
SECTION IV: TECHNICAL PROPOSAL REQUIREMENTS

The Procuring Agencies seek to award two (2) separate Contracts (Agreements) to a qualified Offeror to provide Pharmacy Benefit Services for the respective 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). The purpose of this Section IV of the RFP is to set forth the programmatic duties and responsibilities required of the Offeror and to obtain required submissions concerning those duties and responsibilities. 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 IV of this RFP.

Notes:

1. Unless otherwise stated, all of the requirements contained in this section pertain to both the DCS and NYSIF Programs.
2. Numbers, data, or statistics which may appear in the Exhibits 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 Minimum Mandatory Requirements in Section III of this RFP and are responsive to the duties and responsibilities set forth in this Section IV of this RFP.

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

A. Program Administration

1. Executive Summary**a. Required Submission**

The Offeror must submit an Executive Summary outlining its capacity to administer the DCS and NYSIF Prescription Drug Programs (also 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; and
- (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 Formulary Development and Management
 - (m) Rebate Administration

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- (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 Notification
 - (u) Financial Support Services
 - (v) Transition and Termination of Contract
 - (w) Information Technology Support Services
 - (x) New to You Prescriptions Program
 - (y) 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 as a reference as required in Exhibit I.V, Program References.

2. 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 (as defined in Section VIII) 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 Programs Services.

a. Required Submission

The Offeror must demonstrate that it has the financial and operational wherewithal to administer the Programs as required by this RFP. Offerors should provide detailed responses to the following:

- (1) What experience does the Offeror have in managing/supervising a Prescription drug program similar to the Programs described in this RFP?

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- (2) Explain how the Offeror's account team will be prepared to actively manage the administrative, operational, and clinical aspects of the Programs?
 - (3) What internal systems or procedures does the Offeror have in place to provide financial, legal, and audit oversight of the Programs?

B. DCS and NYSIF Prescription Drug Program Services

In this section, the Offeror must demonstrate its capacity to provide the required services for administration of the Programs.

1. Account Team

The Procuring Agencies expect the successful Offeror to have a proactive, experienced account leader(s) and team(s) in place who are dedicated solely to the Programs and who have the authority and expertise to coordinate the appropriate resources to implement and administer the Programs.

a. Duties and Responsibilities

- (1) 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.
 - (a) The account team(s) must be comprised of qualified and experienced individuals who 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;
 - (b) 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 Programs requirements and to address any issues that may arise during the performance of the separate resultant Agreements.
- (2) The Offeror's dedicated account team(s) must be experienced, accessible, and sufficiently staffed to:
 - (a) 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; and

- (b) Immediately notify the Procuring Agencies in writing of actual or anticipated events impacting Program costs and/or delivery of services to Enrollees such as, but not limited to, legislation, litigation, drug recalls and withdrawals, class action settlements, and operational issues;
- (3) The Offeror's dedicated account team(s) must ensure that the Programs are in compliance with all legislative and statutory requirements. If the Offeror is unable to comply with any legislative or statutory requirements, the Procuring Agencies 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, subject to the Department's review and approval and/or Program material.

b. Required Submission

- (1) 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). Complete Exhibit I.B, 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 you 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(s) 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.

(b) 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(s) 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 SPDs and/or Program material.

2. Premium Development Services (Exclusive to DCS)

The Offeror must provide underwriting assistance and support to the Department in the development of premium rates chargeable to DCS Program participants consistent with the interests and goals of the DCS Program and the State. The Department intends to develop premium rates to be as accurate as possible, taking into account all significant elements that can affect Program costs including but not limited to trend factors, projected Pharma Revenue, changes in enrollment, changes in the Specialty Pharmacy drug list as well as changes in the Flexible Formularies. The development of premium rates that closely match the actual costs enables the plan to provide rate stability, one of the primary goals of the

State, and to meet the budgetary needs of the State and participating employers that participate in NYSHIP.

a. Duties and Responsibilities

The Offeror will be responsible for 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) Development of claim, trend, and administrative fee projections 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 the formularies including the Empire Plan's Specialty Drug list, Flexible Formulary, Excelsior Plan Drug List and the EGWP and Medicare Part D supplemental drug lists); and
- (3) Working with the Department and its contracted actuarial consultant through the annual rate 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), and GOER.

b. Required Submission

- (1) Provide the names, qualifications and job descriptions of those key individuals who will provide premium rate development services for the DCS Programs. Describe their experience in providing financial assistance and support to other large health plans. Complete Exhibit I.B of this RFP, for all key staff involved in the premium rate development.
- (2) Describe the general steps that you will follow to develop the annual premium renewal recommendation for submission to the Department. Include any different steps that will be employed to develop the first year premium versus the premium for subsequent years of the Agreement. Include a description and source of the data

you will utilize, assumptions you will use and how these assumptions will be developed, as well as any resources you will utilize.

- (3) Confirm the Offeror's commitment to work with the Department and its contracted actuarial consultant on the annual rate renewal recommendation and your availability to present such recommendation to the Department, DOB and GOER.

Note: The responses to the above three questions should be general descriptions of the financial methodology you intend to use for assisting and supporting the Department with the DCS Program. Responses should **NOT** include any specific cost information or values relative to the development of cost/rate projections and trends for the DCS Programs; that information must be restricted to your Cost Proposal.

3. **Implementation Plan**

The Offeror must have an implementation plan to ensure that the Programs will be fully functioning on January 1, 2019. The Offeror must propose two implementation plans, one for the Department and one for NYSIF. The implementation plans must be detailed, comprehensive, and exhibit a firm commitment by the Offeror to complete all Program implementation activities by December 31, 2018.

a. **Duties and Responsibilities**

- (1) The Offeror must commence an implementation period beginning upon approval of the resultant separate Agreements by OSC. During the implementation period, the Contractor must undertake and complete all implementation activities, including but not limited to those specific activities set forth below. Such implementation activities must be completed no later than December 31, 2018, so that the Programs are fully operational on January 1, 2019.
- (2) ***Implementation and Start-up Guarantee:*** The Offeror must complete all Implementation and Start-up activities no later than December 31, 2018 so that, effective January 1, 2019, the Offeror can assume full operational responsibility for the Programs. For the purpose of this guarantee, the Offeror must, on or before January 1, 2019, have in place and operational:
 - (a) A contracted Retail Pharmacy Network that meets the access standards set forth in Section IV.B.10.b of this RFP, under the subheading "Retail Pharmacy Network." Additionally, in order to meet the Offeror's implementation

guarantee, the network implemented on January 1, 2019 **must** include all chain pharmacies identified in the Offeror's Proposed Retail Pharmacy Network File. Acceptable reasons for non-participation of any pharmacies identified in the Offeror's Proposed Retail Pharmacy Network File contracting collectively on January 1, 2019 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 January 1, 2019, the Retail Pharmacy Network must meet all requirements set forth in Section IV.B.10. 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/Medications (for those Enrollees that do not participate in the Specialty Pharmacy Program);

- (b) A fully operational Mail Service Pharmacy Process utilizing facilities as necessary to ensure that Enrollees have access to all Covered Drugs, including Specialty Drugs/Medications (for those Enrollees that do not participate in the Specialty Pharmacy Program) as set forth in Section IV.B.10 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;
- (c) A fully operational Specialty Pharmacy Program utilizing facilities as necessary to ensure that Enrollees have access to all covered Specialty Drugs/Medications (for those Enrollees that participate in the Specialty Pharmacy Program) as set forth in Section IV.B.10 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;
- (d) A fully operational call center providing all aspects of customer support and services as set forth in Section IV.B.4. of this RFP. The call center must be open and operational a minimum of thirty (30) days prior to Program

Implementation Date to assist Enrollees with questions concerning Program transition;

- (e) 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 IV.B.12 of this RFP;
- (f) 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; and
- (g) (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 IV.B.4.a.(7) of this RFP.

Amended July 17, 2017

b. Required Submission

- (1) Provide separate detailed implementation plans (narrative, diagram, and timeline) upon each Contract's approval, on or around ~~October~~ **January 1, 2017 2018** that results in the implementation of all Program Services by the required date of December 31, 2018, 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, Flexible Formulary development, mail service and specialty Pharmacy transition, customized website design, eligibility feeds, claims testing and EGWP approval and transition.
- (2) ***Implementation and Start-Up Guarantee:*** The Offeror must guarantee that all of the Implementation and Start-Up requirements listed above in Section B.3.a.(2) of this RFP is fully operational on or before December 31, 2018. The Offeror shall propose, separately for each Program, the forfeiture of a percentage of the 2019 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 2019 Claims Administration Fees (prorated on a daily basis). However, Offerors may propose higher or lower percentages.

The Offeror's quoted percent to be credited for each day that all Implementation and Start-up requirements are not met is _____ percent (%) of the 2019 Claims Administration Fee (prorated on a daily basis) for the DCS Program and _____ percent (%) of the 2019 Claims Administration Fee (prorated on a daily basis) for NYSIF's Program.

4. 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. Exhibit II.L, Empire Plan Prescription Drug Program Monthly Call Center Volume, of this RFP illustrates the current Pharmacy Benefit Manager's call center volume for the DCS Program. Exhibit II.K.1, Empire Plan Prescription Drug Program Website Statistics, provides the number of members who have utilized the current DCS customized Program website from October 2015 through October 2016.

a. Duties and Responsibilities

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

- (1) 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.
- (2) (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 with The Empire Plan's Medical Program vendor (currently UnitedHealthcare) and AT&T. 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 IV of the RFP.

- (3) 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 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.IV.4.b.(8)(a) through (d) of this RFP.
- (4) 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.
- (5) 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, Flexible Formulary and Excelsior Plan Drug List alternatives.
- (6) 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.

- (7) (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, comparative drug check functionality, Prescription drug history for both retail and mail claims and the Flexible Formulary (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; and
- (8) **Call Center Telephone Guarantees:** The Offeror must provide separate guarantees for the DCS and NYSIF Programs for the following four (4) measures of service on the toll-free customer service telephone line:
- (a) **Call Center Availability:** The Programs' service level standard requires that the Offeror's telephone line will be operational and available to Enrollees, Claimants, Dependents, and pharmacies at least ninety-nine and five-tenths percent (99.5%) of the Offeror's Call Center Hours. The call center availability shall be reported monthly and calculated quarterly;
- (b) **Call Center Telephone Response Time:** The Programs' service level standard requires that at least ninety percent (90%) of the incoming calls to the Offeror's telephone line will be answered by a customer service representative

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 customer service representative. The call center telephone response time shall be reported weekly for the first month of the Agreement, and then monthly for the remainder of the Agreement, and calculated quarterly;

- (c) **Telephone Abandonment Rate:** The Programs' service level standard requires that the percentage 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 will not exceed three percent (3%). The telephone abandonment rate shall be reported weekly for the first month of the Agreement, and then monthly for the remainder of the Agreement, and calculated quarterly; and
- (d) **Telephone Blockage Rate:** The Programs' service level standard requires that not more than three percent (3%) of incoming calls to the Offeror's customer service telephone line will be blocked by a busy signal. The telephone blockage rate shall be reported weekly for the first month of the Agreement, and then monthly for the remainder of the Agreement, and calculated quarterly.

b. Required Submission

- (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 with The Empire Plan Medical Program, or other party designated by the Department, and AT&T. 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. 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 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 you will utilize to develop it. Confirm that you 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 Flexible Formulary (including 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 above, 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 Availability:**

The Standard Credit Amount for each .01 to .25% below the standard of ninety-nine and five-tenths percent (99.5%) that the Offeror's telephone is not operational and available to Enrollees, Claimants, Dependents and Pharmacies during the Offeror's Call Center Hours calculated on a quarterly basis, is \$100,000 per quarter for DCS and \$7,500 for NYSIF, respectively. However, Offerors may propose higher or lower amounts.

The Offeror's quoted amount to be credited against the Claims Administration Fee for each .01 to .25% below the standard of ninety-nine and five-tenths percent (99.5%) (or the Offeror's proposed guarantee) that the Offeror's telephone line is not operational and available to Enrollees, Claimants, Dependents, and Pharmacies during the Offeror's Call Center Hours calculated on a quarterly basis, is \$_____ per quarter for DCS and \$ _____per quarter for NYSIF;

(b) **Call Center Telephone Response Time:**

The Standard Credit Amount for each .01 to 1.0% below the standard of ninety percent (90%) of incoming calls to the Offeror's telephone line that is not answered by a customer service representative within sixty (60) seconds is \$25,000 per each quarter for DCS and \$7,500 for NYSIF, respectively. However, Offerors may propose higher or lower amounts.

The Offeror's quoted amount to be credited 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, calculated on a quarterly basis, is \$_____ per quarter for DCS and \$_____ per quarter for NYSIF;

(c) **Telephone Abandonment Rate:**

The Standard Credit Amount 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%) is \$25,000 per each quarter for DCS and \$7,500 for NYSIF, respectively. However, Offerors may propose higher or lower amounts.

The Offeror's quoted amount to be credited 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), calculated on a quarterly basis, is \$_____ per quarter for DCS and \$_____ per quarter for NYSIF; and

(d) **Telephone Blockage Rate:**

The Standard Credit Amount for each .01 to 1.0% of incoming calls to the Offeror's telephone line that are blocked by a busy signal, in excess of the standard of three percent (3%) is \$25,000 per each quarter for DCS and \$7,500 for NYSIF, respectively. However, Offerors may propose higher or lower amounts.

The Offeror's Quoted amount to be credited 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), calculated on a quarterly basis, is \$ per quarter for DCS and \$ ____ per quarter for NYSIF.

