurance, (CGL) shall be written on the current edition of ISO occurrence form CG 00 01, or a substitute form providing equivalent coverage and shall cover liability arising from premises operations, broad form property damage, personal & advertising injury, cross liability coverage, and liability assumed in a contract (including the tort liability of another assumed in a contract). Insurance policies that remove	The State rejects the requested modification to this section.

			or restrict blanket contractual liability located in the “insured contract” definition (as stated in Section V, Number 9, Item f in the Insurance Services Offices (ISO) Commercial General Liability (CGL) policy) so as to limit coverage against Claims that arise out of the work, or that remove or modify the “insured contract” exception to the employers’ liability exclusion, or that do not cover the Additional Insured for Claims involving injury to employees of the Named Insured or subcontractors, are not acceptable. Policy shall include bodily injury, property damage, and broad form contractual liability coverage. The limits under such policy shall not be less than the following:”	
102	142	5.4.3 Customer Service	Please provide additional details on the call volume for the past two years for each of the three Programs requiring dedicated contact centers. Attachment 57 includes commercial call statistics for 2022; however, Offeror would like to see similar statistics for the EGWP and Workers’ Compensation programs. Will you provide reports for each of the requested Programs, and	DCS Response: See Amended Attachment 57. CY 2021 data is now provided, and Offerors will see After-Hours and Weekend Calls already split on this attachment (see last two columns). NYSIF Response: NYSIF does not maintain this information.

			include volume during standard hours (7 a.m. to 7 p.m. ET M-F) and for after hours and weekends?	
103	147	5.5.4 Empire Plan Medicare Rx	RFP requests Offeror to provide a side-by-side comparison in Excel of our formulary to the proposed Empire Plan Advanced Flexible Formulary included in this RFP. Attachment 51 includes a list of drugs by name only. Given the importance of these formulary compositions, will the Agencies provide detailed formulary listings by NDC to allow a detailed analysis? This is critical for non-incumbent Offerors to have a similar insight as the incumbent.	Please see New Attachment 100 August 2023 Formularies by NDC.
104	150	5.7.2.d	The RFP states, “Confirm your enrollment and claims processing system has the capacity to administer 1) Social Security number; 2) Employee identification number and; 3) an alternate identification number assigned by the Department or NYSIF.” Will the employee identification number and/or alternate identification number assigned by NYSIF always be 9 digits?	No, the employee identification number assigned will not always be 9 digits. The most common number of digits is 8; however, it may be less than 8 and NYSIF may seek to expand to over 9 digits in the future.
105	158	5.10.C.1 Pharmacy Contracting	Offeror is agreeable to the requirement but reserves the right to redact information	The State is agreeable to the redaction of information concerning other client’s information related to Section 5.10.C Pharmacy Contracting to the extent the information can be redacted without impeding the intent of the section.

			concerning other clients and information that is not required to confirm compliance with the terms of the agreement and applicable law. Please confirm this is acceptable.	.
106	159	5.10.D.1 Pharmacy and Program Audit	The RFP states, “Confirm ample resources will be made available to Department and NYSIF in response to OSC audits, including access to the Offeror’s online claims processing system and historical claims data files.” Would NYSIF please elaborate on “including access to the online claims processing system? For audit purposes, to ensure the security of other clients’ proprietary data and PHI, we would provide access to view NYSIF claimant or claim-specific information via Offeror’s audit team hosted Webex. Is this acceptable to NYSIF?	Yes. Any data that is available through the online claims processing system would have to be available as part of an audit.
107	159	5.10.D.2 Pharmacy and Program Audit	The RFP states, “Confirm that current Prescription Drug industry pricing source material (e.g. Medi-Span) will be made available in its entirety, for the duration of the Agreement resulting from this RFP by the Offeror for access up to 6 (six) Department Staff as determined by the Department.” Would NYSIF please clarify what is	DCS Response: RFP Section 5.10.D.2, requires the Contractor to provide access up to 6 (six) Department Staff to their current Prescription Drug industry pricing source material (e.g., Medi-Span) at no additional cost to the Department in its entirety, for the duration of the Agreement. For purposes of this response “made available in its entirety” means … For purpose of fulfilling this requirement screen shots alone of the material is not acceptable to the Department. NYSIF Response: Yes.

			meant by “made available in its entirety”? The Medi-Span database is licensed through Wolters Kluwer, and Offerors are restricted from sharing their proprietary database with any third-party. For audits, we normally provide reports of Medi-Span AWP unit costs, screen prints of pricing effective dates in our adjudication platform, and screen prints of pricing set-up. Is this acceptable to NYSIF?	
108	165	5.10.F.6 Specialty Drugs	Attachment 32 does not contain NPI’s or Provider IDs in order for us to run a thorough analysis. May we please request for an updated list with NPI’s and/or Provide IDs for the HCAP Providers for the NYS Empire Plan?	Please see Response to Question 77.
109	170	5.11	The RFP states, “Can the adjudication system interact with a debit card program for flexible spending accounts?” Please confirm this applies only to the DCS Program and not the NYSIF Program.	Confirmed. See Amended Section 5.11.1.q of the RFP to note that this requirement is Exclusive to DCS.
110	175	5.14.A.3	The RFP states, “Confirm that the Offeror will send notification letters, subject to the approval of the Department, to the Enrollee and/or Physician to advise of the Prior Authorization review and their appeal rights.”	DCS Response: Confirmed this applies to DCS. NYSIF Response: No communications via Onboard by Offeror.

			Does this requirement apply to both Programs? If this requirement applies to NYSIF, would it be acceptable to send communications to physicians through the New York Onboard claims system instead of via traditional letters?	
111	175	5.14.A.1.a Prior Authorization	The Workers' Compensation Board published a state-specific formulary and Prior Authorization process. Is NYSIF requesting an alternative drug list in addition to the New York Workers' Compensation Drug Formulary?	No.
112	187	General Question	URGENT: Offeror requests feedback from the Agencies prior to the September 15 date listed in the timeline of key events Due to technical delays (some by Offeror and some by the Agencies) resulting in Offeror's late receipt of claims and data files essential to preparing our bid, Offeror requests modification to the timeline of key events to allow additional time to submit questions relating to claims data beyond the September 1, 2023 deadline for submission of Offeror questions. Please confirm this accommodation.	See Amended RFP, Section 1.9, Timeline of Key Events, for updated Proposal Due Date.

