New York State Department of Civil Service
Request for Proposals #RX-2017-1
Pharmacy Benefit Services for The Empire Plan, Excelsior Plan, Student Employee Health Plan and the New York State Insurance Fund Workers' Compensation Prescription Drug Programs
Official Answers to Offerors Questions

Following are the Department's answers to questions regarding the RFP #RX-2017-1, Pharmacy Benefit Services for The Empire Plan, Excelsior Plan, Student Employee Health Plan and the New York State Insurance Fund Workers' Compensation Prescription Drug Programs.

Note: If the Offeror's questions included their name, the name has been replaced with "Offeror."

Questions and Answers as of July 17, 2017
Note – July 18, 2017: Response to Question 19 has been updated
Note – August 2, 2017: 2 New Questions Asked and Answers Provided, including a Revised Exhibit II.A

Question	Section	Question and Answer
Q1	Section I Page 1-5	Section I.D notes that the Programs cover up to a ninety (90) day supply of covered drugs through retail pharmacies. What are the days' supply requirements for the retail 30 network verses the retail 90 network?
A1		**There is one Retail Network; copays vary based on network type (mail versus retail) and the number of days' supply. The Empire Plan allows for up to a ninety (90) day supply of covered drugs (copay varies based on days' supply) and the Student Employee Health Plan allows for up to a thirty (30) day supply of covered drugs.**
Q2	Section II Page 2-13 Material Deviations Exhibit I.I	Regarding Extraneous Terms, the instructions in Exhibit I.I state that the Offeror should explain any impact on the Administrative, Technical or Cost Proposal(s) resulting from the proposed alternate wording. We are interpreting this to mean that the Extraneous Terms should be structured as modifications to the contracts included in Section VII of the RFP. Is this accurate? In addition, so that Offerors are uniformly identifying Extraneous Terms, can the Procuring Agencies provide guidance on the difference between "Additional" and "Supplemental" Extraneous Term classifications; and the difference between "Or Equal" and "Alternative" Extraneous Term classifications?
A2		**Offerors must independently satisfy the applicable requirement(s) of the RFP as issued. In addition to, but not in lieu of, its response to the RFP's stated requirements, the Offeror may propose supplemental, "or equal", additional or alternative terms (Extraneous Terms) to the stated requirements within the Proposal, provided that, in the State's sole judgment, the Extraneous Term(s) does not constitute material deviations to the stated requirements. Material deviations from the specifications, terms, and conditions set forth in the RFP may render the Proposal nonresponsive and may result in rejection of the Proposal. See Section II.A.7.c for all requirements.**
Q3	Section II Page 2-17 & 2-18	Sections b and c on pages 2-17 to 2-18 appear to be duplications of Sections b and c on the pages 2-16 and 2-17. Can the Procuring Agencies confirm these were duplication and that there were not other provisions intended to be included within this RFP section?
A3		**Confirmed; this is a duplication. See amended Section II.**