5. Empire Plan Medicare Rx (Exclusive to DCS)

a. Duties and Responsibilities

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 January 1, 2019. 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 and, to the extent possible, it mirrors the benefits and drug coverage available to the Empire Plan's non-Medicare-primary enrollees and dependents. Empire Plan Medicare Rx currently covers 267,100 Medicare-primary enrollees and their dependents.

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:

- (1) 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;

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- (2) Fully supporting the Department with all operational aspects of a fully compliant 800 series EGWP including, but not limited to:
 - (a) Medicare PDP EGWP premium development
 - (b) Enrollment, including providing temporary commercial plan coverage for Enrollees and/or Dependents who are pending enrollment by Medicare
 - (c) Enrollee Opt-Out process
 - (d) ~~Health Insurance Claim Number (HICN)~~ Medicare Beneficiary Identifier (MBI) administration
 - (e) Formulary management
 - (f) Issuing of Medicare PDP EGWP member identification cards
 - (g) Member Communications, including required explanation of benefits statements
 - (h) Claims Processing
 - (i) Administration of a Medicare Part D supplemental wrap with the goal of providing Medicare primary Enrollees with a prescription drug benefit replicating as closely as possible the prescription drug benefit design for non-Medicare-primary retirees in The Empire Plan
 - (j) Timely administration of catastrophic reinsurance claims
 - (k) Administration of Low Income Subsidy requirements, including direct

reimbursement of Low Income Subsidies to eligible Enrollees of the Plan.

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- (3) 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: Payment Date, Carrier ID, Benefit Plan, Benefit Program, Last Name, First Name, DOB, **HICN MBI**, Member ID, SSN, # of Payments, Payment Start Date, Payment End Date, ADJ Reason Code, ADJ Reason Code Description, and LIS Premium Subsidy Amount. 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;
- (4) Prepare 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;
- (5) 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;

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- (6) The Department acknowledges and agrees that it shall be responsible solely (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 **HICNs Medicare Beneficiary Identifiers (MBIs)** for all eligible Medicare-primary members enrolled in the Empire Plan Medicare Rx Program.
- (7) 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; and

- (8) 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.
- (9) 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;
- (10) 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; and
- (11) 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.

b. Required Submission

- (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.

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- (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) Health Insurance Claim Number (HICN) Medicare Beneficiary Identifier (MBI) administration
 - (e) Formulary management
 - (f) Issuing of Medicare PDP EGWP member identification cards
 - (g) Member Communications, including required explanation of benefits statements
 - (h) Claims Processing
 - (i) Administration of a Medicare D supplemental wrap with the goal of providing Medicare-primary Enrollees with a prescription drug benefit replicating as closely as possible the prescription drug benefit design for non-Medicare-primary retirees in The Empire Plan
 - (j) Timely administration of catastrophe reinsurance claims
 - (k) Administration of Low Income Subsidy requirements, including direct reimbursement of Low Income Subsidies to eligible Enrollees of the Plan.
- (3) Confirm that you 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 to the proposed Empire Plan Flexible Formulary included in this RFP. Comment on reasons for variances. Please note that the Department's goal is to make the Medicare Part D and Empire Plan Flexible Formulary align as closely as possible.
- (5) Provide a sample member communications package, including proposed benefit card, for the Empire Plan Medicare Rx.
- (6) Describe in detail the transition services you 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 Entities, 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 2014, 2015 and 2016.
 - (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?

6. Enrollee Communication Support

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

a. Duties and Responsibilities

- (1) All Enrollee communications developed by the Offeror are subject to the Procuring Agencies' review and prior written approval, including but not limited to any regular standardized 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. The Department or NYSIF in its sole discretion reserves the right to require any change it deems necessary.

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- (2) (Exclusive to DCS) The Offeror will be responsible for providing Enrollee communication support and services to the Department including, but not limited to:
- (a) Developing language describing the DCS Program for inclusion in Exhibit II.D, *Empire Plan Certificate of Insurance*, Exhibit II.D.1, *NYSHIP General Information Book*, and any other form of communication, subject to the Department's review and approval;
 - (b) 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;
 - (c) Timely reviewing and commenting on proposed DCS Program communication material developed by the Department;
 - (d) 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; and
- (3) (Exclusive to DCS) Upon request, subject to the approval of DCS, on an "as needed" basis, the Offeror agrees to provide staff to attend Health Benefit Fairs, select conferences, and benefit design information sessions, etc. in NYS and elsewhere in the United States. **The Offeror agrees that the costs associated with these services are included in the Offeror's Claims Administration Fee.**
- (4) 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, generic appeal letters, Flexible Formulary, disruption letters, etc. All such communications must be approved by the Procuring Agencies.
- (5) (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 Exhibit II.E.1b, NYSIF PBM Claimant Card, of this RFP.

b. Required Submission

- (1) Please describe the organizational resources currently dedicated to Enrollee communications including any changes that would occur if you were awarded the resultant Agreements. Please detail the process that will be utilized to develop Enrollee communications including, but not limited to the role of the Offeror's legal department. Provide several examples of the Programs communications you have developed for Enrollees. Confirm your 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 Flexible Formulary and Excelsior Plan Drug List communications set forth in Flexible Formulary Development and Management within Section IV.B.15.a. of this RFP.

- (2) (Exclusive to DCS) Describe the resources that will be available to the Department to support the Department's development of various Enrollee communications and your ability to provide input into such communications quickly.
- (3) (Exclusive to DCS) Confirm that staff will be available to attend 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. Please see Exhibit II.M, Vendor Attendance – Union Events, Select Conferences and Benefits Design Information Sessions, for a summary of DCS Program presentations that took place in the past 12-month period.
- (4) Confirm your commitment to work with the Procuring Agencies to develop appropriate customized forms and letters for the Programs. Provide examples of how you have worked with other large clients to produce customized communications.
- (5) (Exclusive to SIF) 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.

7. **Enrollment Management**

The Programs require the Offeror to ensure the timely processing of enrollment data as well as cancellation of benefits in accordance with each of the Programs' eligibility rules.

The Employee Benefits Division of the Department of Civil Service utilizes a web-based enrollment system for the administration of Employee benefits known as the New York Benefits Eligibility & Accounting Systems (NYBEAS). NYBEAS is the source of eligibility information for all Empire Plan, Excelsior Plan, and SEHP Enrollees and Dependents. Enrollment information is set forth in Exhibits II.B Enrollment by Month, Exhibit II.B.1, Total Empire Plan, Excelsior Plan and SEHP Enrollment by Age and Exhibit II.B.2, Covered Lives by Bargaining Unit or Other Group.

Note: The enrollment counts depicted in these exhibits may vary slightly due to timing differences in exhibit generation.

When a person enrolls in The Empire Plan, Excelsior Plan, or SEHP, the Department's 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. An example of The Empire Plan Employee Benefit Card is provided in Exhibit II.E. An example of the Excelsior Plan Employee Benefit Card is provided in Exhibit II.E.1a. 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 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 Exhibit II.E.1.

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 Exhibit II.E.1b of this RFP.

a. Duties and Responsibilities

The selected Offeror will be responsible for the maintenance of accurate, complete, and up-to-date enrollment files, located in the United States, based on information provided by the Department and NYSIF. 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 files who are enrolled in the EGWP or another Medicare Part D plan, and produce management reports and data files. The Offeror is required to provide enrollment management services including but not limited to:

(1) ***Initial Testing:***

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

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(2) (Exclusive to DCS) Providing an enrollment system capable of receiving secure enrollment transactions (Monday through Friday) and having all transactions for **Commercial plan enrollees** fully loaded to the claims processing system within twenty-four (24) hours of release of a retrievable file by the Department. The Offeror shall immediately notify the Department 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 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 **Commercial plan** enrollment file within a 24-hour period. The Offeror must be capable of loading both **Commercial plan** files within the twenty-four (24) 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 transaction set in the format specified by the Department. The latest transaction format is contained in Exhibit II.G, NYBEAS Enrollment Record Layout – Control Header and Exhibit II.G.1., NYBEAS Enrollment Record Layout – Transaction Set Header. The Offeror is required to:

- (a) 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 NYSHIP population;
 - (ii) Report the Empire Plan Alternate ID number (beginning with 890) in addition to the EGWP issued ID number when reporting information for EGWP plan members. Dependents enrolled in the EGWP plan must be linked back to the policy holder in the Departments 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 **HICN MBI** from CMS to the Department, so that the Department can update its system as appropriate to report these changes on the 834 transaction file; and
 - (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 file.
 - (b) Accept EGWP plan- eligible member enrollments to P.O. Box information as the Department attests to their eligibility and that they continue to reside in the EGWP service area;
 - (c) Maintain eligibility files, and transmit and receive a reconciliation file to/from the Department electronically, on a monthly basis in the Department's eligibility file format. The Department will provide the file format to the Offeror;
 - (d) Generate a reconciliation eligibility file monthly or on demand for both the Commercial plan and EGWP plan. The file will, at a minimum, contain the member's Social Security Number, the policy holder alternate ID, NYSHIP assigned IDs, demographic information, enrollment date, and termination date. For the reconciliation of the EGWP plan eligibility information, the file must also include the Medicare Part D Plan information and PDP information; and
 - (e) Receive any other special update files from the Department containing eligibility additions and deletions, including emergency updates.
- (3) (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 Exhibit II.N, NYSIF Claim Eligibility Process, of this RFP.

- (4) 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;
- (5) 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;
- (6) Cooperating fully with any State or Procuring Agency initiatives 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;
- (7) (Exclusive to DCS) Maintaining a read-only connection to the NYBEAS enrollment system for the purpose of providing the Offeror's staff with access to current Program enrollment information. Offeror's 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;
- (8) (Exclusive to DCS) Meeting the administrative requirements for National Medical Support Notices. A child covered by a Qualified Medical Child

Support Order (QMCSO), 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 QMCSO;

- (9) 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. Occurrences of these situations are very rare; and
- (10) (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 in order to provide a limited number of cost-effective medication benefits to the injured worker. See Exhibit II.T, NYSIF Short Fill Process, of this RFP.

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- (11) **Enrollment Management Guarantee:** The Offeror must propose a performance 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 the NYSIF.

b. Required Submission

- (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?

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- (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 on-line?
 - (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.

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- (d) ~~(Exclusive to DCS)~~ Confirm your enrollment and claims processing system has the capacity to administer a Social Security number, Employee identification number and 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 you will maintain a read-only connection to the NYBEAS enrollment system, and that Offeror's 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.

- (6) (Exclusive to DCS) Describe your ability to meet the administrative requirements for National Medical Support Orders and dependents covered by a Qualified Medical Child Support Order (QMCSO), including storing this information in your system so that information about the Dependent is only released to the individual named in the QMCSO.
- (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 you 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 Exhibit II.T, NYSIF Short Fill Process, of this RFP.

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- (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 the 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 the 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.

The Offeror's quoted amount to be credited against the Claims Administration Fee for each 24-hour period beyond twenty-four (24) hours from the release by the Department, and for each 24-hour period beyond twelve (12) hours from the 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 \$_____ for DCS and \$_____ for NYSIF.

8. Reporting

(Exclusive to DCS) Reporting must be structured to provide assurances 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 very tight time frames. In order to fulfill its obligations to enrolled members and ensure contract compliance, the Program requires that the Offeror provide accurate claims data information on a claim processing cycle basis as well as specific summary reports concerning the Programs and its administration.

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

(Exclusive to NYSIF) 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 within very tight time frames.

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.

a. Duties and Responsibilities

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

- (1) Ensuring that all financial reports including cycle claim reports are generated from amounts billed to the Programs, and tie to the quarterly and annual financial experience reports, and Rebate reports;
- (2) Developing, in conjunction with the Agencies, standard electronic management, financial, and utilization reports required by the Department for its use in the review, management, monitoring and analysis of the DCS Program. These reports must tie to the amounts billed to the DCS Program. The final format of reports is subject to the Agencies review and approval;
- (3) Supplying reports in paper format and/or in an electronic format (Microsoft Access, Excel, Word) as determined by the Agencies. The primary reports and data files are listed in this section of the RFP under Annual, Semi-Annual, Quarterly, Monthly and Ad-Hoc Reports and include the time frames for submittal to the Department;
- (4) Providing direct, secure access to the Offeror's claims system and any online and web-based reporting tools to the Agencies offices;

(5) 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 the Agencies. Information required in the Ad Hoc Reports may include but is not limited to providing:

- (a) Forecasting and trend analysis data
- (b) Data necessary to track drug pricing
- (c) Utilization data on the Mail Order Pharmacy and the Special Pharmacy Program
- (d) Utilization review savings
- (e) Benefit design modeling analysis
- (f) Reports to meet clinical program review needs
- (g) Reports segregating claims experience for specific populations
- (h) Reports to monitor Agreement compliance

(6) **Management Reports and Claim File Guarantees:** The Offeror must propose a performance guarantee. The service level standard requires that accurate management reports and claim files as specified in Section IV.B.8.a.(7) of this RFP will be delivered to the Agencies no later than their respective due dates inclusive of the date of receipt.