<table>
<tr>
<td>113</td>
<td>187</td>
<td>General Question</td>
<td>URGENT: Offeror requests feedback from the Agencies prior to the September 15 date listed in the timeline of key events

Offeror is currently loading claims data and seeing that there may be a potential truncation of claims in files. Will the Agencies please provide total claims counts for the full dataset and claims counts for breakouts by DCS Commercial, DCS EGWP, and NYSIF. We are concerned that some of the DCS Data (NSHIP) files may be truncated; meaning, the files are cut off mid-record.</td>
<td>Please refer to Amended Attachment 86 (Amended Attachment 84 provides the Layout Specifications) which will be provided to all Offerors who submitted a completed Attachment 10 Confidentiality Non-Disclosure Agreement.

This information is not truncated and is provided in .txt files in the layout specifications provided in Amended Attachment 84.

Total Claims Counts For the Full DCS Dataset: 30,073,862

Claims Counts for DCS Commercial, DCS EGWP:

<table>
<tr><td>Carrier ID</td><td>Carrier Description</td><td>Claims Count</td></tr>
<tr><td>1207</td><td>NYSHIP Foreign Carrier</td><td>112</td></tr>
<tr><td>Carrier ID</td><td>Carrier Description</td><td>Claims Count</td></tr>
<tr><td>1207</td><td>NYSHIP Foreign Carrier</td><td>112</td></tr>
<tr><td>Carrier ID</td><td>Carrier Description</td><td>Claims Count</td></tr>
<tr><td>1268</td><td>NYSHIP COB</td><td>15,953</td></tr>
<tr><td>9482</td><td>EGWP Primary</td><td>9,132,260</td></tr>
<tr><td>3413</td><td>EGWP OHI</td><td>10,437,807</td></tr>
<tr><td>9482</td><td>EGWP Primary</td><td>9,132,260</td></tr>
<tr><td>6027</td><td>Empire Commercial</td><td>10,487,730</td></tr>
<tr><td></td><td></td><td></td></tr>
</table>

NYSIF 2022 Informational Claims File has not been amended. Total Claims Count: 250,111</td>
</tr>
<tr>
<td>114</td>
<td>187</td>
<td>General Question</td>
<td>URGENT: Offeror requests feedback from the Agencies prior to the September 15 date listed in the timeline of key events

On initial review of the claims data, the data are missing formulary indicators. Without formulary indicators, we cannot provide a formulary disruption or comparison report. The data</td>
<td>Please refer to Amended Attachment 86 (Amended Attachment 84 provides the Layout Specifications) which will be provided to all Offerors who submitted a completed Attachment 10 Confidentiality Non-Disclosure Agreement</td>
</tr>
</table>

			also appears to be missing Member ID numbers; this will impact patient level utilization counts for this set of data. Offeror requests revised claims data that provides complete formulary details. Without complete level of information, this provides the incumbent PBM with a significant advantage over non-incumbent bidders since we do not have the full data details available to us to prepare our financial offer.	
115	187	General Question	URGENT: Offeror requests feedback from the Agencies prior to the September 15 date listed in the timeline of key events Please provide guidance on how to break out claims data to allow Offeror to split the data into three components for the DCS Commercial, DCS EGWP, and NYSIF breakouts. Please also confirm that the data file includes an identifier to allow Offeror to determine which claims are vaccine claims.	Please refer to Amended Attachment 86 (Amended Attachment 84 provides the Layout Specifications) which will be provided to all Offerors who submitted a completed Attachment 10 Confidentiality Non-Disclosure Agreement.
116	187	6.1	Is there a public document that lists current pricing for each Program? Is so, where can it be found?	No.
117	187	6.1	Do the current contracts with the Programs have	This question is outside of the scope of the RFP.

			performance guarantees in place that are identical to the ones stated within this RFP?	
118	189	6.4.1	Under section 6.4.1, the language states that the guarantees must apply for the entire term without qualification or condition. Will the State confirm whether Changes in Law or material adverse market conditions would allow for appropriate changes to the impacted guarantees?	Section 8.8, Modification of Program Services, addresses the process and conditions under which the Department would consider modifications to the fees and guarantees made by the Contractor under the terms of the Agreement.
119	192	6.4.1	Will the State please clarify how DAW 1,2,9 should be classified in terms of Brand/Generic status? Will the claims be classified as Brand/Generic based on the Methodology outlined in section 6.4, or will the DAW status alone supersede that methodology and the expectation is any claim with a DAW 1,2,9 status would be classified as Generic per the table in section 3.10?	DCS Response: For the purposes of measurement and reconciliation of financial guarantees, claims are classified as Brand or Generic based on the methodology outlined in Section 6.4 of the RFP. For the purpose of claims adjudication and how member copay is assessed, the Offeror must follow the requirements outlined in Section 3.10, including DAW requirements. NYSIF Response: The Brand/Generic Classification is part of the DCS Program. NYSIF relies on the WCB formulary and determinations are made on the basis of the medication being formulary or non-formulary. NYSIF reconciles performance guarantees annually.
120	193	6.4.1.h	Per subsection 6.4.1.h, will the State confirm that as long as the Brand/Generic methodology is in place for reconciliation of financial guarantees, it is permissible to use a different Brand/Generic methodology for purposes of adjudication? Offeror's adjudication platform does not allow for custom	DCS Response: Per subsection 6.4.1h, the Offeror is required to modify its classification methodology to replicate the results of the Programs' methodology for determining the brand name/generic classification of drugs or do this through an annual claims reconciliation process. Members are charged the generic copayments for the drugs listed on the "Brands Classified as Generics list" and are included in the annual claims reconciliation. NYSIF Response: The Brand/Generic Classification is part of the DCS Program. NYSIF relies on the WCB formulary and determination are made on the basis of the medication being formulary or non-formulary. NYSIF reconciles performance guarantees annually.