Question	Section	Question and Answer
Q4	Section II Page 2-22	Section II of the RFP states that MWBE goal for DCS is 0.05% with no separate MBE and WBE goals. Appendix D states the DCS goal is 0.03% with separate MBE and WBE sub goals. Please clarify the DCS MWBE goal and applicable MBE and WBE goals, if any. How is the goal measured? As percent of gross cost, net cost after copay, net cost after copay and rebates, or some other basis?
A4		**See Amended Appendix D for revised MWBE goals. The goal is measured as a percent of net claims cost after copay and net of rebates and CMS subsidies and inclusive of administrative fees. Note that the goal can be split any way – the goal does not need to be equally split between MBE and WBE.**
Q5	Section II Page 2-22	For purposes of this solicitation, the Department hereby establishes an overall goal of 0.05 percent for MWBE participation. A separate MWBE participation goal of 0 percent has been established for the performance of the NYSIF contract. Appendix D Lists the following goal: For purposes of this Contract, the Department hereby establishes an overall goal of .03 percent for MWBE participation, .015 percent for New York State-certified minority- owned business enterprise ("MBE") participation and .015 percent for New York State-certified women-owned business enterprise ("WBE") participation (collectively, "MWBE Contract Goals") based on the current availability of MBEs and WBEs.
A5		**See Amended Appendix D**
Q6	Section II Page 2-22 Omnibus	This subsection refers to a list of jurisdictions in Article 21 of Appendix A. Article 21 of Appendix A provides a list indicated to be current as of 2002. Is this list of states current and, if not, can the Procuring Agencies provide an updated list?
A6		**See amended Section II to edit that the list of jurisdictions is in Article 21, not Article 20. Offeror should contact NYS Department of Economic Development for a current list.**
Q7	Section II Page 2-27 Vendor Responsibility	Regarding Section II.B. 6, Vendor Responsibility Requirements – State Finance Law § 163, if a proposed Key Subcontractor has submitted a VRQ to the Office of the State Comptroller in the last six months, is it necessary for them to submit a new one in association with this procurement?
A7		**It is not necessary to submit a new Vendor Responsibility Questionnaire (VRQ). The VRQ on file with OSC will have to be recertified after the six-month period.**
Q8	Section III Page 3-2	After reviewing Section III of the Administrative Proposal, we do not meet one of the minimum requirements needed to participate in the RFP. Currently, we insure 680,000 covered lives; however, the RFP indicates that we must currently insure 5 million lives. Please note: our PBM, does cover 1 in 3 Americans, which is approximately 78.5 members nationwide. Since we partner with a PBM, can you please let us know if we would still be able to participate in this RFP?
A8		**See amended Section VIII. The Offeror must demonstrate that it meets the Minimum Mandatory Requirement of providing Point of Service prescription claims adjudication and pharmacy benefit management services for a minimum of five million (5,000,000) lives. If you do not meet this Minimum Mandatory Requirement, the Department cannot accept a proposal from your organization.**
Q9	Section III Page 3-4	There are two fields in Exhibit 1.Y.2 named "Pharmacy Corporate ID" and "Contracting Entity Name". Can you please provide an example or provide further clarification as to what these fields will include?

Question	Section	Question and Answer
A9		**The Contracting Entity Name" field will include the name of the entity the Offeror contracts with for the retail pharmacy's participation in the Offeror's network. The Contracting Entity Name may not be the same name as the retail pharmacy. The "Pharmacy Corporate ID" represents the unique identifier, if any, of the contracting entity. In past RFP's, we have typically seen Pharmacy Corporate ID# presented as three or four digit identifiers.**
Q10	Section III Page 3-5	We are not currently URAC-accredited, but is in the process of preparing for National Committee for Quality Assurance (NCQA) Utilization Management and URAC certification and accreditation. All systems and processes have been developed and implemented within the principles and policies that would permit full accreditation — we are not aware of any deficiencies that would prohibit certification.
A10		**The Department will only accept proposals from Offerors that attest and demonstrate they meet all of the Minimum Mandatory Requirements as of the submission date. See amended Section III.**
Q11	Section III Page 3-16	Section III.H.4 indicates that while each bidder should propose one MAC list, a second MAC list may be implemented during the contract term, but that if a second MAC list is implemented, the financial guarantees may be adjusted to account for the impact of that event. Given the guidance here, we would like to ensure that all bidders are given an equal opportunity to provide an aggressive financial offer. We are therefore planning to propose financial guarantees based on one MAC list, and assuming that if a second MAC list is implemented, those guarantees will be subject to negotiation. Please confirm that this is the guidance being provided by DCS. Also, can DCS confirm if a second MAC list is in place today with the current vendor and, if so, how the two different lists are applied to the program?
A11		**Yes, the RFP requires one MAC List. Yes, if a second MAC List is implemented, guarantees would be subject to negotiation. Yes, there is a second MAC List in place today. Today, one MAC List applies to the mail service and all retail pharmacies, with the exception of NYS independent pharmacies. The second MAC List applies to all NYS independent pharmacies. Note that approximately 84% of the drugs on each list have the same MAC price.**
Q12	Section III Page 3-18	Question 13 asks if Offeror's pricing is equal to or better than all other clients of Offeror. For purposes of responding to the question, and to ensure an "apples to apples" comparison, is it appropriate for Offerors to compare the pricing offer to pricing terms offered to clients of a roughly equal or smaller size to the Procuring Agencies and with a comparable benefit structure (e.g., a Medicaid client would not be included in such comparison)?
A12		**If the pricing proposed is not equal or better to other clients, please explain the reasons why. Size and benefit design may be contributing factors.**
Q13	Section IV Page 4-11	This section requires eligibility updates to be applied within 24 hours of release by DCS. For the EGWP, enrollment cannot be applied until the member is approved by CMS. Please modify this requirement to one business day from release by DCS for commercial members and one business day from CMS approval for EGWP members.
A13		**See amended Section IV and Section VII.A. Enrollment records for EGWP participants are exempt from the Enrollment Management Guarantee. However, the Offeror is required to meet all CMS enrollment requirements, including any mandated turnaround times.**