(7) Supplying reports in paper format and/or in an electronic format (Microsoft Access, Excel, Word) as determined by the Department. The primary reports and data files are listed under Annual, Semi-Annual, Quarterly, Monthly, Weekly, and Ad-Hoc Reports and include the time frames for submittal to the Agencies:

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

- (1) Generating and submitting monthly, quarterly, semi-annual and annual reports per NYSIF specification. Specifications will be provided upon contractor selection;
- (2) Capturing and providing NYSIF with electronic files of eligibility and authorization on the GC3, GPI or similar code level. The Offeror should have the capability to capture drug denials on the GPI and NDC code

levels;

- (3) Providing direct, secure access to the Contractor's claims system and any online and web-based reporting tools to NYSIF's offices;
- (4) Providing NYSIF with an online decision support tool with ad-hoc query capability;
- (5) 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:
 - (a) Forecasting and trend analysis data;
 - (b) Data necessary to track drug pricing;
 - (c) Utilization data on the Mail Order Pharmacy and the Special Pharmacy Program;
 - (d) Utilization review savings;
 - (e) Benefit design modeling analysis;
 - (f) Reports to meet clinical program review needs;
 - (g) Reports segregating claims experience for specific populations; and
 - (h) Reports to monitor Agreement compliance.
- (6) The Offeror must work with NYSIF to resolve reporting issues according to the timeframes described in Section IV.B.8.a.(8) (NYSIF Reporting) of this RFP;
- (7) **Management Reports and Claim File Guarantees:** The Offeror must propose a performance guarantee. The NYSIF's Program service level standard requires that accurate management reports and claim files as specified in Section IV.B.8.a.(8) (NYSIF Reports) of this RFP will be delivered to NYSIF no later than their respective due dates inclusive of the date of receipt; and
- (8) Supplying reports in paper format and/or in an electronic format (Microsoft Access, Excel, Word) as determined by NYSIF. The primary reports and data files are listed in the prior section of the RFP under Annual, Semi-Annual, Quarterly, Monthly, Weekly, and Daily Reports and include the time frames for submittal to NYSIF.

Annual Reports

Annual Financial Summary Report: The Offeror must submit an annual report of the Agencies charges and credits no later than seventy-five (75) Days after the end of each Calendar Year. These statements must detail, at minimum, claims paid during the year, claims administration costs, performance credits, audit credits, drug settlement proceeds, EGWP subsidies, rebates (earned and paid), and coordination of benefit (COB) savings (exclusive to DCS). Such detail must include all charges by the Offeror to the DCS Program.

Annual Rate Renewal Report (exclusive to DCS): The Offeror must submit an Annual Premium Renewal no later than September 1 of each Calendar Year. This renewal package must detail all assumptions utilized to back up the rate renewal request, including, but not limited to: paid claim amounts, administrative fees, projected Pharma Revenue, EGWP subsidies, COB recoveries, changes in enrollment, changes in the Specialty Pharmacy drug list as well as changes in the Flexible Formulary.

Annual Mail Service Pharmacy Process Satisfaction Survey Summary Report: The Offeror must submit a report which details, in summary form, the results of Enrollee satisfaction surveys designed to evaluate the level of Program Enrollee satisfaction with the Mail Service Pharmacy Process. The surveys should cover areas of order processing, quality of services, and timeliness. The format of the survey instrument and reports is subject to NYS input and approval. The report is due annually, on May 1st of the year following the Calendar Year being surveyed. The report must include Enrollee comments and an accounting and resolution of any Enrollee issues.

Annual Summary Reporting: The Offeror must prepare and present an annual report that details Programs' performance, industry trends and anticipated market developments including the introduction of generics and potential new product developments. This presentation should include comparisons of the DCS Program to book of business statistics, and other similar plan statistics. Clinical, financial and service issues as well as strategies and opportunities for plan savings are to be comprehensively addressed. In addition, the Offeror should be proactive by reporting any areas that need improvement, potential problem areas, and any solutions that can be implemented. The annual presentation and report is due to DCS each August after the end of each complete Calendar Year; the report

is due to NYSIF 60 days after the Program year.

Annual Report of Claims and Credits Paid by Agency: The Offeror must submit a report that details claims and credits paid by agency. The Offeror is required to submit this report in the current format specified by the Department in Exhibit II.F, Schedule of Prescription Drug Reports, unless otherwise specified by the Department. The report is due thirty (30) Days after the end of the Calendar Year. The report must accurately reflect only Final Paid Claims.

Mail Service Pharmacy Process Accuracy Annual Report: The Offeror is required to submit an annual report that provides a breakdown of the various errors and calculates the accuracy rate of transactions processed using the Offeror's Mail Service Pharmacy Process. The Offeror is required to work out the final format of this report with the Agencies. The report is due thirty (30) Days after the end of the Calendar Year.

Rebate True-up File: The Offeror is required to transmit a computerized file via secure transfer containing a yearly true-up of rebate records in a format specified by the Department. 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.

Catastrophic Reinsurance and Low Income Cost Sharing Subsidy Reconciliation Reports: The Offeror is required to submit detailed annual reconciliation reports for the Catastrophic Reinsurance receipts and Low Income Cost Sharing subsidy for the EGWP by December 31st of the year following year of incurral.

Semi-Annual Reports

Top 100 Brand Name and Generic Drugs – Retail Pharmacy Report: The Offeror is required to submit a semi-annual report that details the top 100 brand name and top 100 Generic Drugs dispensed to Enrollees of the DCS Program through the Offeror's Retail Pharmacy Network sorted by drug spend and script count. The report should include fields such as: drug name, indication of use (i.e., cholesterol, diabetes, etc.), preferred drug indicator, number of Rx's, number of Enrollees utilizing the drug, Rx cost, average cost per script, average Copayment, and average Days' supply. The Offeror should closely follow the current format specified by the Department in Exhibit II.F.6, Top 100 Brand Name and Generic Drugs – Retail Pharmacy. The numbers should be submitted on a year-to-year

comparison basis. Any trends or abnormalities should be submitted in a narrative.

The report is due sixty (60) Days after the end of the second and fourth quarter.

Top 20 Therapeutic Categories Report: The Offeror is required to submit a semi-annual report that details the top 20 therapeutic categories by drug spend on the Flexible Formulary Drug List (broken down by drug) utilized by Enrollees of the DCS Program (combined Retail, Mail Service and Specialty Pharmacy). The report should include fields such as: drug name, number of Rx's, number of members utilizing the drug, Rx cost, average cost per script, preferred drug indicator, average Copayment, and average Day's supply. The Offeror should closely follow the current format specified by the Department in Exhibit II.F.7, Top Therapeutic Categories – Retail and Mail. The numbers should be submitted on a year-to-year comparison basis. Any trends or abnormalities should be submitted in a narrative. The report is due sixty (60) Days after the end of the second and fourth quarter.

Top 100 Brand Name and Generic Drugs – Mail Service Pharmacy Report: The Offeror is required to submit a semi-annual report that details the top 100 brand name and top 100 Generic Drugs dispensed to Enrollees of the DCS Program through the Offeror's Mail Service Pharmacy sorted by drug spend and script count. The report should include fields such as: drug name, indication of use (i.e., cholesterol, diabetes, etc.), preferred drug indicator, number of Rx's, number of members utilizing the drug, Rx cost, average cost per script, preferred drug indicator, average Copayment, and average Day's supply. The Offeror should closely follow the current format specified by the Department in Exhibit II.F.8, Top 100 Brand Name and Generic Drugs – Mail Service Pharmacy. The numbers should be provided on a year-to-year comparison basis. Any trends or abnormalities should be provided in a narrative. The report is due sixty (60) Days after the end of the second and fourth quarter.

Top 100 Specialty Drugs – Specialty Pharmacy Report: The Offeror is required to submit a semi-annual report that details the top 100 Specialty Drugs dispensed to Enrollees of the DCS Program through the Offeror's Designated Specialty Pharmacy sorted by drug spend and script count. The report should include fields such as: drug name, indication of use (i.e., cholesterol, diabetes, etc.) preferred drug indicator, number of Rx's, number of members utilizing the drug, Rx cost, average cost per script, preferred drug indicator, average Copayment, and average Days' supply. The Offeror should closely follow the current format specified by the Department in Exhibit II.F.5, Top 100 Drugs -- Specialty. The numbers should be provided on a year-to-

year comparison basis. Any trends or abnormalities should be provided in a narrative. The report is due sixty (60) Days after the end of the second and fourth quarter.

Quarterly Reports

Quarterly Financial Summary Reports: The Offeror must submit quarterly financial reports which present the DCS Program's experience for the most recent quarter (based on a Calendar Year) and the experience from the beginning of the Calendar Year to the end of the quarter being reported. The quarterly reports must also include projections of:

- Annual financial performance;
- Assessment of DCS Program costs;
- Incurred claim triangles;
- Pharma Revenue;
- Coordination of benefit recoveries (exclusive to DCS);
- Audit recoveries;
- Drug settlement and litigation recoveries;
- Administrative expenses;
- Premium projection for subsequent plan year (exclusive to DCS)
- Trend statistics; and
- Such other information as the Department deems necessary.

The reports are due on a quarterly basis, fifteen (15) Days after the end of the reporting period;

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); 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 Exhibit II.F.10, 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 Exhibit I.Y.3, 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.

Quarterly Audit Report: The Offeror must submit a quarterly audit report detailing audits planned, audits initiated, audits in progress, audits completed, audit findings, audit recoveries, and any other enforcement action by the Offeror. The report should include fields such as: Pharmacy name, NABP number, recovery amounts, audit method or type, and basis for and method of recovery. The Offeror should closely follow the current format specified by the Department in Exhibit II.F.11, Quarterly Audit Report. The report is due thirty (30) Days after the end of the quarter.

Quarterly Coordination of Benefit Report (Exclusive to DCS): The Offeror must submit a report that details the amount of recoveries received as a result of coordinating benefits with other Plans including Medicare. The Offeror’s report should identify the COB source, the Enrollee, the original claim amounts, and the amount received from the other insurance carriers or Medicare. The Offeror is required to work out the final format of this report with the Department. The report is due thirty (30) Days after the end of the quarter.

Quarterly Rebate and Other Pharma Revenue Report (Exclusive to DCS): 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 should closely follow the current format specified by the Department in Exhibit II.F.12, Quarterly Rebate and Other Pharma Revenue Report – Manufacturer Detail. 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 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.

Quarterly Rebate and Other Pharma Revenue Report (Exclusive to NYSIF): 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 Exhibit II.P, 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.

Quarterly Participating Agency Claims (Exclusive to DCS): The Offeror is required to submit a quarterly report that details claims by Participating Agency. The Offeror is required to submit this report in the current format specified by DCS in Exhibit II.F, Schedule of Prescription Drug Reports, unless otherwise specified by the Department. The report is due thirty (30) Days after the end of the quarter.

Quarterly Generic Appeals, Prior Authorization and Medical Exception Report (Exclusive to DCS): The Offeror is required to submit a quarterly report that provides the number of generic appeals, prior authorization and medical exception requests, by individual drug. The report must include numerical breakdowns on the number of generic appeals, prior authorization and medical exception requests made by the individual drug as well as the success/declination rate of these requests, as well as subsequent appeals. The Offeror should closely follow the current format specified by the Department in Exhibit II.J, Generic Appeals Report and Exhibit II.H.1, Prior Authorization Quarterly Report. The report is due thirty (30) Days after the end of the quarter.

Quarterly Prior Authorization Report (Exclusive to NYSIF): The Offeror is required to submit a quarterly report that provides the number of prior authorization requests by individual drug. The report must include numerical breakdowns on the number of prior authorization requests made by the individual drug as well as the success/declination rate of these requests, as well as subsequent appeal. The report should follow format specified by NYSIF in Exhibit II.X, NYSIF Report Fields, of this RFP. The report is due thirty (30) Days after the end of the quarter.

Quarterly Website Analytics Report (Exclusive to DCS): The Offeror is required to submit a quarterly report that provides comprehensive performance information for

the Offeror's customized DCS Program website as set forth in Section IV.B.4.a.(7) of this RFP. The report must include summarized and detailed website performance information and statistics, as well as proposed modifications to the layout and design of the website to improve communications with Enrollees. The report is due thirty (30) Days after the end of the quarter.

Quarterly EEO Workforce Utilization Compliance Report (Exclusive to DCS): The Offeror is required to submit a quarterly report identifying the work force utilized on the Contract in accordance with State and Federal statutory and constitutional non-discrimination provisions as set forth in Section II.B.3 of this RFP. Form EEO-101 Workforce Utilization Compliance Report is due ten (10) Days after the end of the quarter.

Quarterly MWBE Compliance Report (Exclusive to DCS): The Offeror is required to submit a quarterly report documenting the progress made toward achievement of the MWBE goals of the Contract pursuant to New York State Executive Law Article 15-A and 5 NYCRR 140-145 as set forth in Section II.B.3 of this RFP. Form MWBE-103 Quarterly M/WBE Contractor Compliance Report is due ten (10) Days after the end of the quarter.

Additional Quarterly Reports (Exclusive to NYSIF): The Contractor is responsible for submitting the following, but not limited to, additional reports. The reports are due one hundred eighty (180) Days after the end of the quarter. For fields see Exhibit II.P, NYSIF Rebate File Processes, of this RFP. However, the FUND will work with the Contractor to provide the specific formats for each report. Issue resolution timeframe: within one (1) week of the original submission.