			Brand/Generic methodologies, but we can accommodate custom definitions for annual reconciliations.	
121	207	6.6.C.2.b Retail Pharmacy Network Generic Pricing	This provision requires the Offeror to maximize the discount achieved on behalf of the Programs for Generic Drugs dispensed by Retail and Mail Service pharmacies. In light of the requirement for the Offeror to use the same MAC List and associated pricing for reimbursing Retail and Mail Service pharmacies, can the Procuring Agencies confirm that this obligation to maximize the discounts achieved on Generic Drugs dispensed by Retail and Mail Service pharmacies applies on a combined basis?	Confirmed.
122	201, 206, 214	6.6-6.7 Retail Pharmacy Network Claims; Mail Service Pharmacy Process - Claims	Does the following exclusion “NYSIF Program non- network claims” include out of network claims and physicians dispensed claims?	Yes.
123	213	6.7 Mail Service Pharmacy Process - Claims	Please confirm the Mail Brand discount guarantee will be based on actual acquisition cost and Mail Generic will be based on the Retail Pharmacy Generic.	Please see the following Attachments for details on Brand at Mail and Generic at Mail discounts: Amended Att. 83: Brand Name Drugs dispensed in a Mail Service Pharmacy shall be billed to the Programs using Lesser of Logic*, incorporating guaranteed contracted pricing. Enter the Offeror's Guaranteed Discount off AWP for Brands and the Guaranteed Dispensing Fee for Brands. Amended Att. 15: * Mail Service Pharmacy Brand Prescriptions shall be charged to the Plan at : • the lowest of the Pharmacy-Submitted Ingredient Cost plus dispensing fee plus prescribing fee(s) (if applicable); • the Pharmacy’s Usual and Customary Price (no dispensing

				fee is to be paid on claims when the pricing basis is usual and customary); • the Guaranteed Discount off of AWP plus dispensing fee plus prescribing fee(s) (if applicable); or, • the WCB Fee Schedule (NYSIF Program only). Amended Att. 83: Generic Drugs dispensed in a Mail Service Pharmacy shall be billed to the Programs using Lesser of Logic, incorporating the Programs MAC List for Retail and Mail Service Pharmacies and guaranteed contracted pricing. The Offeror's Guaranteed Minimum Discount off of Aggregate AWP for Generic Drugs must be the same as the amount quoted for Retail Network Pharmacies (footnote 2). The Guaranteed Minimum Discount reconciliation will be combined for Retail and Mail Service Pharmacy dispensed Generic Drugs.
124	213	6.7 Mail Service Pharmacy Process - Claims	Please confirm if any claims should be excluded from the Mail Brand discount calculation, and if so, which category(ies) of claims.	Aside from Brand Drugs Classified as Generics, no categories of claims should be excluded from the Mail Brand discount calculation.
125	219	6.10 Dispensing Fee and Prescribing Fee	Per the Prescribing fee definition in Section 6.10, what drugs are subject to the “prescribing authority”?	The Department does not see the term “prescribing authority” used in Section 6.10. If the Offeror is asking what drugs have “statutory authority,” self-administered hormonal contraceptives are currently the only drugs authorized under NYS law to be prescribed by pharmacists. Please see New Attachment 99, Prescribing Fee-Eligible Medications, for a list of medications under this class. However, as noted in Amended Attachment 83, the Department is aware of several bills in the 2023 NYS legislative session which would have expanded this authority and DCS would like to allow for the possibility of future laws broadening drugs given statutory authority to be prescribed by pharmacists.
126	219	6.10 Dispensing Fee and Prescribing Fee	Please provide more detail on the Prescribing Fee. Can you provide us a list of drugs that meet this requirement?	Please see Response to Question 125.
127	223	6.11 Specialty Pharmacy Program Pricing	The RFP states, “The Department reserves the right to remove medications from the Specialty Pharmacy Program Drug List at any time.” Offeror requests modification to exempt the EGWP program from this requirement, as we are required	As stated in 3.9.G, EGWP members are not required to use the Designated Specialty Pharmacy; therefore, this reservation of rights applies to the Exclusive Specialty Drug List that is used for the Commercial Plan.

			to follow the CMS definition of specialty, which is a cost of $950/month in 2024 (and may be adjusted in 2025 and beyond). Offeror does not know what that cost threshold will be for 2025. Per CMS rules, all specialty drugs under the EGWP plan must be driven by the CMS definition.	
128	226	6.12.a 100% Pharma Revenue Guarantee	The Pharma Revenue Guarantee requirement states, in part, that, “The Contractor agrees that any Program specific Pharma Revenue agreement shall derive total Pharma Revenue that meets or exceeds the Pharma Revenue derived from any other Pharma Revenue agreements the Contractor uses to administer its Book of Business for each individual drug. Contractor’s obligation to provide its best pharmaceutical agreement rates is appropriately tied to the Program’s benefit design, preferred drug designations, and utilization in the cost proposal. Benefit design, preferred drug designations, and utilization are the characteristics of a plan that are typically tied to rebate amounts received by pharmacy benefit	Confirmed. Section 8.6.a of the RFP requires that the Contractor’s obligation to provide its best pharmaceutical agreement rates is compared to, “clients of the Contractor with a comparable benefit design and consistent preferred drug designations in the class, provided the Programs’ utilization of the drugs generating Pharma Revenue in the class is equal to or greater than those of other clients.”

			managers from pharmaceutical manufacturers under rebate agreements. Please confirm that Contractor's obligation to provide its best pharmaceutical agreement rates is compared to "clients of the Contractor with a comparable benefit design and consistent preferred drug designations in the class, provided the Programs' utilization of the drugs generating Pharma Revenue in the class is equal to or greater than those of other clients.	
129	227	6.12.1.b. 100% Pharma Revenue Guarantee	The RFP states: "Upon final audit determination by the Procuring Agencies, any audit liability amount assessed by the Procuring Agencies shall be paid/credited to the Programs within thirty (30) Days of the date of the Procuring Agencies' final determination." Would the Agencies consider the following revision of terms: Offeror will Pay the Programs quarterly within 90 Days of the end of each quarter, the greater of 100% Pharma Revenue received or will Pay the Programs quarterly within 60 Days of the end of each quarter, the minimum	Request to modify payment terms rejected. Resulting Contractor must comply with the payment requirements as specified in the RFP and the resulting Contract.

			guaranteed amount attributable to the Programs' by formulary.	
130	231	6.12.3.b	Section 6.12(b) specifies that Offerors are to provide, in Attachment 91, adequate documentation to support the Offeror's Pharma Revenue Guarantee. Could the Procuring Agencies provide a description of what the documentation requested would be expected to consist of? Please confirm that the Procuring Agencies do not desire or permit additional conditions or terms related to the Pharma Revenue Guarantee that would modify, condition or otherwise impact the valuation of the guarantee to be provided in Attachment 90.	Adequate documentation may include, but would not be limited to, written justification to support the guarantees quoted. For example, if the Offeror is proposing substantial year-over-year increases, the Procuring Agencies expect a comprehensive narrative in support of those increases.
131	235	6.15.1.c Payments/(Credits) to/from the Contractor	Offeror proposes the following modification to this item: c. Upon final audit determination by the Procuring Agencies, any audit liability amount assessed by the Procuring Agencies shall be paid/credited to the Programs within thirty (30) Days of the date of the Procuring Agencies' final determination.	Modification request rejected. The modification language proposed is identical to the language in RFP Section 6.15.1.c.