Question	Section	Question and Answer
Q14	Section IV Page 4-12 Page 7-22	Dedicated Call Centers are required 7 a.m. to 7 p.m. Is that during regular business days or seven days a week?
A14		**The Dedicated Call Center is required 7 a.m. to 7 p.m., 365 Days per year.**
Q15	Section IV Page 4-19	Regarding Section IV.B.5.a.(6), the Health Insurance Claim Number (HICN) will be replaced with the Medicare Beneficiary Identifier (MBI) beginning April 2018, with a full transition required by April 2019. The initiative was first outlined in the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 (Additional details: https://www.cms.gov/medicare/ssnri/index.html). Will this question be revised in accordance with the CMS regulations that will be in place beginning in April of 2019, as the HICN will no longer apply?
A15		**See amended Section IV and VII.A to update MBI replacing HICN.**
Q16	Section IV Page 4-27	Please confirm that eligibility related to the EGWP Program will be exempt from the 24 hour turnaround time guarantee, and subject to CMS enrollment requirements, since loading eligibility under the EGWP is dependent on CMS approval.
A16		**See response for Question 13. The performance guarantee is on the Commercial plan, not on EGWP.**
Q17	Section IV Page 4-29	Please describe the data transfer process the State will use to submit data for persons who are covered by QMCSO to the Offeror.
A17		**The enrollment file notes if there is a National Medical Support Notice in place.**
Q18	Section IV Page 4-36	In reference to the requirement below, please detail the timeframes in which the offeror is required to resolve issues for each report/report type. While timeframes to deliver reports are included in Section IV.B.8.a.(8) (NYSIF Reporting), timeframes to resolve issues are not included. 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;
A18		**There is no timeframe specified to resolve the issues; the Offeror is to work with NYSIF to resolve any issues prior to the expected delivery date so that the reports are delivered according to the specified timeframes.**
Q19	Section IV Page 4-57 & Exhibit I.Y.1	The Network Management section notes that Offerors are encouraged to propose a network 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 EGWP and NYSIF programs are subject to different requirements than the commercial program. May Offerors propose different networks for the Commercial, EGWP and NYSIF programs? If yes, can you provide separate zip code lists for commercial, EGWP, and NYSIF members? Would three separate Exhibit I.Y.1's need to be completed for each proposed network?
A19		**Update July 27, 2017** **See Amendments to Section III, IV, VIIA, and Exhibits I.Y.1, I.Y.2, and I.Y.3. Offerors may exclude one or more chain pharmacies for the Retail Pharmacy Network proposed for the DCS Commercial and NYSIF Programs. The DCS EGWP must follow all CMS guidelines, including its "Any Willing Pharmacy" requirements.**

Question	Section	Question and Answer
Q20	Section IV Page 4-58 IV.B.10 Retail Pharmacy Network	This provision requires the selected Offeror to include in its Retail Pharmacy Network any Pharmacy(ies) upon the Department's or NYSIF's request, where such inclusion is deemed necessary by the Procuring Agencies to meet the needs of Enrollees even if not otherwise necessary to meet the minimum access guarantees outlined in the RFP. Please confirm that for any pharmacy so added to the Offeror's retail pharmacy network at the request of DCS or NYSIF, claims processed at these pharmacies will be excluded from the calculation of the guaranteed minimum discounts for Brands, Generics and Specialty drugs if the pharmacy will not agree to the terms proposed to the other pharmacies in the network.
A20		**Confirmed.**
Q21	Section IV Page 4-63	Does the incumbent PBM'S pharmacy network contracts include a provision prohibiting the use of manufacturer coupons.
A21		**The DCS program prohibits the use of manufacturer coupons.**
Q22	Section IV Page 4-66	Will the DCS consider changing the response time for audit requests for information and/or clarification to within thirty (30) Business Days? In some instances, depending on the nature of the request, it may take more than 15 days to gather information (e.g. data extract request).
A22		**The Department reserves the right to negotiate with the successful Offeror within the scope of the RFP and in the best interests of the Department.**
Q23	Section IV Page 4-83 IV.B.10 Specialty Pharmacy Program	To provide a more level comparison across Offerors relative to the list of Specialty Drugs/Medications proposed for inclusion in the Specialty Pharmacy Program, will guidance be provided regarding which drugs or drug classes should be included on the Specialty fee schedule. Our experience indicates that including certain classes such as HIV and Transplant can improve member adherence. However, including certain drugs such as Enoxaparin can materially improve the Specialty discount performance while its classification as a Specialty drug is inconsistent across PBM's. If additional guidance is not expected, how will differing fee schedules be evaluated across Offerors?
A23		**The evaluation of the Specialty Program will account for differences in Specialty drugs proposed by the Offerors.**
Q24	Section IV Page 4-91 B.11.a(1)(i)	This Subsection specifies that all claims data is the property of the State and it will be shared with the carriers and consultants specified by the Department. Is it the Procuring Agencies' expectation that the successful proposer will be permitted to require third party recipients to execute an appropriate confidentiality agreement and to otherwise reasonably protect the confidentiality of the claims data, including the PHI contained in the claims records and the proposer's interests in the pricing data contained in the claims records, which constitutes the proposer's protectable trade secret information?
A24		**Yes, the expectation is that the successful Offeror will require third-party recipients to execute an appropriate confidentiality agreement to protect the confidentiality of the claims data, including the PHI contained in the claims records.**
Q25	Section IV Page 4-94 Claims Processing	The Stony Brook Student Health Center was mentioned as a pharmacy used by the SEHP population. Is this considered an in-house pharmacy and are there other in-house pharmacies that are used by any of the programs? If so, can you please provide the pharmacy indicator(s) (i.e. NABP, NPI, NCPDP) and designate how these pharmacies should be treated (i.e. no bill/no pay, pass-through, included in network and guarantees)?

