AMENDED RFP - OCTOBER 30, 2023

REQUEST FOR PROPOSALS

ENTITLED:

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

RELEASE DATE:

August 14, 2023

AMENDED PROPOSAL DUE DATE:

November ~~2~~ 13, 2023

IMPORTANT NOTICE: A Restricted Period under the Procurement Lobbying Law is currently in effect for this Procurement and it will remain in effect until State Comptroller approval of the resultant Contract. During the Restricted Period for this Procurement ALL communications must be directed, in writing, solely to the Designated Contact as listed in Section 2.1(1) of this RFP and shall be in compliance with the Procurement Lobbying Law and the New York State Department of Civil Service "*Rules Governing Conduct of Competitive Procurement Process*" (refer to RFP, Section 2: Procurement Protocol and Process).

All inquiries, questions, filings, and submission of Proposals must be directed in writing to:

New York State Department of Civil Service
Attn: Office of Financial Administration, Floor 17
Agency Building 1, Empire State Plaza
Albany, New York 12239
DCSprocurement@cs.ny.gov

Timothy Hogues
Commissioner
New York State Department of Civil Service

Daniel Yanulavich
Director
Employee Benefits Division

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SECTION 1: INTRODUCTION

1.1 Purpose

The New York State Department of Civil Service (Department or DCS) has issued this Request for Proposal (RFP) to secure the services of a vendor to enter into separate contracts to administer The Empire Plan, Excelsior Plan, Student Employee Health Plan and the New York State Insurance Fund Workers' Compensation Prescription Drug Programs. The New York State Insurance Fund (Fund or NYSIF) will oversee the contract for workers' compensation. "Procuring Agencies" means DCS and NYSIF.

This RFP defines minimum contract requirements, details response requirements, and outlines the process for evaluating responses and selecting a qualified organization (Offeror). Project Services are set forth in detail in Section 3. Terms used herein shall have the meanings specified in the *Glossary of Defined Terms* (Attachment 15) or in the body of this RFP. If there is a conflict in a definition, the body of the RFP will control.

1. Resulting Contracts

The Offeror must agree to be bound by its Proposal which will be explicitly incorporated by reference into separate executed Agreements with the Procuring Agencies.

The Selected Offeror must be willing to enter into a contractual agreement containing, at a minimum, those terms and provisions identified in this RFP. *Program Services Matrix* (Attachment 97) identifies RFP provisions which are applicable to both DCS and NYSIF, or exclusive to DCS or NYSIF. Whether a provision or requirements in the RFP is exclusive to DCS or NYSIF is also identified in the body of the RFP. Bidder should assume that any requirements not identified in the RFP as exclusive to either DCS or NYSIF are applicable to both Procuring Agencies. The body of the RFP would control and take precedence if there are any conflicts between the body of the RFP and *Program Services Matrix* (Attachment 97).

Appendix A – Standard Clauses for New York State Contracts, dated June 2023 is applicable to both DCS and NYSIF.

DCS

The following Appendices are exclusive to DCS:

1. Appendix B – (Standard Clauses for all Department Contracts), dated April 2022; and
2. Appendix C – (New York State Department of Civil Service Information Security Requirements), dated March 2023.

The Contract with DCS resulting from a successful award will include the following documents. Conflicts between these documents will be resolved in the following descending order of precedence:

1. Appendix A – Standard Clauses for New York State Contracts, dated June 2023;
2. The Contract body and other writing(s) setting forth the final agreements, clarifications and terms between the RFP and Contractor's Bid. Clarifications must be specifically noted in writing as to what was offered by the Contractor and what was accepted by the State. If not, such clarifications shall be considered last in the order of precedence;
3. Appendix B – (Standard Clauses for all Department Contracts), dated April 2022;
4. Appendix C – (New York State Department of Civil Service Information Security Requirements), dated March 2023;
5. This RFP including any Addenda (other than Appendix A) applicable to DCS; and
6. Selected Contractor's Bid or Proposal, including ~~and~~ any clarifications resulting from Management Interviews or Department Requests for Clarifications and Contractor's responses.

NYSIF

The following Appendices are exclusive to NYSIF:

1. APPENDIX B-1 – General Specifications, dated March 2023 (NYSIF);
2. APPENDIX B-2 – Contract Provisions, dated February 2023 (NYSIF);
3. APPENDIX B-3 – NYSIF Vendor Security Survey (NYSIF);
4. APPENDIX B-4 – NYSIF Mutual Non-Disclosure Agreement (NYSIF); and
5. APPENDIX D – Participation by Minority and Women-Owned Business Enterprises: Requirements and Procedures (NYSIF).

The Contract with NYSIF resulting from a successful award will include the following documents. Conflicts between these documents will be resolved in the following descending order of precedence:

1. Appendix A – Standard Clauses for New York State Contracts, dated June 2023;
2. The Contract body and other writing(s) setting forth the final agreements, clarifications and terms between the RFP and Contractor's Bid.

Clarifications must be specifically noted in writing as to what was offered by the Contractor and what was accepted by the State. If not, such clarifications shall be considered last in the order of precedence;

3. APPENDIX B-1 – General Specifications, dated March 2023 (NYSIF);
4. APPENDIX B-2 – Contract Provisions, dated February 2023 (NYSIF);
5. APPENDIX B-3 – NYSIF Vendor Security Survey (NYSIF);
6. APPENDIX B-4 – NYSIF Mutual Non-Disclosure Agreement (NYSIF);
7. APPENDIX D – Participation by Minority and Women-Owned Business Enterprises: Requirements and Procedures (NYSIF)
8. This RFP including any Addenda (other than Appendix A) applicable to NYSIF; and
9. Selected Contractor's Bid or Proposal, including ~~and~~ any clarifications resulting from Management Interviews or Department Requests for Clarifications and Contractor's responses.

After Agreements are separately executed with the Contractor and DCS and NYSIF, any change to the scope of the Agreement, including but not limited to the inclusion of any individual Network Pharmacy(ies), requested by one Procuring Agency shall have no impact on the other Procuring Agency Agreement or cost thereunder, unless the other Procuring Agency likewise agrees to said change(s). The Department and NYSIF will only contract with a single Offeror, which will be the sole contact with regard to all provisions of the Agreements. If the Offeror's Proposal includes Key Subcontractors or Affiliates, the Offeror will be considered the Prime Contractor, and the Offeror shall assume full responsibility for the fulfillment of all of the responsibilities under the Agreements. The Department and NYSIF reserves the right to approve (or disapprove) any or all Key Subcontractors.

This RFP and other relevant information may be reviewed at: https://www.cs.ny.gov/RxBenefit2023RFP/.

1.2 Period of Performance

It is DCS' and NYSIF's intent (DCS and NYSIF are hereafter collectively referred to as the "Procuring Agencies") to execute two separate Contracts (Agreements) for terms beginning with an Implementation Period of a minimum of six (6) months followed by an additional five (5) years of service.

The DCS Contract shall begin on The DCS Project Services Start Date, through and including December 31, 2029. The "DCS Project Services Start Date" is January 1, 2025, or 180 Days after OSC approves the Contract, whichever is later.

The NYSIF Contract shall begin on the NYSIF Project Services Start Date through and including March 31, 2030. The NYSIF Project Services Start Date is April 1, 2025, or 180 Days after OSC approves the Contract, whichever is later.

In accordance with New York State policy and New York State Finance Law section 112(2), the resulting contract is deemed executory until it has been approved by the New York State Attorney General's Office (AG) and approved and filed by the New York State Office of the State Comptroller (OSC).

[**Note:** The DCS Project Services Start Date and the NYSIF Project Services Start Date may be collectively referred to as the "Project Services Start Date."]

1.3 Overview of the NYS Health Insurance Program and the NYS Insurance Fund

The New York State Health Insurance Program (NYSHIP) was established by the New York State Legislature in 1957 to provide essential health insurance protection to New York State (NYS) employees, retirees, and their eligible Dependents[1]. Civil Service Law allows the New York State Health Insurance Program the option to be self-funded, which occurred in 2014. Public authorities, public benefit corporations, and other quasi-public entities, such as the NYS Thruway Authority and the Dormitory Authority may choose to participate in NYSHIP; those that do are called Participating Employers (PEs). Article XI of the NYS Civil Service Law also allows local units of government such as school districts, special districts, and municipal corporations to participate in NYSHIP; those local government units which choose to participate in NYSHIP are called Participating Agencies (PAs). At present, there are roughly 100 Participating Employers and about 800 Participating Agencies in NYSHIP. Under Article XI of the Civil Service Law, as amended and 4 New York Code of Rules and Regulations (NYCRR) Part 73, as amended, the President, who also serves as the Commissioner of the Department, through the Department's Employee Benefits Division (EBD) is responsible for the ongoing administration of NYSHIP.

NYSHIP currently covers over 606,000 NYS, PA and PE Employees and Retirees. Eligible covered Dependents bring the total number of covered lives to about 1,177,000.

[1] Eligible Dependents means the spouse, domestic partner, and children under twenty-six (26) years of age of an Enrollee (defined as the policyholder). Young adult dependent children aged twenty-six (26) or over are also eligible if they are incapable of supporting themselves due to a mental or physical disability acquired before termination of their eligibility for coverage under NYSHIP. For additional details on eligible dependents and requirements, please see the following links to the NYSHIP General Information Books for State, PE, and PA enrollees below: 2021 General Information Book NYS Active Employees

NYSHIP currently provides health insurance coverage through The Empire Plan, a Participating Provider Organization (PPO) with managed care components, and eight (8) Health Maintenance Organizations (HMOs). The Excelsior Plan is a lower cost version of The Empire Plan available only to PAs. Additionally, the Student Employee Health Plan (SEHP) is administered through The Empire Plan contracts. SEHP is a health insurance plan for graduate student employees of the New York State and New York City University systems. NYS and PE Employees and Retirees may elect to enroll in either The Empire Plan or in HMOs offered through NYSHIP. NYSHIP offers only The Empire Plan and the Excelsior Plan to PAs. PAs may, and frequently do, offer HMOs directly to their own employees and retirees as an alternative to Empire Plan coverage.

NYSIF

The New York State Insurance Fund (NYSIF) was established in 1914 as part of the original enactment of the New York Workers' Compensation Law. NYSIF's mission is to guarantee the availability of workers' compensation insurance at the lowest possible cost to New York employers and to provide timely, appropriate indemnity and medical payments to injured workers, while maintaining a solvent fund. Since inception, NYSIF has fulfilled the dual roles for which it was created: to compete with other carriers to ensure a fair marketplace and to be a guaranteed source of coverage for employers who cannot secure coverage elsewhere.

NYSIF is the largest workers' compensation carrier in New York State and among the top 10 largest workers' compensation carriers in the nation, insuring approximately 139,000 policyholders, with more than $1.8 billion in annual earned premium and over $22 billion in assets. A self-supporting insurance carrier, NYSIF operates without taxpayer funding.

In addition to workers' compensation insurance, NYSIF provides disability benefits coverage for off-the-job injuries to more than 56,000 New York employers. In 2018, NYSIF added paid family leave as a component of its disability benefits product, providing New Yorkers with job-protected, paid time away from work to care for their families.

1.4 Overview of The Empire Plan, Excelsior Plan, and Student Employee Health Plan

The Empire Plan, Excelsior Plan, and SEHP (collectively referred to as the DCS Program(s)) are comprehensive health insurance programs for New York's Public Employees and their families. The DCS Programs are sponsored by the Council on Employee Health Insurance (CEHI). The Council is composed of the President of the Civil Service Commission, the Director of the Office of Employee Relations (OER), and

the Director of the Division of the Budget (DOB). The Department holds the contracts with the DCS Programs third party administrators. All components of the DCS Programs are self-funded.

This RFP seeks to secure the services of a qualified Offeror under a self-funded Administrative Services Only (ASO) arrangement for The Empire Plan, Excelsior Plan, Student Employee Health Plan, and NYS Insurance Fund Workers' Compensation Prescription Drug Programs. The Employee Benefits Division (EBD) within the Department is responsible for the administration of the DCS Programs. The Empire Plan currently has over 538,000 Enrollees with roughly 1,049,000 covered lives. The Empire Plan benefit design has four (4) main parts including:

1. Hospital Program benefits that include coverage for drugs dispensed and administered by the hospital. This program is currently administered by Empire BlueCross (which will be known as Anthem Blue Cross effective January 1, 2024);

2. Medical Program benefits include drugs when dispensed and administered by a physician in an office setting. This program is currently administered by UnitedHealthcare Insurance Company (UHC) of New York;

3. Mental Health and Substance Use Program benefits that include coverage for drugs when dispensed by an approved facility, residential or day treatment program. This Program is currently administered by Carelon (f/k/a Beacon Health Options); and

4. Prescription Drug Program benefits that includes coverage for prescription drugs dispensed through retail network pharmacies, through the Mail Service Pharmacy Process, through the Specialty Pharmacy Program, and through non-network pharmacies. This program is currently administered by CVS Caremark.

The benefit design of The Empire Plan is the result of collective bargaining between NYS and the various unions representing its employees. Benefits are administratively extended to non-represented NYS employees, employees of PAs and PEs, and retirees. Therefore, the benefit design is subject to change from time-to-time as the result of those negotiations, and there are variations in The Empire Plan's benefit design among the bargaining units. The benefit design cannot deviate from that which has been collectively bargained. The majority of the active workforce is represented by various unions, and union participation in the design and oversight of NYSHIP is active and ongoing. The Excelsior Plan, available to NYS local governments who participate with NYSHIP, is a more affordable version of The Empire Plan. It offers many of the same features and benefits of The Empire Plan, with a higher degree of cost sharing by covered individuals. The collective bargaining units and the unions representing the collective bargaining units are identified in *DCS/NYSIF Prescription Drug Program Copayment Matrix* (Attachment 27), as well as the other groups that participate in The Empire Plan, the Excelsior Plan, and the SEHP.

The Empire Plan also provides benefits to members of the SEHP through the various Empire Plan contracts with the carriers/third party administrators. The SEHP was established in 1994 through collective bargaining. The SEHP became part of NYSHIP in 2002 to provide basic health insurance protection to graduate student Employees of the State University of New York and their eligible Dependents. This benefit was extended to the graduate student Employees of the City University of New York (CUNY) on January 1, 2009. Like The Empire Plan, the SEHP includes hospital, medical, managed mental health and substance use benefits, and prescription drug benefits. SEHP covers roughly 5,000 employees; their eligible covered Dependents bring the total number of average covered lives to about 5,700.

1.5 Overview of the DCS and NYSIF Prescription Drug Programs

The Programs utilize The Empire Plan, Excelsior Plan, SEHP, and State Insurance Fund identification cards to access retail network pharmacies and the mail service pharmacy, including designated specialty pharmacy(ies). The Programs include a number of utilization management controls including mandatory generic substitution (required for all formularies under NYS Law), prior authorization, physician education, and various other cost containment provisions. For a detailed description of the Programs, refer to Section 3 of this RFP. The Empire Plan, Excelsior Plan, and the SEHP provides benefits to Enrollees and covered Dependents and the NYSIF provides benefits to injured workers (Claimants) for Covered Drugs subject to applicable copayments (DCS Programs only), days' supply limits and benefit maximums. The Programs cover up to a ninety (90) Day supply of Covered Drugs through retail pharmacies, the mail service pharmacy, and the specialty pharmacy program, with refills up to one (1) year. For SEHP enrollees, a thirty (30) Day supply limitation applies at retail network pharmacies. *DCS/NYSIF Prescription Drug Program Copayment Matrix* (Attachment 27) of this RFP provides the applicable Copayments, supply limits, and benefit maximums by plan. Also, for information purposes, links to the Department's current *NYSHIP General Information Book, Empire Plan Certificate of Insurance, Empire Plan At A Glances* and *2022 NYSHIP Benefit Plan Comparison*, is included as Attachment 29, *Various Empire Plan Publications*, of this RFP.

DCS Program Enrollees who receive a Covered Drug from a network pharmacy incur out-of-pocket costs that are, in most instances, limited to the applicable Copayment. DCS Program Enrollees who receive a Covered Drug from a non-network pharmacy, or who do not use their identification card and pay the full amount for a prescription at a network pharmacy, receive specific reimbursement based on whether the drug is categorized as a Level 1 (usually Generic), Level 2 (usually Preferred Brand) or Level 3 (usually Non-Preferred Brand) drug. These provisions are set forth in claims processing within Sections 3 and 5 of this RFP.

1. The DCS Programs currently have four (4) formulary benefit designs that the Offeror must administer. The Flexible Formulary Preferred Drug List (PDL) and the Advanced Flexible Formulary Preferred Drug List may be collectively referred to in this RFP as, "the formularies."

    a. **Flexible Formulary Preferred Drug List** – The three-level Flexible Formulary is a Preferred Drug list in which Brand Drugs may be assigned to different Copayment levels based on clinical judgment and value to the Program. Drugs may be excluded from coverage if a therapeutic equivalent is on the Flexible Formulary, or a therapeutically equivalent over-the-counter drug is available. It features Level 1 drugs that are assigned the lowest Copayment and generally include all covered Generic Drugs and certain Brand Drugs. Level 2 drugs are assigned a higher Copayment and include Preferred Brand Drugs that have been selected because of their overall healthcare value. Level 3 drugs have the highest Copayment and include Non-Preferred Brand Drugs and Multi-Source Brand Drugs (with a generic equivalent). In addition, Copayments differ depending on whether a prescription is filled at retail or by mail order, and according to the number of Days' supply. The Flexible Formulary drug list also has a "Brand for Generic" feature. With this feature, a Brand Drug may be placed on Level 1, or excluded, and the generic equivalent placed on Level 3, or excluded. The Offeror must ensure that drugs excluded from the Formulary meet the Flexible Formulary criteria specified in Section 3.14 and Section 5.15 of this RFP. With State approval, these placements may be revised mid-year when such changes are advantageous to the DCS Program. SEHP enrollees represented by GSEU have this Plan design.

    b. **Advanced Flexible Formulary Preferred Drug List** – The three-level Advanced Flexible Formulary is a Preferred Drug list in which Brand Drugs may be assigned to different Copayment levels based on clinical judgment and value to the Program. Drugs may be excluded from coverage if a therapeutic equivalent is on the Advanced Flexible Formulary, or a therapeutically equivalent over-the-counter drug is available. It features Level 1 drugs that are assigned the lowest Copayment and generally include all covered Generic Drugs and certain Brand Drugs. Level 2 drugs are assigned a higher Copayment and include Preferred Brand Drugs that have been selected because of their overall healthcare value. Level 3 drugs have the highest Copayment and include Non-Preferred Brand Drugs and Multi-Source Brand Drugs (with a generic equivalent). In addition, Copayments differ depending on whether a prescription is filled at retail or by mail order, and according to the number of Days' supply. The Advanced Flexible Formulary Preferred Drug List also has a "Brand for Generic" feature. With this feature, a brand-name drug may be placed on Level 1, and the generic equivalent placed on Level 3, or excluded. The Offeror must ensure that drugs excluded from the Advanced Flexible Formulary meet the Advanced Flexible Formulary criteria specified in Section 3.14 and Section 5.15 of the RFP. With State

approval, these placements may be revised mid-year when such changes are advantageous to the DCS Program. Most active Empire Plan Members have this Plan design.

c. **Empire Plan Medicare Rx –** The Empire Plan also has a Center for Medicare and Medicaid Services (CMS)-approved and compliant Employer Group Waiver Plan (EGWP), which is referred to as Empire Plan Medicare Rx. Empire Plan Medicare Rx is the EGWP for Medicare-primary Empire Plan enrollees and Dependents that is a Medicare Part D Prescription Drug Plan (PDP) with supplemental wrap coverage that provides benefits and drug coverage equivalent to, or in excess of, the benefits available to the Empire Plan's non-Medicare-primary enrollees and Dependents.

d. **Excelsior Plan Preferred Drug List** – This three-level formulary is for employees enrolled in the Excelsior Plan. This formulary may exclude certain drugs in a therapeutic category as well as have certain Generic Drugs subject to a Level 2 or 3 Copayment. Under the Excelsior Plan's benefit Copayment design, Level 1 drugs have the lowest Copayment, Level 2 drugs have the mid-range Copayment, and Level 3 drugs have the highest Copayment. The goal of the Excelsior Plan Drug List is to offer a therapeutically sound formulary that costs 15% less than The Empire Plan formularies (currently .14% of enrollee contracts have this plan). However, effective January 1, 2024, a large group within a Participating Agency (approximately 13,500 members and dependents) will move from The Empire Plan to the Excelsior Plan. This move will increase membership in the Excelsior Plan to 1.26%. The Offeror's proposed Book of Business PDL may be used for this program, subject to compliance with the Frozen Formulary Law disallowing mid-year changes to the formulary and requiring a 90-day notification requirement prior to the start of the plan year. Offerors should note that the Excelsior Plan does not currently include Medicare Part D prescription drug coverage. Medicare-primary enrollees and dependents receive the same drug coverage as those who are Plan primary. The Department will explore the option of adding EGWP coverage to the Excelsior Plan in Calendar Year 2025.

2. NYSIF provides prescription coverage to injured workers who are employed by individuals and companies that have workers' compensation policies with NYSIF. All medically necessary and appropriate drugs that are causally related to the loss are covered. NYSIF was created by Section 76 of the New York State Workers' Compensation Law (WCL). Responsibility for the daily operations and policy making of NYSIF rests with the Executive Director and his staff. The Board of Commissioners (Commissioners) oversees the administration of NYSIF.

   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. NYSIF Claimants do not incur Copayments or out-of-pocket costs when utilizing network or non-network pharmacies. The NYSIF Program currently employs a

single formulary benefit design that the Contractor must administer.

a. **NYSIF PDL** - The NYSIF PDL proposed for the NYSIF Program must include all drugs meeting the definition of Covered Drugs in this RFP. The selected Offeror is required to effectively communicate the content and requirements of the Program's PDL to Network Pharmacies, medical providers, and Enrollees. The design of the NYSIF Program must comply with the WCB Formulary.

1.6 Covered Drugs under the DCS and NYSIF Prescription Drug Programs

The DCS and NYSIF Programs cover medically necessary prescription drugs and insulin dispensed by a licensed pharmacy. The Programs cover prescription oral drugs, self-injectables and infusion drugs dispensed by a licensed pharmacy.

The following prescription drugs are covered when they are medically necessary and dispensed by a licensed retail pharmacy or through the mail service pharmacy:

1. FDA-approved drugs that must bear the legend "Rx Only."

2. State-restricted drugs (drugs or medicines that can be dispensed in accordance with New York State law [or by the laws of the state or jurisdiction in which the Prescription is filled] by Prescription only).

3. Compound Drug(s) Compound Drugs that have a claim cost to the Program that exceeds $200 will require prior authorization under this Program.

4. Injectable insulin.

5. Grace Fill of a Specialty Drug filled at a Network, Non-Network or Mail Service Pharmacy and subsequent fills processed by the Designated Specialty Pharmacy. 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.

6. Contraceptive drugs, devices and other products, including over-the-counter contraceptive drugs, devices and other products, approved by the FDA and as prescribed or otherwise authorized under State or Federal law. "Over-the-counter contraceptive products" means those products provided for in comprehensive guidelines supported by HRSA. Coverage also includes emergency contraception when provided pursuant to a prescription or order or when lawfully provided over-the-counter. You may request coverage for an alternative version of a contraceptive drug, device and other product if the Covered contraceptive drug, device and other product is not available or is deemed medically inadvisable, as determined by Your Doctor.

7. Coverage for abortion services includes any Prescription Drug prescribed for an abortion, including both Generic Drugs and Brand-Name Drugs, even if those Prescription Drugs have not been approved by the FDA for abortions, if the Prescription Drug is a recognized medication for abortions in one of the following reference compendia:

   -The WHO Model Lists of Essential Medicines;
   -The WHO Abortion Care Guidelines; or,
   -The National Academies of Science, Engineering and Medicine Consensus Study Report.

8. Vitamins and supplements that are FDA-approved Prescription drugs and bear the legend “Rx Only” or are recommended for preventive services without cost sharing under the Patient Protection and Affordable Care Act (PPACA), including certain over-the-counter (OTC) products with a Prescription. PPACA preventive services recommendations can be found at: www.uspreventiveservicestaskforce.org.

9. Covered Prescription drugs dispensed by on-premises pharmacies to patients in a skilled nursing facility, rest home, sanitarium, extended care facility, convalescent hospital or similar facility. Such on-premises pharmacies are considered Non-Network Pharmacies and require submission of a claim form for reimbursement.

10. Claims for drugs dispensed outside of the United States that have an available U.S. FDA-approved equivalent.

11. Orally administered anti-cancer medication used to kill or slow the growth of cancerous cells.

12. Off-label cancer drugs.

13. Smoking cessation drugs, including over-the-counter drugs for which there is a written order, and Prescription drugs prescribed by a physician or other provider.

14. Certain preventive vaccinations in accordance with the Patient Protection and Affordable Care Act (PPACA) mandates, administered at a Vaccination Network Pharmacy, will be covered at no cost. The covered preventive vaccines are: influenza – flu, pneumococcal – pneumonia, meningococcal – meningitis, herpes zoster – shingles, COVID-19, Hepatitis A, Hepatitis B, Human papillomavirus (HPV), measles, mumps, rubella, tetanus, diphtheria, pertussis and varicella (chickenpox).

15. Certain prescription and over-the-counter medications that are recommended for preventive services without cost sharing and have in effect a rating of “A” or “B” in the current recommendations of the U.S. Preventive Services Task Force (USPSTF). Note: When available over-the-counter, USPSTF “A” and “B” rated medications require a prescription order to process without cost sharing.

1.7 DCS and NYSIF Prescription Drug Program Exclusions and Limitations

Coverage for the following drugs are excluded or limited under the Programs:

1. Drugs obtained with no Prescription order, including over-the-counter products (except insulin, smoking cessation drugs and over-the-counter preventive drugs or devices provided in accordance with guidelines supported by the Health Resources and Services Administration or with an “A” or “B” rating from the United States Preventive Services Task Force).

2. Drugs taken or given at the time and place of the Prescription order and billed by the Doctor.

3. Drugs provided by any governmental program or statute (other than Medicaid) unless there is a legal obligation to pay.

4. Drugs for which there is no charge or legal obligation to pay in the absence of insurance.

5. Drugs administered by a facility while the patient is in a licensed hospital. This limit applies only if the hospital in which the member is a patient operates on its premises, or allows to be operated on its premises, a facility that dispenses pharmaceuticals, and dispenses such drugs administered to the patient by the hospital.

6. Any drug refill that is more than the number approved by the Doctor or other health professional.

7. 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.

8. The administration of any drug or injectable insulin with the exception of covered preventive vaccines administered at a vaccination network pharmacy.

9. Any drug refill which is dispensed more than one (1) year after the original date of the prescription order.

10. Any drug labeled "Caution: Limited by Federal Law to Investigational Use," or experimental drugs except for drugs used for the treatment of cancer as specified in Section 3221(k)(12) of New York State Insurance Law as may be amended from time to time. Prescribed drugs approved by the U.S. Food and Drug Administration for the treatment of certain types of cancer shall not be excluded when the drug has been prescribed for another type of cancer. However, coverage shall not be provided for experimental or investigational drugs or for any drug that the Food and Drug Administration has determined to be

contraindicated for treatment of the specific type of cancer for which the drug has been prescribed. Experimental or investigational drugs shall also be covered when approved by an External Appeal Agent in accordance with an external appeal. If the External Appeal Agent approves coverage of an experimental or investigational drug that is part of a clinical trial, only the costs of the drug will be covered. Coverage will not be provided for the costs of experimental or investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs not otherwise covered by the Programs for nonexperimental or non- investigational drugs provided in connection with such clinical trial.

11. Immunizing agents, biological sera, blood or blood plasma, except immune globulin.

12. Any drug that a Doctor or other health professional is not authorized by his or her license to prescribe.

13. **(Exclusive to DCS)** Drugs for an injury or sickness related to employment for which benefits are provided by any state or Federal Workers' Compensation, employer's liability or occupational disease law, or under Medicare or other governmental program.

14. Drugs purchased prior to the start of coverage or after coverage ends. However, if the person is totally disabled on the date coverage ends, benefits for the disabling condition will be provided on the same basis as if coverage had continued, with no change in coverage effective until the day the person is no longer totally disabled or for three (3) months after the date his/her coverage ended, whichever is earlier.

15. Any drug prescribed and/or dispensed in violation of NYS or Federal Law.

16. Prescription drug products excluded from the formulary (unless approved under the Medical Exception Program) or excluded under plan design.

17. Drugs furnished solely for the purpose of improving appearance rather than physical function or control of organic disease, which include, but are not limited to:

    a. Nonamphetamine anorexiants, except when prescribed for morbid obesity;

    b. Products used to promote hair growth; and

    c. Products (ex., Retinoic Acid) used for prevention of skin wrinkling.

18. Coverage for drugs where the amount dispensed exceeds the supply limit.

19. Coverage for drugs as a replacement for a previously dispensed drug.

20. Products for which the primary use is nutrition.

21. Any non-medically necessary drugs.

22. Foreign drugs for which there is no available U.S. equivalent approved by the FDA.

1.8 Offeror Eligibility

Offeror means any responsible and eligible entity submitting a responsive Proposal to this RFP. It shall be understood that references in the RFP to "Offeror" shall include an entity's proposed Subcontractors or Affiliates (as defined in Section 4.3 of this RFP), if any. The Procuring Agencies request Proposals only from qualified Offerors, meeting the following Minimum Mandatory Requirements, as specified below.

1. The Offeror must, at time of Proposal submission and throughout the term of the Contracts, possesses the legal capacity to enter into Contracts with the Procuring Agencies.

2. The Offeror, at time of Proposal submission and throughout the term of the Contracts, must be authorized to conduct business in New York State, or, if the Offeror is not so authorized at time of Proposal Due Date (as specified in Section 1.9 of this RFP), then the Offeror must, at the time of Proposal Due Date, have filed an application for authority to do business in New York State with the New York State Secretary of State. Such application must be approved prior to Contract Award. (For details concerning this requirement, refer to: https://dos.ny.gov/form-corporation-or-business. To register with the Secretary of State, contact: https://www.dos.ny.gov/corps/index.html). The Offeror shall notify the Department immediately in the event that there is any change in the above corporate status.

3. The Offeror must represent and warrant that, at the time of Proposal submission, it has completed, obtained, or performed all registrations, filings, approvals, authorizations, consents, and examinations required by any governmental authority for the provision of the delivery of Project Services (as detailed in Section 3 of this RFP) and agree that it will, during the term of the Contracts, comply with any requirements imposed upon it by law or regulation.

4. As of the Proposal Due Date, the Offeror must have the capability to dispense all covered prescriptions, including Compound Drugs, through the mail service pharmacy process. The Offeror must attest that it either owns or has subcontracted, a currently operational facility(ies) with available capacity to fully administer the Program's Mail Service Pharmacy Process. The Offeror must

attest that it will be capable of processing all the Programs' mail order prescriptions as of the Project Services Start Date. The Programs do not require the facility(ies) processing prescriptions under the mail service pharmacy process be within New York State. Any facility serving the Programs' mail service pharmacy process must be registered with the NYS Education Department and meet all the requirements of Section 6808 of the New York State Education Law. The Offeror must recognize the full prescribing authority of medical professionals granted by NYS where allowed by state law.

5. The Offeror must represent and warrant that, at time of Proposal submission, it has the capability to dispense Specialty Medications through one or more Designated Specialty Pharmacy(ies), for those Employee groups participating in the Specialty Pharmacy Program.

6. As of the Proposal Due Date, provides Point of Service prescription claims adjudication and pharmacy benefit management services for a minimum of five million (5,000,000) lives.

   The Offeror must provide a list of client organizations with the number of lives served through each client to clearly demonstrate that the Offeror meets the minimum requirement of five million (5,000,000) lives. In determining lives, the Offeror should:

   a. Include both at-risk and fee-for-service business;

   b. Include Medicaid business;

   c. Count all lives [i.e., DCS: an Enrollee, a Dependent spouse and two (2) eligible Dependent Children count as four (4) – NYSIF: Claimant (1)];

   d. Exclude any non-Pharmacy benefit management business;

   e. Exclude any mail service only lives; and

   f. Exclude any discount card program lives.

7. The Selected Offeror possesses adequate staffing resources, financial resources, and organizational capacity to perform the type, magnitude, and quality of work specified in the RFP.

8. The Offeror must understand and indicate its agreement no later than the Project Services Start Date, and throughout the term of the contract, the Offeror shall have one Retail Pharmacy Network which covers the three individual components (DCS Commercial, DCS EGWP and NYSIF).

The Offeror's Retail Pharmacy Network must substantially maintain the composition of independent Network Pharmacies included in the Programs' current Retail Pharmacy Network. Substantially maintain the composition shall mean that an Offeror must include contracts with independent pharmacies accounting for seventy-five percent (75%) or more of the DCS Programs' prescription drugs dispensed through independent pharmacies, based on the Informational Claims File for 2022. The files can be obtained by following the instructions included in *Informational Claims File – DCS and NYSIF* (Attachment 86), which requires that Offerors have the latest version of the IBM Aspera Web Plugin (Aspera Connect) to use the application.

The Procuring Agencies are seeking a broad network for the DCS Commercial, DCS EGWP, and the NYSIF components. Therefore, Offerors may not exclude Chain Pharmacies in their Retail Pharmacy Network.

a. The Offeror's proposed Retail Pharmacy Network must also meet the following minimum Retail Pharmacy Network access guarantees for each of the three individual component programs:

    i. Ninety percent (90%) of Enrollees in urban areas will have at least one (1) Network Pharmacy within two (2) miles of an Enrollee's home;

    ii. Ninety percent (90%) of Enrollees in suburban areas will have at least one (1) Network Pharmacy within five (5) miles of an Enrollee's home; and

    iii. Seventy percent (70%) of Enrollees in rural areas will have at least one (1) Network Pharmacy within fifteen (15) miles of an Enrollee's home.

b. To demonstrate satisfaction of this requirement, the Offeror must submit all information required below based on the Geo-Coded Census file provided by the Procuring Agencies. The file containing the Enrollment by Zip Code and Geo Access network Report can be obtained by following the instructions, which requires that Offerors have the latest version of the IBM Aspera Web Plugin (Aspera Connect) to use the application, included in Attachment 22, *Enrollment by ZIP Code & Geo Access Network Report File*. Based on these files, the Offeror must submit with their Administrative Proposal the following:

    i. Attachment 20, *Offeror's Proposed Retail Pharmacy Network Access Prerequisite Worksheets* for each of the three Programs;

    ii. Offeror's Geo Access Reports for each of the three component Programs to meet the access requirements specified in Section

1.8(8)(a) (See Attachment 18, *Offeror's Proposed Retail Pharmacy Network File* and Attachment 22, *Enrollment by ZIP Code & Geo Access Network Report File*); and

iii. Attestation – The Offeror must attest that, as of the Project Services Start Date, it will hold executed contracts with all pharmacies identified in its proposed Retail Pharmacy Network File, Attachment 18, *Offeror's Proposed Retail Pharmacy Network File* (See Attachment 19, *File Layout Specifications for the Offeror's Proposed Retail Pharmacy Network File* for the file layout) for participation in the Programs Retail Pharmacy Networks commencing on the Project Services Start Date, that are consistent with the duties and responsibilities of the Offeror set forth in Sections 3.9 and 5.10. of this RFP. To fulfill this requirement, the Offeror may utilize executed, specific to the Programs, pharmacy contracts contingent on award and/or existing pharmacy agreements that can be made applicable to the Programs. The Offeror must also attest that it will have completed its credentialing process for all pharmacies included in that file. The Offeror shall agree to provide documentation, including contracts, as required to demonstrate satisfaction of this requirement.

All Enrollees must be counted in calculating whether the Offeror meets the Retail Pharmacy Network access guarantees. No Enrollee may be excluded even if there is no pharmacy located within the minimum mandatory access requirements.

[**Note:** The Offeror's proposed Retail Pharmacy Network access standards will be scored as part of the evaluation of the Offeror's retail pharmacy network and the Offeror's Network Pharmacy Access Guarantees will be evaluated in accordance with the criteria specified in Section 7, entitled "Evaluation and Selection Criteria."]

9. In addition to any provisions set forth in this RFP and the *Standard Clauses for New York State Contracts* (Appendix A), *Standard Clauses for All Department Contracts* (Appendix B, Exclusive to DCS), *General Specifications* (Appendix B-1, Exclusive to NYSIF), *Contract Provisions* (Appendix B-2, Exclusive to NYSIF), *NYSIF Vendor Security Survey* (Appendix B-3, Exclusive to NYSIF), *NYSIF Mutual Non-Disclosure Agreement* (Appendix B-4, Exclusive to NYSIF), and *Information Security Requirements* (Appendix C, Exclusive to DCS), *Participation by Minority and Women-Owned Business Enterprises: Requirements and Procedures* (Appendix D, Exclusive to NYSIF) related to audit or the production of records, the selected Offeror must understand and indicate its agreement to maintain and make available, as required by the State, a complete and accurate set of books and records for review by the State. Such books and records shall include, but are not limited to, pharmacy contracts, manufacturer's rebate agreements, detailed claim records, and any and all other financial records as

deemed necessary by the State to discharge their fiduciary responsibilities to the Programs' participants and to ensure that public dollars are spent appropriately.

10. The Offeror must understand and indicate its agreement to comply with all specific duties and responsibilities set forth in Section 3.2 of this RFP, entitled "Implementation Plan," including Section 3.2(1)(d) requiring the Offeror to issue a financial guarantee supporting its commitment to satisfy all implementation requirements.

    [**Note:** The Offeror's proposed Implementation and Start-Up Guarantee will be evaluated in accordance with the criteria specified in Section 7, entitled "Evaluation and Selection Criteria."]

11. The Offeror must understand and indicate its agreement that it has submitted as part of its Proposal, if so required by the RFP, or will submit all Transmittal letters, Statements, Formal Certifications and Exhibits as required in Section 2 of this RFP related to the Offeror's compliance with all applicable Federal and State rules, laws, regulations and executive orders.

12. The Offeror must understand and indicate its agreement that it will execute the duties and responsibilities set forth in Section 3 of this RFP in strict conformance to the requirements described in that section of the RFP.

13. The Offeror must understand and indicate its agreement to that it has the ability to adjudicate all Point of Service claims under the Programs using the applicable Copayments (DCS only) for Brand and Generic Drugs as described in Section 3 of this RFP.

14. The Offeror must understand and indicate its agreement that as of the Proposal Due Date, the Offeror has current Utilization Review Accreditation Commission (URAC) accreditation in the area of Pharmacy Benefit Management.

    [**Note:** Any Offeror that fails to satisfy any of the above Minimum Mandatory Requirements shall be eliminated from further consideration.]

1.9 Timeline of Key Events

EVENT	DATE
RFP Release Date	August 14, 2023
Deadline for Submission of *Offeror Affirmation of Understanding and Agreement* (Attachment 1)	See below*
Pre-Proposal Conference	August 21, 2023
Deadline for Submission of Offeror Questions	September 1, 2023, 5:00pm ET
Release Date of Official Responses to Offeror Questions	~~September 15~~ October 6, 2023
Proposal Due Date	November ~~2~~ 13, 2023
Anticipated Technical Management Interviews	~~November~~ ~~30~~ December 11, 2023
Anticipated Tentative Contract Award	December 28, 2023
Anticipated OSC Approval of Contract Award and Commencement of Implementation Period	May 22, 2024, subject to appropriate approvals
Anticipated DCS Project Services Start Date	January 1, 2025, or 180 Days after OSC approves the DCS Contract, whichever is later
Anticipated NYSIF Project Services Start Date	April 1, 2025, or 180 Days after OSC approves the NYSIF Contract, whichever is later

*Prior to the Offeror's initial contact with the Department, the Offeror must complete and submit *Offeror Affirmation of Understanding and Agreement* (Attachment 1) to the Designated Contact identified in Section 2.1(1) of this RFP.

SECTION 2: PROCUREMENT PROTOCOL AND PROCESS

2.1 Rules Governing Conduct of Competitive Procurement Process

All inquiries, questions, filings, and submission of Proposals in regard to the RFP must be directed in writing to the Designated Contact listed below. Proposals may not be submitted by e-mail or facsimile. Any inquiries, questions, filings, or submission of Proposals that are submitted to any other contact or physical address shall not be considered as official, binding or as having been received by the Department.

1. Designated Contact

In accordance with New York State Finance Law § 139-j(2)(a) (Procurement Lobbying Law (PLL)), the following individual is the Designated Contact for this Solicitation. All questions relating to this Solicitation must be addressed to the following Designated Contact:

Carole Blanchard
New York State Department of Civil Service
Attn: Office of Financial Administration, Floor 17
Agency Building 1, Empire State Plaza
Albany, New York 12239
DCSprocurement@cs.ny.gov

2. Restrictions on Contacts Between Offerors and State Staff During the Procurement Process

a. Pursuant to New York State Finance Law sections 139-j and 139-k, this Procurement imposes certain restrictions on communications between the Department and an Offeror during the procurement process. An Offeror is restricted from making contacts from the earliest posting, on the Department's website, in a newspaper of general circulation, or in the procurement opportunities newsletter in accordance with Article 4-C of the Economic Development Law, of written notice, advertisement or solicitation of a request for Proposal, invitation for bids, or solicitation of proposals, or any other method provided for by law or regulation for soliciting a response from Offerors intending to result in a Contract with the Department through final award and approval of the Contract by the Department and, if applicable, the Office of the State Comptroller to other than the Designated Contact (unless it is a Contact that is included among certain statutory exceptions set forth in State Finance Law §139-j(3)(a)). This time period is defined as the Restricted Period. The Designated Contact for this procurement is set forth in Section 2.1(1) of this RFP. Staff is required to obtain certain information from an Offeror whenever contacted about the procurement during the restricted period and is

required to make a determination of the Offeror's responsibility that addresses the Offeror's compliance with the statutory requirements. Certain findings of non-responsibility can result in rejection for contract award and in the event of two findings within a 4-year period, the Offeror is debarred from obtaining governmental Procurement Contracts. The Department's policy and procedures can be found in the *Procurement Lobbying Policy* (Attachment 2). Further information about these requirements can be found at: https://www.ogs.ny.gov/ACPL/.

b. The Department strictly controls communications between any Offeror and participants in the procurement process. "Offeror" means the individual or entity, or any employee, agent or consultant or person acting on behalf of such individual or entity, who contacts the Department about a governmental procurement during the restricted period of such governmental procurement whether or not the caller has a financial interest in the outcome of the procurement; provided, however, that a governmental agency or its employees that communicate with the Department regarding a governmental procurement in the exercise of its oversight duties shall not be considered an Offeror. "Offeror" includes prospective Offerors prior to the due date for the submission of offers/bids in response to the solicitation document.

3. Pre-Proposal Conference

A Pre-Proposal Conference will be held approximately one week after the RFP Release Date at 10:00 a.m. using a virtual platform. Attendance is not mandatory but is strongly encouraged for Offerors intending to submit a Proposal. If Offeror's organization plans to attend the Pre-Proposal Conference, please notify the Designated Contact identified in Section 2.1(1) of this RFP via e-mail at the address noted in Section 2.1(1) at least 24 hours before the conference with the name, email address, and affiliation of each person attending.

4. Submission of Errors or Omissions in this RFP Document

By participating in activities related to this RFP, and/or by submitting a Proposal in response to this RFP, an Offeror agrees to be bound by its terms, including, but not limited to, this process by which an Offeror may submit errors or omissions for consideration. If an Offeror believes there is an error or omission in this RFP, the Offeror may raise such issue as follows:

a. Process for Submitting Assertions of Errors or Omissions in RFP Document

i. *Time Frame:* The Department must receive assertions of errors or omissions in the RFP process which are or should have been

apparent prior to the Proposal Due Date, in writing, five Business Days after the Release Date of Official Responses to Questions specified in Section 1.9 of this RFP. Business Day(s) means every Monday through Friday, from 8:00 a.m. to 5:00 p.m. ET, except for days designated as state holidays by the Department.

ii. *Content:* The submission alleging the error or omission must clearly and fully state the legal and/or factual grounds for the assertion and must include all relevant documentation.

iii. *Format of Submission:* All submissions asserting an error or omission must be in writing and submitted to the Designated Contact in hard copy at the address provided in Section 2 of this RFP.

The envelope or package must clearly and prominently display the following statement:

"Submission of Errors or Omissions for the Pharmacy Benefit Services for The Empire Plan, Excelsior Plan, Student Employee Health Plan, and NYS Insurance Fund Workers' Compensation Prescription Drug Programs Request for Proposals"

Any assertion of an error or omission which does not conform to the requirements set forth in this section shall be deemed waived by the Offeror and the Offeror shall have no further recourse.

b. The Review Process for Assertions of Errors or Omissions in RFP

The Department shall conduct the review process for submission of errors or omissions. The Commissioner may appoint a designee who will review the submission and make a recommendation to the Commissioner as to the disposition of the matter. At the discretion of the Commissioner, or the Commissioner's designee, the Offeror may be given the opportunity to meet with the Commissioner or the Commissioner's designee to support its submission. The Offeror may, but need not, be represented by counsel at such a meeting. Any and all issues concerning the manner in which the review process is conducted shall be determined solely by the Commissioner or designee.

The Commissioner or designee shall review the matter, and the Commissioner shall issue a written decision within twenty Business Days

after the close of the review process. If additional time for the issuance of the decision is necessary, the prospective Offeror shall be advised of the delay and of the time frame within which a decision may be reasonably expected. The Commissioner's decision will be communicated to the party in writing and shall constitute the agency's final determination in the matter.

The Department reserves the right to determine and act in the best interests of the State in resolving any assertion of error or omission in this RFP document. The Department may elect to extend the Proposal Due Date as may be appropriate. Notice of any such extension will be provided to all organizations who provided an email address on the submitted *Offeror Affirmation of Understanding and Agreement* (Attachment 1). Notice of any extension will also be posted to: https://www.cs.ny.gov/RxBenefit2023RFP/.

5. Submission of Questions

Using the *Questions Template* (Attachment 4), a prospective Offeror may submit questions concerning the content of this RFP via email to the Designated Contact's address specified in Section 2 of this RFP. Only those questions received prior to the Questions Due Date specified in Section 1 of this RFP, will be accepted. After the Questions Due Date, the Department will provide an email notification of the posting of all questions and the Department's official answers to all those individuals who provided an email address on the submitted *Offeror Affirmation of Understanding and Agreement* (Attachment 1), the *Questions Template* (Attachment 4), and those individuals who register to attend the pre-proposal conference. The questions and answers will also be posted to: https://www.cs.ny.gov/RxBenefit2023RFP/.

[**Note**: See Bid Deviations section below, specifically 7(b) with regard to submission of questions.]

6. Submission of Proposal

a. The Offeror's Proposal must be organized and separated into three separate sections: Administrative Proposal; Technical Proposal; and Financial Proposal. To facilitate the evaluation process, an Offeror must follow the submission requirements described below:

   i. One ORIGINAL hard copy and fifteen additional hard copy versions of each of the three sections of the RFP, separated into Administrative, Technical and Financial sections.

   ii. Each ORIGINAL hard copy of each section must be marked "ORIGINAL," contain original signatures of an official(s) authorized

to bind the Offeror to its provisions on all forms submitted that require the Offeror's signature. The remaining hard copies of each section may contain a copy of the official's signature on all forms submitted that require the Offeror's signature and should be numbered sequentially (i.e., Copy #1, Copy #2).

iii. A master electronic submission containing all of the ORIGINAL hard copy sections of the proposal must be provided on electronic media. Electronic media shall be included on unprotected Microsoft Windows formatted USB 2.0 or higher storage drive and must be clearly labeled by proposal section and identified as the master electronic submission. In situations where proposal content differs between the ORIGINAL bound hard copies and the master electronic submission, the master electronic submission is deemed controlling. The master electronic submission should be inserted in the Financial Proposal box.

iv. The Offeror must submit fifteen additional USB drives which each contain an electronic copy of the Administrative and Technical Proposal ONLY. The USB drives must conform to the technical specifications outlined in Section 2 of this RFP. Each of the sixteen electronic copies should be labeled by section and uniquely designated with a number (e.g., "TECHNICAL & ADMINISTRATIVE COPY 1", "TECHNICAL & ADMINISTRATIVE COPY 2, etc."). The fifteen USB drives that contain only the Administrative and Technical Proposals should be packaged in the sealed box/envelope labeled Administrative Proposals.

v. The electronic copy shall be formatted in a manner consistent with searchable and selectable text

vi. Each Proposal must include a table of contents.

vii. Each major section of the Proposal, including attachments, must be labeled with an index tab that completely identifies the title of the section, subsection or attachment as named in the table of contents.

viii. Each page of the Proposal (both the hard copies and the USB), including attachments, must be dated and numbered consecutively.

b. Proposals should be placed and packaged together, by section, in sealed boxes/envelopes (i.e., all Administrative Proposals in one box, all Technical Proposals in a second box, and all Financial Proposals in a third box). Each sealed box/envelope should contain a label on the outside, which contains the information below. Each sealed box/envelope should

be submitted to the Designated Contact at the address provided in Section 2.1(1) of this RFP.

New York State Department of Civil Service
Request for Proposals
"Pharmacy Benefit Services"

OFFEROR NAME
OFFEROR ADDRESS

Indicate content, as applicable
ADMINISTRATIVE, TECHNICAL, or FINANCIAL PROPOSAL
There must be no Financial/cost information included in the Offeror's Administrative Proposal or Technical Proposal, except for proposed performance guarantees.

c. All Proposals must be mailed or hand-delivered to the address provided in Section 2.1(1) of this RFP. To make arrangements for hand-delivery, the Offeror must notify the Designated Contact twenty-four hours prior to delivery. All Proposals must be received by 3:00 p.m. ET on the Proposal Due Date as set forth in Section 1.9 of the RFP.

d. Any proposal received after 3:00 p.m. ET on the Proposal Due Date, as specified in Section 1.9, shall not be accepted by the Department and may be returned to the submitting entity at the Department's discretion. All Proposals submitted become the property of the Department.

e. The Department will accept amendments and/or additions to an Offeror's Proposal if the amendment and/or addition is received by the Proposal Due Date. All amendments to an Offeror's Proposal must be submitted in accordance with the format set forth in Section 2.1(6) of this RFP and will be included as part of the Offeror's Proposal.

f. An Offeror is solely responsible for timely delivery of the Proposal to the Department prior to the Proposal Due Date stated in Section 1.9 of this RFP. Delays in United States mail deliveries or any other carrier, including couriers or agents of New York State, shall not excuse late bid submissions. If the Proposals is delivered by mail or courier, the Department recommends that it be sent "Returned Receipt Requested", so the Offeror obtains proof of timely delivery. No phone, facsimile or e-mail submission of Proposals will be accepted for this RFP. In addition, it is the sole responsibility of the Offeror to verify that all elements of the proposal submission are complete, correct and without error.

7. Bid Deviations

a. The Procuring Agencies will not entertain bid deviations to *Standard Clauses for New York State Contracts* (Appendix A).

   The Department will also not entertain material and substantive bid deviations to the solicitation, to *Standard Clauses for All Department Contracts* (Appendix B), and *Information Security Requirements* (Appendix C), Exclusive to DCS

   The NYSIF will also not entertain material and substantive bid deviations to the solicitation, to *General Specifications* (Appendix B-1), *Contract Provisions* (Appendix B-2), and *NYSIF Vendor Security Survey* (Appendix B-3), *NYSIF Mutual Non-Disclosure Agreement* (Appendix B-4), and *Participation by Minority and Women-Owned Business Enterprises: Requirements and Procedures* (Appendix D).

   New York State law precludes awarding a contract based on material deviation(s) from the specifications, terms, and/or conditions set forth in the solicitation. Therefore, Proposals containing a bid deviation (including additional, inconsistent, conflicting, or alternative terms) that are a material and substantive change from the specifications, terms, and conditions set forth in the solicitation may render the Proposal non-responsive and may result in rejection of the Proposal.

b. If an Offeror has an issue or concern regarding provisions in the solicitation and is considering submission of a proposal containing a bid deviation, the Offeror is strongly advised to raise such issues and/or concerns during the question and answer period so that the Department may give due consideration to the issue prior to the submission of Proposals. Failure to use the question and answer period and instead submitting a Proposal containing a bid deviation could render the entire Proposal non-responsive and rejected in its entirety.

c. In general, a material and substantive bid deviation is one that would

   i. Impair the interests of New York State;

   ii. Place the successful Offeror in a position of unfair economic advantage;

   iii. Place other Offerors at a competitive disadvantage; or

   iv. Which, if it had been included in the original solicitation, could have formed a reasonable basis for an otherwise qualified Offeror to change its determination concerning the submission of a Proposal. For example, a deviation that would substantially shift liability (risk)

or financial responsibility from the Offeror to New York State would be considered material.

d. Unless specifically required by the solicitation to be submitted as part of an Offeror's proposal, an Offeror is further advised that its standard, pre-printed material (including but not limited to product literature, order forms, manufacturer's license agreements, standard contracts or other pre-printed documents), which are physically attached or summarily referenced in the Offeror's Proposal are not considered as having been submitted with or intended to be incorporated as part of the official offer contained in the Proposal. Rather, such material shall be deemed by the Department to have been included by Offeror for informational or promotional purposes only. If such materials are requested by the solicitation, an Offeror must ensure that the materials are properly referenced.

e. To submit a non-material bid deviation, an Offeror must complete and submit the proposed deviation(s) using the *Non-Material Deviations Template* (Attachment 8), as part of the Administrative Proposal. If a non-material bid deviation does not meet these requirements, it shall not be considered by the State and shall be rejected.

f. An Offeror who does not submit the *Non-Material Deviations Template* (Attachment 8), as part of the Administrative Proposal is presumed to have no bid deviations.

8. Notification of Tentative Contract Award

A tentative award letter will be sent to the selected Offeror indicating a tentative award subject to successful contract negotiations. The remaining Offerors will be notified of the tentative award and the possibility that failed negotiations could result in an alternative award.

9. Debriefing

Unsuccessful Offerors will be advised of the opportunity to request a Debriefing and the timeframe by which such requests must be made. Debriefings are subject to the *NYS Department of Civil Service Debriefing Guidelines* (Attachment 5). An unsuccessful Offeror's written request for a debriefing shall be submitted to the Designated Contact at the address provided in Section 2.1(1) of this RFP.

10. Submission of a Protest

By participating in activities related to this Procurement, and/or by submitting a Proposal in response to this RFP, an Offeror agrees to be bound by its terms including, but not limited to, the process by which an Offeror may submit a protest of a non-responsive determination or the selection award for consideration. In the event the Offeror elects to submit a protest of a non-responsive determination, the Offeror agrees it shall not be permitted to also submit a protest on the selection decision. In the event that an Offeror decides to submit a protest, the Offeror may raise such issue according to the following provisions.

a. **Process for Submitting a Protest of a Non-Responsive Determination or a Selection Decision**

i. Time Frame: Any protest must be received no later than 5:00 p.m. ET on the tenth Business Day after an Offeror's receipt of written notification by the Department of a non-responsive determination or tentative award.

ii. Content: The protest must fully state the legal and factual grounds for the protest and must include all relevant documentation.

iii. Format of Submission: The protest must be in writing and submitted to the Designated Contact at the address provided in Section 2.1(1) of this RFP.

iv. A protest of either a non-responsive determination or a selection decision must have one of the following statements clearly and prominently displayed on the envelope or package:

"Submission of Non-Responsive Determination Protest for Request for Proposals Pharmacy Benefit Services for The Empire Plan, Excelsior Plan, Student Employee Health Plan, and NYS Insurance Fund Workers' Compensation Prescription Drug Programs"

OR

"Submission of Tentative Award Protest for Request for Proposals Pharmacy Benefit Services for The Empire Plan, Excelsior Plan, Student Employee Health Plan, and NYS Insurance Fund Workers' Compensation Prescription Drug Programs"

v. Any assertion of protest which does not conform to the requirements set forth in this section shall be deemed waived by the Offeror, and the Offeror shall have no further recourse.

b. **Review of Submitted Protests**

i. The Department shall conduct the review process of submitted protests. The Department's Commissioner may appoint a designee to review the submission and to make a recommendation to the Commissioner as to the disposition of the matter. The Commissioner's designee may be an employee of the Department but, in any event, shall be someone who has not participated in the preparation of this RFP, the evaluation of Proposal, the determination of non-responsiveness, or the selection decision. At the discretion of the Commissioner, or the Commissioner's designee, the Offeror may be given the opportunity to meet with the Commissioner or the Commissioner's designee, to support its submission. The Offeror may, but need not, be represented by counsel at such a meeting. The Department shall be represented by counsel at such meeting. Any issues concerning the way the review process is conducted shall be determined solely by the Commissioner, or the Commissioner's designee.

ii. The Commissioner, or the Commissioner's designee, shall review the matter, and shall issue a written decision within twenty Business Days after the close of the review process. If additional time is necessary for the issuance of the decision, the Offeror shall be advised of the time frame within which a decision may be reasonably expected. The Commissioner's decision will be communicated to the party in writing and shall constitute the Department's final determination in the matter.

iii. If an Offeror protests the selection decision or a non-responsive determination, the Department shall continue contract negotiations regarding the terms and conditions of the contract with the selected Offeror.

11. Department of Civil Service Reservation of Rights

In addition to any rights articulated elsewhere in this RFP, the Department reserves the right to:

a. Make or not make an award under the RFP, either in whole or in part;

b. Prior to the bid opening, amend the RFP. If the Department elects to amend any part of this RFP, such amendments will also be posted to:

https://www.cs.ny.gov/RxBenefit2023RFP/.

c. Prior to the bid opening, direct Offerors to submit Proposal modifications addressing subsequent RFP amendments;

d. Withdraw this RFP, at any time, in whole or in part, prior to OSC approval of award of the Contract;

e. Waive any requirements that are not material;

f. Disqualify any Offeror whose conduct and/or Proposal fails to conform to any of the mandatory requirements of this RFP;

g. Require clarification at any time during the Procurement process and/or require correction of apparent errors for the purpose of assuring a full and complete understanding of an Offeror's Proposal and/or to determine an Offeror's compliance with the requirements of this RFP;

h. Reject any or all Proposals received in response to this RFP;

i. Change any of the scheduled dates stated in this RFP;

j. Seek clarifications and revisions of Proposals;

k. Establish programmatic and legal requirements to meet the Department's needs, and to modify, correct, and/or clarify such requirements at any time during the Procurement, provided that any such modifications would not materially benefit or disadvantage any particular Offeror;

l. Eliminate any mandatory, non-material specifications that cannot be complied with by all of the Offerors;

m. For the purposes of ensuring completeness and comparability of the Proposals, analyze submissions and make adjustments or normalize submissions in the Proposal(s), including the Offeror's technical assumptions, and underlying calculations and assumptions used to support the Offeror's computation of costs, or to apply such other methods it deems necessary to make level comparisons across Proposals;

n. Use the Proposal and the Department's own investigation of an Offeror's qualifications, experience, ability or financial standing, and any other material or information submitted by the Offeror in response to the Department's request for clarifying information, if any, in the course of evaluation and selection under this RFP;

o. Negotiate with the successful Offeror within the scope of this RFP in the best interests of the Department;

p. Utilize any and all ideas submitted in the Proposal(s) received except to the extent such information/ideas are protected under the New York State Freedom of Information Law, Article 6 of the Public Officers Law as critical infrastructure information or trade secrets;

q. If the Department determines that contract negotiations between the Department and the selected Offeror are unsuccessful, the Department may invite the Offeror with the next highest Total Combined Score to enter into negotiations for purposes of executing a Contract. Prior to negotiating with the Offeror with the next highest Total Combined Score, the Department will notify the Offeror originally selected and provide the date when negotiations shall cease should an agreement not be reached. Scores will not be recalculated for any remaining Offerors should contract negotiations between the Department and the selected Offeror be unsuccessful because of material differences in key provision(s);

r. Unless otherwise specified in this RFP, every offer is firm and non-revocable for a minimum period of three hundred and sixty-five Days from the Proposal Due Date as set forth in the RFP; and

s. Any Offeror whose Proposal might become eligible for a tentative award may be asked to extend the time for which its Proposal shall remain valid if the original award is withdrawn.