132	243-244	7.3.1.a.i Claim Costs	Drugs that are commonly classified as Specialty Drugs are generally priced and procured under different terms than non-specialty drugs due to significant variations in the competition within a given therapeutic class, lower levels of utilization, manufacturer-imposed restrictions on which pharmacies may dispense certain Specialty Drugs, and/or other characteristics and factors not typically associated with drugs not commonly considered to be Specialty Drugs. Accordingly, through inclusion or exclusion of certain drugs in its proposed Specialty Drug list, an Offeror can materially impact the overall effective Specialty Drug discount it can propose to the Procuring Agencies. Section 7.3(1)(a)(i).a states that the Procuring Agencies will make adjustments based on the Offeror's Specialty Drug List compared to the list currently in place with DCS. Because of the disproportionate impact of Specialty Drug spend on a pharmacy benefit program, it is very important for Offerors to understand the scoring of the Specialty Drug component of their offers. Accordingly, will the Procuring Agencies please	The cost evaluation will include the following steps: 1. Establish an estimate of Average Wholesale Price (AWP) and claim counts for retail, mail, and specialty prescriptions in 2025 based on the Empire Plan's actual 2022 utilization and specialty drug list. 2. Compare each Offeror's proposed specialty drug list to the Empire Plan's actual 2022 specialty drug list. 3. An adjustment will be made for drugs that appear on the Offeror's proposed specialty drug list but are not on the actual Empire Plan 2022 specialty drug list. This adjustment will be made by determining the 2022 actual AWP and claim counts for these drugs, adjusting these totals for projected cost and utilization trend changes, adjusting for the location (specialty or retail) where specialty drugs are filled, subtracting them from the estimated 2025 retail and mail totals, and adding them to the estimated 2025 specialty totals. 4. An adjustment will be made for drugs that do not appear on the Offeror's proposed specialty drug list but are on the actual Empire Plan 2022 specialty drug list. This adjustment will be made by determining the 2022 actual AWP and claim counts for these drugs, adjusting these totals for projected cost and utilization trend changes, subtracting them from the estimated 2025 specialty totals, and adding them to the estimated 2025 retail and mail totals. An assumption of the split between retail and mail totals will be used based on the Empire Plan's aggregate 2022 experience. Also, please note that if Offerors do not achieve the Guaranteed Discounts for Brand Drugs and Generic Drugs dispensed to Enrollee/Claimants through the Specialty Pharmacy, they shall reimburse the Programs the difference between the Ingredient Cost the Programs were charged and the Ingredient Cost of what the Programs would have been charged if the Guaranteed Discount off aggregate AWP had been obtained. This difference, if any, will be credited to the Programs annually.

			provide a more detailed description of the calculations that will be used to evaluate Offerors' Specialty Drug Lists and compare them to other Offerors?	
133	248	8.1 Work in The Continental United States of America	Section 8, item 1 of the RFP states: "All work performed by Contractor personnel under this Contract must be performed within the Continental United States of America." Appendix 15 defines "Continental United States of America" as "the 49 states and the District of Columbia, with the exception of Hawaii." Would the Procuring Agencies be willing to modify Section 8 to refer to the United States (as opposed to the Continental United States) to allow performance in Hawaii and territories, including adjudicating member claims in those locations. If you are unwilling to make that modification, can you confirm that adjudicating such claims would not constitute a violation of this provision.	Modification request rejected. Procuring agencies confirm that the adjudication of a member's claim(s) in Hawaii or U.S. Territories does not constitute a violation of this section.
134	255	8.5.b.ii Audit Authority	RFP states audit activity may include, but not necessarily be limited to "Assessment of the Contractor's eligibility, financial and claim processing systems to verify accuracy of data on the	No. The annual SOC report will not provide adequate assurance that the eligibility and claims data are accurate and being reported properly.

			reports provided to the Procuring Agencies in accordance with Section 3.7 “Reporting Services” and Program Reporting (Attachment 36) of this Agreement.” Please confirm that such reporting would be satisfied via Offeror’s annual SOC I/II audit report, conducted by an independent party.	
135	255	8.5.d Audit Authority	Section d notes, in part, that “The Contractor must make available for audit all data in its computerized files that is relevant to and subject to the Agreement. Such data may, at DCS and/or NYSIF’s discretion, be submitted to the DCS in machine- readable format, or the data may be extracted by the DCS and/or NYSIF from information provided by the Contractor or by the Contractor under the direction of the DCS and/or NYSIF.” Offeror requests modification to acknowledge that such data will be considered Contractor’s Confidential Information and that Offeror and the Agencies shall partner to determine which confidential documents are legally permitted to be transmitted outside of the Offeror’s facilities.	DCS Response: No. The DCS NYSHIP units are HIPAA covered entities and the resulting Contractor a Business Associate as it relates to the PBM services. The claims data belongs to DCS or NYSHIP respectively and is managed by the PBM under the terms of the resulting Contract. With regard to DCS those elements of the data that are relevant to and subject to the Agreement and are deemed Contractor’s Confidential Information are covered under Section 8.7 of the RFP, Contractors Confidential Information. NYSIF Response: No. The claims data belongs to NYSIF and is managed by the PBM under the terms of the resulting contract.