<table>
<tr><th>Question</th><th>Section</th><th>Question and Answer</th></tr>
<tr><td>A25</td><td></td><td>Claims from SUNY network pharmacies, including the Stony Brook Student Health Service Pharmacy (NPI 1073633269), are treated as traditional retail network pharmacies and are required to adhere to the retail network contract. The SUNY pharmacies are reimbursed based on the terms of the contract between the Offeror and each SUNY pharmacy. We are not aware of any “in-house” pharmacies in the Empire Plan Prescription Drug Program.</td></tr>
<tr><td>Q26</td><td>Section IV
Page 4-102</td><td>To assist all bidders to gain an understanding of this requirement, please provide for each of the last two years the number of members, total number of claims and total claims cost for which retrospective COB was sought and the total number of members from which claims were recovered, the total number of claims recovered, and total dollars recovered.</td></tr>
<tr><td>A26</td><td></td><td>See table below, as well as accompanying footnotes, for information available.

<table>
<tr><th></th><th>2015</th><th>2016</th><th>Total*</th></tr>
<tr><td>Members</td><td>125</td><td>138</td><td>263</td></tr>
<tr><td>Unrecovered Claims**</td><td>7,803</td><td>8,623</td><td>16,426</td></tr>
<tr><td>Recovered Claims</td><td>1,398</td><td>1,742</td><td>3,140</td></tr>
<tr><td>Invoicing***</td><td>$367,300</td><td>$407,700</td><td>$775,000</td></tr>
<tr><td>Recoveries</td><td>$326,400</td><td>$354,500</td><td>$680,900</td></tr>
</table>
*Totals for members. If a member had a recovery in both years, it will appear in each count.
**Unrecovered claims could be counted in multiple years until the claims are written-off or recovered.
***Invoiced dollars do not include unrecovered claims above.</td></tr>
<tr><td>Q27</td><td>Section IV
Page 4-105 - 4-108
Page 5-9 – 5-11
Page 7-55–7-57
Page 7-85–7-88</td><td>Regarding the requirements indicated in Section IV.B.13.a.(4), and other sections as detailed in the Section and Sub-Section Reference column:

Please confirm that a product that is therapeutically equivalent to another Prescription Drug Product (but does not include the same active ingredient or a modified version of that same active ingredient) would not be eligible for exclusion?

Also, please confirm that if the active ingredient of a Prescription Drug Product is available in an over-the-counter version, regardless of indication, it may be eligible for exclusion?</td></tr>
<tr><td>A27</td><td></td><td>Confirmed - a product that is therapeutically equivalent to another Prescription Drug Product (but does not include the same active ingredient or a modified version of that same active ingredient) cannot be excluded unless it is therapeutically equivalent AND the same active ingredient.