- By NYSIF Office - Quarterly Top 25 Claimants by Drug Cost; By NYSIF Office
- BY NYSIF Office - Quarterly Top 25 Claimants by Drug Cost;
- By NYSIF Office - Quarterly Top 25 Claimants by Rx Count;
- By NYSIF Office - Quarterly Top 25 Medications by Drug Cost;
- By NYSIF Office - Quarterly Top 25 Medications by Rx Count;
- By NYSIF Office - Quarterly Top 10 Products by Drug Cost;
- By NYSIF Office - Quarterly Top 10 Products by Rx Count;
- By NYSIF Office - Quarterly Top 25 Schedule II Narcotics by Drug Cost;
- By NYSIF Office - Quarterly Top 25 Schedule II Narcotics by Rx Count;
- By NYSIF Office - Quarterly Top 25 Prescribers by Drug Cost;
- By NYSIF Office - Quarterly Top 25 Prescribers by Rx Count;

By NYSIF Office - Quarterly Top 25 Schedule II Prescribers by Drug Cost;
By NYSIF Office - Quarterly Top 25 Schedule II Prescribers by Rx Count;
By NYSIF Office - Quarterly Top 25 DAW1 Prescribers by Drug Cost;
By NYSIF Office - Quarterly Top 25 DAW1 Prescribers by Rx Count;
By NYSIF Office - Quarterly Compound Prescribers by Drug Cost;
By NYSIF Office - Quarterly Compound Prescribers by Rx Count;
By NYSIF Office - Quarterly Top 25 Claimants with Multiple Prescribers;
By NYSIF Office - Quarterly Top 25 Claimants with Multiple Pharmacies; and
Results of PBM's Patient Education Initiatives.

Monthly Reports

Monthly Report of Paid Claims by Month Incurred (Exclusive to DCS): The Offeror is required to submit a monthly report that provides summarized paid claims by month of incurral. The Offeror is required to submit this report in the current format specified by the Department in Exhibit II.F, Schedule of Prescription Drug Reports, unless otherwise specified by the Department. The report is due thirty (30) Days after the end of the month.

Monthly Report of Paid Claims by Pharmacy and Rx Type: The Offeror is required to submit a monthly report that provides summarized paid claims by Pharmacy type by Rx type. This report must distinguish reversals and allow the Department to verify Guaranteed Discounts. The Offeror is required to submit this report in the current format as specified by the Department in Exhibit II.F, unless otherwise specified by the Department. The report is due thirty (30) Days after the end of the month.

Monthly Report of Program MAC List: 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, 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 and the change in price from the previous Program MAC List. 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 Exhibit II.F.3, Empire Plan 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 Exhibit II.F.14, Drug Performance Report, unless otherwise specified by the Department. The report is due thirty (30) days after the end of the month.

Monthly Report of Generic and Brand Effective Rate, Specialty and Mail Service Performance (exclusive to NYSIF): Each month the Offeror is required to submit a summary by month of performance of the Generic and Brand Effective Rates for Retail, Specialty Drugs, and Mail Service Pharmacy Brand Drug claims. The following information should be included for the Generic and Effective Rates – number of claims, Ingredient Cost, Dispensing Fee, Tax Paid, Total AWP, WCB Fee Schedule, Amount Paid, Actual Discount off WCB Fee Schedule, Claim Number, Unit Number, Office, NDC, GPI, DAW Type, Generic Availability. The Offeror should include data fields listed in Exhibit II.X, NYSIF Report Fields, of this RFP. 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, Drug Name, Strength, Initial MAC Price, Current Price, Quantity Filled, Actual Savings, Annual Savings. The Offeror is required to submit this report specified by the Department in Exhibit II.F.13, Monthly MAC Savings Report, unless otherwise specified by the Department. The report is due thirty (30) Days after the end of the month.

Program Customer Service Monthly Reports: Each month the Offeror is required to submit a customer service report that measures the Offeror's customer service performance including customer service availability, customer service telephone response time, the telephone abandonment rate, the telephone blockage rate, claims processing, enrollment, and mail service turnaround. The Offeror is required to work out the final format of these reports with each agency. The reports are due fifteen (15) Days after the end of the month. For the first two months of the Agreement resulting from this RFP, these reports will be due on a weekly basis. After two months, the Agencies will re-examine the required

frequency of these reports and establish due dates with the Selected Offeror.

Card Issuance File (Exclusive to NYSIF): Each month the Offeror is required to submit a computerized file via secure transfer with the names of all NYSIF Claimants who have been issued a permanent ID card that is used when filing their injury-related prescriptions. The Fund will work with the Offeror to provide the specific format for the report. The report is due no later than fifteen (15) Days after the end of the month being reported.

Additional Monthly Reports (Exclusive to NYSIF): The Offeror is responsible for submitting the following, but not limited to, additional reports. The reports are due no later than fifteen (15) Days after the end of the month being reported. The Fund will work with the Offeror to provide the specific formats for each report. For fields see Exhibit II.X, NYSIF Report Fields, of this RFP. Issue resolution timeframe: within one (1) week of the original submission.

- Monthly Predictive Modeling Alert Summary;
- Acetaminophen High Dosage;
- Early Intervention Summary;
- Early Intervention Detail;
- Script Alert Summary;
- Script Alert Detail;
- Intervention Rx Summary;
- Intervention Rx Detail; and
- Savings based on WCB Fee Schedule

Bi-Weekly Reports (Exclusive to DCS)

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 Exhibit II.F.1, New York State Detailed Claim File Layout, 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 by claims processing cycle broken down by drug type (generic/brand) utilizing the fields and the format specified by the Department in Exhibit II.F.4, 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.

Weekly Reports (Exclusive to NYSIF)

Detailed Claim File Data: The Offeror must transmit to NYSIF a computerized file via secure transfer, containing only those pharmacy bills that are in accordance with the defined NYSIF business rules for pharmacy bill submission and contains only those pharmacy bills that have been successfully matched to an established NYSIF claim. Upon Offeror selection, NYSIF will provide a comprehensive list of edit rules and rejection codes that are based on the structure or content of a pharmacy bill record. The file will contain detailed claim records in the format specified by NYSIF in Exhibit II.O, NYSIF Billing Process, of this RFP unless otherwise specified by NYSIF, to support the weekly invoice. NYSIF requires that all claims processed and reversed be included. The file must facilitate reconciliation of claim payments to amounts charged to the NYSIF Program and include the current status of the claim (i.e., fields identifying claims as paid, reversed). The Offeror is required to securely forward the required claims data on a claims processing cycle basis to NYSIF within three (3) days after the end of each claims processing cycle.

Weekly Invoice: The Offeror must submit a weekly Vendor invoice which consists of two parts: Hard copy of the invoice of the Vendor Invoice submitted to the FUND via USPS, and Electronic submission of a Detailed Claim File Data supporting the charges on the Vendor Invoice. The Offeror is required to submit this report in the current format specified by the FUND in Exhibit II.R, NYSIF Invoice, of this RFP, unless otherwise specified by the FUND. The report is due on the Monday following the week reported.

Aging Bill Report File: The Offeror is required to submit a computerized pharmacy billing file via secure transfer with bills previously submitted in the instant enrollment/Short Fill file that remain unmatched to an established NYSIF claim. In the event there are not records meeting the above criteria, an empty file should be transmitted. The Offeror is required to submit this report in the current format

specified by the FUND in Exhibit II.S, Aging Short Fill File Layout, of this RFP, unless otherwise specified by the FUND. The report is due each Monday.

Additional Weekly Reports (Exclusive to NYSIF): The Offeror is responsible for submitting the following, but not limited to, additional reports. The reports are due on the Monday following the week reported. The Fund will work with the Offeror to provide the specific formats for each report. For fields see Exhibit II.X, NYSIF Report Fields, of this RFP. Issue resolution timeframe: within one (1) week of the original submission.

Weekly Predictive Modeling Alert Summary; and
Weekly Predictive Modeling Alert Detail.

Daily Reports (Exclusive to NYSIF)

Short Fill Report File: The Offeror is required to submit a computerized file via secure transfer with pharmacy bills for those injured workers of NYSIF policyholders where the bill cannot be matched to an established NYSIF claim. The Offeror is required to submit this report in the current format specified by the FUND in Exhibit II.T, NYSIF Short Fill Process, of this RFP, unless otherwise specified by the FUND. The report is due daily. Issue resolution timeframe: prior to the next scheduled submission.

Claim Eligibility/Enrollment File Error Report: The Offeror is required to submit a computerized file as confirmation of the receipt and processing of the NYSIF Eligibility/Enrollment File. The Offeror is required to submit this report in the current format specified by the FUND in Exhibit II.U, NYSIF Error Process, of this RFP, unless otherwise specified by the FUND. The report is due daily. Issue resolution time frame: prior to the next scheduled submission.

Reports Required at Other Frequencies

MAC Alert Notice (Exclusive to DCS): 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 Exhibit II.F.9, MAC Alert Notice. This report must be submitted in accordance with the time frames specified in Section IV.B.14.a.(4) of this RFP, under the subheading “Mandatory Generic Substitution at Retail and Mail.”

Additional Reports (Exclusive to NYSIF):

The reports specified in Exhibit II.Y, NYSIF Additional Reports, of this RFP are required on a Yearly basis, but the Offeror should be prepared to provide these reports on a Quarterly and Monthly basis as requested by NYSIF. NYSIF may require such reports to include data collected for each NYSIF office and statewide.

b. Required Submission

(Exclusive to DCS)

- (1) 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.
- (2) 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 you believe this will bring to the Programs.
- (3) Confirm that you will provide reports in the specified format (paper and/or electronic – Microsoft Access, Excel, Word), as determined by the Agencies.
- (4) Confirm that you 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 you propose for Agencies staff to execute in order to obtain systems access.
- (5) Confirm that your ability and willingness to provide Ad Hoc Reports and other data analysis. Provide examples of Ad Hoc reporting that you have performed for other clients.
- (6) **Management Reports 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 Section IV.B.8.a.(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 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.

The Offeror's quoted amount to be credited against the DCS Program's Claims Administration Fee for each management report or claim file that is not received by its respective due date, is \$__per report for each Business Day between the due date and the date the accurate management report or claims file is received by the Departments inclusive of the date of receipt.

(Exclusive to NYSIF)

- (1) Confirm your agreement to generate and submit all daily, weekly, monthly, quarterly, semi-annual, and annual reports per NYSIF specification;
- (2) Confirm you 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;
- (3) Confirm that you will provide reports in the specified format (paper and/or electronic – Microsoft Access, Excel, Word), as determined by NYSIF;
- (4) Confirm that you will provide NYSIF with an on-line decision support tool with ad-hoc query capability;
- (5) Confirm that your ability and willingness to provide Ad Hoc Reports and other data analysis. Provide examples of Ad Hoc reporting that you have performed for other clients;
- (6) Describe how your proposed system will accept pharmacy bills from the Offeror's network pharmacies;

- (7) Describe how your proposed system will edit these pharmacy bills in accordance with NYSIF business rules;
- (8) Describe how the proposed system will reject, with reason, any pharmacy bills that do not adhere to NYSIF business rules;
- (9) Describe the method for notification of your network pharmacy in the event of rejection;
- (10) Describe how the pharmacy bills submitted will validate against the claim eligibility information provided by NYSIF;
- (11) Confirm that the weekly billing file will follow the specifications in Exhibit II.O, NYSIF Billing Process, of this RFP;
- (12) Describe the encryption and secure transmission protocol for the pharmacy billing files;
- (13) Describe how the system will be monitored for performance;
- (14) Describe how NYSIF will be notified in the event of a system and/or transmission failure;
- (15) Describe how it will be determined into which file Established Claim or Instant Enrollment/Short Fill, the pharmacy bill will be placed;
- (16) 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;
- (17) Describe how card issuance information is tracked in your system;
- (18) Describe your encryption and secure transmission protocol for your electronic files;
- (19) Confirm your agreement to create specified electronic files in the form of an ASCII text file;
- (20) Describe how rebate information is tracked in your system;
- (21) Describe the process that determines when a rebate is included in the quarterly rebate and annual true-up files; and

- (22) **Management Reports and Claim File Guarantees:** The NYSIF Program's service level standard requires that accurate management reports and claims files will be delivered to the NYSIF no later than their respective due dates. For the management reports and claim files listed in Section IV.B.8.a(8) (NYSIF Reports) of this RFP, the Offeror must propose a performance guarantee. The Offeror shall propose the forfeiture of a specific dollar amount of the NYSIF Claims Administration Fee for failure to meet this standard.

The Standard Credit Amount for each management report or claim file that is not received by its respective due date is \$75 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.

The Offeror's quoted amount to be credited against the NYSIF Claims Administration Fee for each management report or claim file that is not received by its respective due date, is \$_____per report for each Business Day between the due date and the date the accurate management report or claims file is received by the NYSIF inclusive of the date of receipt.

9. Transition and Termination of Agreements

The Offeror shall ensure that upon termination of the separate Agreements, 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.

a. Duties and Responsibilities

- (1) The Offeror must commit to fully cooperate with the successor contractor to ensure the timely, smooth transfer of information necessary to administer the Programs.
- (2) 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:
 - (a) 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:
 - (i) 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;
 - (ii) 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;
 - (iii) 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; and

- (iv) 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.

- (b) Transition of Enrollee information on all non-transferable compounds and controlled medications.

- (3) 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.

- (4) 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.

- (5) The selected Offeror shall be responsible for transitioning the Programs in accordance with the approved Transition Plans.

- (6) 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:
 - (a) 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;

- (b) Complete all required reports in the reporting Section IV.B.8. of this RFP;
- (c) Provide the Programs with sufficient staffing in order to address State audit requests and reports in a timely manner;
- (d) Agree to fully cooperate with all the Department, NYSIF or Office of the State Comptroller (OSC) audits consistent with the requirements of Article XIX of the resulting Agreements and Appendices A and B;
- (e) Perform timely reviews and responses to audit findings submitted by the Department, NYSIF and the Comptroller's audit unit in accordance with the requirements set forth in Article XIX "Audit Authority," Section VII, Contract Provisions;
- (f) Remit reimbursement due the Program within fifteen (15) days upon final audit determination consistent with the process specified in Article XIX "Audit Authority" and Article XV "Payments/(credits) to/from the contractor" of Section VII, Contract Provisions and Appendix B; and
- (g) (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.