136	255	8.5.e Audit Authority	Section e notes, in part, that "The Offeror shall, at the DCS' and/or NYSIF's request, and in a time period specified by the Department, search its files, retrieve information and records, and provide to the auditors such documentary evidence as they require." Please confirm that the time period specified will provide Offeror with a reasonable amount of time to collect and provide requested records.	Confirmed, the State will work with the Contractor to determine a reasonable time period to address any requests. If the State and the Contractor can't not agree on the time period, the State will make the final determination.
137	255	8.5.j Audit Authority	Section j. states, "The Contractor shall provide the Department with unlimited access and monthly updates to the Prescription Drug industry reference material for drug classification and drug pricing that the Offeror will be utilizing for the Programs, including but not limited to Medi-Span Master Drug Database and Drug Application File or equivalent if different reference materials are used." Do the Agencies currently have a Medi-Span contract/license and/or a First DataBank contract/license? If not, Offerors' First DataBank and Medi-Span contracts preclude us from making wholesale table extractions of their proprietary data and providing it to a third party	DCS Response: DCS currently does not have a contract or license with Medi-Span or First DataBank. RFP Section 8.5.j, requires the Contractor to provide the Department with unlimited access and monthly updates to the Prescription Drug industry reference material for drug classification and drug pricing that the Offeror will be utilizing for the Programs, including but not limited to Medi-Span Master Drug Database and Drug Application File or equivalent if different reference materials are used. Unlimited access does not mean table extractions but direct access to the source material. The Department would consider entering into a third-party permission agreement with the Contractor's provider to the extent such agreement does not restrict the use of the material by the Department for the purposes required under the RFP Section 8.5.j. NYSIF Response: NYSIF has access to Medi-Span.

			without a contract and permissions in place with that third party.	
138	257	8.6.b Ensuring Lowest Net Cost to the Program	Offeror is agreeable to the requirement but reserves the right to redact information concerning other clients and information that is not required to confirm compliance with the terms of the agreement and applicable law. Please confirm this is acceptable.	The State is agreeable to the redaction of information concerning other clients and information that is not required to confirm compliance with this requirement. If a dispute arises with regard to what information is acceptable the State will make the final determination.
139	258	8.7 Contractor's Confidential Information	Section 8 notes, in part, that "The sharing of that information with the DCS (or a third-party acting on behalf of the DCS) will be governed under the terms of this provision and no additional Non-disclosure or Confidentiality Agreement will be requested or required by the Contractor to provide such access." Due to the highly confidential nature of the proprietary details requested under audit, such as pharma contracts, acquisition cost pricing, network agreements, etc., Offeror requests modification to allow a Non-Disclosure Agreement between Offeror and the Agencies' third party auditor to ensure they are subject to confidentiality terms agreed to by Offeror and the Agencies. Alternatively, please	Modification request rejected. If the Department shares Contractor's Confidential Information with a third-party contractor, the Department will have the third-party contractors execute an Agency NDA or the third-party contractor would be subject to the terms of a contract between the Department and the third-party contractor which confidentiality terms are no less restrictive than the terms of Section 8.7 which requires the Department to maintain the confidentiality of Contractors proprietary information subject to any laws or regulations.

			confirm that upon award, the Agencies will allow for a NDA/CA agreement to be executed between all applicable parties.	
140	Appendix A	10. Records	Would the State be open to having virtual audits or audits at a mutually agreeable venue with the State of New Jersey? Offeror proposes a modification to the language set forth in Section 10. Records. Due to the proprietary and confidential nature of certain items, we would ask that copying of such items like pharmacy network contracts and rebate agreements not be completed.	1. Requests to make an audit virtual or to perform audit work outside of New York State must be made to the authorized entity performing the audit. 2. The State does not agree to any modification of Appendix A, Standard Clauses for All New York State Contracts. For Department purposes Section 8.7, Contractor's Confidential Information provides an alternative to providing copies of the Contractor's Confidential Information.
141	Appendix B	Section 41	This section states that a contractor must, within twenty-four (24) hours of the discovery or reasonable belief of a Security Incident (defined as "unauthorized disclosure or loss of sensitive or Confidential Information"), provide a written report of the incident. Given the high frequency of unsuccessful and/or immaterial incidents that present no risk that such sensitive information will be compromised, please confirm that the requirements of this section do not apply to such activity such as pings and other broadcast attacks on Business	Confirmed the requirements of Appendix B Section 41, does not apply to unsuccessful activity/attacks at the Business Associates firewall including pings and other broadcast attacks, port scans, unsuccessful log-on attempts, and denials of service.

			Associate's firewall, port scans, unsuccessful log-on attempts, denials of service, and other such minor incidents.	
142	Appendix B	16.a	The RFP states, "The Department represents that the purchases on behalf of the State of New York are not subject to any state or local sales or use taxes, or to federal excise taxes." Offeror requests modification as we are unable to agree to this term as written. While we agree in principal that direct purchases by New York State are exempt, their purchase of pharmaceutical drugs is not a direct purchase. Rather, these transactions are between the Member (not tax exempt) and the pharmacy and subject to applicable taxes.	Appendix B, Section 16.a, is with regard to purchases made by the Department on behalf of the State of New York, not a member purchase. In addition, we are not aware of any New York tax being imposed on a member for purchase of a pharmaceutical drug which is being procured under the Pharmacy Plan.
143	Appendix B	17. State's Authority to Conduct Financial and Performance Audits	Similar to above, Offeror proposes a modification to the language set forth in Section 17. State's Authority to Conduct Financial and Performance Audits. Due to the proprietary and confidential nature of certain items, we would ask that copying of such items like pharmacy network contracts and rebate agreements not be completed.	See RFP Section 8.7 which provides an alternative to copying (physical or digital) Contractor's Confidential Information.