12. Disclaimers

The Department is not liable for any cost incurred by any Offeror prior to approval of the Contract by OSC. Additionally, no costs will be incurred by the Department for any prospective Offeror or Offeror's participation in any Procurement-related activities. Further, the Department shall not be liable for any costs incurred prior to the Implementation Period performing activities set forth in Section 3 of this RFP. The Department has taken care in preparing the data accompanying this RFP (hard copy attachments, website attachments, and sample document attachments). However, the Department does not warrant the accuracy of the data. The numbers or statistics which appear in hardcopy attachments, website attachments, and sample document attachments referenced throughout this RFP are for informational purposes only and should not be used or viewed by prospective Offerors as guarantees or representations of any levels of past or future performance or participation. Accordingly,

prospective Offerors should rely upon and use such numbers or statistics in preparing their Proposal at their own discretion.

2.2 Compliance with Applicable Laws, Rules and Regulations, and Executive Orders

1. Disclosure of Proposal Contents – Freedom of Information Law (FOIL)

a. NOTICE TO OFFEROR AND ITS LEGAL COUNSEL

All materials submitted by an Offeror in response to this RFP shall become the property of the Department and may be returned to the Offeror at the sole discretion of the Department. Proposals may be reviewed or evaluated by any person, other than one associated with a competing Offeror, designated by the Department. Offerors may anticipate that Proposals will be evaluated by staff and consultants retained by the Department and may also be evaluated by staff of other New York State agencies interested in the provision of the subject services including, but not limited to, the Office of Employee Relations (OER), and the Division of the Budget (DOB), unless otherwise expressly indicated in this RFP. The Department has the right to adopt, modify, or reject any or all ideas presented in any material submitted in response to this RFP.

The Department shall take reasonable steps to protect from public disclosure any records or portions thereof relating to this solicitation that are exempt from disclosure under FOIL. Information constituting trade secrets or critical infrastructure information for purposes of FOIL must be clearly marked and identified as such by the Offeror upon submission. To request that materials be protected from FOIL disclosure, the Offeror must follow the procedures below regarding FOIL. If an Offeror believes that any information in its Proposal or supplemental submission(s) constitutes proprietary and/or trade secret or critical infrastructure information and desires that such information not be disclosed pursuant to the New York State Freedom of Information Law, Article 6 of the Public Officers Law, the Offeror must make that assertion by completing a *Freedom of Information Law Request for Redaction Chart* (Attachment 11). The Offeror must complete the form specifically identifying by page number, line, or other appropriate designation, the specific information requested to be protected from FOIL disclosure and the specific reason why such information should not be disclosed. Page 2 of *Freedom of Information Law Request for Redaction Chart* (Attachment 11) contains information regarding appropriate justification for protection from FOIL disclosure. Vague, non-specific, or summary assertions that material is

proprietary, or trade-secret are inadequate and will not result in protection from FOIL disclosure.

The completed *Freedom of Information Law Request for Redaction Chart* (Attachment 11) must be submitted to the Department at the time of its Proposal submission; it should be included with the Requested Redactions (USB storage drive and Hard Copy) described below. It should not be included in the Offeror's Proposal. If the Offeror chooses not to assert that any Proposal material and/or supplemental submission should be protected from FOIL disclosure, the Offeror should so advise the Department by checking the applicable box on *Freedom of Information Law Request for Redaction Chart* (Attachment 11) and submitting it to the Department at the time of its Proposal submission, but separately from its Proposal. If a completed *Freedom of Information Law Request for Redaction Chart* (Attachment 11) form is not submitted, the Department will assume that the Offeror chooses not to assert that any proposal material or supplemental submission, as applicable should be protected from FOIL disclosure.

The FOIL-related materials described herein are not considered part of the Offeror's Proposal and shall not be reviewed as a part of the Procurement's evaluation process.

Acceptance of the identified information by the Department does not constitute a determination that the information is exempt from disclosure under FOIL. Determinations as to whether the materials or information may be withheld from disclosure will be made in accordance with FOIL at the time a request for such information is received by the Department.

b. Requested Redactions (USB Storage Drive and Hard Copy):

At the time of Proposal submission, the Offeror is required to identify the portions of its Proposal that it is requesting to be redacted in the event that its Proposal is the subject of a FOIL request as follows.

The Offeror must provide an electronic copy of the Administrative Proposal, the Technical Proposal, and the Financial Proposal on a separate USB storage drive of the type outlined in RFP Section 2, which reflect the Offeror's requested redactions. Additionally, the Offeror must provide a separately bound hardcopy of each of the three Proposal documents with redactions marked, but not applied, that are included on the USB storage drives. The electronic documents must be prepared in PDF format. Each specific portion of the Proposal documents requested to be protected from FOIL disclosure must be identified using the Adobe

"Mark for Redaction" function; do not use the "Apply Redactions" function; or by highlighting such portions in yellow. The resulting documents must show the Offeror's requested redactions as outlined, while the content remains visible. This will allow the Department to either apply or remove requested redactions when responding to FOIL requests. The documents included on the USB storage drives and in hard copy must be complete Proposals, including all Attachments. No section may be omitted from the USB storage drive or hard copy even if the entire section is requested to be redacted; such sections should be marked for redaction, not removed. For forms, attachments, and charts, please mark for redaction only those cells/fields/entries that meet the criteria for protection from FOIL, not the entire page. Do not request redaction of Department-supplied materials or information.

During the Proposal evaluation process, the Department may request additional information through clarifying letters. Any requested redactions for additional written material provided by the Offeror in response to the Department's requests also must be submitted following the instructions, above.

2. Public Officers Law

All Offerors and Offerors' employees and agents must be aware of and comply with the requirements of the New York State Public Officers Law (POL), particularly POL sections 73 and 74, as well as all other provisions of New York State law, rules and regulations, and policy establishing ethical standards for current and former State employees. Failure to comply with these provisions may result in disqualification from the Procurement process, termination, suspension or cancelation of the Contract and criminal proceedings as may be required by law. An Offeror must submit an affirmative statement as to the existence of, absence of, or potential for conflict of interest on the part of the Offeror because of prior, current, or proposed contracts, engagements, or affiliations, by submitting a completed *New York State Required Certifications* (Attachment 7), in the Offeror's Administrative Proposal.

3. New York State Required Certifications

An Offeror is required to submit the signed *New York State Required Certifications* (Attachment 7) with its Administrative Proposal. This attachment sets forth the Offeror's required Certification on the following:

a. MacBride Fair Employment Principles;

b. Non-Collusive Bidding;

c. Executive Order No. 177 regarding discrimination and harassment;

d. Sexual Harassment Prevention;

e. Public Officer Law Requirements and Conflict of Interest Disclosure; and

f. Executive Order No. 16 regarding business operations in Russia.

4. New York Subcontractors and Suppliers

An Offeror is required to complete *New York State Subcontractors and Suppliers* (Attachment 12). New York State businesses have a substantial presence in State contracts and strongly contribute to the economies of the State and the nation. In recognition of their economic activity and leadership in doing business in NYS, an Offeror for this RFP is strongly encouraged and expected to consider NYS businesses in the fulfillment of the requirements of the Contract. Such partnering may be as subcontractors, suppliers, protégés, or other supporting roles. *New York State Subcontractors and Suppliers* (Attachment 12) must be submitted with the Offeror's Technical Proposal.

5. MWBE Goals (Exclusive to NYSIF)

It is the policy of NYSIF to encourage the greatest possible participation by Minority and Women-Owned Business Enterprises (MWBE) as Bidders, subcontractors and suppliers on its procurement contracts, consistent with New York State laws.

For purposes of this procurement, NYSIF conducted a comprehensive review of the services required under this procurement and determined that the Contract does not offer sufficient opportunities to set specific goals for participation by MWBEs as subcontractors, service providers, and suppliers to Contractor. Nevertheless, Bidder/Contractor is encouraged to make good faith efforts to promote and assist in the participation of MWBEs on the Contract for the provision of services and materials. The directory can be viewed at the New York State Certified MWBEs website.

Please see Appendix D for further information.

SECTION 3: PROJECT SERVICES

The Procuring Agencies seek to award two (2) separate Contracts (Agreements) to a qualified Offeror to provide Pharmacy Benefit Services for the respective Procuring Agencies' prescription drug programs. The Department is seeking to secure the services of a qualified Offeror to administer The Empire Plan, Excelsior Plan, and Student Employee Health Plan Prescription Drug Programs (collectively referred to as DCS Program(s)). NYSIF is seeking to secure the services of a qualified Offeror to administer the NYS Workers' Compensation Prescription Drug Program (referred to as NYSIF Program). Delivery of Project Services will impact over 1 million covered lives.

Notes:

1. Unless otherwise stated, all requirements contained in this section pertain to both the DCS and NYSIF Programs.

2. Numbers, data, or statistics which may appear in the Attachments referenced throughout this RFP are for informational purposes only and should not be used or viewed by prospective Offerors as guarantees or representations of any levels of past or future performance or participation.

The Procuring Agencies will accept Proposals only from qualified Offerors and will consider for evaluation and selection purposes only those Proposals that they determine meet the Offeror Eligibility Requirements in Section 1.8 of this RFP and are responsive to the duties and responsibilities set forth in this Section 3 of this RFP.

Please note that Offerors must <u>not</u> include any financial / cost information in the Technical Proposal, including attachments. This financial / cost information pertains to Ingredient Cost discounts, dispensing fees, prescribing fees, discount and pharma rebate guarantees, and administrative fees requested in the Financial Proposal. Specific savings estimates (dollars or percentages) must not be quoted in the Technical Proposal or in any attachments submitted with the Technical Proposal. Proposed Performance Guarantee amounts, including fee amounts to be put at risk, are not considered to be financial / cost information and should be included in the Technical Proposal.

3.1 Account Team

The successful Offeror shall have a proactive, knowledgeable, experienced and qualified account leader(s) and team(s) dedicated solely to the Programs who have the responsibility and authority to command the appropriate resources necessary to implement and deliver Project Services (hereinafter "Account Team").

1. Duties and Responsibilities

a. The Offeror must maintain, for the entire term of the Agreement, an organization of sufficient size with staff that possesses the necessary skills and experience to administer, manage, and oversee all aspects of the Programs during implementation, operation, and transition.

   i. The Account Team(s) must be comprised of qualified and experienced individuals whose number and qualifications are acceptable to the Procuring Agencies and who are responsible for ensuring that the operational, clinical, and financial resources are in place to operate the Programs in an efficient manner. The Account Team must include an Account Executive;

   ii. The Offeror must ensure that there is a process in place for the Account Team(s) to gain immediate access to appropriate corporate resources and senior management necessary to meet all Program requirements and to address any issues that may arise during the performance of each Contract.

b. The Offeror's dedicated Account Team(s) must be experienced, accessible, and sufficiently staffed, as determined by the Procuring Agencies, to:

   i. Provide timely responses (within 1 to 2 Business Days) to administrative and clinical concerns and inquiries posed by the Department, or other staff on behalf of the Council of Employee Health Insurance, or NYSIF, or union representatives regarding member-specific claims issues for the duration of the separate Agreements to the satisfaction of the Procuring Agencies. The Department shall provide to the Contractor a written list of names of those individuals in its workforce (as defined in 45 CFR §160.103) that are authorized to receive or access Enrollee PHI on its behalf.

   ii. Provide urgent responses (within 3 Business Hours or less for requests submitted by 2 p.m. on a Business Day) to access to coverage concerns and inquiries posed by the Department, or other staff on behalf of the Council of Employee Health Insurance, or NYSIF, or union representatives regarding member-specific access to coverage issues for the duration of the respective Procuring Agencies' Contract to the satisfaction of the Procuring Agencies. The Department shall provide to the Contractor a written list of names of those individuals in its workforce (as defined in 45 CFR §160.103) that are authorized to receive or access Enrollee PHI on its behalf.

iii. Immediately notify the Procuring Agencies in writing of actual or anticipated events impacting Program costs and/or delivery of services to Members such as, but not limited to, legislation, litigation, drug recalls and withdrawals, class action settlements, and operational issues.

c. The proposed Account Team must guarantee that the Programs comply with all legislative and statutory requirements. In the event the Offeror is unable to comply with any legislative or statutory requirements, the Department must be notified in writing immediately. The Offeror is required to work with the Department to develop accurate NYSHIP General Information Book and Certificate of Insurance language, and any other forms of communication and/or Program material, subject to the Department's review and approval.

3.2 Implementation Plan

The Offeror must have an implementation plan to ensure that the Programs will be fully functioning on the respective Project Services Start Date. The Offeror must propose two implementation plans, one for the Department and one for NYSIF. The implementation plans must designate an Implementation Team composed of individuals who have completed an implementation for at least one large client. A large client is considered any employer with at least 50,000 covered lives. DCS Program Implementation activities must be completed by the DCS Project Services Start Date, which is January 1, 2025, or 180 Days after OSC approves the Contract, whichever is later. NYSIF Program Implementation activities must be completed by the NYSIF Project Services Start Date, which is April 1, 2025, or 180 Days after OSC approves the Contract, whichever is later.

1. Duties and Responsibilities

a. The Implementation Plan must include evaluation and assessment activities and development of a project plan to achieve Contract requirements and deliver the Project Services.

b. The Offeror must provide, subject to the Procuring Agencies' final approval, separate Implementation Plans that result in the implementation of all services by the required timeframes, indicating estimated timeframes for individual task completion, testing dates and objectives, and areas where complications may be expected. Each Implementation Plan must include key activities such as training of call center staff, website

development, network development, transition of benefits, eligibility feeds and testing claims processing. Also, Implementation Plans must identify and describe areas where complications may be expected and what steps Offeror will take to ensure timely implementation.

c. The Offeror shall provide a comprehensive Implementation Plan, at least six months prior to the DCS Project Services Start Date and six months prior to the NYSIF Project Services Start Date, which will allow the Procuring Agencies to review the Offeror's readiness in the areas outlined in Section 5.3.1.

d. Implementation and Start-up Guarantee: The Offeror must complete all Implementation and Start-up activities by the Procuring Agencies respective Project Services Start Date, with the exceptions noted below. For the purpose of this guarantee, the Offeror must have in place and operational:

   i. A contracted Retail Pharmacy Network in place, that meets or exceeds the required access standards set forth in Section 3.9 of this RFP. Additionally, in order to meet the Offeror's implementation guarantee, the network implemented **must** include all chain pharmacies identified in the *Offeror's Proposed Retail Pharmacy Network File* (Attachment 18). Acceptable reasons for non-participation of any pharmacies identified in the Offeror's Proposed Retail Pharmacy Network File contracting collectively include and are limited to: a Pharmacy's violation of state and/or federal laws; a Pharmacy's failure to meet the Offeror's credentialing criteria; or a Pharmacy's failure to fulfill its contractual obligations and no remedy can be achieved. On the Project Services Start Date, the Retail Pharmacy Network must meet all requirements set forth in Section 3.9. of this RFP, under the subheadings "Retail Pharmacy Network," "Pharmacy Credentialing," and "Pharmacy Contracting" and be available to fill Enrollee Prescriptions for all Covered Drugs including Specialty Drugs (for those Enrollees that do not participate in the Specialty Pharmacy Program).

   ii. A fully operational Mail Service Pharmacy Process utilizing facilities as necessary to ensure that Enrollees have access to all Covered Drugs, including Specialty Drugs (for those Enrollees that do not participate in the Specialty Pharmacy Program) as set forth in Section 3.9 of this RFP, under the subheading "Mail Service Pharmacy Process." The Offeror must have a plan in place to facilitate the transfer of Prescription information, including open refills, prior authorizations and generic appeals from the previous

Program administrators and outline the procedures that will be utilized to ensure a smooth mail service transition for Enrollees.

iii. A fully operational Specialty Pharmacy Program utilizing facilities as necessary to ensure that Enrollees have access to all covered Specialty Drugs (for those Enrollees that participate in the Specialty Pharmacy Program) as set forth in Section 3.9 of this RFP under the sub-heading "Specialty Pharmacy Program." The Offeror must have a plan in place to facilitate the transfer of specialty Prescription information, including open refills and prior authorizations, from the previous Program administrator and outline the procedures that will be utilized to assure a smooth Specialty Pharmacy Program transition for affected Enrollees.

iv. A fully operational call center providing all aspects of customer support and services as set forth in Section 3.3. of this RFP. The call center must be open and operational a minimum of thirty (30) days prior to the Project Services Start Date to assist Enrollees with questions concerning Program transition.

v. An online claims processing system that applies the Procuring Agencies' approved edits and point-of-service edits, including drug utilization review edits, as set forth in Section 3.13 of this RFP.

vi. An online claims processing system with real-time access to the most updated, accurate enrollment and eligibility data provided by the Procuring Agencies to correctly pay claims for eligible Enrollees/Dependents consistent with the Programs benefit designs, including any benefit design changes implemented during the term of the contract, and contractual obligations.

vii. **(Exclusive to DCS)** A fully functioning customized Program website with a secure dedicated link from the Department's website able to provide Enrollees with online access to the specific website requirements as set forth in Section 3.3(1)(g) of this RFP.

viii. **(Exclusive to DCS)** A fully functional integration plan to manage a group enrollment of all active NYSHIP participants from the incumbent Contractor to the Selected Offeror's Commercial Prescription Drug Plan and EGWP. The Offeror agrees to use the initial load text file to update its Commercial enrollment system and its EGWP enrollment system, and provide the following:

1) An initial testing report identifying all participants who may be eligible to receive a Low-Income Subsidy.

2) A report identifying all participants who are covered under two (2) or more enrollment records.

3) ~~A report identifying all participants who were assessed a Medicare Part D Late Enrollment Penalty.~~

34) The Offeror agrees to use these reports, and with direction from the Department, to resolve discrepancies in the initial enrollment and eligibility file to minimize member disruption.

ix. **(Exclusive to DCS)** A fully functioning enrollment system capable of receiving and applying all enrollment updates as set forth in Section 3.6 of this RFP.

x. **(Exclusive to DCS)** An integration plan capable of transitioning all DCS Program data, including but not limited to, a minimum of one (1) year of historical Enrollee claim data, detailed COB data, reporting formats, Mail Service Pharmacy, Specialty Pharmacy.

xi. **(Exclusive to DCS)** An integration plan able to provide sufficient time to test loading of enrollment information that will provide at a minimum two (2) full initial load file tests to ensure members are enrolled in the Commercial Plan and EGWP appropriately. In instances where members are covered under two (2) or more enrollment records, benefits will coordinate in accordance with NYSHIP plan designs. The testing of the files will ensure seamless transition for participants who are covered under two (2) or more enrollment records.

3.3 Customer Service

The Programs require that the Offeror provide quality customer service to Enrollees/ Claimants. The DCS Program provides access to customer service representatives through The Empire Plan's consolidated toll-free number. Through this toll-free number, members access representatives who respond to questions, complaints and appeals regarding DCS Program benefits, mail order services, Network Pharmacies, the Specialty Pharmacy Program, processing point of sale Prescriptions, drug status, claim status, etc.. NYSIF's Program provides 24-hour, 7-Day a week telephone support via a toll-free number, to assist its Claimants with locating participating pharmacies, eligibility and benefit verification.

The Offeror is required to agree to customer service performance guarantees that reflect strong commitments to quality customer service. Attachment 56, *Empire Plan Monthly Call Center Volume*, of this RFP illustrates the current Pharmacy Benefit Manager's call center volume for the DCS Program. Attachment 55, *Empire Plan*

Website Statistics, provides the number of members who have utilized the current DCS customized Program website from March 2021 through February 2023.

1. Duties and Responsibilities

The Offeror will be responsible for all customer support and services including, but not limited to:

a. Providing Enrollees access to information on all Prescription drug benefits and services related to the Programs through separate toll-free numbers 24 hours a day 365 Days a year.

b. **(Exclusive to DCS)** The Empire Plan consolidated toll-free telephone service is provided through the AT&T voice network services under a contract with The Empire Plan's Medical Program vendor and is available to callers 24 hours a Day, 365 Days a year. The Offeror is required to establish and maintain a transfer connection (currently an AT&T T-1 line), including a backup system that will transfer calls to the Offeror's line at their customer service site. The Offeror is required to ~~sign a shared service agreement~~ work with The Empire Plan's Medical Program vendor (currently UnitedHealthcare) and AT&T to set up a connection. AT&T then bills the Offeror directly. In addition, the Offeror is also required to provide 24 hours a Day 365 Days a year access to a TTY number for callers utilizing a TTY device because of a hearing or speech disability. The TTY number must provide the same level of access to customer service as required by this Section 3 of the RFP.

c. Maintaining separate call centers for the Programs. The call centers must be located in the United States and staffed by fully trained customer service representatives and supervisors available 24 hours a Day 365 Days a year. The Offeror must maintain separate Dedicated Call Centers for the Programs between the hours of 7:00 a.m. and 7:00 p.m. ET. During off hours, calls may be routed to a designated call center(s) located in the United States staffed by fully trained customer service representatives and supervisors. The call centers must also provide immediate access (either through warm transfers or call-back within four (4) hours) to Pharmacist(s) 24 hours a Day 365 Days a year. The Dedicated Call Centers must be open and operational a minimum of 30 days prior to the Programs' implementation date to assist Enrollees with questions concerning the Programs' transition. The call centers must meet the Offeror's proposed customer service telephone guarantees set forth in Section 3.3(1)(i) and 5.4(8) of this RFP. [Note: In accordance with New York State Labor Law section 773, the head of each State agency is required to use reasonable best efforts to ensure that all state-business-related contracts for call

centers and customer service work be performed by contractors, agents, or subcontractors entirely within the State of New York.]

d. Customer service staff must use an integrated system to log and track all Enrollee calls. The system must create a record of the Enrollee contacting the call center, the call type, and all customer service actions and resolutions.

e. Customer service representatives must be trained and capable of responding to a wide range of questions, complaints and inquiries including but not limited to: Program benefit levels, refills, order status, prices and billing, point-of-service issues, prior authorization, claim reimbursement, eligibility, generic appeals, Mail Service Pharmacy Process, Specialty Pharmacy Process services, Advanced Flexible and Flexible Formularies and Excelsior Plan Drug List alternatives.

f. Maintaining a backup customer service staff located in the United States with Program-specific training to handle any overflow when the Dedicated Call Center is unable to meet the Offeror's proposed customer service performance guarantees. This backup system would also be utilized in the event the primary customer service center(s) become unavailable.

g. **(Exclusive to DCS)** Maintaining and timely updating a secure online customized website accessible by Enrollees which is available twenty-four (24) hours a Day, 7 Days a week, except for regularly scheduled maintenance, which will provide, at a minimum, access to information regarding: DCS Program benefits, Network Pharmacy locations, eligibility, mail service order status, Copayment information, claim status, drug cost tools, comparative drug check functionality, Prescription drug history for both retail and mail claims and the Formularies (including alternatives for Non-Preferred Brand Name and excluded drugs). The website must be operational and available to Enrollees thirty (30) Days prior to the Implementation Date. The Department shall be notified of all regularly scheduled maintenance at least one (1) Business Day prior to such maintenance being performed. The Offeror must establish a dedicated link to the customized website for the DCS Program 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. Access to the online Network Pharmacy locator must be available to Enrollees without requiring them to register on the website. Any costs associated with customizing and updating the website or establishing a dedicated link for the DCS Program shall be borne solely by the Offeror. The Offeror shall fully cooperate with any Department initiatives to use new technologies, processes, and methods to improve

the efficiencies of the customized website including development of an integrated Enrollee portal.

h. In accordance with federal and State law, the Offeror must provide access to a translation line or interpretation service to Members who do not read, speak, write or understand English as their primary language in order to remove potential barriers to accessing services.

i. Call Center Telephone Guarantees: The Offeror must provide separate guarantees for the DCS and NYSIF Programs for the following four measures of service on the toll-free customer service telephone line (if the Offeror has separate lines for the Specialty and Mail Service Pharmacy, those telephone lines must be reported separately but included in the overall Call Center Telephone Guarantees):

    i. Call Center Response Time Guarantee: The Programs' service level standard requires that, at a minimum, 90% of incoming calls to the Contractor's telephone line(s) will be answered by a Customer Service Representative (CSR) within sixty (60) seconds. Response time is defined as the time it takes incoming calls to the Offeror's telephone line to be answered by a CSR. The call center telephone response time shall be reported on a weekly basis for the first month of the Contract, and then reported monthly for the remainder of the Contract and calculated quarterly.

    ii. Call Center Availability Guarantee: The Programs' service level standard requires that the Offeror's telephone line(s) will be operational and available to Members, Claimants, Dependents and pharmacies equal to or better than 99.6% of the Offeror's required up-time (24 hours a Day, 7 days a week, 365 days a year). The telephone line availability shall be reported monthly and calculated quarterly.

    iii. Telephone Abandonment Rate Guarantee: The Programs' service level standard requires that the percentage of incoming calls to the Offeror's telephone line(s) in which the caller disconnects prior to the call being answered by a call center representative will not exceed 3%. The telephone abandonment rate shall be reported weekly for the first month of the Contract, and then reported monthly for the remainder of the Contract and calculated quarterly.

    iv. Telephone Blockage Rate Guarantee: The Programs' service level standard requires that not more than 3% of incoming calls to the Offeror's telephone line(s) will be blocked by a busy signal. The telephone blockage rate shall be reported weekly for the first month

of the Contract, and then reported monthly for the remainder of the Contract and calculated quarterly.

j. **(Exclusive to DCS)** Secure Online Customized Website Guarantee: The Offeror must provide a guarantee for the DCS Program for the following measure of website service:

i. Website Accuracy Guarantee: The DCS Program's service level standard requires that inaccurate information, as reported by DCS, posted on the customized website is corrected within 3 Business Days.

ii. Website Update Timeliness Guarantee: The DCS Program's service level standard requires that requested updates, such as posting quarterly Formularies or copayment information, to the website occur within 5 Business Days. Website updates shall be reported monthly for the duration of the Contract and calculated quarterly.

3.4 Empire Plan Medicare Rx (Exclusive to DCS)

The Offeror will be responsible for implementing and administering a Center for Medicare and Medicaid Services- (CMS) approved and compliant Employer Group Waiver Plan (EGWP) for the Empire Plan's Medicare-eligible retirees beginning on the DCS Project Services Start Date. Empire Plan Medicare Rx is for Medicare-primary Empire Plan enrollees and Dependents. It is a Medicare Part D Prescription Drug Plan (PDP) with supplemental wrap coverage that provides benefits and drug coverage equivalent to, or in excess of, the benefits available to the Empire Plan's non-Medicare-primary enrollees and Dependents. Empire Plan Medicare Rx currently covers approximately 302,000 Medicare-primary enrollees and their Dependents.

1. Duties and Responsibilities

Required services for the EGWP shall include, but are not limited to, the following tasks. Such other tasks may be added in guidance and further regulation by CMS:

a. Disclosing to CMS, on a timely basis and on behalf of the Department, any filings, applications, reports, formularies, and other DCS Program material necessary for the Department to comply with the requirements of an "800-series" EGWP.

b. Fully supporting the Department with all operational aspects of a fully compliant 800-series EGWP including, but not limited to:

i. Medicare PDP EGWP premium development

ii. Enrollment, including providing temporary commercial plan coverage for Enrollees and/or Dependents who are pending enrollment by Medicare

iii. Enrollee Opt-Out process

iv. Eligibility Reconciliations on a cadence and format determined by the Department

v. Medicare Beneficiary Identifier (MBI) administration

vi. Formulary management

vii. Issuing of Medicare PDP EGWP member identification cards

viii. Member Communications, including required explanation of benefits statements

ix. Claims Processing

x. Administration of a Medicare Part D supplemental wrap with the goal of providing Medicare primary Enrollees with a prescription drug benefit that provides benefits and drug coverage that provides benefits and drug coverage equivalent to, or in excess of, the benefits available to the Empire Plan's non-Medicare-primary enrollees and Dependents in The Empire Plan

xi. Timely administration of catastrophic reinsurance claims

xii. Administration of Low Income Subsidy requirements, including direct reimbursement of Low Income Subsidies to eligible Enrollees of the Plan

c. Submit an LIS report to the Department no later than fifteen (15) Business Days from the date the Offeror receives the subsidy payment from CMS. The report must include the following information regarding payments made by the Offeror to LIS Enrollees: NYSHIP Enrollee's name; NYSHIP Enrollee's SSN; LIS eligible individual's name; LIS eligible individual's SSN; LIS eligible individual's DOB; LIS eligibility start date, LIS eligibility end date; Monthly subsidy amount received from CMS for the LIS individual; Dual Eligibility indicator; Date LIS payment received from CMS

(MM/DD/YYYY); LIS payment/adjustment start date; LIS payment/adjustment end date; LIS adjustment reason code/description; LIS eligible individual's MBI. Within forty-five (45) Business Days from the date the Offeror receives the Low Income Subsidy (LIS) payment from CMS, the Offeror must send the LIS beneficiary the low-income premium subsidy payment.

d. Prepare , upon request by the Department, timely reconciliations of administrative fees, forecast versus incurred prescription drug claims, CMS (Part D) capitated and reinsurance fees, CMS enrollee low-income subsidy payments and pharmacy rebates. The Offeror must provide such records and reports in a manner, form, and timeliness acceptable to the Department.

e. Promptly credit the Department for all CMS premium subsidy payments (excluding LIS) and all pharmacy rebates received by the Offeror under the Medicare PDP EGWP plus Medicare D supplemental wrap.

f. The Department acknowledges and agrees that it shall be solely responsible for (1) for providing creditable coverage notices required with respect to the Empire Plan Medicare Rx Program; and (2) for determining whether enrolled individuals are Medicare Primary. The Offeror will work with the Department to obtain Medicare Beneficiary Identifiers (MBIs) for all eligible Medicare-primary members enrolled in the Empire Plan Medicare Rx Program.

g. The Offeror acknowledges that the information furnished in connection with the administration of the Medicare Rx Program is being provided to obtain federal funds. The Offeror shall require all sub-contractors, including any plan administrators, if applicable, that submit information required by CMS to obtain any subsidies or payments on behalf of the DCS Program to acknowledge that information provided in connection with the key subcontract is used for the purpose of obtaining federal funds.

h. The Offeror acknowledges that its provision of services pursuant to this section of this RFP is subject to audit and evaluation by the U.S. Department of Health and Human Services pursuant to 42 CFR Subpart R or other authority as may be cited by the federal government, as well as by the State of New York pursuant to Appendix A and Appendix B of the resultant Agreement. The Offeror shall comply with any record retention requirements required pursuant to 42 CFR Subpart R in this regard.

i. The Offeror is required to consult with the Department in analyzing its experience with the Empire Plan Medicare Rx, and recommending as well as implementing other permitted options under Medicare Part D that may be of advantage to the Department, agencies participating in NYSHIP and

NYSHIP Enrollees.

j. Upon finalization of a subrogation process by CMS, the Offeror will be required to identify and recover claim payments made by the DCS Program from other plans that should have been the primary payer. The Offeror must apply appropriate procedures for the coordination of benefits based on the Department's records, including for members with multiple accounts and those moving between different Benefit Programs or lines of coverage. For Medicare primary members who are discovered to have both Commercial and EGWP accounts open concurrently in error, the Offeror will correct coverage to reflect EGWP for the accurate period and adjust Commercial as necessary. Accordingly, the Offeror will be required to move any claims erroneously paid under Commercial to EGWP for payment.

k. Utilizing the name of the Department's current EGWP, Empire Plan Medicare Rx, or a different name as directed by the Department, in all EGWP communication materials and identification cards.

3.5 Member Communication Support

The Department regularly provides information regarding Program benefits to Members through publications, the Department's website, media, and attendance at various meetings. The successful Offeror will be required to assist the Department with the creation, review and presentation of Prescription Drug Program materials that will enhance a Member's understanding of the Prescription Drug Program benefits.

The Offeror will also be required to assist NYSIF with various Claimant communications including the issuing of ID cards, information packets, forms and letters, as requested.

1. Duties and Responsibilities

a. All Member communications developed by the Offeror are subject to the Department's review and prior written approval, including but not limited to any regular standardized direct communication with Members or their Physicians in connection with Member drug utilization or the processing of Member claims, either through mail, e-mail, fax or telephone. The Department or NYSIF in its sole discretion reserves the right to require any change it deems necessary.

b. **(Exclusive to DCS)** The Offeror will be responsible for providing Enrollee communication support and services to the Department including, but not

limited to:

i. Developing language describing the DCS Program for inclusion in materials such as the materials presented in Attachment 29, *Various Empire Plan Publications*, and any other form of communication, subject to the Department's review and approval.

ii. Developing articles for inclusion in *Empire Plan Reports* and other publications on an "as needed" basis, detailing DCS Program benefit features and/or highlighting trends in drug utilization.

iii. Timely reviewing and commenting on proposed DCS Program communication material developed by the Department.

iv. Developing timely and accurate Summary of Benefits and Coverage (SBC) documents that will be consolidated with coverage information from other Program vendors for The Empire Plan, Student Employee Health Plan and Excelsior Plan. Upon Enrollee request, the Contractor must direct Enrollees to the Department's website to view the SBC or distribute a copy of the SBC to the Enrollee within the federally required time period.

c. **(Exclusive to DCS)** Upon request, subject to the discretion and approval of DCS, on an "as needed" basis, the Offeror agrees to provide staff to attend (in-person or virtually) Health Benefit Fairs, select conferences, and benefit design information sessions, etc. in NYS and elsewhere in the United States. A Calendar Year summary of the prescription drug program vendor's attendance at various events is available in Attachment 58, *Vendor Attendance*. **The Offeror agrees that the costs associated with these services are included in the Offeror's Claims Administration Fee.**

d. The 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 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. CMS-required communications are exempt from the customization requirement.

e. **(Exclusive to NYSIF)** The Offeror must assist NYSIF in developing a customized Claimant information packet that will include information on available prescription drug services as well as a permanent ID card to be used when filling injury-related prescriptions. See sample

ID card in Attachment 31, *NYSIF Claimant Card Letter*, of this RFP.

f. **(Exclusive to DCS)** 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 with a secure dedicated link from the Department's website with the ability to provide Members with online access to the specific website requirements as set forth in Section 3.3(1)(g) of this RFP. The website must conform to the New York State website style provided by the Department of Civil Service and meet all NYS Web Accessibility requirements

g. The Offeror must include a web-based user interface compatible with:

   i. Google Chrome current version for Windows;
   ii. Mozilla Firefox current version;
   iii. Safari current version; and
   iv. Microsoft Edge current version.

h. The websites must be mobile friendly, fully functional, and display correctly on devices such as:

   i. Smartphones;
   ii. iPhones;
   iii. iPads;
   iv. Tablets; and
   v. Laptops.

3.6 Enrollment Management

The Department currently utilizes a web-based enrollment system for the administration of employee benefits known as the New York Benefits Eligibility and Accounting System (NYBEAS). The intent is for a replacement or upgraded system prior to or during the term of the resulting Contract. NYBEAS is the source of eligibility information for all Empire Plan, Excelsior Plan, and SEHP Members. Enrollment information is outlined in *Enrollment by Plan, by Month* (Attachment 23), *Enrollment by Plan, by Age* (Attachment 24), *Covered Lives by Plan* (Attachment 25), and *Covered Lives by Union / Group* (Attachment 26).

[**Note:** The enrollment counts depicted in these attachments may vary slightly due to timing differences in attachment generation.]

When a person enrolls in The Empire Plan, Excelsior Plan, or SEHP, the Department's benefit card contractor issues an Employee Benefit Card. An Enrollee with individual coverage will receive one card containing the Enrollee's 9-digit alternate identification

number and name. An Enrollee with family coverage will receive two cards containing the Enrollee's alternate identification number and name, as well as Dependents' names. This universal card is used by Enrollees and Dependents for all components of The Empire Plan. Examples of benefit cards is provided in Attachment 30, *Employee Benefit Cards*.

The Department will not accept an alternative approach to ID cards, with the exception of ID cards required for the EGWP. It is the responsibility of the Offeror to ensure that the Retail Pharmacy Network accepts The Empire Plan Employee Benefit Card as evidence of coverage and is capable of submitting claims when presented with The Empire Plan Employee Benefit Card. These cards include The Empire Plan consolidated toll-free number as well as information on out-of-pocket limits, that pharmacies may use to contact the DCS Program if they need claim submission assistance. The Offeror should not expect any modification of the current identification card as part of implementation. Separate Prescription drug cards will not be issued, with the exception of ID cards required for the EGWP.

The SEHP Employee Benefit Card displays the Enrollee's 9-digit alternate identification number and name and the expiration date of coverage. The SEHP Employee Benefit Cards are issued annually by a Department contractor and have an expiration date of August 31st of each year. An example of this card is provided in *Employee Benefit Cards* (Attachment 30).

NYSIF's Claim Eligibility process ensures that Claimants receive convenient prescription-filling services and that Network Pharmacy bill the NYSIF Program with the proper Carrier Case Number (i.e., Claim Number). A sample ID card is provided in Attachment 31, *NYSIF Claimant Card Letter,* of this RFP.

1. **<u>Duties and Responsibilities</u>**

   The Selected Offeror must maintain accurate, complete, and up-to-date enrollment files, located in the United States, based on information provided by the Department and NYSIF. In the case of conflict, the Offeror must agree that the Department-provided enrollment system information governs. These enrollment files shall be used by the Offeror to process retail, mail order and specialty pharmacy claims, provide customer service, identify individuals in the enrollment file for whom Medicare is primary, and produce management reports and data files.

   The Offeror must provide enrollment management services including but not limited to:

   a. Initial Testing:

i. Performing an initial enrollment load to commence upon receipt of the enrollment file from the Department and NYSIF during the Implementation Period. The file must be EDI Benefit Enrollment and Maintenance Transaction set 834 (ANSI x.12 834 standard) and be either 834 (4010x095A1) or 834 (005010x220), fixed-length ASCII text file, or a custom file format. The determination of the format of the file will be made by the Procuring Agencies.

ii. Testing to determine if the initial enrollment file and daily enrollment transaction loaded correctly and that the enrollment system interfaces with the claims processing system to accurately adjudicate claims. The selected Offeror shall submit enrollment test files to the Department and NYSIF for auditing, provide the Department and NYSIF with secure, online access required to ensure accurate loading of the Programs' enrollment data, and promptly correct any identified issues to the satisfaction of the Department and NYSIF.

b. **(Exclusive to DCS)** Providing an enrollment system capable of receiving, reading, interpreting, and storing secure enrollment transactions (Monday through Friday) and having all transactions for Commercial plan members loaded to the claims processing system within twenty-four (24) hours of the release of a retrievable file by the Department. The Offeror shall, on a daily basis, manually review and load any transactions which did not process correctly from the daily ANSI x.12 834 standard 005010x220 file by reviewing the correct enrollment date maintained in the NYBEAS. The Offeror shall immediately notify the Department of each transaction that did not process correctly and any delay in loading enrollment transactions. In the event the Offeror experiences a delay due to the quality of the data supplied by the Department, the Offeror shall immediately load all records received (that meet the quality standards for loading) within twenty-four (24) hours of their release, as required. The Department will release enrollment changes to the Offeror in an electronic format daily (Monday through Friday). On occasion, the Department will release more than one enrollment file within a twenty-four hour period. The Offeror must be capable of loading all enrollment files within the twenty-four hour performance standard. The format of these transactions will be in an EDI Benefit Enrollment and Maintenance transaction set, utilizing an ANSI x.12 834 standard 005010x220 transaction set in the format specified by the Department. The latest formats for the Commercial file are contained in Attachment 43, *NYSBEAS Enrollment Record Layout – Control Header*, Attachment 44, *NYBEAS Commercial Enrollment Record Layout – Transaction Set Header*. The layout of the EGWP detail file, header record and trailer record are contained in Attachment 45, *NYBEAS EGWP Enrollment Record Layout – Detail File*, Attachment 46, *NYBEAS EGWP*

Enrollment Record Layout –Header and Attachment 47, *NYBEAS EGWP Enrollment Record Layout –Trailer*. The Offeror must also have the capability to receive alternate identification numbers and any special update files from the Department containing eligibility additions and deletions, including emergency updates if required.

c. Acknowledge the Department's NYBEAS system is the controlling system for member enrollment and demographic information and, but not limited to:

    i. Update enrollment and eligibility information solely based on the 834 transaction file for the Commercial NYSHIP population, and the EGWP eligibility file for the EGWP NYSHIP population.

    ii. 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. Dependents enrolled in the EGWP must be linked back to the policy holder in the Department's system. Additionally, the Offeror is required to report back to the Department the Medicare Group Plan Number and the Medicare Prescription Drug Plan Number on all files for the membership.

    iii. Report data changes of name, date of birth, gender, or MBI from CMS to the Department, so that the Department can update its system as appropriate to report these changes on the 834 transaction and EGWP eligibility files.

    iv. Report address changes made to the Offeror to the Department via a file. The Department will update its system as appropriate and report these changes on the 834 transaction and EGWP eligibility files.

d. Coordinate enrollments, disenrollments, and cancellations of the EGWP using the EGWP eligibility file, including if a member has multiple alternate IDs (i.e., Dependent Survivors' coverage).

e. Accept and enroll members into the EGWP using the EGWP eligibility file and submit the enrollment to CMS when a member is prospectively identified as Medicare primary.

    i. 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.

f. Accept and enroll members into the EGWP using the EGWP eligibility file

and submit the enrollment to CMS with the earliest EGWP enrollment date CMS allows, including but not limited to, when a member is retroactively identified as Medicare primary. The Contractor is required not only to submit the enrollment to CMS for the member, but also to extend Commercial Coverage until such point when the member is enrolled in the EGWP.

g. Process disenrollments for the EGWP using the EGWP eligibility file when a member is prospectively terminated from EGWP coverage (including ending Empire Plan coverage in its entirety or losing Medicare primacy). The Offeror will accept the disenrollment or cancellation on the EGWP eligibility file and use it to either disenroll or cancel an enrollment into the EGWP and submit the appropriate transaction to CMS.

h. 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.

i. Accept EGWP eligible member enrollments with P.O. Box information as the Department attests to their eligibility and that they continue to reside in the EGWP service area.

j. Maintain eligibility files and generate a reconciliation eligibility file monthly for the Commercial Plan and quarterly for the EGWP. The file will contain data elements defined by the Department, but at a minimum will include, the member's Social Security Number, the policyholder alternate ID, NYSHIP assigned IDs (e.g., COBRA or Dependent Survivor), demographic information, enrollment date, and termination date. For the reconciliation of the EGWP eligibility information, the file must also include the MBI, Medicare Part D Plan information and PDP information.

k. Receive any other special update files from the Department containing eligibility additions and deletions, including emergency updates, which must be made within twenty-four (24) hours.

l. Providing the Department with all CMS Transaction Reason Codes (TRC) on an electronic Feedback file. Such responsibility must include, but not be limited to:

    i. Transmitting all TRC codes, with the exception of the Low Income Amount, received for a given member (enrollee or Dependent) with ordered sequencing so all TRC codes may be

processed in order.

ii. Providing the Feedback file to the Department on a daily basis.

iii. Submitting in a .txt file layout in accordance with Attachment 46, *NYBEAS EGWP Enrollment Record Layout – Header,* as outlined in this RFP.

iv. Initial testing to ensure the daily Feedback file loaded correctly and subsequent enrollment transactions are processed programmatically.

v. Notifying the Department within twenty-four (24) hours if a Feedback file was unable to post.

m. **(Exclusive to NYSIF)** Providing an enrollment system capable of receiving secure enrollment transactions every day, including weekends and holidays, and having all transactions fully loaded to the claims processing system within twelve (12) hours of release of a retrievable file by the NYSIF. The Offeror shall immediately notify the NYSIF of any delay in loading enrollment transactions. In the event the Offeror experiences a delay due to the quality of the data supplied by the NYSIF, the Offeror shall immediately load all records received (that meet the quality standards for loading) within twelve (12) hours of their release, as required. The NYSIF will release enrollment changes, including all additions, modifications and deletions since the previous transmission, to the Offeror in an electronic format daily (every day, including weekends and holidays). On occasion, the NYSIF will release more than one enrollment file within a 12-hour period. The Offeror must be capable of loading both files within the twelve (12) hour performance standard. The format of these transactions will be a fixed length ASCII text file. The ASCII text file is encrypted and transmitted each Business Day using a secure transmission protocol. Upon selection, the Offeror will be provided with the claim eligibility file specifications and the schedule for the transmission of the file. The latest transaction format for NYSIF is contained in Attachment 59, *NYSIF Eligibility Process*, of this RFP.

n. Ensuring the security of all enrollment information as well as the security of a HIPAA-compliant computer system in order to protect the confidentiality of Enrollee/Dependent data contained in the enrollment file. Any transfers of enrollment data within the Offeror's system or to external parties must be completed via a secured process compliant with the information security requirements set forth in *Information Security Requirements* (Appendix C, Exclusive to DCS).

o. Providing a backup system or have a process in place where, if enrollment

information is unavailable or not current at the point of service, Enrollees can obtain Prescriptions without interruption, at the point of service. Short fill policies should be included in the Pharmacy Provider manual.

p. Cooperating fully with any State, Procuring Agency or third-party initiatives on behalf of the Department to use new technologies, processes, and methods to improve the efficiencies of maintaining enrollment data including any enrollment file conformance testing requested during the course of the Agreement resulting from this RFP.

q. **(Exclusive to DCS)** Maintaining a read-only connection to the NYBEAS enrollment system for the purpose of providing the Offeror's authorized staff with access to current Program enrollment information. Offeror's authorized staff must be available to access enrollment information through NYBEAS, Monday through Friday, from 9:00 a.m. to 5:00 p.m., with the exception of NYS holidays as indicated on the Department's website.

r. **(Exclusive to DCS)** Meeting the administrative requirements for National Medical Support Notices. A child covered by a National Medical Child Support Order (NMCSO), or the child's custodial parent, legal guardian, or the provider of services to the child, or a NYS agency to the extent assigned the child's rights, may file claims and the Offeror must make payment for covered benefits or reimbursement directly to such party. An Offeror will be required to store this information in their system so that any claim payments or any other plan communication distributed by the Offeror, including access to information on the Offeror's website would go to the person designated in the NMCSO.

s. 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.

t. **(Exclusive to NYSIF)** The Offeror must provide an instant enrollment or "short fill" service to injured workers of NYSIF policyholders. This service should allow immediate acceptance by any pharmacy in the Offeror's Retail Pharmacy Network to provide a limited number of cost-effective medication benefits to the injured worker. See Attachment 65, *NYSIF Short Fill Process*, of this RFP.

u. Sharing data with entities to be determined by the State, including, but not limited to, health benefits administrators for New York State Agencies, Participating Employers and Participating Agencies.

v. 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).

w. Administering insurance coverage for any employee and their Eligible Dependents whom the Department determines is eligible for coverage.

x. Adhering to the Option Transfer Period which shall be the period announced by the State to allow eligible Enrollees to join the plan, change coverage, or add eligible Dependents.

y. Providing the State with online access to their enrollment information in real-time.

z. Maintaining a dedicated team to manually review enrollment and eligibility transactions that do not upload to the Offeror's system and report transactions that did not process in a format acceptable to the Department within one Business Day of discovery.

aa. Enrollment Management Guarantee: The Offeror must guarantee 100% of all Commercial Program enrollment records that meet the quality standards for loading will be loaded into the Offeror's enrollment system within twenty-four (24) hours of release by the Department and within twelve (12) hours of release by the NYSIF.

3.7 Reporting Services

(Exclusive to DCS) The Offeror must provide the Department with regular, periodic reports, as specified below, that that are designed to document that Member, network, and account management service levels are being maintained and that claims are being paid and billed according to the terms of the agreements with pharmacies and the terms of the Agreements resulting from this RFP. The selected Offeror may, on occasion, be requested to provide ad-hoc reporting and analysis within twenty-four (24) hours.

In order to fulfill its obligations to Members and ensure Contract compliance, the selected Offeror must provide accurate claims data information on a claim processing cycle basis as well as summary reports concerning the Prescription Drug Program and its administration.

All electronic files must be in a format acceptable to the Department. The Department will initially review and approve the proposed file format during the Implementation Period, but this file format may be adjusted during the term of the Contract at the discretion of the Department. Upon receipt by the Department, all electronic files are first validated for compliance with the agreed-upon format. Files that fail to adhere to this structure are rejected in their entirety and must be re-submitted.

(Exclusive to NYSIF) Offeror's Reporting must be structured to provide assurances that Claimant, network and account management service levels are being maintained and that claims are being paid and billed according to the terms of the agreements with pharmacies and the terms of the separate Agreements resulting from this RFP. The selected Offeror may on occasion be requested to provide ad-hoc reporting and analysis upon twenty-four (24) hour written notice from NYSIF.

In order to fulfill its obligations to enrolled members and ensure contract compliance, the NYSIF Program requires that the Offeror provide accurate claims data information on a claim processing cycle basis as well as specific summary reports concerning the NYSIF Program and its administration.

All electronic files received by NYSIF are first validated for compliance with the specified file structure. Files that fail to adhere to this structure are rejected in their entirety.

Upon selection, the Contractor will be provided with detailed specifications for all files exchanged between NYSIF and the Contractor. In general, these specifications include the use of:

- Either fixed length ASCII text format and/or delimited ASCII text files
- Standard structure for all including order
- Header record
- Detail records
- Footer record containing defined control totals, e.g., record count, hash totals, etc.
- Standard encryption/decryption methodology
- Standard secure file transfer protocol

1. Duties and Responsibilities

a. **(Exclusive to DCS)** The Offeror must be responsible for reporting services including, but not limited to:

i. Ensuring that all 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.

ii. Developing and delivering accurate and timely management, financial, and utilization reports as specified below and/or in *Program Reporting* (Attachment 36). These reports will be delivered to the Department no later than their respective due dates and are required by the Department for its use in the review,

management, monitoring, and analysis of the DCS Program. The exact format (paper and/or electronic Microsoft Access, Excel, Word), frequency, and due dates for such reports will be specified by the Department.

iii. Providing direct, secure access to the Offeror's claims system and any online and web-based reporting tools to the Department's offices.

iv. Providing ad hoc reports and other data analysis at no additional fee to the Department. The exact format, frequency, and due dates for such reports shall be specified by the Department. Any ad hoc report generated for the Department must be reflective of the Program's actual claims experience and Member population. Information required in the ad hoc reports may include, but is not limited to:

1) Forecasting and trend analysis data;

2) Data necessary to track drug pricing;

3) Utilization data on the Mail Order Pharmacy and the Specialty Pharmacy Program;

4) Utilization review savings;

5) Benefit design modeling analysis;

6) Reports to meet clinical Program review needs;

7) Reports segregating claims experience for specific populations including Department assigned Benefit Programs (see *Benefit Programs* (Attachment 28)); and

8) Reports to monitor Contract compliance.

v. Reporting of all performance guarantees as specified within the Contract and for any occurrence when a performance guarantee is not met, when requested by the Department, Contractor will provide a root cause analysis and detail corrective action.

vi. Assisting and supporting the Department with all aspects of the premium rate development including, but not limited to:

1) Providing a team of qualified and experienced individuals

who are acceptable to the Department and who will assist and support the Department in developing premium rates consistent with the financial interests and goals of the DCS Program and the State;

2) Developing projected aggregate claim, trend and Administrative Fee amounts for each DCS Plan Year. Analysis of all DCS Program components impacting the DCS Program cost shall be performed including, but not limited to, claims, trend factors, Administrative Fees, projected Pharma Revenue, Employer Group Waiver Plan (EGWP) subsidies, changes in enrollment, changes in the Specialty Pharmacy Drug List as well as changes in all the formularies; and

3) Working with the Department and its contracted actuarial consultant through the annual premium renewal process to further document and explain any premium rate recommendation. This process includes presenting the premium rate recommendation to staff of the Department, Division of the Budget (DOB), Office of Employee Relations (OER) and the State's public employee unions.

Reporting Services and Claim File Guarantees*:* The DCS Program's service level standard requires that reporting services and claims files listed in *Program Reporting* (Attachment 36), will be accurate and delivered to the Department no later than their respective due dates inclusive of the date of receipt. The Offeror must propose the credit against the DCS Program's Claims Administration Fee of a specific dollar amount per report per each Business Day between the due date and the date the report or claims file is received by the DCS inclusive of the date of receipt.

b. **(Exclusive to NYSIF)** The selected Offeror will be responsible for accurate reporting services including, but not limited to:

i. Generating and submitting monthly, quarterly, semi-annual and annual reports per NYSIF specification. Specifications will be provided to the Contractor.

ii. Capturing and providing NYSIF with electronic files of eligibility and authorization on the GC3, GPI or similar code level. The Contractor should have the capability to capture drug denials on the GPI and NDC code levels.

iii. Providing direct, secure access to the Contractor's claims system and any online and web-based reporting tools to NYSIF's offices.

iv. Providing NYSIF with an online decision support tool with ad-hoc query capability.

v. Providing Ad Hoc Reports and other data analysis at no additional cost. The exact format, frequency, and due dates for such reports shall be specified by NYSIF. Information required in the Ad Hoc Reports may include but is not limited to providing:

1) Forecasting and trend analysis data

2) Data necessary to track drug pricing

3) Utilization data on the Mail Order Pharmacy and the Special Pharmacy Program

4) Utilization review savings

5) Benefit design modeling analysis

6) Reports to meet clinical program review needs

7) Reports segregating claims experience for specific population

8) Reports to monitor Agreement compliance

vi. The Offeror must work with NYSIF to resolve reporting issues according to the timeframes described in this section of the RFP.

vii. Reporting Services and Claim File Guarantees: The NYSIF Program's service level standard requires that reporting services and claims files listed in this Section and/or in *Program Reporting* (Attachment 36), will be accurate and delivered to the NYSIF by their respective due dates. The Offeror must propose a forfeiture amount for each Calendar Day the NYSIF has not received the NYSIF Program management report and claims file by their respective due date.

c. Annual Reports

Rebate True-up File: The Offeror is required to transmit a computerized file, in a format specified by the Department, via secure transfer containing a yearly true-up of rebate records. The true-up rebate file must match all of the billing records provided by the Offeror in the bi-weekly pharmacy billing files. The report is due one hundred fifty (150)

Days after the end of the Calendar Year.

d. Quarterly Reports

Quarterly Performance Guarantee Report: The Offeror must submit quarterly the DCS Program's Performance Guarantee report that details the Offeror's compliance with all of the Offeror's proposed Performance Guarantees. The report should include the areas of: Implementation; system availability; customer service (telephone availability, response time, blockage rate, abandonment rate, website accuracy and website update timeliness); claims processing; management reports and claim files; enrollment; mail service turnaround; and, Pharmacy composition and access. The Offeror should closely follow the current format specified by the Department in Attachment 41, *Quarterly Performance Guarantee Report*. Documentation of compliance should be included with this report. The report is due thirty (30) Days after the end of the quarter.

Quarterly Network Access: The Offeror must submit a measurement of the Network access (using Attachment 20, *Offeror's Proposed Retail Pharmacy Network Access Prerequisite Worksheet*) based on a "snapshot" of the network taken on the last day of each quarter. The report is due thirty (30) Days after the end of the quarter.

(Exclusive to DCS): Quarterly Rebate and Other Pharma Revenue Report: The Offeror is required to submit a quarterly rebate and Other Pharma Revenue report detailing the amount of rebates and other Pharma Revenue received from the Offeror during the quarter. The report must include breakdowns by each manufacturer and drug with quarterly and year-to-date numbers, as well as any adjustments that are performed. The Offeror must follow the current format specified by the Department in Attachment 42, *Quarterly Rebate and Other Pharma Revenue Report*. The Offeror's process for documenting rebates and other Pharma Revenue by manufacturer and issuing the payment of rebates and other Pharma Revenue to the DCS Program should not exceed sixty (60) Days from the end of the quarter in which the initial claims were processed. This report is due at the time the rebates and other Pharma Revenue are paid to the Program.

(Exclusive to NYSIF): Quarterly Rebate and Other Pharma Revenue Report: The Offeror is required to submit a quarterly rebate and other Pharma Revenue report detailing the amount of rebates and other Pharma Revenue received from the Offeror during the quarter. The report must include breakdowns by each manufacturer and drug with

quarterly and year-to-date numbers, as well as any adjustments that are performed. The report must also be broken down to each individual prescription filled. The Offeror should closely follow the format specified by NYSIF in Attachment 61, *NYSIF Rebate File Processes (Quarterly/Yearly)*, of this RFP. The Offeror's process for documenting rebates and other Pharma Revenue by manufacturer and issuing the payment of rebates and other Pharma Revenue to the NYSIF Program should not exceed one hundred fifty (150) Days from the end of the quarter in which the initial claims were processed. This report is due at the time the rebates and other Pharma Revenue are paid to the Program.

e. Monthly Reports

(Exclusive to DCS): Pharmacy Program Monthly Status Report: The Offeror is required to submit a monthly report that provides summarized information on: Production Statistics, Performance Guarantees, Customer Care Statistics, Mail Order Pharmacy Statistics, Prior Authorization Statistics, Appeals and Clinical Review Statistics, Top Therapeutic Classes by Commercial and EGWP, Top Drugs by Total Drug Cost and by Volume for Commercial and EGWP. The Offeror is required to submit this report in a format specified by the Department. The report is due thirty (30) Days after the end of the month.

Monthly Report of Program MAC List(s): Each month the Offeror is required to submit an updated Program MAC List that details all the drugs included on the Program MAC List and the corresponding prices used to charge the Programs. The following information shall be included: GPI, NDC, drug name, form, strength, reference product, FDA rating, date the product was initially placed on the MAC List, initial MAC price, previous MAC price, current MAC price, effective date of current MAC price, the change in price from the previous Program MAC List and **(Exclusive to DCS)** the Date the MAC Alert was sent to DCS. Drugs that are added or deleted from the Program MAC List shall be clearly marked or highlighted. The Offeror is required to submit this report in the current format specified by in Attachment 37, *Empire Plan Monthly MAC List*, unless otherwise specified by the Departments. The report is due thirty (30) Days after the end of the month.

Drug Performance Reports: Each month the Offeror is required to submit a report with key monthly and year to date performance metrics, including utilization, cost, and discount statistics, for Brand and Generic drugs dispensed through the Retail Pharmacy Network and the Mail Service Pharmacy, and for Specialty Drugs dispensed through the Specialty Pharmacy Process. The Offeror is required to submit this report in the

current format specified by DCS in Attachment 40, *Drug Performance Report*, unless otherwise specified by the Department. The report is due thirty (30) days after the end of the month.

MAC Saving Reports: Each month the Offeror is required to submit year-to-date and annualized savings projections of the MAC price increases and decreases based on expected utilization. The following information shall be included: GPI, NDC, Drug Name, Strength, Initial MAC Price, Current Price, Quantity Filled, Actual Savings, Annual Savings and **(Exclusive to DCS)** the Date the MAC Alert was sent to DCS. There must also be a Key for the FDA Rating, if needed, to ensure that all generic medications are AB-rated. The Offeror is required to submit this report specified by the Department in Attachment 39, *Monthly MAC Savings Report*, unless otherwise specified by the Department. The report is due thirty (30) Days after the end of the month.

f. **(Exclusive to DCS)** Bi-Weekly Reports

Detailed Claim File Data: The Offeror must transmit to the Department and/or its Decision Support System (DSS) Vendor a computerized file via secure transfer, containing detailed claim records in the format specified by the Department in Attachment 34, *NYS Detailed Claim File Layout (DCS)*, unless otherwise specified by the Department, to support the bi-weekly invoice. The Department requires that all claims processed, reversed and adjusted be included in claims data. The file must facilitate reconciliation of claim payments to amounts charged to the DCS Program and include the current status of the claim (i.e., fields identifying claims as paid, adjusted, reversed). A rejected claim file is also required upon request by the Department. The Offeror is required to securely forward the required claims data on a claims processing cycle basis to the Department and/or its DSS vendor within fifteen (15) Days after the end of each claims processing cycle and submit a summarized report (also within fifteen (15) Days after the end of each claims processing cycle) by claims processing cycle broken down by drug type (Generic/Brand) utilizing the fields and the format specified by the Department in Attachment 35, *Cycle Claim Report*. Based upon the analysis of the information contained in the report any important programmatic information, trends or abnormalities should be provided in a narrative.

g. **(Exclusive to DCS)** Reports Required at Other Frequencies

MAC Alert Notice: The Offeror is required to submit a report of the financial impact of enforcing mandatory generic substitution via a “MAC Alert Notice” utilizing the current format specified by the Department in Attachment 38, *MAC Alert Notice*. This report must be submitted in

accordance with the time frames specified in Section 3.12 of this RFP, under the subheading “Mandatory Generic Substitution at Retail and Mail.”