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- (7) The selected Offeror is required to reach separate agreements with the Procuring Agencies on 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.

 - (8) 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.

 - (9) 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.

b. Required Submission

- (1) 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.

- (2) Provide an outline of the key elements and tasks that would be included in your separate Transition Plans to ensure that all the required duties and responsibilities are completed if you were the incumbent contractor. Include a brief explanation on how you would accomplish this with the successor contractor.

- (3) Please detail the level of customer service that you will provide after the termination date of the Agreements resulting from this RFP.

10. 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:

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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/medication, as required by Section IV.B.10. of this RFP, under the subheading “Network Management.” The Offeror must propose a Retail Pharmacy Network that meets or exceeds the Programs’ minimum access guarantees at the time of proposal submission that is credentialed and contracted for participation in the Programs’ Retail Pharmacy Network commencing on January 1, 2019. Please note that Offerors are encouraged to propose a network **for the DCS Commercial and NYSIF Programs** that excludes one or more chain pharmacies if that exclusion is expected to minimize costs, so long as they meet the minimum access guarantees. **The DCS 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 overall Guaranteed Minimum Discount off of AWP for all Brand Drugs dispensed, as set forth in Exhibit V.A, Proposed Claim Reimbursement Quote, plus the applicable brand dispensing

fee. All Generic Drug Retail Pharmacy Network claims shall be charged to the Program at Pass-through Pricing subject to the Offeror's proposed overall Guaranteed Minimum Discount off of AWP for all Generic Drugs dispensed, as set forth in Exhibit V.A plus the applicable generic dispensing fee. 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. *Do not include any cost information in the Technical Proposal.*

a. Duties and Responsibilities

- (1) 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.
- (2) The Programs require that the Offeror have available to Enrollees on January 1, 2019 its proposed Retail Pharmacy Network in accordance with the requirements set forth in Section IV.B.3.a.(2)(a) guaranteeing effective implementation of their proposed Retail Pharmacy Network.
- (3) The Offeror is required to include Independent Pharmacies in its Proposed Retail Pharmacy Network. In developing its proposed Retail Pharmacy Network, the Offeror is expected to use its best efforts to substantially maintain the composition of independent Network Pharmacies included in the Programs' current Retail Pharmacy Network 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.
- (4) 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.
- (5) The Offeror must effectively communicate the content (including any subsequent changes) and requirements of the Program's Flexible Formulary to their Retail Pharmacy Network.

- (6) Prior to January 1, 2019, 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.
- (7) Offerors must establish a process to provide Enrollees with access to Limited Distribution Drugs through the Retail Pharmacy Network.
- (8) **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:
- (a) 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;
- (b) 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
- (c) 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.

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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).

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b. Required Submission

(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 above. The access guarantee must be provided in terms of actual distance from Enrollees' residences and must meet or exceed the minimum access guarantees stipulated above.

DCS Commercial Program

% of Enrollees with Access to Retail Pharmacies	Enrollee Location	Access Guarantee One Pharmacy at least within
_%	Urban	_ miles
_%	Suburban	_ miles
_%	Rural	_ miles

DCS EGWP

% of Enrollees with Access to Retail Pharmacies	Enrollee Location	Access Guarantee One Pharmacy at least within
_%	Urban	_ miles
_%	Suburban	_ miles
_%	Rural	_ miles

NYSIF Program

% of Enrollees with Access to Retail Pharmacies	Enrollee Location	Access Guarantee One Pharmacy at least within
_%	Urban	_ miles
_%	Suburban	_ miles
_%	Rural	_ miles

(2) Please compare the current DCS Program network pharmacies that have submitted claims in 2016 with your Proposed Retail Pharmacy Network File

(Exhibit I.Y.1). 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 Exhibit I.Y.4, 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 exhibit can be obtained by following the instructions included in Exhibit I.Y.4 and meeting the requirements specified in Section III.B.5. of this RFP.

- (3) Please confirm that if selected, you will provide an updated Exhibits I.Y.1, Offeror's Proposed Retail Pharmacy Network File, I.Y.3, Offeror's Proposed Retail Pharmacy Network Access Prerequisite Worksheet and I.Y.4, Comparison of DCS Current Program Network Pharmacies and the Offeror's Proposed Retail Pharmacy Network on December 1, 2018 confirming that the Offeror's proposed Retail Pharmacy Network will be implemented as required on January 1, 2019. 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) Describe the approach(es) you would use to solicit additional pharmacies to enhance your proposed Retail Pharmacy Network or to fulfill a request to add an individual independent Pharmacy.
- (6) Please identify Limited Distribution Drugs and indicate the authorized distributors that will participate in the Retail Pharmacy Network proposed for the Programs. If you are unable to secure the participation of the authorized distributors in your Retail Pharmacy Network, describe the process you will utilize to provide Enrollees with access to these drugs placing no additional steps or burdens on the Enrollee.
- (6) **Network Pharmacy Access Guarantees:** You 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.

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The Offeror's quoted amount to be credited against the Claims Administration Fee is \$_____ for DCS Commercial, \$_____ for DCS EGWP, and \$_____ for NYSIF for each .01 to 1.0% below the ninety percent (90%) minimum access guarantee (or the Offeror's proposed guarantee) for any quarter in which the Network Pharmacy Access-for Urban Areas Guarantee, is not met by the Offeror.

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 Offeror's quoted amount to be credited against the Claims Administration Fee is \$_____ for DCS Commercial, \$_____ for DCS EGWP, and \$_____ for NYSIF for each .01 to 1.0% below the ninety percent (90%) minimum access guarantee (or the Offeror's proposed guarantee) for any quarter in which the Network Pharmacy Access for Suburban Areas Guarantee, is not met by the Offeror.

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.

The Offeror's quoted amount to be credited against the Claims Administration Fee is \$_____ for DCS Commercial, \$_____ for DCS EGWP, and \$_____ for NYSIF for each .01 to 1.0% below the seventy percent (70%)

minimum access guarantee (or the Offeror's proposed guarantee) for any quarter in which the Network Pharmacy Access for Rural Areas Guarantee, is not met by the Offeror.

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 Exhibit I.Y.3, Offeror's Proposed Retail Pharmacy Network Access Prerequisite Worksheet. The report is due thirty (30) Days after the end of the quarter.

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.

a. Duties and Responsibilities

- (1) The selected Offeror must ensure its Retail Pharmacy Network is credentialed in accordance with all applicable federal and state laws, rules and regulations.
- (2) 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.
- (3) The Offeror must maintain credentialing records and make them available for review by the Procuring Agencies upon request.

b. Required Submission

- (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 you 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 do you conduct a complete review?

- (b) What steps do you 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? What steps, if any, do you take to advise members when a Pharmacy has been removed from the Retail Pharmacy Network?

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. Contracting 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 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 cost information in the Technical Proposal.

a. Duties and Responsibilities

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

- (1) Ensuring that all Network Pharmacies contractually agree to and comply with all of the Programs' requirements and benefit design specifications;

- (2) (Exclusive to DCS) Ensuring all Network Pharmacy contracts include a provision prohibiting the use of pharmacy manufacturer coupons that reduce or waive Enrollee Copayments;

- (3) (Exclusive to DCS) Recruiting licensed Pharmacies affiliated with home care

agencies that are participating providers under The Empire Plan's Home Care Advocacy Program administered by The Empire Plan's medical carrier. These licensed pharmacies are provided in Exhibit II.E.2, HCAP Providers for NYS Empire Plan, of this RFP;

- (4) 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 detailed in Section VII of the RFP, Article 12.6.0.
- (5) Notifying the Department and NYSIF in writing of any plan to renegotiate 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;
- (6) 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;
- (7) (Exclusive to DCS) Upon the request of the Department, resoliciting 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;
- (8) Committing to administering Pharmacy contracts consistent with all representations made in the Offeror's cost proposal, including all representations regarding the administration of generic pricing and maintenance of MAC list(s); and
- (9) (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.

b. Required Submission

- (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.

- (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 your 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 you 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 you will put in place to circumvent the referral of bills by participating pharmacies to third party billers for collection.

Pharmacy and Program Audit

The protection of the Programs' assets must be a top priority of the selected Offeror. The selected Offeror must have a strong audit presence throughout its organization. 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.

a. Duties and Responsibilities

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

- (1) Providing ample audit resources including access to the Offeror's on-line 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;
- (2) Providing the Procuring Agencies with access and monthly updates to the Prescription Drug industry reference material (e.g., Medi-Span) for drug classification and drug pricing that the Offeror will be utilizing for the

Programs;

- (3) Conducting routine and targeted on-site audits of Network Pharmacies, the Mail Service Pharmacy and the Specialty Pharmacy(ies). Pharmacies that deviate significantly from patterns of dispensing in terms of cost, drug selection, overrides, Day's supply or utilization are to be identified and targeted for on-site and desk audits in accordance with established selection and screening criteria. On-site audits must also be conducted upon request by the 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, on-site audits must be conducted at least once during the course of the resultant Agreements for Pharmacies that fall into the top fifty (50) in terms of total dollar spend for the Programs. Any modifications to the proposed Pharmacy audit programs must receive prior approval by the State;
- (4) 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;
- (5) 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;
- (6) Agreement to fully cooperate with all Department, NYSIF and/or OSC audits consistent with the requirements of Appendices A and B as set forth in Section VII, Contract 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 requirements of Article XIX "Audit Authority" in Section VII, Contract Provisions. 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 on-site audits, as requested by the Department, NYSIF and/or OSC;

- (7) 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 V, "Payments/ (Credits) to/from the Contractor" and Appendix B of Section VII, Contract Provisions;
- (8) Utilizing the auditing tools and performance measures proposed by the Offeror to identify fraud and abuse by Network Pharmacies and/or Enrollees; and,
- (9) Permitting the Department, NYSIF, or a designated third party to audit pharmacy bills and drug company revenues.

b. Required Submission

- (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 for the duration of the Agreement resulting from this RFP by the Offeror for access up to 3 (three) Department Staff.
- (3) Describe the Pharmacy audit program you would conduct for the Programs including a description of the criteria you use to select pharmacies for audit and a description of the policy that you follow 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 you find that a Pharmacy is billing incorrectly or otherwise acting

against the interests of your clients. Please indicate whether you have 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 do you have in place to address illegal or criminal activities by the Pharmacy?

- (5) Provide a copy of the audit language 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 RFP Section IV.B.10.a.(6) and (7) of this RFP, under the subheading "Pharmacy 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 V, "Payments/ (Credits) to/from the Contractor" and Appendix B of Section VII.
- (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 you will permit the Department, NYSIF, or a designated third party to audit pharmacy bills and drug company revenues.

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/Medications 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. Exhibit II.K, Mail Service Pharmacy Claims, of this RFP presents the mail service Prescription volume from October 1, 2015 through October 28, 2016.

a. Duties and Responsibilities

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

- (1) 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/Medications 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 Exhibit V.A, Proposed Claim Reimbursement Quote, including Specialty Drugs/Medications 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 Exhibit V.A. 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;
- (2) Ensuring that all the Procuring Agencies’ approved edits including, but not limited to, enforcing utilization edits (i.e., refill too soon, duplicate therapy, etc.) are built into the Prescription fulfillment system to protect an Enrollee’s safety as well as to control Programs’ costs;
- (3) 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;

- (4) 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 IV.B.10.b.(19) and (20) of this RFP, under the subheading "Mail Service Pharmacy Process."
 - (a) 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.
 - (b) Customer service representatives 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;
- (5) 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.
- (6) Having efficient procedures in place to handle routine Prescriptions, "urgent"

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- Prescriptions, and Prescriptions that require “special” handling (i.e. temperature control, limited shelf life, high cost, etc.);
- (7) 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;
 - (8) 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;
 - (9) 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;
 - (10) Maintaining a system that notifies Enrollees/Claimants about potential health and safety issues with their Prescriptions;
 - (11) 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.;
 - (12) Providing prompt notification to Enrollees regarding out of stock items, partial fill orders, and changes to Prescriptions (e.g., approved or required dispensing of generics 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 the Enrollee first to obtain permission to contact their Physician to offer alternative medications, or to 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;
 - (13) (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;

- (14) (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.
- (15) (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.
- (16) 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;
- (17) 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;

- (18) 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;
- (19) 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;
- (20) Having a backup mail order facility(ies) to handle any overflow and/or situations where the primary mail order facility is unavailable;
- (21) 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;
- (22) The Offeror shall 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 AWP's unless market conditions exist making dispensing the more cost-effective NDC impractical or impossible;
- (23) 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 7, 2019, by the Mail Service Pharmacy, must be received by the mailing agent no later than Thursday, January 10, 2019; and

- (24) 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 7, 2019, by the Mail Service Pharmacy, must be received by the mailing agent no later than Tuesday, January 15, 2019.

b. Required Submission

- (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 b.(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 Exhibit V.A;

- (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 2016 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 you 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 you would utilize to meet the mail service Prescription drug delivery requirements of the Programs; and
 - (f) Identify the facilities listed in b.(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 you 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 do you assist the Enrollee with this process?
- (4) Describe the capabilities of the Mail Service Pharmacy call tracking system.