144	Appendix B	General Question	While we would not permit others to background check our employees, we will, upon request, provide validation that the agreed upon background check was performed and pass prior to placement of the individual. Offeror proposes the following modification to this paragraph: “The State also reserves the right to: (a) conduct a background check or otherwise approve any Contractor Staff performing work on this Contract or having access to Data; and (b) refuse access to, eject or require replacement of any personnel at the Department’s discretion for any reason.”	The State reserves the right to conduct a background check or otherwise approve any Contractor Staff performing work on the Contract or having access to State Data as may be required to comply to maintain compliance with any applicable Federal or State laws, rules, and regulations or policies. In lieu of performing its own background check, the State may accept validation from the Contractor that the agreed upon background check was performed and passed a suitability determination prior to placement of the individual.
145	Appendix B	A. Confidentiality	Offeror requests modification to remove the following clause as we do not allow clients to contract with our employees: “Upon the request of the State or Department, all of Contractor’s officers, agents, employees and subcontractors with access to Data shall cooperate in executing a written confidentiality/nondisclosure agreement and/or security addendum under applicable confidentiality and privacy laws, rules, and regulations or policies. If the State or Department does not request	The Department denies this request for modification. The State reserves this right to request the execution of a written confidentiality/nondisclosure agreement and/or security addendum to maintain compliance with any applicable confidentiality and privacy laws, rules, and regulations or policies.

			the execution of a written confidentiality/nondisclosure agreement and/or security addendum then”	
146	Appendix B	B. Non-disclosure	Offeror requests modification to remove the following clause as we do not share subpoenas with clients: “Contractor shall promptly notify the Department of any subpoena, warrant, judicial, administrative or arbitral order of an executive or administrative agency or other governmental authority of competent jurisdiction (a “Demand”) that it receives and which relates to or requires production of the information or data Contractor is processing or storing on the State’s behalf where the State is the object of the underlying subpoena, warrant, judicial, administrative or arbitral order. If Contractor is required to produce information or data in response to such Demand, Contractor will provide the Department with the information or data in its possession that it plans to produce in response to the Demand prior to production of such information or data. Except as otherwise required by law, Contractor shall provide the Department with reasonable time to assert its rights with	Modification request rejected.

			respect to the withholding of such information or Data from production."	
147	Appendix B	B. Non-disclosure	Offeror requests modification to include subcontractors within the following provision: "Contractor agrees that access to and use of sensitive and Confidential Information is limited to authorized employees and legally designated agents, [and subcontractors] for authorized purposes only."	Modification request rejected: for purposes of Appendix B, Section 28(b) the reference to "legally designated agents" includes subcontractors as defined in response to Question 161 below, within the phrase "Contractor agrees that access to and use of sensitive and Confidential Information is limited to authorized employees and legally designated agents, for authorized purposes only."
148	Appendix B	D. Data Ownership and Use	Note: Track changed intended. Offeror requests "Data" to be defined and confirm that Contractor is permitted to use Data as required by law and/or as permitted or required in the Agreement. Offeror also requests the following modification: Contractor agrees that Data shall not be distributed, used, repurposed, transmitted, exchanged or shared across other applications, environments, or business units of the Contractor or otherwise passed to other contractors, agents, subcontractors or any other interested parties, except ~~as expressly and specifically agreed to in writing by the Department~~to the extent each	a) Please see Amended Attachment 15 to include the following definition: Data means any information, analytic derivatives, formula, algorithms, or other content that the Department or State may provide to the Contractor pursuant to this Contract. Data includes, but is not limited to, any of the foregoing that the Department and/or Contractor (i) uploads to a Cloud Service, and/or (ii) creates and/or modifies using a Cloud Service. b) The State confirms that the Contractor is permitted to use Data as required by applicable law and/or as permitted or required in the Agreement. c) Request to modify the language of Appendix B, Section 30, Data Ownership and Use, is rejected.

			recipient agrees to and complies with all restrictions on the use of Data at least as restrictive as those outlined herein. This provision shall survive the termination of the Contract.	
149	Appendix B	38 Accessibility	The Accessibility Policy requires that the Department's Information Communication Technology shall be accessible to persons with disabilities as determined by accessibility compliance testing. Offeror does not typically provide raw testing results to clients; will providing a VPAT (Voluntary Product Accessibility Template) report meet the Agencies' needs?	The State may accept a VPAT report as proof of accessibility compliance but reserves the right to request additional information consistent with New York State Enterprise IT Policy NYS-P08-005, Accessibility of Information Communication Technology Policy.
150	Appendix B	38 Accessibility	The RFP states, "Such accessibility compliance testing will be conducted by Contractor and any report on the results of such testing must be satisfactory to the Department." Please provide additional guidance on the Agencies' determination of "satisfaction" as accessibility compliance and interpretation of guidelines is inherently subjective.	See New York State Enterprise IT Policy NYS-P08-005, Accessibility of Information Communication Technology Policy for compliance criteria.

151	Appendix B	40 Migration	The RFP states, “Contractor's services performed under this Contract will ensure easy migration of the Data including Confidential Information under this Contract by providing its solution in a manner designed to do so. This may include maintaining that information in a format that allows Department to easily transfer it to an alternative application platform. Contractor will make its Application Programming Interfaces (APIs) available to Department.” Does the language in this item mean that APIs for any purpose must be made available as part of this contract, or does this mean that APIs specifically involved with data migration must be made available? For example, Offeror’s Price Quote API is not associated with data migration. Would that still be an API that Offeror must make available to them as part of the contract? Our Pharmacy Claims API could be viewed as an API that has utility within a migration context, since some amount of claims history typically is moved with migrations from one PBM to another.	This section is specific to Data migration.

152	Appendix B-3	General Question	The drop-down list as defined in the instructions do not have drop-down options in the response section of the document. Will there be a fillable attachment that will be resent, or do we just note as instructed?	This is the vendor security survey; business does not evaluate.
153	Appendix B-4	Section 7	This Section requires that the contractor return or destroy all NYSIF Confidential Information (as defined) within five days of contract termination. In light of other applicable record retention provisions (such as Section 10 of Appendix A, which requires records pertinent to contract performance to be maintained for six years after they were made) would not require NYSIF's PBM to immediately return or destroy records that the PBM requires in order to complete services post termination, such as auditing pharmacies and collecting rebates.	Any concerns or requested changes should be listed in the comments and limitations section of the bid.
154	Appendix B-4	Section 8	This Section requires the contractor to use best efforts to comply with NYSIF's "rules, regulations, policies and procedures that might affect CONTRACTOR's delivery of services or products in effect (the "Policies & Procedures"), including but not limited to AGENCY's security procedures,	NYSIF will not be providing any additional URLs at this time. Many policies and rules can be found throughout the RFP. Any concerns or requested changes should be listed in the comments and limitations section of the bid.

			procurement policies and privacy policies." Would NYSIF be willing to provide urls linking to any policies or rules that would be in scope so bidders can familiarize themselves with these documents?	
155	Appendix C	Section 1	With regard to Item 1. Compliance in which it is stated that "Accordingly, Contractor warrants, covenants and represents that it shall fully comply with all New York State Information Technology Cybersecurity Policies, Standards and Procedures published by the New York State Chief Information Security Office at https://its.ny.gov/policies , as amended from time to time, that are applicable to the Project Services being provided by Contractor." Please advise whether there is a specific list of policies applicable to this PBM services project that can be provided to all prospective bidders.	There is no specific list of Policies applicable to this PBM services project. Contractor must use their best judgment to determine whether a NYS cybersecurity policy is applicable to the specific PBM service being provided. If there is a question regarding applicability of a specific policy it should be presented to the Department for review and response.