3.8 Transition and Termination of Agreements

The Offeror shall ensure that upon termination of the respective Procuring Agencies’ Contracts, any transition to another organization be done in a way that provides Enrollees with uninterrupted access to their Prescription drug benefits and associated customer services through the final termination of the respective Agreements resulting from this RFP. This includes but is not limited to: ensuring Enrollees/Claimants can continue to fill their Prescriptions through network pharmacies, the Mail Service Pharmacy Process and the Specialty Pharmacy Program; the processing of all non-network claims; verification of enrollment; and, providing sufficient staffing to ensure Enrollees continue to receive good customer service even after the termination date of the Agreements resulting from this RFP. It is also imperative that the Programs continue to have dialogue with key personnel of the Offeror, maintain access to online systems and receive data/reports and other information regarding the Programs after the effective end date of the Agreements. In addition, the Offeror and the selected successor shall fully cooperate with the Department and NYSIF to create and establish separate transition plans in a timely manner for each Program.

1. Duties and Responsibilities

a. The Offeror must commit to fully cooperate with the successor contractor to ensure the timely, smooth transfer of information necessary to administer the Programs.

b. The Offeror must, within one hundred twenty (120) Days of the end of the Agreements resulting from this RFP, or within forty-five (45) Days of notification of termination, if the Agreements resulting from this RFP are terminated prior to the end of their term, provide the Procuring Agencies with separate, detailed written plans for transition, which outline, at a minimum, the tasks, milestones and deliverables associated with:

   i. Transition of Program data, including but not limited to a minimum of one year of historical Enrollee claim data, detailed COB data, report formats, Mail Service Pharmacy, Specialty Pharmacy and retail scripts with available refills, prior authorization approved through dates, generic appeal approved through dates and exceptions that have been entered into the adjudication system on behalf of the Enrollee, as well as other data the successor contractor may request and the Procuring Agencies approve during implementation of the Programs in the format acceptable to

the Procuring Agencies.

The transition of open refill prior authorization and generic appeal files should include but not be limited to the following:

1) Providing a test file to the successor contractor in advance of the implementation date to allow the new contractor to address any potential formatting issues.

2) Providing one or more pre-production files at least four (4) weeks prior to implementation that contains Enrollee Prescription refill availability, one year of claims history and prior authorization and appeal approved-through dates as specified by the Procuring Agencies working in conjunction with the successor contractor.

3) Providing a second production file to the new Contractor by the close of business January 2nd (or 2 days after the Agreements resulting from this RFP terminate) that contains all Enrollee Prescription refill availability as specified by the Procuring Agencies, working in conjunction with the selected successor contractor.

4) Providing a lag file due seven (7) Days after the implementation date to capture any refills that may have been in process but not yet shipped at the Offeror's Mail Service and Designated Specialty Pharmacy(ies) after the end of the year.

ii. Transition of Enrollee information on all non-transferable compounds and controlled medications.

c. Within fifteen (15) Business Days from receipt of the Transition Plan, the respective Procuring Agency shall either approve the Transition Plan or notify the Contractor, in writing, of the changes required to the Transition Plan so as to make it acceptable to the Department or NYSIF.

d. Within fifteen (15) Business Days from the contractor's receipt of the required changes, the Contractor shall incorporate said changes into the respective Transition Plan and submit such revised Transition Plan to the Department or NYSIF.

e. The selected Offeror shall be responsible for transitioning the Programs in accordance with the approved Transition Plans.

f. To ensure that the transition to a successor contractor provides

Enrollees with uninterrupted access to their Prescription Drug benefits and associated customer services, and to enable the Department or NYSIF to effectively manage the separate Agreements resulting from this RFP, the Offeror is required to provide the following Contractor-related obligations and deliverables to the Programs through the final financial settlement of the Agreements resulting from this RFP:

i. Provide all Contractor-provided services associated with claims incurred, as applicable to the respective Programs, on or before the scheduled termination date of the Agreements resulting from this RFP, including but not limited to paying network claims, Mail Service Pharmacy claims, Specialty Pharmacy claims, manual submit claims including but not limited to: Medicaid, VA , Skilled Nursing Facility claims, out-of-network claims, foreign claims, in-network claims, COB claims, Student Health Center Claims, and Medicare, reimbursing late filed claims if warranted, reimbursing customer credit balance accounts, resolution of Mail Service Pharmacy process and Specialty Pharmacy Process issues, repaying or recovering monies on behalf of the Program for Medicare claims, retaining NYBEAS access, continuing to provide updates on pending litigation and settlements and claims/rebate data for class action litigation that the Contractor or the NYS Attorney General's Office has/may file on behalf of the Programs. In addition, the Offeror must continue to provide the Procuring Agencies access to any online claims processing data and history and online reporting systems through the final settlement dates, unless the Procuring Agencies notify the Offeror that access may be ended at an earlier date;

ii. Complete all required reports in the reporting Section 3.7 and referenced in Attachment 36, *Program Reporting*, of this RFP;

iii. Provide the Programs with sufficient staffing in order to address State audit requests and reports in a timely manner;

iv. Agree to fully cooperate with all the Department, NYSIF or Office of the State Comptroller (OSC) audits in accordance with the requirements outlined in this RFP;

v. Provide timely reviews and responses to audit findings submitted by the Department, NYSIF and the OSC's audit unit in accordance with the requirements in this RFP; and

vi. Remit reimbursement due the Programs within fifteen (15) days

upon final audit determination consistent with the process specified in Section 8.5, “Audit Authority” and Section 6.15 “Payments/(credits) to/from the contractor” of this RFP and Appendix B (Exclusive to DCS) and Appendix B-2 (Exclusive to NYSIF).

i. **(Exclusive to DCS)** Assist the Department in all activities necessary to ensure the correct and adequate interface between NYSHIP and the Centers for Medicare and Medicaid Services (CMS) with respect to the administration of the EGWP in accordance with Subpart R of 42CFR423 and the Medicare Prescription Drug Improvement and Modernization Act (P.L. 108-173). Such assistance includes but is not limited to the provision of accurate data within the Offeror’s control.

g. The selected Offeror is required to reach separate agreements with the Procuring Agencies that addresses receiving and applying enrollment updates, keeping dedicated phone lines open with adequate available staffing to provide customer service at the same levels provided prior to termination of the Agreements resulting from this RFP, adjusting phone scripts, and transferring calls to the successor contractor’s lines.

h. The selected Offeror is required to transmit point-of-service messaging to their Retail Pharmacy Network upon the termination date of the Agreements resulting from this RFP instructing Pharmacists to submit Enrollee claims to the appropriate RXBIN, RXPCN, RXGRP or other claim identification information as specified by the Department and NYSIF working in conjunction with the selected Offeror.

i. If the selected Offeror does not meet all of the Transition Plan requirements in the time frame stated above, the selected Offeror will permanently forfeit 100% of all Claims Administration Fees (prorated on a daily basis) from the due date of the Transition Plan requirement(s) to the date the Transition Plan requirement(s) are completed to the satisfaction of the Procuring Agencies. The amount shall be calculated by dividing the Claims Administrative Fees for each cycle that includes a day the requirements are not met, by the number of days in that cycle and multiplying the quotient of that calculation by the number of days in the cycle during which the requirement was not met.

3.9 Network Management

The selected Offeror must have a comprehensive nationwide Retail Pharmacy Network in place to allow adequate access for Enrollees to obtain all Covered Drugs

through the Retail Pharmacy Network. Through this RFP, the Programs are seeking a Pharmacy Network that delivers the most aggressive discounts possible, while meeting the minimum guarantees for Network Pharmacy access. In addition, the selected Offeror is required to have a fully functioning Mail Service Pharmacy Process that allows Enrollees to obtain all Covered Drugs and is capable of handling the mail service Prescription volume of the Programs:

A. Retail Pharmacy Network

The current programs include a nationwide retail pharmacy network through which enrollees can obtain all Covered Drugs including any and all drugs that could be classified as specialty drugs, as required by this section. The Procuring Agencies are seeking a broad network for the DCS Commercial, DCS EGWP, and the NYSIF Programs. Therefore, Offerors may not exclude Chain Pharmacies in their Retail Pharmacy Network. In addition, the Offeror must propose a Retail Pharmacy Network that meets or exceeds the Programs' minimum access guarantees at the time of implementation and throughout the term of the contract that is credentialed and contracted for participation in the Programs' Retail Pharmacy Network commencing on the Project Services Start Date. The EGWP must follow all CMS guidelines, including its "Any Willing Pharmacy" requirements. The Offeror may choose to enter into Program-specific Pharmacy contracts that are contingent on award and/or utilize existing Pharmacy agreements that can be made applicable to the Programs to meet the Programs' requirement that the Offeror have executed contracts with all the Network Pharmacies included in the Offeror's Proposed Retail Pharmacy Network File upon the submission date of their Proposal. [**Note:** Because the Procuring Agencies provide significant purchaser volume, the Department and NYSIF expect each Offeror will present a Proposal with network contracts at reimbursement rates more favorable than the Offeror's standard pharmacy contracts.]

- All Brand Drug Retail Pharmacy Network claims shall be charged to the Programs at Pass-through Pricing subject to the Offeror's proposed Guaranteed Minimum Discount off of AWP for all Brand Drugs dispensed, , plus the applicable Guaranteed Maximum Dispensing Fee for Brand Name Drugs plus the Guaranteed Maximum Prescribing Fee, if applicable as set forth in Attachment 83, *Proposed Claim Reimbursement Quote*.

- All Generic Drug Retail Pharmacy Network claims shall be charged to the Program at Pass-through Pricing subject to the Offeror's proposed Guaranteed Minimum Discount off of AWP for all Generic Drugs dispensed, plus the applicable Guaranteed Maximum Dispensing Fee for Generic Drugs plus the Guaranteed Maximum Prescribing Fee, if applicable as set forth in Attachment 83, *Proposed Claim Reimbursement Quote*.

- Retail and Mail Service Pharmacy claims meeting the Programs' definition of Compound Drugs shall be charged to the Programs utilizing Pass-through Pricing in accordance with the Offeror's proposed (and Procuring Agencies' approved) methodology plus the applicable compound dispensing fee.

[**Note:** Do not include any financial/cost information in the Technical Proposal.]

1. <u>Duties and Responsibilities</u>

a. The Offeror must maintain a credentialed and contracted Retail Pharmacy Network that meets or exceeds the Programs' minimum access standards throughout the term of the resultant Agreements.

b. The Programs require that the Offeror have available to Enrollees on the Project Services Start Date its proposed Retail Pharmacy Network in accordance with the requirements set forth in Section 3.2(1)(d) guaranteeing effective implementation of their proposed Retail Pharmacy Network.

c. As required in Section 1.8(8), the Offeror is required to substantially maintain the composition of independent Network Pharmacies in its proposed Retail Pharmacy Network. In developing its proposed Retail Pharmacy Network, the Offeror is expected to have contracts beginning on the Project Services Start Date, and throughout the term of the contract, with independent pharmacies accounting for seventy-five percent (75%) or more of the DCS Programs' prescription drugs dispensed through independent pharmacies, based on the *Informational Claims File for 2022 for DCS and NYSIF* (Attachment 86). The layout specifications for these files are displayed in Attachment 84 (*Layout Specification for DCS Program Informational Claims Data File*) and Attachment 85 (*Layout Specifications for NYSIF Program Informational Claims Data File*), provided such Pharmacies meet the requirements of Pharmacy Credentialing and Pharmacy Contracting of this RFP, and are willing to accept the proposed aggressive reimbursement rates.

d. The Selected Offeror shall include in its Retail Pharmacy Network any Pharmacy(ies) upon the Department's or NYSIF's request, where such inclusion is deemed necessary by the Procuring Agencies to meet the needs of Enrollees even if not otherwise necessary to meet the minimum access guarantees outlined below.

e. The Offeror must effectively communicate the content (including any subsequent changes) and requirements of the Program's Formularies to their Retail Pharmacy Network.

f. Prior to the Project Services Start Date, the Selected Offeror must ensure

that their Network Pharmacies have the correct claim identification information (i.e., RX BIN #, RXPCN, RXGRP, effective date, phone number for questions, etc.) to facilitate accurate claims submission and uninterrupted access for Enrollees.

g. Offerors must establish a process to provide Enrollees with access to Limited Distribution Drugs through the Retail Pharmacy Network.

h. Network Pharmacy Access Guarantee: The Selected Offeror must propose a Retail Pharmacy Network that throughout the term of the Agreements resulting from this RFP meets or exceeds the Procuring Agencies' minimum access guarantees as follows:

   i. Ninety percent (90%) of Enrollees in urban areas will have at least one (1) Network Pharmacy within two (2) miles of an Enrollee's home;

   ii. Ninety percent (90%) of Enrollees in suburban areas will have at least one (1) Network Pharmacy within five (5) miles of an Enrollee's home; and

   iii. Seventy percent (70%) of Enrollees in rural areas will have at least one (1) Network Pharmacy within fifteen (15) miles of an Enrollee's home.

   [**Note**: In calculating whether the Offeror meets the minimum access guarantees, all Enrollees must be counted; no Enrollee may be excluded even if a Pharmacy is not located within the minimum access area.]

   Offerors should provide a guarantee, separately for each of the three Programs (the DCS Commercial Program, the DCS EGWP, and the NYSIF Program), and for each of the three (3) measurements and areas (urban, suburban, and rural). These guarantees are based on the distance, in miles, from a Program Enrollee's home (zip code) to the nearest Network Pharmacy location.

   Urban, suburban and rural are based on U.S. Census Department classifications, as determined by GeoAccess. Offerors may guarantee better access than the minimums, but the access guarantees must follow the same structure as the above minimum (i.e., access guarantees for each of the three (3) areas based on the entire Program population).

B. Pharmacy Credentialing

Offerors must ensure that their Network Pharmacies meet the licensing

standards required by the state in which they operate. Network pharmacies are also required to meet the credentialing criteria established by the Offeror. These criteria should be designed to ensure quality pharmaceutical care.

1. Duties and Responsibilities

a. The Selected Offeror must ensure its Retail Pharmacy Network is credentialed in accordance with all applicable federal and state laws, rules and regulations.

b. The Offeror must credential Pharmacies in a timely manner and shall have an effective process by which to confirm Network Pharmacies continuing compliance with credentialing standards.

c. The Offeror must maintain credentialing records and make them available for review by the Procuring Agencies upon request.

d. The Offeror must have a procedure in place to notify impacted members in writing if a pharmacy they utilize is terminated from the Retail Pharmacy Network and such notification must provide the member with information on the nearest three Retail Pharmacy Network alternatives.

C. Pharmacy Contracting

Contracts with pharmacies should be written to utilize the Programs' market strength to obtain maximum discounts while also ensuring the Programs' access guarantees are met. This should include reimbursement provisions which are lower than the Offeror's standard reimbursement rates for Network Pharmacies. The Contractor's staff should keep abreast of current market conditions and have the wherewithal to adjust contracts with pharmacies to reflect the best interests of the Programs. The Offeror must ensure that all Network Pharmacies contractually agree and comply with the Programs' requirements and benefit design. The Program expects Offerors to negotiate aggressive discounts off of AWP for Brand Drugs and manage a Program MAC List(s) for Generic Drugs dispensed to Enrollees. Contracts should be consistent with and support proposed access guarantees to ensure long-term stability of the Retail Pharmacy Network.

[**Note:** Do not include any financial/cost information in the Technical Proposal.]

1. Duties and Responsibilities

The Offeror will be responsible for providing Pharmacy contracting services including but not limited to:

a. Ensuring that all Network Pharmacies contractually agree to and comply with all of the Programs' requirements and benefit design specifications. In addition, the Contractor shall, pursuant to the terms of this RFP and the resulting Contract, provide any pharmacy network agreement requested for the Programs to evaluate program requirements and benefit design specifications. If Contractor identifies, in writing, the information requested as Contractors' Confidential or Proprietary information access to the information will be provided pursuant to Section 8.7, Contractor's Confidential Information.

b. **(Exclusive to DCS)** Ensuring all Network Pharmacy contracts include a provision prohibiting the use of pharmacy manufacturer coupons that reduce or waive Enrollee Copayments. Manufacturer coupons are also prohibited for use in the Mail Service and Specialty Pharmacies.

c. **(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, *HCAP Providers for the NYS Empire Plan*, of this RFP.

d. Ensuring that Network Pharmacies accept as payment-in-full the Offeror's reimbursement for all claims processed based on the Program's Lesser of Logic as defined in the *Glossary of Defined Terms* (Attachment 15) of this RFP.

e. Notifying the Department and NYSIF in writing of any plan to re-negotiate the financial terms of any Network Pharmacy contract utilized by the Programs for any Pharmacy that is located in the State of New York, or for any such Pharmacy located outside the NYS that accounts for more than 0.25% of total Program final paid claim Ingredient Costs.

f. Notifying the Procuring Agencies in writing within one (1) Business Day of any changes to contracts with Retail Pharmacy Network Chain Pharmacies or independent Pharmacies negotiating collectively with the Offeror, including but not limited to, those identified as participating in the Offeror's proposed network.

g. **(Exclusive to DCS)** Upon the request of the Department, re-soliciting the entire Pharmacy Network to obtain more aggressive reimbursement rates that would pass-through to the Program in exchange for a smaller, select network that meets proposed access guarantees, as modified.

h. Committing to administering Pharmacy contracts consistent with all representations made in the Offeror's financial proposal, including all

representations regarding the administration of Generic Drug pricing and maintenance of MAC list(s).

i. **(Exclusive to NYSIF)** Ensuring there are mechanisms in place to circumvent the referral of bills by participating pharmacies to third-party billers for initial billing and subsequent collection.

D. Pharmacy and Program Audit

The protection of the Programs' assets must be a top priority of the selected Offeror. The selected Offeror must have an experienced and highly credentialed auditing department with experienced, trained and qualified personnel that can fully and efficiently comply with all of the auditing requirements of the awarded Contract and the Programs. In this regard, any audits of the Programs by the Offeror must be overseen by an on-staff licensed Certified Public Accountant (CPA) who has at least ten (10) years of audit experience (or, with the written permission of the Procuring Agencies, a third-party retained by Offeror with the same experience) (the "Audit Leader"). In addition, any personnel working on an audit of the Programs under the Audit Leader must also be accountants and/or auditors with at least three (3) years audit experience and/or similar professionals with the same experience (or, with the written permission of the Procuring Agencies, employees of a third-party retained by Offeror with the same experience).

The Offeror is responsible for the oversight and audit of pharmacies that dispense drugs for Enrollees. Staff should be well-trained and experienced. Claims systems should have logic programmed which help to focus audit resources.

1. Duties and Responsibilities

The selected Offeror must have a staffed and experienced, trained and highly credentialed audit unit employing a comprehensive Pharmacy and Program audit program that includes but is not limited to:

a. Providing ample audit resources including access to the Offeror's online claims processing system and historical claims data files to the Department, NYSIF and OSC at their respective offices through the date of the final financial settlement of the Agreement resulting from this RFP.

b. Providing the Procuring Agencies with 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.

c. Conducting routine and targeted onsite audits of Network Pharmacies, the Mail Service Pharmacy and the Specialty Pharmacy(ies). Audits must be conducted according to a plan agreed to by the Procuring Agencies. Pharmacies that deviate significantly from patterns of dispensing in terms of cost, drug selection, overrides, Days' supply or utilization are to be identified and targeted for on-site and desk audits in accordance with established selection and screening criteria. Onsite audits must also be conducted upon request by the Procuring Agencies, or when information is received by the Offeror that indicates a pattern of conduct by a Pharmacy that is not consistent with the respective Programs design and objectives. Periodic, onsite audits must be conducted at least once during the course of the Contract for Pharmacies that fall into the top fifty (50) in terms of total dollar spend for the Programs or whose average prescription cost exceeds the program average prescription cost by 300%. Any modifications to the proposed Pharmacy audit programs must receive prior approval by the Procuring Agencies.

d. Providing reports to the Procuring Agencies detailing audits planned, audits initiated, audits in progress, audits completed, audit findings, audit recoveries, and any other enforcement action by the Offeror. The Offeror must inform the Procuring Agencies in writing of any allegation or other indication of potential fraud and abuse identified within seven (7) Business Days of such allegations or identification. The Procuring Agencies must be fully informed of all fraud and abuse investigations impacting the Programs upon commencement, regardless of whether the individual fraud and abuse investigation has a material financial impact to the State;

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.

f. Agreement to fully cooperate with all Department, NYSIF and/or OSC audits consistent with the requirements of Appendices A, B, B-1 and C and as set forth in Section 8, Additional Provisions including provision of access to protected health information and all other Confidential Information when required for audit purposes as determined by the Department and/or OSC as appropriate. The Offeror must respond to all State (including OSC) audit requests for information and/or clarification within fifteen (15) Business Days. The Offeror must perform timely reviews and respond in a time period specified by the Department or NYSIF to preliminary findings submitted by the Department, NYSIF or the Comptroller's audit unit in accordance with the "Audit Authority" requirements of Section 8.5. Such audits may include but are not limited

to: mail order claims; Enrollee-submitted paper claims; and on-line Pharmacy claims. Use of statistical sampling of claims and extrapolation of findings resulting from such samples shall be acceptable techniques for identifying claims errors. The Selected Offeror shall facilitate audits of network pharmacies, including onsite audits, as requested by the Department, NYSIF and/or OSC;

g. Remitting 100% of pharmacy audit recoveries to DCS and/or NYSIF as applicable within thirty (30) Days upon final audit determination consistent with the process specified in Section 6.15, "Payments/ (Credits) to/from the Contractor" and Appendix B (Exclusive to DCS) and Appendix B-2 (Exclusive to NYSIF).

h. Utilizing the auditing tools and performance measures proposed by the Offeror to identify fraud and abuse by Network Pharmacies and/or Enrollees.

i. Permitting the Department, NYSIF, or a designated third party to audit pharmacy bills and drug company revenues.

E. Mail Service Pharmacy Process

The current Programs include a Mail Service Pharmacy Process by which Enrollees can obtain all Covered Drugs through the mail including any and all drugs that could be classified as Specialty Drugs or require special preparation or handling for enrollees who do not have the Specialty Pharmacy Program benefit**. To fulfill this requirement, the Offeror may use compounding or specialty pharmacies provided that they meet all Mail Service pricing provisions and service standards with no additional steps or burdens placed on the Enrollee.** Enrollees are entitled to fill Prescriptions for up to a ninety (90) Day supply with refills up to one year. The Mail Service Copay (DCS only) shall apply when the Enrollee utilizes the Mail Service Pharmacy Process to obtain medications. Attachment 54, *Mail Service and Specialty Pharmacy Claims*, of this RFP presents the mail service Prescription volume from January 2021 through December 2022.

1. Duties and Responsibilities

The Offeror must provide all aspects of Mail Service Pharmacy Process. Such responsibility shall include, but not be limited to:

a. Having a fully staffed and fully operational Mail Service Pharmacy Process throughout the term of the resultant Agreements, utilizing one or more Mail Service Pharmacy Process Facilities meeting all New York State legal requirements. 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. Offerors must establish a process to provide Enrollees with access to Limited Distribution Drugs placing no additional steps or burdens on the Enrollee. Prescriptions are considered to be "submitted through the Mail Service Process" if they are submitted by phone, fax, internet, e-prescribing or mail to any Mail Service Pharmacy Process Facility, regardless of how the Prescription is filled. All covered Prescriptions, except for Limited Distribution Drugs, submitted through the Mail Service Pharmacy Process or through a Mail Service Pharmacy Process Facility shall be charged to the Program based on the Offeror's mail service pricing terms and dispensing fees (if any) applicable to Brand Name, Generic, and Compound Drug claims as set forth in Attachment 83, *Proposed Claim Reimbursement Quote*, including Specialty Drugs for certain enrollees. Limited Distribution Drugs submitted through the Mail Service Pharmacy Process shall be charged to the Program based on the Offeror's Retail Network pricing terms and dispensing fees (if any) applicable to Brand Name, Generic and Compound Drug claims as set forth in Attachment 83, *Proposed Claim Reimbursement Quote*. The Mail Service Pharmacy Process shall apply the same Programs' benefit design features as the Network Pharmacies, including but not limited to Mandatory Generic Substitution, DUR, Prior Authorization and Flexible Formulary, and application of appropriate Copayments.

b. Ensuring that all the Procuring Agencies' approved edits including, but not limited to, enforcing utilization edits (e.g., refill too soon, duplicate therapy) are built into the Prescription fulfillment system to protect an Enrollee's safety as well as to control Programs' costs.

c. Ensuring that all Mail Service Pharmacy Process Facilities utilized in the Offeror's Mail Service Pharmacy Process meet all Prescription drug packaging regulatory requirements. Any facility located outside New York State that will provide service for the Program must be registered with the NYS Department of Education and meet all requirements of Section 6808-b of NYS Education Law. The Mail Service Pharmacy Process must recognize the full prescribing authority of Medical Professionals granted by NYS where allowed by state law.

d. Providing a simple, user friendly method(s) of ordering, reordering, or transferring Prescriptions from retail to mail. Maintaining a Dedicated Call Center located in the United States employing a staff of Pharmacists, and a staff of fully trained customer service representatives, and supervisors available 24 hours a Day 365 Days a year that must meet the Offeror's proposed Mail Service Pharmacy Process guarantees set forth in Section 5.10 of this RFP, under the subheading "Mail Service

Pharmacy Process."

i. The Offeror must have an integrated system for customer service staff to utilize to respond to, log and track all Enrollee inquiries. The system must create a record of the Enrollee contacting the call center, the call type and all customer service actions and resolutions.

ii. Customer Service Representatives (CSR) must be trained and capable of responding to a wide range of questions, complaints, and inquiries including but not limited to: Programs' benefit levels, refills, order status, prices and billing, point-of-service issues, prior authorization, eligibility, generic appeals, Mail Service Pharmacy Process, Specialty Pharmacy Process services and complaints and Flexible Formulary alternatives. Callers must be able to reorder and check order status through both the customized website (DCS only) and the consolidated telephone line. Enrollees must also have access to their Prescription drug history file (both retail and mail) via the customized website.

e. Providing pre-addressed, postage-paid mail service envelopes to Enrollees, health benefit administrators and for inclusion in Empire Plan publications, at the request of the State.

f. Having efficient procedures in place to handle routine Prescriptions, "urgent" Prescriptions, and Prescriptions that require "special" handling (i.e., temperature control, limited shelf life, high cost, etc.).

g. Providing standard mail service delivery using packaging that is appropriate for the drug dispensed and the address it is shipped to at no additional cost to the Programs or the Enrollee. Easy open caps also must be provided to Enrollees upon request at no additional cost.

h. Having a system in place to track all Prescriptions (both intervention and nonintervention) received for processing through the Mail Service Pharmacy Process from the date the Prescription is received to the date the mailing agent picks up the package. The Offeror must also be able to track fill accuracy rates.

i. Maintaining a process to collect information necessary to ensure Enrollee safety. The process should collect such information as drug allergies, chronic medical conditions, and other medications taken on a regular basis.

j. Maintaining a system that notifies Enrollees/Claimants about potential health and safety issues with their Prescriptions.

k. Maintaining efficient procedures regarding inventory management of the Mail Service Pharmacy Process Facility(ies) including, but not limited to, backorders, inventories of high-demand drugs, supplies of difficult to obtain drugs, backup supplier contracts, etc..

l. Providing prompt notification to Enrollees regarding out-of-stock items, partial fill orders, and changes to Prescriptions (e.g., approved or required dispensing of Generic Drugs instead of Brand Drugs). In out-of-stock situations, the Offeror must have a system in place to ensure that Prescriptions are filled in the most efficient manner whether it be through an alternate facility(ies) or obtaining a re-stock from a supplier. If necessary, the Offeror shall ~~call~~ contact the Enrollee first to obtain permission to contact their Physician to offer alternative medications, or to offer to return the prescription. This contact may be through a call, email or other secure means. If the Physician authorizes use of an alternative medication, a letter notifying the Enrollee of the change must be sent to the Enrollee before the medication is shipped or must accompany the Prescription.

m. **(Exclusive to DCS)** Calling the prescribing Physician when a DAW-1 is indicated on the Prescription to confirm that the Physician understands the financial impact to the Enrollee and/or the DCS Program to determine if the Physician is willing to allow the generic version of the drug to be dispensed to the Enrollee. If the Physician was previously contacted regarding the same Prescription for a particular Brand Drug for the same Enrollee and required that the Brand Drug be dispensed, no call is required. If the Physician authorizes use of the generic version of the drug, a phone call shall be made to the Enrollee to advise of the approved change before the medication is shipped or the Offeror shall include a letter with the Prescription informing the Enrollee of their Physician's approval. If the Enrollee has indicated on the mail service order form that they do not wish their Physician to be contacted for such determinations, no call shall be made.

n. **(Exclusive to DCS)** 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. The Mail Service Pharmacy Process Facility will not be required to inform Enrollees if there is a consistent history of the acceptance of shipments of the same medication that exceed the maximum amount specified. If the brand name drug is dispensed, the Offeror shall cause the dispensing facility to collect the applicable Brand Drug Copayment plus the calculated Ancillary Charge, if any. Under no circumstances shall the Enrollee's total cost exceed what the actual cost of the Brand Drug

would have been to the Program.

o. **(Exclusive to DCS)** The Offeror is expected to assist Enrollees, upon request, to establish a payment plan so that Prescriptions that are essential to an Enrollee's health will continue to ship when the outstanding amount exceeds the Offeror's proposed maximum limits.

p. Notifying the Procuring Agencies of nationwide out-of-stock issues, including information from the manufacturer or wholesaler regarding the anticipated date that the drug will resume shipment.

q. Utilizing best efforts to complete Physician clarification, verification, or other interventions within the five (5) Business Day service level standard. Should this require more than eight (8) Business Days, the Offeror shall call the Enrollee and offer the Enrollee the option of returning the prescription or continuing the intervention attempt.

r. 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.

s. Providing all necessary clinical and educational support to Enrollees, and/or their family/caregiver utilizing the Mail Service Pharmacy Process, including Enrollees taking injectable, infusion or other drugs requiring special handling or special administration.

t. Having a backup mail order facility(ies) to handle any overflow and/or situations where the primary mail order facility is unavailable.

u. Promoting the utilization of the Mail Service Pharmacy Process through targeted mailings, Physician communications, etc., if the Department determines that such promotions are in the best financial interests of the Programs. All such activities, including mailings, are subject to change and require the prior written approval of the Procuring Agencies. Any regular direct communication with Enrollees or their Physicians in connection with Enrollee drug utilization or the processing of Enrollee claims, either through mail, e-mail, fax or telephone must be submitted for the Procuring Agencies' approval. The cost of any approved promotion shall be borne by the Offeror, unless the Procuring Agencies specifically request a particular activity not required to be performed under the resultant Agreements. The Procuring Agencies will not approve any mail order promotions that it determines will not result in a reduced net cost to the Programs.

v. The Offeror shall, at all times, act in the best interests of the Programs

when dispensing Generic Drugs through the Mail Service Pharmacy Process by avoiding the dispensing of NDCs with higher AWPs unless market conditions exist making dispensing the more cost-effective NDC impractical or impossible.

w. Turnaround Time for Nonintervention Mail Service Prescriptions Guarantee: Offerors must propose, separately for each Program, a Turnaround Time for Nonintervention Mail Service Prescriptions performance guarantee. The Program's service level standard requires at least ninety-five percent (95%) of all nonintervention mail service Prescriptions will be turned around in two (2) Business Days (not including the date of Prescription receipt). Turnaround time is measured from the day after the Prescription is received by the Mail Service Pharmacy to the date the Prescription is received by the mailing agent. For example, a Prescription order received on Monday, January 9, 2023, by the Mail Service Pharmacy, must be received by the mailing agent no later than Thursday, January 12, 2023.

x. Turnaround Time for Intervention Mail Service Prescriptions Guarantee: Offerors must propose, separately for each Program, a Turnaround Time for Intervention Mail Service Prescriptions performance guarantee. The Programs service level standard requires at least ninety-eight percent (98%) of all intervention mail service Prescriptions will be turned around in five (5) Business Days (not including the date of Prescription receipt). Turnaround time is measured from the day after the Prescription is received by the Mail Service Pharmacy to the date the Prescription is received by the mailing agent. For example, a Prescription order received on Monday, January 9, 2023, by the Mail Service Pharmacy, must be received by the mailing agent no later than Tuesday, January 17, 2023.

F. Specialty Drugs

The Programs provide coverage for Medically Necessary Drugs including Specialty Drugs. Specific to the DCS Program, drugs dispensed and billed by a Physician's office or drugs dispensed in a hospital setting are not the responsibility of the DCS Program and are covered under the Medical or Hospital portion of The Empire Plan.

Enrollees in all Employee groups receive Specialty Drugs benefits through the Specialty Pharmacy Program.

Specialty Drugs Received through the Retail Pharmacy Network or the Mail Service Pharmacy Process

For those groups that receive Specialty Drugs through the Retail Pharmacy

Network or the Mail Service Pharmacy Process, the Programs make no distinction for Specialty Drugs for pricing purposes and the Offeror is strictly prohibited from proposing an alternative pricing arrangement for any FDA approved drug or class of drugs. All drugs shall be classified as either Brand, Generic, or Compound for pricing purposes based on the methodologies set forth in Section 6 of this RFP. Proposals that exclude Specialty Drugs from proposed pricing for Brand, Generic and Compound Drugs, whether by omission or by the submission of an alternate pricing proposal will be removed from consideration. The Programs shall be entitled to all manufacturer revenue derived from Specialty Drugs.

1. Duties and Responsibilities

a. The Offeror must provide Enrollees with access to all Medically Necessary Specialty Drugs covered by the Programs through its proposed Retail Pharmacy Network and through the Mail Service Pharmacy Process in accordance with each Enrollee group benefit design as set forth in Attachment 27, *DCS/NYSIF Prescription Drug Program Copayment Matrix.* In the case of Limited Distribution Drugs, the Offeror shall provide Enrollees with access in accordance with the following:

i. ***Retail Pharmacy Network Access***

The Offeror's Retail Pharmacy Discount Guarantees, dispensing fees and prescribing fee(s), if applicable, as proposed in Attachment 83, *Proposed Claim Reimbursement Quote,* shall apply for all Specialty Drug claims dispensed at retail pharmacies. Specialty Drug claims originating at Retail Pharmacies will be included with all claims in the respective Brand or Generic Guaranteed Minimum Discount. The Enrollee shall be charged the applicable retail Copayment

ii. ***Mail Service Pharmacy Process Access***

The Offeror must facilitate the Enrollee's receipt of the Limited Distribution Drug. The Offeror shall secure the participation of the authorized distributor in its Retail Pharmacy Network and bill the Programs consistent with the Offeror's contracted discount off AWP for the Limited Distribution Drug, plus any dispensing fee. The Enrollee shall be charged the applicable mail order Copayment.

b. **(Exclusive to DCS)** Individuals receiving home infusion services through the Home Care Advocacy Program (HCAP), a component of The Empire

Plan's Medical/Surgical Program, have their home infusion drugs covered under the Prescription Drug Program.

Currently the DCS Program has a network of licensed pharmacies affiliated with home care agencies participating in The Empire Plan's HCAP Program administered by The Empire Plan's medical carrier. The Offeror is expected to secure contracts with the licensed pharmacies provided in Attachment 32, *HCAP Providers for the NYS Empire Plan*, of this RFP to ensure continued utilization of a network Prescription drug benefit for those Enrollees utilizing the HCAP Program. An Offeror may propose to utilize entities owned by or affiliated with the Offeror to serve as an HCAP Provider. The Department at its sole discretion shall determine whether it is in the best interests of the DCS Program to allow the entity to participate in the HCAP Program. The Prescription drugs dispensed to Enrollees via the entities or pharmacies owned by or affiliated with the Offeror must be charged to the DCS Program based on the Offeror's mail service pricing terms and dispensing fees applicable to brand name, generic, and Compound Drug claims as proposed in Attachment 83, *Proposed Claim Reimbursement Quote*.

c. **(Exclusive to DCS)** Site of Care Program. Effective July 1, 2023, for ratified unions (see Attachment 29, *Various Empire Plan Publications*, for State/CSEA contract language on this program) a Site of Care Redirection Program will be implemented for the infusion of Remicade and its biosimilars. Effective January 1, 2024, the Program may expand to include all infused drugs as determined by the Hospital Program, with the exception of drugs used to treat cancer and hemophilia. Upon implementation, the Department will inform the vendor of the ratified unions covered by the Site of Care Program. Prescription drug Copayments associated with infusions under the Program will be waived and there will be no additional Prior Authorizations required when the enrollee uses a non-hospital infusion site of care.

G. Specialty Pharmacy Program

All DCS Program Employee groups and NYSIF Claimants participate in the Specialty Pharmacy Program, which provides an enhanced level of clinical management for Enrollees taking Specialty Drugs. Under the current plan design, an Enrollee/Claimant is allowed to have a Grace Fill of certain Specialty Drugs dispensed from any available Pharmacy. However, Specialty Drugs identified for short-term therapy for which a delay in starting therapy would not affect clinical outcomes are not eligible for this Grace Fill benefit and must be filled through the Designated Specialty Pharmacy. After the first Specialty Drug Prescription is filled through either the Retail or Mail Service Pharmacy, future fills are subject to a Hard Edit (DCS only), meaning that Enrollees/Claimants are required to obtain the drug through the Specialty Pharmacy Process,

subject to the mail service Copayment (DCS only) when dispensed by the designated Specialty Pharmacy. This requirement does not apply to enrollees in the Empire Plan Medicare Rx program.

In addition to a Grace Fill at Retail, certain Specialty Drugs available through the Specialty Pharmacy Program, as well as all Specialty Medications covered under the NYSIF Program, are also available through the Retail Pharmacy Network because of their clinical requirements and/or urgent dispensing timeframe or NYS laws and regulations. All drugs filled at a Retail Pharmacy Network are subject to the Retail Network Pharmacy Pass-through Pricing and Copayments (DCS only). For those drugs available only through the Specialty Pharmacy Program, the Offeror may propose dispensing fees on a drug-by-drug basis, commensurate with the clinical services provided for each. All drugs shall be classified as either Brand, Generic, or Compound for pricing purposes based on the classification methodologies set forth in Section 6 of this RFP. The Programs shall be entitled to all manufacturer revenue derived from Specialty Drugs.

Drugs to be included in the Specialty Pharmacy Program, Specialty Drugs/ Medications are:

- "orphan drugs;"
- drugs requiring special handling, special administration and/or intensive Enrollee monitoring/testing;
- biotech drugs developed from human cell proteins and DNA, targeted to treat disease at the cellular level; or,
- other drugs identified by the Programs as used to treat Enrollees with chronic or life-threatening diseases.

The Offeror must provide a Special Pharmacy Program where Members/Claimants receive their Specialty Drugs through one or more designated pharmacies that offer enhanced clinical management. The process must provide extensive clinical support in the most cost-effective manner possible for the Programs.

1. Duties and Responsibilities

The Offeror must provide all aspects of the Specialty Pharmacy Program. Such responsibility must include, but not be limited to:

a. Developing a listing of the Specialty Drugs proposed for inclusion in the Specialty Pharmacy Program.

b. Having a fully staffed and fully operational Specialty Pharmacy Program in which Specialty Drugs are provided by one or more Designated Specialty Pharmacies. All Designated Specialty Pharmacies must meet all New York State legal requirements. Any facility located outside New York State that will provide service for the Programs must be registered with the NYS Department of Education and meet all requirements of Section 6808-b of NYS Education Law. The Specialty Pharmacy Process must recognize the full prescribing authority of Medical Professionals granted by NYS where allowed by state law.

c. The Offeror must establish a process to provide Enrollees with access to Limited Distribution Drugs not available through the Designated Specialty Pharmacy(ies), which places no additional steps or burdens on the Enrollee. The Offeror shall secure the participation of the authorized distributor in its Retail Pharmacy Network and bill the Programs consistent with the Offeror's contracted discount off AWP for the Limited Distribution Drug, plus any dispensing fee. The Enrollee shall be charged the applicable retail Copayment.

d. Providing a fully staffed and fully operational customer support call center available to Enrollees 24 hours a Day, 365 Days a year including Pharmacists, clinicians, and registered nurses trained in an Enrollee's specific Specialty Drug therapies. The Offeror must provide callers with access to customer service staff and Pharmacists through The Empire Plan consolidated line and the NYSIF Program toll-free line who are able to respond timely to questions, complaints and inquiries including but not limited to: Programs' benefit inquiries, refills, order status, price estimates, billing, point-of-service issues, Specialty Pharmacy Process complaints, preferred drug status, and claim status. Callers must be able to reorder and check order status through both the customized website (DCS only) and the Programs' telephone lines. Enrollees must also have real-time web access to their Prescription drug history file (retail, mail, and specialty) via a customized website (DCS only).

e. Administering a safety monitoring system that complies with the Food and Drug Administration (FDA) Amendments Act of 2007 which requires a Risk Evaluation and Mitigation Strategy (REMS) from the Specialty Drugs manufacturers for certain drugs to ensure the benefits of a drug outweigh its risks.

f. **(Exclusive to DCS)** Contracting a nationwide network of appropriately licensed clinicians and/or coordinating with appropriately trained HCAP clinicians to administer the Specialty Drugs to Enrollees in a home setting and providing Enrollees with education on proper treatment regimens and possible side effects.

g. **(Exclusive to DCS)** Site of Care Program. Effective July 1, 2023, for ratified unions (see Attachment 29, *Various Empire Plan Publications*, for State/CSEA contract language on this program) a Site of Care Redirection Program will be implemented for the infusion of Remicade and its biosimilars. Effective January 1, 2024, the Program may expand to include all infused drugs as determined by the Hospital Program, with the exception of drugs used to treat cancer and hemophilia. Upon implementation, the Department will inform the vendor of the ratified unions covered by the Site of Care Program. Prescription drug Copayments associated with infusions under the Program will be waived and there will be no additional Prior Authorizations required when the enrollee uses a non-hospital infusion site of care.

h. Completing Physician consultation, coordination of care, patient care management and other interventions on a clinically appropriate and timely basis.

i. Providing all necessary clinical and educational support to Enrollees, and/or their family/caregiver utilizing the Specialty Pharmacy Process, including but not limited to explaining the treatment plan and ancillary supplies, disease/drug education, side- effect management, compliance management and administration training.

j. **(Exclusive to DCS)** Applying the same Programs' benefit design features as the Mail Service Pharmacy Process, including but not limited to Mandatory Generic Substitution, DUR, Prior Authorization and application of appropriate Copayments. Specialty Drugs that are subject to the Designated Specialty Pharmacy Passive Edit and are dispensed at a Network Pharmacy must be subject to the Network Pharmacy Copayments.

k. Ensuring that all the Procuring Agencies' approved edits including, but not limited to, enforcing utilization edits (e.g., refill too soon, duplicate therapy) are built into the Prescription fulfillment process system to protect Enrollees' safety as well as to control Programs' costs.

l. Ensuring that all Designated Specialty Pharmacies utilized in the Offeror's Specialty Pharmacy Program meet all Prescription drug packaging regulatory requirements. The Offeror must ensure that Specialty Drugs/ Medications are shipped to Enrollees in appropriate packing materials so that Specialty Drugs are safe and effective and delivered on time.

m. Providing a simple, user-friendly method(s) of ordering, reordering, and

transferring Prescriptions from the retail and mail setting to the Designated Specialty Pharmacy(ies) including pre-addressed postage paid Specialty Pharmacy Program envelopes. The Offeror must send a Specialty Pharmacy Program letter to Enrollees, subject to review and approval by DCS, who have received a Grace Fill of a Specialty Drug through a Network Pharmacy. The letters must be sent within seven (7) Days of the Prescription being filled to Enrollees who have received a Specialty Drug subject to the Designated Specialty Pharmacy Hard Edit (DCS Only) and within thirty (30) Days of the Prescription being filled to Enrollees who have received a Specialty Drug subject to the Designated Specialty Pharmacy Passive Edit. Enrollees are allowed one Grace Fill for Specialty Drugs, except Specialty Drugs identified as being for short-term therapy for which a delay in starting therapy would not affect clinical outcome are not eligible for a Grace Fill.

n. Maintaining a comprehensive system for the Offeror's staff to utilize to track all Enrollee inquiries including, but not limited to: Programs' benefits, refills, order and claim status, prices, billing, Flexible and Advanced Flexible Formulary inquiries and Specialty Pharmacy Process complaints. The system shall include call type, customer service actions, and resolutions.

o. Having a system in place to track all Prescriptions received for processing through the Specialty Pharmacy Process from the date the Prescription is received to the date the Prescription is shipped. The Offeror must also be able to track fill accuracy rates.

p. Maintaining a process to collect information from individuals necessary to ensure Enrollee safety. The process should collect such information as drug allergies, chronic medical conditions, and other medications taken on a regular basis.

q. Ensuring that the Designated Specialty Pharmacy(ies) have efficient procedures regarding inventory management including, but not limited to, backorders, inventories of high demand drugs, supplies of difficult to obtain drugs, backup supplier contracts, etc..

r. Providing notification to Enrollees as soon as possible for out-of-stock items, partial fill orders, and changes to Prescriptions (e.g., dosing or method of administration). In out-of-stock situations, the Offeror must have a system in place to ensure that Prescriptions are filled in the most efficient manner whether it be through an alternate facility(ies) or obtaining a re-stock from a supplier. The Offeror must contact the Enrollee's Physician, if necessary, to offer alternative medications or offer to return the Prescription. If the Physician authorizes use of an alternative medication, a letter notifying the Enrollee of the change must

be sent to the Enrollee before the medication is shipped or must accompany the Prescription.

s. **(Exclusive to DCS)** Informing the Enrollee prior to shipping if the total amount for a new Prescription order submitted through the Specialty 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. The Designated Specialty Pharmacy will not be required to inform an Enrollee if there is a consistent history of the acceptance of shipments of the same medication that exceed the $100 amount specified.

t. **(Exclusive to DCS)** The Offeror is expected to assist Enrollees, upon request, to establish a payment plan so that Specialty Drug Prescriptions that are essential to an Enrollee's health will continue to ship when the outstanding amount exceeds the Offeror's proposed maximum limits.

u. Promptly notifying the State of nationwide out of stock issues, including information from the manufacturer or wholesaler regarding the anticipated date that the drug will resume shipment.

v. Having backup Designated Specialty Pharmacies to handle any overflow and/or situations where the primary Specialty Program facility is unavailable.

w. **(Exclusive to DCS)** The mail order Copayment shall apply to all drugs dispensed through the Specialty Pharmacy Program as well as Limited Distribution Drugs facilitated through the Specialty Pharmacy Program.

x. Recommending newly launched Specialty Drugs for inclusion in the Specialty Pharmacy Program based on the established criteria/definition of Specialty Drug, in a format to be approved by the Procuring Agencies (see Attachment 36, *Program Reporting*, for a Brief Description, which includes providing the PBM's actual Specialty Acquisition Cost). If Contractor identifies in writing the information requested as Contractors' Confidential or Proprietary information access to the information will be provided pursuant to Section 8.7, Contractor's Confidential Information.

y. Prior to inclusion in the Programs, or if not accepted by the Procuring Agencies to be included in the Programs, the Offeror must bill the Programs for these Prescriptions consistent with Attachment 83, *Proposed Claim Reimbursement Quote*, based on where each Prescription was actually dispensed. Inclusion of new Specialty Drugs shall have a cost-neutral or positive financial impact on the Programs,, and in no case shall the Ingredient Cost of a newly added Specialty Drug charged to the

Programs exceed the lowest of: (a) the Guaranteed Minimum Discount off of Aggregate AWP for Specialty Drugs proposed by the Offeror in as provided in Attachment 83, *Proposed Claim Reimbursement Quote*, plus Guaranteed Dispensing Fee as provided in Attachment 89, *Specialty Pharmacy Program Dispensing Fees*; (b) MAC plus Guaranteed Dispensing Fee as provided in Attachment 89, *Specialty Pharmacy Program Dispensing Fees*; or (c) WAC plus Guaranteed Dispensing Fee as provided in Attachment 89, *Specialty Pharmacy Program Dispensing Fees*. The 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.

H. Vaccination Network (Exclusive to DCS)

The Department has implemented an immunization program in which members can receive preventive vaccines in accordance with the Advisory Committee on Immunization Practices (ACIP) recommendations, at pharmacies that participate in the Offeror's Vaccination Network thereby allowing improved access to preventive vaccines, including all seasonal and non-seasonal vaccines that are permitted by NYS law or under federal guidelines to be administered by a licensed pharmacist or, when authorized by applicable law or regulation, a pharmacy intern. ACIP-recommended vaccinations administered at a vaccination network pharmacy will be covered at no cost to Members, subject to applicable age guidelines (e.g., the Herpes Zoster Shingrix vaccine is covered for Enrollees age 19 and over at a $0 copay). The COVID-19 vaccine is also available at $0 copay. The vaccine benefit will be extended to non-Medicare primary enrollees and Dependents in The Empire Plan, Excelsior Plan and Student Employee Health Plan, as Medicare primary enrollees already have coverage for these vaccines in a pharmacy setting under either Medicare Part B or D.

1. Duties and Responsibilities

The Offeror will arrange for provision of vaccine services permitted by applicable DCS Law, through the Offeror's Vaccination Network, for non-Medicare primary enrollees to obtain seasonal and non-seasonal preventive vaccinations, including the COVID-19 vaccine and booster, when administered by a licensed pharmacist or, when authorized by applicable law or regulation, a pharmacy intern.

The Vaccination Network will provide:

a. Seasonal Vaccines (influenza)

b. Non-Seasonal Vaccines. Non-Seasonal Vaccines (vaccines for viruses other than influenza) will be in effect until superseded or revoked by the Department through written notice to the Contractor during the term of the Agreement that results from this RFP.

c. COVID-19 Vaccines and Boosters (vaccines and boosters for COVID-19 are covered without Copayment).

3.10 Claims Processing

The Offeror is required to process all claims submitted under the Programs. The Selected Offeror must be capable of processing, as applicable to the respective Programs, Network Pharmacy claims and claims for scripts filled through the Mail Service Pharmacy Process and/or the Specialty Pharmacy(ies) for all Covered Drugs including Specialty Drug Claims. The Offeror must also process manual submit claims including but not limited to Medicaid, VA, Skilled Nursing Facility claims, out-of-network claims, foreign claims, in network manual claims and COB including Medicare B primary claims and Student Health Center claims. Claims for all Covered Drugs adjudicated at a chain and independent Retail Pharmacy Network Pharmacies and through the Mail Service Pharmacy Process and Specialty Pharmacy(ies) must be processed according to the applicable benefit design and contracted arrangements in place.

The Offeror's claims processing system shall include controls to identify questionable claims, prevent inappropriate payments, and ensure accurate reimbursement of claims in accordance with the applicable benefit design, Programs' provisions and negotiated agreements with pharmacies. All Program provisions for drug utilization review, benefit design and other utilization or clinical management programs must be adhered to for all prescriptions.

Enrollee Submitted Claims (DCS Only) on the Commercial Plan 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. Enrollee Submitted Claims (DCS Only) on the EGWP must follow CMS rules, which allow for submission within thirty-six (36) months from the Date of Service. The DCS Program count of Enrollee Submitted Claims can be found in Attachment 73, *2020-2022 Incurred Claims by Month - Combined,* of this RFP.

1. Duties and Responsibilities

a. The Offeror must provide all aspects of claims processing. Such responsibility shall include, but not be limited to:

i. Verifying that the Programs benefit designs have been loaded into the system appropriately to adjudicate and calculate cost sharing and other edits correctly.

ii. Accurate and timely processing of all claims submitted under the Programs in accordance with the benefit design applicable to the Enrollee at the time the claim was incurred as specified to the Offeror by the Procuring Agencies.

iii. Charging the Programs consistent with the Offeror's Financial Proposal.

iv. Developing and maintaining claim payment procedures, guidelines, and system edits that guarantee accuracy of claim payments for covered expenses only, utilizing all edits as proposed and approved by the Procuring Agencies. The Offeror shall utilize Refill Too Soon edits and duplication of therapy edits for all claims unless exceptions are specifically approved in advance by the Procuring Agencies. The Offeror's system must ensure that refilling Prescriptions prior to use of the minimum prescribed Day's supply does not result in over-dispensing.

v. Managing Flexible Formulary, Advanced Flexible Formulary and Empire Plan Medicare Rx placement of drugs consistent with the Programs' design and ensuring application of appropriate Copayments based on level assignment (Copayments do not apply to NYSIF's Program).

vi. Maintaining claims histories for 24 months online and archiving older claim histories for 6 years and the balance of the calendar year in which they were made with procedures to easily retrieve and load claim records.

vii. Maintaining the security of the claim files and ensuring HIPAA compliance.

viii. Reversing all attributes of claim records, e.g., AWP, quantity, Days' supply, etc., processed in error including the reversal of any Claims Administration Fee associated with the original claim and crediting the Programs for all costs associated with the claim processed in error including but not limited to the Claims Administration Fee.

ix. Agreeing that all claims data is the property of the State. Upon the request of the Department, the Offeror shall share appropriate claims data with other DCS Program carriers and consultants for various programs (e.g., Disease Management, Centers of

Excellence) and the Department's DSS vendor (DCS only). The Offeror cannot share, sell, release, or make the data available to third parties in any manner without the prior consent of the Procuring Agencies. The Procuring Agencies understand that the Selected Offeror will be required to share certain claims data with pharmaceutical manufacturers for purposes of obtaining for the Programs all Pharma Revenue due it under the Agreements resulting from this RFP. The Offeror shall inform the Procuring Agencies of the types of data being shared for these specific authorized purposes.

x. Maintaining a backup system and disaster recovery system for processing claims, which are compliant with the information security requirements set forth in *Information Security Requirements* (Appendix C, Exclusive to DCS), and *NYSIF Vendor Security Survey* (Appendix B-3, Exclusive to NYSIF) in the event that the primary claims payment system fails or is not accessible.

xi. Maintaining a claims processing system capable of integrating and enforcing the various utilization review components of the Programs, including, but not limited to: Mandatory Generic Substitution, Prior Authorization, messaging capability in the current NCPDP format, and a concurrent DUR program to aid the Pharmacist at the point of sale.

xii. Maintaining an electronic claims processing system capable of obtaining information from Network Pharmacies to ensure consistent enforcement of the Programs mandatory generic substitution provisions. In particular, the claims processing system must be capable of capturing information concerning the availability of the generic at the Pharmacy submitting the electronic claim. If a Generic Drug is available to be dispensed by the Retail Pharmacy Network, the Program's mandatory generic substitution rules shall be applied. If the Network Pharmacy does not have the A-rated or authorized generic in stock, mandatory generic substitution provisions will not apply and the Enrollee shall receive the Brand Drug, be charged the applicable generic Copayment (DCS only) and the Program charged based on generic pricing. The claims processing system shall reject claims for Brand Drugs subject to mandatory generic substitution that are submitted with a DAW-0 code with appropriate messaging and requires resubmission of the claim since a DAW-0 code provides no indication of Generic Drug availability in the Pharmacy. The Programs' logic for the Pharmacy Submitted DAW codes is listed below:

Pharmacy Submitted DAW	Enrollee Copay	Ancillary Charge	Pricing
0*	Brand	No	Brand
1	Brand	Yes	Generic
2	Brand	Yes	Generic
3	Generic	No	Generic
4	Generic	No	Generic
5	Generic	No	Generic
6	Generic	No	Generic
7	Brand	No	Brand
8	Generic	No	Generic
9	Generic	No	Generic

*Logic applies unless the claim is rejected pursuant to this section.

xiii. Maintaining a claims processing system capable of ensuring that claims are consistently processed with the appropriate brand name/generic/ compound classification in accordance with the requirements set forth in Section 6.4.

xiv. Maintaining a Programs' MAC List(s) for Pharmacies.

xv. Ensuring the claims processing system is capable of implementing and/or complying with the Programs' "Lesser of Logic".

xvi. **(Exclusive to DCS)** Processing Enrollee Submitted Claims in accordance with the following:

1) For Prescriptions filled with a Brand Drug with no generic equivalent, the Enrollee will be reimbursed using the Offeror's Guarantee Minimum Discount off of Aggregate AWP for the Retail Pharmacy Network plus dispensing fee and prescribing fee, if applicable, for Brand Drugs not to exceed the submitted charges, less the applicable Copayment;

2) For Prescriptions filled with a Brand Drug that has a generic equivalent, the Enrollee will be reimbursed up to the amount the DCS Program would reimburse the Retail Pharmacy Network for filling the Prescription with that drug's generic equivalent; not to exceed the submitted charges, less the applicable Copayment;

3) For Prescriptions filled with a Generic Drug the Enrollee will be reimbursed up to the amount the DCS Program would

reimburse the Retail Pharmacy Network for that Prescription, not to exceed the submitted charges, less the applicable Copayment;

4) For Prescriptions filled with a Compound Drug the Enrollee will be reimbursed up to the amount the DCS Program would reimburse the Retail Pharmacy Network for that Prescription, not to exceed the submitted charges, less the applicable Copayment; and

5) If the Enrollee has two Empire Plan coverages, the DCS Program will reimburse 100% of the copay. For specific methodology on how the DCS Program must be charged for Enrollee Submitted Claims, see Section 6.8. of this RFP entitled "Enrollee Submitted Claims."

xvii. **(Exclusive to NYSIF)** Processing Non-Network Pharmacy claims submitted to the Offeror as paper bills in accordance with Chapter V of title 12 NYCRR and Attachment 67, *NYSIF Paper Bills*, of this RFP.

xviii. **(Exclusive to DCS)** Processing claims for Employees enrolled in the SEHP who fill Prescriptions at SUNY pharmacies. These pharmacies are required to adhere to the retail network contract and prescriptions under this arrangement must be dispensed according to the Plan design for the SEHP (see Attachment 27, DCS/NYSIF Prescription Drug Program Copayment Matrix), including required prior authorizations and Days' supply limits.

xix. Processing all manually submitted claims including but not limited to Medicaid, VA, Skilled Nursing Facility claims, out-of-network claims (DCS and NYSIF), foreign claims, in-network manual claims, COB claims, and Medicare Part B primary claims in accordance with the Offeror's proposed Claims Adjudication Guarantee; NYSIF claims must also be processed in accordance with Chapter V of title 12 NYCRR and Attachment 67, *NYSIF Paper Bills*, of this RFP.

xx. Analyzing and monitoring claim submissions to promptly identify errors, fraud and abuse and reporting to the State such information in a timely fashion in accordance with a State approved process. The Programs shall be charged only for accurate (i.e., the correct dollar amount) claims payments of covered expenses. The Programs will be charged a Claims Administration Fee only for Final Paid Claims. The Offeror shall credit the Programs the amount of any overpayment regardless of whether any overpayments are recovered from the Pharmacy and/or Enrollee in

instances where a claim is paid in error due to Offeror error, or due to fraud or abuse, without additional administrative charge to the Programs. The Offeror shall report fraud and abuse to the appropriate authorities. In cases of overpayments resulting from errors only found to be the responsibility of the State, the Offeror shall use reasonable efforts to recover any overpayments and credit 100% of any recoveries to the Programs upon receipt; however, the Offeror is not responsible to credit amounts that are not recovered.

xxi. Establishing a process where Pharmacies can verify eligibility of Enrollees and Dependents during Call Center Hours.

xxii. Requiring network pharmacies to submit to the Offeror for each drug dispensed the Pharmacy's Submitted Cost to ensure that the Programs are charged according to the Programs' Lesser of Logic. Further, if an Ancillary Charge (applicable only to DCS) is applied, it will be deducted from the total claim cost.

xxiii. **(Exclusive to DCS)** Identifying Enrollees enrolled in Medicare Part D. The Offeror's claims processing system must decline claims at the point of service for Enrollees who are enrolled in a Medicare Part D Plan other than the DCS Program EGWP. Messaging to the Pharmacy must instruct the Pharmacist to submit the claim to the Enrollee's Medicare Part D Plan.

xxiv. **(Exclusive to DCS)** Establishing a process to support and respond to Federal Medicare Part D audits.

xxv. Having a process in place (fully staffed with ample telephone trunks) available 24 hours a Day, 7 Days a week where a Pharmacist can call to quickly resolve point-of-service issues.

xxvi. **(Exclusive to DCS)** In instances where a member is covered under two (2) separate Empire Plan policies (Dual Empire Plan Coverage), the Offeror must reimburse one hundred percent of the copay, regardless of the type of Empire Plan coverage (e.g., Medicare Part D versus Empire Plan Commercial Coverage).

b. Claims Processing Guarantees: The Offeror must provide for the following four program service level standards:

i. Program Claims Processing System Availability Guarantee: The Offeror must propose separate performance guarantees for the respective Programs. The Programs service level standard

requires that the claims processing system will be available at least ninety-nine and five-tenths percent (99.5%) of the time excluding periods of scheduled down time, which shall be reported to the Department in advance and kept to a minimum, based on a 24 hours a Day, 7 Days a week availability, calculated on a quarterly basis.

ii. Program Claims Processing System Accuracy Guarantee: The Offeror must propose separate performance guarantees for the respective Programs. The Programs service level standard requires that the claims processing system will accurately process claims at the point of service in accordance with the Program's benefit design at least ninety-nine and five-tenths percent (99.5%) of the time excluding periods of scheduled down time, which shall be reported to the Department in advance and kept to a minimum, based on a 24 hours a Day, 7 Days a week availability, calculated on a quarterly basis.

iii. **(Exclusive to DCS)** Turnaround Time for Claims Adjudication Guarantee: The Offeror must propose a performance guarantee. The Programs service level standard requires that ninety-nine and five-tenths percent (99.5%) of Enrollee Submitted Claims that require no additional information in order to be properly adjudicated that are received by the contractor will be turned around within ten (10) Business Days of receipt. Turnaround time is measured from the date the Enrollee-submitted claim is received in the Offeror's Program designated Post Office Box to the date the Explanation of Benefits is received by the mailing agent.

iv. **(Exclusive to NYSIF)** Turnaround Time for Claims Adjudication Guarantee: The Offeror must propose a performance guarantee. The NYSIF Program's service level standard requires that ninety-nine and five-tenths percent (99.5%) of Non-Network Pharmacy submitted claims that require no additional information in order to be properly adjudicated that are received by the contractor will be turned around within thirty (30) Calendar Days of receipt. Turnaround time is measured from the date the Non-Network Pharmacy submitted claim is received in the Offeror's Program designated Post Office Box to the date the Explanation of Benefits is received by the mailing agent.