- (5) Confirm that you 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 your system tracks mail service fill accuracy rates including all error types tracked by the system. In addition, detail the error types your system reports and include a mail service fill accuracy report for 2016. How are member reported errors tracked and reported? What type of investigations and process modifications would you 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 your 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 you 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.) you utilize 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 your primary supplier;
 - (c) What is the percentage of Prescriptions that are filled when initially submitted to the primary mail service pharmacy facility you are proposing; and
 - (d) How are backorders and out of stock situations handled with members?
- (14) (Exclusive to DCS) Describe your 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:
- Eye/Ear Drops
Lotions and Ointments
Syrups
- (18) Please describe what proposed strategies you would implement with your 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.

The Offeror's quoted amount to be credited against the Claims Administration Fee for each .01 to 1.0% below ninety-five percent (95%) (or the Offeror's proposed guarantee) of all non-intervention mail service Prescriptions not

turned around within two (2) Business Days, calculated on a quarterly basis, is \$_____ for DCS and \$_____ for NYSIF.

(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.

The Offeror's quoted amount to be credited against the Claims Administration Fee for each .01 to 1.0% below ninety-eight percent (98%) (or the Offeror's proposed guarantee) of all intervention mail service Prescriptions not turned around within five (5) Business Days, calculated on a quarterly basis, is \$_____ for DCS and \$_____ for NYSIF.

Specialty Drugs/Medications

The Programs provide coverage for Medically Necessary Drugs including Specialty Drugs/Medications. 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/Medications benefits through the Specialty Pharmacy Program.

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

For those groups that receive Specialty Drugs/Medications through the Retail Pharmacy Network or the Mail Service Pharmacy Process, the Programs make no

distinction for Specialty Drugs/Medications for pricing purposes and the Offeror is strictly prohibited from proposing an alternative pricing arrangement for any FDA approved drug or class of drugs. All drugs shall be classified as either brand name, generic, or compound for pricing purposes based on the methodologies set forth in Section V of this RFP. **Proposals that exclude Specialty Drugs/Medications from proposed pricing for brand name, generic and Compound Drugs, whether by omission or by the submission of an alternate pricing proposal will be removed from consideration.** The Programs shall be entitled to all manufacturer revenue derived from Specialty Drugs/Medications.

a. **Duties and Responsibilities**

- (1) The Offeror must provide Enrollees with access to all Medically Necessary Specialty Drugs/Medications 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 Exhibit II.C, DCS/NYSIF Prescription Drug Program Copayment and Benefit Maximum Matrix. In the case of Limited Distribution Drugs, the Offeror shall provide Enrollees with access in accordance with the following:

(a) Retail Pharmacy Network Access

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 of AWP for the Limited Distribution Drug, plus any dispensing fee. The Enrollee shall be charged the applicable retail Copayment.

(b) 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.

- (2) (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 Exhibit II.E.2, HCAP Providers for 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 Exhibit V.A.

b. Required Submission

- (1) Explain how your proposed network provides access to all medically necessary covered Specialty Drugs/Medications.
- (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 you 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 insurer.
- (4) (Exclusive to DCS) For those HCAP providers that do not have affiliated pharmacies, how do you propose coordinating with HCAP and supplying the medication to the Enrollee? Will you utilize the Mail Service Pharmacy Process?
- (5) Confirm that necessary ancillary supplies that accompany certain Specialty

Drugs/Medications will be delivered to the Enrollee at no additional cost to the Programs or Enrollee.

- (6) Indicate the licensed pharmacies in Exhibit II.E.2, HCAP Providers for NYS Empire Plan, with whom you have a current Network Pharmacy contract.

Specialty Pharmacy Program

NYSIF Claimants and all DCS Program Employee groups participate in the Specialty Pharmacy Program, which provides an enhanced level of clinical management for Enrollees taking Specialty Drugs/Medications. 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/Medication 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/Medications 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 name, Generic, or Compound for pricing purposes based on the classification methodologies set forth in Section V of this RFP. The Programs shall be entitled to all manufacturer revenue derived from Specialty Drugs/Medications.

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

1. "orphan drugs";
2. drugs requiring special handling, special administration and/or intensive Enrollee monitoring/testing;
3. biotech drugs developed from human cell proteins and DNA, targeted to treat disease at the cellular level; or,
4. 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 Enrollees/Claimants receive their Specialty Drugs/Medications 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.

a. Duties and Responsibilities

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

- (1) Developing a listing of the Specialty Drugs/Medications proposed for inclusion in the Specialty Pharmacy Program;
- (2) Having a fully staffed and fully operational Specialty Pharmacy Program in which Specialty Drugs/Medications 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.
- (3) The Offeror must establish a process to provide Enrollees with access to Limited Distribution Drugs not available through the Designated Specialty Pharmacy(ies), which places no additional steps or burdens on the Enrollee. The Offeror 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.

- (4) 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/Medication 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 web access to their Prescription drug history file (retail, mail, and specialty) via a customized website (DCS only).
- (5) 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/Medications manufacturers to ensure the benefits of a drug outweigh its risks.
- (6) (Exclusive to DCS) Contracting a nationwide network of appropriately licensed clinicians and/or coordinating with appropriately trained HCAP clinicians to administer the Specialty Drugs/Medications to Enrollees in a home setting and providing Enrollees with education on proper treatment regimens and possible side effects.
- (7) Completing Physician consultation, coordination of care, patient care management and other interventions on a clinically appropriate and timely basis.
- (8) 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.

- (9) (DCS only) 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/Medications 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.
- (10) Ensuring that all the Procuring Agencies' approved edits including, but not limited to, enforcing utilization edits (e.g., refill too soon, duplicate therapy, etc.) are built into the Prescription fulfillment process system to protect an Enrollees safety as well as to control Programs' costs.
- (11) 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/Medications are safe and effective and delivered on time.
- (12) 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 who have received a Grace Fill of a Specialty Drug/Medication 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/Medication 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/Medication subject to the Designated Specialty Pharmacy Passive Edit. Enrollees are allowed one Grace Fill for Specialty Drugs/Medications, 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.
- (13) 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 Formulary inquiries and Specialty Pharmacy Process complaints. The system shall include call type, customer service actions, and resolutions.

- (14) 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.
- (15) 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.
- (16) 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.
- (17) 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.
- (18) (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.

- (19) (Exclusive to DCS) The Offeror is expected to assist Enrollees, upon request, to establish a payment plan so that Specialty Drug/Medication Prescriptions that are essential to an Enrollee's health will continue to ship when the outstanding amount exceeds the Offeror's proposed maximum limits.
- (20) 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.
- (21) Having backup Designated Specialty Pharmacies to handle any overflow and/or situations where the primary Specialty Program facility is unavailable.
- (22) (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 Special Pharmacy Program.
- (23) Recommending newly launched Specialty Drugs/Medications for inclusion in the Specialty Pharmacy Program based on the established criteria/definition of Specialty Drug/Medications, in a format to be approved by the Procuring Agencies. Prior to inclusion in the Programs, or if not accepted by the Procuring Agencies to be included in the Programs, the Offeror must bill the Programs for these Prescriptions consistent with the Offeror's contracted discount off of AWP at the dispensing Network Pharmacies or the Guaranteed Discount at the Mail Service Pharmacy Process, based on where each Prescription was actually dispensed. Inclusion of new Specialty Drugs/Medications shall have a cost-neutral or positive financial impact on the Program, and in no case shall the Ingredient Cost of a newly added Specialty Drug/Medication charged to the Program exceed the Guaranteed Discount on Specialty Pharmacy Drugs.

b. Required Submission

- (1) Provide a listing of the Specialty Drugs/Medications that you propose for inclusion in the Specialty Pharmacy Program, along with an indication of how they meet the minimum criteria. Also, please state if you propose additional

criteria. Please state whether the Designated Specialty Pharmacy(ies) you propose regularly dispense any other Specialty Drugs/Medications which you are not proposing for the Programs.

- (2) Provide a detailed description of your proposed Specialty Pharmacy Program. Include the following:
 - (a) Customer service call center
 - (b) Administration of REMS
 - (c) (Exclusive to DCS) Whether Specialty Drugs/Medications administration will be through 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) Do you 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 Exhibit II.E.2, HCAP Providers for 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/Medications 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/Medications 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 your system provide the ancillary supplies that accompany some of the Specialty Drugs/Medications?

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- (7) Describe the criteria you will use to evaluate new Specialty Drugs/Medications that enter the market and whether they should be included in the Specialty Pharmacy Process.

Vaccination Network (Exclusive to DCS)

The Department has implemented an immunization program in which enrollees can receive preventive vaccines in accordance with Affordable Care Act (ACA) mandates, at pharmacies that participate in the Offeror's Vaccination Network thereby allowing improved access to preventive vaccines, including influenza, pneumococcal, meningococcal and zoster that are permitted by NYS law to be administered by a pharmacist. Certain preventive vaccinations administered at a vaccination network pharmacy will be covered at no cost to Enrollees. The covered preventive vaccines are: influenza, pneumococcal, meningococcal, and herpes zoster (The Herpes Zoster vaccine is covered for Enrollees age fifty-five (55) through fifty-nine (59), subject to \$5 copay, but is only preventive (\$0 copay) for Enrollees age 60 and older). 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.

a. Duties and Responsibilities

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

The Vaccination Network will provide:

- (1) Seasonal Vaccines (vaccines for influenza are covered without copayment).
- (2) 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.

b. Required Submission

The Offeror shall provide the Department with a listing of Network Pharmacies

participating in the Vaccination Network.

11. **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/Medication 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 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) 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. The DCS Program count of Enrollee Submitted Claims can be found in Exhibit III.A, 2014 to 2016 Projected Incurred Claims, of this RFP.

a. **Duties and Responsibilities**

- (1) The Offeror must provide all aspects of claims processing. Such responsibility shall include but not be limited to:
 - (a) Verifying that the Programs benefit designs have been loaded into the system appropriately to adjudicate and calculate cost sharing and other edits correctly;

- (b) 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;
- (c) Charging the Programs consistent with the Offeror's proposed pricing quotes;
- (d) 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;
- (e) Managing 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);
- (f) 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;
- (g) Maintaining the security of the claim files and ensuring HIPAA compliance;
- (h) Reversing all attributes of claim records, e.g., AWP, quantity, Day's 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;
- (i) 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;

- (j) Maintaining a backup system and disaster recovery system for processing claims in the event that the primary claims payment system fails or is not accessible;
- (k) 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;
- (l) 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:

<u>Pharmacy Submitted DAW</u>	<u>Enrollee Copay</u>	<u>Ancillary Charge</u>	<u>Pricing</u>
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 Section IV.11.a.(1).(l).

- (m) 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 V.C.3.a.(7);
- (n) Maintaining a Programs' MAC List for Pharmacies;
- (o) (Exclusive to DCS) Processing Enrollee Submitted Claims in accordance with the following:
- (i) For Prescriptions filled with a Brand Drug with no generic equivalent, the Enrollee will be reimbursed using the Offeror's Minimum overall guaranteed Discounted Ingredient Cost for the Retail Pharmacy Network and dispensing fee for Brand Drugs not to exceed the submitted charges, less the applicable Copayment;
 - (ii) 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;
 - (iii) 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;

- (iv) 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
- (v) 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 V.C.7. of this RFP entitled "Enrollee Submitted Claims."
- (p) (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 Exhibit II.V, NYSIF Paper Bills, of this RFP;
- (q) (Exclusive to DCS) Processing claims for Employees enrolled in the SEHP who fill Prescriptions at the SUNY Stony Brook Student Health Service Pharmacy, and other SUNY pharmacies as may be requested by the Department during the term of the Agreement resulting from this RFP. Prescriptions under this arrangement must be dispensed according to the Plan design for the SEHP (see Exhibit II.C), including required prior authorizations and, where applicable, Day's supply limits. The Offeror must monitor the submission of SEHP claims and inform the Department if the SUNY Pharmacies submit charges in excess of the amounts that are paid to the Program's Retail Network Pharmacies for the same NDC's;
- (r) 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 to the Offeror's proposed Claims Adjudication Guarantee; NYSIF claims must also be processed in accordance with Chapter V of title 12 NYCRR and Exhibit II.V, NYSIF Paper Bills, of this RFP;
- (s) 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 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, 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;

- (t) Establishing a process where Pharmacies can verify eligibility of Enrollees and Dependents during Call Center Hours;
- (u) 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;
- (v) (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;
- (w) (Exclusive to DCS) Establishing a process to support, and respond to Federal Medicare Part D audits;
- (x) 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;
- (z) (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).

- (2) **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.
- (3) (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.
- (4) (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.

b. Required Submission

- (1) Provide a flow chart and step-by-step description of your 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 you propose at the point of service to ensure proper claim adjudication, including a detailed description and example of how your proposed refill-too-soon (RTS) edit will operate to ensure cost effective dispensing of Drugs under the Programs. Confirm that you will implement your proposed full RTS edit on January 1, 2019.