Confirmed - if the active ingredient of a Prescription Drug Product is available in an over-the-counter version, regardless of indication, it is eligible for exclusion.</td></tr>
<tr><td>Q28</td><td>Section IV
Page 4-105 - 4-106
Page 5-10
Page 7-85–7-86
Page 7-92</td><td>Regarding Generic substitution and the addition of Generics to the MAC list, please confirm that the expectation is for Generic substitution to be enforced within 21 days and that products need to be added to MAC within 21 days.</td></tr>
</table>

Question	Section	Question and Answer
A28		**The requirements for Generic substitution differ depending upon whether the change will result in a lower or higher cost to the Program. Changes that will result in a lower net cost to the Program must be added within 14 Days after the first date of shipment provided that the majority of Retail Network Pharmacies are able to obtain the Generic Drug.** **Changes that may result in a higher net cost to the Program may be substituted 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.**
Q29	Section IV Page 4-105 Page 7-53	In part (a) of the Duties and Responsibilities subsection of Section IV, under "Reports Required at Other Frequencies," Exhibit II.F.9, the MAC Alert Notice, displays a GCN field. Earlier, within the "Monthly Report of Program MAC List" requirement on Page 4-44, it is stated that MAC information shall be included at the GPI level. Are First Databank's GCN field and Medi-Span's GPI field considered to be similar, acceptable groupings of drugs for reporting purposes and other purposes throughout the requirements, or must the Offeror use Medi-Span's GPI whenever it is specifically referenced within the proposal requirements?
A29		**See amended Exhibit II.F.9, GPI replaces GCN.**
Q30	Section IV Page 4-111	Please confirm DCS is subject to state appeals requirements and not ACA or ERISA requirements. Is the fee referenced in this section charged to/payable by the plan or member?
A30		**Confirmed - DCS is subject to state appeals requirements.** **The vendor will be responsible for paying any fees charged by DFS for performance of the external reviews. All external appeals costs shall be funded through the Offeror's Claims Administration Fees and will not be charged separately to DCS.**
Q31	Section IV Page 4-126	Can DCS provide the formulary and benefits assigned to the Student Health Plan?
A31		**The Student Employee Health Plan uses The Empire Plan Flexible Formulary for prescription drugs – see Exhibit II.I.1 of RFP #RX-2017-1.** **At A Glance: https://www.cs.ny.gov/employee-benefits/young-adult-option/shared/publications/at-a-glance/2017/sehp-aag-jan-2017.pdf**
Q32	Section IV Page 4-126	Will the DCS accept proposals that assume the selected Offeror's standard Formulary(ies)?
A32		**The Offeror must propose an annual Formulary for the Empire Plan and Student Employee Health Plan which is reviewed and approved by the Department on an annual basis consistent with the requirements of the RFP.** **The Offeror should use a formulary adopted by its Book of Business for the Excelsior Plan only.**
Q33	Section V Page 5-1 & 5-2	The exhibits for Section V appear to require vendors to provide the same pricing guarantees to both DCS and NYSIF. Please confirm if that is the intent. In addition Section II, Subsection A.7.c (Material Deviations) gives vendors the flexibility to propose Extraneous Terms. Please advise if the State intends for Extraneous Terms to be applicable to the pricing offer (i.e., may a bidder propose different pricing guarantees for DCS than for NYSIF?).
A33		**Confirmed. Offerors are required to provide the same pricing guarantees to both DCS and NYSIF. The Procuring agencies will not amend this requirement as a result of Extraneous Terms proposed by Offerors.**

Question	Section	Question and Answer
Q34	Section V Page 5-5 & 5-6	Exhibit V.H. outlines a listing of Generic Drugs in which DCS classifies as Brand Drugs, according to Medi-Span indicators. Regarding Exhibit V.H, please confirm the following: • What is the frequency in which drugs are added or removed? • On what basis are changes made to Exhibit V.H.? • If additions or deletions occur, when will the vendor be notified of such changes? • Does the vendor have the ability to approve additions to the list? • Does the vendor have the ability to revise the guarantees if the State adds drugs during the contract term if the addition adversely affects vendor's ability to meet previously agreed upon targets?
A34		**DCS does not anticipate adding any new drugs to the list during the term of the contract. If the State does add new drugs to the list, there is no expectation that guarantees will need to be revised. However, deletions from the list may occur if the drug is subsequently deemed obsolete or is reclassified as a Generic Drug by Medi-Span. Any changes to the list will be at the sole discretion of DCS and the vendor will be notified by DCS.**
Q35	Section V Page 5-20	This provision requires the Offeror to maximize the discount achieved on behalf of the Programs for Generic Drugs dispensed by Retail and Mail Service pharmacies. In light of the requirement for the Offeror to use the same MAC List and associated pricing for reimbursing Retail and Mail Service pharmacies, can the Procuring Agencies confirm that this obligation to maximize the discounts achieved on Generic Drugs dispensed by Retail and Mail Service pharmacies applies on a combined basis?
A35		**Confirmed. The actual discounts achieved on Generic Drugs dispensed by Retail and Mail Service pharmacies will be calculated on a combined basis.**
Q36	Section V Page 5-31 Dispensing Fees	Is the intent of the cost proposal structure that all programs (Commercial, EGWP, and Workers Compensation) receive and are to be reconciled under the same set of discount and dispense fee guarantees? And that these guarantees will be static over the five year contract term?
A36		**The discount and dispensing fees proposed by the vendor selected from this RFP will apply to both the DCS and NYSIF programs; however, the reporting and calculation of the performance guarantees will be performed separately for the DCS Program (Commercial and EGWP) and for the NYSIF Program in accordance with the contracts that result from this RFP. The guarantees will be static over the five-year contract term.**