3.11 Retrospective Coordination of Benefits (Exclusive to DCS)

The Selected Offeror must be capable of administering a retrospective coordination of

benefits (COB) recovery program. Data from the last two years of this program is provided in Attachment 95, *Retrospective Coordination of Benefits (COB).* The DCS Program's current COB process is administered on a retrospective basis. A claim is not stopped at the point of service nor is there any current plan to have Prescriptions stopped at the point of service to verify COB coverage unless it is indicated that the Enrollee has enrolled in a Medicare Part D Plan other than the DCS Program EGWP. The DCS Program allows members to receive Prescriptions and have the Selected Offeror seek COB recoveries after the Prescription is dispensed.

1. Duties and Responsibilities

a. The Selected Offeror is required to pursue collection of any money due the DCS Program from other payers or Enrollees who have primary Prescription drug coverage through another carrier and to credit the DCS Program's account one hundred percent (100%) of all recoveries within fifteen (15) Days after the end of the month.

b. The Selected Offeror must maintain a system capable of receiving a historical COB data file from the current contractor and benefits information obtained from Enrollee surveys. The Offeror's system must be capable of tracking the date an initial letter is sent to the Enrollee or other carrier until the point money is recovered.

c. The Selected Offeror must develop for Department review and approval COB correspondence including, but not limited to; an Enrollee questionnaire to confirm other Prescription drug coverage information, a letter(s) instructing Enrollees to file for reimbursement from the primary plan and advising that the Enrollee must reimburse the DCS Program for the cost of their claims and a collection letter(s) to other carriers who owe the DCS Program reimbursement.

d. The Selected Offeror must have a system in place to facilitate collection, without Enrollee intervention, when the primary plan claims adjudicator is the same as the Selected Offeror.

[**Note:** Offerors may choose to enter into a Key Subcontract for the provision of these services; however, the cost of this service must be included in the Offeror's proposed Claims Administration Fee with all gross recoveries credited to the DCS Program (no carve-out of Key Subcontractor fees will be permitted). The Department will not allow any alternative fee arrangement in this regard.]

3.12 Utilization Management

A. Mandatory Generic Substitution at Retail and Mail

Appropriate utilization of cost-effective clinically equivalent Generic Drugs is an integral component of the Programs benefit design. To promote the use of Generic Drugs, the Programs have a mandatory generic substitution requirement that mandates that FDA approved generic equivalents be substituted for the equivalent Brand Drug or the Enrollee pays the Non-Preferred Brand Drug Copayment plus an Ancillary Charge (DCS only) equal to the difference in the Ingredient Cost of the Brand Drug and the Ingredient Cost of the Generic equivalent, not to exceed the cost of the drug, unless otherwise directed by the Department. Mandatory generic substitution will be applied to all specific NDCs of Brand Drugs for which there is an FDA-approved A-rated Generic Drug (including but not limited to, Generic Drugs rated AA, AB, AN, AO, AT, etc.) or an authorized Generic Drug, as permissible by NYS law. Network Pharmacies shall comply with all state laws related to mandatory generic substitution. The Programs' mandatory generic substitution provisions shall apply to any claim where the A-rated or authorized Generic drug is required or permitted to be substituted under state law. Mandatory generic substitution provisions will not apply to B-rated or unrated Generic drugs or in the unlikely event that state law prohibits dispensing of the A-rated or authorized Generic Drug.

Mandatory generic substitution provisions shall apply if a Physician writes a Prescription with a Dispense as Written (DAW) code for a Brand Drug that has an A-rated or authorized Generic Drug available. The Enrollee should be informed that an Ancillary Charge (DCS only) will be applied and the Pharmacist should offer to contact the prescribing Physician for approval to dispense the Generic Drug. Enrollees who receive a multi-source Brand Name drug because of a DAW notation are still required to pay both the applicable Brand Drug Copayment and the Ancillary Charge (DCS only). Mandatory generic substitution does not apply to the strength of a particular drug for which there is no approved Generic Drug.

The Department's Program currently has the following exceptions to the mandatory generic substitution requirement: Coumadin, Dilantin, Lanoxin, Levothroid, Mysoline, Premarin, Synthroid, Tegretol and Tegretol XR. Because the drugs are exceptions to the mandatory generic substitution requirement, no Ancillary Charge can be imposed. The drug placement on the Offeror's proposed Drug List will determine the Copayment (DCS only) for these drugs subject to the Program's benefit design which requires that a Brand Drug with a Generic equivalent be placed on the third level of the Flexible or Advanced Flexible Formulary. An appeal cannot change the level status of these drugs on the Offeror's proposed Formulary.

1. Duties and Responsibilities

To ensure strict adherence to the Program's Mandatory Generic Substitution Requirement and to ensure that the Programs are provided to Enrollees and the Procuring Agencies at the lowest cost, the Offeror is required to:

a. Unless otherwise directed by the Procuring Agencies, apply mandatory generic substitution to all specific NDC's of Brand Drugs for which there is an FDA-approved A-rated Generic Drug (including but not limited to, Generic Drugs rated AA, AB, AN, AO, AT, etc.) or an authorized Generic Drug as permissible by NYS law. Network Pharmacies shall comply with all state laws related to mandatory generic substitution. The Programs' mandatory generic substitution provisions shall apply to any claim where the A-rated or authorized Generic Drug is required or permitted to be substituted under state law. Mandatory generic substitution provisions will not apply to B-rated or unrated Generic Drugs or in the unlikely event that state law prohibits dispensing of the A-rated or authorized Generic Drug.

b. **(Exclusive to DCS)** Establish the Ancillary Charge by calculating the difference in the Discounted Ingredient Cost of the Brand Drug and the Ingredient Cost of the equivalent A-rated Generic Drug or authorized Generic Drug based on the Programs' MAC List price assigned when a Brand Drug for which an A-rated or authorized Generic Drug has been introduced in the market is dispensed to the Enrollee. In such cases, the Enrollee shall be responsible for paying the applicable Non-Preferred Brand Drug Copayment plus Ancillary Charge not to exceed the cost of the drug to the Programs. The Ancillary Charge shall be assessed even in the event a Physician has specifically directed a Pharmacist to dispense the Brand Drug rather than the A- rated or authorized Generic Drug through DAW notation.

c. Monitor the pharmaceutical industry on behalf of the Department to identify Generic Drugs expected to enter the market. Prior to the actual introduction of the Generic Drug to market, the Offeror shall inform the Department of anticipated shipping dates of the first Generic Drug introduced into the market for one or more strengths of a particular Brand Drug.

d. **(Exclusive to DCS)** Following the first shipment of a first Generic Drug for one or more strengths of a particular Brand Drug, the Offeror is required to:

    i. Inform the Department as soon as practicable but in no event later than 14 Days ,during Business Hours, after the first date of shipment, (from manufacturer to wholesaler or retailer) of the financial impact of enforcing mandatory generic substitution via

the “MAC Alert Notice” detailed in Section 3.7. of this RFP, under the subheading “Reports Required at Other Frequencies;”

ii. For those drugs that will result in a lower net cost to the Program by enforcing mandatory generic substitution, the Offeror shall provide the “MAC Alert Notice” referenced in (i) above. The Offeror shall add the GPI to the Programs’ MAC List(s) and begin enforcement as soon as practicable but in no event later than 14 Days after the first date of shipment provided that the majority of Retail Network Pharmacies are able to obtain the Generic Drug. In the case where a GPI is already subject to MAC pricing the Offeror is required to immediately apply the MAC price and mandatory generic substitution to any NDC added to the GPI following the first date of shipment;

iii. For those drugs that could potentially result in a higher net cost to the Programs by enforcing mandatory generic substitution, the Offeror shall provide the “MAC Alert Notice” referenced in (i) above. The Department, in its sole discretion, may determine that enforcement is contrary to the best financial interests of the DCS Program and shall inform the Offeror whether mandatory substitution shall be applied. If the Offeror does not receive a formal response to the information provided via the “MAC Alert Notice,” enforcement shall commence, and the GPI shall be added to the Programs’ MAC List(s) effective on the 21st Day after shipment of the first A-rated generic equivalent drug or authorized Generic Drug provided that the majority of pharmacies are able to obtain the Generic Drug. In the event the Department decides to exercise its discretion not to enforce mandatory generic substitution, the Offeror shall apply MAC pricing to the Generic Drug;

iv. To assist the Department in determining when mandatory generic substitution should be enforced based on an adequate supply of Generic drugs being available in the market, the Offeror shall survey its Retail Pharmacy Network to identify the Pharmacies that are unable to obtain the new Generic Drug within 21 Days and weekly thereafter until the shortage resolves. The Offeror shall submit this information to the Department and provide any additional information as required by the Department to reach a determination. The Department, in its sole discretion, shall determine based on such evidence how the DCS Program’s mandatory generic substitution provisions will be applied. The DCS Program will not consider, and the Offeror shall not act on availability information provided by third party sources, including but not limited to Medi-Span or wholesalers;

v. For Preferred Brand Drugs for which an A-rated or authorized Generic Drug has been introduced into the market for one or more strengths of a Brand Drug, the status of the Brand Drug shall be changed from preferred to non-preferred status concurrent with the commencement of the enforcement of mandatory generic substitution. Enrollees who are prescribed strengths of the Preferred Brand Drug for which an A-rated or authorized Generic Drug has been introduced shall receive the Generic Drug and be charged the Generic Drug Copayment unless the prescribing Physician requires that the Brand Drug be dispensed. In that case, the Enrollee shall be charged the applicable Non-Preferred Brand Drug Copayment and Ancillary Charge. Enrollees who are prescribed strengths of the Preferred Brand Drug for which no A-rated or authorized Generic Drug has been introduced shall continue to receive the prescribed drug at the applicable Preferred Brand Drug Copayment;

vi. For Non-Preferred Brand Name drugs for which an A-rated or authorized Generic Drug has been introduced into the market for one or more strengths of a Brand Drug, the status of the Brand Drug shall remain Non-Preferred for all strengths. Concurrent with enforcement of mandatory generic substitution, Enrollees who are prescribed strengths of the Non-Preferred Brand Drug for which an A-rated or authorized Generic Drug has been introduced shall receive the Generic Drug and be charged the generic Copayment unless the prescribing Physician requires that the Brand Drug be dispensed. In that case, the Enrollee shall be charged the applicable Non-Preferred Brand Drug Copayment and Ancillary Charge. Enrollees who are prescribed strengths of the Non-Preferred Brand Drug for which no A-rated or authorized Generic Drug has been introduced shall continue to receive the prescribed drug at the applicable Non-Preferred Brand Drug Copayment; and

vii. The Offeror shall require the dispensing Network Pharmacy to inform the Enrollee prior to dispensing the Brand Drug, that an Ancillary Charge will be applied in addition to the applicable Non-Preferred Brand Drug Copayment. If the prescribing Physician requires the Brand Drug be dispensed, the Offeror shall require the dispensing Network Pharmacy to collect the applicable Brand Drug Copayment plus the calculated Ancillary Charge. However, under no circumstances shall the Enrollee's total cost exceed what the actual cost of the Brand Drug would have been to the DCS Program after application of the Programs' Lesser of Logic provisions.

e. Charge the Programs based on the Programs' MAC List price assigned to the GPI of the dispensed Brand Drug subject to the Programs' Lesser of Logic plus the applicable dispensing fee and prescribing fee(s), if applicable, as set forth within the Claim Ingredient Cost Section 6.4 and as defined in Attachment 15 (*Glossary of Defined Terms*) of this RFP.

f. Promptly notify and receive the Procuring Agencies prior written approval for any and all exceptions to the Programs' mandatory substitution provisions, other than those resulting the Programs' Mandatory Substitution Appeal Process. Following commencement of mandatory generic substitution, the Offeror must receive the Procuring Agencies written approval prior to suspending enforcement of the Programs' mandatory generic substitution provisions.

g. Maintain an electronic claims processing system capable of obtaining information from Network Pharmacies to ensure consistent enforcement of the Programs' mandatory generic substitution provisions. In particular, the claims processing system must be capable of capturing information concerning the availability of the Generic Drug at the Network Pharmacy submitting the electronic claim. If a Generic Drug is available to be dispensed by the Network Pharmacy, the Programs' mandatory generic substitution rules shall be applied. If the Network Pharmacy does not have the A-rated or authorized Generic Drug in stock, mandatory generic substitution provisions will not apply and the Enrollee shall receive the Brand Drug, be charged the applicable Generic Drug Copayment (DCS only) and the Programs charged based on Generic Drug pricing. The Offeror's claims processing system must reject, with appropriate messaging, claims for Brand Drugs subject to mandatory generic substitution that are submitted with a DAW-0 code requiring resubmission of the claim (since a DAW-0 code provides no indication of Generic Drug availability in the Pharmacy). Similar rules can be applied to other DAW submission codes as necessary to ensure consistent, accurate application of the Programs' mandatory generic substitution requirements.

h. Immediately notify the Procuring Agencies of changes (from brand to generic or generic to brand) in the NDC classification submitted by the Offeror, subject to the Programs' definitions of Brand and Generic Drugs contained in the *Glossary of Defined Terms* (Attachment 15) of this RFP; and

i. **(Exclusive to DCS)** Manage the Narrow Therapeutic Index (NTI) list of multi-source Brand Drugs not subject to Ancillary Charges and make recommendations to the Department of suggested additions or deletions based on clinical evidence.

B. Mandatory Generic Substitution Appeal Process (Exclusive to DCS)

An Enrollee may appeal the requirement to pay the Ancillary Charge. This process is also referred to as a "Dispense as Written exception request." Generic appeal review is based upon the demonstrated need for the Brand Drug on an individual Enrollee basis. It is not related to the specific drug as much as it is to the ability of the Enrollee to tolerate the Generic Drug. The criteria may include: previous clinical issues with the Generic Drug, reported allergy to an inert ingredient, co-morbid conditions that require multiple drug therapies, etc. The Offeror is expected to develop a generic appeals process that would allow for exceptions based upon compelling evidence provided by the treating Physician. Each individual case should be decided upon its own merits. For the DCS Program, there must be at least one level of appeal. If an appeal is unsuccessful, an Enrollee may request an external appeal as required by the NYS Insurance Law. Attachment 53, *Generic Appeals Selected Statistics*, of this RFP provides the number of generic appeals reviewed for the period of January 1, 2021, through December 31, 2022.

1. Duties and Responsibilities

The Offeror shall administer a Mandatory Generic Substitution Appeal, also known as a "Dispense as Written exception request" process. The Selected Offeror is required to oversee and enforce the DCS Program's generic appeal process including:

a. Administering a clinically sound generic appeal process at no additional cost to the DCS Program or to the Enrollee. The process must include developing an appeal form and criteria for establishing medical necessity, reviewing appeals for medical necessity, preparing communications to notify Enrollees (subject to Department review and approval) of the outcome of appeals within five (5) Business Days, and integrating the decisions into the claims processing systems including reimbursing the Enrollee for any Ancillary charge paid up to 30 Days prior to receipt of the approved generic appeal.

b. Reporting the results of the generic appeal process for the DCS Program to the Department on a drug-by-drug basis in the format and frequency required in the "Reporting" Section 3.7 of this RFP.

c. Following a successful generic appeal, charging the Enrollee for the Brand Drug at the Level 3 Copayment with no Ancillary Charge.

d. Loading into the Offeror's claims processing system one or more files from the incumbent contractor of the previously approved Generic

Appeal requests by the DCS Project Services Start Date, once an acceptable file is received and a lag file seven (7) days after the implementation date to capture any Appeals that may have been in process but not yet concluded as reported in the initial file.

e. Responding to all External Appeals on behalf of the Department as requested by the New York State Department of Financial Services (DFS). The DFS External Appeals Process provides an opportunity for Enrollees and Dependents to appeal denied coverage on the basis that a prescription drug is not medically necessary or is an experimental or investigational drug. The Offeror will be responsible for paying any fees charged by DFS for performance of the external reviews directly to DFS. All external appeals costs will be included in the Offeror's Claims Administration Fees and will not be charged separately to DCS. See Attachment 81, *External Appeal Review Fees* for the External Appeals filed by Empire Plan, Excelsior and SEHP Enrollees between January 1, 2021, and December 31, 2022.

3.13 Clinical Management/Drug Utilization Review (DUR)

Clinical management and drug utilization review programs help to control costs and attempt to ensure that Enrollees are receiving safe and effective drug treatment. The Procuring Agencies require the Selected Offeror to have clinical management/drug utilization programs including a mandatory generic substitution program, a prior authorization program, a concurrent review program, retrospective review programs, and a medical exception program. Any clinical management and drug utilization review program built into the Offeror's EGWP is required for the Commercial Plan at no additional cost to the State. The Selected Offeror is required to provide these programs; however, an Offeror is not prevented from offering other value-oriented programs except for Step Therapy programs. The Offeror should not propose the inclusion of Step Therapy as an alternative treatment program in its submission under Clinical Management and Drug Utilization Review **(Exclusive to DCS)**. No clinical management and drug utilization review programs can be funded by Pharmacy manufacturers. The Procuring Agencies reserves the right to not participate in any program offered by the Selected Offeror and the right to opt out of any program at any time.

The Selected Offeror is required to administer and enforce a comprehensive clinical management and DUR program that integrates the various Programs' components, which include at a minimum:

Prior Authorization Program: to determine the medical appropriateness of Prescription drugs that have an increased risk of inappropriate utilization;

Concurrent DUR Program: to aid the dispensing Pharmacist in identifying potential drug therapy problems at the point of sale;

Retrospective DUR Program: to look at any long-term effects of drug treatment designed to safeguard Enrollee health and help Physicians make more informed decisions about Prescription drugs. In addition, the Procuring Agencies are interested in receiving information on Physician education/profiling and patient education programs which the Offeror believes would add value to the Programs; and

(Exclusive to DCS) Medical Exception Program: allows for a medical necessity review and an exception determination to allow the use of drugs that are excluded from the Flexible Formularies and/or the Excelsior Plan Drug List, when other covered therapeutic alternatives are ineffective or clinically inappropriate as documented by the prescribing Medical Professional. If such exception is approved, the copay charged to the Enrollee will be assessed at the non-preferred brand level.

[**NOTE:** The Cost, including all Administrative and travel costs, if any, of all the Clinical Management / Drug Utilization Review Programs in this Section 3.13 are required to be in the Offeror's Proposed Claims Administration Fee.]

A. Prior Authorization

The Programs current Prior Authorization Program determines the medical appropriateness of Prescription drugs that have an increased risk of inappropriate utilization or a high cost. Drugs currently subject to prior authorization have been recommended by the current contractor and reviewed by the Department. *Prior Authorization Drug Lists – January 2023 (*Attachment 49), provides current lists of the drugs subject to prior authorization, for the Flexible, Advanced Flexible and Excelsior formularies. The DCS Program allows Enrollees to appeal denied coverage on the basis that a Prescription drug is not medically necessary or is an experimental or investigational drug. Attachment 50, *Prior Authorization Selected Statistics*, provides the number of Program prior authorizations reviewed and certified for the 2020-22 period.

The NYSIF Program also prior authorizes certain Prescription drugs. The clinical determination is made by NYSIF and conveyed to the Contractor to allow dispensing at a Network Pharmacy.

1. Duties and Responsibilities

To ensure that the resources available to the DCS Program are utilized for appropriate, Medically Necessary Drug therapy, the Selected Offeror is required to administer prior authorization programs for the Programs which include, at a minimum:

a. A Prior Authorization Program for high-cost Prescription drugs that are prescribed for very specific medical indications. Only medications that have been identified by the Offeror as appropriate for Prior Authorization and reviewed by the State shall be included in the Prior Authorization Program. The Prior Authorization Program also subjects specific drugs in certain categories to clinical criteria before benefits are authorized for payment including but not limited to: anti-obesity agents; topical tretinoin; antifungal agents; Hepatitis C agents; Hepatitis B agents for interferon use; select Osteoporosis agents; Respiratory Syncytial Virus (RSV) Therapy agents, select stimulant agent; Multiple Sclerosis agents; Low Molecular Weight Heparin agents; Growth Hormones; Cancer; Pain/Arthritis; Psychosis agents and, Pulmonary Arterial Hypertension agents. Only medications that have been identified as appropriate for the Prior Authorization Program by the Offeror and reviewed by the Procuring Agencies shall be included in the Prior Authorization Program;

b. **(Exclusive to DCS)** Informing Medical Professionals who request, by phone, fax, or secure internet portal, a Prior Authorization for a Specialty Drug about the DCS Program's Specialty Pharmacy Program and providing the information necessary to utilize the Specialty Pharmacy Program to obtain the drug;

c. Monitoring market changes and recommending deletions or additions to the list of drugs requiring Prior Authorization on an ongoing basis which must be reviewed by the Procuring Agencies prior to implementation of any changes to the list of medications;

d. **(Exclusive to DCS)** Preparing and sending communications (reviewed and approved by the Department) to notify Enrollees and/or their Physicians of the outcome of their prior authorization request and notifying them of the date the Prior Authorization is approved through;

e. Promptly loading approved prior authorizations determined by the Offeror or received from NYSIF for the NYSIF Program into the claims processing system;

f. **(Exclusive to DCS)** Administering an expeditious, HIPAA compliant, internal appeals process which allows Physicians and/or Enrollees and Dependents to appeal denied coverage on the basis that a Prescription drug is not medically necessary or is an experimental or investigational drug. For the Prior Authorization Program, there must be at least one level of appeal, and it must be expeditious and Patient Protection and Affordable Care Act (PPACA) compliant;

g. **(Exclusive to DCS)** Responding to the New York State Department of

Financial Services' External Appeals Process that provides an opportunity for Enrollees and Dependents to appeal denied coverage on the basis that a Prescription drug is not medically necessary or is an experimental or investigational drug. The Offeror is responsible for fees associated with the External Appeal process. Refer to Attachment 81, *External Appeal Review Fees*, for select data regarding External Appeals;

h. Loading one or more files of Prior Authorization approved-through dates from the incumbent contractors, prior to the Project Services Start Date, once acceptable files are received, and a lag file seven (7) days after the implementation date to capture any Prior Authorizations that may have been in process but not yet concluded as reported in the initial file.

i. **(Exclusive to NYSIF)** A Prior Authorization process that is fully automated without requiring dispensing pharmacies to manually contact Offeror to request review by NYSIF as detailed in Attachment 68, *NYSIF PBM Prior Authorization Process*, of this RFP. The Offeror should provide training and training materials to NYSIF staff in the utilization of this process.

j. **(Exclusive to DCS)** ***Turnaround Time for Prior Authorizations Guarantee:*** The Offeror must propose a performance guarantee. The Programs service level standard requires that at least ninety-five percent (95%) of Prior Authorization requests that are received by the Offeror will be turned around within two (2) Business Days. Turnaround time is measured from the date all necessary supporting information from the Physician for the Prior Authorization request is received by the Offeror, by any origin (i.e., electronically, telephonically, via fax, or in the Programs designated Post Office Box), to the date the Offeror's response is received by the mailing agent.

B. Concurrent Drug Utilization Review (DUR)

The Programs current Concurrent DUR program aids the dispensing Pharmacist in identifying potential drug therapy safety issues at the point of sale, as well as various other point of sale edits that are related to benefit design such as "refill too soon," and Preferred/Non-Preferred Drug designation. Any retrospective drug utilization and safety requirements built into the Offeror's EGWP is required to be implemented for the Commercial Plan at no additional charge. The costs for such program will be incorporated into the Contractor's Administrative Fee.

1. Duties and Responsibilities

To safeguard Enrollee health and ensure adherence with the Programs'

benefit design, the Selected Offeror must administer a concurrent DUR program which includes at a minimum:

a. A point-of-service system at all Retail Pharmacy Network locations, Mail Service Pharmacy Process Facilities and Specialty Pharmacies which is continually updated with the latest patient safety edits with the capacity to "message" Pharmacists related to safety issues prior to the dispensing of the Prescription drug.

b. A fully integrated point-of-service system capable of enforcing the Programs' benefit design features, where any program built into the Offeror's EGWP is implemented for the Commercial Plan.

c. **(Exclusive to NYSIF)** A point of service edit specifically related to opioid weaning that can be implemented only when there is a NYS Workers' Compensation Notice of decision to do so.

C. Retrospective DUR Program

The DCS Program's current Retrospective DUR Program reviews Enrollee prescription profiles for drug therapy complications. In the event a potential drug complication is identified, alert letters are sent to the prescribing Physician. Any retrospective drug utilization and safety requirements built into the Offeror's EGWP is required to be implemented for the Commercial Plan at no additional charge. The costs for such program will be incorporated into the Contractor's Administrative Fee. The DCS Program is designed to safeguard the Enrollee's health and help Physicians make more informed decisions about Prescription drugs. It is NYSIF's intent to implement a similar program with the Selected Offeror.

1. Duties and Responsibilities

To safeguard the Enrollee's health the Selected Offeror must administer a Retrospective DUR Program which:

a. Using the Offeror's standards, including any relevant program built into the Offeror's EGWP (segment-specific Retrospective DUR programs are allowed), evaluates the Enrollee's Prescription drug utilization against the Enrollee's profile using FDA and other evidence-based guidelines to identify potential safety related concerns. The Offeror shall alert the prescribing Physicians to drug specific, Enrollee-specific health, safety and utilization issues including potential overuse of opioids or other identified high-risk drugs.

b. Identifies potential drug therapy complications for Enrollees, develops Physician alerts (subject to Department and/or NYSIF review and approval) and sends the alerts to the prescribing Physician.

c. Reports the results of its Retrospective DUR Program initiatives, including outcomes, to the Department on a quarterly basis and to NYSIF on a monthly basis in a mutually agreed upon format.

D. Medical Exception Program (Exclusive to DCS)

The DCS' current Medical Exception Program allows for a medical necessity review and an exception determination to allow the use of drugs that are excluded from the Flexible Formularies and/or the Excelsior Plan Drug List, when other covered therapeutic alternatives are ineffective or clinically inappropriate as documented by the prescribing Medical Professional. If such exception is approved, the copay charged to the Enrollee will be assessed at the non-preferred brand level for Brand Drugs and the level one for generic drugs. The costs for such program will be incorporated into the Contractor's Administrative Fee.

[**Note:** Drugs that are only FDA approved for cosmetic indications are excluded from the Plan and are not eligible for a medical exception.]

1. Duties and Responsibilities

a. Administer a Medical Exception Program that reviews clinical appropriateness of allowing an exception to the formulary for an excluded drug when other covered therapeutic alternatives are ineffective or clinically inappropriate as documented by the prescribing Medical Professional. An appropriate trial of formulary alternatives must be undertaken before a formulary exception can be approved.

E. Physician Education

1. Duties and Responsibilities

Subject to review and approval by the Procuring Agencies, the Offeror must undertake a Physician education program involving communications with prescribing Physicians which includes at a minimum:

a. Analysis of Physicians' drug or condition specific prescribing patterns.

b. Educating Physicians about the clinical and economic aspects of their prescribing decisions. Any communication with Physicians prescribing medications for Enrollees shall make the Physician aware of the

distribution channel most cost effective to the Programs and the Enrollee.

c. Reporting the results of its Physician Education initiatives to the State on a quarterly basis in a mutually agreed upon format.

d. The Physician Education Program may not be funded by pharmaceutical manufacturers.

F. Patient Education (Exclusive to DCS)

The Empire Plan currently includes a Patient Education Program to notify Enrollees of the cost-effective utilization of Prescription drugs.

1. Duties and Responsibilities

a. Subject to State review and approval by the Department, the Offeror must develop and implement a patient education program consisting of communications to Enrollees which:

a. Analyzes drug utilization from a clinical standpoint to identify and facilitate communication with Enrollees that have chronic diseases to maximize health benefits of drug treatment

b. Analyzes drug utilization to identify and facilitate communication with Enrollees not managing their drug utilization in the most cost-effective manner for the Enrollee

c. Reports the results of its patient education initiatives to the Department on a quarterly basis in a mutually agreed upon format

d. The Patient Education Program may not be funded by Pharmacy manufacturers.

G. Patient Education (Exclusive to NYSIF)

The NYSIF Plan currently includes a Patient Education Program to notify opioid-naive Claimants of the risks associated with opioid use. This program may be expanded in the future to include other drug classes.

1. Duties and Responsibilities

a. Subject to State review and approval by the Department, the Offeror must develop and implement a patient education program consisting of communications to Enrollees which:

i. Upon initial fill of an opioid drug, enrollees will be informed of the risks associated with use of the drug;

ii. Reports the results of its patient education initiatives to NYSIF on a monthly basis in a mutually agreed upon format; and

iii. The Patient Education Program may not be funded by Pharmacy manufacturers.

H. Other Safety-Related Programs

The Procuring Agencies are interested in any other clinical management or drug utilization review programs that are intended to promote the health and well-being of Enrollees. Offerors may propose other programs of this nature, not already being utilized by the Programs as a requirement of the Contractor under duties and responsibilities set forth in the RFP. The State reserves the right, if allowed by NYS Finance Law, to participate in any such program(s) offered. For any such program(s), the Offeror must clearly indicate whether or not there is a cost to the State for said program(s) (do not disclose the dollar amount, if any, in the Technical Proposal) and, if there is a cost, whether or not the cost is included in the Offeror's proposed Claims Administration Fee. If there is a cost for a program(s) and that cost is not included in the Offeror's proposed Claims Administrative Fee, Offerors are advised that the Department may be precluded by NYS Finance Law from participating in such program(s).

Should the State choose to participate in such program(s), the State reserves the right to opt out of any such program(s) at any time during the term of the Agreements in such case(s), the Claims Administrative Fee shall be reduced by the cost incurred by the State for that program(s).

3.14 Drug List Development and Management

The Selected Offeror is required to efficiently develop, administer and maintain multiple Flexible Formularies that ensure Enrollee access to appropriate, quality pharmaceutical care based on sound clinical criteria. The DCS Program currently has three (3) benefit designs: Advanced Flexible Formulary Drug List, Flexible Formulary Drug List, and the Excelsior Plan Drug List. The Empire Plan Medicare Rx benefit (Medicare Part D formulary with "wrap" coverage through the Advanced Flexible Formulary) must provide benefits equal to or in excess of the prescription drug benefit for non-Medicare- primary members as closely as possible. The DCS Program requires that all Covered Drugs be classified as preferred or non-preferred. Formulary management, in particular designation of drugs as preferred (which generally means Level 1 or Level 2), non-preferred, or excluded, is critical to the clinical and financial success of the DCS Program. The Offeror must use sound clinical criteria in any

decisions that are made to place drugs on the Formularies. The Offeror must ensure that drugs excluded from the Formulary meet the Flexible Formulary or Advanced Flexible Formulary criteria below.

The Formularies generally feature Generic Drugs on the first level, Preferred Brand Drugs on the second level, and Non-Preferred Brand Drugs on the third level. The Drug Lists proposed for the DCS Program must include all drugs meeting the definition of Covered Drugs in this RFP. The Selected Offeror is required to effectively communicate the content and requirements of the DCS Program's Formularies to Network Pharmacies, medical providers and Enrollees. The design of the DCS Program's Prescription Drug benefit does not require a Brand Drug in every therapeutic category. Offerors should assume that the DCS Program will pursue "low list price" rapid-acting insulins. The DCS Program understands that this strategy will reduce rebate-eligible Final Paid Claims in the insulin class. Further, Offerors should assume that the DCS Program will pursue a blended approach to the coverage of biosimilars wherein rebate value is retained but the formularies offer competitively priced biosimilars. For the purpose of preparing a response to this RFP, if an Offeror proposes a formulary that does not include a Preferred Brand Drug in every therapeutic category, the Offeror must include the clinical rationale and financial implications of the Offeror's determination. Offerors will submit cost information as required in Section 6, Financial Proposal of this RFP.

[**Note:** Do not include any financial information in the Technical Proposal.]

Advanced Flexible and Flexible Formularies (may be collectively referred to as the "formularies"): Under the Flexible Formularies, Generics may be on Level 1 or excluded. Brand Drugs may be on Level 1, 2, or 3 or excluded. A proposed Drug List(s) that includes Generics on Level 2 or Level 3 does not meet the Program requirements for the formularies and would not be acceptable. Formularies are custom and are subject to the Department's approval. Drugs may be excluded from the formularies based on sound clinical and financial criteria. Proposed drug exclusions must meet the following criteria:

Access to one or more drugs in select therapeutic categories may be restricted (not covered) if the drug(s) has no clinical advantage over other generic and brand name medications in the same therapeutic class. Drugs considered to have no clinical advantage that may be excluded include any products that follow either the **Flexible Formulary** or **Advanced Flexible Formulary:**

Flexible Formulary

- Contain an active ingredient available in and therapeutically equivalent to another drug covered in the class;
- Contain an active ingredient that is a modified version of and therapeutically equivalent to another covered Prescription Drug Product; or
- Are available in over-the-counter form or comprised of components that are

available in over-the-counter form or equivalent.

Advanced Flexible Formulary

- Contain an active ingredient available in or are therapeutically equivalent to another drug covered in the class;

- Contain an active ingredient that is a modified version of or are therapeutically equivalent to another covered Prescription Drug Product; or

- Are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent.

All but the approximately 5,700 members of GSEU and their dependents have collective bargaining agreements or have had provisions extended which allow for drug exclusions under the Advanced Flexible Formulary..

See Attachment 51, *Preferred Drug Lists – January 2023*, which include a section listing Excluded Drugs and Preferred Alternatives. Attachment 52, *Excluded Drug Lists – January 2023 (by NDC),* provides an Excel list of excluded drugs, by formulary and by NDC. *Generic Dispensing Rate (GDR) by Union* is provided in Attachment 96. Offerors do not need to replicate the formularies, including Brand for Generic (B4G) strategies, currently in place.

In addition, the current benefit design does not allow Enrollees with Commercial Coverage to appeal a drug's placement on the second or third level of the Drug List(s). Enrollees are able to appeal a drug exclusion through the Medical Exception Program, in the event other therapeutic alternatives are ineffective or clinically inappropriate as documented by the prescribing Medical Professional.

The Flexible and Advanced Flexible Formularies are updated quarterly, but drug exclusions and uptiers are done once a year on January 1st. Mid-year changes to these formularies outside of what has been agreed to in collective bargaining or permissible under the New York State Frozen Formulary law (Chapter 780 of the Laws of 2021, as amended by Chapter 99 of the Laws of 2022) are generally not acceptable. Mid-year changes resulting from drug recalls, the introduction of new clinically superior drugs, drugs off patent, or patient safety issues are allowed. Quarterly changes must be proposed by the Selected Offeror and approved by DCS.

The Flexible and Advanced Flexible Formularies includes a "Brand for Generic" (B4G) feature. This feature is not mandated nor prohibited and may be utilized, subject to Department approval, when financially advantageous to the Plan. The current B4G strategies in place do not need to be replicated in the Offeror's proposal. With this feature, subject to Department approval, a brand-name drug may be placed on Level 1, and the new generic equivalent placed on Level 3, or

excluded. ~~With Department approval, these placements may be revised mid-year when such changes are advantageous to The Empire Plan.~~ Mid-year changes, subject to Department approval, are allowed.

Excelsior Plan Drug List

Under the Excelsior Plan Drug List, both Brand and Generic Drugs may be placed on Level 1, 2 or 3 or excluded. A proposed Excelsior Plan Drug List that includes Generics on Level 2 or Level 3 and/or has Brand Drugs on Level 1 meets Program requirements and would be acceptable for the Excelsior Plan. Drugs may be excluded from the Excelsior Plan Drug List based on sound clinical and financial criteria. In addition, the current benefit design does not allow an Enrollee to appeal a drug's placement on the second or third level of the Excelsior Plan Drug List. Pursuant to the New York State Frozen Formulary Law , the Excelsior Plan Drug List may not be updated quarterly. The goal of the Excelsior Plan Drug List is to offer a therapeutically sound formulary that results in a Plan design that costs a minimum of 15% less than The Empire Plan Advanced Flexible Formulary.

A. Drug List Development and Management (Exclusive to DCS)

1. Duties and Responsibilities

The Offeror must provide PDL development and management services for the DCS Program. Such responsibility shall include but not be limited to:

a. Developing and administering multi-level formularies, consistent with the DCS Program's benefit designs. The Empire Plan Medicare Rx program must meet or exceed the prescription drug benefit for non-Medicare primary members as closely as possible. The Offeror's PDLs must be based on sound clinical criteria. The Offeror's Book of Business PDL, or PDL used for The Excelsior Plan which meets the requirements of the New York State Frozen Formulary Law, must include non-self-administered, intravenous and intramuscular injectable drugs covered under the Excelsior Plan benefit design. In designating a drug as preferred or non-preferred for the Empire Plan's formularies, the Offeror must ensure that drugs recognized in documented medical evidence and studies as clinically superior to similar drugs in a therapeutic class be designated as preferred. In situations where there are multiple drugs in a therapeutic class of similar clinical characteristics, net costs shall be considered in determining a drug's status as preferred or non-preferred. The composition of the PDL for the formularies will be developed by the Offeror and reviewed annually (and revised quarterly, if allowed under the frozen formulary law) by the Department.

Any recommended mid-year changes to the Flexible Formularies must meet the requirements of the New York State Frozen Formulary Law and

union agreements, where applicable, and shall be provided to the Department with a summary of the clinical and financial implications to the DCS Program. The Department, at its sole discretion, may approve mid-year changes. In the instance when a change to the formularies is approved outside of the annual update, the Offeror must communicate the change to Members thirty (30) days in advance of the action. For the Excelsior Plan, the New York State Frozen Formulary Law must be met.

b. Developing Preferred Drug Lists for each of the benefit designs, subject to the review and approval of the Department, for the purpose of distributing printed copies to Enrollees and medical providers. Additionally, electronic copies will be developed for posting on the Department's website and the Offeror's customized website for the DCS Program in order to inform Enrollees and providers of the placement of the most commonly prescribed medications on each Preferred Drug List. The Department shall be responsible for the distribution of the printed PDLs provided by the Offeror on an annual basis to Enrollees. The Offeror shall be responsible for producing and distributing all other copies of the printed PDLs, including but not limited to supplies sent to agencies, those sent with Offeror mailings to Enrollees and individual requests by Enrollees or providers. The Offeror is required to promptly mail the Preferred Drug List to Enrollees who call requesting a copy. Copies of the Advanced Flexible Formulary, Flexible Formulary and Excelsior Drug Lists from January 2023 are presented in Attachment 51 *Preferred Drug Lists – January 2023* (Excel versions are available). Offerors do not need to replicate the formularies, including Brand for Generic (B4G) strategies, currently in place.

c. Compiling and organizing the Drug Lists in several versions:

    i. The most commonly prescribed medications (for posting and distribution), which includes an alphabetical listing of Preferred Drugs, a list of Non-Preferred Drugs, an Excluded Drug List and a listing of Preferred Drugs categorized by therapeutic category.

    ii. Comprehensive Formularies listing all covered prescription drugs on the formularies, including any tiering structure that it has adopted and any restrictions on the manner in which a prescription drug may be obtained, in a matter that is easily accessible. The Comprehensive formularies shall clearly identify the preventive prescription drugs that are available without copay.

    iii. Standalone Excluded Drug Lists.

    iv. Prior Authorization Drug Lists.

    v. Exclusive Specialty Drug Lists.

The Offeror must work with the Department on the format of these PDLs. The Drug Lists that are developed for distribution to Enrollees, and providers and posted on the website must provide notice of the pending introduction of a generic equivalent for one or more strengths of a particular Brand Drug that could result in one or more strengths of the drug being moved to non-preferred status during the year. The PDLs shall also list the name of the reference product in parenthesis next to the name of the Generic Drug (i.e., rosuvastatin (Crestor)) unless the Department otherwise directs. The PDLs shall indicate those drugs that require Prior Authorization and those that have quantity limits. The Offeror shall inform the Department of any rebate implications to the DCS Program as a result of including this information on the PDLs.

d. Developing the PDLs in a timely manner so that the Department approved, printed PDLs are available to be communicated to Enrollees and posted to the website at least forty-five (45) Days before the start of the Calendar Year, to coincide with the DCS Program's option transfer period for Enrollees.

e. Developing and mailing a Department pre-approved disruption letter, via first class mail, to Enrollees who are affected by: a drug's exclusion; a Preferred Brand Drug's reclassification to a non-preferred status (unless the reclassification is the result of the introduction of an equivalent generic); or, if a Prior Authorization requirement or quantity limit is newly added to a drug for the formularies. Mailings must be sent 45-days prior to January 1 and 30-days prior for any allowable mid-year formulary change. Disruption mailings for the Enrollees in the Excelsior Plan will follow the disruption mailing plan employed for the Offeror's Book of Business PDL and must be sent 90-day prior to January 1. Such letters must be sent to Enrollees who have utilized a medication at least once within the latest four-month time period, regardless of the Day's supply or whether the medication is categorized as maintenance or acute. An additional mailing must be sent to Enrollees who are new users of a medication between the date claims records were selected for the initial disruption mailing and the date that the PDL changes go into effect. Such communications should provide to the Enrollee information concerning clinically appropriate alternatives on the first and second level, when applicable, of the PDL as of the effective date of the drug's exclusion or change from preferred to non-preferred status. In situations where Enrollees are affected by a Generic Drug's reclassification to a Brand Drug, the Offeror agrees to send a disruption letter to affected Enrollees.

Notifying the Department in writing when any drug recall or voluntary drug withdrawal occurs, including Plan utilization, by union. The Offeror must take proper action to help promote patient safety. The Offeror will notify Enrollees, Network Pharmacies and/or prescribing Physicians of the drug or device recalls or drug or device withdrawals

at no additional cost to the Program. Such notification must be timely and all written materials subject to Department review and prior written approval. The Offeror must assist the Department in collecting monies from recalled products.

f. Using reasonable efforts to monitor the industry on behalf of the DCS Program and notifying the Department in writing of any class action lawsuits for which a class has been certified and of any proposed orders or settlements that the DCS Program may be entitled to participate in as a member of the class. Unless otherwise notified by the Department, the Offeror shall file claims on behalf of the Program and take all steps necessary to ensure the DCS Program's interests in the class action suit or proposed settlement are protected. Any recoveries collected by the Offeror on behalf of the DCS Program, net of the Offeror's actual costs in securing the DCS Program's participation in the recovery, due the DCS Program must be credited to the DCS Program within fifteen (15) Days upon the Offeror's receipt. The Offeror shall make reasonable efforts to maximize recoveries. Distribution of recoveries, net of the Offeror's actual costs incurred on behalf of the DCS Program, shall be made consistent with the terms of the final settlement order or court decision. The Offeror shall assist the State in its recovery efforts and provide the claims and rebate data required to file a claim on behalf of the DCS Program when requested by the Department;

g. Holding an annual meeting with the Department, DOB and OER, to review upcoming changes to the Advanced Flexible and Flexible Formularies as well as the Medicare Part D Drug List prior to the effective date of any changes. This meeting will include a review of the Offeror's Book of Business PDL strategy. Upon the Department's request, the Offeror shall provide a detailed explanation of the clinical and/or financial basis for the decision to change the classification of the drug(s) on the Flexible and Advanced Flexible Formularies as well as a detailed cost analysis of the impact of the changes to the Program. Changes are subject to Department, DOB and OER approval.

h. Assigning a new strength of a drug to the same PDL Level as the preexisting strengths of the drug in the event a new strength of a drug already on the formularies is shipped from the manufacturer or wholesaler.

i. Working with the medical carrier and the mental health and substance use carriers to develop communications such as, but not limited to provider newsletters to ensure that participating providers in those networks are fully apprised of the level/status of Covered Drugs.

j. The Offeror will be responsible for ensuring the formularies will be electronically available to Medical Professionals on Rx Hub and Level 1 and Level 2 drugs will be designated as Preferred.

k. The Offeror will be responsible for protecting the value of the DCS Program's pricing discounts by taking appropriate steps to control Prescription Drug AWP increases.

l. The Offeror will be responsible for developing, recommending, and implementing Brand for Generic strategies for the formularies that are financially beneficial to the State. All Brand for Generic placements are subject to Department approval. This feature is not mandated nor prohibited and may be utilized, subject to Department approval, when financially advantageous to the Plan. The current B4G strategies in place do not need to be replicated in the Offeror's proposal. These placements may be revised mid- year, with Department approval, when such changes are advantageous to The Empire Plan.

B. Drug List Development and Management (Exclusive to NYSIF)

The Offeror must provide PDL composition and management services for the NYSIF Program. Such responsibility shall include but not be limited to:

a. Maintaining a formulary compliant with the WCB standard, including the categorization of drugs and the NYS WCB Medical Treatment Guidelines, e.g., drugs requiring prior authorization; covered Drugs dispensed not requiring prior authorization; certain drugs will have time frames during with prior authorization is not required.

b. Agreeing that the Offeror does not and will not accept payments from drug companies to promote specific products.

c. Providing NYSIF with an electronic file of all formulary drugs including dosages, NDC numbers, GPI and GC3 codes. The frequency of this file submission will be determined by NYSIF and will be provided upon vendor selection.

3.15 Consolidated Appropriations Act (Exclusive to DCS)

The Consolidated Appropriations Act (CAA) requires all applicable health plans conduct and document a Non-Quantitative Treatment Limitation (NQTL) comparative analysis as well as submit prescription drug spending information, known as RxDC Reporting.

1. Duties and Responsibilities

a. The Offeror must conduct and document a Non-Quantitative Treatment Limitation (NQTL) comparative analysis to verify that the Plan is compliant with the Mental Health Parity and Addiction Equity Act. This analysis must be included in the Administration Fee and not charged separately.

b. The Offer must collect and report on prescription drug information (RxDC Reporting). This collection and reporting must be included in the Administration Fee and not charged separately.

c. The Offeror must ensure it is in compliance with all other provisions of the CAA.

3.16 Consulting (Exclusive to DCS)

The Contractor is responsible for providing advice and recommendations regarding the DCS Program.

1. Duties and Responsibilities

a. Informing the Department in a timely manner concerning such matters as cost containment strategies, new drugs, conversion from Brand Drugs to Generic Drugs and how it will impact cost, formulary configuration, technological improvements, e-prescribing, Pharmacy innovations, and State/Federal legislation (i.e., Medicare, Prescription drug mandates, etc.) that may affect the DCS Program. The Contractor must provide information and recommendations to the Department on Formulary placement of new generic and biological therapies prior to release into the marketplace to the extent such information is available in the public realm. The Contractor must also make available to the State one or more members of the clinical or account management team to discuss the implications of these new trends and developments. The Department is not under any obligation to act on such advice or recommendation; and

b. Assisting the Department with recommendations and evaluation of proposed benefit design changes and implementing any changes necessary to accommodate DCS Program modifications resulting from collective bargaining, legislation, or within the statutory discretion of the State. Recommendations must include a preliminary analysis of all associated costs, a clinical evaluation, and the anticipated impact of proposed DCS Program modifications and contemplated benefit design changes on Enrollees. In the event of a design change and the Contractor requests any change in compensation such change will be in accordance with Section 8.8 Modification of Program Services of this Agreement. Additionally, the Contractor will be responsible for making collective bargaining changes using Department benefit codes.

SECTION 4: ADMINISTRATIVE PROPOSAL

This section of the RFP sets forth the requirements for the Offeror's Administrative Proposal. The Department will consider for evaluation and selection purposes only those Proposals the Department determines to be in compliance with the requirements set forth in this section of the RFP. Any Offeror which fails to satisfy any of these requirements shall be eliminated from further consideration.

The Offeror's Administrative Proposal must respond to all of the following items as set forth below in the order and format specified and using the forms set forth in this RFP. Additional details pertaining to the required forms are found in Section 2 of this RFP.

4.1 Formal Offer Letter

The Offeror must submit a formal offer in the form of the *Formal Offer Letter* (Attachment 3). The formal offer must be signed and executed by an individual with the capacity and legal authority to bind the Offeror in its offer to the State. The copy of the Offeror's Administrative Proposal marked "ORIGINAL" requires a letter with an original signature; the remaining copies of the Offeror's Administrative Proposal may contain photocopies of the signature. Except as otherwise permitted under Section 2.1(7), Bid Deviations, the Offeror must accept the terms and conditions as set forth in this RFP, *Standard Clauses for New York State Contracts* (Appendix A), *Standard Clauses for All Department Contracts* (Appendix B), *General Specifications* (Appendix B-1, Exclusive to NYSIF), *Contract Provisions* (Appendix B-2, Exclusive to NYSIF), *NYSIF Vendor Security Survey* (Appendix B-3), *NYSIF Mutual Non-Disclosure Agreement* (Appendix B-4, Exclusive to NYSIF), Information *Security Requirements* (Appendix C, Exclusive to DCS), *and Participation by Minority and Women-Owned Business Enterprises: Requirements and Procedures (NYSIF)* (Appendix D, Exclusive to NYSIF), and agree to enter into a Contractual Agreement with the Department containing, at a minimum, the terms and conditions identified in this RFP and appendices as cited herein and as referenced in Section 1.1 Purpose, Resulting Contracts. If an Offeror proposes to include the services of a Subcontractor(s) or Affiliate(s), the Offeror must be required to assume responsibility for those services as "Prime Contractor". The Department will consider the Prime Contractor solely responsible for contractual matters.

4.2 Offeror Attestation Form

The Offeror must complete and submit an executed copy of the *Offeror Attestations Form* (Attachment 13) attesting that it meets or exceeds the criteria for eligibility to bid as set forth in Section 1 of this RFP. A person legally authorized to represent the Offeror must execute this certification.

4.3 Subcontractors or Affiliates

The Offeror must complete the *Subcontractors or Affiliates* form (Attachment 9) to identify all Subcontractors or Affiliates with whom the Offeror subcontracts to provide Project Services. For purposes of reporting in the *Subcontractors or Affiliates* form (Attachment 9), Subcontractors include (1) all vendors who will provide $100,000 or more in Project Services over the term of the Contract that results from this RFP and (2) any vendor who will provide Project Services in an amount lower than the $100,000 threshold, and who is a part of the Offeror's Account Team (described in Section 3.1, Account Team). For each Subcontractor identified, the Offeror must complete and submit the *Subcontractors or Affiliates* form (Attachment 9) and indicate whether or not, as of the date of the Offeror's Proposal, a subcontract has been executed between the Offeror and the Subcontractor for services to be provided by such subcontractor relating to the RFP. For the purpose of this RFP, Affiliate is defined as a person or organization which, through stock ownership or any other affiliation, directly, indirectly, or constructively controls another person or organization, is controlled by another person or organization, or is, along with another person or organization, under the control of a common parent. On the *Subcontractors or Affiliates* form (Attachment 9), the Offeror must:

1. Mark the applicable box if the Offeror will not be subcontracting with any Subcontractor(s) or Affiliate(s) to provide Project Services.

2. Indicate whether or not, as of the date of the Offeror's Proposal, a subcontract (or shared services agreement) has been executed between the Offeror and the Subcontractor or Affiliate for services to be provided by the Subcontractor or Affiliate relating to this RFP.

3. Provide a brief description of the services to be provided by the Subcontractor or Affiliate.

4. Provide a description of any current relationships with such Subcontractor or Affiliate and the clients/projects that the Offeror and Subcontractor or Affiliate are currently servicing under a formal legal agreement or arrangement, the date when such services began and the status of the project.

4.4 New York State Standard Vendor Responsibility Questionnaire

The Offeror must complete and submit an executed copy of the New York State Vendor Responsibility Questionnaire. A person legally authorized to represent the Offeror must execute the questionnaire. The questionnaire must be completed by all Subcontractors as defined above.

The Department recommends each Offeror file the required Questionnaire online via the New York State VendRep System. To use the VendRep System, please refer to https://www.osc.state.ny.us/files/state-vendors/vendrep/pdf/ac3290s.pdf.

By submitting a Proposal, the Offeror agrees to fully and accurately complete the Questionnaire. The Offeror acknowledges that the State's execution of the Contract will be contingent upon the State's determination that the Offeror is responsible, and that the State will rely on the Offeror's responses to the Questionnaire when making its responsibility determination. The Offeror agrees that if it is found by the State that the Offeror's responses to the Questionnaire were intentionally false or intentionally incomplete, on such finding, the Department may terminate the Contract. In no case shall such termination of the Contract by the State be deemed a breach thereof, nor shall the State be liable for any damages for lost profits or otherwise, which may be sustained by the Contractor as a result of such termination.

4.5 New York State Tax Law Section 5-a

Tax Law § 5-a requires certain Offerors awarded state Contracts for commodities, services and technology valued at more than $100,000 to certify to New York State Department of Taxation and Finance (DTF) that they are registered to collect New York State and local sales and compensating use taxes. The law applies to Contracts where the total amount of such Offeror's sales delivered into New York State is in excess of $300,000 for the four quarterly periods immediately preceding the quarterly period in which the certification is made, and with respect to any Affiliates and Subcontractors whose sales delivered into New York State exceeded $300,000 for the four quarterly periods immediately preceding the quarterly period in which the certification is made.

An Offeror is required to file the completed and notarized Form ST-220-CA with the Department certifying that the Offeror filed the ST-220-TD with DTF. The Offeror should complete and return the certification forms within five Business Days from the date of request (if the forms are not completed and returned with bid submission). Failure to make either of these filings may render an Offeror non-responsive and non-responsible. The Offeror must take the necessary steps to provide properly certified forms within a timely manner to ensure compliance with the law.

Website links to the Offeror certification forms and instructions are provided below.

1. Form ST-220-TD must be filed with and returned directly to DTF and can be found at: http://www.tax.ny.gov/pdf/current_forms/st/st220td_fill_in.pdf. Unless the information upon which the ST-220-TD is based changes, this form only needs to be filed once with DTF. If the information changes for the Offeror, its Affiliate(s), or its Subcontractor(s), a new Form ST-220-TD must be filed with DTF.

2. Form ST-220-CA must be submitted to the Department. This form provides the required certification that the Offeror filed the ST-220-TD with DTF. This form can be found at: http://www.tax.ny.gov/pdf/current_forms/st/st220ca_fill_in.pdf.

4.6 Insurance Requirements

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. In addition, companies writing insurance intended to comply with the requirements of this Section 4.6 should be licensed or authorized by DFS to issue insurance in the State of New York. The Department may, in its sole discretion, accept policies of insurance written by a non-authorized carrier or carriers when certificates and/or other policy documents are accompanied by a completed Excess Lines Association of New York (ELANY) affidavit or other documents demonstrating the company's strong financial rating. 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. These policies must be written in accordance with the requirements of the paragraphs below, as applicable.

An Offeror shall deliver to the Department evidence of the insurance required by this RFP and any Contract resulting from this RFP in a form satisfactory to the Department. Policies must be written in accordance with the requirements of the paragraphs below, as applicable. While acceptance of insurance documentation shall not be unreasonably withheld, conditioned or delayed, acceptance and/or approval by the Department does not, and shall not be construed to, relieve an Offeror of any obligations, responsibilities or liabilities under this RFP or any Contract resulting from this RFP.

The Offeror shall not take any action or omit to take any action that would suspend or invalidate any of the required coverages during the term of any Contract resulting from this RFP.