- (2) Please describe your claims processing system platform including any backup system utilized. Describe your 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?
- (3) Describe the capabilities of your claim processing system to perform, at the point of service, for each of the following required Programs' components:
 - (a) The Programs generic substitution requirements based on the Programs' definition of a Generic Drug as set forth in Section VIII of this RFP;
 - (b) A Prior Authorization Program for specific drugs that have an increased risk of inappropriate utilization;
 - (c) A concurrent DUR program identifying Enrollee drug therapy safety edits and Programs' benefit edits;
 - (d) Messaging capabilities to the Network Pharmacy;
 - (e) Eligibility verification;
 - (f) Customized edits for individual Enrollees;
 - (g) Utilization of some medications intended to treat conditions limited to one sex;
 - (h) Historic claims look up capability to reduce Enrollee disruption at the point of sale;
 - (i) (Exclusive to DCS) Multi-level cost sharing;

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- (j) Identification and pricing of compounded Prescriptions consistent with the Programs' definitions and requirements set forth in this RFP; and
- (k) 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.
- (4) Please describe how your 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.
- (5) Describe how your adjudication system feeds the reporting and billing systems and any claim update data delays.
- (6) Do you own the adjudication system, license the software or contract out this service?
- (7) How quickly are your systems brought into compliance when a new version or capability of the standard NCPDP format for claims transmission is released?
- (8) Describe the current Network Pharmacy available overrides to your 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 your claims processing system and confirm whether it over-rides your client's program benefit design? If so, provide the circumstances where you would load an override edit at the point of service. If applicable, describe the circumstances where you would approve the dispensing of quantities in excess of the benefit design amounts within your concurrent DUR program.
- (9) 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?

- (10) 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.
- (11) Identify the resources that are available to a Pharmacist who is having difficulty processing a claim at the point of service. How do you ensure that the Pharmacist is able to get through to a person to resolve the issue?
- (12) (Exclusive to DCS) Confirm that your 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.
- (13) Explain how your claims processing system collects overpayments from your Retail Pharmacy Network.
- (14) 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;
- (15) 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.

(16) Can the adjudication system interact with a debit card program for flexible spending accounts?

(17) What data elements are required by your claims system to process a compound medication claim? How do you guard against inappropriate or inaccurate compound claims? How do you ensure that only those claims that meet the definition of a compound in Section VIII of this RFP are processed as compound claims thereby protecting the Programs' financial interest?

(18) **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 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 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 amount.

The Offeror's quoted amount to be credited against the Claims Administration Fee for each .01 to .25% below the standard of ninety-nine and five-tenths percent (99.5%) (or the Offeror's proposed guarantee) that the Offeror's online claims processing system for the Programs, based on a 24 hours a day, 7 Days a week availability excluding periods of scheduled down time, which shall be reported in advance to the Department and kept to a minimum, is not available, as calculated on a quarterly basis, the Offeror shall credit against the Program's Claims Administration Fee the amount of \$_____ for DCS and \$_____ for NYSIF.

(19) (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.

The Offeror's quoted amount to be credited against the Claims Administration Fee for each .01 to .25% 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 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 percent (99.5%) as calculated on a quarterly basis, is \$_____ for DCS.

(20) (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.

The Offeror's quoted amount to be credited against the Claims Administration Fee for each .01 to .25% of 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 NYSIF'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 percent (99.5%) as calculated on a quarterly basis, is \$ _____ for NYSIF.

12. Retrospective Coordination of Benefits (Exclusive to DCS)

The selected Offeror must be capable of administering a retrospective coordination of benefits (COB) recovery program. 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.

a. Duties and Responsibilities

- (1) 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.
- (2) 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.

- (3) 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.
- (4) 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.

b. Required Submission

Provide a flow chart and step-by-step description of the process you will employ to conduct the DCS Program's retrospective coordination of benefits (COB) requirement. Specifically, please detail how you will collect, store, and investigate COB information for other insurance.

13. Utilization Management

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 Formulary. An appeal cannot change the level status of these drugs on your proposed Formulary.

a. Duties and Responsibilities

To ensure strict adherence to the Program's Mandatory Generic Substitution Requirement and protect the financial interests of the Programs, the Offeror is required to:

- (1) 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.

- (2) (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.
- (3) 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.
- (4) (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:
 - (a) Inform the Department as soon as practicable but in no event later than 14 Days 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 IV.B.8.a. of this RFP, under the subheading "Reports Required at Other Frequencies;"
 - (b) 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” as described in (a) above. The Offeror shall add the GPI to the Programs’ MAC List 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;

- (c) 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” as described in (a) 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 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;
- (d) 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;

- (e) 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;
- (f) 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
- (g) 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.

- (5) 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 as set forth within "Program Claims Reimbursement" of the Contract Provisions, Section VII of this RFP;
- (6) 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;
- (7) 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;

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- (8) 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 Section VIII of the RFP; and
 - (9) (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. Required Submission

- (1) Please explain in detail the process you 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 your claims processing system will enforce the Programs' generic substitution requirement for a Generic Drug within the time limits specified above.
- (2) How do your 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 you intend to follow to ensure that drugs meeting the definition of generic as set forth in this RFP are identified in your system as Generic Drugs subjecting them to the generic pricing requirements set forth in Section V and mandatory generic substitution for A-rated or authorized Generic Drugs.
- (4) Please detail how your 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 your 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 your 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 you will manage the NTI list for the DCS Program including the parties responsible for making NTI recommendations.

Mandatory Generic Substitution Appeal Process (Exclusive to DCS)

An Enrollee may appeal the requirement to pay the Ancillary Charge. 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. Exhibit II.J.1, Generic Appeal Selected Statistics, of this RFP provides the number of generic appeals reviewed for the period of January 1, 2014 through October 31, 2016.

a. Duties and Responsibilities

The Offeror shall administer a Mandatory Generic Substitution Appeal process. The selected Offeror is required to oversee and enforce the DCS Program's generic appeal process including:

- (1) 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;

- (2) 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 of this RFP;
- (3) Following a successful generic appeal, charging the Enrollee for the Brand Drug at the Level 3 Copayment with no Ancillary Charge;
- (4) Loading into your claims processing system one or more files from the incumbent contractor of the previously approved Generic Appeal requests by the January 1, 2019 implementation 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; and
- (5) 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 Exhibit III.J, External Appeal Review Fees for the External Appeals filed by Empire Plan, Excelsior and SEHP Enrollees between November 1, 2014 and October 31, 2016.

b. Required Submission

- (1) Describe in detail how you would administer the required generic appeal processes 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 your criteria? Do you require generic appeals to be updated after a specific time period? If so, what is the process?
 - (d) Do you currently administer a generic appeals process? If yes,

provide the number of appeals you review 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:

- (a) Crestor
- (b) Ortho Tri-Cyclen
- (c) Lexapro
- (d) Wellbutrin
- (e) Lamictal

(e) How the Enrollee's claim will be handled during the appeal processing. In the event of a successful appeal, confirm that you 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 you will load previously approved Generic Appeals data into your claims adjudication system.

14. 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 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. The selected Offeror is required to provide these programs; however, an Offeror is not prevented from offering other value oriented programs. 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 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:

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

A Concurrent DUR Program: to aid the dispensing Pharmacist in identifying

potential drug therapy problems at the point of sale;

A 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

A Medical Exception Program (Exclusive to DCS): Allows for a medical necessity review and an exception determination to allow the use of drugs that are excluded from the Empire Plan Flexible Formulary 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 OF ALL THE PROGRAMS LISTED ABOVE IS REQUIRED TO BE IN YOUR CLAIMS ADMINISTRATION FEE.

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. Exhibit II.H, Drugs that Require Prior Authorization, provides a current list of the drugs subject to prior authorization. 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. Exhibit II.H.2, Prior Authorization Selected Statistics, provides the number of Program prior authorizations reviewed and certified for the period January 1, 2014 through October 31, 2016.

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.

a. 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:

- (1) 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;
- (2) (Exclusive to DCS) Informing Medical Professionals who request, by phone, fax, or secure internet portal, a Prior Authorization for a Specialty Drug/Medication about the DCS Program's Specialty Pharmacy Program and providing the information necessary to utilize the Specialty Pharmacy Program to obtain the drug;
- (3) 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;
- (4) (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;
- (5) Promptly loading approved prior authorizations determined by the Offeror or received from NYSIF for the NYSIF Program into the claims processing

system;

- (6) (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;
- (7) (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 Exhibit III.J, External Appeal Review Fees, for select data regarding External Appeals;
- (8) Loading one or more files of Prior Authorization approved-through dates from the incumbent contractors, prior to the January 1, 2019 implementation 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;
- (9) (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 Exhibit II.W, 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; and
- (10) (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 the Prior Authorization request is received by the Offeror in the Programs designated Post Office Box to the date the Offeror's response is received by the mailing agent.

b. Required Submission

- 1) Referring to the drugs or the drug categories subject to Prior Authorization, describe in detail how you would propose to administer Prior Authorizations including:
 - a) The process and criteria you 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 your projected staffing level for this unit?
 - c) A description of any current prior authorization programs you manage 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 you utilize 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 you utilize to measure program effectiveness (*Do not include any reference to specific monetary savings*); and
 - f) How you will transition Enrollees with current prior authorizations and their Prescriptions into your system. Specifically address whether your system has the flexibility to grandfather benefits for Enrollees currently taking drugs that would require preauthorization.
- 2) For each of the drugs currently subject to Prior Authorization under the DCS Program, please list the time period of the authorizations that you 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 you 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 you currently respond to DFS External Appeals within the required time frames.

Note: Do not include any cost information in the Technical Proposal.

- 5) (Exclusive to NYSIF) Provide a flow chart detailing the Prior authorization Process as detailed in Exhibit II.W, NYSIF PBM Prior Authorization Process, of this RFP.
- 6) (Exclusive to NYSIF) Confirm that you 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 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 the Prior Authorization request is received by the Offeror 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 round within two (2) Business Days from the date the Prior Authorization request is received by the Offeror 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.

The Offeror's quoted amount to be credited against the Claims Administration Fee for each .01 to .25% of Prior Authorization requests that are received by the Offeror not turned around within two (2) Business Days from the date received in the Department designated Post Office Box to the date the Offeror's response is received by the mailing agent, below the standard of ninety-five percent (95%) as calculated on a quarterly basis, is \$_____ for DCS.

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.

a. 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:

- (1) 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;
- (2) A fully integrated point-of-service system capable of enforcing the Programs’ benefit design features: and
- (3) (Exclusive to NYSIF) A point of service edit specifically related to opioid weaning that can be implemented only when there is a NYS Worker’s Compensation Notice of decision to do so.

b. Required Submission

- (1) Please detail the full scope of the Concurrent DUR program that you are proposing to utilize for the Programs. Include the qualifications of the staff responsible for oversight of your Concurrent DUR program.
- (2) Describe the software you will utilize to administer the Concurrent DUR program that you will implement for the Programs. Please specify if you have developed this software, purchased it from a third party source, or is it a system you purchased and have adapted for your use.
- (3) ***Program Safety Edits***
 - (a) Within your Concurrent DUR program describe all safety edits currently enforced through your claims processing system including, but not limited to the safety edits below:

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- (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; and
 - (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 do you monitor the effectiveness of the safety alerts program?

(4) ***Program Benefit Edits***

- (a) Within your Concurrent DUR program describe how your 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; and
 - (iii) drug exclusions or limitations.
- (5) Describe the methods you utilize 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.

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. 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 Offeror who is awarded the contract.

a. Duties and Responsibilities

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

- (1) Using the Offeror's standards, 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 narcotics acetaminophen or other identified high risk drugs;
- (2) 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; and
- (3) 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.

b. Required Submission

Describe the Retrospective DUR Program that you propose to put in place for the Programs including:

- (1) The qualifications of the staff that would perform these reviews;
- (2) How you identify and select areas for retrospective review and the methods utilized to inform and educate Physicians;
- (3) A timeline for these reviews.
- (4) What type of follow-up you conduct after communicating the information to the Physician;
- (5) How you measure the effectiveness of your Retrospective DUR Program

including any statistical measures of the success of your efforts (*Do not include any reference to specific monetary savings*);

- (6) Whether you currently administer a Retrospective DUR Program for other clients; and
- (7) The reporting capability for your described program.
- (8) Provide examples of the communications to physicians resulting from the retrospective DUR Program.
- (9) Provide examples of reports of your described program.

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 Empire Plan Flexible Formulary 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: Drugs that are only FDA approved for cosmetic indications are excluded from the Plan and are not eligible for a medical exception.

a. Duties and Responsibilities

- (1) 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.

b. Required Submission

- (1) Provide a flow chart and step-by-step description of the process you 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; and
- (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. Exhibit III.I, Medical Exception Program Claims Experience, provides data regarding the number of exception requests for a select time frame.

Physician Education

a. 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:

- (1) Analysis of Physicians' drug or condition specific prescribing patterns;
- (2) 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;
- (3) Reporting the results of its Physician Education initiatives to the State on a quarterly basis in a mutually agreed upon format; and
- (4) The Physician Education Program may not be funded by pharmaceutical

manufacturers.

b. Required Submission

Please describe/present the Physician communication/education programs you propose for the Programs. Describe your objectives and approach to Physician profiling and education including:

- (1) Whether you currently administer a Physician profiling and education program for other clients similar to the Programs;
- (2) A description of the method(s) and analysis you use to select Physicians for profiling and whether your clinical programs involve peer-to-peer Physician discussions;
- (3) The frequency of your educational efforts;
- (4) The number of Physicians you have 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;
- (5) How you measure the effectiveness of your Physician profiling program including any statistical measures of the success of your efforts. (*Do not include any reference to specific monetary savings*);
- (6) Whether you will adapt your Physician Education Program standards to meet the Program's needs as specified by the Department; and
- (7) Confirm that the Physician Education program will not be funded by pharmaceutical manufacturers.

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.

a. Duties and Responsibilities

- (1) 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; and
- (d) The Patient Education Program may not be funded by Pharmacy manufacturers.

b. Required Submission

- (1) Describe your objectives and approach to patient education including:
 - (a) Whether you 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) you propose to use to educate and inform patients;
 - (c) The number of educational interventions and the expected Enrollee response rate;
 - (d) How you measure the effectiveness of your patient education program including any statistical measures of the success of your efforts. *(Do not include any reference to specific monetary savings); and*
 - (e) Confirm that the Patient Education Program will not be funded by Pharmacy manufacturers.