Question	Section	Question and Answer
Q37	Section V Page 5-34 Page 7-105 & 7-106	Section V, Cost Proposal, Section 11(a)(1) states, in part: "The Contractor agrees that any Program specific Pharma Revenue agreement shall derive total Pharma Revenue that meets or exceeds the Pharma Revenue derived from any other agreements the Contractor uses to administer its Book of Business for each individual drug." Section V, Cost Proposal, Section 11(a)(6), states, in part: "If the Contractor's business model allows for more than one Pharma Revenue agreement with manufacturers, the Contractor agrees that in no instance will the Programs receive less Pharma Revenue *in any therapeutic class than other clients of the Contractor with a comparable benefit design and consistent preferred drug designations in the class, provided the Programs' utilization of the drugs generating Pharma Revenue in the class is equal to or greater than those of other clients*." (emphasis added). Section VII, Agreement Provisions ("DCS Contract"), Article XIII states: "In addition, all Pharma Revenue agreements with manufacturers and other entities applicable to the Program must meet or exceed the Contractor's best existing Pharma Revenue agreements for all individual drugs ensuring that in no instance will the Program receive less Pharma Revenue in any therapeutic class than other clients of the Contractor with a comparable benefit design and consistent preferred drug designations in the class provided the Program's utilization of the drugs generating Pharma Revenue in the class is equal to or greater than those of other clients." Section VII, DCS Contract, Section 13.7.0 states, in part: "Utilize manufacturer agreements for DCS Program that meet or exceed the Contractor's best existing Pharma Revenue agreement for all individual drugs." Section VII, Contract Provisions ("NYSIF Contract"), Article XII essentially repeats the above provisions. Contractor's obligation to provide its best pharmaceutical agreement rates is appropriately tied to the Program's benefit design, preferred drug designations, and utilization in Cost Proposal, Section 11(a)(6) and Section VII, Agreement Provisions, Article XII. Benefit design, preferred drug designations, and utilization are the characteristics of a plan that are typically tied to rebate amounts received by pharmacy benefit managers from pharmaceutical manufacturers under rebate agreements. However, in Section V, Cost Proposal, Section 11(a)(1); Section VII, Contract Provisions, Sections 13.7.0; and corresponding provisions in the NYSIF Contract, it appears DCS has created ambiguity by omitting the connection of Contractor's obligation to provide its best rebate agreement pricing to the Program's benefit design, preferred drug designation, and utilization. Please confirm that Contractor's obligation to provide its best pharmaceutical agreement rates is compared to "*clients of the Contractor with a comparable benefit design and consistent preferred drug designations in the class, provided the Programs' utilization of the drugs generating Pharma Revenue in the class is equal to or greater than those of other clients*."
A37		**Confirmed.**
Q38	Section V Page 5-43	Section V.C.14.a.(1) indicates that claims payments shall be made to the vendor between two to five business days following receipt of invoice. Given the size of these payments, it is important for any vendor to have a good understanding of what to expect with regard to the timing. Please provide, over the last 12 months, the average timing of those reimbursements.
A38		**All payments over the last 12 months have been made within 5 days of receiving an invoice.**