1. General Conditions

a. All policies of insurance required by this Solicitation or any Contract resulting from this RFP shall comply with the following requirements:

i. Coverage Types and Policy Limits. The types of coverage and policy limits required from the Selected Offeror are specified in Section 4.6(2) of this RFP.

ii. Policy Forms. Except as may be otherwise specifically provided herein or agreed to in any Contract resulting from this RFP, all policies of insurance shall be written on an occurrence basis.

iii. Certificates of Insurance/Notices. The Selected Offeror shall provide the Department with a Certificate or Certificates of Insurance, in a form satisfactory to the Department, as detailed below, and pursuant to the timelines set forth in Section 4.6(1)(m) of this RFP. Certificates should reference the Solicitation or award number and shall name the New York State Department of Civil Service, Agency Building 1, Empire State Plaza, Albany, NY 12239, as the certificate holder.

iv. Document Submissions. An Offeror shall deliver to the Department evidence of the insurance required by this RFP and any Contract resulting from this RFP upon notification of tentative award.

b. Certificates of Insurance shall:

i. Be in the form acceptable to the Department and in accordance with the New York State Insurance Law (e.g., an ACORD certificate);

ii. 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;

iii. Be signed by an authorized representative of the insurance carrier of the referenced insurance carriers; and

iv. Contain the following language in the Description of Operations / Locations / Vehicles section of the Certificate or on a submitted endorsement as applicable: Additional insured protection afforded is on a primary and non-contributory basis. A waiver of subrogation is granted in favor of the additional insureds.

c. 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, although the Department reserves the right to request other proof of insurance. An Offeror should refrain from submitting entire

insurance policies, unless specifically requested by the Department. If an entire insurance policy is submitted but not requested, the Department shall not be obligated to review and shall not be chargeable with knowledge of its contents. In addition, submission of an entire insurance policy not requested by the Department does not constitute proof of compliance with the insurance requirements and does not discharge an Offeror from submitting the requested insurance documentation.

d. Primary Coverage: All liability insurance (excluding Professional Liability insurance) policies where the Department is required to be included as an additional insured, shall provide that the required coverage shall be primary and non-contributory to other insurance available to the Department and their officers, agents, and employees. Any other insurance maintained by the Department and their officers, agents, and employees shall be excess of and shall not contribute with the Offeror's insurance.

e. Breach for Lack of Proof of Coverage: The failure to comply with the requirements of this RFP at any time during the term of any Contract resulting from this Solicitation shall be considered a breach of the terms of any Contract resulting from this Solicitation and shall allow the Department and their officers, agents, and employees to avail themselves of all remedies available under any Contract resulting from this Solicitation, at law or in equity.

f. Self-Insured Retention/Deductibles: Certificates of Insurance must indicate the applicable deductibles/self-insured retentions for each listed policy. Deductibles or self-insured retentions above $100,000.00 are subject to approval from the Department. Such approval shall not be unreasonably withheld, conditioned or delayed. An Offeror shall be solely responsible for all claim expenses and loss payments within the deductibles or self-insured retentions. If the Offeror is providing the required insurance through self-insurance, evidence of the financial capacity to support the self-insurance program along with a description of that program, including, but not limited to, information regarding the use of a third-party administrator shall be provided upon request.

g. Subcontractors: Prior to the commencement of any work by a Subcontractor, the Offeror shall require such Subcontractor to procure policies of insurance as required by this section and maintain the same in force during the term of any work performed by that Subcontractor. An Additional Insured Endorsement (ISO coverage form CG 20 38 04 13), or the equivalent, evidencing such coverage shall be provided to the Offeror prior to the commencement of any work by a subcontractor and pursuant to the timelines set forth in Section 4.6(1)(m) of this RFP, as applicable,

and shall be provided to the Department upon request. For subcontractors that are self-insured, the subcontractor 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 subcontractor would have been required to pursuant to this section had the subcontractor obtained such insurance policies.

h. Waiver of Subrogation: For all liability policies (with the exception of Professional Liability Insurance and Cyber Liability Insurance), the Offeror shall cause to be included in its policies insuring against loss, damage or destruction by fire or other insured casualty a waiver of the insurer's right of subrogation against the Department and their officers, agents, and employees, or, if such waiver is unobtainable (i) an express agreement that such policy shall not be invalidated if the Offeror waives or has waived before the casualty, the right of recovery against the Department and their officers, agents, and employees or (ii) any other form of permission for the release of the Department or any entity authorized by law or regulation to use any Contract resulting from this Solicitation and their officers, agents, and employees. A Waiver of Subrogation Endorsement shall be provided upon request. A blanket Waiver of Subrogation Endorsement evidencing such coverage is also acceptable.

i. 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 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.

j. Excess/Umbrella Liability Policies: Required insurance coverage limits may be provided through a combination of primary and excess/umbrella liability policies. If coverage limits are provided through excess/umbrella liability policies, then a Schedule of underlying insurance listing policy information for all underlying insurance policies (insurer, policy number, policy term, coverage and limits of insurance), including proof that the

excess/umbrella insurance follows form must be provided upon request. Unrelated underlying policies included in the Schedule that are not required to meet the insurance requirements may be redacted from the Schedule.

k. Notice of Cancellation or Non-Renewal: Policies shall be written so as to include the requirements for notice of cancellation or non-renewal in accordance with the New York State Insurance Law. Within five Business Days of receipt of any notice of cancellation or nonrenewal of insurance, the Offeror shall provide the Department with a copy of any such notice received from an insurer together with proof of replacement coverage that complies with the insurance requirements of this Solicitation and any Contract resulting from this Solicitation.

l. Policy Renewal/Expiration: Upon policy renewal/expiration, evidence of renewal or replacement of coverage that complies with the insurance requirements set forth in this Solicitation and any Contract resulting from this Solicitation shall be delivered to the Department. If, at any time during the term of any Contract resulting from this Solicitation, the coverage provisions and limits of the policies required herein do not meet the provisions and limits set forth in this Solicitation or any Solicitation and any Contract resulting from this Solicitation, or proof thereof is not provided to the Department, the Offeror shall immediately cease work. The Offeror shall not resume work until authorized to do so by the Department.

m. Deadlines for Providing Insurance Documents after Renewal or Upon Request: As set forth herein, certain insurance documents must be provided to the Department contact identified in the Contract Award Notice after renewal or upon request. This requirement means that the Offeror shall provide the applicable insurance document to the Department as soon as possible but in no event later than the following time periods:

    i. For certificates of insurance: 5 Business Days from request or renewal, whichever is later;

    ii. For information on self-insurance or self-retention programs: 15 Calendar Days from request or renewal, whichever is later;

    iii. For other requested documentation evidencing coverage: 15 Calendar Days from request or renewal, whichever is later;

    iv. For additional insured and waiver of subrogation endorsements: 30 Calendar Days from request or renewal, whichever is later; and

v. For notice of cancellation or non-renewal and proof of replacement coverage that complies with the requirements of this section: 5 Business Days from request or renewal, whichever is later.

Notwithstanding the foregoing, if the Offeror shall have promptly requested the insurance documents from its broker or insurer and shall have thereafter diligently taken all steps necessary to obtain such documents from its insurer and submit them to the Department, the Department shall extend the time period for a reasonable period under the circumstances, but in no event shall the extension exceed 30 Calendar Days.

2. <u>Specific Coverage and Limits</u>

Insurance Type		Proof of Coverage is Due
Commercial General Liability	No less than $1,000,000 each occurrence	Upon notification of tentative award and updated in accordance with Contract
General Aggregate	$2,000,000	
Personal and Advertising Injury	$1,000,000	
Medical Expenses Limit	$5,000	
Business Automobile Liability Insurance	No less than $1,000,000 each accident	
Professional Errors and Omissions	$5,000,000 each occurrence	
Data Breach/Cyber Liability	$5,000,000 each occurrence	
Workers' Compensation		
Disability Benefits		

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, independent contractors, 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 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:

i. Each Occurrence – $1,000,000

ii. General Aggregate – $2,000,000

iii. Personal Advertising Injury – $1,000,000

Coverage shall include, but not be limited to, the following:

i. Premises liability;

ii. Independent contractors/subcontractors;

iii. Blanket contractual liability, including tort liability of another assumed in a contract;

iv. Defense and/or indemnification obligations, including obligations assumed under any Contract resulting from this Solicitation;

v. Cross liability for additional insureds.

b. Business Automobile Liability Insurance: The Offeror shall maintain Business Automobile Liability Insurance in the amount of at least $1,000,000 each accident, covering liability arising out of automobiles used in connection with performance under any Contract resulting from this RFP, including owned, leased, hired and non-owned automobiles bearing or, under the circumstances under which they are being used, required by the Motor Vehicles Laws of the State of New York to bear, license plates.

c. Professional Errors and Omissions Insurance: The Offeror shall maintain Professional Errors and Omissions (Professional Liability) in the amount of at least $5,000,000 each occurrence, for claims arising out of but not limited to delay or failure in diagnosing a disease or condition and alleged wrongful acts, including breach of contract, bad faith, and negligence. Such insurance shall apply to professional errors, acts, or omissions arising out of the scope of services. The policy shall cover professional misconduct or lack of ordinary skill for those positions defined in the Scope of Services of this Contract.

If coverage is written on a claims-made policy, the Contractor warrants that any applicable retroactive date precedes the start of work; and that

continuous coverage will be maintained, or an extended discovery period exercised, throughout the performance of the services and for a period of not less than three years from the time work under this Contract is completed. Written proof of this extended reporting period must be provided to the Department prior to the policy's expiration or cancellation.

d. Data Breach/Cyber Liability Insurance: An Offeror is required to maintain during the term of any Contract and as otherwise required herein, Data Breach and Privacy/Cyber Liability Insurance in the amount of at least $5,000,000 each claim, including coverage for failure to protect Confidential Information and failure of the security of the Offeror's computer systems or the Department systems due to the actions of the Offeror which results in unauthorized access to the Department or their data. Coverage may be satisfied through alternative insurance policies.

   Said insurance shall provide coverage for damages arising from, but not limited to the following:

   i. Breach of duty to protect the security and confidentiality of nonpublic proprietary corporate information;

   ii. Personally, identifiable nonpublic information (e.g., medical, financial, or personal in nature in electronic or non-electronic form);

   iii. Privacy notification costs;

   iv. Regulatory defense and penalties;

   v. Website media liability; and

   vi. Cybertheft of customer's property, including but not limited to money and securities.

   If the policy is written on a claims-made basis, Contractor must submit to the Department an Endorsement providing proof that the policy provides the option to purchase an Extended Reporting Period ("tail coverage") providing coverage for no less than one year after work is completed in the event that coverage is cancelled or not renewed. This requirement applies to both primary and excess liability policies, as applicable.

e. Workers' Compensation Insurance. To comply with coverage provisions of Workers' Compensation Law (WCL) Section 57, businesses must be legally exempt from obtaining workers' compensation insurance coverage; or obtain such coverage from insurance carriers; or be a Board-approved self-insured Employer or participate in an authorized group self-insurance plan. An Offeror must provide one of the following forms:

i. Form CE-200, Certificate of Attestation for New York Entities With No Employees and Certain Out of State Entities, That New York State Workers' Compensation and/or Disability Benefits Insurance Coverage is Not Required, which is available on the Worker's Compensation Board's website (www.businessexpress.ny.gov); or

ii. For C-105.2 (9/15), Certificate of Workers' Compensation Insurance, sent to the Department by the Contractor's insurance carrier upon request, or if coverage is provided by the New York State Insurance Fund, they will provide Form U-26.3 to the Department upon request from the Contractor; or

iii. Form SI-12, Certificate of Workers' Compensation Self-Insurance, available from the New York State Workers' Compensation Board's Self-Insurance Office; or

iv. Form GSI-105.2, Certificate of Participation in Workers' Compensation Group Self-Insurance, available from the Contractor's Group Self-Insurance Administrator.

f. Disability Benefits Insurance: To comply with coverage provisions of WCL Section 220(8), regarding disability benefits, businesses must be legally exempt from obtaining disability benefits insurance coverage; or obtain such coverage from insurance carriers; or be a Board-approved self-insured Employer. An Offeror must provide one of the following forms:

i. Form CE-200, Certificate of Attestation for New York Entities With No Employees and Certain Out of State Entities, That New York State Workers' Compensation and/or Disability Benefits Insurance Coverage is Not Required, which is available on the Workers' Compensation Board's website (www.businessexpress.ny.gov); or

ii. Form DB-120.1, Certificate of Disability Benefits Insurance, sent to the Department by the Contractor's insurance carrier upon request; or

iii. Form DB-155, Certificate of Disability Benefits Self-Insurance, available from the New York State Workers' Compensation Board's Self-Insurance Office.

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SECTION 5: TECHNICAL PROPOSAL REQUIREMENTS

The purpose of Section 5 of the RFP is to set forth the submissions required of the Offeror. The Offeror's Technical Proposal must contain responses to all required submissions from the Offeror in the format requested. Each Offeror may submit only one Technical Proposal. Each Offeror's Technical Proposal will be evaluated based on the responses to the required submissions contained in Section 5 of this RFP. An Offeror must not include any financial information in the Technical Proposal, including attachments. Specific cost or savings estimates (dollars or percentages) must not be quoted in the Technical Proposal or in any attachments submitted with the Technical Proposal.

5.1 Executive Summary

In an Executive Summary, the Offeror must describe its capacity and proposed approach to administering the DCS and NYSIF Prescription Drug Programs (hereby collectively referred to as the "Programs"). The Executive Summary must include:

1. The name and address of the Offeror's main and branch offices and the name of the senior officer who will be responsible for this account.

2. A description of the Offeror's understanding of the requirements presented in this RFP and how the Offeror can assist the Procuring Agencies in accomplishing their objectives.

3. A statement explaining the Offeror's, and, if applicable, the Offeror's Key Subcontractor's, previous experience managing the Prescription drug plans of other state governments or large public entities or any other organizations with over 100,000 covered lives, as well as any previous experience managing a Self-Funded Prescription Drug Program. Detail how this experience qualifies the Offeror and, if applicable, the experience of its Key Subcontractors to undertake the functions and activities required by this RFP.

4. An explanation of how the following administrative and operational components will be performed by the Offeror include an organizational chart explicitly detailing responsibility for the following functions:

    a. Network Management

    b. Specialty Pharmacy Program

    c. Mail Service Pharmacy Process

    d. Claims Processing

e. Retrospective Coordination of Benefits

f. Customer Service

g. Enrollee Communication Support

h. Enrollment Management

i. Reporting

j. Clinical Management/ Prior Authorization

k. Drug Utilization Review (concurrent, retrospective and narcotics)

l. Flexible and Advanced Flexible Formulary Development and Management

m. Rebate Administration

n. Account Management

o. Mandatory Generic Substitution and Generic Appeals Process

p. Pharmacy Audit and Responses to NYS Audits

q. Drug Lawsuits/Settlements

r. Medicare Part D Prescription Drug Program Administration

s. Medical Exception Program

t. Drug Recall and Withdrawal Notification

u. Financial Support Services

v. Transition and Termination of Contract

w. Information Technology Support Services

x. Vaccine Program

If the proposed organizational structure has been used in administering the program of another client, provide the client's name and include the client's information as required in Section 1.8(6).

1. General Qualifications. The DCS Prescription Drug Program covers over one million lives and incurs claims costs in excess of $3 billion annually (before

rebates and CMS subsidies). The Workers' Compensation Program fills approximately 525,000 prescriptions annually and incurs costs in excess of $80 million annually. The Offeror must have the experience, reliability and integrity to ensure that each Program member's health care needs are addressed in a clinically appropriate and cost-effective manner. The terms of the Offeror's proposal must demonstrate explicit acceptance of and responsiveness to the Programs duties and responsibilities set forth in this RFP, ensuring full compliance with the respective Program's Services.

5.2 Account Team

1. The Offeror must provide an organizational chart and narrative description illustrating how the Offeror proposes to administer, manage, and oversee all aspects of the Programs. Include the following:

    a. Names, qualifications, and job descriptions of the key individuals proposed to comprise the implementation, operational, clinical, and account management team(s) for the Offeror and its Key Subcontractor(s) (if applicable). A dedicated Account Executive must be listed. Complete Attachment 14, *Biographical Sketch Form*, of this RFP for all key members of the proposed account management team(s). Where key individuals are not named, include qualifications of the individuals that the Offeror would seek to fill the positions; and

    b. Reporting relationships and the responsibilities of each key position of the account management team(s); and how the team will interact with other business units or functional areas within the Offeror's organization, including, but not limited to, customer service, clinical services, reporting, auditing, and network management. The Offeror must include the percentage of time (by position) dedicated to the Program and reporting relationships. Describe how the account management team interfaces with senior management and ultimate decision makers within the Offeror's organization.

2. Describe the experience of the individual(s) who will assume the role of account leader for the Programs. Include a description of the individual's experience with clients whose needs were of similar size and scope as those of the Procuring Agencies.

3. Confirm that the Account Team will be readily accessible to the Programs. Describe where the Account Team(s) will be based. The Offeror must:

    a. Describe how the Offeror proposes to ensure that timely responses (one (1) to two (2) Business Days) are provided to administrative concerns and inquiries; and

b. Describe what actions will be taken if the Procuring Agencies express concern that the Account Team is not adequately staffed; and

c. Describe the protocols that will be put into place to ensure the Procuring Agencies will be kept abreast of actual or anticipated events impacting Program costs and/or delivery of services to Enrollees. Provide a representative scenario.

4. Describe the Corporate resources that will be available to the Account Team to ensure compliance with all legislative and statutory requirements. Confirm the Offeror's commitment to notify the Procuring Agencies immediately if the Offeror were unable to comply with any legislative or statutory requirements and to work with the Procuring Agencies to take the appropriate remedial action(s) to come into compliance as soon as practicable. Confirm the Offerors commitment to work with the Department to develop accurate Certificates and/or Program material.

5.3 Implementation Plan

The Offeror must provide a detailed Implementation Plan in narrative, diagram, and timeline formats, designed to meet the implementation by the specified completion dates for the respective Procuring Agencies Contracts.

1. Provide separate detailed implementation plans (narrative, diagram, and timeline) at least six months prior to the respective Procuring Agencies Project Services Start Date, that results in the implementation of all Program Services by the required Project Service Start Date, indicating: roles, responsibilities, estimated timeframes for individual task completion, testing dates and objectives, and areas where complications may be expected. Include key activities such as member and Pharmacy communications, training of customer service staff, report generation, Formulary development, mail service and specialty Pharmacy transition, customized website design, eligibility feeds, claims testing and EGWP approval and transition.

2. The Implementation Plan must include estimated timeframes for individual task completion, testing dates and objectives, and areas where complications may be expected. It must include key activities such as:

   a. Training of call center staff;

   b. Website development;

   c. Network development;

d. Transition of benefits; and

e. Eligibility feeds and testing claims processing.

3. Implementation and Start-Up Guarantee: The Offeror must guarantee that all of the Implementation and Start-Up requirements listed above in Section 5.3(2) of this RFP is fully operational on or before the respective Project Services Start Date, with the exception of opening the Dedicated Call Center and completing work on the customized website. The Dedicated Call Center must be opened at least 30 Days prior to the DCS Project Services Start Date. The customized website must be live and operational at least 30 Days prior to the DCS Project Services Start Date. This guarantee is not subject to the limitation of liability provisions of the Contract.

   Utilizing the *Performance Guarantees* form (Attachment 6), the Offeror shall propose, separately for each Program, the forfeiture of a percentage of the 2025 Claims Administration Fee (prorated on a daily basis) for each Day that all Implementation and Start-Up requirements are not met. The Standard Credit Amount for each Day that all Implementation and Start-Up requirements for the DCS or NYSIF Program are not met is fifty percent (50%) of the 2025 Claims Administration Fees (prorated on a daily basis). However, Offerors may propose higher or lower percentages.

5.4 Customer Service

1. Confirm the Offeror will provide Enrollees access to Program information on Claimants through separate consolidated toll-free numbers twenty-four (24) hours a day, 365 Days a year.

2. **(Exclusive to DCS)** Confirm the Offeror will ~~enter into a shared service agreement~~ work with The Empire Plan Medical Program, or other party designated by the Department, and AT&T to set up a connection. Confirm the Offeror will provide twenty-four (24) hours a Day, 365 Days a year access to a TTY number for callers utilizing a TTY device because of a hearing or speech disability.

3. Confirm the Offeror will maintain separate call centers, located in the United States, for each Program employing a staff of fully trained Customer Service Representatives (CSRs) and supervisors available 24 hours a Day, 365 Days a year. Indicate if any call centers are located in New York State. The Offeror must maintain separate Dedicated Call Centers for the Programs between the hours of 7:00 a.m. and 7:00 p.m. ET. During off hours, calls may be routed to a designated call center(s) located in the United States staffed by fully trained customer service representatives and supervisors. The call centers must also provide immediate

access (either through warm transfers or call-back within four (4) hours) to Pharmacist(s) 24 hours a Day, 365 Days a year.

4. Describe the information, resources, and system capabilities that are available for the customer service representatives to address and resolve member inquiries. Include:

    a. Whether any Interactive Voice Response (IVR) system is proposed;

    b. A sample of the IVR script and a description of customizable options, if any, the Offeror proposes for the Programs;

    c. A description of the management reports and information available from the system including the key statistics the Offeror proposes to report; and

    d. A description of the capabilities of the Offeror's phone system to record calls, track call types, reasons, and resolutions.

5. Describe the training that is provided to CSR and Pharmacist staff before they go "live" on the phone with Enrollees. Include:

    a. A description of the internal reviews that are performed to ensure quality service is being provided to Enrollees;

    b. The first call resolution rate for the proposed call centers;

    c. The call center locations, average staff, and turnover rate for call center employees;

    d. Ratio of management and supervisory staff to customer service representatives; and

    e. Proposed staffing levels including the logic used to arrive at the proposed staffing levels.

6. Describe the backup systems of the Offeror's primary telephone system which would be used in the event the primary telephone system fails, is unavailable, or at maximum capacity. If a backup system is needed, explain how, and in what order calls from Enrollees will be handled. Confirm that backup staff will have DCS Program and NYSIF Program specific training. Indicate the number of times the backup system has been utilized over the past two (2) years. Confirm that calls will be handled exclusively by the Offeror's Dedicated Call Centers and that the backup call center would only be used in case of system failure or call overflow.

7. **(Exclusive to DCS)** Describe the information and capabilities your website provides to members and describe the process the Offeror will utilize to develop it. Confirm that the Offeror will develop a customized website for the DCS Program and that it will be operational and available to Enrollees thirty (30) Days prior to the Implementation Date. Also, confirm that the following information, at a minimum, will be available on the website: DCS Program benefits, Network Pharmacy locations, eligibility, mail service order status, Copayment information, claim reimbursement forms, claim status, Prescription drug history for both retail and mail claims and the Drug Lists (Flexible or Advanced Flexible and Excelsior). The Preferred Drug List and the Excluded Drug List must contain alternatives for Non-Preferred Brand Name and excluded drugs. Provide the URL of your main website and provide a dummy ID and password so that the Department may view the capabilities and user-friendliness of your website.

8. Call Center Telephone Guarantees: For each of the four (4) Call Center Telephone Guarantees below, the Offeror shall propose, separately for each Program, the forfeiture of a specific dollar amount of the Claims Administration Fees, for failure to meet the Offeror's proposed guarantee.

    a. Call Center Telephone Response Time: 90% of incoming calls to the Offeror's telephone line must be answered by a customer service representative within sixty (60) seconds.

    Utilizing the *Performance Guarantees* form (Attachment 6), the Offeror must propose a credit against the Claims Administration Fee for each .01 to 1.0% of incoming calls to the Offeror's telephone line below the standard of ninety percent (90%) (or the Offeror's proposed guarantee) that is not answered by a customer service representative within sixty (60) seconds. The Standard Credit Amount is $25,000 per each quarter for DCS and $7,500 for NYSIF, respectively. However, Offerors may propose higher or lower amounts.

    b. Call Center Availability: The Offeror's telephone line must be operational and available to Enrollees, Claimants, Dependents and Pharmacies 99.6% of the Offeror's Call Center Hours.

    Utilizing the *Performance Guarantees* form (Attachment 6), the Offeror must propose a credit against the Claims Administration Fee for each .01 to .25% below the standard of ninety-nine and five-tenths percent (or the Offeror's proposed guarantee) that the Offeror's telephone line is not operational and available during the Offeror's Call Center Hours. The Standard Credit Amount is $100,000 per quarter for DCS and $7,500 for NYSIF, respectively. However, Offerors may propose higher or lower amounts.

c. Telephone Abandonment Rate: No more than 3% of calls to the Offeror's telephone line will disconnect a call prior to the call being answered by a customer service representative.

   Utilizing the *Performance Guarantees* form (Attachment 6), the Offeror must propose a credit against the Claims Administration Fee for each .01 to 1.0% of incoming calls to the Offeror's telephone line in which the caller disconnects prior to the call being answered by a customer service representative in excess of the standard of three percent (3%) (or the Offeror's proposed guarantee). The Standard Credit Amount is $25,000 per each quarter for DCS and $7,500 for NYSIF, respectively. However, Offerors may propose higher or lower amounts.

d. Telephone Blockage Rate: No more than 3% of incoming calls to the Offeror's telephone line will be blocked by a busy signal.

   Utilizing the *Performance Guarantees* form (Attachment 6), the Offeror must propose a credit against the Claims Administration Fee for each .01 to 1.0% of incoming calls to the Offeror's telephone line that is blocked by a busy signal in excess of the standard of three percent (3%) (or the Offeror's proposed guarantee). The Standard Credit Amount is $25,000 per each quarter for DCS and $7,500 for NYSIF, respectively. However, Offerors may propose higher or lower amounts

9. Secure Online Customized Website Guarantees (Exclusive to DCS): The Offeror shall propose the forfeiture of a specific dollar amount of the Claims Administration Fees, for failure to meet the Offeror's proposed guarantee.

   a. Website Accuracy Guarantee: The Offeror shall take no more than 3 Business Days to correct information appearing on the customized website.

      Utilizing the *Performance Guarantees* form (Attachment 6), the Offeror must propose a credit against the Claims Administration Fee for each Business Day in excess of the standard of 3 Business Days (or the Offeror's proposed guarantee) to correct inaccurate information on the customized website. The Standard Credit Amount is $25,000 per each quarter for DCS. However, Offerors may propose higher or lower amounts.

   b. Website Update Timeliness Guarantee: The Offeror shall take no more than 5 Business Days to post correct information to the customized website.

      Utilizing the *Performance Guarantees* form (Attachment 6), the Offeror must propose a credit against the Claims Administration Fee for each Business Day in

excess of the standard of 5 Business Days (or the Offeror's proposed guarantee) to post accurate information on the customized website. The Standard Credit Amount is $25,000 per each quarter for DCS. However, Offerors may propose higher or lower amounts.

5.5 Empire Plan Medicare Rx (Exclusive to DCS)

1. Describe your experience in implementing and administering a Medicare PDP EGWP plus Medicare D supplemental wrap for customers of similar scope and size to The Empire Plan.

2. Confirm your understanding of the requirements to support the implementation and administration of a Medicare PDP EGWP plus Medicare D supplemental wrap for The Empire Plan on behalf of the Department, including the Offeror's proposed approach for the following:

    a. Medicare PDP EGWP premium development

    b. Enrollment, including providing temporary Commercial Coverage for Enrollees and/or Dependents who are pending enrollment by Medicare

    c. Enrollee Opt-Out process

    d. Eligibility Reconciliations on a cadence and format determined by the Department

    e. Medicare Beneficiary Identifier (MBI) administration

    f. Formulary management

    g. Issuing of Medicare PDP EGWP member identification cards

    h. Member Communications, including required explanation of benefits statements

    i. Claims Processing

    j. Administration of a Medicare D supplemental wrap with the goal of providing Medicare-primary Enrollees with a prescription drug benefit that provides benefits and drug coverage equivalent to, or in excess of, the benefits available to the Empire Plan's non-Medicare-primary enrollees and dependents

    k. Ensure an override process for medications covered under the Medicare PDP EGWP when providing temporary Commercial

Coverage for Enrollees and/or Dependents who are pending enrollment or re-enrollment by Medicare

l. Timely administration of catastrophic reinsurance claims

m. Administration of Low Income Subsidy requirements, including direct reimbursement of Low Income Subsidies to eligible Enrollees of the Plan

3. Confirm that the Offeror will develop, and timely submit to, CMS and/or Enrollees all required filings and DCS Program material related to the implementation and administration of a Medicare Rx Program on behalf of the Department.

4. Provide a copy of your proposed Medicare Part D formulary and provide a side-by-side comparison in Excel to the proposed Empire Plan Advanced Flexible Formulary included in this RFP. Comment on reasons for variances. Please note that the Department's goal is to provide benefits and drug coverage equivalent to, or in excess of, the benefits available to the Empire Plan's non-Medicare-primary enrollees and dependents.

5. Provide a sample member communications package, including proposed benefit card, for the Empire Plan Medicare Rx.

6. Describe in detail the transition services the Offeror will utilize to assist members who are newly eligible for the EGWP plus Medicare D supplemental wrap, including formulary disruption, prior authorization, mail order and retail pharmacy refills, Specialty Program medications, and quantity limits.

7. Describe the member termination process under the EGWP PDP, including the timing of termination after the termination date is received by the Department.

8. Describe your capability to provide the services necessary to support and assist the Department in maximizing DCS Program savings by analyzing its experience with the Empire Plan Medicare Rx and recommending other permitted options under Medicare Part D that may be advantageous to the Department, Participating Agencies, Participating Employers, and Enrollees.

9. Confirm your understanding and describe your ability to identify and recover claim payments made by the DCS Program from other Medicare Part D plans that should have been the primary payer, upon finalization of the subrogation process by CMS.

10. The Offeror must provide documentation confirming its Medicare D Plan Overall star rating by the Centers for Medicare & Medicaid Services (CMS) Star Quality Rating System for 2021, 2022 and 2023.

a. Please provide the last three (3) years of CMS Star Rating for the Offeror's Medicare D Plan

b. Has CMS frozen enrollment any time during the last three (3) years?

5.6 Member Communication Support

The Offeror must provide a narrative describing in detail the proposed processes that will be utilized to develop Member Communication Support specified in Section 3.5 of this RFP, including the following:

1. Describe the role of the Offeror's legal department.

2. Provide two examples of communications the Offeror has developed for other clients.

3. Confirm the Offeror's understanding that all Programs communications developed by the Offeror are subject to the Procuring Agencies' final approval.

[**Note: (Exclusive to DCS)** There are specific requirements for the Advanced Flexible and Flexible Formularies and Excelsior Plan Drug List communications set forth in Drug List Development and Management within Section 5.15 of this RFP.]

4. **(Exclusive to DCS)** Describe the resources that will be available to the Department to support the Department's development of various custom Enrollee communications and your ability to provide input into such communications quickly.

5. **(Exclusive to DCS)** Confirm that staff will be available to attend (in-person or virtually) Health Benefit Fairs, select conferences, and benefit design information sessions, etc., in New York State and elsewhere in the United States. Describe the experience and qualifications of staff that will be attending these events. See Attachment 58, *Vendor Attendance*, for a summary of DCS Program presentations that took place from 2019-22.

6. Confirm your commitment to work with the Procuring Agencies to develop appropriate customized forms and letters for the Programs. Provide examples of how the Offeror has worked with other large clients to produce customized communications. Provide details on how the Offeror will separate the Programs from other Book of Business clients for enterprise-wide issues such as Global coding errors.

7. **(Exclusive to NYSIF)** Confirm your commitment to develop a customizable

information packet that will include a permanent ID card and other prescription drug information for the NYSIF Program. Provide samples of information packets developed and customized for other clients.

8. **(Exclusive to DCS)** Detail the Offeror's experience in working with large clients who have required customized websites or web portals for benefits information.

9. Complete a second *Biographical Sketch Form* (Attachment 14), for all staff proposed for involvement in Member Communication Support.

10. **(Exclusive to DCS) Member Communication Support Guarantee**. Utilizing the *Performance Guarantees* form (Attachment 6), the Offeror must propose a forfeiture amount (Standard Credit Amount) for each type of form or letter, including but not limited to notification of drug recalls or withdrawals, notification of mid-year formulary changes, that is mailed more than 30 Calendar Days from when the Procuring Agencies approve it. The forfeited amount (Standard Credit Amount) for each type of form or letter mailed after thirty Calendar Days is $1,000 per occurrence, calculated quarterly. However, an Offeror may propose higher or lower amounts.

11. **(Exclusive to DCS) Formulary Coding Accuracy Guarantee.** Utilizing the *Performance Guarantees* form (Attachment 6), the Offeror must propose a forfeiture amount (Standard Credit Amount) for each instance of incorrect coding, such a coding not updating to reflect formulary decisions for the start of the Plan Year, or the Offeror applying Book changes to the Plan without DCS approval. The forfeited amount (Standard Credit Amount) for each occurrence of incorrect coding being applied is $1,000 per occurrence calculated quarterly. However, Offerors may propose higher or lower amounts.

5.7 Enrollment Management

1. Describe your testing plan to ensure that the initial enrollment loads for the DCS and NYSIF Programs are accurately updated to your system and that they interface correctly with your claims system.

    a. What quality controls are performed before the initial and ongoing enrollment transactions are loaded into the claims adjudication system?

    b. How does your system identify transactions that will not load into your enrollment system? What exceptions will cause enrollment transactions to fail to load into your enrollment system? What steps are taken to resolve the exceptions, and what is the turnaround time for the exception records to be added to your enrollment file?

2. Describe your system capabilities for retrieving and maintaining Commercial

enrollment information within twenty-four (24) hours of its release by the Department and within twelve (12) hours of release by the NYSIF as well as:

a. How your system maintains a history of enrollment transactions and how long enrollment history is kept online. Is there a limit to the quantity of history transactions that can be kept online?

b. How your system handles retroactive changes and corrections to enrollment data.

c. **(Exclusive to DCS)** Detail how your enrollment system captures the information necessary to produce the reports entitled “Claims and Credits Paid by Agency” and “Quarterly Participating Agency Claims” required in the Reporting Section of this RFP.

d. Confirm your enrollment and claims processing system has the capacity to administer 1) a Social Security number; 2) Employee identification number and; 3) an alternate identification number assigned by the Department or NYSIF. Does your system have any special requirements to accommodate these three identification numbers? Explain how Dependents are linked to the Enrollee in the enrollment system and claims processing system.

3. Describe how your enrollment system, data transfers, and procedure for handling enrollment data are HIPAA compliant.

4. Describe the backup system, process or policy that will be used to ensure that Enrollees receive needed Prescription drugs in the event that enrollment information is not immediately available at the point of service.

5. **(Exclusive to DCS)** Confirm that the Offeror will maintain a read-only connection to the NYBEAS enrollment system, and that Offeror’s authorized staff will be available to access enrollment information through NYBEAS during the required hours, Monday through Friday, from 9:00 a.m. to 5:00 p.m., with the exception of NYS holidays as indicated on the Department’s website.

6. **(Exclusive to DCS)** Describe your ability to meet the administrative requirements for National Medical Support Orders and Dependents covered by a National Medical Child Support Order (NMCSO), including storing this information in your system so that information about the Dependent is only released to the individual named in the NMCSO.

7. Describe your ability and the process 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.

8. **(Exclusive to NYSIF)** Confirm that the Offeror will administer the instant enrollment or "Short Fill" service to allow immediate acceptance by any pharmacy in the Offeror's Retail Pharmacy Network in order to provide a limited number of cost-effective medications to the injured worker in accordance with Attachment 65, *NYSIF Short Fill Process*, of this RFP.

9. Enrollment Management Guarantee: The Programs' service level standard requires that one hundred percent (100%) of all Commercial Program enrollment records that meet the quality standards for loading will be loaded into the Offeror's enrollment system within twenty-four (24) hours of release by the Department and within twelve (12) hours of release by NYSIF. The Offeror shall propose, separately for each Program, the forfeiture of a specific dollar amount of the Claims Administration Fee for failure to meet the standards.

   The Standard Credit Amount for each 24-hour period beyond twenty-four (24) hours from release by the Department that one hundred percent (100%) of the Commercial Program enrollment records that meet the quality standards for loading is not loaded into the Offeror's enrollment system is $5,000. However, Offerors may propose higher or lower amounts.

   The Standard Credit Amount for each 24-hour period beyond twelve (12) hours from release by the NYSIF that one hundred percent (100%) of the Program enrollment records that meet the quality standards for loading is not loaded into the Offeror's enrollment system is $375. However, Offerors may propose higher or lower amounts.

5.8 Reporting Services

1. (Exclusive to DCS)

a. How will reversed, rejected, and adjusted (adjusted claims are exclusive to DCS) claims be reflected in the reconciliation of the cycle claim reports to the quarterly and annual financial experience statements? Will this process be the same for claims billed within the cycle or outside of the cycle? Please describe in detail how reversed or modified claims are identified within your claims data. Please describe how your system allows the Agencies to identify only Final Paid Claims within your claims data. Explain how a claim reversed in a different billing cycle would be identified in your claims data.

b. The Offeror must submit examples of the financial and utilization reports that have been listed without a specified format in the reporting requirements above as well as any other reports that the Offeror is

proposing to produce for the Agencies to be able to analyze and manage the Programs. Provide an overview of your reporting capabilities with the value the Offeror believes this will bring to the Programs.

c. Confirm that the Offeror will provide reports in the specified format (paper and/or electronic – Microsoft Access, Excel, Word), as determined by the Agencies.

d. Confirm that the Offeror will provide direct, secure access to your claims system and any online and web-based reporting tools to the Agencies' offices. Include a copy of the data sharing agreement the Offeror propose for Agencies staff to execute in order to obtain systems access.

e. Confirm that your ability and willingness to provide Ad Hoc Reports and other data analysis. Provide examples of Ad Hoc reporting that the Offeror has performed for other clients.

f. Reporting Services and Claim File Guarantees: The DCS Program's service level standard requires that accurate management reports and claims files will be delivered to the Agencies no later than their respective due dates. For the management reports and claim files listed in Attachment 36, *Program Reporting,* as well as in Section 3.7 of this RFP, the Offeror must propose a performance guarantee. The Offeror shall propose the forfeiture of a specific dollar amount of the Claims Administration Fee for failure to meet this standard.

   The Standard Credit Amount for each management report or claim file that is not accurate or is not received by its respective due date is $1,000 per report per each Business Day between the due date and the date the accurate management report or claims file is received by the Department inclusive of the date of receipt. However, Offerors may propose higher or lower amounts.

2. (Exclusive to NYSIF)

a. Confirm the Offeror's agreement to generate and submit all daily, weekly, monthly, quarterly, semi-annual, and annual reports per NYSIF specification.

b. Confirm the Offeror will provide NYSIF with electronic file of eligibility and authorization on the GC3, GPI or similar code level. Indicate your capability for capturing drug denials on the NDC code levels. If unable to capture denials on the GC3 or GPI code level, provide a detailed description of your denial coding system.

c. Confirm that the Offeror will provide reports in the specified format (paper and/or electronic – Microsoft Access, Excel, Word), as determined by NYSIF.

d. Confirm that the Offeror will provide NYSIF with an on-line decision support tool with ad-hoc query capability.

e. Confirm the Offeror's ability and willingness to provide Ad Hoc Reports and other data analysis. Provide examples of Ad Hoc reporting that the Offeror has performed for other clients.

f. Describe how the Offeror's proposed system will accept pharmacy bills from the Offeror's network pharmacies.

g. Describe how the Offeror's proposed system will edit these pharmacy bills in accordance with NYSIF business rules.

h. Describe how the proposed system will reject, with reason, any pharmacy bills that do not adhere to NYSIF business rules.

i. Describe the method for notification of the Offeror's network pharmacy in the event of rejection.

j. Describe how the pharmacy bills submitted will validate against the claim eligibility information provided by NYSIF.

k. Confirm that the weekly billing file will follow the specifications in Attachment 60, *NYSIF Billing Process*, of this RFP.

l. Describe the encryption and secure transmission protocol for the pharmacy billing files.

m. Describe how the system will be monitored for performance.

n. Describe how NYSIF will be notified in the event of a system and/or transmission failure.

o. Describe how it will be determined into which file Established Claim or Instant Enrollment/Short Fill, the pharmacy bill will be placed.

p. Describe the process for tracking Aging Bills and how it will be determined whether or not a bill is to be placed in the Aging Bill files.

q. Describe how card issuance information is tracked in your system.

r. Describe the Offeror's encryption and secure transmission protocol for your electronic files.

s. Confirm the Offeror's agreement to create specified electronic files in the form of an ASCII text file.

t. Describe how rebate information is tracked in the Offeror's system.

u. Describe the process that determines when a rebate is included in the quarterly rebate and annual true-up files.

v. Reporting Services and Claim File Guarantees: In this part of its Technical Proposal, the Offeror must state its agreement and guarantee that all NYSIF Program management reports and claims files in Section 3.7 and, as applicable, in Attachment 36, *Program Reporting,* will be accurate and delivered to the Department no later than their respective due dates. The Offeror shall propose the forfeiture of a specific dollar amount of the NYSIF Claims Administration Fee for failure to meet this standard.

Utilizing the *Performance Guarantees* form (Attachment 6), the Offeror must propose a forfeiture amount (Standard Credit Amount) for each calendar day the Department has not received the NYSIF Program management report and claims file by their respective due date. The forfeited amount (Standard Credit Amount) for each management report or claim file that is not received by its respective due date is $100 per Calendar Day per report. However, an Offeror may propose a higher amount.

5.9 Transition and Termination of Agreements

1. The Offeror must provide a narrative describing in detail:

a. Confirm the Offeror will commit to fully cooperate with the successor contractor to ensure the timely receipt of all information necessary to transfer administration of the Prescription Drug Program.

b. Provide an outline of the key elements and tasks that would be included in your separate Transition Plans for each of the Procuring Agencies to ensure that all the required duties and responsibilities are completed if the Offeror were the incumbent contractor. Include a brief explanation on how the Offeror would accomplish this with the next Selected Offeror.

c. Please detail the level of customer service that the Offeror will provide after the termination date of the Agreements resulting from this RFP.

2. **Transition and Termination Guarantee:** In this part of its Technical Proposal, the Offeror must state its agreement and guarantee all Transition Plan requirements outlined in Section 3.8 of this RFP will be completed in the required time frames to the satisfaction of the Department.

   Utilizing the *Performance Guarantees* form (Attachment 6), the Offeror must propose a forfeiture amount (Standard Credit Amount) for each Day or part thereof that the Transition Plan requirements are not met. The forfeited amount (Standard Credit Amount) is $1,000 for each Day this guarantee is not met for each program. However, an Offeror may propose higher amounts.

5.10 Network Management

A. Retail Pharmacy Network

1. Propose separate access guarantees for each of the three Programs in the tables below for the Programs' Retail Pharmacy Networks that meet or exceed the minimums set forth in Section 3.9. The access guarantee must be provided in terms of actual distance from Enrollees' residences and must meet or exceed the minimum access guarantees stipulated in Section 3.9, Network Management.

DCS Commercial Program

% of Commercial Enrollees with Access to Retail Pharmacies	Commercial Enrollee Location	Access Guarantee One Pharmacy at least within
_%	Urban	_ miles
_%	Suburban	_ miles
_%	Rural	_ miles

DCS EGWP

% of EGWP Enrollees with Access to Retail Pharmacies	EGWP Enrollee Location	Access Guarantee One Pharmacy at least within
_%	Urban	_ miles
_%	Suburban	_ miles
_%	Rural	_ miles

NYSIF Program

% of NYSIF Claimants with Access to Retail Pharmacies	NYSIF Claimants Location	Access Guarantee One Pharmacy at least within
_%	Urban	_ miles
_%	Suburban	_ miles
_%	Rural	_ miles

2. Compare the current DCS Program network pharmacies that have submitted claims in 2022 with the *Offeror's Proposed Retail Pharmacy Network File* (Attachment 18). Identify whether each of the Program's current network pharmacies will or will not participate in the Offeror's proposed Retail Pharmacy Network in accordance with the instructions provided in Attachment 21, *Comparison of DCS Current Program Network Pharmacies and the Offeror's Proposed Retail Pharmacy Network*. The file containing the DCS Program's current network pharmacies and instructions for completing the attachment can be obtained by following the instructions, which requires that Offerors have the latest version of the IBM Aspera Web Plugin (Aspera Connect) to use the application, included in Attachment 21.

3. Confirm that if selected, the Offeror will provide an updated Attachment 18, *Offeror's Proposed Retail Pharmacy Network File*, Attachment 20, *Offeror's Proposed Retail Pharmacy Network Access Prerequisite Worksheet* and Attachment 21, *Comparison of DCS Current Program Network Pharmacies and the Offeror's Proposed Retail Pharmacy Network* thirty days prior to the Project Services Start Date confirming that the Offeror's proposed Retail Pharmacy Network will be implemented as required on the respective Project Services Start Date. If necessary, the Selected Offeror shall submit a second file affirmatively identifying any deviations from the proposed Retail Pharmacy Network along with a detailed explanation for all deviations.

4. Confirm that your independent pharmacy network substantially maintains the composition of independent Network Pharmacies in the Programs' current Retail Pharmacy Network. Substantially maintain the composition shall mean that an Offeror must include contracts with independent pharmacies accounting for seventy-five percent (75%) or more of the DCS Programs' prescription drugs dispensed through independent pharmacies, based on the informational claims file for 2022 (Attachment 84, *Layout Specifications for DCS Program Informational Claims Data File*) as required in Section 1.8(8) and described in Sections 3.9 and 5.10. Describe the approach(es) the Offeror would use to solicit additional pharmacies to enhance your proposed Retail Pharmacy Network or to fulfill a request to add an individual independent Pharmacy.

5. Identify Limited Distribution Drugs and indicate the authorized distributors that will participate in the Retail Pharmacy Network proposed for the Programs. If the Offeror is unable to secure the participation of the authorized distributors in your Retail Pharmacy Network, describe the process the Offeror will utilize to provide Enrollees with access to these drugs placing no additional steps or burdens on the Enrollee.

6. **Network Pharmacy Access Guarantees**: The Offeror must guarantee that throughout the term of the Agreements resulting from this RFP, Enrollees living in urban, suburban and rural areas will have access, as proposed by the Offeror, to a Network Pharmacy.

   The Offeror must propose an access guarantee that meets or exceeds the minimum access guarantees set forth in the "Retail Pharmacy Network" Section of this RFP. The Offeror shall propose, separately for each Program, the forfeiture of a specific dollar amount of the Claims Administration Fee for failure to meet these guarantees.

   The Standard Credit Amount for each .01 to 1.0% below the ninety percent (90%) minimum access guarantee, for any quarter, in which the Network Pharmacy Access for Urban Areas is not met by the Offeror, is $100,000 per each quarter for DCS and $7,500 for NYSIF. However, Offerors may propose higher or lower amounts.

   The Standard Credit Amount for each .01 to 1.0% below the ninety percent (90%) minimum access guarantee for any quarter in which the Network Pharmacy Access for Suburban Areas is not met by the Offeror, is $100,000 per each quarter for DCS and $7,500 for NYSIF. However, Offerors may propose higher or lower amounts.

   The Standard Credit Amount for each .01 to 1.0% below the seventy percent (70%) minimum access guarantee for any quarter in which the Network

Pharmacy Access for Rural Areas is not met by the Offeror, is $100,000 per each quarter for DCS and $7,500 for NYSIF. However, Offerors may propose higher or lower amounts.

Measurement of compliance with each access guarantee will be based on a "snapshot" of the Retail Pharmacy Network taken on the last Day of each quarter within the current plan year. The results must be provided in the format contained in Attachment 20, *Offeror's Proposed Retail Pharmacy Network Access Prerequisite Worksheet*. The report is due thirty (30) Days after the end of the quarter.

B. Pharmacy Credentialing

1. Describe the Offeror's process to ensure that network pharmacies meet the applicable state licensing requirements and are in compliance with all other federal and state laws, rules and regulations. What is the resource, data base, or other information used by your organization to verify this information?

2. Describe your approach for credentialing Network Pharmacies.

    a. Specify if the Offeror will utilize an external credentialing verification organization. When was the credentialing verification process last completed? What is your process for confirming continuing compliance with credentialing standards? How often does the Offeror conduct a complete review?

    b. What steps does the Offeror take between credentialing periods to ensure that Network Pharmacies that are officially sanctioned, disciplined, or had their licenses revoked are removed from the Retail Pharmacy Network as soon as possible?

    c. What steps, if any, does the Offeror take to advise members when a Pharmacy has been removed from the Retail Pharmacy Network?

C. Pharmacy Contracting

1. Confirm that your agreements with Network Pharmacies require their compliance with all the Programs' requirements and benefit design specifications. Provide a copy of the Offeror's proposed Pharmacy contract, rate sheet, and provider manual. The Offeror must confirm that it will, pursuant to the terms of this RFP and the resulting Contract, provide to the State or to a third-party acting on behalf of the State, any pharmacy network agreement(s) in scope of the Program Services, so that the State can evaluate whether a Network Pharmacy meets Program requirements

and benefit design specifications. If Contractor identifies the information in writing as Contractors' Confidential or Proprietary information access to the information will be provided pursuant to Section 8.7, Contractor's Confidential Information. Such access is in addition to the State's Audit Authority as specified in this RFP.

2. **(Exclusive to DCS)** Confirm that licensed Pharmacies affiliated with home care agencies that are participating providers under The Empire Plan's Home Care Advocacy Program are, or will be, recruited into the Offeror's Retail Pharmacy and Specialty Pharmacy network, if applicable.

3. Please confirm that your Network Pharmacy contracts require the Pharmacy to apply the Program's Lesser of Logic to all the Programs' claims.

4. Please confirm that the Offeror will notify the Procuring Agencies in writing of any changes to the Network Pharmacy contracts or any plans to renegotiate the financial terms of the contracts utilized by the Programs for any New York State Pharmacy or significant out-of-state Pharmacy.

5. **(Exclusive to NYSIF)** Describe in detail the mechanisms the Offeror will put in place to circumvent the referral of bills by participating pharmacies to third party billers for collection.

D. Pharmacy and Program Audit

1. Confirm that 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.

2. 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.

3. Describe the Pharmacy audit program the Offeror would conduct for the Programs including a description of the criteria the Offeror uses to select pharmacies for audit and a description of the policy that the Offeror follows when a Pharmacy audit detects possible fraudulent activity by the Pharmacy or an enrollee. Include all types of audits performed and offered by your organization.

4. Describe the corrective action, monitoring and recovery efforts that take place when the Offeror finds that a Pharmacy is billing incorrectly or otherwise acting against the interests of your clients. Please indicate whether the Offeror has a fraud and abuse unit within your organization

and its role in the Pharmacy audit program. In the extreme case of potentially illegal activity, what procedures does the Offeror have in place to address illegal or criminal activities by the Pharmacy?

5. Provide a copy of the audit language, in its entirety, pursuant to the terms of this RFP and the resulting Contract, that is contained in your standard contract(s) for Network Pharmacies.

6. Confirm that the Offeror will fully cooperate with all Department, NYSIF and/or Office of the NYS Comptroller (OSC) audits, as described in Section 3.9 of this RFP, under the subheading "Pharmacy and Program Audit."

7. Confirm that the Offeror will remit 100% of pharmacy audit recoveries to DCS and/or NYSIF as applicable within thirty (30) Days upon final audit determination consistent with the process specified in Section 6.15, "Payments/ (Credits) to/from the Contractor" and Appendix B (Exclusive to DCS) and Appendix B-2 (Exclusive to NYSIF).

8. Describe the Offeror's proposed auditing tools and performance measures for identifying fraud and abuse by Network Pharmacies and/or Enrollees.

9. Confirm that the Offeror will permit the Department, NYSIF, or a designated third-party, to audit pharmacy bills – including all elements of a claim - and drug company revenues.

E. Mail Service Pharmacy Process

1. Identify and describe the facility(ies) that the Offeror will use in the Mail Service Pharmacy Process for the Programs including the following:

    a. Location(s) of all facilities owned, operated, or subcontracted by the Offeror that are capable of filling Prescriptions through the Mail Service Pharmacy Process including, but not limited to, any compounding or Specialty Pharmacies that fill or dispense Prescriptions through the mail.

    b. Location(s) of all other facilities including, but not limited to, any compounding or Specialty Pharmacies that the Offeror is proposing to utilize in the normal course of the Mail Service Pharmacy Process to dispense all mail order Prescriptions to Enrollees.

    c. Confirmation that the facilities listed in 1(a) or (b) above that are utilized to fill any Enrollee Prescriptions submitted through the Mail Service Pharmacy Process will be priced in accordance with the

Offeror's Guaranteed Mail Order Pharmacy Process pricing as proposed in Attachment 83, *Proposed Claim Reimbursement Quote*.

d. The total capacity of all facilities identified in response to question (a) including, but not limited to the total number of scripts dispensed in 2022 and customers serviced. Describe any technology changes and/or staffing changes that would be necessary to service the Mail Service Pharmacy Process Prescription volume of the Programs.

e. Describe the backup mail order process facility(ies) that the Offeror would utilize to handle any overflow, out of stock situations and/or situations where the primary mail order facility is unavailable. Provide any other alternative methods the Offeror would utilize to meet the mail service Prescription drug delivery requirements of the Programs.

f. Identify the facilities listed in 1(a) or (b) above that have a commercial compounding license and indicate if they compound all drugs covered by the Programs. If there are any drugs that your facilities are unable to compound or do not compound, please detail the process the Offeror will utilize to provide Enrollees with access to all Compound Drugs through the Mail Service Pharmacy Process when the Prescription is submitted through the Mail Service Pharmacy Process.

2. Provide a flow chart describing each step in the Mail Service Pharmacy Process taken prior to dispensing the medication. Describe the system edits for eligibility, prior authorization, utilization, including refill too soon and duplicate therapy utilized to ensure Enrollee safety and Programs' cost control.

3. What steps would a member need to follow to establish their initial order and set up their billing account (exclusive to DCS), when transitioning from the previous contractor's Mail Service Pharmacy? Describe the process that a member must follow when ordering, reordering Prescriptions via mail or moving Prescriptions from a retail Pharmacy to the Mail Service Pharmacy Process. How does the Offeror assist the Enrollee with this process?

4. Describe the capabilities of the Mail Service Pharmacy call tracking system.

5. Confirm that the Offeror will supply sufficient quantities of mail order forms and pre-paid envelopes to encourage mail service utilization.

6. Describe the process to be utilized to handle the following types of Prescriptions including any instructions provided to the Enrollee:

    a. Urgent Prescriptions; will there be additional handling or delivery costs for these Prescriptions?

    b. Prescriptions that require “special” handling (i.e., temperature control, special preparation, controlled substances, limited shelf life, etc.);

    c. Narcotics for the original fill for an Enrollee; and

    d. Prescriptions requested to be mailed in easy open caps.

7. Please detail the system in place to track Prescriptions received through the Mail Service Pharmacy Process. Include the time from the receipt of the order until the delivery agent picks up the package. Specifically, detail how the actual date of receipt of the Prescription and the date the delivery agent picks up the package are recorded.

8. Please describe how the Offeror’s system tracks mail service fill accuracy rates including all error types tracked by the system. In addition, detail the error types the Offeror’s system reports and include a mail service fill accuracy report for 2022. How are member reported errors tracked and reported? What type of investigations and process modifications would the Offeror undertake to address accuracy errors that have the potential to critically impact the Enrollee’s health and safety?

9. Please detail when a Prescription is designated as requiring intervention, and how the system tracks the point at which an intervention is deemed necessary. Describe how the Offeror’s system tracks these Prescriptions and calculates turnaround times for intervention claims. What is the definition of a Prescription that requires external intervention? Would that ever include a Prescription for a medication that is out of stock or a Prescription that has simply aged in the processing system?

10. Describe the process that the Offeror will utilize to provide Enrollees with access to Limited Distribution Drugs when the Prescription is submitted through the Mail Service Pharmacy Process.

11. Please describe/present the process in place to ensure that Enrollees receive all necessary clinical information and support related to Prescriptions dispensed through the Mail Service Pharmacy Process. Please detail the role of licensed Pharmacists in the Mail Service

Pharmacy Process clinical program. Is the process for providing clinical support to Enrollees utilizing the Mail Service Pharmacy Process integrated with or independent of the customer service call center?

12. Describe the process and channels (web, phone access, hard copy, etc.) the Offeror utilizes to collect the information necessary to develop and maintain an Enrollee safety profile.

13. Describe your drug purchasing and inventory philosophy including:

    a. What are the time frames as they relate to back orders or shipment from an alternate mail order facility;

    b. What are the time frames as they relate to backorders or shipments that are from the Offeror's primary supplier;

    c. What is the percentage of Prescriptions that are filled when initially submitted to the primary mail service pharmacy facility the Offeror is proposing; and

    d. How are backorders and out of stock situations handled with members?

14. **(Exclusive to DCS)** Describe the Offeror's Enrollee communication process for out-of-stock items, partial fill orders, when an Enrollee appears to be ineligible, when there are changes to a Prescription that would result in Ancillary Charges, and when there are billing issues that prevent a Prescription from being immediately shipped. Confirm that the Offeror will arrange payment plans with Enrollees, on request.

15. New York State Law does not require but permits substitution of B-rated or unrated generics. Will the Mail Service Pharmacy Process facilities utilized for the Programs fill a Prescription written for a Brand Drug with a B-rated or unrated Generic Drug or will the Enrollee have to obtain a Prescription from the prescribing Physician written for the B-rated or unrated Generic Drug in order to avoid receiving the Brand Drug and paying the higher Brand Drug Copayment?

16. Are there any situations where a Prescription written for a Brand Drug is submitted through the Mail Service Pharmacy Process and the Mail Service Pharmacy Process facilities utilized for the Programs are prevented from substituting an A-rated or authorized Generic Drug in accordance with the Programs' benefit design?

17. Please describe how the Day's supply is determined for the following forms of Prescription Drugs, dispensed by the Mail Service Pharmacy:

a. Eye/Ear Drops

b. Lotions and Ointments

c. Syrups

18. Please describe what proposed strategies the Offeror would implement with the Offeror's Mail Service Pharmacy to compete with Low-Cost 30- and 90-Day programs offered by Retail Pharmacies?

19. **Turnaround Time for Nonintervention Mail Service Prescriptions Guarantee**: The Programs' service level standard requires that at least ninety-five percent (95%) of all nonintervention mail service Prescriptions will be turned around in two (2) Business Days (not including the date of Prescription receipt). Turnaround time is measured from the Day after the Prescription is received by the Mail Service Pharmacy to the date the Prescription is received by the mailing agent. The Offeror shall propose, separately for each Program, the forfeiture of a specific dollar amount of the Claims Administration Fee, for failure to meet this guarantee.

    The Standard Credit Amount for each .01 to 1.0% below the ninety-five percent (95%) of all nonintervention mail service Prescriptions not turned around within two (2) Business Days, is $25,000 per each quarter for DCS and $375 for NYSIF. However, Offerors may propose higher or lower amounts.

20. **Turnaround Time for Intervention Mail Service Prescriptions Guarantee**: The Programs' service level standard requires that at least ninety-eight percent (98%) of all intervention mail service Prescriptions will be turned around in five (5) Business Days (not including the date of Prescription receipt). Turnaround time is measured from the date the Prescription is received by the Mail Service Pharmacy to the date the Prescription is received by the mailing agent. The Offeror shall propose, separately for each Program, the forfeiture of a specific dollar amount of the Claims Administration Fee for failure to meet this guarantee.

    The Standard Credit Amount for each .01 to 1.0% below the ninety-eight percent (98%) of all intervention mail service Prescriptions not turned around within five (5) Business Days is $25,000 per each quarter for DCS and $375 for NYSIF. However, Offerors may propose higher or lower amounts.

F. Specialty Drugs

Specialty Drugs Received through the Retail Pharmacy Network or the Mail Service Pharmacy Process

1. Explain how the Offeror's proposed network provides access to all medically necessary covered Specialty Drugs.

2. Explain the mechanisms in place to facilitate the delivery of Limited Distribution Drugs to Enrollees. Confirm that Enrollees will be charged the Mail Service Copayment for Limited Distribution Drugs submitted to the Mail Service Pharmacy (DCS only).

3. **(Exclusive to DCS)** Confirm that the Offeror will solicit participation in the Retail Pharmacy Network all licensed pharmacies affiliated with the Empire Plan Home Care Advocacy Program. Describe the capability of the Offeror to coordinate and/or integrate services with The Empire Plan's medical vendor.

4. **(Exclusive to DCS)** For those HCAP providers that do not have affiliated pharmacies, how does the Offeror propose coordinating with HCAP and supplying the medication to the Enrollee? Will the Offeror utilize the Mail Service Pharmacy Process?

5. Confirm that necessary ancillary supplies that accompany certain Specialty Drugs will be delivered to the Enrollee at no additional cost to the Programs or Enrollee.

6. Indicate the licensed pharmacies in Attachment 32, *HCAP Providers for the NYS Empire Plan*, with whom the Offeror has a current Network Pharmacy contract.

7. **(Exclusive to DCS)** Site of Care. Confirm that the Offeror understands that there will be a Site of Care Redirection Program in effect for certain groups, which will require the waiving of copays for medications in the program.

G. Specialty Pharmacy Program

1. Provide a listing of the Specialty Drugs that the Offeror proposes for inclusion in the Specialty Pharmacy Program, along with an indication of how they meet the minimum criteria. Also, please state if the Offeror proposes additional criteria. Please state whether the Designated Specialty Pharmacy(ies) the Offeror proposes regularly dispense any other Specialty Drugs which the Offeror is not proposing for the Programs.

2. Provide a detailed description of the Offeror's proposed Specialty Pharmacy Program. Include the following:

    a. Customer service call center

    b. Administration of REMS

    c. **(Exclusive to DCS)** Whether Specialty Drugs administration will be through the Home Care Advocacy Program (HCAP) or a Specialty Pharmacy Program contracted network

    d. Clinical management, including demonstration of outcomes improvement

    e. Fulfillment process, including cold-chain supply and shipping logistics

    f. Transition process from Grace Fill at Retail or Mail

3. Does the Offeror propose to use one dedicated Specialty Pharmacy or several different Specialty Pharmacies? What are the advantages to this approach? Indicate which of the licensed Pharmacy(ies) in Attachment 32, *HCAP Providers for the NYS Empire Plan*, will participate in the Specialty Pharmacy Program.

4. Detail the mechanisms in place to ensure the prompt, safe, and effective delivery of all Specialty Drugs in the Specialty Pharmacy Program to Enrollees. Describe the mechanisms the Offeror proposes to facilitate delivery of Limited Distribution Drugs to Enrollees. Describe override procedures the Offeror proposes to facilitate urgent or same-Day delivery of Specialty Drugs in the Specialty Pharmacy Program as well as override procedures proposed when the Designated Specialty Pharmacy is precluded from shipping the medications, i.e., to an Enrollee residing in a skilled nursing facility or foreign country.

5. **(Exclusive to DCS)** Describe the capability of the Offeror to coordinate and/or integrate services with The Empire Plan's medical vendor in providing HCAP services. For those HCAP providers that do not provide medications, how do you propose supplying the medication?