156	Appendix C	Section 3.2	To avoid inundating the Department with notification of insignificant system changes, please confirm that that only notification required would be those changes that only notification required would be those changes that lessen security to systems.	DCS Response: Correct, the Contractor is only required to notify the Department of any changes to systems, facilities or WISP controls impacting Confidential Information. And does not apply to notification of insignificant system changes which do not lessen the security of the Contractor's systems. NYSIF Response: Notifications would pertain to Information Security changes, only.
157	Appendix D	Section I: General Provisions	Please confirm that the contract goals for MWBE participation are applicable only to the NYSIF contract.	Confirmed. Offeror should model data based on informational files provided by procuring agencies
158	Appendix D	MWBE Goals	The RFP notes that NYSIF's review has determined that the Contract does not offer sufficient opportunities to set specific goals for MWBEs as subcontractors; however, Appendix D notes that NYSIF has established a 30% overall outsourcing goal (18% MBE, 12% WBE) for this Contract. Please confirm bidders are not required to meet the 30% goals and can propose alternative utilization percentages as part of a good faith effort to incorporate MWBE utilization. If an alternative percentage is proposed, does bidder need to submit a request for a waiver with the RFP response? Please also clarify what the 30% participation amount is based on (e.g., NYSIF admin fees or NYSIF drug spend).	Please see revised Appendix D.

159	Attachment 10	Confidentiality and Non-Disclosure Agreement	When should Offerors that have signed and submitted attachment 10 expect to receive the data disclosed in: - Attachment 22 - Attachment 86	There is no defined deadline for submission of the Attachment 10 Confidentiality and Non-Disclosure Agreement, specified in the RFP. The information will be provided as soon as practicable upon receipt of completed and approved Attachment 10.
160	Attachment 15	Glossary of Defined Terms, Definition of AWP	Offeror requests an alternative definition of AWP. Offeror proposes this definition: "Average Wholesale Price" or "AWP" means the average wholesale price of a prescription drug as identified by drug pricing services such as Medi-Span, the drug manufacturer or other source recognized in the retail prescription drug industry (the "Pricing Source"). If the Pricing Source discontinues the reporting of AWP or materially changes the manner in which AWP is calculated or reported, then Express Scripts reserves the right to make an equitable adjustment as necessary to maintain the parties' relative economics and the pricing intent of this Agreement.	Alternative definition not accepted. DCS requires the use of Medi-Span and per 6.4.1.d of the RFP, if Medi-Span changes its methodology related to how drugs are classified, the Contractor and the Procuring Agencies will meet and agree in writing. Per the definition of AWP used in Amended Attachment 15, *Glossary of Defined Terms,* Medi-Span is used unless the Parties mutually agree in writing to utilize a different source for AWP information.

161	Attachment 15	Glossary of Defined Terms	Will the State provide standardized definitions of the following terms in the RFP: Subcontractor, Vendor, and Supplier?	Please see Amended Attachment 15 to include the additional definitions: A) Subcontractor means any individual or legal entity (including but not limited to sole proprietor, partnership, limited liability company, firm or corporation) who has entered into a contract, express or implied, for the performance of a portion of the Contract with a Contractor. B) Vendor is any entity that will provide Program Services under the resulting Contract and could refer to the successful Offeror or their subcontractors depending on the context. C) Supplier means any entity that will provide supplies (i.e., inventory) as part of the Program Services under the resulting Contract and could refer to a subcontractor depending on context.
162	Attachment 20	Offeror's Proposed Retail Pharmacy Network Access Prerequisite Worksheet	How would the State like for bidders to account for incomplete data (i.e. incorrect addresses or invalid zip codes), to complete the enrollee count for Attachment 20.	Incomplete data was removed prior to this information being made available to Offerors; the data available through Attachment 20 is complete.
163	Attachments 23-27	General Question	Under the Empire Plan, how should Offerors be identifying Commercial vs. EGWP Enrollees/Totals within Attachments 23-27? The provided attachments do not include indicator differentiating these lines of business. a. How do the EGWP/Commercial Enrollments values at bottom of Attachment 25 here under “a” tie to Attachment 26 under “b”? b. These are the values at the bottom of Attachment 26; however they do not expand on which are Commercial vs. EGWP – there is an item that notes Retirees but those values	Please see Amended Attachments 25 and 26.

			do not tie to EGWP membership above.	
164	Attachment 36	Program Reporting	Offeror proposes a modification to the “Quarterly Performance Guarantee Report”. We can provide quarterly reporting at 60 days form the end of each quarter. Is this acceptable?	The modification is rejected. DCS requires the Quarterly Performance Guarantee Report 30 Days after the end of the quarter.
165	Attachment 36	Program Reporting	Would the State define or explain more about what they’re looking for in terms of “Documentation of compliance should be included with this report” for the “Quarterly Performance Guarantee Report”?	Documentation of compliance means that the vendor must submit reports detailing how these performance standards are met. For example, for the Customer Service Blockage Rate, the Department expects to receive a back-up Monthly report detailing the date/number of calls received/how many were blocked, and percent blocked.
166	Attachment 59	NYSIF Eligibility Process	The RFP states, “Prior authorized drugs. Uses GPI codes. Up to 20 occurrences. Up to 14 character GPI, though NYSIF will typically send a 10 character code.” This is not a required field on the file layout; however, if the Offeror receives the client defined information in this field, would NYSIF expect the Offeror to lock in or block that 10-character GPI for the specified timeframe when it is received in eligibility?	NYSIF Response: NYSIF will work with the vendor during implementation on the business process to follow for this situation.
167	Attachment 60	NYSIF Billing Process	“Date of Paper Bill Payment.” The date the paper bill provider/pharmacy is paid is not available at the time of billing.	This is the date NYSIF paid a paper bill and is usually null. If NYSIF paid the pharmacy directly this may be a basis to reverse a duplicate payment from the PBM.