Question	Section	Question and Answer
Q39	Section V Page 5-43 Page 7-112	V.C.14.a.6 requires payment of Pharma Revenue within 60 days. VII.15.5.0 requires payment of Pharma Revenue within 150 days. Please clarify the timing or Pharma Revenue payments.
A39		**See amended Section VII.A and VII.B – requires payment within 60 days.**
Q40	Section VI Page 6-2	The MWBE scoring guidelines mention that 10% of total points awarded (100 out of 1000 possible points) are directly related to the vendor's ability to comply with MWBE requirements and capabilities. Please clarify the scoring mechanism for the MWBE requirements, and confirm if the 100 points allocated to MWBE compliance are factored into the total 1000 points, or if the points will be added to the total 1000 points (similar to "extra credit").
A40		**The Diversity Practice Questionnaire offers an additional 100 points that will be added to an Offeror's scored Technical Proposal, resulting in a maximum score of 1,100 points. The combined Technical Proposal Score and the Diversity Practices Score will then be converted to points for each Offeror such that the Offeror with the highest technical score will receive 250 points. See amended Section VI.**
Q41	Section VII	The RFP document states that the contract will be awarded to a single vendor; Will NYSIF accept proposals specific to the Workers' Compensation PBM services from vendors who specialize in that market?
A41		**No, proposals will only be accepted from Offerors that are submitting from both programs.**
Q42	Section VII Page 7-8 & 7-12	This definition refers to Standard Version 5.1. The current industry standard is D.0. Please revise this to D.0.
A42		**See amended Section VII.A and VII.B.**
Q43	Section VII Page 7-12	1.78.0 says Pass-through Pricing means the DCS Program is charged the same Ingredient Cost and/or dispensing fee paid to the dispensing Network Pharmacy or Mail Service Pharmacy for the Generic Drug, Brand Drug, Compound Drug or vaccine dispensed. This would seem to indicate that the State wants mail claims to be charged at the PBM's actual acquisition cost (AAC). The rest of the RFP is based on having guaranteed discounts, not AAC, at Mail. Please clarify that the reference to Mail Service Pharmacy in this definition applies only if the PBM does not own the Mail Service Pharmacy and that AAC pricing for mail claims is not required if the PBM owns the Mail Service Pharmacy.
A43		**No, the State does not want mail claims to be charged at the PBM's AAC. The RFP requires Offerors to propose a discount for Brand Drugs dispensed at the Mail Service Pharmacy.**
Q44	Section VII Page 7-22	This provision requires the Offeror to offer "immediate" access to pharmacists, 24 hours a day, through the customer service call centers. Offeror will maintain pharmacists on duty during the 7am to 7pm period during which a dedicated call center team must be maintained and will maintain pharmacists on call for prompt call back to members during other times, or in the event that all pharmacists on duty are counseling other members. In the event of an actual medical emergency, Offeror's call center staff will always advise callers to contact 911 or other local emergency services. In order to ensure that a pharmacist is always available 24 hours a day with zero delay, an Offeror would need to assign a fairly high number of pharmacists to the call center, with a significant portion of them idle much of the time, creating inefficiency and adding additional overhead cost that would be a drag on the pricing terms an Offeror can provide the Procuring Agencies. Do the Procuring Agencies accept the approach Offeror describes above as compliant with the language in Section 6.5.2?