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.

a. Duties and Responsibilities

- (1) 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) Upon initial fill of an opioid drug, enrollees will be informed of the risks associated with use of the drug;
 - (b) Reports the results of its patient education initiatives to NYSIF on a monthly basis in a mutually agreed upon format; and
 - (c) The Patient Education Program may not be funded by Pharmacy manufacturers.

b. Required Submission

- (1) Describe your objectives and approach to patient education including:
 - (a) Whether you 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) you propose to use to educate and inform patients;
 - (c) The number of educational interventions and the expected Enrollee response rate;
 - (d) How you measure the effectiveness of your patient education program including any statistical measures of the success of your efforts. *(Do not include any reference to specific monetary savings); and*
 - (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 CLAIMS ADMINISTRATION FEE.

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).

a. Duties and Responsibilities

N/A

b. Required Submission

(1) Please describe the purpose of any other clinical management or drug utilization review programs that you are proposing 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 you are proposing and confirm whether or not the costs for the Program are included in the Claims Administration Fee.

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

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 two (2) benefit designs: Flexible Formulary Drug List, and the Excelsior Plan

Drug List. The Empire Plan Medicare Rx benefit (Medicare Part D formulary and supplemental drug list) must replicate the prescription drug benefit for non-Medicare-primary retirees 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 or exclude drugs from the Formularies.

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. For the purpose of preparing a response to this RFP, if an Offeror proposes a 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 V, Cost Proposal of this RFP.

Note: Do not include any cost information in the Technical Proposal.

Flexible Formulary: Under the Flexible Formulary, Generics may be on Level 1 or excluded. Brand Drugs may be on Level 1, 2, or 3 or excluded. A proposed Drug List that includes Generics on Level 2 or Level 3 does not meet the Program requirements for the Flexible Formulary Drug List and would not be acceptable. Drugs may be excluded from the Flexible Formulary 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:

- a. contain an active ingredient available in and therapeutically equivalent to another drug covered in the class;

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- b. contain an active ingredient that is a modified version of and therapeutically equivalent to another covered Prescription Drug Product, or;
 - c. are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent.

See Exhibit II.I.3, Empire Plan Flexible Formulary Excluded Drug List, for the list of drugs that are excluded from the 2017 Flexible Formulary.

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 Flexible Formulary. The Flexible Formulary is updated once a year on January 1st. Mid-year changes to the Flexible Formulary are generally not acceptable. However, mid-year changes resulting from drug recalls, the introduction of new clinically superior drugs, drugs off patent, or patient safety issues are allowed.

The Flexible Formulary includes a "Brand for Generic" feature. With this feature, 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.

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. The Excelsior Plan Drug List may be updated throughout the year. It is currently updated on January 1 and July 1 each year. 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 Flexible Formulary.

a. 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:

- (1) Developing and administering multi-level formularies, consistent with the

Program's benefit designs. The Empire Plan Medicare Rx program must replicate the prescription drug benefit for non-Medicare primary retirees as closely as possible. The Offeror's PDLs must be based on sound clinical criteria. The Offeror's Book of Business PDL for the Excelsior Plan 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 Flexible Formulary drug list, 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 Flexible Formulary will be developed by the Offeror and reviewed annually by the Department;

- (2) The Offeror may recommend and the Department may, at its sole discretion, approve a mid-year change in a drug's status from non-preferred to preferred for the Flexible Formulary. Any recommended mid-year changes to the Flexible Formulary shall be provided to the Department with a summary of the clinical and financial implications to the DCS Program. In the instance when a change to the Flexible Formulary is approved outside of the annual update, the Offeror's communication responsibilities are the same as the annual update. For the Excelsior Plan, the timing of up-tiers and exclusion shall be consistent with the Offeror's Book of Business PDL;
- (3) 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. Printed copies of the Flexible Formulary Drug List from 2016 and 2017 are presented in Exhibits II.I through II.I.1. The Excelsior Plan Drug List for 2017 is presented in Exhibit II.I.2;

- (4) Compiling and organizing the PDLs in two versions, limited to the most commonly prescribed medications for posting and distribution: an alphabetical listing of Preferred Drugs and a listing of Preferred Drugs categorized by therapeutic category. A full listing of the PDLs must be available for posting on the website. The Offeror must work with the Department on the format of the PDLs. The PDLs 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., simvastatin (Zocor)) 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;
- (5) 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;
- (6) Developing and mailing a Department preapproved 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 Flexible Formulary Drug List. Disruption mailings for the Enrollees in the Excelsior Plan will follow the disruption mailing plan employed for the Offeror's Book of Business PDL. 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;

- (7) Notifying the Department in writing when a Class I drug recall or voluntary drug withdrawal occurs. The Offeror must take proper action to help promote patient safety. The Offeror will review with the Department the need to communicate and at the Department's discretion will notify Enrollees, Network Pharmacies and/or prescribing Physicians of the Federal Food and Drug Administration drug or device recalls and manufacturer 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;
- (8) 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;

- (9) Holding an annual meeting with the Department to review upcoming Flexible Formulary and Medicare Part D Drug List changes 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 Formulary Drug List as well as a detailed cost analysis of the impact of the changes to the Program;
- (10) 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 Flexible Formulary Drug List is shipped from the manufacturer or wholesaler;
- (11) Working with the medical carrier and the mental health and substance abuse carrier 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;
- (12) The Offeror will be responsible for ensuring the Empire Plan Flexible Formulary will be electronically available to Medical Professionals on Rx Hub and Level 1 and Level 2 drugs will be designated as Preferred;
- (13) 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;
- (14) The Offeror will be responsible for developing, recommending, and implementing Brand for Generic strategies for the Flexible Formulary that are financially beneficial to the State. All Brand for Generic placements are subject to Department approval. These placements may be revised mid-year, with Department approval, when such changes are advantageous to The Empire Plan; and,
- (15) The Offeror will be responsible for administering a New to You Prescriptions Program. This program requires Enrollees to have two 30-day fills of a newly prescribed medication at a Retail Pharmacy prior to being able to obtain a 90-day fill through the Retail Pharmacy or Mail Service Pharmacy.

b. Required Submission**Preferred Drug List Management – General**

- (1) Do you currently develop, maintain and administer plans with three copay level benefit designs utilizing one or more Preferred drug lists? Detail your proposed plan and your capability to administer the Program's formulary benefit DCS Program designs.
- (2) Describe the various preferred drug lists you have available:
 - (a) Do you have a standard three copay level preferred drug list used for your Book of Business?
 - (b) Do you maintain multiple standard and custom preferred drug lists? Provide a description of the differences.
 - (c) What is the goal of these alternative preferred drug lists?
 - (d) What role do clients play in the development of your preferred drug lists?
 - (e) How often are changes made for both additions and deletions?
 - (f) Are there special considerations for biological and specialty Pharmacy products in your preferred drug list and/or process?
- (3) What Preferred Drug Lists are you proposing to use in managing the DCS Program? Please provide copies. 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 your clinical rationale for limiting these drugs to Level 3?
- (4) Explain how you would work with the medical carrier and the mental health and substance abuse carrier to ensure that participating providers in their networks are fully apprised of the level status of Covered Drugs.
- (5) Confirm that the Empire Plan Flexible Formulary Drug List 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.

- (6) Describe the strategy which would be implemented to control Prescription Drug AWP increases.
- (7) Describe how you will develop, recommend, and implement Brand for Generic strategies for the Flexible Formulary that are financially beneficial to the State.
- (8) Do you currently administer a “New to You Prescriptions” Program or one similar to this for your book of business? Detail your capability to administer the New to You Prescriptions Program.

Preferred/Non-Preferred/Excluded Determination

- (1) Describe in detail the process employed to determine whether a drug is designated as preferred, non-preferred or excluded, including:
 - (a) All standards and criteria used in this determination;
 - (b) 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;
 - (c) The role of net cost in this determination;
 - (d) 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;
 - (e) Whether the process is governed by formal procedures to ensure sound clinical examination resulting in quality pharmaceutical care;
 - (f) 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;
 - (g) 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;

- (h) Whether the process is different for innovative new therapies than for therapies that already have a competitive alternative; and
 - (i) The conditions that would cause a drug's preferred, non-preferred, or excluded status to change and several recent examples.
- (2) Describe the type of analysis you would perform when a Preferred Brand Drug is being considered for movement to a Non-Preferred Brand Drug list and vice versa.
- (3) 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.

Preferred Drug List Strategy

- (1) How are Generic equivalents considered in your assessment of individual therapeutic categories on your PDL?
- (2) How does your PDL development process promote the use of the most cost-effective drug within the therapeutically equivalent drugs in the class, including Generics? Provide three examples.
- (3) Does your PDL strategy currently allow for drug exclusions? Do your proposed Flexible Formulary and Excelsior PDLs contain Drug exclusions? If so, please list proposed excluded drugs and rationale. Describe how you use exclusion leverage to negotiate rebates with Pharmacy manufacturers to provide the best value to the DCS Program.
- (4) Describe your 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 your current strategy and its rationale for the proton pump inhibitor class, statin class, and lifestyle drugs (Viagara, Levitra, etc.).
- (5) Describe your 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.

- (6) Please detail your 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.
- (7) Explain how your 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.
- (8) Describe how the anticipated upcoming release of a new Generic drug 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 your proposed PDL have drugs anticipated to go generic in 2017 as non-preferred? Please explain the rationale for such classification.

Voluntary Drug Recalls, Withdrawals, and Drug Lawsuits/Settlements

- (1) Describe your process for complying with the applicable Program requirements in the event of a Class I drug recall or voluntary drug withdrawal including the time notification standards you employ. Identify the services that would be provided to the Program and Enrollees. How is the Program reimbursed when a medication is recalled or withdrawn?
- (2) Describe your 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.

Preferred Drug List Development and Management (Exclusive to NYSIF)

The selected Offeror is required to efficiently develop, administer, and maintain a

single Preferred Drug List (PDL) that ensures Claimant access to appropriate, quality pharmaceutical care based on sound clinical criteria. The Program requires that all Covered Drugs be classified as preferred or non-preferred. PDL 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 Program. The Offeror must use sound clinical criteria in any decisions that are made to place or exclude drugs from the PDL.

The Drug List generally features Generic Drugs on the first level, Preferred Brand Drugs on the second level, and Non-Preferred Brand Drugs on the third level. The PDL proposed for the 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 does not require a Brand Drug in every therapeutic category. For the purpose of preparing a response to this RFP if an Offeror proposes a Preferred Drug List 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 V, Cost Proposal of this RFP.

Note: Do not include any cost information in the technical proposal.

a. Duties and Responsibilities

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

- (1) Creating and maintaining a formulary that is tailored to NYSIF specifications, including the categorization of drugs, e.g., drugs requiring prior authorization, covered drugs dispensed not requiring prior authorization;
- (2) Providing NYSIF with a list of therapeutic categories routinely excluded from coverage;
- (3) Agreeing that the Offeror does not and will not accept payments from drug companies to promote specific products;
- (4) Notifying NYSIF a minimum of three weeks prior to any additions, deletions and modifications to the existing formulary and whether or not the affected

drugs are covered or require prior authorization;

- (5) Notifying NYSIF a minimum of three weeks prior to the inclusion of new drugs in the formulary and specify whether or not the drugs are covered or require prior authorization; and,
- (6) 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.

b. Required Submission

- (1) Describe how you will create and maintain multiple formularies that are tailored to NYSIF specifications, 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;
- (2) Provide in electronic format, preferably Excel, a list of therapeutic categories you routinely exclude from coverage;
- (3) Confirm that you do not and will not accept payments from drug companies to promote specific products;
- (4) Confirm you will notify NYSIF a minimum of three weeks prior to any additions, deletions and modifications to the existing formulary and whether or not the affected drugs are covered or require prior authorization;
- (5) Confirm you will notify NYSIF a minimum of three weeks prior to the inclusion of new drugs in the formulary and specify whether or not the drugs are covered or require prior authorization; and,
- (6) Confirm you 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.

Amended July 17, 2017

Voluntary Drug Recalls, Withdrawals, and Drug Lawsuits/Settlements

- ~~(1) Describe your process for complying with the applicable Program requirements in the event of a Class I drug recall or voluntary drug withdrawal including the time notification standards you employ. Identify the services that would be provided to the Program and Enrollees. How is the Program reimbursed when a medication is recalled or withdrawn?~~
- ~~(2) Describe your 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.~~

C. Diversity Practices Questionnaire

Diversity practices are the efforts of contractors to include New York State-certified Minority and Women-owned Business Enterprises (“MWBEs”) in their business practices. Diversity practices may include past, present, or future actions and policies, and include activities of contractors on contracts with private entities and governmental units other than the State of New York. Assessing the diversity practices of contractors enables contractors to engage in meaningful, capacity-building collaborations with MWBEs.

The Department has determined, pursuant to New York State Executive Law Article 15-A, that the assessment of the diversity practices of respondents to this procurement is practical, feasible, and appropriate. Accordingly, respondents to this procurement shall be required to include as part of their response to this procurement, as described in this section and in Section VI, herein, Form Exhibit IV.B, Diversity Practices Questionnaire.

a. Required Submission

The Offeror must submit the Diversity Practices Questionnaire (Exhibit IV.B) signed by both the Offeror's authorized representative and public notary. The Offeror's completion of the questionnaire is voluntary and blank submissions will not disqualify an Offeror from the procurement.