			We can provide a supplemental file process to address this requirement. Alternatively, we could delay billing NYSIF until after we pay the pharmacy. Are either of these solutions acceptable to NYSIF?	
168	Attachment 78	NY Prescription Plan Payments	Can you please provide the following information for NYSIF's 2022 Rx spend broken down by in-network and out-of-network below:	NYSIF claimants must use in network pharmacies per current regulation. This information about non-network is not readily available and is variable and by exception only.
169	Attachment 83	Proposed Claim Reimbursement Quote	Is NYSIF interested in workers' compensation transparent pricing?	This question is outside of the scope of the RFP.
170	Attachment 83	Proposed Claim Reimbursement Quote	Is NYSIF receiving manufacturer rebates today for your current PBM? If so, what is the average rebate value per prescription?	This question is outside of the scope of the RFP.
171	Attachment 83	Proposed Claim Reimbursement Quote	Can you please provide NYSIF's current Retail Pharmacy Guaranteed Minimum Discount Off of Aggregate AWP for both Brands and Generics?	This question is outside of the scope of the RFP.
172	Attachment 83	Proposed Claim Reimbursement Quote	There is only one box for Brand Guarantee/Generic Guarantee (Retail, Mail, and Specialty) on Attachment 83. Is the State expecting only a single rate for all 5 years (no tiered pricing by year)?	Yes, per Section 6.4.1 of the RFP pricing guarantees must be for the entire term of the Agreements without qualification or condition.

173	Attachment 83	Proposed Claim Reimbursement Quote	Guarantee boxes are not separated out by EGWP, Commercial, and Worker's Compensation programs. Is the State's intent that all guarantees are merged into a single guarantee covering all programs, or may the Offeror provide separate guarantees per program (Commercial, EGWP, NYSIF)? Our Pharmacy contracts differ based on the various client/benefit types.	Guarantees for Brand/Generic at Retail, Brand/Generic at Mail and Specialty are across all programs.
174	Attachment 83	Proposed Claim Reimbursement Quote	Will the State clarify if a retail 90 day benefit is in place or would be accepted, and if so at what days' supply does the 90 day pricing apply?	No, if the Offeror is referring to a program wherein a separate retail pharmacy network is in place to dispense a 90-day supply of medication, subject to different guarantees from the core retail pharmacy network, such a program is not in place for the State.
175	Attachment 83	Proposed Claim Reimbursement Quote	Per Attachment 83 it appears bidders are to quote one guarantee for all populations including the Workers Compensation group (NYSIF). Please confirm.	See Response to Question 173.
176	Attachment 83	Proposed Claim Reimbursement Quote	Per review of attachments 83, 88 and 89 it appears bidders are required to just quote an aggregate specialty guarantee on Attachment 83. Please confirm.	Confirmed.
177	Attachment 83	Proposed Claim Reimbursement Quote	Please confirm that the reference to Attachment 88 where it is stated "Specialty Drugs dispensed through the Specialty Pharmacy Program shall be billed to the Program	Confirmed; see Amended Attachment 83 for amendment to footnote (7).

			using Lesser of Logic, incorporating guaranteed contracted pricing. Enter the Offeror's Guaranteed Discount off AWP for Specialty Drugs dispensed through the Specialty Pharmacy Program. The Offeror may propose a guaranteed contracted dispensing fee, on an NDC basis, for each drug proposed to be included in the Specialty Pharmacy Program on Attachment 88" should be interpreted to refer to Attachment 89 – Specialty Pharmacy Program Dispensing Fees.	
178	Attachment 88	Retail and Mail Service Pharmacy Generic Drugs MAC List Costs per GPI	Please confirm that where it is stated "Attachment 87 Instructions: Submit in Excel format on a USB storage device," it should be interpreted and submitted as Attachment 88, consistent with the file name and header.	Confirmed; see Amended Attachment 88
179	Attachment 90	Pharma Revenue Guarantee Quote	Is the intent to be truly aggregated or is there a way to break DCS out by formulary?	Yes, the intent is to aggregate the rebate across all formularies. Offerors should review Attachment 42 for a sample Quarterly Rebate and Other Pharma Report. This sample breaks rebates out by Rebate ID (formulary).
180	Attachment 90	Pharma Revenue Guarantee Quote	Should Offeror assume certain participation in formulary utilization management/step therapy if disclosed in the RFP? If Offeror is required to mirror current formulary set-up, the Agencies must provide detailed formulary set-ups, utilization	No, the Offeror is not required to mirror current formulary set-up but must be aware of collective bargaining requirements and limitations under the Frozen Formulary law. Step therapy is not allowed. As stated on Amended Attachment 90, "The Offeror's Minimum Per Final Paid Claim Pharma Revenue Guarantee Quote is not contingent upon the Programs' participation in any of the Offeror's formulary management or intervention programs, including step therapy. The Offeror may not make such quotes contingent upon use of their Book of Business Formulary.

			management criteria, and step therapy details, in addition provide NDC level documents of the same.	Nor shall the Offeror's Minimum Per Final Paid Claim Pharma Revenue Guarantee Quote be contingent or dependent on the timing of any patent expirations and/or introduction of generic equivalent drugs, including but not limited to early and/or at risk generic launches." The Department's current PBM contract contains "Transition and Termination of Agreements" requirements. That is, the Department's expectation is that the incumbent vendor will work with the incoming vendor to ensure that member refills, prior authorizations and generic appeals are transitioned in the new contract.
181	Attachment 91	Documentation to Support Pharma Revenue Guarantee Quote	Please provide additional details as to what constitutes adequate document for Attachment 91. What type of support is being requested as it notes "Attachment 91 will consist of the Offeror's Documentation to Support Pharma Revenue Guarantee Quote." "The Offeror is required to provide adequate documentation as determined by the Procuring Agencies, to support the Offeror's offer relative to Pharma Revenue in Attachment 90. Said documentation is to be provided as Attachment 91, Documentation to Support Pharma Revenue Guarantee Quote, of the Offeror's Proposal."	Please see Response to Question 130.
182	Attachment 92	Claims Administration Fee(s) Quote	Would the State accept a per member per month (PMPM) administration fee for the Medicare population?	No, Attachment 92 requires Offerors to quote Per Each Final Paid Claim.