Question	Section	Question and Answer
A44		**Yes, the approach described would be compliant with the language in Section 6.5.2. The call center(s) must provide immediate access (either through warm transfers or call-back within four (4) hours) to a Pharmacist(s) 24 hours a Day – 365 Days a year. See amended Section VII.A.**
Q45	Section VII Page 7-109	This section and the pricing exhibits appear to require every claim (brand and generic, 30 day and 90 day, specialty and non-specialty) to be subject to the same Pharma Revenue guarantee. That could lead to unintended consequences. PBMs will aim to fill as many 90 day brand claims, 90 day specialty claims, and highly rebated claims (i.e. the most expensive drugs in many situations) as possible to maximize the guarantees, and fill as few generic claims as possible where no rebates are earned. To avoid this conflict of interest will the State allow rebate guarantees to be quoted on a Per Brand Claim basis, and for guarantees to be differentiated based on channel such as Retail 30, Retail 90, Mail, and Specialty?
A45		**No. One guaranteed quote is required, as requested by the RFP. Any necessary protections will be included in the contract.**
Q46	Section VIII Page 8-12 Pharma Revenue	There are a number of copay programs in the market currently in which funding by manufacturers or non-profit organizations is used to reduce the total cost of a number of drugs. These fall into two types: (1) copay assistance in which the funding is used to reduce the member's cost. These programs are typically applied at retail pharmacies. The member receives the value of the assistance through a lower copay and the plan sees no change in its cost for the claim; and (2) copay offset programs in which the funding is applied to reduce the cost of the drug to the payer. These programs are typically applied at the PBM's specialty pharmacy and result in significant savings for the plan while the member pays the regular or slightly reduced copay. We have seen cases where the value of both copay assistance programs and copay offset programs appear to be included in the Pharma Revenue calculations even though the plan sponsor derives a financial benefit only from copay offset programs and not from copay assistance programs. Please confirm that Pharma Revenue guarantees may include the value of copay assistance or offset programs only to the extent that the financial benefit of the program goes to the State and not to the member
A46		**Pharma Revenue guarantees should not include the impact of copay assistance programs or copay offset programs.**
Q47	Exhibit V.F	We offer a number of programs that some clients want and some clients think are not appropriate for their population. Are bidders required to offer a single price for each of the programs (DCS Commercial, DCS EGWP, NYSIF) that includes all services described in a bidder's proposal, or may a bidder offer a base administrative fee for services that each of the State's programs currently have and list additional fees for optional programs described in the proposal that the State may want to consider adding?
A47		**No, administrative fees should be quoted in accordance with Section IV and in the manner required by Exhibit V.F**
Q48	General	Is it possible to have the RFP for #RX-2017-1 Pharmacy Benefit Services for The Empire Plan, Excelsior Plan, Student Health Plan and New York State Insurance Fund Workers' Compensation Prescription Drug Programs in a Word version so we can respond to it?
A48		**A Word version of Section III has been added.**

Question	Section	Question and Answer
Q49	General	Can you please provide a precise total membership count by program, broken out by population (i.e. EGWP, actives)?
A49		**Commercial Plan (non-Medicare):** **Enrollees: 337,789; Dependents: 482,686; Total: 820,475** **EGWP (Medicare):** **Enrollees: 199,584; Dependents: 68,862*; Total: 268,446** ***represents the covered dependents enrolled in the EGWP.*** **Note: due to timing, the total Commercial + EGWP does not perfectly reconcile to the numbers presented in Exhibit II.B.2.**
Q50	General	Within the DCS claim file, are we to assume the Medicare Part B flag is an indicator of the member's participation in the Medicare Part D EGWP program? If not, can you please provide an indicator that can be used to identify EGWP specific claims?
A50		**Yes, within the DCS claim file, the Medicare Part B flag is an indicator of the member's participation in the Medicare Part D EGWP program.**
Q51	General	Can you provide us a summary of compound claims both at home delivery and through the retail channel (including 90-day supply)? Or is there a way to identify this on the provided data?
A51		**See new Exhibit III.K – NYSHIP Compound Claims Summary**
Q52	General	Please provide the number of calls received by the incumbent PBM call center(s) in 2016 broken out by program.
A52		**See new Exhibit II.Z – Call Statistics: Commercial and EGWP**
Q53	Section IV, Page 4-137 and Page 4-139 & 4-140	**Update August 2, 2017** In the July 17, 2017 update to Section IV – Technical Proposal Requirements, the State noted an amendment striking the two questions on Voluntary Drug Recalls, Withdrawals, and Drug Lawsuits/Settlements on Pages 139-140 of the document; however, these questions still appear on Page 137 of the document. Please confirm it was the State's intent to remove the original questions on Voluntary Drug Recalls, Withdrawals, and Drug Lawsuits/Settlements, or whether we should still respond to those two questions.
A53		**Offerors should respond to the questions that still appear on Page 4-137. The amendment made on July 17, 2017 deleted the duplicative questions on Page 4-139 & 4-140.**
Q54	Exhibit II.A	**Update August 2, 2017** Regarding the updated census file provided on July 31, 2017, please confirm that "M" in column G = Medicare members and "N" equals commercial members. "M" shows 199,026 members and "N" shows 343,834 members, with 214 rows with no value in Column G. Please provide the M/N indicators for the 214 rows with no value in Column G, or advise how we should treat them in our network access reporting.
A54		**Confirmed. In Column G, an "M" denotes Medicare members and "N" represents members who do not have Medicare (i.e., Commercial members). The 214 blank rows in the file provided on July 31, 2017, reflected members who do not have Medicare and are Young Adult Enrollees.** **See revised Exhibit II.A. The 214 formerly blank rows in the Enrollment by Zip Code & Geo Access Network Report File have been updated to reflect an "N" to indicate that they do not have Medicare and are Commercial members.**