6. How does the Offeror's system provide the ancillary supplies that accompany some of the Specialty Drugs?

7. Describe the criteria the Offeror will use to evaluate new Specialty Drugs that enter the market and whether they should be included in the

Specialty Pharmacy Process.

H. Vaccination Network (Exclusive to DCS)

1. The Offeror shall indicate in Attachment 21, *Comparison of DCS Current Program Retail Network Pharmacies and the Offeror's Proposed Retail Pharmacy Network*, which of the Network Pharmacies participate in the Vaccination Network. The file containing the DCS Program's current network pharmacies and instructions for completing the attachment can be obtained by following the instructions, which requires that Offerors have the latest version of the IBM Aspera Web Plugin (Aspera Connect) to use the application included in Attachment 21.

5.11 Claims Processing

1. The Offeror must provide a narrative describing in detail the proposed processes that will be utilized in claims processing as specified in Section 3.10 of this RFP, including the following:

    a. Provide a flow chart and step-by-step description of the Offeror's proposed claims processing methodology for adjudicating each of the following claim types: Mail Order, Specialty Pharmacy, Network Pharmacy, Enrollee-submitted claims. For NYSIF Program the additional following claims types must be included and Non-Network Pharmacy claims, network pharmacy claims submitted by third party billers, network pharmacy claims submitted directly to NYSIF, Instant Enrollment (short fill) Claims. Provide a description of the comprehensive edits the Offeror proposes at the point of service to ensure proper claim adjudication, including a detailed description and example of how the Offeror's proposed refill-too-soon (RTS) edit will operate to ensure cost effective dispensing of Drugs under the Programs. Confirm that the Offeror will implement the Offeror's proposed full RTS edit on the respective Project Services Start Date.

    b. Please describe the Offeror's claims processing system platform including any backup system utilized. Describe the Offeror's disaster recovery plan and how Enrollee disruption will be kept to a minimum during a system failure. What is the process for Enrollees trying to get a Prescription when the claims payment system is down or is not accessible?

    c. Describe the capabilities of the Offeror's claim processing system to perform, at the point of service, for each of the following required Programs' components:

i. The Programs generic substitution requirements based on the Programs' definition of a Generic Drug as set forth in the *Glossary of Defined Terms* (Attachment 15) of this RFP.

ii. A Prior Authorization Program for specific drugs that have an increased risk of inappropriate utilization.

iii. A concurrent DUR program identifying Enrollee drug therapy safety edits and Programs' benefit edits.

iv. Messaging capabilities to the Network Pharmacy.

v. Eligibility verification.

vi. Customized edits for individual Enrollees.

vii. Utilization of some medications intended to treat conditions limited to one sex.

viii. Historic claims look up capability to reduce Enrollee disruption at the point of sale.

ix. **(Exclusive to DCS)** Multi-level cost sharing.

x. Identification and pricing of compounded Prescriptions consistent with the Programs' definitions and requirements set forth in this RFP.

xi. Recognition of Pharmacy submitted cost and ensuring the Programs receive the Lesser of Logic for all Prescriptions filled at a network and Non-Network Pharmacy or through the Mail Service and Specialty Pharmacy Processes.

d. Describe how the Offeror's claims processing system will reject Network Pharmacy claims submitted with a DAW-0 code and send appropriate messaging to Pharmacists to ensure submission of a code that provides an indication of the Generic Drug's availability in the Pharmacy to facilitate consistent and accurate application of the Programs' mandatory generic substitution provisions.

e. Describe how the Offeror's claims processing system will ensure that the Programs are charged according to the Programs' Lesser of Logic.

f. Describe how the Offeror's adjudication system feeds the reporting and billing systems and any claim update data delays.

g. Does the Offeror own the adjudication system, license the software, or contract out this service?

h. How quickly are the Offeror's systems brought into compliance when a new version or capability of the standard NCPDP format for claims transmission is released?

i. Describe the current Network Pharmacy available overrides to the Offeror's claims adjudication system. How would overrides from the Retail Pharmacy Network and messaging to the retail Pharmacy network be tracked and reported to the Procuring Agencies? Describe the loading of an override within the Offeror's claims processing system and confirm whether it overrides the Offeror's client's program benefit design? If so, provide the circumstances where the Offeror would load an override edit at the point of service. If applicable, describe the circumstances where the Offeror would approve the dispensing of quantities in excess of the benefit design amounts within the Offeror's concurrent DUR program.

j. Describe how the Mail Service Pharmacy Process, Specialty Pharmacy Program and Network Pharmacy Claims will be subjected to the same prior authorization/quantity limitations, Point of Service and DUR edits and how a common Enrollee profile is maintained for each Enrollee? Is this process on-line for both systems?

k. Describe how any changes to the benefit design would be monitored, verified and tested for the Programs, and the quality assurance program to guarantee that changes to other client benefit programs do not impact the Programs.

l. Identify the resources that are available to a Pharmacist who is having difficulty processing a claim at the point of service. How does the Offeror ensure that the Pharmacist is able to get through to a person to resolve the issue?

m. **(Exclusive to DCS)** Confirm that the Offeror's claims processing system has the capability to: stop claims at the point of service for Enrollees who are enrolled in a Medicare Part D plan other than the DCS Program EGWP and send messaging to the Pharmacy to instruct the Pharmacist to submit the claim to the Enrollee's Medicare Part D Plan.

n. Explain how the Offeror's claims processing system collects overpayments from the Offeror's Retail Pharmacy Network.

o. Confirm the Offeror will reverse all attributes of claim records, e.g., AWP, quantity, Day's supply, etc., processed in error or due to fraud including the reversal of any Claim Administration Fee associated with the original claim and crediting the Programs for all costs associated with the claim processed in error, including but not limited to the Claim Administration Fee.

p. Describe how the Offeror will analyze and monitor claim submissions to promptly identify errors, fraud and abuse and report such information in a timely fashion to the State in accordance with a State approved process. Confirm the Programs shall be charged only for accurate (i.e., the correct dollar amount) claims payments of covered expenses and will be charged a Claims Administration Fee only for Final Paid Claims. Confirm the Offeror will credit the Programs the amount of any overpayment regardless of whether any overpayments are recovered from the Pharmacy and/or Enrollee in instances where a claim is paid in error due to Offeror error, or due to fraud or abuse. In cases of overpayments resulting from errors only found to be the responsibility of the Department, the Offeror shall use reasonable efforts to recover any overpayments and credit 100% of any recoveries to the Programs upon receipt; however, the Offeror, is not responsible to credit amounts that are not recovered.

q. **(Exclusive to DCS)** Can the adjudication system interact with a debit card program for flexible spending accounts?

r. What data elements are required by the Offeror's claims system to process a compound claim? How does the Offeror guard against inappropriate or inaccurate compound claims? How does the Offeror ensure that only those claims that meet the definition of a Compound in the *Glossary of Defined Terms* (Attachment 15) of this RFP are processed as compound claims thereby protecting the Programs' financial interest?

2. Claims Processing Guarantees: In this part of its Technical Proposal, the Offeror must state its agreement and guarantee for the following four program service level standards:

   a. ***Programs' Claims Processing System Availability Guarantee*:** The Programs' service level standard requires that the Programs' online claims processing system be available at least ninety-nine and five-tenths percent (99.5%) of the time excluding periods of

scheduled down time which shall be reported in advance to the Department and kept to a minimum, based on 24 hours a Day, 7 Days a week availability (or the Offeror's proposed guarantee). The Offeror shall propose, separately for each Program, the forfeiture of a specific dollar amount of the Claims Administration Fee for failure to meet this guarantee.

The Standard Credit Amount for each .01 to .25% below the ninety-nine and five-tenths percent (99.5%) that the Offeror's online claims processing system for the Programs are not available, is $100,000 per each quarter for DCS and $7,500 for NYSIF. However, the Offeror may propose higher or lower amounts.

b. ***Programs' Claims Processing System Accuracy Guarantee*:** The Programs' service level standard requires that the online claims processing system will accurately process claims at the point of service in accordance with the Program's benefit design at least ninety-nine and five-tenths percent (99.5%) of the time excluding periods of scheduled down time, which shall be reported to the Department in advance and kept to a minimum, based on a 24 hours a Day, 7 Days a week availability, (or the Offeror's proposed guarantee). The Offeror shall propose, separately for each Program, the forfeiture of a specific dollar amount of the Claims Administration Fee for failure to meet this guarantee.

The standard credit amount for each .01 to .25% below the ninety-nine and five-tenths percent (99.5%) that the Offeror's online claims processing system does not accurately process claims at the point of service in accordance with the Programs Benefit design, is $100,000 per each quarter for DCS and $7,500 for NYSIF. However, the Offeror may propose higher or lower amounts.

c. **(Exclusive to DCS) *Turnaround Time for Claims Adjudication Guarantee*:** The DCS Program's service level standard requires that at least ninety-nine and five-tenths percent (99.5%) of Enrollee-submitted claims that require no additional information in order to be properly adjudicated that are received by the Offeror and not turned around within ten (10) Business Days from the date the claim is received in the Department's Designated Post Office Box to the date the Explanation of Benefits is received by the mailing agent. The Offeror shall propose the forfeiture of a specific dollar amount of the Claims Administration Fee for failure to meet this guarantee.

The Standard Credit Amount for each .01 to .25% of the DCS Program's Enrollee-submitted claims that require no additional information in order to be properly adjudicated that are received by the Offeror and not turned around within ten (10) Business Days from the date the claim is received in the Department designated Post Office Box to the date the Explanation of Benefits is received by the mailing agent below the standard of ninety-nine and five-tenths (99.5%) is $5,000 per each quarter for DCS. However, the Offeror may propose higher or lower amounts.

d. **(Exclusive to NYSIF)** ***Turnaround Time for Claims Adjudication Guarantee*****:** The NYSIF Program's service level standard requires that at least ninety-nine and five-tenths percent (99.5%) of Non-Network Pharmacy claims that require no additional information in order to be properly adjudicated that are received by the Offeror and not turned around within thirty (30) Calendar Days from the date the claim is received in NYSIF's Designated Post Office Box to the date the explanation of Benefits is received by the mailing agent. The Offeror shall propose the forfeiture of a specific dollar amount of the Claims Administration Fee for failure to meet this guarantee.

The Standard Credit Amount for each .01 to .25% of the NYSIF Program's Non-Network Pharmacy submitted claims that require no additional information in order to be properly adjudicated that are received by the Offeror and not turned around within thirty (30) Calendar Days from the date the claim is received in the FUND's designated Post Office Box to the date the Explanation of Benefits is received by the mailing agent below the standard of ninety-nine and five-tenths (99.5%) is $375 per each quarter for NYSIF. However, the Offeror may propose higher or lower amounts.

5.12 Retrospective Coordination of Benefits (Exclusive to DCS)

1. Provide a flow chart and step-by-step description of the process the Offeror will employ to conduct the DCS Program's retrospective coordination of benefits (COB) requirement. Specifically, please detail how the Offeror will collect, store, and investigate COB information for other insurance.

5.13 Utilization Management

A. Mandatory Generic Substitution at Retail and Mail

1. Please explain in detail the process the Offeror will utilize to administer the Programs' mandatory generic substitution provisions in accordance with the requirements set forth in this RFP including, but not limited to, how the Offeror's claims processing system will enforce the Programs' generic substitution requirement for a Generic Drug within the time limits specified in 3.12(1)(d) under Mandatory Generic Substitution at Retail and Mail.

2. How does the Offeror's Retail Pharmacy Network contracts protect the financial interests of the Programs in the event a network Pharmacist does not have a required generic in stock when presented with a Prescription requiring dispensing of the generic under law or pursuant to the provisions of the Programs' mandatory generic substitution program after the maximum twenty-one (21) Day period?

3. Explain in detail the process the Offeror intends to follow to ensure that drugs meeting the definition of generic as set forth in this RFP are identified in the Offeror's system as Generic Drugs subjecting them to the generic pricing requirements set forth in Section 6 and mandatory generic substitution for A-rated or authorized Generic Drugs.

4. Please detail how the Offeror's system will distinguish between A-rated and authorized Generic Drugs requiring generic substitution, A-rated generics not requiring substitution including, but not limited to Narrow Therapeutic Index (NTI) drugs (DCS only), and non-A-rated Generic Drugs. Please describe the capability of the Offeror's system to apply MAC pricing but not enforce generic substitution for non-A-rated Generic Drugs, NTI drugs, or for available A-rated Generic Drugs that the Department has directed the Offeror not to enforce the Programs' mandatory generic substitution requirement.

5. Please detail the process for updating the Offeror's claims processing system upon distribution of a new Generic Drug to ensure prompt application of MAC pricing and/or mandatory generic substitution.

6. **(Exclusive to DCS)** Please describe how the Offeror will manage the NTI list for the DCS Program including the parties responsible for making NTI recommendations.

B. Mandatory Generic Substitution Appeal Process (Exclusive to DCS)

1. Describe in detail how the Offeror would administer the required

generic appeal processes (also referred to as a “Dispense as Written exception request”) for the DCS Program including:

a. The turnaround time.

b. Qualifications of the staff that would conduct the review.

c. A description of the criteria that would be used to determine whether the brand name medication is medically necessary. Are there any dollar thresholds within the Offeror’s criteria? Does the Offeror require generic appeals to be updated after a specific time period? If so, what is the process?

d. Does the Offeror currently administer a generic appeals process? If yes, provide the number of appeals the Offeror reviews annually and the approval and denial rates for a client similar to the Program (for the most recent Calendar Year); and for the following list of drugs:

   i. Combigan

   ii. Keppra

   iii. Divigel

   iv. Crestor

   v. Lexapro

e. How the Enrollee’s claim will be handled during the appeal processing. In the event of a successful appeal, confirm that the Offeror will retroactively adjust claims incurred within 30 Days from the date of receipt of a completed appeals form. Describe how member refunds will be handled.

2. Confirm that the Offeror will load previously approved Generic Appeals data into the Offeror’s claims adjudication system.

5.14 Clinical Management / Drug Utilization Review (DUR)

A. Prior Authorization

1. Referring to the drugs or the drug categories subject to Prior Authorization, describe in detail how the Offeror would propose to administer Prior Authorizations including:

a. The process and criteria the Offeror utilize to identify drugs that the Programs should consider for prior authorization.

b. The qualifications of each level of staff making decisions with regard to the pre-authorization process, denial, and appeal. Based on the DCS Program's number of prior authorizations, what is the Offeror's projected staffing level for this unit?

c. A description of any current prior authorization programs the Offeror manages including the list of drugs subject to prior authorization and the number of cases reviewed, approved and declined for a client similar to the DCS Program (for the most recent Calendar Year).

d. The process the Offeror utilizes to contract and collect the appropriate information from Physicians in order to make a determination. Provide a timeline for completion of approvals and denials.

e. The methods the Offeror utilizes to measure program effectiveness *(Do not include any reference to specific monetary savings)*.

f. How the Offeror will transition Enrollees with current prior authorizations and their Prescriptions into the Offeror's system. Specifically address whether the Offeror's system has the flexibility to issue prior use exceptions for Enrollees currently taking drugs that would require Prior Authorization.

2. For each of the drugs currently subject to Prior Authorization under the DCS Program, please list the time period of the authorizations that the Offeror would apply to each. Also, please confirm what steps the Offeror will perform to reauthorize at the end of the authorization period.

3. 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 outcome of the Prior Authorization review and their appeal rights.

4. Confirm that the Offeror currently respond to DFS External Appeals within the required time frames.

[**Note:** Do not include any financial / cost information in the Technical Proposal.]

5. **(Exclusive to NYSIF)** Provide a flow chart detailing the Prior authorization Process as detailed in Attachment 68, *NYSIF PBM Prior Authorization Process*, of this RFP.

6. **(Exclusive to NYSIF)** Confirm that the Offeror will provide training to NYSIF staff in the utilization of automated Prior Authorization System. Provide copies of the training materials.

7. **(Exclusive to DCS) Turnaround Time for Prior Authorizations Guarantee**: The Program's service level standard requires that at least ninety-five percent (95%) of Prior Authorization requests that are received by the Offeror will be turned around within two (2) Business Days. Turnaround time is measured from the date the Prior Authorization request is received by the Offeror, by any origin (i.e., electronically, telephonically, via fax, or in the Programs designated Post Office Box), to the date the Offerors response is received by the mailing agent.

   The Standard Credit Amount for each .01 to .25% of the Prior Authorizations received by the Offeror not turned around within two (2) Business Days from the date the Prior Authorization request is received by the Offeror, by any origin (i.e., electronically, telephonically, via fax, or in the Programs designated Post Office Box), to the date the Offerors response letter is received by the mailing agent below the standard of ninety-five percent (95%) is $25,000 per each quarter for DCS. However, the Offeror may propose higher or lower amounts.

B. Concurrent Drug Utilization Review (DUR)

1. Please detail the full scope of the Concurrent DUR program that the Offeror proposes to utilize for the Programs. Include the qualifications of the staff responsible for oversight of the Offeror's Concurrent DUR program.

2. Describe the software the Offeror will utilize to administer the Concurrent DUR program that you will implement for the Programs. Please specify if the Offeror has developed this software, purchased it from a third-party source, or is it a system the Offeror purchased and have adapted for the Offeror's use.

3. Program Safety Edits

   a. Within the Offeror's Concurrent DUR program describe all safety edits currently enforced through the Offeror's claims processing system including, but not limited to the safety edits below:

      i. drug-drug interaction including OTC drugs and herbal supplements, if applicable

      ii. drug-allergy interaction

iii. drug-medical condition interaction

iv. minimum daily dosage

v. exceeding maximum dosage

vi. therapeutic duplication

vii. drug-gender interaction

viii. drug-age interaction

ix. drug-pregnancy interaction

x. compliance with FDA approved drug utilization guidelines

b. Please describe for each edit the messaging sent to the Pharmacist including whether the edit is classified as a soft or hard edit. Describe the type of actions required by the Pharmacist at the point of service following receipt of these alerts. How does the Offeror monitor the effectiveness of the safety alerts program?

4. Program Benefit Edits

   a. Within the Offeror's Concurrent DUR program describe how the Offeror's program monitors the following at the point of service, including whether the edits are hard edits or soft edits, and whether the Program monitors overrides at the Pharmacy Level:

      i. Refill too soon, including a description of the methodology utilized

      ii. Prior authorization

      iii. Drug exclusions or limitations

5. Describe the methods the Offeror utilizes to measure Program effectiveness (Do not include any reference to specific monetary savings).

6. Describe any other programs the Offeror proposes to provide to administer utilization management on behalf of the Programs.

C. Retrospective DUR Program

1. Describe the Retrospective DUR Program that the Offeror propose to put in place for the Programs including:

    a. The qualifications of the staff that would perform these reviews.

    b. How the Offeror identifies and selects areas for retrospective review and the methods utilized to inform and educate Physicians.

    c. A timeline for these reviews.

    d. What type of follow-up the Offeror conducts after communicating the information to the Physician.

    e. How the Offeror measures the effectiveness of their Retrospective DUR Program including any statistical measures of the success of the Offeror's efforts (Do not include any reference to specific monetary savings).

    f. Whether the Offeror currently administers a Retrospective DUR Program for other clients and, if applicable, how the Retrospective DUR Program for the Commercial Plan differs from the Retrospective DUR Program for the EGWP.

    g. The reporting capability for the Offeror's described program.

    h. Provide examples of the communications to physicians resulting from the retrospective DUR Program.

    i. Provide examples of reports of the Offeror's described program.

D. Medical Exception Program (Exclusive to DCS)

1. Provide a flow chart and step-by-step description of the process the Offeror will employ to conduct the DCS Program's medical exception program. Specifically, please detail the process for receiving, assessing, and responding to the prescribing Medical Professional's Medical Exception requests.

2. Does the Offeror currently have a program in place similar to the DCS Program's medical exception program? If so, please describe in detail the structure of the Offeror's program including, but not limited to:

    a. Define the specific criteria required for approval of a medical exception request including the required number of trials of

formulary alternatives that must be undertaken before a medical exception can be approved.

b. Provide examples of all communication materials related to the Offeror's Program that it uses for other clients.

3. Will the Offeror accept a letter of medical necessity from an enrollee's physician, which details the enrollee's formulary alternative trials and any other clinical documentation supporting medical necessity? If so, explain in detail what specific information is required for approval.

4. The Offeror must confirm that it possesses adequate qualified staffing resources to perform the services of the DCS Medical Exception Program. Attachment 80, *Medical Exception Program Claims Experience*, provides data regarding the number of exception requests for a select time frame.

E. Physician Education

1. Describe/present the Physician communication/education programs you propose for the Programs. Describe the Offeror's objectives and approach to Physician profiling and education including:

   a. Whether the Offeror currently administers a Physician profiling and education program for other clients similar to the Programs.

   b. A description of the method(s) and analysis the Offeror uses to select Physicians for profiling and whether the Offeror's clinical programs involve peer-to-peer Physician discussions.

   c. The frequency of the Offeror's educational efforts.

   d. The number of Physicians the Offeror has contacted as part of a Physician Education Program and the results of those efforts in the areas of increased compliance with recommended protocols and modifying patient Prescription utilization.

   e. How the Offeror measures the effectiveness of their Physician profiling program including any statistical measures of the success of their efforts. [**Note:** Do not include any reference to specific monetary savings.]

   f. Whether the Offeror will adapt their Physician Education Program standards to meet the Program's needs as specified by the Department.

   g. Confirm that the Physician Education program will not be funded by pharmaceutical manufacturers.

F. Patient Education (Exclusive to DCS)

1. Describe the Offeror's objectives and approach to patient education including:

    a. Whether the Offeror currently administers a patient education program for other clients.

    b. The identification and selection of categories of drugs to apply retrospective review and the method(s) the Offeror proposes to use to educate and inform patients.

    c. The number of educational interventions and the expected Enrollee response rate.

    d. How the Offeror measures the effectiveness of their patient education program including any statistical measures of the success of the Offeror's efforts. [**Note:** Do not include any reference to specific monetary savings.]

    e. Confirm that the Patient Education Program will not be funded by Pharmacy manufacturers.

G. Patient Education (Exclusive to NYSIF)

1. Describe the Offeror's objectives and approach to patient education including:

    a. Whether the Offeror currently administer a patient education program for other clients.

    b. The identification and selection of categories of drugs to apply retrospective review and the method(s) the Offeror proposes to use to educate and inform patients.

    c. The number of educational interventions and the expected Enrollee response rate.

    d. How the Offeror measures the effectiveness of their patient education program including any statistical measures of the success of the Offeror's efforts. [**Note:** Do not include any reference to specific monetary savings.]

    e. Confirm that the Patient Education Program will not be funded by Pharmacy manufacturers.

[**Note:** The cost of all the programs listed above are required to be in the Offeror's Proposed Claims Administration Fee.]

H. Other Safety-Related Programs

1. Describe the purpose of any other clinical management or drug utilization review programs that the Offeror proposes to administer for the Program with the Pharmacy, Physicians, Enrollees, etc.. Include a detailed description of how the program operates and its benefit to the Programs and Program's Enrollees.

2. Identify the funding source behind any of the programs the Offeror proposes and confirm whether or not the costs for the Program are included in the Claims Administration Fee.

5.15 Drug List Development and Management

1. Preferred Drug List Management – General (Exclusive to DCS)

a. Does the Offeror currently develop, maintain and administer plans with three copay level benefit designs utilizing one or more Preferred drug lists? Detail the Offeror's proposed plan and their capability to administer the Program's formulary benefit according to the Program's benefit designs.

b. Describe the various preferred drug lists the Offeror has available:

   i. Does the Offeror have a standard three copay level preferred drug list used for your Book of Business?

   ii. Does the Offeror maintain multiple standard and custom preferred drug lists? Provide a description of the differences.

   iii. What is the goal of these alternative preferred drug lists?

   iv. What role do clients play in the development of the Offeror's preferred drug lists?

   v. How often are changes made for both additions and deletions?

   vi. Are there special considerations for biological and specialty Pharmacy products in the Offeror's preferred drug list and/or process?

c. What Preferred Drug Lists is the Offeror proposing to use in managing

the DCS Program? Please provide a list by NDC in Excel format that includes the tier (1=generic, 2=preferred brand, 3=non-preferred brand). Are there any therapeutic classes that are composed of only Non-Preferred Drugs due to documented medical evidence of inferior clinical attributes of the Brand Drugs in comparison with competing generics and/or clinically documented safety concerns? What is the Offeror's clinical rationale for limiting these drugs to Level 3?

d. Explain how the Offeror would work with the medical carrier and the mental health and substance use carrier to ensure that participating providers in their networks are fully apprised of the level status of Covered Drugs.

e. Confirm that the Empire Plan Flexible and Advanced Flexible Formulary Drug List(s) will be made available on Rx Hub and Level 1 and Level 2 drugs will be designated as Preferred. Describe how Rx Hub will be utilized for the benefit of the DCS Program including how it will encourage physicians to prescribe lower cost alternative medications to Enrollees.

f. Describe the strategy which would be implemented to control Prescription Drug AWP increases.

g. Describe how the Offeror will develop, recommend, and implement Brand for Generic strategies for the formularies that are financially beneficial to the State.

2. <u>Preferred/Non-Preferred/Excluded Determination (Exclusive to DCS)</u>

a. Describe in detail the process employed to determine whether a drug is designated as preferred, non-preferred or excluded, and confirm the Offeror's ability to exclude drugs, and/or change the tiering of drugs, subject to State approval, based on the Flexible Formulary or Advanced Flexible Formulary criteria in Section 3.14, Drug List Development and Management, including:

   i. All standards and criteria used in this determination

   ii. The qualifications of the current participants in the review process, as well as any requirements related to ensuring that the participants in the process are independent, objective, and free of conflict of interest

   iii. The role of net cost in this determination

   Whether the designation of preferred/non-preferred or excluded status is governed by formal corporate policies and procedures

detailing standards of review and criteria, is considered in reaching such determination

iv. Whether the process is governed by formal procedures to ensure sound clinical examination resulting in quality pharmaceutical care

v. Whether a record is made of the process leading to preferred/non-preferred or excluded designations and whether the Department will have access to either original records and/or summaries detailing the basis for designations

vi. How often a drug's preferred/non-preferred or excluded status is reviewed and revised and is the review process done on a predetermined scheduled basis? If so, what is the schedule for the review process and are there exceptions to these scheduled meetings

vii. Whether the process is different for innovative new therapies than for therapies that already have a competitive alternative

viii. The conditions that would cause a drug's preferred, non-preferred, or excluded status to change – understanding the constraints of the frozen formulary law and collectively bargained agreements - and several recent examples.

b. Describe the type of analysis the Offeror would perform when a Preferred Brand Drug is being considered for movement to a Non-Preferred Brand Drug list and vice versa.

c. Provide a diagrammatic illustration of the process from receipt of notification of a new drug entry into the marketplace from the manufacturer to the PDL decision-making process, identifying any and all clinical and financial considerations impacting the placement of the product. Please include estimated time frames.

3. <u>Preferred Drug List Strategy (Exclusive to DCS)</u>

a. How are Generic equivalents considered in the Offeror's assessment of individual therapeutic categories on your PDL?

b. How does the Offeror's PDL development process promote the use of the most cost-effective drug within the therapeutically equivalent drugs in the class, including Generics, rapid-acting insulin and biosimilars? Provide three examples. Confirm that the Offeror will include "low list" rapid-acting insulins on the formularies. ~~Provide three examples.~~

c. Does the Offeror's PDL strategy currently allow for drug exclusions? Do the Offeror's proposed Flexible, Advanced Flexible and Excelsior PDLs contain Drug exclusions? Is the Offeror able to exclude drugs based on the Flexible Formulary or Advanced Flexible Formulary criteria set forth in Sections 3.14 and 5.15, Drug List Development and Management (Exclusive to DCS)? Using the excluded drug by NDC Excel list provided in Attachment 52 *Excluded Drug Lists - January 2023 (by NDC)*, Offerors must compare their Proposed Excluded Drug List to the list provided, and for any addition to the list, provide the rationale for each drug's exclusion and how it qualifies under the exclusion criteria. Indicate any instance if a currently excluded drug is covered by the Offeror. Describe how the Offeror uses exclusion leverage to negotiate rebates with Pharmacy manufacturers to provide the best value to the DCS Program.

d. Describe the Offeror's strategy and process for evaluating and determining the appropriate PDL designation for the introduction of "me too" drugs including drugs with OTC equivalents. Please describe the Offeror's current strategy and its rationale for the proton pump inhibitor class, statin class, and lifestyle drugs (Cialis, Levitra, etc.).

e. Describe the Offeror's strategy and process for determining the appropriate PDL designation for the introduction of "successor drugs," including extended release products. Provide an example of this strategy.

f. Please detail the Offeror's strategy and process for determining the appropriate copay level designation for the introduction of "combination drugs" including, but not limited to any net cost analysis comparing the cost of the new combination drug and the cost of its component drugs. How does this process evaluate comparative cost when the new combination drug does not come in all strengths available in either of the component drugs or if the single combination drug does not meet the usual dosing levels of one of the component drugs? Please provide an example of this strategy.

g. Explain how the Offeror's business model ensures that the placement of drugs on the PDLs will result in the best value to the DCS Program and Enrollees. Describe how manufacturer contracting is integrated into this process.

h. Describe how the anticipated upcoming release of a new Generic drug or biosimilar impacts the placement of its Brand Drug equivalent on the Preferred Drug Lists. Will the rebates available for similar Brand Drugs impact its placement? Does the Offeror's proposed PDL have drugs anticipated to go generic or have biosimilars available in 2025 as non-preferred? Please explain the rationale for such classification.

4. <u>Drug Recalls, Withdrawals, and Drug Lawsuits/Settlements (Exclusive to</u>

DCS)

a. Describe the Offeror's process for complying with the applicable Program requirements in the event of a drug recall or drug withdrawal including the time notification standards the Offeror employs. Identify the services that would be provided to the Program and Enrollees. How is the Program reimbursed when a medication is recalled or withdrawn?

b. Describe the Offeror's process for identifying drug lawsuits and settlements on behalf of the Program. Confirm that the Offeror will notify the Department in a timely manner of class action lawsuits or settlements in which the Program may participate. Confirm that the Offeror will credit the Program for net recoveries within fifteen (15) Days upon receipt by the Offeror. Describe how the Offeror's actual costs incurred in the settlement will be allocated to the Program.

5. Preferred Drug List Development and Management (Exclusive to NYSIF)

a. Describe how the Offeror will maintain a formulary compliant with the WCB standard, including the categorization of drugs and the NYS WCB Medical Treatment Guidelines, e.g., drugs requiring prior authorization, Covered Drugs dispensed not requiring prior authorization Certain drugs will have time frames during which prior authorization is not required;

b. Confirm that the Offeror does not and will not accept payments from drug companies to promote specific products;

c. Confirm the Offeror will provide NYSIF with an electronic file of all formulary drugs including dosages, NDC numbers, GPI and GC3 codes. The frequency of this file submission will be determined by NYSIF and will be provided upon vendor selection.

5.16 Consolidated Appropriations Act (CAA) (Exclusive to DCS)

1. The Offeror must provide a narrative describing how it will conduct and document a NQTL comparative analysis and confirm the analysis will be provided upon request at no additional charge. This narrative should also include a summary of its planned activities to ensure compliance with other provisions of the CAA, including, but not limited to, posting machine-readable files related to claims payments, and enrollee transparency tools when required.

   The Offeror must provide a narrative describing how it will collect and report on prescription drug information (RxDC Reporting) and confirm that the repots will be provided upon request. The Offeror must confirm the collection and reporting will be included in the Administration Fee and not charged separately.

5.17 Consulting (Exclusive to DCS)

1. The Offeror must provide a narrative describing how it will inform the Department in a timely manner concerning such matters as cost containment strategies, new drugs, conversion from Brand Drugs to Generic Drugs and how it will impact cost, formulary configuration, technological improvements, e-prescribing, Pharmacy innovations, and State/Federal legislation (i.e., Medicare, Prescription drug mandates, etc.) that may affect the DCS Program. The Offeror must confirm that it will make available to the State one or more members of the clinical or account management team to discuss the implications of these new trends and developments. The Offeror must confirm its understanding that the Department is not under any obligation to act on such advice or recommendation; and

2. The Offeror must provide a narrative description of how it will assist the Department with recommendations and evaluation of proposed benefit design changes. The Offeror must confirm that it will implement any changes necessary to accommodate DCS Program modifications resulting from collective bargaining (using Department benefit codes), legislation, or within the statutory discretion of the State. In the event of a design change and the Contractor requests any change in compensation such change will be in accordance with Modification of Program Services provision (Section 8.8).

SECTION 6: FINANCIAL PROPOSAL

6.1 General

1. Purpose

The purpose of this section of the RFP is to set forth the duties and responsibilities required of the Offeror as regards to its cost quotes and to pose questions (i.e., the information and documentation required under the Confirmations and Required Submissions sections) concerning those duties and responsibilities. The Offeror's Financial Proposal must contain responses to all questions in the format requested, as well as the financial attachments required in Section 6.3, below. The Financial Proposal evaluation will analyze the relative impact of each Offeror's Financial Proposal on the Programs' claims costs and administration costs and net savings that will result for the Offeror's Pharma Revenue Guarantee. Each Offeror may submit ONLY ONE Financial Proposal. Each Financial Proposal will be evaluated with the following goal in mind: the lowest possible total combined Program cost over the term of the Agreements resulting from this RFP while being responsive to the requirements of the RFP.

2. Informational Claim Data Files

To assist Offerors in the development of their Financial Proposal, **the Procuring Agencies have** produced informational claim data files containing claims paid for the period **January 1, 2022, through December 31, 2022**. The informational claim file data layouts for the DCS (Attachment 84, *Layout Specifications for DCS Program Informational Claims Data File*) and NYSIF (Attachment 85, *Layout Specifications for NYSIF Program Informational Claims Data File*) Programs can be obtained by prospective Offerors by following the instructions in Attachment 86, *Informational Claims Files for DCS and NYSIF*, which requires that Offerors have the latest version of the IBM Aspera Web Plugin (Aspera Connect) to use the application.

6.2 Evaluation Process – General

1. The evaluation of Financial Proposals will be conducted by applying each Offeror's cost quotes to normalized claim data. In particular, the evaluation will involve the following:

    a. Analysis of the impact of proposed Guaranteed Discounts and dispensing fees, and the Offeror's per final paid claim Pharma Revenue Guarantee on combined Program claim costs;

b. Analysis of the impact of the Offeror's proposed Claims Administration Fees for administering the Programs; and

c. **(Exclusive to DCS)** Analysis of the impact of the Offeror's proposed Vaccine Administration Fees.

6.3 Analysis of Financial Components

1. Financial Attachments to Complete

a. The Offeror must complete the following financial attachments in strict accordance with the directions set forth in this RFP and submit them as part of their Financial Proposal:

i. Attachment 83 - *Proposed Claim Reimbursement Quote*

ii. Attachment 88 - *Retail and Mail Service Pharmacy Generic Drugs – MAC List Costs per GPI*

iii. Attachment 89 - *Specialty Pharmacy Program Dispensing Fees*

iv. Attachment 90 - *Pharma Revenue Guarantee Quote*

v. Attachment 91 - *Documentation to Support Pharma Revenue Guarantee Quote*

vi. Attachment 92 - *Claims Administration Fee(s) Quotes*

vii. Attachment 93 - *Vaccination Administration Fees*

2. Financial Attachments – Informational

a. The following attachments are provided for informational purposes in order to assist Offerors in submitting their Financial Proposal:

i. Attachment 84 - *Layout Specifications for DCS Program Informational Claims Data File*

ii. Attachment 85 - *Layout Specifications for NYSIF Program Informational Claims Data File*

iii. Attachment 86 – *Informational Claims File for DCS and NYSIF* (The Informational Claims Files for DCS and NYSIF can be obtained by following the instructions included in Attachment

86 and requires that Offerors have the latest version of the IBM Aspera Web Plugin (Aspera Connect) to use the application)

iv. Attachment 87 - *Designated Specialty Pharmacy Identifiers*

v. Attachment 88 - *Retail and Mail Service Pharmacy Generic Drugs – MAC List Costs per GPI*

vi. Attachment 94 - *DCS "Brands Classified as Generics"*

6.4 Claim Ingredient Cost - General

The Procuring Agencies require full transparency of claim ingredient costs in the Retail Pharmacy Network. The Offeror shall propose a Guaranteed Minimum Discount off of Aggregate AWP of all Brand Drugs dispensed through the Retail Pharmacy Network. The Offeror is required to propose a Guaranteed Minimum Discount off of Aggregate AWP of all Generic Drugs dispensed through the Retail Pharmacy Network and Mail Service Pharmacy Process. The Offeror shall propose a Guaranteed Discount off of AWP of Brand Drugs dispensed to Enrollees/Claimants through the Mail Service Pharmacy Process. The Offeror is required to propose a Guaranteed Minimum Discount off of Aggregate AWP of Specialty Drugs dispensed to Enrollees/Claimants through the Specialty Pharmacy Program. The Offeror must also propose a pricing methodology for Compound Drugs dispensed to Enrollees/Claimants that will be utilized for both Retail claims and Mail Service Pharmacy Process claims. This section sets forth the Program requirements related to those guarantees.

1. Claim Ingredient Cost - General

a. All proposed discounts, dispensing fees and prescribing fee(s), if applicable, for Brand and Generic Drugs must be guaranteed for the entire term of the Agreements **without qualification or condition**. In addition, the Selected Offeror's proposed Compound Drug pricing methodology must be guaranteed for the entire term of the Agreements **without qualification or condition**.

b. All proposed discounts and dispensing fees for Specialty Drugs apply only to Enrollees/Claimants who participate in and have drugs dispensed through the Specialty Pharmacy Program and must be guaranteed for the entire term of the Agreements **without qualification or condition**.

c. The Contractor shall utilize the Medi-Span field coded R028 entitled

"AWP unit price" as the source of Average Wholesale Price (AWP) information for purposes of calculating Ingredient Cost.

d. During the term of the Agreements, in the event the Medi-Span reporting service changes its methodology related to any of the information fields used in the Procuring Agencies' classification of Brand and Generic Drugs, or its methodology for coding drugs in connection with these information fields, the Contractor shall be obligated to inform the Procuring Agencies in writing of such changes within 30 Days of learning of such changes. Upon written notification, the Contractor and the Procuring Agencies will meet and agree in writing to any Brand and/or Generic Drug classification changes that may be necessary to enable each to maintain the same economic position and obligations as are set forth in the Agreements.

e. If, during the term of the Agreements, industry events have caused the Contractor's source of AWP to become obsolete or no longer available, the Procuring Agencies and the Contractor shall agree on revised pricing terms. In no event shall the Programs' actual costs for drugs increase as the result of new pricing terms. The Contractor shall notify the Procuring Agencies in writing as soon as any information indicating a problem with the future use of the Contractor's AWP source is received. Within two weeks of the initial notification, and no less than 120 Days prior to the effective date of any revision, the Contractor shall submit a detailed written proposal to the Procuring Agencies for effectively revising pricing terms including but not limited to a file containing the Contractor's pricing for all drugs dispensed during the prior six months utilizing the current AWP source and the Contractor's revised pricing for such drugs using the proposed methodology. The Contractor's Proposal should ensure continued alignment of the Contractor's interests with those of the Programs. In no event can the Contractor's Proposal deviate from the Programs' Lesser of Logic.

f. To protect Enrollees/Claimants from disruption due to reclassification of drugs, during the term of the Agreements, and to assure that Offeror's Proposals are evaluated consistently, drugs shall be classified for pricing purposes in accordance with current Program Brand /Generic Drug classifications and in accordance with the definitions in the *Glossary of Defined Terms* (Attachment 15) of this RFP.

g. Offerors must use the Programs current Brand/Generic classification methodology, which is primarily based on a particular set of Medi-Span indicators.

The following methodologies shall be used by Offerors and will be used by the Procuring Agencies in their evaluation of Offerors' Proposals to determine the appropriate Brand/Generic Drug classification so as to comply with the contractual definitions set forth in the *Glossary of Defined Terms* (Attachment 15) of this RFP.

i) Classification Methodology General

1) Drugs shall be classified for pricing purposes during the term of the Agreements in accordance with the Programs' classification determinations based on the definitions contained in Attachment 15, *Glossary of Defined Terms,* of this RFP. No later than November 15th of each Plan Year, the Contractor shall submit for the Programs' written approval a file containing all NDCs dispensed through the Program during the prior year and the classification of each NDC derived from application of the Contractor's electronic classification process. To the extent the Contractor's electronic process results in classifications inconsistent with the Programs' determinations, the Contractor commits to modify its classification methodology to replicate the results of the Programs' determination, including the steps set forth in 6.4.1(g)(i)(2) below. The Programs' determination shall be final.

2) To the extent the electronic process fails to comprehensively replicate drug classifications consistent with the definitions of Brand and Generic Drugs set forth in Attachment 15, *Glossary of Defined Terms,* of this RFP, the Contractor agrees to modify to the extent possible its electronic processing system before January 1, 2025, including setting appropriate Copayment levels as required, and to undertake all other necessary manual steps to ensure that the result of the prescription processing process from a cost basis to both Enrollee and Plan is in accordance with the DCS determination of classification.

3) The Contractor shall conduct a year end reconciliation each Plan Year to ensure that the claim amount charged to the Plan is in accordance with the definition of Brand and Generic Drugs set forth in the *Glossary of Defined Terms* (Attachment 15) this RFP. The reconciliation will include claims paid during the Plan Year and is to be completed by February 15th of the following year. If

DCS's review of the Contractor's reconciliation indicates an adjustment is required, then DCS reserves the right to make an adjustment to the Contractor's submitted reconciliation. The Contractor shall credit or debit the Plan as applicable no later than 30 Days following the date of reconciliation and reflect the result in the Annual Financial Statement.

ii) Brand Name Drug Determination Methodology

1) A drug labeled with the identifier "M" or "O" in the Medi-Span Multi-Source code shall be processed as a Brand Drug unless the same drug is identified as "G" in the Medi-Span Brand-Name code.

2) In addition to drugs identified as "M" or "O" in the Medi-Span Multi-Source code, a drug that is identified as "N" in the Medi-Span Multi-Source code shall be designated a Brand Drug if the drug is identified as "T" in the Medi-Span Brand- Name code.

iii) Generic Drug Determination Methodology

1) A drug identified as "Y" in the Medi-Span Multi-Source code shall be designated as a Generic Drug.

2) In addition to drugs identified as "Y" in the Medi-Span Multi-Source code, a drug identified as "N" in the Medi-Span Multi-Source Code shall be designated as a Generic Drug if the corresponding Medi-Span Brand-Name code for such drug is "B" or "G."

3) In addition, a drug identified as "G" in the Medi-Span Brand-Name Code shall be designated as a Generic Drug, regardless of the identifier designated in the Medi-Span Multi-Source code.

4) As stated in the *Glossary of Defined Terms* (Attachment 15), no drug approved through an FDA Generic Drug approval process, including any FDA approval process established for approving generic equivalents of biologic drugs, shall be processed as a Brand Drug regardless of the assigned Medi-Span indicators or the result of the Offeror/Contractor's proposed methodology for determining the appropriate classification of a drug. Furthermore, the DCS Program classifies a small list of drugs as Generic Drugs that are

classified by Medi-Span as Brand Drugs (see Attachment 94, *DCS Brands Classified as Generic Drugs*). The drugs listed in Attachment 94, *DCS "Brands Classified as Generics,"* must be classified as Generic Drugs during the term of the agreement with DCS, unless a change to the list is requested by DCS in writing.

5) Attachment 76 *Current Brand-Generic Classification* presents a listing of the NDC's dispensed to DCS Program Enrollees/Claimants in 2022 and the required brand name/generic drug classification assigned to each NDC.

iv) Compound Drug Determination Methodology

1) A Compound Drug is a drug with two or more ingredients (solid, semi-solid or liquid), where the primary active ingredient is an FDA approved Covered Drug with a valid NDC requiring a Prescription for dispensing, combined together in a method specified in a Prescription issued by a medical professional. The end result of this combination must be a Prescription medication for a specific patient that is not otherwise commercially available in that form or dose/strength from a single manufacturer. The Prescription must identify the multiple ingredients in the Compound, including active ingredient(s), diluent(s), ratios or amounts of product, therapeutic use and directions for use. The act of compounding must be performed or supervised by a licensed Pharmacist. Any commercially available product with a unique assigned NDC requiring reconstitution or mixing according to the FDA approved package insert prior to dispensing will not be considered a Compound Prescription by the Programs.

h. The Selected Offeror shall be required to submit a file containing the NDC's dispensed to Enrollees/Claimants in 2022 and the resulting brand/generic classification of each NDC derived from application of the Contractor's electronic classification process. If, at that time, the Procuring Agencies determine that the Selected Offeror's proposed classification methodology does not replicate the results of the Programs' methodology for determining the brand name/generic classification of drugs, the Selected Offeror must modify its classification methodology to replicate the results of the Programs' methodology, either automatically through the claims adjudication system or through an annual claims reconciliation process. The Procuring Agencies determination shall be final.

i. The Programs' Lesser of Logic, as defined in the *Glossary of Defined Terms* (Attachment 15), shall apply to all claims processed under the Programs.

2. Claim Ingredient Cost - General

a. Offerors must confirm their agreement to perform/fulfill and comply with the Duties and Responsibilities contained within Section 6.4.1 "Claim Ingredient Cost - General" above including, but not limited to:

i. The guarantee that all discounts, dispensing fees and prescribing fee(s), if applicable, shall remain in effect during the entire term of the Agreements, **without qualification or condition**;

ii. Pricing for Specialty Drugs shall apply only to Enrollees/Claimants who participate in and fill a prescription through the Specialty Pharmacy Program. Specialty Drugs for all other Enrollees/Claimants and/or claims shall be priced using the Offeror's proposed pricing for retail and mail service drugs;

iii. AWP will be determined by Medi-Span utilizing the field coded R028 entitled "AWP unit price;"

iv. Confirmation that if the Procuring Agencies determine that industry events have caused the Contractor's proposed source of AWP to become inflated against new industry standards, obsolete, or unavailable, the Contractor agrees to negotiate revised pricing terms ensuring that the Programs' actual costs for drugs in no event increase as the result of new pricing terms, in accordance with Section 6.4.1(e)) above;

v. Drugs will be classified as brand name, generic, or compound consistent with Section 6.4.1(g) above;

vi. Prescriptions shall be processed consistent with the Programs' classification of drugs on an NDC basis. Confirmation that, if selected, the Offeror agrees to submit a file containing the NDC's dispensed to Enrollees/Claimants in 2022 and the resulting brand/generic classification of each NDC utilizing the Offeror's proposed methodology for determining the brand name/generic classification of drugs. Confirmation that, if the Procuring Agencies determine that

the Offeror's proposed classification methodology does not replicate the results of the Programs' methodology for determining the brand name/generic classification of drugs, the Offeror shall agree to modify its classification methodology to replicate the results of the Programs' methodology either automatically through the claims adjudication system or through an annual claims reconciliation process; and

vii. Applying the Programs' Lesser of Logic to all claims.

3. Required Submission – Claim Ingredient Cost - General

b. Confirm the Offeror's agreement to utilize the Medi-Span field coded R028 entitled "AWP unit price" as the source of AWP information for calculating Ingredient Cost.

6.5 Mandatory Generic Substitution at Retail and Mail

Encouraging utilization of cost-effective clinically equivalent Generic Drugs is an integral component of the Programs' benefit design. To promote the use of Generic Drugs, the Programs have a mandatory generic substitution requirement that mandates that FDA approved A-rated Generic Drugs and authorized Generic Drugs be substituted for equivalent Brand Drugs or the Enrollee/Claimant pays the applicable Level 3 Drug Copayment plus an "Ancillary Charge." Under the NYSIF Program, there are no Copayments or Ancillary Charges collected from the Enrollee/Claimant. The Selected Offeror must apply this requirement on a consistent basis at the retail network pharmacies and through the Mail Service Pharmacy Process.

1. Duties and Responsibilities: Mandatory Generic Substitution at Retail and Mail

To ensure strict adherence to the Programs' Mandatory Generic Substitution Requirement and protect the financial interests of the Programs, the Contractor shall be required to:

a. Apply mandatory generic substitution to all specific NDC's (active or inactive) of Brand Drugs for which there is an FDA- approved A-rated Generic Drug (including but not limited to, Generic Drugs rated AA, AB, AN, AO, AT, etc.) or an authorized Generic Drug as permissible by NYS law. Retail network pharmacies shall comply with all state laws related to mandatory generic substitution. The Programs' mandatory generic substitution provisions shall apply to any claim where the A-rated or

authorized Generic Drug is required or permitted to be substituted under state law. Mandatory generic substitution provisions will not apply to B-rated or unrated Generic Drugs or in the unlikely event that state law prohibits dispensing of the A-rated or authorized Generic Drug.

b. **(Exclusive to DCS)** Establish the Ancillary Charge by calculating the difference in the Discounted Ingredient Cost of the Brand Drug and the Discounted Ingredient Cost of the equivalent A-rated Generic Drug or authorized Generic Drug based on the Programs' MAC List price assigned when a Brand Drug for which an A-rated or authorized Generic Drug has been introduced in the market is dispensed to the Enrollee. In such cases, the Enrollee shall be responsible for paying the applicable Level 3 Drug Copayment plus Ancillary Charge not to exceed the cost of the drug to the DCS Program. The Ancillary Charge shall be assessed even in the event a doctor has specifically directed a Pharmacist to dispense the Brand Drug rather than the A-rated or authorized Generic Drug through DAW notation.

c. Monitor the pharmaceutical industry on behalf of the Procuring Agencies to identify Generic Drugs expected to enter the market. Prior to the actual introduction of the Generic Drug to market, the Contractor shall inform the Procuring Agencies of anticipated shipping dates of the first generic introduced into the market for one or more strengths of a particular Brand Drug.

d. **(Exclusive to DCS)** Following the first shipment of a first NDC for a Generic Drug for one or more strengths of a particular Brand Drug (i.e., MAC Alerts are required for new NDCs of new GPIs and for new NDCs for GPIs already on the MAC List), the Contractor shall be required to:

    i. Inform the Department as soon as practicable but in no event later than fourteen (14) Days during normal Business Hours after the first date of shipment, (from manufacturer to wholesaler or retailer) of the financial impact of enforcing mandatory generic substitution via the "MAC Alert Notice" detailed in Sections 3 and 5 of this RFP under "Reporting Services;"

    ii. For those drugs that will result in a lower net cost to the Programs by enforcing mandatory generic substitution, the Contractor shall provide the "MAC Alert Notice" as described in (a) above. The Contractor shall add the GPI to the Programs' MAC List (if the GPI is not on the Programs' MAC List already) and begin enforcement as soon as practicable but in no event later than fourteen (14) Days during normal Business Hours after the first date of shipment provided that the participating retail network pharmacies are able to obtain the Generic Drug;

iii. For those drugs that could potentially result in a higher net cost to the Programs by enforcing mandatory generic substitution, the Contractor shall provide the “MAC Alert Notice” as described in (a) above. The Contractor shall also notify the Department whether the drug should be included in the Brand for Generic strategy. The Department, in its sole discretion, may determine that enforcement is contrary to the best financial interests of the Programs and shall inform the Contractor whether Mandatory Substitution shall be applied. If the Contractor does not receive a formal response to the information provided via the “MAC Alert Notice,” enforcement shall commence, and the GPI shall be added to the Programs’ MAC List (if the GPI is not on the Programs’ MAC List already) effective on the 21st Day after shipment of the first A-rated generic equivalent drug or authorized Generic Drug provided that the pharmacies are able to obtain the Generic Drug. In the event the Department decides to exercise its discretion not to enforce mandatory generic substitution, the Contractor shall apply MAC pricing to the Generic Drug when dispensed;

iv. To assist the Department in determining whether or not mandatory generic substitution should be enforced within 21 Days, the Contractor shall survey its Retail Pharmacy Network to identify the pharmacies that are unable to obtain the new Generic Drug within 21 Days. The Contractor shall submit this information to the Department and provide any additional information as required by the Department to reach a determination. The DCS, in its sole discretion, shall determine based on such evidence how the Programs’ mandatory generic substitution provisions will be applied. The Programs will not consider, and the Contractor shall not act on availability information provided by third party sources, including but not limited to Medi-Span;

v. For preferred Brand Drugs for which an A-rated or authorized Generic Drug has been introduced into the market for one or more strengths of a Brand Drug, the status of the Brand Drug shall be changed from preferred to Non-Preferred status concurrent with the commencement of the enforcement of mandatory generic substitution. Enrollees prescribed strengths of the Preferred Brand Drug for which an A-rated or authorized Generic Drug has been introduced shall receive the Generic Drug and be charged the Level 1 Copayment. If the prescribing Physician requires that the Brand Drug be dispensed, the Enrollee will be charged the applicable Level 3 Drug Copayment and Ancillary Charge. Enrollees prescribed strengths of the

preferred Brand Drug for which no A-rated or authorized Generic Drug has been introduced shall continue to receive the prescribed drug at the applicable Level 2 Copayment and mandatory generic substitution provisions shall not apply;

vi. For Non-Preferred Brand Drugs for which an A-rated or authorized Generic Drug has been introduced into the market for one or more strengths of a Brand Drug, the status of the Brand Drug shall remain Non-Preferred for all strengths. Concurrent with enforcement of mandatory generic substitution, Enrollees prescribed strengths of the Non-Preferred Brand Drug for which an A-rated or authorized Generic Drug has been introduced shall receive the Generic Drug and be charged the Level 1 Copayment. If the prescribing Physician requires that the Brand Drug be dispensed, the Enrollee will be charged the applicable Level 3 Drug Copayment and Ancillary Charge. Enrollees prescribed strengths of the Non-Preferred Brand Drug for which no A-rated or authorized Generic Drug has been introduced shall continue to receive the prescribed drug at the applicable Level 3 Drug Copayment and mandatory generic substitution provisions shall not apply; and

vii. The Contractor shall cause the dispensing Network Pharmacy to inform the Enrollee prior to dispensing the Brand Drug, that an Ancillary Charge would be applied in addition to the applicable Level 3 Drug Copayment. If the prescribing Physician requires the Brand Drug be dispensed, the Contractor shall cause the dispensing Network Pharmacy to collect the applicable Level 3 Drug Copayment plus the calculated Ancillary Charge. However, under no circumstances shall the Enrollee's total cost exceed what the actual cost of the Brand Drug would have been to the DCS Program after application of the Programs' Lesser of Logic provisions.

e. Charge the Programs based on the Programs' MAC List price assigned to the GPI of the dispensed Brand Drug plus the applicable dispensing fee plus the prescribing fee(s), if applicable, as set forth in this section of the RFP;

f. Receive written approval from the Procuring Agencies for any and all exceptions to the Programs' mandatory substitution provisions, beyond the approval of specific generic appeals or approval through the Medical Exception Program. Following commencement of mandatory generic substitution, the Contractor must receive Procuring Agencies' written approval prior to suspending enforcement of the Programs' mandatory generic substitution provisions;

g. Maintain an electronic claims processing system capable of obtaining information from Network Pharmacies to ensure consistent enforcement of the Programs' mandatory generic substitution provisions. In particular, the claims processing system must be capable of capturing information concerning the availability of the Generic Drug at the Network Pharmacy submitting the electronic claim. If a Generic Drug is available to be dispensed by the Network Pharmacy, the Programs' mandatory generic substitution rules shall be applied. If the Network Pharmacy does not have the A-rated or authorized Generic Drug in stock, mandatory generic substitution provisions will not apply and the Enrollee/Claimant shall receive the Brand Drug, be charged the applicable Generic Drug Copayment and the Plan charged based on Generic Drug pricing. Currently, the Programs reject, with appropriate messaging, claims for Brand Drugs subject to mandatory generic substitution that are submitted with a DAW 0-code and require resubmission of the claim (since a DAW 0-code provides no indication of Generic Drug availability in the Network Pharmacy). Similar rules can be applied to other DAW submission codes as necessary to ensure consistent, accurate application of the Programs' mandatory generic substitution requirements.

2. Confirmation - Mandatory Generic Substitution at Retail and Mail

a. Confirm the Offeror's agreement to perform/fulfill and comply with the Duties and Responsibilities contained within this Section 6.5 "Mandatory Generic Substitution at Retail and Mail" section above.

6.6 Retail Pharmacy Network Claims

a. The cost of all Covered Drugs dispensed at network pharmacies shall be charged to the Programs consistent with the requirements set forth in this RFP, including but not limited to the Lesser of Logic and Pass-through Pricing set forth in Section 6.4.1(i) and in the *Glossary of Defined Terms* (Attachment 15) above. Under no circumstances may the Enrollee be charged costs not specifically provided for under the Plan benefit design.

A. General Provisions

The following general provisions apply to all claims submitted by Retail Pharmacy Networks:

1. Duties and Responsibilities - Retail Pharmacy Network Claims - General

a. The Contractor shall ensure that the Network Pharmacy collects the appropriate Copayment (plus Ancillary Charge, if applicable) specified in Attachment 27 *DCS/NYSIF Prescription Drug Program Copayment Matrix,* from the Enrollee/Claimant and will charge the Programs the Discounted Ingredient Cost as determined through the application of the Lesser of Logic set forth in Section 6.4.1(i) and in the *Glossary of Defined Terms* (Attachment 15) plus the Contractor's applicable pharmacy contracted dispensing fee, plus the prescribing fee(s), if applicable, minus the applicable Copayment for all drugs dispensed through a Network Pharmacy.

b. **(Exclusive to DCS)** If the current Discounted Ingredient Cost plus the dispensing fee plus the prescribing fee(s), if applicable, or the submitted cost is less than the applicable Copayment, then the Contractor shall ensure that the Network Pharmacy charges the Enrollee the lesser amount.

c. The Contractor shall implement a control process at point of service intended to protect the Programs from any inflated AWP costs associated with "repackaged" drugs charged to the Programs.

2. <u>Confirmation – Retail Pharmacy Network Claims - General</u>

a. Confirm the Offeror's agreement to perform/fulfill and comply with the Duties and Responsibilities in Section 6.6.A of this RFP, under subheading "General Provisions."

3. <u>Required Submission – Retail Pharmacy Network Claims - General</u>

a. The Offeror is required to describe the process it proposes to utilize to ensure that the Programs' financial interests are protected from any inflated AWP costs associated with "repackaged" drugs charged to the Program.

B. <u>Retail Pharmacy Network Brand Name Drug Pricing</u>

1. <u>Duties and Responsibilities – Brand Name Drug Pricing</u>

a. The Contractor shall charge the Program utilizing Pass-through Pricing for all Brand Name Drugs dispensed to Enrollees/Claimants through the Network Pharmacies. The Contractor's pharmacy contracted Guaranteed Minimum Discount off of Aggregate AWP, pharmacy contracted dispensing fee(s) and prescribing fee(s), if applicable, for Brand Drugs shall be applicable to the aggregate AWP for all Brand Drugs dispensed to Enrollees/Claimants from a Network Pharmacy;

b. Guarantee a Minimum Discount off of Aggregate AWP for all Brand Drugs dispensed at Retail Network Pharmacies as defined in the RFP. The Contractor shall guarantee the Programs that its management of Brand Drug costs dispensed by pharmacies shall result in each Program achieving the Contractor's Guaranteed Minimum Discounts during each Program Year as proposed by the Contractor in its Proposal.

   The discounts achieved off of the aggregate AWP for all Brand Drugs as a result of Pass-through Pricing will be calculated utilizing the following formula: 1 minus (Sum of Ingredient Costs of dispensed Brand Drugs divided by sum of the AWP of dispensed Brand Drugs).

   The aggregate discount calculation will be based on Final Paid Claim Pharmacy Prescriptions filled with a Brand Drug including Empire Plan Medicare Rx claims. Claims submitted for secondary payer consideration, Compound Drug claims, powders, subrogation claims, long term care pharmacy claims, nursing home pharmacy claims, Veterans Affairs hospital pharmacy claims, NYSIF Program non-network claims and claims submitted by governmental entities must be excluded from the aggregate discount calculation. In addition, claims with a calculated AWP discount greater than 50% must be verified by the Offeror that the quantity and the validity of the calculated discount is correct, subject to the approval of the Procuring Agencies; and

c. If the aggregate discounts obtained, as calculated utilizing the formula set forth in the prior paragraph, are less than the Guaranteed Minimum Discount off of Aggregate AWP proposed, the Contractor shall reimburse each Program, the difference between the Ingredient Cost each Program was charged utilizing Pass-through Pricing and the Ingredient Cost the Programs would have been charged if the Guaranteed Minimum Discount off of Aggregate AWP had been obtained. The Programs will be credited annually for this difference in Ingredient Cost. The Programs shall retain the benefit of any cost savings, in excess of the Contractor's Guaranteed Minimum Discounts off of Aggregate AWP for all Brand Drugs dispensed by pharmacies.

   This calculation shall be performed for each Program Year based on claims paid for each incurred year. Specifically, the Contractor shall perform a reconciliation to include claims incurred in each Program Year and paid through June of the following Program Year. The reconciliation shall be submitted to the Procuring Agencies on July 31st (Reconciliation Due Date). Contractor shall pay/credit each Program within 30 Days.. If the Procuring Agencies' review of the Contractor's calculations indicates an adjustment to the calculation is required, then the Procuring Agencies reserve the right in their sole discretion to make

an adjustment to the Contractor's calculations and adjust the amount due to the Programs or to the Contractor.

The Programs shall retain the benefit of any cost savings, in excess of the Contractor's Guaranteed Minimum Discount off of Aggregate AWP set forth in duties and responsibilities of Section 6.6.B entitled "Retail Pharmacy Network Claims." Any shortfall in the Guaranteed Minimum Discount set forth in Section 6.6.B. cannot be recovered by the Contractor in subsequent years.

2. Confirmation – Brand Name Drug Pricing

a. The Selected Offeror agrees to perform/fulfill and comply with the Duties and Responsibilities in Section 6.6.B of this RFP, under subheading "Retail Pharmacy Network Brand Name Drug Pricing."

b. The Selected Offeror agrees that it has an obligation to maximize the discounts achieved on behalf of the Program for Brand Drugs dispensed by network pharmacies.

3. Required Submission – Brand Name Drug Pricing

a. The Selected Offeror is required to provide its Guaranteed Minimum Discount in Attachment 83, *Proposed Claim Reimbursement Quote*, as a percent off of Aggregate AWP for all Brand Drugs dispensed at Retail Pharmacy Network Pharmacies in Attachment 83.

C. Retail Pharmacy Network Generic Pricing

1. Duties and Responsibilities – Retail Pharmacy Network Generic Pricing

a. The Contractor shall charge the Programs utilizing Pass-through Pricing for all Generic Drugs dispensed to Enrollees/Claimants through the Network Pharmacies.

b. To maximize savings for the Programs on Generic Drugs dispensed through a Network Pharmacy, the Contractor is required to:

i. Create and maintain a single, Program-specific Maximum Allowable Cost (MAC) List called the Programs' MAC List for Retail and Mail Service Pharmacies, setting the maximum price the Programs will be charged, and the amount the dispensing Network Pharmacy will be paid, for the Ingredient Cost for the drugs required to be included on the Programs' MAC List. The MAC price assigned shall not exceed the Discounted Ingredient Cost to the Programs achieved

through Pharmacy submitted pricing or pricing achieved by using the Contractor's highest contracted Retail Pharmacy Brand Discount off of AWP applied to the AWP of the dispensed Generic Drug.

NOTE: Each Procuring Agency, respectively, reserve its rights for the Contractor to create and maintain a second MAC List should industry or programmatic events necessitate the use of a second list. The use of a second MAC List will be at the sole discretion and approval of each Procuring Agency, respectively. The Guaranteed Minimum Discount off of Aggregate AWP and the Guaranteed Maximum Dispensing Fee and Prescribing Fee guarantees for generic drugs will be subject to negotiation if a second MAC List is utilized. As MAC Lists are set by GPI, not NDC, but MAC Alerts are done at the NDC level, DCS requires that the Offeror submit monthly adjudication reports and credit the applicable invoice for any NDC where the MAC price of the GPI is higher than the highest contracted Retail Pharmacy Brand Discount off of AWP of the Generic NDC.

ii. Assign a MAC price to all NDCs of drugs included within a GPI, including NDCs of all Brand Drugs, containing an A-rated or authorized Generic Drug form of the original Brand Drug in the GPI. The Contractor shall add the GPI to the Programs' MAC List and set a MAC price for the GPI in accordance with Section 6.5.1. The provisions of these paragraphs require that MAC pricing be applied in no event later than 21 Days after the first shipment of a first NDC for a Generic Drug from the manufacturer to a wholesaler or retailer. All A-rated or authorized Generic Drugs shall be placed on the MAC List in all instances including, but not limited to circumstances in which the Department in its sole discretion decides not to enforce mandatory generic substitution of the Brand Drug in that GPI. There shall be one MAC price applicable to all NDCs included in the GPI on the Programs' MAC List. However, depending on particular market factors, it may be in the best interests of the Programs, and therefore appropriate, for more than one MAC price to be assigned within a GPI. Such situations would require that the Contractor provide any information the Procuring Agencies deem necessary to support such action and obtain prior written approval from the Procuring Agencies;

iii. Assign a MAC price to the NDCs of B-rated or unrated Generic Drugs included within a GPI that does <u>not</u> include an A-rated or authorized Generic Drug. The Offeror shall add the GPI to the Programs' MAC List and set a MAC price for the Generic Drug NDCs included in the GPI as soon as practicable, but in no event

later than 21 Days after the first shipment of a first NDC for a Generic Drug from the manufacturer to a wholesaler or retailer concurrent with transmission of the MAC Alert notice. The Contractor shall not apply the MAC price to the NDC(s) for Brand Drugs dispensed in the GPI and shall not enforce the Programs' mandatory generic substitution provisions for Brand Drugs dispensed in this GPI. There shall be one MAC price applicable to all Generic Drug NDCs included in the GPI on the Programs' MAC List. However, depending on particular market factors, it may be in the best interests of the Programs, and therefore appropriate, for more than one MAC price to be assigned within a GPI. Such situations would require that the Contractor provide any information the Procuring Agencies deem necessary to support such action and obtain prior written approval from the Procuring Agencies;

iv. Charge the Programs for Generic Drugs not on the MAC list dispensed, utilizing Pass-through Pricing at the Contractor's pharmacy contracted Guaranteed Minimum Discount off of Aggregate AWP of the dispensed Generic Drug as proposed by the Contractor in its Proposal. The only Generic Drugs not on the MAC list will be Generic Drugs included in GPIs required to be on the Programs' MAC List, but which have not yet been assigned a MAC price within the required time frame;

v. The Contractor shall inform the Department of any market- based condition which makes the strict compliance with paragraphs (i)-(iv) above contrary to the financial interests of the Programs. The Contractor shall agree that, in cases where the Department, at its sole discretion, determines that the above requirements are contrary to the best financial interests of the Programs, the Department may waive such requirements;

vi. Monitor the Programs' MAC List pricing to ensure that NDCs contained in GPIs subject to MAC pricing are paying at the MAC price after application of the Programs' Lesser of Logic provisions. The Contractor shall notify the Programs of any GPIs subject to MAC pricing in which the majority of claims are processing at a basis other than the MAC price;

vii. Agree that there shall be no increases to Programs' MAC List prices where such adjustment is intended to limit the discount achieved on behalf of the Programs to the Guaranteed Minimum Discounts off of Aggregate AWP for all Generic Drugs dispensed by Network Pharmacies during the Plan Year as proposed in Attachment 83, *Proposed Claim Reimbursement Quote*;

viii. Provide to the Department full access to the Programs' MAC List used to price Generic Drugs dispensed by Network and Mail Service Pharmacies for the Programs. The Programs' MAC List provided in the Offeror's proposal as Attachment 88, *Retail and Mail Service Pharmacy Generic Drugs - MAC List Costs per GPI*, must support the Contractor's Guaranteed Minimum Discounts off of Aggregate AWP for all Generic Drugs dispensed by Retail and Mail Service Pharmacies for the Program as proposed by the Contractor in its Proposal.

(**Note:** The Selected Offeror must be prepared to provide valid documented market rationale to support their Programs MAC pricing should the Procuring Agencies request this information. In order to protect the Programs' financial interests from the date of the award until the termination date of the Agreements, the Selected Offeror must agree that any <u>increases</u> to the proposed Programs' MAC pricing must be justified to the Procuring Agencies with valid documented market rationale. Following selection, the Selected Offeror shall manage the content of the Programs' MAC List consistent with the requirements of the RFP. Prices for new GPIs added to the Programs' MAC List shall be equivalent to or below the Selected Offeror's most aggressive MAC price for that drug. To ensure compliance with these requirements, the Selected Offeror shall notify the Department monthly of all changes, additions, and deletions made to the Programs' MAC List in the format specified in Attachment 35, *Cycle Claim Report*, and the requirements specified in Sections 3.7 and 5.8, entitled "Reporting Services." Compliance with these requirements as noted herein shall be a condition of contract award. Should the Selected Offeror fail to comply with the requirements noted herein, the State reserves the right to deem the Selected Offeror non-responsive and withdraw said conditional award. Throughout the term of the Agreements, the Contractor shall commit to use its best efforts to maintain the aggregate effectiveness of the Programs' MAC List. The Contractor must ensure that MAC pricing is reduced to an appropriate level based on any change in market conditions such as increased competition within a GPI.

ix. The Contractor shall strictly enforce all requirements of the Programs' mandatory generic substitution provision as detailed in the duties and responsibilities of Section 6.5 entitled "Mandatory Generic Substitution at Retail and Mail."

x. The Contractor must Guarantee a Minimum Discount off of Aggregate AWP for all Generic Drugs dispensed at Retail

Pharmacies as defined in the RFP. The Contractor shall guarantee the Programs that its management of Generic Drug costs dispensed by pharmacies, including maintenance of the Programs' MAC List, and application of pricing provisions related to Generic Drugs that do not meet the requirements for inclusion on the Programs' MAC List, shall result in the Programs achieving the Contractor's overall Guaranteed Minimum Discounts during the Program Year as proposed in the Contractor's Proposal.

The discount achieved off of Aggregate AWP for all Generic Drugs as a result of Pass-through Pricing will be calculated utilizing the following formula: 1 minus (Sum of Ingredient Costs of dispensed Generic Drugs at Retail Pharmacies divided by sum of the AWP of dispensed Generic Drugs).

The aggregate discount calculation will be based on Final Paid Claim Pharmacy Prescriptions filled with a Generic Drug including Empire Plan Medicare Rx claims. Claims submitted for secondary payer consideration, Compound Drug claims, powders, subrogation, long term care pharmacy claims, nursing home pharmacy claims, Veterans Affairs hospital pharmacy claims, NYSIF Program non- network claims and claims submitted by governmental entities must be excluded from the aggregate discount calculation. In addition, claims with a calculated AWP discount greater than 90% and a total AWP greater than $500 must be verified by the Offeror that the quantity and validity of the calculated discount is correct, subject to the approval of the Procuring Agencies. **The setting of a Guaranteed Minimum Discount off of Aggregate AWP for all Generic Drugs dispensed at Retail Network Pharmacies shall in no way modify the Contractor's contractual obligation to maximize the Programs' aggregate discount above the Contractor's Guaranteed Minimum Discount off of Aggregate AWP**; and

xi. If the overall aggregate discount obtained, as calculated utilizing the formula set forth in the prior paragraph, is less than the Contractor's Guaranteed Minimum Discounts, the Contractor shall reimburse the Programs the difference between the Ingredient Cost the Programs were charged utilizing Pass-through Pricing and the Ingredient Cost the Programs would have been charged if the Guaranteed Minimum Discount off of Aggregate AWP had been obtained. The Programs will be credited annually for this difference in Ingredient Cost. The Programs shall retain the benefit of any cost savings, in excess

of the Contractor's Guaranteed Minimum Discounts off the aggregate AWP for all Generic Drugs dispensed by Retail and Mail Service Pharmacies.

These calculations shall be performed for each Program Year based on claims paid for each incurred year. Specifically, the Contractor shall perform a reconciliation to include claims incurred in each Program Year and paid through June of the following Program Year. The reconciliation shall be submitted to the Procuring Agencies on or before July 31st (the "Reconciliation Due Date"). Contractor shall pay/credit each Program the applicable amount, if any, within 30 Days of the Reconciliation Due Date. If the Procuring Agencies' review of the Contractor's calculations indicates an adjustment to the calculation is required, then the Procuring Agencies reserve the right in their sole discretion to make an adjustment to the Contractor's calculations and adjust the amount due to the Programs or to the Contractor.

The Programs shall retain the benefit of any cost savings, in excess of the Contractor's Guaranteed Minimum Discount off the aggregate AWP set forth in duties and responsibilities of Section 6.6 entitled "Retail Pharmacy Network Claims." Any shortfall in the Guaranteed Minimum Discount set forth in Section 6.6. cannot be recovered by the Contractor in subsequent years. The Contractor is not allowed to apply any separate "offsets" to the cost savings that inure to the benefit of the Procuring Agencies under this subsection.

2. <u>Confirmation – Retail Pharmacy Network Generic Pricing</u>

a. Confirm the Offeror's agreement to perform/fulfill and comply with the duties and responsibilities listed in the Retail Pharmacy Network Generic Pricing in Sections 6.6.C. of this RFP, under subheading "Retail Pharmacy Network Generic Pricing."

b. The Offeror agrees that it has an obligation to maximize the discount achieved on behalf of the Program for Generic Drugs dispensed by Retail and Mail Service pharmacies.

c. The Offeror agrees that it will develop a Program's MAC List for Retail and Mail Service Pharmacies in order to maximize the discount achieved on behalf of the Programs for Generic Drugs.

3. <u>Required Submission – Retail Pharmacy Network Generic Pricing</u>

a. The Offeror is required to provide its Program's MAC list unit cost information in Attachment 88, *Retail and Mail Service Pharmacy Generic Drugs - MAC List Costs per GPI*, in accordance with the instructions provided in the files.

b. The Offeror is required to provide its Guaranteed Minimum Discount as a percent off of Aggregate AWP for all Generic Drugs dispensed by Retail and Mail Service Pharmacies in Attachment 83, *Proposed Claim Reimbursement Quote*.

D. Retail Pharmacy Network Compound Drug Pricing

Compound Drugs must be classified as compounds consistent with the definition in the *Glossary of Defined Terms* (Attachment 15) of this RFP. Drugs assigned a unique NDC that require reconstitution and/or mixing prior to dispensing do not meet the Programs' definition of a Compound Drug and shall be processed in accordance with the requirements set forth in this RFP.

1. Duties and Responsibilities – Retail Pharmacy Network Compound Drug Pricing

The Contractor shall be required to:

a. Utilize its pricing methodology for Compound Drugs utilizing Pass-through Pricing, as proposed by the Contractor in its Proposal in Attachment 83, *Proposed Claim Reimbursement Quote*, for the entire term of the Agreements. (Note: If an Offeror has multiple methods of pricing, the Offeror may propose each pricing method in Attachment 83. for Procuring Agency consideration and selection.) The proposed pricing methodology(ies) for Compound Drugs must be the same for Retail and Mail Service Pharmacy Process claims.

b. **(Exclusive to DCS)** Charge Enrollees the applicable Level 2 Drug Copayment for all Compound Drugs. If the current Discounted Ingredient Cost or the submitted cost is less than the applicable Level 2 Drug Copayment, then the Offeror shall ensure that the Enrollee is charged the lesser amount.

c. Process Compound Drug claims in a manner that verifies the validity of the claim as a Compound Drug according to the Programs' definition of a Compound Drug and provides appropriate claim Level control procedures to protect the financial interests of the Programs.

d. Conduct due diligence as well as audit Network Pharmacies to ensure that drugs are being properly classified as Compound Drugs consistent with the Programs' definition of a Compound Drug and to ensure that

compound claims are priced in accordance with the Contractor's pricing methodology for Compound Drugs, as proposed by the Contractor in its Proposal, selected by the Procuring Agencies.

2. Confirmation – Retail Pharmacy Network Compound Drug Pricing

a. The Selected Offeror agrees to perform/fulfill and comply with the Duties and Responsibilities in Section 6.6.D. of this RFP, under subheading "Retail Pharmacy Network Compound Drug Pricing."

3. Required Submission – Retail Pharmacy Network Compound Drug Pricing

a. In Attachment 83, *Proposed Claim Reimbursement Quote* the Offeror is required to provide its pricing methodology utilizing Pass-through Pricing for Compound Drugs dispensed by Network Pharmacies; its dispensing fees; and if the Offeror is proposing the use of NCPDP transaction standards for Compound Drugs, a level of effort fee based on the claims level of effort code. The Offeror will notify DCS, in writing, a minimum of 30 Days in advance of any changes to the Contractor's book of business Level of Effort fees, and such revised fees will be charged consistent with the pricing provisions of the Agreement.

6.7 Mail Service Pharmacy Process - Claims

The current Programs include a Mail Service Pharmacy Process by which Enrollees/Claimants can obtain all Covered Drugs through the mail including any and all drugs that could be classified as Specialty Drugs for Enrollees/Claimants who do not participate in the Specialty Pharmacy Program. Enrollees are entitled to fill Prescriptions for up to a ninety (90) Day supply with refills up to one year at a cost savings to the Enrollee and the DCS Program.

A. General Provisions - Claims

The following provisions shall apply to all claims submitted through the Mail Service Pharmacy Process.

1. Duties and Responsibilities – Claims

The Contractor shall be required to:

a. Consistently enforce and administer all provisions of the Program (including but not limited to mandatory generic substitution, drug utilization review, prior authorization, refill too-soon edits, etc.) to the claims dispensed through the Mail Service Pharmacy Process,

consistent with the processing of claims through the Retail Pharmacy Network process;

b. Charge the Programs for those drugs dispensed to the Enrollee/Claimant in original manufacturer packaging, based on the Contractor's source of AWP as proposed by the Contractor in its Proposal for the 11-digit NDC of the package size dispensed through the Mail Service Pharmacy Process, subject to MAC pricing for Generic drugs. If the drug is not dispensed to the Enrollee/Claimant in original manufacturer packaging (i.e., dispensed from bulk), the Programs shall be charged based on the Contractor's source of AWP as proposed by the Contractor in its Proposal for the 11-digit NDC of the package size from which the drug was originally dispensed by the Mail Service Pharmacy Process Facility, subject to MAC pricing for Generic drugs. If the drug is dispensed from a bulk package size for which no AWP is reported in the Contractor's proposed AWP source as proposed by the Contractor in its Proposal, the Programs will be charged based on the reported AWP for the NDC of the largest package size contained in the Contractor's AWP source as proposed by the Contractor in its Proposal. The Programs shall not be charged based on an NDC assigned to repackaged drugs or based on package sizes prepared by special arrangement with the original manufacturer, unless such packaging offers a net savings to the Programs;

c. Charge the Programs based on the Contractor's pricing terms, dispensing fees (if any) and prescribing fee(s) (if applicable), applicable to Brand, Generic, and Compound Drug claims as set forth in Attachment 83, *Proposed Claim Reimbursement Quote,* of the Contractor's Proposal for all prescriptions submitted through the Mail Service Pharmacy Process. If multiple Compound Drug pricing methodologies were proposed by the Contractor in its Proposal, the Programs must be charged according to the methodology selected by the Procuring Agencies for Compound Drug claims. The Programs' Lesser of Logic shall be applied at all times during the Contract term;

d. **(Exclusive to DCS)** Ensure that the Mail Service Pharmacy Process Facilities collect the appropriate Copayment specified in Attachment 27*, DCS/NYSIF Prescription Drug Program Copayment Matrix*, from the Enrollee and charge the Programs the balance of the Discounted Ingredient Cost as determined through the application of the Lesser of Logic set forth in the *Glossary of Defined Terms* (Attachment 15) plus the Contractor's applicable proposed Guaranteed Dispensing Fee minus the applicable Copayment for all drugs dispensed through the Mail Service Pharmacy Process; and

e. **(Exclusive to DCS)** Inform 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. The Mail Service Pharmacy Process Facility will not be required to inform Enrollees if there is a consistent history of the acceptance of shipments that exceed the maximum amount specified for the same medications. If the Brand Drug is dispensed, the Contractor shall cause the dispensing facility to collect the applicable Level 3 Drug Copayment plus the calculated Ancillary Charge, if any. Under no circumstances shall the Enrollee's total cost exceed what the actual cost of the Brand Drug would have been to the Program.

f. The Contractor is required to maximize savings to the Program through aggressive pricing and discounts, consistent with Lesser of Logic and the Contractor's Financial Proposal. The Contractor agrees that all records supporting Lesser of Logic are subject to audit by DCS and its consultants or other State auditors with authority under Section 8 and/or Appendices A, B & B-1 of this RFP.

2. Confirmation – General Provisions - Claims

a. Confirm the Selected Offeror's agrees to perform/fulfill and comply with the Duties and Responsibilities in Section 6.7 of this RFP, under subheading "General Provisions."

B. Mail Service Pharmacy Process - Brand Name Drug Pricing

The Contractor must classify Brand Drugs in accordance with the definition in the *Glossary of Defined Terms* (Attachment 15) as well as the methodology outlined in Section 6.4.1(g) of the RFP entitled "Brand Drug Determination Methodology."

1. Duties and Responsibilities – Brand Name Drug Pricing

The Contractor shall be required to:

a. Utilize the Guaranteed Discount off of AWP as proposed by the Offeror in its Financial Proposal to determine the Ingredient Cost of the Prescription to charge the Programs. The Guaranteed Discount off of AWP shall be applicable to individual Brand Drug prescriptions dispensed to Enrollees/Claimants through the Mail Service Pharmacy Process.

b. Ensure that the Mail Service Pharmacy Process dispensing facility collects the appropriate Brand Drug Copayment (plus Ancillary

Charge if applicable) from the Enrollee and charges the Programs the balance of the Discounted Ingredient Cost plus the Guaranteed Dispensing Fee, if any, for Brand Drugs dispensed through the Mail Service Pharmacy Process, as proposed by the Offeror in Attachment 83, *Proposed Claim Reimbursement Quote*. If the current Discounted Ingredient Cost plus the Guaranteed Dispensing Fee (if applicable) or the submitted cost is less than the applicable Level 2 or Level 3 Drug Copayment then the Contractor shall ensure that the Enrollee/Dependent is charged the lesser amount.

c. Guarantee a Discount off of AWP for Brand Drugs dispensed through the Mail Service Pharmacy as defined in the RFP. The Contractor shall guarantee the Programs that the Plan will achieve the Contractor's Guaranteed Discounts off of AWP during the Plan Year, as proposed by the Contractor in its Proposal.

d. The discount achieved off of AWP for Brand Drugs dispensed at Mail Service Pharmacies shall be billed to the Programs using Lesser of Logic, incorporating guaranteed contracted pricing; and

e. If the Guaranteed Discount off of AWP for Brand Drugs is less than the Guaranteed Minimum Discount off of AWP as proposed by the Offeror in its Financial Proposal, the Contractor shall reimburse the Programs the difference between the Ingredient Cost the Programs were charged and the Ingredient Cost the Programs would have been charged if the Guaranteed Minimum Discount off of AWP had been obtained. The Programs will be credited annually for this difference in Ingredient Cost. The Programs shall retain the benefit of any cost savings, in excess of the Contractor's proposed Guaranteed Minimum Discounts off of AWP for Brand Drugs dispensed by the Mail Service Pharmacy.

f. This calculation shall be performed by the Contractor for each Program Year based on claims paid for each incurred year. Specifically, the Contractor shall perform a reconciliation to include claims incurred in each Program Year and paid through June of the following Program Year. The Contractor shall pay/credit each Program the applicable amount, if any, within 30 Days of the Reconciliation Due Date. If the Procuring Agencies' review of the Contractor's calculations indicates an adjustment to the calculation is required, then the Procuring Agencies reserve the right in their sole discretion to make an adjustment to the Contractor's calculations and adjust the amount due to the Programs or to the Contractor.

g. In addition to performing this reconciliation, the Contractor shall provide reporting on the Actual Acquisition Cost , pursuant to the terms of this RFP and the resulting Contract, for Brand drugs dispensed through the

Mail Service Pharmacy to the Procuring Agencies on July 31st. If Contractor identifies in writing the information requested as Contractors' Confidential or Proprietary information access to the information will be provided pursuant to Section 8.7, Contractor's Confidential Information.

2. <u>Confirmation – Brand Name Drug Pricing</u>

a. Confirm the Offeror's agreement to perform/fulfill and comply with the Duties and Responsibilities Section 6.7.B of this RFP, under subheading "Mail Service Pharmacy Process -- Brand Name Drug Pricing."

3. <u>Required Submission – Brand Name Drug Pricing</u>

a. The Offeror is required to provide the Offeror's fixed contracted Guaranteed Discount off of AWP for Brand Drugs dispensed through the Mail Service Pharmacy Process on Attachment 83, *Proposed Claim Reimbursement Quote*. The Offeror shall assume in its pricing that the Procuring Agencies will not allow promotion of the Mail Service Pharmacy Process. However, the Procuring Agencies reserve the right during the term of the Agreements to allow promotion of the Mail Service Pharmacy Process provided such promotion is in the best financial interests of the State and complies with all applicable state laws and regulations.

C. <u>Mail Service Pharmacy Process – Generic Drug Pricing</u>

The Contractor shall classify Generic Drugs in accordance with the definition in the *Glossary of Defined Terms* (Attachment 15) as well as the methodology outlined in Section 6.4.1(g)(iii) of the RFP entitled "Generic Drug Determination Methodology."

1. <u>Duties and Responsibilities – Generic Drug Pricing</u>

The Contractor shall be required to:

a. Utilize the Programs' MAC list for Retail and Mail Service Pharmacies to determine the Ingredient Cost of each Prescription charged to the Programs. The Contractor's Programs' MAC list for Retail and Mail Service Pharmacies shall be applicable to the aggregate AWP for all Generic Drugs dispensed to Enrollees/Claimants through the Mail Service Pharmacy Process;

b. Ensure that the Mail Service Pharmacy Process dispensing facility collects the Level 1 Drug Copayment from the Enrollee and charges the Programs the balance of the Discounted Ingredient Cost plus the

Contractor's Guaranteed Dispensing Fee for Generic Drugs dispensed through the Mail Service Pharmacy Process, if any, as proposed by the Contractor in its Proposal. If the current Discounted Ingredient Cost plus the dispensing fee (if applicable) or the submitted cost is less than the applicable Level 1 Drug Copayment then the Contractor shall ensure that the Enrollee is charged the lesser amount;

c. The Contractor must Guarantee al Minimum Discount off of Aggregate AWP for all Generic Drugs dispensed through the Mail Service Pharmacy Process as defined in the RFP. The Contractor shall guarantee the Programs that its management of Generic Drug costs dispensed by the Mail Service Pharmacy, including maintenance of the Programs' MAC List for Retail and Mail Service Pharmacies, and application of pricing provisions related to Generic Drugs that do not meet the requirements for inclusion on the Programs' MAC List, shall result in the Programs achieving the Contractor's overall Guaranteed Minimum Discounts during the Program Year as proposed in the Contractor's Proposal.

d. The discount achieved off of Aggregate AWP for all Generic Drugs dispensed through the Mail Service Pharmacy Process as a result of Lesser of Logic will be calculated utilizing the following formula: 1 minus (Sum of Ingredient Costs of dispensed Generic Drugs at Mail Service Pharmacies divided by sum of the AWP of dispensed Generic Drugs). The aggregate discount calculation will be based on Final Paid Claim Pharmacy Prescriptions filled with a Generic Drug including Empire Plan Medicare Rx claims. Claims submitted for secondary payer consideration, Compound Drug claims, powders, subrogation, long term care pharmacy claims, nursing home pharmacy claims, Veterans Affairs hospital pharmacy claims, NYSIF Program non-network claims and claims submitted by governmental entities must be excluded from the aggregate discount calculation. In addition, claims with a calculated AWP discount greater than 90% and a total AWP greater than $500 must be verified by the Offeror that the quantity and validity of the calculated discount is correct, subject to the approval of the Procuring Agencies. The setting of a Guaranteed Minimum Discount off of Aggregate AWP for all Generic Drugs dispensed through the Mail Service Pharmacy Process shall in no way modify the Contractor's contractual obligation to maximize the Programs' aggregate discount above the Contractor's Guaranteed Minimum Discount off of Aggregate AWP; and

e. If the overall aggregate discounts obtained, as calculated utilizing the formula set forth in the prior paragraph, are less than the Guaranteed Minimum Discount off of Aggregate AWP as proposed by the Offeror in its Financial Proposal, the Contractor shall reimburse the

Programs, the difference between the Ingredient Cost the Programs were charged utilizing Pass-through Pricing and the Ingredient Cost the Programs would have been charged if the Guaranteed Minimum Discount off of Aggregate AWP had been obtained. The Programs will be credited annually for this difference in Ingredient Cost. The Programs shall retain the benefit of any cost savings, in excess of the Contractor's proposed Guaranteed Minimum Discounts off of Aggregate AWP for all Generic Drugs dispensed by pharmacies.

f. This calculation shall be performed by the Contractor for each Program Year based on claims paid for each incurred year. Specifically, the Contractor shall perform a reconciliation to include claims incurred in each Program Year and paid through June of the following Program Year. The reconciliation shall be submitted to the Procuring Agencies on July 31st. The Contractor shall pay/credit each Program the applicable amount, if any, within 30 Days of the Reconciliation Due Date. If the Procuring Agencies' review of the Contractor's calculations indicates an adjustment to the calculation is required, then the Procuring Agencies reserve the right in their sole discretion to make an adjustment to the Contractor's calculations and adjust the amount due to the Programs or to the Contractor

2. <u>Confirmation – Generic Pricing</u>

a. The Selected Offeror agrees to perform/fulfill and comply with the Duties and Responsibilities in Section 6.7.C of this RFP, under subheading "Mail Service Pharmacy Process - Generic Drug Pricing."

3. <u>Required Submission – Generic Pricing</u>

a. The Offeror is required to provide its Guaranteed Minimum Discount as a percent off of Aggregate AWP for all Generic Drugs dispensed through the Mail Service Pharmacy Process on Attachment 83, *Proposed Claim Reimbursement Quote*.

b. The Offeror is required to provide a listing of the Offeror's proposed "house generics" to be dispensed through the Mail Service Pharmacy Process.

D. <u>Mail Service Pharmacy Process – Compound Drug Pricing</u>

The Contractor must classify Compound Drugs in accordance with the definition in the *Glossary of Defined Terms* (Attachment 15) of this RFP. Drugs assigned a unique NDC that require reconstitution and/or mixing prior to dispensing do not meet the Programs' definition of a Compound Drug and shall

be processed in accordance with the requirements set forth in the RFP.

1. <u>Duties and Responsibilities – Compound Drug Pricing</u>

The Contractor shall be required to:

a. Utilize its pricing methodology for Compound Drugs utilizing Pass-through Pricing, as proposed by the Contractor in Attachment 83, *Proposed Claim Reimbursement Quote*, of its Proposal, for the entire term of the Agreement. (**Note:** If an Offeror has multiple methods of pricing, the Offeror may propose each pricing method in Attachment 83 for Procuring Agency consideration and selection.) The Contractor's pricing methodology(ies) for Compound Drugs, as proposed by the Contractor in its Proposal, must be the same for retail and Mail Service Pharmacy Process claims;

b. Charge Enrollees the applicable Level 2 Drug Copayment for all Compound Drugs. If the current Discounted Ingredient Cost or the submitted cost is less than the applicable Level 2 Drug Copayment then the Contractor shall ensure that the Enrollee is charged the lesser amount;

c. Process Compound Drug claims in a manner that verifies the validity of the claim as a Compound Drug according to the Programs' definition and provides appropriate claim control mechanisms to protect the financial interests of the Programs; and

d. Conduct due diligence to ensure that drugs are being properly classified as Compound Drugs consistent with the Programs' definition of a Compound Drug and ensure that compound claims are priced in accordance with the Contractor's pricing methodology for Compound Drug, as proposed by the Contractor in its Proposal, selected by the Procuring Agencies.

2. <u>Confirmation – Compound Drug Pricing</u>

a. The Selected Offeror agrees to perform/fulfill and comply with the Duties and Responsibilities in Section 6.7.D of this RFP, under subheading "Mail Service Pharmacy Process – Compound Drug Pricing."

3. <u>Required Submission – Compound Drug Pricing</u>

a. In Attachment 83, *Proposed Claim Reimbursement Quote*, the Offeror is required to provide its pricing methodology utilizing Pass-through Pricing for Compound Drugs dispensed by Network Pharmacies; its dispensing fees; and if the Offeror is proposing the

use of NCPDP transaction standards for Compound Drugs, a level of effort fee based on the claims level of effort code. The Offeror will notify DCS, in writing, a minimum of 30 Days in advance of any changes to the Contractor's book of business Level of Effort fees, and such revised fees will be charged consistent with the pricing provisions of the Agreement.

6.8 Enrollee Submitted Claims

The cost to the Program for Prescriptions for which Enrollees submit direct claims for reimbursement will be charged to the DCS Program at the actual amount reimbursed by the Contractor. For the DCS Programs, such reimbursement shall be based on the lesser of the submitted cost, minus the applicable Copayment; or the Discounted Ingredient Cost, plus the applicable (Brand Drug/Generic Drug) Guaranteed Maximum Dispensing Fee, plus the Guaranteed Maximum Prescribing Fee (if applicable), minus the applicable Copayment. In the case of an Enrollee who has dual Empire Plan coverage, the applicable Copayment will not be subtracted from the reimbursement for the secondary claim.

1. Duties and Responsibilities – Enrollee Submitted Claims

The Contractor shall be required to utilize the following methodology to charge the Programs:

a. **(Exclusive to DCS)** Brand Drugs, including Specialty Drugs, must be charged to the Programs utilizing the Guaranteed Minimum Discount off of Aggregate AWP for Brand Drugs dispensed at the Retail Pharmacy Network plus Retail Brand Guaranteed Maximum Dispensing Fee for Brand Drugs, plus the Guaranteed Maximum Prescribing Fee (if applicable), minus the applicable Copayment;

b. **(Exclusive to DCS)** Generic Drugs, including Specialty Drugs, must be charged to the Program utilizing the Contractor's assigned MAC price for the Retail and Mail Service Pharmacies, plus the applicable dispensing fee for Generic Drugs, plus the prescribing fee(s), if applicable, minus the applicable Copayment. Generic Drugs without a MAC price must be charged to the DCS Program using the Contractor's Guaranteed Minimum Discount off of Aggregate AWP for Brand Drugs, as proposed by the Contractor in its Proposal, off of AWP of the dispensed Generic Drug, plus the Guaranteed Maximum Dispensing Fee for Generic Drugs, minus the applicable Copayment;

c. **(Exclusive to DCS)** Compound Drugs must be charged to the DCS Program by applying the Contractor's pricing methodology for Compound Drugs as defined in Section 6.7.D of the RFP, under the

subheading “Retail Pharmacy Compound Drug Pricing,” as proposed by the Contractor in its Proposal, plus the Guaranteed Maximum Dispensing Fee for Compound Drugs minus the applicable Level 2 Drug Copayment;

d. **(Exclusive to DCS)** The Program’s Lesser of Logic must be applied to all Enrollee Submitted Claims; and

e. **(Exclusive to NYSIF)** For the NYSIF Program, all Enrollee/Dependent Submitted Claims must be charged to the Program at the submitted cost, (i.e., Enrollees/Dependents must be reimbursed one hundred percent (100%) of their actual cost).

2. Confirmation – Enrollee Submitted Claims

a. The Selected Offeror agrees to perform/fulfill and comply with the duties and responsibilities listed in the Enrollee Submitted Claims section above.

6.9 Non-Network Pharmacy Submitted Claims (Exclusive to NYSIF)

The cost to the NYSIF Program for Prescriptions for which Non-Network Pharmacies submit direct claims for reimbursement will be charged to the NYSIF Program in accordance with New York State Worker’s Compensation Board laws and regulations, specifically, Section 440 of Chapter V. of Title 12 NYCRR (New York Codes Rules and Regulations).

NYSIF operates a mandatory pharmacy network in accordance with the provisions of 12 NYCRR 440.

1. Duties and Responsibilities – Non-Network Pharmacy Submitted Claims

The Contractor shall be required to utilize the following methodology to charge the Programs:

a. Brand Drugs, including Specialty Drugs, must be charged to the NYSIF Program at the New York State Workers’ Compensation Board rates, currently a twelve percent (12%) discount off of AWP, plus a $4 Dispensing Fee; and

b. Generic Drugs, including Specialty Drugs, must be charged to the NYSIF Program at the New York State Workers’ Compensation Board rates, currently a twenty percent (20%) discount off of AWP, plus a $5 Dispensing Fee.

c. NYSIF operates a mandatory pharmacy network in accordance with the provision of 12 NYCRR 440.

2. Confirmation – Non-Network Pharmacy Submitted Claims

a. The Selected Offeror agrees to perform/fulfill and comply with the duties and responsibilities listed in the Non-Network Pharmacy Submitted Claims section above.

6.10 Dispensing Fee and Prescribing Fee

A Dispensing Fee is the amount of money, if any, paid to the pharmacies in compensation for the services rendered for filling a Prescription under the Agreements. The level of dispensing fees should encourage appropriate dispensing and compliance with the Programs' mandatory generic substitution requirements.

(Exclusive to DCS) A Prescribing Fee is the amount of money, if any, and subject to authorization under NYS law, paid to pharmacies in compensation for the services rendered in prescribing certain statutorily authorized (e.g., self-administered oral hormonal contraceptives) medications.

1. Duties and Responsibilities – Dispensing Fees and Prescribing Fees

a. Dispensing fees at Retail Network Pharmacies shall be subject to Pass-through Pricing, up to a Guaranteed Maximum Dispensing Fee applied to aggregate claims. Prescribing fee(s), if applicable, at Retail Network Pharmacies shall be subject to Pass-through Pricing, up to a Guaranteed Maximum Prescribing Fee applied to aggregate claims. Dispensing fees for claims filled at the Specialty Pharmacy(ies), may be variable commensurate with the level of clinical services offered through the Specialty Pharmacy Program and should be proposed under Attachment 89, *Specialty Pharmacy Program Dispensing Fees*. (**Note:** Offerors may propose a different Guaranteed Maximum Dispensing Fee at Retail Network Pharmacies for Brand Drugs vs. Generic Drugs. Offerors shall propose a single Guaranteed Dispensing Fee for the Mail Service Process – see Attachment 83, *Proposed Claim Reimbursement Quote*)

b. The Contractor shall be required to guarantee its dispensing fee(s) and prescribing fee(s), if applicable,, as proposed by the Contractor in its Proposal, for the entire term of the Agreements.

c. No dispensing fee shall be charged to the Programs for any claim that is paid on the basis of the Pharmacy's Usual and Customary price.

d. The Contractor must guarantee the overall maximum dispensing fee for Brand, Generic and Compound claims, respectively, dispensed at Retail Network Pharmacies, as proposed by the Contractor in its Proposal. The level of dispensing fees achieved as a result of Pass-through Pricing at Retail Pharmacies will be calculated utilizing the following formula: Total Retail Network Dispensing Fees paid by each Program on an annual basis divided by the number of Final Paid Claims at Retail Network Pharmacies for each of Generic, Brand, and Compound claims.

e. If the overall aggregate dispensing fees paid, as calculated utilizing the formula set forth in the prior paragraph, are more than the Guaranteed Maximum Dispensing Fee proposed for each of Brand, Generic, and Compound claims at Retail Network Pharmacies, the Contractor shall reimburse each Program the difference between the Dispensing Fee the Programs were charged utilizing Pass-through Pricing and the Dispensing Fee the Programs would have been charged if the Guaranteed Maximum Dispensing Fee had been obtained.

f. This calculation shall be performed for each Program Year based on claims for each incurred year. Specifically, the Contractor shall perform a reconciliation to include claims incurred in each Program Year and paid through June of the following Program Year. The reconciliation shall be submitted to the Procuring Agencies on July 31st. The Contractor shall pay/credit each Program the applicable amount, if any, within 30 Days of the Reconciliation Due Date. If the Procuring Agencies' review of the Contractor's calculations indicates and adjustment to the calculation is required, then the Procuring Agencies reserve the right in their sole discretion to make an adjustment to the Contractor's calculations and adjust the amount due to the Programs or to the Contractor. The Programs shall retain the benefit of any cost savings in excess of the Guaranteed Maximum Dispensing Fees set forth in Section 6.10. Any shortfall in the Guaranteed Maximum Dispensing Fees set forth in Section 6.10 cannot be recovered by the Contractor in subsequent years.

g. **(Exclusive to DCS)** The Contractor must guarantee the overall maximum prescribing fee(s), (if applicable) for Brand and Generic claims, respectively, dispensed at Retail Network Pharmacies, as proposed by the Contractor in its Proposal. The level of prescribing fee(s), if applicable, achieved as a result of Pass-through Pricing at Retail Pharmacies will be calculated utilizing the following formula:

Total Retail Network Prescribing Fees (if applicable) paid by each Program on an annual basis divided by the number of Final Paid Claims at Retail Network Pharmacies for each of Generic, and Brand claims.

h. **(Exclusive to DCS)** If the overall aggregate prescribing fees, if applicable, paid, as calculated utilizing the formula set forth in the prior paragraph, are more than the Guaranteed Maximum Prescribing Fee proposed for each of Brand, and Generic claims at Retail Network Pharmacies, the Contractor shall reimburse the DCS Program the difference between the Prescribing Fee the DCS Program was charged utilizing Pass-through Pricing and the Prescribing Fee, if applicable, the DCS Program would have been charged if the Guaranteed Maximum Prescribing Fee had been obtained.

i. **(Exclusive to DCS)** This calculation shall be performed for each Program Year based on claims for each incurred year. Specifically, the Contractor shall perform a reconciliation to include claims incurred in each Program Year and paid through June of the following Program Year. The reconciliation shall be submitted to DCS on July 31st. The Contractor shall pay/credit the DCS Program the applicable amount, if any, within 30 Days of the Reconciliation Due Date. If the DCS review of the Contractor's calculations indicates and adjustment to the calculation is required, then the Department reserves the right in its sole discretion to make an adjustment to the Contractor's calculations and adjust the amount due to the Program or to the Contractor. The Program shall retain the benefit of any cost savings in excess of the Guaranteed Maximum Prescribing Fees set forth in Section 6.10. Any shortfall in the Guaranteed Maximum Prescribing Fees set forth in Section 6.10 cannot be recovered by the Contractor in subsequent years.

2. <u>Confirmation – Dispensing Fees and Prescribing Fees</u>

a. The Selected Offeror agrees to perform/fulfill and comply with the duties and responsibilities listed in the Dispensing Fee and Prescribing Fee section above.

3. <u>Required Submission – Dispensing Fees and Prescribing Fees</u>

a. The Offeror is required to provide the Offeror's proposed Guaranteed Maximum Dispensing Fees and Guaranteed Maximum Prescribing Fees, if applicable, for Retail Brand and Generic claims on Attachment 83, *Proposed Claim Reimbursement Quote*.

b. The Offeror is required to provide the Offeror's proposed fixed dispensing fees for mail order Brand and Generic claims on Attachment 83, *Proposed Claim Reimbursement Quote*.

c. The Offeror is required to complete Attachment 89, *Specialty Pharmacy Program Dispensing Fees*, listing the Offeror's proposed dispensing fees for each drug proposed to be included in the Offeror's Specialty Pharmacy Program.

6.11 Specialty Pharmacy Program Pricing

All DCS Program Enrollee Groups and NYSIF Claimants participate in the Specialty Pharmacy Program, which provides an enhanced level of clinical management for Enrollees/Claimants taking Specialty Drugs. Under the current plan design, an Enrollee/Claimant is allowed to have a Grace Fill of certain Specialty Drugs dispensed from any Pharmacy. However, Specialty Drugs identified for short-term therapy for which a delay in starting therapy would not affect clinical outcomes are not eligible for this Grace Fill benefit and must be filled through the Designated Specialty Pharmacy. After the first Specialty Drug Prescription is filled through Retail or Mail Service Pharmacy, future fills are subject to a Hard Edit (DCS only), meaning that Enrollees are required to obtain the drug through the Specialty Pharmacy Process, subject to the mail service Copayment (DCS only) when dispensed by the Designated Specialty Pharmacy. This requirement does not apply to enrollees in the Empire Plan Medicare Rx program.

In addition to a Grace Fill at Retail, certain Specialty Drugs available through the Specialty Pharmacy Program as well as all Specialty Medications covered under the NYSIF Program are also available through the Retail Pharmacy Network, because of their clinical requirements and/or urgent dispensing timeframe or NYS laws and regulations. All drugs filled at a Retail Pharmacy Network are subject to the Retail Network Pharmacy Pass-through Pricing and Copayments (DCS only). For those drugs available only through the Specialty Pharmacy Program, the Offeror may propose dispensing fees on a drug by drug basis, commensurate with the clinical services provided for each (Attachment 89, *Specialty Pharmacy Program Dispensing Fees*). All drugs shall be classified as either Brand Name, Generic, or Compound for pricing purposes based on the classification methodologies set forth in Section 6.4.1(g) of this RFP. The Programs shall be entitled to all manufacturer revenue derived from Specialty Drugs.

Drugs which may be included in the Specialty Pharmacy Program, Specialty Drugs are:

a) "orphan drugs";

b) drugs requiring special handling, special administration and/or intensive

patient monitoring/testing;

c) biotech drugs developed from human cell proteins and DNA, targeted to treat disease at the cellular level; or,

d) other drugs identified by the Program as used to treat patients with chronic or life-threatening diseases.

The DCS Program requires that medications dispensed under the Specialty Pharmacy Program meet the conditions above. Offerors should not include oral tablets of generic medications that historically been available through Retail Network Pharmacies. **The Department reserves the right to remove medications from the Specialty Pharmacy Program Drug List at any time.** Adding medications to the list and/or applying utilization management to medications may be made no more than quarterly, subject to review and approval by DCS and OER. Offerors should provide information listed in the "Specialty Drug Proposals" Report listed in Attachment 36, *Program Reporting*, when proposing changes to medications under the Specialty Pharmacy Program.

The Offeror must provide a Special Pharmacy Program where Enrollees/Claimants receive their Specialty Drugs through one or more designated pharmacies that offer enhanced clinical management. The process must provide extensive clinical support in the most cost-effective manner possible for the Program.

1. <u>Duties and Responsibilities – Specialty Pharmacy Program Pricing</u>

a. Consistently enforce and administer all provisions of the Program (including but not limited to mandatory generic substitution, drug utilization review, prior authorization, refill too-soon edits) to the claims dispensed through the Specialty Pharmacy Process, consistent with the processing of claims through the Retail and Mail Service Pharmacy Network processes.

b. Charge the Programs for those drugs dispensed to Enrollees/Claimants in original manufacturer packaging, based on the Contractor's source of AWP for the 11-digit NDC of the package size dispensed through the Specialty Pharmacy Process. If the drug is not dispensed to the Enrollee/Claimant in the original manufacturer packaging (i.e., dispensed in bulk), the Programs shall be charged based on the Contractor's source of AWP for the 11-digit NDC of the package size from which the drug was originally dispensed by the Designated Specialty Pharmacy. If the drug is dispensed from a bulk package size for which no AWP is reported in the Contractor's AWP source, the

Program shall be charged based on the reported AWP for the NDC of the largest package size contained in the Contractor's AWP source. The Programs shall not be charged based on an NDC assigned to repackaged drugs or based on package sizes prepared by special arrangement with the original manufacturer unless such packaging offers a net savings to the Programs.

c. Charge the Programs based on the Contractor's pricing terms and dispensing fees (if any) applicable to Brand and Generic, Specialty Drug claims as set forth in Attachment 83, *Proposed Claim Reimbursement Quote* and Attachment 89, *Specialty Pharmacy Program Dispensing Fees*, for all prescriptions submitted through the Specialty Pharmacy Program.

d. Ensure that the Designated Specialty Pharmacy(ies) collects the appropriate Copayment specified by the Department (plus Ancillary Charge, if applicable) from the Enrollee and will charge the Programs the balance of the Discounted Ingredient Cost plus the Offeror's applicable guaranteed dispensing fee set forth in Section 6.10. of the RFP, minus the applicable Copayment for all drugs dispensed through the Specialty Pharmacy Process.

e. Classify Brand Drugs consistent with the definition in the *Glossary of Defined Terms* (Attachment 15) as well as the methodology outlined earlier within Section 6.4.1(g)(ii) of the RFP entitled "Brand Drug Determination Methodology."

f. Classify Generic Drugs consistent with the definition in the *Glossary of Defined Terms* (Attachment 15) as well as the methodology outlined earlier within Section 6.4.1(g)(iii) of the RFP entitled "Generic Drug Determination Methodology."

g. Propose a fixed contracted Guaranteed Discount off of Average Wholesale Price (AWP) that will be utilized to determine the Ingredient Cost of the Prescription to charge the Programs. The Offeror's Guaranteed Discount shall be applicable to the aggregate AWP of all Prescriptions for Brand Drugs and Generic Drugs dispensed to Enrollees/Claimants through the Specialty Pharmacy. The Contractor shall guarantee the Procuring Agencies that its management of drug costs dispensed through the Specialty Pharmacy Process shall result in the Programs achieving the Contractor's overall Guaranteed Minimum Discounts during each Program Year as proposed in the Offeror's Financial Proposal. The discounts achieved off of the aggregate AWP for all Brand Drugs and Generic Drugs dispensed to Enrollees/Claimants through the Specialty Pharmacy Process will be calculated utilizing the following formula: 1 minus (Sum of Ingredient

Costs of Brand Drugs and Generic Drugs dispensed through the Specialty Pharmacy Process divided by sum of the AWP of Brand Drugs and Generic Drugs dispensed through the Specialty Pharmacy Process). The aggregate discount calculation will be based on Final Paid Claim Pharmacy Prescriptions filled through the Specialty Drug Process. Claims submitted for secondary payer consideration, Compound Drug claims, powders, and subrogation claims must be excluded from the aggregate discount calculation. In addition, claims with a calculated AWP discount greater than 50% must be verified by the Contractor that the quantity and the validity of the calculated discount is correct, subject to the approval of the Procuring Agencies.

h. If the overall aggregate discounts obtained, as calculated utilizing the formula set forth in the prior paragraph, are less than the Guaranteed Minimum Discount off of Aggregate AWP as proposed by the Offeror in its Financial Proposal, the Contractor shall reimburse the Programs, the difference between the Ingredient Cost the Programs were charged utilizing Lesser of Logic and the Ingredient Cost the Programs would have been charged if the Guaranteed Minimum Discount off of Aggregate AWP had been obtained. The Programs will be credited annually for this difference in Ingredient Cost. The Programs shall retain the benefit of any cost savings, in excess of the Contractor's proposed Guaranteed Minimum Discounts off of Aggregate AWP for all Brand Drugs and Generic Drugs dispensed to Enrollees/Claimants through the Specialty Pharmacy.

i. This calculation shall be performed by the Contractor for each Program Year based on claims paid for each incurred year. Specifically, the Contractor shall perform a reconciliation to include claims incurred in each Program Year and paid through June of the following Program Year. The reconciliation shall be submitted to the Procuring Agencies on July 31st. The Contractor shall pay/credit each Program the applicable amount, if any, within 30 Days of the Reconciliation Due Date. If the Procuring Agencies' review of the Contractor's calculations indicates an adjustment to the calculation is required, then the Procuring Agencies reserve the right in their sole discretion to make an adjustment to the Contractor's calculations and adjust the amount due to the Programs or to the Contractor

j. Act in the best financial interests of the Programs when dispensing Generic Drugs through the Specialty Pharmacy Process by avoiding the dispensing of NDC's with higher AWPs unless market conditions exist making dispensing the more cost effective NDC impractical or impossible.

k. The Contractor is required to maximize savings to the Program through

aggressive pricing and discounts, consistent with Lesser of Logic and the Contractor's Financial Proposal. The Contractor agrees that all records supporting Lesser of Logic are subject to audit by DCS and its consultants or other State auditors with authority under Section 8, Additional Provisions and/or Appendices A, B & B-1 of this RFP.

2. Confirmation – Specialty Pharmacy Program Pricing

a. The Selected Offeror confirms their understanding that the Department reserves the right to remove medications from the Specialty Pharmacy Program Drug List at any time.

b. The Selected Offeror agrees to perform/fulfill and comply with to the Duties and Responsibilities – Section 6.11 of this RFP, under the subheading "Specialty Pharmacy Program Pricing."

3. Required Submission – Specialty Pharmacy Program Pricing

a. The Offeror is required to provide the Offeror's Guaranteed Discount off of Aggregate Average Wholesale Price (AWP) for Brand Drugs and Generic Drugs dispensed under the Specialty Pharmacy Program as set forth in Attachment 83, *Proposed Claim Reimbursement Quote*, of the RFP.

6.12 100% Pharma Revenue Guarantee

The Empire Plan is one of the largest health insurance plans in the country. The DCS Program has adopted a three-level drug benefit structure for Enrollees to enhance the ability of the DCS Program to obtain direct discounts from manufacturers. The Contractor is required to manage the Program's Drug List and to negotiate, on the Programs' behalf, agreements with manufacturers for direct discounts off of the cost of drugs dispensed to Program Enrollees/Claimants. Manufacturer discounts related to Programs utilization can make a drug with a higher AWP competitive with clinically comparable drugs with lower AWPs. However, the Contractor's receipt of revenue related to the Programs' utilization can create a potential conflict of interest in the decision to classify a drug as Preferred, Non-Preferred or excluded.

Full transparency is critical to protecting the interests of the State, Participating Agencies and Enrollees/Claimants and ensuring alignment of the Programs' financial interests with those of the Contractor. This section details the Contractor's duties and responsibilities with regard to management of Pharma Revenue on the Programs' behalf.

Definitions

Pharma Revenue is defined as set forth in the *Glossary of Defined Terms* (Attachment 15). Such revenues include but are not limited to revenues described as: formulary rebates; market share rebates; administrative fees; AWP caps; inflation protection program; or by any other name.

A **Final Paid Claim** is defined as set forth in the *Glossary of Defined Terms* (Attachment 15). A Final Paid Claim is a claim processed and paid by the Contractor for a Prescription drug or covered medication, OTC product or non-drug device, provided to an Enrollee/Claimant, including but not limited to, claims for Prescriptions filled at a Retail Pharmacy or through the Mail Service Pharmacy Process or the Specialty Pharmacy Process. A claim that is denied prior to processing is not considered a Final Paid Claim. In addition, a claim that is processed and paid but is subsequently voided, reversed, or otherwise adjusted is not a Final Paid Claim. Zero balance claims are considered Final Paid Claims. Consistent with the definition of a Final Paid Claim, the Pharma Revenue guarantee per Final Paid Claim quoted applies to rebatable and non-rebatable claims.

In Calendar Year 2022, there were approximately 16.8 million Final Paid Claims (Commercial + EGWP). This is a subset of the claims that Offerors will see on Attachment 84, *Layout Specifications for DCS Program Informational Claims Data File*, which will show Original or Replacement claims as well as Voided claims.

1. Duties and Responsibilities – Pharma Revenue Guarantee

The Contractor agrees to and shall:

a. Negotiate Pharma Revenue agreements with manufacturers that maximize savings to the Programs, leveraging the significant enrollment of the Programs for each individual drug. 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.

b. Pay the Programs quarterly within 60 Days of the end of each quarter, the greater of 100% Pharma Revenue received or the minimum guaranteed amount attributable to the Programs' combined utilization.

c. Calculate and distribute Pharma Revenue to the Programs in a fully

transparent and verifiable process. The Contractor agrees that all direct and indirect revenue arrangements with manufacturers, suppliers, or other vendors shall be disclosed and the revenue generated related or attributable to the Programs' utilization shall be credited to the Programs. The Contractor acknowledges and agrees that the records, methods, and calculations utilized to total and distribute these amounts to the Programs are subject to audit by the State under the audit authority set forth in Section 8, Additional Provisions and Appendices A and B of the RFP thereto. In addition, the Contractor shall pursuant to the terms of this RFP and the resulting Contract provide all agreements as necessary for the Programs to evaluate Drug List decisions including direct access to any manufacturer contracts in unredacted form, under which the Programs is entitled to derive Pharma Revenue pursuant to the terms of the Agreements. If Contractor identifies in writing the information requested as Contractors' Confidential or Proprietary information access to the information will be provided pursuant to Section 8.7, Contractor's Confidential Information.

d. Not enter into any agreement that has the effect of diverting, shortchanging, or trading off any form of Pharma Revenue that would otherwise be due the Programs for other consideration. There shall be no fees charged to the Programs or received from a manufacturer, separate from the Claims Administration Fees as described and authorized in the RFP, by the Contractor for rebate or other Pharma Revenue administration. The Contractor shall not divert, shortchange, or trade off Pharma Revenue that would otherwise inure to the Programs' financial benefit for Enrollee/Claimant drug utilization in return for reduced drug acquisition costs or other monetary or non-monetary consideration from manufacturers.

e. Upon selection of the Selected Offeror and as a condition of contract award and throughout the term of the Agreements, the Selected Offeror/Contractor shall pursuant to the terms of this RFP and the resulting Contract provide, upon the request of the State, all information and documentation related to Pharma Revenue agreements, including but not limited to, full direct access by the Procuring Agencies staff or their agents to complete unredacted Pharma Revenue agreements pursuant to which the Programs derives Pharma Revenue. If Contractor identifies in writing the information requested as Contractors' Confidential or Proprietary information access to the information will be provided pursuant to Section 8.7 Contractor's Confidential Information.

f. Utilize manufacturer agreements for the Programs that meet or exceed the Contractor's best existing Pharma Revenue agreements for all

individual drugs. If the Contractor's business model allows for more than one Pharma Revenue agreement with manufacturers, the Contractor agrees that in no instance will the Programs receive less Pharma Revenue in any therapeutic class than other 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. The Contractor, as part of its Proposal, must propose a process satisfactory to the Procuring Agencies to confirm compliance with this provision and must implement and administer said satisfactory process under the Agreements. The Programs shall receive full pass-through of 100% of Pharma Revenue derived from any Pharma Revenue agreement with a pharmaceutical manufacturer. Where any Pharma Revenue contracts allow for higher Pharma Revenue for Mail Service Pharmacy or Specialty Pharmacy Program claims, the Programs will receive the full financial benefit of those higher rates receiving 100% of the Pharma Revenue derived from those agreements on mail order claims. If manufacturer agreements provide less Pharma Revenue for Mail Service Pharmacy or Specialty Pharmacy Program claims than retail claims for the same drug, the terms of the manufacturer agreement applicable to retail claims shall be applied to Program Mail Service Pharmacy and Specialty Pharmacy Program claims for purposes of calculating the amount of Pharma Revenue due the Programs.

g. The Contractor, as part of its Proposal, must propose a Minimum Pharma Revenue Guarantee Per Final Paid Claim that will be utilized by the Contractor in calculating the minimum annual amount due to the Programs for Pharma Revenue. The Minimum Pharma Revenue amount due the Programs on an annual basis will be calculated according to the formula: Contractor's Minimum Per Final Paid Claim Pharma Revenue Guarantee multiplied by the number of Final Paid Claims (as defined in the *Glossary of Defined Terms* (Attachment 15), which includes rebate- and non-rebate eligible claims but not Voided claims) incurred for the DCS Program and the NYSIF Program for the respective Program Year.

h. Ensure the Contractor's Minimum Pharma Revenue Guarantee Per Final Paid Claim is not contingent upon the Programs' participation in any of the Contractor's formulary management or intervention programs, including, but not limited to, step therapy and Brand for Generic (B4G) strategies. The Contractor's Minimum Pharma Revenue Guarantee Per Final Paid Claim is also not contingent on the Program's use of the Contractor's book of business or standard formulary offerings, or the timing of any patent expirations and/or introduction of generic equivalent drugs, including but not limited to early and/or at risk Generic Drug launches. Any B4G strategy

proposed must be financially advantageous to the State. The Programs will review the guaranteed amount only in the event of legislative, regulatory, or judicial action excluding patent litigation not specific to the Contractor's business practices that serves to void existing Pharma Revenue agreements materially compromising the Contractor's ability to obtain contracted Pharma Revenue necessary to meet the Contractor's Minimum Pharma Revenue Guarantee Per Final Paid Claim. Further, any exclusions the Offeror is proposing as part of its Formulary must comply with the requirements of Section 3.14 and 5.15.

i. Calculate and perform an annual reconciliation of the Pharma Revenue credit to the Pharma Revenue earned. As part of this annual reconciliation the Contractor shall be required to:

    i. Calculate the Pharma Revenue guarantee on all Final Paid Claims, incurred for the respective Program Year. The Pharma Revenue guarantee shall be on the aggregate level, not separated for each therapeutic class**.**

    ii. Credit the Programs an amount calculated based on the following formula: if in any Program Year, the Pharma Revenue realized and credited to the Programs by the Contractor is less than the amount due the Programs as determined utilizing the minimum Pharma Revenue credit set forth above in (g) of this Section, the amount of the credit shall be equal to the difference between the reported Pharma Revenue credited to the Programs and the Contractor's Minimum Pharma Revenue Guarantee Per Final Paid Claim.

    iii. Submit calculations and documentation supporting the amount of Pharma Revenue reported and credited to the Programs for the Procuring Agencies' review and written approval. The Contractor shall provide all information and documentation deemed necessary by the Procuring Agencies to verify the Programs were credited with all Pharma Revenue due it under the terms of the Agreements.

    If at the close of any Plan Year, the Pharma Revenue credited to the Programs is greater than the higher of the amount derived through application of the Pharma Revenue guarantee formula or the actual Pharma Revenue realized by the Programs, upon notice and verification by the Procuring Agencies, the DCS Program and the NYSIF Program shall pay the Contractor the difference between the amount previously credited to each

Program and the higher of the minimum Pharma Revenue guaranteed amount or actual Pharma Revenue realized during the Program Year.

iv. If at the close of any Program Year, the Pharma Revenue credited to the Programs is less than the actual Pharma Revenue realized by the Programs, the Contractor shall credit each Program the difference between what was previously credited and the full amount due to the Programs.

v. Include such reconciliations as part of the Contractor's annual financial summary report. The Procuring Agencies require the Contractor's Minimum Pharma Revenue Guarantee Per Final Claim Paid be credited to the claims experience on the annual financial reports regardless of the amount of Pharma Revenue that has been received by the Contractor.

2. <u>Confirmation – Pharma Revenue Guarantee</u>

a. The Selected Offeror agrees to the definitions and the Offeror's agreement to perform/fulfill and comply with the duties and responsibilities listed in the Pharma Revenue guarantee section above.

3. <u>Required Submission – Pharma Revenue Guarantee</u>

a. The Offeror is required to provide its proposed Minimum Pharma Revenue Guarantee Per Final Paid Claim in Attachment 90, *Pharma Revenue Guarantee Quote*. Offerors may provide a different Minimum Pharma Revenue Guarantee Per Final Paid Claims for each year of the Agreements. The minimum credit to the Programs for Pharma Revenue shall be the Offeror's Minimum Pharma Revenue Guarantee Per Final Paid Claim (as submitted on Attachment 90) times the number of Final Paid Claims paid for each Program for the respective Program Year as defined in the *Glossary of Defined Terms* (Attachment 15).

b. The Offeror is required to provide adequate documentation as determined by the Procuring Agencies, to support the Offeror's offer relative to Pharma Revenue. Said documentation is to be provided as Attachment 91, *Documentation to Support Pharma Revenue Guarantee Quote*, of the Offeror's Proposal.

6.13 <u>Claims Administration Fees</u>

The Claims Administration Fees are the fees quoted by the Contractor in its

Proposal that the Contractor shall charge the Programs to cover all of the administrative services provided by the Contractor. Three separate Claims Administration Fees must be developed and quoted by Offerors for the Programs: 1) DCS Program Primary; 2) EGWP Medicare Primary; and 3) NYSIF Program. The DCS Program Primary Claims Administration Fee covers the Contractor's administration of The Empire Plan for non-Medicare-primary Enrollees, as well as the SEHP and the Excelsior Plan. The Contractor's EGWP Medicare Primary Claims Administration Fee covers the Contractor's administration of The Empire Plan for Medicare-primary Enrollees. The Contractor's NYSIF Program Claims Administration Fee covers the Contractor's administration of the NYSIF Program.

1. Duties and Responsibilities – Claims Administration Fees

The Contractor shall be required to:

a. Be bound by its Claims Administration Fees, as proposed in the Contractor's Proposal for the entire term of the Agreements.

b. Implement any changes necessary to accommodate Programs modifications resulting from collective bargaining, legislation or within the statutory discretion of the State within 60 Days of notice, or as soon as practicable.

c. Agree not to request higher Claims Administration Fees, and the Procuring Agencies will not consider any increases to the Claims Administration Fees, that are not based on material changes to the Programs requiring the Contractor to incur additional costs. The determination of what constitutes a material change will be in the sole discretion of the Procuring Agencies. Implementation of an alternate formulary or multiple formularies shall not constitute a material change and the Contractor agrees to implement, if required, all alternative formularies at the Claims Administration Fees proposed.

d. Manage all Programs Enrollees/Claimants based on the Contractor's associated Claims Administration Fees as proposed by the Contractor in its Proposal.

e. Submit detailed documentation of additional administrative/clinical costs, over and above existing administrative/clinical costs, with any request for an increase in the Claims Administration Fee(s) resulting from a material change in the benefit structure of the Programs. The Procuring Agencies reserve the right to request, and the Contractor agrees to provide any additional information and documentation the Procuring Agencies deem necessary to verify that the request for an increase to a Claims Administration Fee(s) is warranted. The Procuring Agencies' decision to modify the Claims Administration Fees to the extent necessary to

compensate the Contractor for documented additional costs incurred shall be at the sole discretion of the Procuring Agencies, subject to the approval of a formal amendment to the Agreement(s) by the New York State Attorney General and New York State Office of State Comptroller.

f. Implement all benefit designs as required by the Department with or without final resolution of any request for a Claims Administration Fee(s) adjustment. Refusal to implement changes will constitute a material breach of the Agreement(s) and the Procuring Agencies will seek compensation for all damages resulting.

g. Agree that Claims Administration Fees shall be payable only for Final Paid Claims and that the Programs will not pay a Claims Administration Fee or other charge or fees for any claim that is denied prior to processing or any claim that is subsequently voided, reversed, or otherwise modified.

2. Confirmation – Claims Administration Fees

a. The Selected Offeror agrees to perform/fulfill and comply with the duties and responsibilities listed in section 6.13.1 Claims Administration Fees above.

3. Required Submission – Claims Administration Fees

a. The Offeror is required to provide the Offeror's Claims Administration Fees in Attachment 92, *Claims Administration Fee(s) Quotes*, on a fee per Final Paid Claim basis.

6.14 Vaccination Network Pharmacy Pricing (Exclusive to DCS)

Empire Plan non Medicare-Primary enrollees can receive ACIP-recommended vaccinations with no Copayment when they are administered by a licensed pharmacist or, when authorized by applicable law or regulation, a pharmacy intern at vaccination network pharmacies. Offerors should quote the DCS program for the Administration Fees associated with the vaccination benefits in Attachment 93, *Vaccination Administration Fees*, as indicated below. Offeror's Discount Guarantees in Attachment 83, *Proposed Claim Reimbursement Quote*, should be inclusive of Vaccine Fees, Dispensing Fees and Prescribing Fees, if applicable. Offeror's Claims Administration Fees in Attachment 92, *Claims Administration Fee(s) Quotes*, should be inclusive of Vaccines.

1. Duties and Responsibilities – Vaccination Network Pharmacy Pricing

The Offeror shall be required to quote the DCS Program, on a pass-through

basis, as follows:

a. Seasonal Vaccines shall be charged an Administration Fee to the Program on a Pass-through basis, as proposed in Attachment 93, *Vaccination Administration Fees*;

b. Non-Seasonal Vaccines shall be charged an Administration Fee to the Program on a Pass-through basis, as proposed in Attachment 93, *Vaccination Administration Fees*;

c. COVID-19 Vaccines and Boosters (vaccines and boosters for COVID-19 are covered without Copayment) and, due to the changing nature of the vaccine coverage and financial information, are agreed to through an Enrollment Form, subject to approval by DCS.

d. The Offeror shall be bound by its Vaccination Administration Fee, as proposed in the Contractor's Proposal for the entire term of the Agreements; and

e. Shall implement any changes necessary to accommodate Programs modifications resulting from collective bargaining, legislation or within the statutory discretion of the State within 60 Days of notice, or as soon as practicable.

2. Confirmation – Vaccination Network Pharmacy Pricing

a. The Selected Offeror agrees to perform/fulfill and comply with the Duties and Responsibilities Section 6.14 of this RFP, under subheading "Vaccination Network Pharmacy Pricing."

3. Required Submission – Vaccination Network Pharmacy Pricing

a. The Offeror is required to complete Attachment 93, *Vaccination Administration Fees,* for all Seasonal and Non-Seasonal Vaccines dispensed at Network Participating Pharmacies.

6.15 Payments/(Credits) to/from the Contractor

This section presents details regarding the financial structure and timing of financial transactions related to the Agreements and the specific items Offerors must submit with their Financial Proposal and questions related to those requirements.
The enrollment mix and benefit characteristics are presented in Attachments 23 and 24 (*Enrollment by Plan, by Month and Enrollment by Plan, by Age, respectively)*, and Attachments 71 through 75 *(2020-22 Incurred Claims; Selected Financial Data;, 2020-22 Incurred Claims by Month – Combined; 2020-*

22 Incurred Claims by Month – EGWP; and 20202-22 Incurred Claims by Month – Commercial, respectively) of this RFP; however, the Procuring Agencies cannot guarantee that, during the term of the Agreements, the same enrollment mix and benefit characteristics as those set forth in Attachment 23 and Attachments 71 through 75 of this RFP will exist.

1. <u>Duties and Responsibilities – Financial Structure and Timing of Financial Transactions</u>

a. Each Procuring Agency will separately reimburse the Contractor for claim payments and associated Claims Administration Fees no sooner than two (2) Business Days and no later than five (5) Business Days after receipt of an accurate invoice, following each claims processing cycle (weekly for the NYSIF Program and bi-weekly for the DCS Programs).The Contractor is required to submit a detailed claim file concurrent with each invoice (for the NYSIF Program) and within fifteen (15) Days after the end of each claims processing cycle (for the DCS Programs) to support the submitted invoices. The data file layout and file transmission protocol will be mutually agreed upon by the Selected Offeror and the Procuring Agencies during Implementation, in accordance with the Offeror's Proposal**. Note:** On an annual basis coinciding with the end of the State's fiscal year, the Statewide Financial System (SFS) will be shut down for approximately one to two weeks during which no payment transactions will be processed. The shutdown typically occurs between the last week of March and first week of April. The SFS may also be shut down for short periods during other times of the year for maintenance or upgrades or other reasons that are outside the control of the Department. Payments delayed as a result of the SFS shut down will be processed on the first Business Day after the SFS returns to operation.

b. Any credit amounts due from the Contractor to the Procuring Agencies for failure of the Contractor to meet the performance guarantees set forth in the Agreements shall be applied as a credit against the Claims Administration Fees charged separately to the Programs in the first invoice(s) processed after the performance guarantee has been calculated and agreed to by the Program(s).

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.

d. **(Exclusive to DCS)** Coordination of Benefit recoveries collected by the Contractor shall be aggregated and paid/credited to the DCS Program within fifteen (15) Days after the end of the month.

e. Drug litigation recoveries and settlements shall be paid/credited to the Programs within fifteen (15) Days of receipt by the Contractor.

f. Sixty (60) Days after the end of the first quarter, the Contractor shall pay/credit the Program, the greater of (1) the actual Pharma Revenue received on behalf of the Programs or (2) the Minimum Pharma Revenue Guarantee Per Final Paid Claim, defined in 6.12 and in the *Glossary of Defined Ter*ms (Attachment 15), multiplied by the number of Final Paid Claims incurred for the first quarter.

    i. For each subsequent quarter of the Program Year the calculations shall be performed on a cumulative Program Year-to-Date basis. The Contractor shall pay the greater cumulative amount less the amount previously paid for the Program Year.

    ii. The Contractor shall perform a reconciliation by May 31st of each year and the incremental Pharma Revenue amount shall be paid/credited to the Programs within thirty (30) Days of May 31st.

    iii. At the May 31st Pharma Revenue reconciliation, to the extent that any amount is owed by the Contractor, the Contractor shall pay/credit the Programs, within thirty (30) Days after the Final Pharma Revenue reconciliation for the amount owed.

g. The Agreement(s) is not subject to Article XI-A of NYS Finance Law. The Contractor agrees that Program Services provided under the Agreement(s) shall continue in full force and effect for a minimum of at least thirty (30) days beyond the payment due date as set forth in this Section 6. If after the thirty-fifth (35) calendar day after receipt of an accurate invoice and claims data file, as set forth in this Section 6, the Contractor has not yet received payment from the State for said invoice, the Contractor may proceed under the Dispute Resolution provision in Appendix B, B-1 and B-2 and the Agreement(s) shall remain in full force and effect until such final decision is made, unless the Parties can come to a mutual agreement, in which case, the Agreement(s) shall also remain in full force and effect.

2. <u>Confirmation – Financial Structure and Timing of Financial Transactions</u>

a. The Selected Offeror agrees to perform/fulfill and comply with the Duties and Responsibilities listed in the Financial Structure and Timing of Financial Transactions section above.

3. Required Submission – Financial Structure and Timing of Financial Transactions

a. Describe in detail the Contractor's proposed invoicing process, including the timing for invoice preparation and supporting detail claims files at the end of each cycle, required payment timeframes and whether this structure is in effect for any other self- funded customers.

SECTION 7: EVALUATION AND SELECTION CRITERIA

The Procuring Agencies seek to select a single Offeror to administer, through separate resulting Contracts, their respective Programs (i.e., DCS: The Empire Plan Prescription Drug Program, The Excelsior Plan Prescription Drug Program, and the Student Employee Health Plan Prescription Drug Program; and NYSIF: the New York State Insurance Fund Workers' Compensation Prescription Drug Program). To this end, the Procuring Agencies intend to select that responsive and responsible Offeror whose Proposal offers the "Best Value" to the Procuring Agencies as defined in Section 7.5 of this RFP for the purpose of entering into negotiations for two separate standalone contracts (i.e., one between the Selected Offeror and the Department, and the other between the Selected Offeror and NYSIF).

[**Note**: Access to technical proposals will be made available to representatives of NYS employee unions for review. Representatives of NYS employee unions may participate in Management Interviews and Site visits, if applicable.].

7.1 Administrative Proposal Evaluation

Proposals determined by the Department to satisfy the submission requirements set forth in Section 4 of this RFP will be evaluated by an evaluation team composed of staff from the Department to determine if the Offeror meets all the Minimum Mandatory Requirements as set forth in Section 1.8, Offeror Eligibility. An Offeror's Proposal shall not be considered for award until the Offeror submits a *Formal Offer Letter* (Attachment 3) and an *Offeror Attestations Form* (Attachment 13).

7.2 Technical Proposal Evaluation

The Technical Proposal of any responsive Offeror meeting the Administrative Proposal requirements set forth above will be evaluated by the Department and representatives from other State agencies. Each Offeror's ability and willingness to deliver the Program Services described in this RFP will be evaluated and scored based on a weighted point system. The evaluation of the Offeror's Technical Proposal will be based on that Offeror's written Technical Proposal; responses to clarifying questions, if any; information obtained through reference checks, including any proposed Key Subcontractor(s) who performed services under a contract with the Procuring Agencies and, as deemed necessary by the Procuring Agencies, oral presentation(s) and/or site visits conducted to amplify and/or clarify that Offeror's proposed Technical Proposal.

1. Technical Score Ratings

Each Offeror's Technical Proposal will be evaluated based on the following rating scale and criteria as applied to each response as required in Section 5 of this RFP. A rating of "Excellent" equates to a score of 5 for each evaluated response. Each reduction in the ratings results in a one-point reduction in the score such that a rating of "Poor" equates to a score of 1.

a. Excellent (5)

The Offeror far exceeds the criteria. The services described indicate that the Offeror will provide high-quality services and is proactive and innovative.

b. Good (4)

The Offeror exceeds the criteria. The services described indicate that the Offeror will exceed the requirements of the RFP. The Offeror demonstrates some innovative features not shown in typical proposals.

c. Meets Criteria (3)

The Offeror meets but does not exceed the criteria. The services described indicate that the Offeror will meet the requirements of the RFP.

d. Fair (2)

The Offeror's answer is minimal; or the answer is very general and does not fully address the question; or the Offeror meets only some of the criteria.

e. Poor (1)

The Offeror misinterpreted or misunderstood the question; or the Offeror does not answer the question/criteria in a clear manner, or the Offeror does not answer the question; or the Offeror does not meet the criteria.

2. Performance Guarantee Ratings

A rating of "Excellent" equates to a score of 4 for each evaluated service level standard. Each reduction in the ratings results in a reduction in the score such that a rating of "Poor" equates to a score of 1. An Offeror may propose performance guarantees that exceed the Program's service level standards

presented in this RFP. Proposed Performance Guarantees are contained within *Performance Guarantees* (Attachment 6) and will be evaluated using the following criteria:

a. Excellent (4)

   i. The Offeror's proposed Performance Guarantee exceeds the Program's service level standard contained within this RFP; and

   ii. The Offeror's proposed credit amount is 125% or more of the Standard Credit Amount stated within this RFP.

b. Good (3)

   i. The Offeror's proposed Performance Guarantee equals the Program's service level standard contained within this RFP, and the Offeror's proposed credit amount is 125% or more of the Standard Credit Amount stated within this RFP; or

   ii. The Offeror's proposed Performance Guarantee exceeds the Program's service level standard contained within this RFP; and the Offeror's proposed credit amount is greater than 100% but less than 125% of the Standard Credit Amount stated within this RFP.

c. Meets Criteria (2)

   i. The Offeror's proposed Performance Guarantee equals or exceeds the Program's service level standard contained within this RFP; and

   ii. The Offeror's proposed credit amount equals the Standard Credit Amount stated within this RFP.

e. Poor (1)

   i. The Offeror's proposed Performance Guarantee is below the Program's service level standard contained within this RFP regardless of the credit amount proposed by the Offeror; or

   ii. The Offeror's proposed credit amount is less than 100% of the standard credit amount stated within this RFP regardless of the level of performance the Offeror pledges.

3. <u>Performance Guarantee Standard Credit Amounts</u>

<u>DCS Program</u>

The DCS Program standard credit amount for each Offeror's proposed performance guarantee is $25,000 per quarter, assessed on a quarterly basis with the following exceptions;

a. Implementation and Start-Up (Section 5.3(3)): 50% of the Claims Administration Fee(s) (minimum mandatory requirement);

b. Program Claims Processing System Availability (Section 5.11(2)(a)): $100,000 each per each quarter;

c. Program Claims Processing System Accuracy (Section 5.11(2)(b)): $100,000 each per each quarter;

d. Enrollment Management (Section 5.7(9)): $5,000 for each 24-hour period beyond 24 hours from the release of DCS Program enrollment records;

e. Reporting Services and Claim File (Section 5.8(1)(f)): $1,000 per report per Business Day between the due date and the date the report is received by DCS inclusive of the Day the report is received;

f. Network Pharmacy Access (Section 5.10(A)(b)), under subheading "Retail Pharmacy Network"): $100,000 per quarter for each performance guarantee in each of the three (3) areas in which the Performance Guarantee is not met;

g. Customer Service/Call Center Availability (Section 5.4(8)(6)): $100,000 per each quarter; and

h. Turnaround Time for Claims Adjudication Guarantee (Section 5.11(2)(c)): $5,000 per each quarter.

NYSIF Program

The NYSIF Program standard credit amount for each Offeror's proposed performance guarantee is $7,500 per quarter, assessed on a quarterly basis with the following exceptions:

a. Implementation and Start-Up (Section 5.3(3)): 50% of the Claims Administration Fee(s) (minimum mandatory requirement);

b. Enrollment Management (Section 5.7(9)): $375 for each 24-hour period beyond 12 hours from the release of NYSIF Program enrollment records;

c. Reporting Services and Claim File (Section 5.8(2)(v)): $100 per report per Calendar Day between the due date and the date the report is received by NYSIF inclusive of the Day the report is received;

d. Turnaround Time for Non-Intervention Mail Service Prescriptions Guarantee (Section 5.10(E)(19)) “Mail Service Pharmacy Process”): $375 per each quarter;

e. Turnaround Time for Intervention Mail Service Prescriptions Guarantee (Section 5.10(E)(20)) “Mail Service Pharmacy Process”): $375 per each quarter; and

f. Turnaround Time for Claims Adjudication Guarantee (Section 5.11(2)(d)): $375 per each quarter.

4. Allocation of Technical Score Points

The scores referenced above shall be applied to weighted point values associated with each evaluated Submission response. The relative point value for each section of the Technical Proposal is as follows:

Section	Title	% of Technical Score
5.1	Executive Summary	1.00%
5.2	Account Team	3.00%
5.3	Implementation Plan	2.00%
5.4	Customer Service	6.00%
5.5	Empire Plan Medicare Rx (Exclusive to DCS)	10.00%
5.6	Member Communication Support	3.00%
5.7	Enrollment Management	6.00%
5.8	Reporting Services	5.00%
5.9	Transition and Termination of Agreements	0.50%
5.10	Network Management	25.00%
5.11	Claims Processing	7.00%
5.12	Retrospective Coordination of Benefits (Exclusive to DCS)	2.00%
5.13	Utilization Management	3.00%
5.14	Clinical Management / Drug Utilization Review (DUR)	11.00%
5.15	Drug List Development and Management	14.50%

	(Exclusive to DCS)	
5.16	Consolidated Appropriations Act (Exclusive to DCS)	0.50%
5.17	Consulting (Exclusive to DCS)	0.50%
Total		**100.0%**

5. Technical Proposal Scoring

Qualifying Proposals will be evaluated independently by multiple evaluators based on the pre-established Evaluation Criteria. The average score for each evaluated response shall be applied to the points associated with each question such that an average score of "Excellent" for each evaluated response will result in a maximum available score of 1,000. All Offerors whose Technical Proposal is evaluated will receive a score in this manner. The Technical Proposal Score will then be converted to points for each Offeror such that the Offeror with the highest technical score will receive 250 points. As calculated by the Procurement Manager, all other Offerors are awarded points at a reduced level with 0.01 points being the lowest possible point value that may be assigned. The awarded points are calculated to the hundredth decimal place. The reduction in points shall be calculated in accordance with a predetermined formula. The formula calculates the assigned points of the evaluated Offeror proportionally to the scores of the highest Technical Proposal and the lowest possible Technical Proposal score.

7.3 Financial Proposal Evaluation

The Financial Proposal of any responsive Offeror meeting the Administrative Proposal Evaluation requirements set forth in section 7.1 above will be evaluated by the Department as follows:

1. Financial Proposal Scoring

a. The Department will calculate a Total Projected Cost for each Offeror as the sum of (i), (ii), (iii) and (iv) as follows:

i. **Claim Costs:** Claim costs will be calculated by applying the Offeror's quoted claim discounts, dispensing fees and prescribing fees applicable to brand and generic drugs at mail, retail and specialty pharmacies to common AWP amounts and Final Paid Claim counts projected for the 2025 Plan Year. The claim cost calculation will also include adjustments to the AWP and Final Paid Claim counts based on the listing of Specialty Drugs proposed by each Offeror as compared to the current list of DCS Specialty Pharmacy Program drugs, and for the projected

distribution of the proposed Specialty Drugs at mail, retail, and the Designated Specialty Pharmacy.

ii. **Vaccination Network Pharmacy Pricing:** DCS will apply the Vaccine Administration Fees in Attachment 93*, Vaccination Administration Fees*, of this RFP against normalized vaccine claim counts projected for the 2025 Plan Year.

iii. **Claims Administration Fee(s):** DCS will apply the Claims Administration Fee(s) quoted in Attachment 92, *Claims Administration Fee(s) Quote*, of this RFP against number of Final Paid Claim counts projected for the 2025 Plan Year.

iv. **Pharma Revenue Guarantee:** The Pharma Revenue Guarantee will be calculated by multiplying the Offeror's average Pharma Revenue Guarantee quote(s) presented in Attachment 90, *Pharma Revenue Guarantee Quote*, for the period 1/1/2025 – 12/31/2029 times the normalized Final Paid Claim count projected for the 2025 Plan Year. A 2025 projected claim count of 17,296,000 will be used for the DCS Programs. A projected 2025 claim count of 257,690 will be used for the NYSIF Program. The 2025 projected claim counts above will be used to calculate the Pharma Revenue Guarantee in all five years.

The Procuring Agencies shall then calculate each Offeror's Total Projected Program Cost as the sum of i. through iii. minus iv. above. A Cost Score for each Offeror will be determined based on the following formula, with the lowest Total Program Cost as calculated in accordance with Section 7.4, Total Combined Score, receiving the maximum points:

$$\text{Cost Score of Evaluated Proposal} = 750 * \frac{\text{Lowest Evaluated Total Program Cost}}{\text{Total Program Cost of Proposal being evaluated}}$$

Scores will be calculated to the hundredth decimal place.

2. The Department Reserves the Right to Analyze and/or Normalize:

The Department reserves the right to make other cost calculation adjustments as necessary to determine the evaluated cost of the Offeror's Proposal. Any such adjustments shall be made with the intent to evaluate the Offeror's Proposal on a fair and consistent basis, without prejudice. These normalization adjustments may include, but are not limited to: 1) the application of quoted Claims Administration Fees to the applicable normalized claims basis, 2) the adjustment of the common AWP to reflect any material differences in the Offeror's quoted source pricing, 3)

unforeseen circumstances whereby the normalization of specific factors among Offerors shall result in a more accurate and fair comparison of the Offeror's Financial Proposal as applied to the normalized claim base.

7.4 Total Combined Score

The Total Combined Score assigned to each Offeror will be the sum of the Offeror's Technical Score and Financial Score.

7.5 Best Value Determination

Best Value means that the proposal that optimizes quality, cost, and efficiency among responsive and responsible bidders shall be selected for award (State Finance Law, Article 11, Section 163). Best Value will be determined by a weighted point system, with 75 percent allocated to the Financial Proposal and 25 percent allocated to the Technical Proposal.

It is the Procuring Agencies' desire and intent, if deemed in the best interest of the Department and NYSIF, to select and enter into negotiations for the purpose of executing two separate standalone Contracts, with the responsive and responsible Offeror that has obtained the highest Total Combined Score.

If an Offeror's Total Combined Score is equal to or less than 1 point below the highest Total Combined Score, the Offeror's Proposal will be determined to be substantially equivalent to the Offeror holding the highest score. Among any Offerors' Proposals deemed substantially equivalent, the Procuring Agencies shall select the Offeror that has the highest Financial Proposal Score calculated pursuant to Section 7.3.1 Financial Proposal Scoring of this RFP (lowest cost). Contract award shall be deemed made when notice of proposed contingent award is issued to the Selected Offeror.

By submitting a Proposal in response to this RFP, the Offeror agrees that, if selected, the Offeror will enter into two separate standalone contracts that substantially include the terms set forth in Sections 3, 5, and 8 and Attachment 15 – *Glossary of Defined Terms* of this RFP, and Appendix A and those Appendices that are exclusive to the respective Procuring Agencies (see Section 1.1 Resulting Contracts). After Agreements are separately negotiated and executed with the Contractor and DCS and NYSIF, any change to the scope of the Agreement, including but not limited to the inclusion of any individual independent Network Pharmacy(ies), requested by one Procuring Agency shall have no impact on the other Procuring Agency's Agreement or cost thereunder, unless the other Procuring Agency likewise agrees to said change(s).

In the case of a joint award, as envisioned in the RFP, if the Procuring Agencies determine that contract negotiations between the Procuring Agencies and the Selected Offeror are unsuccessful because of material differences in key provision(s) as determined by the Procuring Agencies, the Procuring Agencies may invite the Offeror with the next highest Total Combined Score to enter into negotiations for purposes of executing two separate stand alone contracts. Should contract negotiations between the Procuring Agencies and the Selected Offeror be unsuccessful, scores will not be recalculated for any remaining Offerors, except in a case where the reason for such failure is based on a determination, made subsequent to contract award, that the Offeror is non-responsive or non-responsible.

If NYSIF determines that contract negotiations between NYSIF and the Selected Offeror are unsuccessful because of material differences in key provision(s) as determined by NYSIF, but the Department does **not** make the same determination and the Department is able to successfully negotiate a contract, then the proposed contract award to the Selected Offeror, in regards to the Department's respective components of the RFP, shall stand; however, the proposed award in regards to the NYSIF components of the RFP shall be withdrawn.

If the Department determines that contract negotiations between the Department and the Selected Offeror are unsuccessful because of material differences in key provision(s) as determined by the Department, then contract negotiations between the Offeror and NYSIF shall be deemed unsuccessful, regardless of whether or not NYSIF and the Offeror's contract negotiations were otherwise successful, and a contract between NYSIF and the Selected Offeror will **not** be finalized or executed by NYSIF. In such case, the contract award shall be withdrawn and the Procuring Agencies may invite the Offeror with the next highest Total Combined Score to enter into negotiations for purposes of executing two separate stand alone contracts. Should contract negotiations between the Department and the Selected Offeror be unsuccessful, scores will not be recalculated for any remaining Offerors, except in a case where the reason for such failure is based on a determination, made subsequent to contract award, that the Offeror is non-responsive or non-responsible.

Should NYSIF decide, at any point in time prior to contract award, to withdraw its respective components from the RFP and/or not make a contract award, then the Offerors' Proposals will be re-scored, excluding NYSIF's evaluation, as provided for in the Procurement's evaluation criteria.

If an Offeror does not meet the Minimum Mandatory Requirements as set forth in the Offeror Eligibility requirements of the RF~~P, a~~t any time prior to Contract award they will be deemed non-responsive and non-responsible. In such case, the tentative contract award shall be withdrawn by the State and the Procuring Agencies may invite the Offeror with the next highest Total Combined Score to enter into negotiations for purposes of executing two separate stand alone contracts.

The Offeror that is determined to provide the Best Value to the Procuring Agencies shall be notified of its conditional award of a Contract subject to the successful negotiation and execution of a Contract with the respective Procuring Agency. The resulting Contract shall incorporate the requirements set forth in the RFP including the Appendices (See Section 1.1, Resulting Contracts).

SECTION 8: ADDITIONAL PROVISIONS

Additional terms and conditions:

1. **Work in The Continental United States of America**

   All work performed by Contractor personnel under this Contract must be performed within the Continental United States of America.

2. **Information Classification**

   The Department has determined that the State information which the Contractor will either host, maintain, or have access to has an impact level of: Confidentiality = High, Integrity = High, and Availability = High; and requires the Contractor, pursuant to IT Standard: Information Classification (NYS-S14-002) (see https://its.ny.gov/system/files/documents/2023/01/nys-s14-002-information-classification-standard_0.pdf), to have the associated baseline security controls implemented to uniformly protect the confidentiality, integrity, and availability of the information entrusted to the Contractor.

3. **Continued Data Access**

   The period that the Contractor must provide the Procuring Agencies continued access to Data beyond the expiration or termination of the Agreement is no less than four years. All Contract provisions related to the protection and security of the Data will survive termination of the Contract. This provision does not limit or lessen the time period or Contractor's obligations pursuant to *Standard Clauses for New York State Contracts* (Appendix A) to establish and maintain Records.

4. **Use and Disclosure of Protected Health Information (Exclusive to DCS)**

   a. The Offeror acknowledges that the Offeror is a "Business Associate" as that term is defined in the HIPAA implementing regulations at 45 CFR 160.103, of the Department as a consequence of the Offeror's provision of Project Services on behalf of the Department within the context of the Offeror's performance under the resulting Contract and that the Offeror's provision of Project Services will involve the disclosure to the Offeror of individually identifiable health information from the Department or other service providers on behalf of the Department, as well as the Offeror's disclosure to the Department of individually identifiable health information as a consequence of the Project Services performed under the resulting Contract. As such, the Offeror, as a Business Associate, will be required to comply with the provisions of this Section.

   b. For purposes of this Section, the term "Protected Health Information" (PHI) means any information, including demographic information collected from an individual, that relates to the past, present, or future physical or mental

health or condition of an individual, to the provision of health care to an individual, or to the past, present, or future payment for the provision of health care to an individual, that identifies the individual, or with respect to which there is a reasonable basis to believe that the information can be used to identify the individual. Within the context of the resulting Contract, PHI may be received by the Offeror from the Department or may be created or received by the Offeror on behalf of the Department in the Offeror's capacity as a Business Associate. All PHI received or created by the Offeror in the Offeror's capacity as a Business Associate and as a consequence of its performance under the resulting Contract is referred to herein collectively as "Department's PHI".

c. The Offeror acknowledges that the Department administers on behalf of New York State, several group health plans as that term is defined in HIPAA's implementing regulations at 45 CFR Parts 160 and 164, and that each of those group health plans consequently is a "covered entity" under HIPAA. These group health plans include NYSHIP, which encompasses the Empire Plan as well as participating health maintenance organizations; the Dental Plan, and the Vision Plan. In this capacity, the Department is responsible for the administration of these "covered entities" under HIPAA. The Offeror further acknowledges that the Department has designated NYSHIP and the Empire Plan as an Organized Health Care Arrangement (OHCA), respectively. The Offeror further acknowledges that

    i. The Offeror is a HIPAA "Business Associate" of the group health plans identified herein as "covered entities" as a consequence of the Offeror's provision of certain services to and/or on behalf of the Department as administrator of the "covered entities" within the context of the Offeror's performance under the resulting Contract, and that the Offeror's provision of such services may involve the disclosure to the Offeror of individually identifiable health information from the Department or from other parties on behalf of the Department, and also may involve the Offeror's disclosure to the Department of individually identifiable health information as a consequence of the services performed under the resulting Contract; and

    ii. Contactor is a "covered entity" under HIPAA in connection with its provision of certain services under the resulting Contract. To the extent Offeror acts as a HIPAA "Business Associate" of the group health plans identified as "covered entities", the Offeror shall adhere to the requirements as set forth herein. Offeror is responsible to obtain from Members and Enrollees all consents and/or authorizations, if any, required for Offeror to perform the services hereunder and for the use and disclosure of information,

including the Department's PHI, as permitted under the resulting Contract.

d. Permitted Uses and Disclosures of the Department's PHI: The Offeror may create, receive, maintain, access, transmit, use and/or disclose the Department's PHI solely in accordance with the terms of the resulting Contract. In addition, the Offeror may use and/or disclose the Department's PHI to provide data aggregation services relating to the health care operations of the Department. Further, the Offeror may use and disclose the Department's PHI for the proper management and administration of the Offeror if such use is necessary for the Offeror's proper management and administration or to carry out the Offeror's legal responsibilities, or if such disclosure is required by law or the Offeror obtains reasonable assurances from the person to whom the information is disclosed that it shall be held confidentially and used or further disclosed only as required by law or for the purpose for which it was disclosed to the person, and the person notifies the Offeror of any instances of which it is aware in which the confidentiality of the information has been breached. Additionally, the Offeror may use and/or disclose the Department's PHI, as appropriate:

    i. for treatment, payment and health care operations as described in 45 CFR Section 164.506(c)(2), (3) or (4); and

    ii. To de-identify the information or create a limited data set in accordance with 45 CFR §164.514, which de-identified information or limited data set may, consistent with this section, be used and disclosed by Offeror only as agreed to in writing by the Department and permitted by law.

e. Nondisclosure of the Department's PHI: The Offeror shall not create, receive, maintain, access, transmit, use, or further disclose the Department's PHI otherwise than as permitted or required by the resulting Contract or as otherwise required by law. The Offeror shall limit its uses and disclosures of PHI when practicable to the information comprising a Limited Data Set, and in all other cases to the minimum necessary to accomplish the intended purpose of the PHI's access, use, or disclosure.

f. Safeguards: The Offeror shall use appropriate, documented safeguards to prevent the use or disclosure of the Department's PHI otherwise than as provided for in the resulting Contract. The Offeror shall maintain a comprehensive written information security program that includes administrative, technical, and physical safeguards that satisfy the standards set forth in the HIPPA Security Rule at 45 CFR §§ 164.308, 164.310, and 164.312, along with corresponding policies and procedures, as required by 45 CFR § 164.316, appropriate to the size and complexity

of the Offeror's operations and the nature and scope of its activities, to reasonably and appropriately protect the confidentiality, integrity and availability of any electronic PHI that it creates, receives, maintains, accesses, or that it transmits on behalf of the Department pursuant to the resulting Contract to the same extent that such electronic PHI would have to be safeguarded if created, received, maintained, accessed or transmitted by a group health plan identified herein.

g. Breach Notification: In addition to the Disclosure of Breach requirements specified in *Standard Clauses for All Department Contracts* (Appendix B), the following provisions shall apply:

    i. Reporting: The Offeror shall report to the Department any breach of unsecured PHI, including any use or disclosure of the Department's PHI otherwise than as provided for by the resulting Contract, of which the Offeror becomes aware. An acquisition, access, transmission, use or disclosure of the Department's PHI that is unsecured in a manner not permitted by HIPAA or the resulting Contract is presumed to be a breach unless the Offeror demonstrates that there is a low probability that Department's PHI has been compromised based on the Offeror's risk assessment of at least the following factors:

        1) The nature and extent of Department's PHI involved, including the types of identifiers and the likelihood of re-identification;

        2) The unauthorized person who used Department's PHI or to whom the disclosure was made;

        3) Whether Department's PHI was actually acquired or viewed; and

        4) The extent to which the risk to Department's PHI has been mitigated.

    ii. Required Information: In addition to the information required in *Standard Clauses for All Department Contracts* (Appendix B), paragraph 40, Disclosure of Breach,) the Offeror shall provide the following information to the Department within in the time period identified in *Standard Clauses for All Department Contracts* (Appendix B), Disclosure of Breach, except when, despite all reasonable efforts by the Offeror to obtain the information required, circumstances beyond the control of the Offeror necessitate additional time. Under such circumstances, the Offeror shall

provide to the Department the following information as soon as possible and without unreasonable delay, but in no event later than thirty (30) Days from the date of discovery:

1) the date of the breach incident;

2) the date of the discovery of the breach;

3) a brief description of what happened;

4) a description of the types of unsecured PHI that were involved;

5) identification of each individual whose unsecured PHI has been, or is reasonably believed to have been, accessed, acquired, or disclosed during the breach;

6) a brief description of what the Offeror is doing to investigate the breach, to mitigate harm to individuals and to protect against any further breaches; and

7) any other details necessary to complete an assessment of the risk of harm to the individual.

iii. The Offeror will be responsible to provide notification to individuals whose unsecured PHI has been or is reasonably believed to have been accessed, acquired or disclosed as a result of a breach, as well as the Secretary of the United States Department of Health and Human Services and the media, as required by 45 CFR Part 164.

iv. The Offeror shall maintain procedures to sufficiently investigate the breach, mitigate losses, and protect against any future breaches, and to provide a description of these procedures and the specific findings of the investigation to the Department upon request.

v. The Offeror shall mitigate, to the extent practicable, any harmful effects from any use or disclosure of PHI by the Offeror not permitted by the resulting Contract.

h. Associate's Agents: The Offeror shall require all of its agents or Subcontractors to whom it provides the Department's PHI, whether received from the Department or created or received by the Offeror on behalf of the Department, to agree, by way of written contract or other written arrangement, to the same restrictions and conditions on the

access, use, and disclosure of PHI that apply to the Offeror with respect to the Department's PHI under the resulting Contract.

i. Availability of Information to the Department: The Offeror shall make available to the Department such information and documentation as the Department may require regarding any disclosures of PHI by the Offeror to fulfill the Department's obligations to provide access to, provide a copy of, and to account for disclosures of the Department's PHI in accordance with HIPAA and its implementing regulations. The Offeror shall provide such information and documentation within a reasonable amount of time of its receipt of the request from the Department. The Offeror must provide the Department with access to the Department's PHI in the form and format requested, if it is readily producible in such form and format; or if not, in a readable hard copy form or such other form and format as agreed to by the Parties, provided, however, that if the Department's PHI that is the subject of the request for access is maintained in one or more designated record sets electronically and if requested by the Department, the Offeror must provide the Department with access to the requested PHI in a readable electronic form and format.

j. Amendment of the Department's PHI: The Offeror shall make the Department's PHI available to the Department as the Department may require to fulfill the Department's obligations to amend individuals' PHI pursuant to HIPAA and its implementing regulations. The Offeror shall, as directed by the Department, incorporate any amendments to the Department PHI into copies of such Department PHI maintained by the Offeror.

k. Internal Practices: The Offeror shall make its internal practices, policies and procedures, books, records, and agreements relating to the use and disclosure of the Department's PHI, whether received from the Department or created or received by the Offeror on behalf of the Department, available to Department and/or the Secretary of the U.S. Department of Health and Human Services in a time and manner designated by the Department and/or the Secretary for purposes of determining the Department's compliance with HIPAA and its implementing regulations.

l. Termination: This Contract may be terminated by the Department at the Department's discretion if the Department determines that the Offeror, as a Business Associate, has violated a material term of this Section. Data return and destruction upon contract termination is governed by *Information Security Requirements* (Appendix C, Exclusive to DCS).

m. Indemnification: Notwithstanding the provisions in Standard Clauses for All Department Contracts (Appendix B), the Offeror agrees to indemnify, defend and hold harmless the State and the Department and its respective employees, officers, agents or other members of its workforce (each of the foregoing hereinafter referred to as "Indemnified Party") against all actual and direct losses suffered by the Indemnified Party and all liability to third parties arising from or in connection with any breach of this section, Use and Disclosure of Protected Health Information, or from any acts or omissions related to this section by the Offeror or its employees, officers, subcontractors, agents or other members of its workforce, without limitations. Accordingly, the Offeror shall reimburse any Indemnified Party for any and all actual and direct losses, liabilities, lost profits, fines, penalties, costs, or expenses (including reasonable attorneys' fees) which may for any reason be imposed upon any Indemnified Party by reason of any suit, claim, action, proceeding or demand by any third party which results from the Offeror's acts or omissions hereunder. The Offeror's obligation to indemnify any Indemnified Party shall survive the expiration or termination of this Contract. This section is not subject to the limitation of liability provisions of the Contract.

n. Miscellaneous:

i. Survival: The respective rights and obligations of Business Associate and the "covered entities" identified herein under HIPAA and as set forth in this Section, Use and Disclosure of Protected Health Information, shall survive termination of the resulting Contract.

ii. Regulatory References: Any reference herein to a federal regulatory section within the Code of Federal Regulations shall be a reference to such section as it may be subsequently updated, amended or modified, as of their respective compliance dates.

iii. Interpretation: Any ambiguity in the resulting Contract shall be resolved to permit covered entities to comply with HIPAA.

5. <u>Audit Authority</u>

In addition to the audit requirements specified in Appendices A, B, B-1 and C to this RFP, the Selected Offeror must comply with the following requirements:

a. the Contractor acknowledges that the Procuring Agencies have the authority to conduct financial and performance audits of the Contractor's delivery of Program services in accordance with the resulting Agreements and any applicable State and federal statutory and regulatory authorities;

b. Such audit activity may include, but not necessarily be limited to, the following activities:

    i. Review of the Contractor's activities and records relating to the documentation of its performance under the resulting Agreement in areas such as determination of Enrollee or Dependent eligibility and application of various DCS program administrative features (e.g., dependent survivor benefits, reasonable adjudication of disabled dependent status).

    ii. Comparison of the information in the Contractor's enrollment file to that on the enrollment reports which will be issued to the Offeror by the DCS.

    iii. Assessment of the Contractor's eligibility, financial and claim processing systems to verify accuracy of data on the reports provided to the Procuring Agencies in accordance with Section 3.7 "Reporting Services" and *Program Reporting* (Attachment 36) of this Agreement.

c. The Contractor must maintain and make available pursuant to the terms of this RFP and the resulting Contract, documentary evidence necessary to perform the reviews referenced herein. Documentation maintained and made available by the Contractor may include, but is not limited to, source documents, books of account, subsidiary records and supporting work papers, claim documentation, pertinent contracts, key subcontracts, provider agreements, and correspondence;

d. 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. The DCS and/or NYSIF acknowledges that it may not access processing environments or systems that contain actual PHI of other clients of Contractor; this shall not limit OSC audit authority under Appendices A & B of the RFP;

e. The Offeror shall, at the DCS' and/or NYSIFs' 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. The Offeror shall make sufficient resources available for the efficient performance of audit procedures;

f. The Contractor may provide comments, if any, on the contents of any audit report prepared by the DCS and/or NYSIF and transmit such comments in

writing to the DCS and/or NYSIF within 30 Days of receiving any audit report. The response will address the findings and each audit recommendation. If the Contractor agrees with the recommendation, the response will include a work plan and timetable to implement the recommendation. If the Contractor disagrees with an audit recommendation, the response will give all details and reasons for such disagreement. Resolution of any disagreement as to the resolution of an audit recommendation shall be subject to the dispute resolution procedures set forth in the resulting Contracts;

g. If the Contractor has an independent audit performed of the records relating to the resulting Agreement, a certified copy of the audit report shall be provided to the DCS and/or NYSIF within ten (10) Days after receipt of such audit report by the Contractor;

h. The audit provisions contained herein shall in no way be construed to limit the audit authority or audit scope of the OSC as set forth in either Appendix A of this RFP, *Standard Clauses for All New York State Contracts*, or Appendix B, *Standard Clauses for All DCS Contracts* or Appendix B-2 (Exclusive to NYSIF), *Contract Provisions*;

i. The Contractor shall provide ample audit resources including access to the Contractor's online claims processing system to the Department and the OSC at their respective offices for three years after the date of the final financial settlement of the Agreement;

j. 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.

k. The Contractor agrees to fully cooperate with all Department, NYSIF and/or OSC audits consistent with the requirements of the RFP including all Appendices as set forth in this RFP, including provision of access to Department and NYSIF Protected Health Information and all relevant other confidential information which may have an impact on this Agreement, when required for audit purposes as determined by the Department, NYSIF and OSC as appropriate. The Contractor must respond to all State audit requests for information and/or clarification within fifteen (15) Days. The Contractor must perform timely reviews and respond in a time period specified by the Department and NYSIF to preliminary findings submitted by the Department, NYSIF and the Comptroller's audit unit in accordance with the requirements of this Section. Such audits may include but are not limited to: mail order claims; Enrollee submitted paper claims; and online

Pharmacy claims. Use of statistical sampling of claims and extrapolation of findings resulting from such samples shall be acceptable techniques for identifying claims errors. The selected Contractor shall facilitate audits of network pharmacies as requested by the Department, NYSIF and/or OSC; and

l. The Contractor shall permit the Department and/or NYSIF or a contracted third party designated by the Department and/or NYSIF to audit all pharmacy bills and drug company revenues to ensure accuracy by the Contractor in performing services under the resulting Contracts and compliance with financial obligations, Performance Guarantees, business operations, and all other contractual obligations. Any designated third-party must be subject to confidentiality terms and conditions that provide for the confidentiality of the requested data which is substantially equivalent to the confidentiality terms of the resulting Contracts (see Section 8.7, Contractor's Confidential Information).

6. Ensuring Lowest Net Cost to the Program

a. The Contractor is required to maximize savings to the Program through negotiation of Pharma Revenue Agreements obtaining discounts or other consideration from manufacturers and passing through 100% of the value of the Pharma Revenue Agreements to the Program, including any consideration that would normally flow to the Contractor or Key Subcontractor(s) based on the Plan's utilization pursuant to the terms of those Pharma Revenue Agreements. In addition, all Pharma Revenue Agreements with manufacturers and other entities applicable to the Program must meet or exceed the Contractor's best existing Pharma Revenue Agreements for all individual drugs ensuring that in no instance will the Program receive less Pharma Revenue in any therapeutic class than other clients of the Contractor with a comparable benefit design and consistent preferred drug designations in the class provided the Program's utilization of the drugs generating Pharma Revenue in the class is equal to or greater than those of other clients.

b. The Contractor is required to maximize savings to the Program through negotiation of customized Retail Pharmacy Network contracts that offer aggressive pricing and discounts, consistent with the Contractor's Financial Proposal in this RFP. The Contractor agrees that all records supporting the pass-through pricing are subject to audit by DCS and its consultants or other State auditors with authority under Section 8.5 of this RFP and/or Appendices A, B & B-1 of this Agreement. In addition, access to or hard copies of all Retail Pharmacy Network contracts must be made available, in Albany County, per Section 8.7, as deemed necessary for the Procuring

Agencies or other State auditors with authority under Section 8.5 Audit Authority and/or Appendices A & B of this Agreement to evaluate whether the Contractor is meeting the requirements of the Agreement.

c. Maximize the discount achieved on behalf of the DCS Program for Generic and Brand Drugs dispensed by Network Pharmacies. The Contractor or its Key Subcontractor, if any, must manage the DCS Programs' MAC List(s) consistent with, or better than, their most aggressive generic pricing list used to reimburse Pharmacies. The Contractor shall charge the Program utilizing Pass-through Pricing for all Generic and Brand Drugs dispensed to Enrollees through the Network Pharmacies.

d. The Contractor is required to maximize savings to the Programs through aggressive pricing and discounts in the Mail Service Pharmacy Process and the Specialty Pharmacy Process, consistent with Lesser of Logic and the Contractor's Financial Proposal. The Contractor agrees that all records supporting Lesser of Logic are subject to audit by DCS and its consultants or other State auditors with authority under Section 8.5 Audit Authority and/or Appendices A, B & B-1 of this RFP.

7. Contractor's Confidential Information (Exclusive to DCS)

Throughout the term of the resulting Contract(s) the Contractor may be required upon the request of the DCS to provide the DCS or a third-party acting on behalf of the DCS with certain information Contractor deems confidential and/or proprietary in nature (hereinafter "Contractor's Confidential Information"). The sharing of that information with 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.

No Waiver, Modification or Limitation of Audit Authority: Nothing in this Section and no exercise by DCS of its Review Authority under this Section shall waive, modify or limit the State's audit rights pursuant to Section 8.5 Audit Authority and Appendices A, B and C to this RFP to conduct audits.

Contractor's failure to comply with the terms of this provision will constitute a material breach of the Agreement(s) and the DCS may seek compensation for all damages resulting from non-compliance.

Contractor's Confidential Information covered under this provision will include, but may not be limited to:

a. Any contracts between the Contractor (or its affiliates) and retail pharmacies in pharmacy networks established by the Contractor or its affiliates.

b. All manufacturer rebate agreements between the Contractor (or its affiliates) and pharmaceutical manufacturers.

c. Specialty Acquisition Cost, when Specialty Drugs are dispensed through the Specialty Pharmacy Program.

d. Actual Acquisition Cost, when Brand Name Drugs are dispensed through the Mail Service Pharmacy.

e. Prescription Drug pricing source materials (e.g., Medi-Span).

f. Third party and pharmacy audit findings and reports related to the resulting Contract.

g. Any contracts between the Contractor (or its affiliates) and any public authority, public benefit corporation, school district, special district, district corporation, municipal corporation, agency, subdivision or quasi-public organization of the state for pharmacy benefit services upon written consent of the public authority, public benefit corporation, school district, special district, district corporation, municipal corporation, agency, subdivision or quasi-public organization.

Exceptions: "Contractor's Confidential Information" does not include information if and to the extent: (a) the information was already known by or available to the receiving party prior to the disclosure by the disclosing party on a non-confidential basis; (b) the information is subsequently disclosed to the receiving party by a third-party who is not under any obligation of confidentiality to the disclosing party; (c) the information has already been or is hereafter independently acquired or developed by the receiving party without violating any confidentiality agreement or other similar obligation; or (d) the information is or becomes generally available or known to the public through no fault of the DCS.

Disclosure due to judicial process, government investigation, legal proceeding, or other similar process: If the DCS is required to disclose Contractor's Confidential Information pursuant to law or as part of a judicial process, government investigation, legal proceeding, or other similar process, such party, if it is reasonably possible to do so, shall give such prior written notice to the Contractor to allow the Contractor to seek an appropriate protective order or modification of any disclosure. Notwithstanding the above, the Contractor agrees and understands that the DCS is subject to certain disclosure laws and

regulations including the NYS Freedom of Information Law including any applicable exemptions to disclosure.

Review Authority: The DCS is required to have access to Contractor's Confidential Information to ensure compliance with the terms and obligations of the resulting Contract including:

a. To understand the discount terms of Network Pharmacies and how the Contractor will meet the Program requirements, including the Claim Reimbursement Quote proposed by the Offeror in their Financial Proposal.

b. To make informed decisions on formulary structure and how the Contractor will meet the Contract requirements, including the Pharma Revenue Guarantee.

c. To ensure the Contractor meets contractual requirements, including its responsibility to provide Lowest Net Cost to the Program as required under the RFP and resulting Contract.

d. To make any other determinations and undertake any other actions the State in its discretion believes are necessary or appropriate for the administration of the Contract.

Access to Contractor Confidential Information: Contractor will provide access to Contractor's Confidential Information, as defined herein, within ten (10) Business Days of the DCS written request for the information. Contractor shall make available, at DCS's offices in Albany, New York, or as otherwise mutually agreed by the Parties, the Contractor's Confidential Information, in electronic or physical form, for DCS's exercise of its Review Authority by one or more DCS representatives that have a need to know (the "Designated DCS Staff"). The Parties agree that Designated DCS Staff may share the Confidential Information with other DCS employees or designated contractors in order to fulfill the requirements of the resulting Contract, law or regulation. The Contractor shall make individuals with knowledge of the Contractor's Confidential Information available to the Designated DCS Staff to answer questions about provisions of the Contractor's Confidential Information as they relate to the services provided by Contractor pursuant to the resulting Contract. The contractor may propose the methods they would use to meet the terms of access to the contractor's confidential information, subject to the State's approval. Access will be provided for a reasonable amount of time for the State to conduct its review.

Designated DCS Staff may make copies (hard or digital) of any Contractor's Confidential Information and/or take notes on such information, as necessary to

fulfill the resulting Contract requirements, law or regulations. In the alternative to providing copies to DCS, Contractor may provide secure access, in a format that is acceptable to DCS, to allow DCS or other authorized entities continued access to Contractor's Confidential Information, in Albany County throughout the term of the resulting Contract. .

Protection of Contractor Confidential Information: DCS agrees to maintain the confidentiality of the Contractor's Confidential Information and that it shall not: (a) transfer or disclose the Contractor's Confidential Information to any persons other than those individual that have a need to know; (b) use the Contractor's Confidential Information for any purpose other than in connection with its exercise of its Review Authority, law or regulation (c) make any record of the Confidential Information except as reasonably necessary in connection with its Review Authority, law or regulation, or (d) take any other action with respect to the Confidential Information inconsistent with the confidential and proprietary nature of such information. DCS shall use the same standard of care in protecting the Confidential Information as it uses to protect its own confidential and proprietary information.

Remedies. In addition to any other remedies which may be available at law, DCS and the Contractor shall be entitled to injunctive relief, specific performance or other equitable relief or any or all of the foregoing, for any breach or threatened breach of this provision without the necessity of proving damages and without waiving any other remedies otherwise available at law or in equity.

Disclosure of Contractor's Confidential Information to Other Government Entities. Nothing in this Section shall preclude DCS from providing, in accordance with the terms of this Section and without the prior written consent of Contractor, Contractor's Confidential Information to another New York State Agency or other appropriate government entity for the following purposes:

a. To a New York State Agency to assist DCS with the Review Authority cited above; or/and

b. To an appropriate government entity to facilitate the recoupment of State moneys that have been improperly expended or to provide information on potential violations of law, including, without limitation, the referral of any such matter to appropriate regulatory, investigative or prosecutorial authorities.

In the event that DCS determines it is necessary to provide Contractor Confidential Information to another New York State Agency to assist NYS DCS with the Review Authority cited above, DCS shall make reasonable efforts to ensure, to the extent practicable as determined by DCS, that the restrictions on

disclosure of Confidential Information contained in the resulting Contract continue to apply to all Confidential Information until such time as the assistance is no longer required of the other New York State Agency.

In the event that DCS determines it is necessary to provide Contractor Confidential Information to an appropriate government entity for the recoupment of State moneys from, or to investigate the potential violation of law by, a party other than the Contractor, DCS shall provide, unless restricted by law enforcement or court order or such notice would impede an investigation, Contractor with prompt notice of such determination and shall make reasonable efforts to ensure, to the extent practicable as determined by DCS, that the restrictions on disclosure of Confidential Information contained in the resulting Contract continue to apply to all Confidential Information until such time as Contractor is made aware of the recoupment or investigational activities of the relevant government entity(ies). In addition, Contractor agrees not to disclose or otherwise make available to any third-party any information concerning or relating to DCS's disclosure of Confidential Information to another government entity pursuant to this sub-section (a) until such time as authorized by DCS and/or the other government entity.

Nothing in this Section shall preclude the State from exercising any appropriate remedy to obtain access to Contractor's Confidential Information pursuant to its contractual, constitutional or statutory authority.

8. Modification of Program Services

a. In the event that laws or regulations enacted by the Federal government and/or the State have an impact upon the conduct of the Agreement in such a manner that the DCS determines that any design elements or requirements of the Agreement must be revised, the DCS shall notify the Contractor of any such revisions and shall provide the Contractor with a reasonable time within which to implement such revisions.

b. 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, the DCS shall notify the Contractor of such changes and shall provide the Contractor with reasonable notice to implement such changes. The Contractor will be responsible for making collective bargaining changes using Department benefit codes.

c. To the extent that any of the events as set forth in this Section shall take place and constitute a material and substantial change in the delivery of services that are contemplated in accordance with the terms of the DCS Program as of the DCS Program Services Start Date and which the

Contractor is required to perform or deliver under the Agreement, the Contractor may submit a written request to the DCS to initiate review of the fee(s) received by the Contractor for services provided and guarantees made by the Contractor under the terms of the Agreement, accompanied by appropriate documentation. The DCS reserves the right to request, and the Contractor shall agree to provide additional information and documentation the DCS deems necessary to verify that an increase in the fee(s), or modification of the guarantees is warranted. The DCS will agree to modify the fee(s) to the extent necessary to compensate the Contractor for documented additional costs determined by DCS to be reasonable and necessary. The DCS will agree to modify guarantees as determined by DCS to be necessary to reflect DCS Program modifications. Should the DCS approve the Contractor's request to modify the fee(s) and/or guarantees, such approval shall be subject to written amendment and approval by OSC and the AG. The Contractor shall implement changes as required by the DCS with or without final resolution of any fee proposal.

d. Any changes made by NYSIF to the scope of its contract with the Contractor for Prescription Drug Program Services after execution of this Agreement, including but not limited to the request to include any individual independent Network Pharmacy(ies), shall have no impact on the resulting DCS Contract or cost thereunder, unless the change is agreed to by DCS.

9. Control of Plan - (Exclusive to DCS)

Unless otherwise stated in the Contract, DCS retains the sole and absolute authority to design, amend, terminate or modify, in whole or in part, all or any portion of the DCS Plan, including the sole authority to control and administer the DCS Plan and any assets of the DCS Plan. DCS shall also have complete discretionary, binding and final authority to construe the terms of the DCS Plan, to interpret ambiguous DCS Plan language, to make factual determinations regarding the provision of benefits and the payment of drug claims, to review denied claims and to resolve complaints by Enrollee(s). Contractor agrees to be a fiduciary for the purpose of initial claim adjudication and all appeals relating to the coverage of prescription drug benefits under the Contract, including but not limited to all External Appeals, as set forth in Section 3, Project Services of this RFP.

10. Use and Disclosure of Protected Health Information and Confidential Information (Exclusive to NYSIF)

Unless stated otherwise in the Contract, all use of and disclosure of PHI and Confidential information will be done in accordance with an executed NYSIF Mutual Non-Disclosure Agreement (NDA) entered into between NYSIF and the awarded bidder. The Non-Disclosure Agreement (NDA) is incorporated by reference, attached hereto Appendix B-4 of this RFP.

11. Entire Contract

The resulting Contract, including all Appendices, constitutes the entire Contract between the parties hereto and no statement, promise, condition, understanding, inducement, or representation, oral or written, expressed or implied, which is not contained herein shall be binding or valid and the Contract shall not be changed, modified, or altered in any manner except by an instrument in writing executed by both parties hereto, except as otherwise provided herein. The Contract is subject to amendment(s) only upon mutual consent of the Parties, reduced to writing and approved by OSC and subject to the termination provisions contained herein.