New York State Department of Civil Service
Request for Proposals #RX-2018-1
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-2018-1, 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 June 22, 2018

Question	Section	Question and Answer
Q1	**Section I.D**	Section D (p.7) notes the allowable days' supply under the current Programs. Please confirm that the intent of the Pharma Revenue guarantee is to apply the same guarantee to all channels *regardless of the days' supply dispensed*. For example, vendors are required to apply the same guarantee whether a claim is dispensed with a 24-day supply or 84-day supply.
A1		**Confirmed.**
Q2	**Section I.F**	Please confirm Rebates cannot exclude claims, such as Limited Distribution Drug claims, claims with invalid service provider identification or prescription numbers; claims for devices without a Prescription Drug component or claims that are not for Prescription Drugs (except for insulins or diabetic test strips); claims for re-packaged NDCs; stale dated claims over 180 days old; compounds; claims from 340B, or claims from entities eligible for federal supply schedule prices (e.g., Department of Veterans Affairs, U.S. Public Health Service, Department of Defense); long term care facility claims; Medicaid Managed Care claims in states where the state law prohibits Administrator from collecting Supplemental Rebates; or for utilization pursuant to a consumer card or discount card program where the plan had no cost liability on the claim or the Prescription Claims are otherwise not eligible for Rebates under the Rebate Agreement with the applicable Drug Manufacturer.
A2		**Confirmed.**
Q3	**Section I.F**	Section F.1 notes that certain OTC's are covered by the Plan (such as insulin, smoking cessation drugs and over-the-counter preventive drugs or devices in accordance with guidelines supported by the Health Resources and Services Administration or with an "A" or "B" rating from the United States Preventive Services Task Force). However, the Definition of a "Final Paid Claim" would suggest that it only applies to "Prescription Drugs" which could allow for the exclusion of certain OTC's or non-drug devices from the minimum Pharma Revenue guarantees. Is this the Procuring Agencies' intent or is a Final Paid Claim also intended to include any non-drug claim processed under the Programs?
A3		**The intent of the Procuring Agencies is to include any OTC product or non-drug device that is covered under the Programs as a Final Paid Claim in accordance with the definition in Section VIII of the RFP.**

Question	Section	Question and Answer
Q4	**Section II.A.7.c**	Section II.A.7.c states that proposals must conform to the terms set forth in the RFP and the Procuring Agencies will not accept material deviations. Please confirm that if an Offeror submits a material deviation, in an Extraneous Term or otherwise, the Procuring Agencies will either disqualify the bidder or reject the material deviation in writing and require it to be removed from the Offeror's proposal. If the Procuring Agencies require a material deviation to be removed from an Offeror's proposal, will that Offeror be provided an opportunity to modify its proposal to conform to the impact of the removal of such term?
A4		**As stated in RFP Section II.A.7.c, a proposal must conform to the terms set forth in the RFP. In accordance with RFP Exhibit I.I, a Bidder may <u>also</u> propose an extraneous term. Such extraneous term will only be considered if it constitutes a non-material deviation from the RFP requirements. An extraneous term must meet the requirements set forth in RFP Section II.A.7.c. An extraneous term that does not comport with the requirements set forth in Section II.A.7.c shall be immediately rejected and shall not be considered by the Department.** **Submission of extraneous terms or material deviations may render the proposal non-responsive and may result in the rejection of the proposal. State Finance Law defines "responsive" as meaning the Bidder meets the minimum specifications or requirements as prescribed in a solicitation for commodities or services by a state agency. See State Finance Law §163(1)(d). This is a fact specific assessment. Refer to the second paragraph in RFP Section II.A.7.c for more detailed information regarding material deviations.** **Finally, if an extraneous term constitutes a material deviation, it shall not be considered by the Department. See opening paragraph of section II.A.7.c. If an extraneous term constitutes a material deviation and therefore not considered by the State, the Bidder shall not be provided with an opportunity to "modify" its proposal. There is no protocol in the RFP for a Bidder to "modify" its proposal after bid opening.**
Q5	**Section II.B.2**	This subsection refers to a list of jurisdictions in Article 20 of Appendix A. Please confirm that this section is intended to refer to Article 21 of Appendix A. Also, 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?
A5		**Confirmed. The list of jurisdictions is in Article 21, not Article 20. Offerors should contact NYS Department of Economic Development for a current list.**
Q6	**Section II.B.3**	Section II of the RFP states that for purposes of this solicitation, the Department hereby establishes an overall goal of 0.05 percent for MWBE participation, 0.025 percent for New York State-certified Minority-owned Business Enterprise ("MBE") participation and 0.025 percent for New York State-certified Women-owned Business Enterprise ("WBE") participation (based on the current availability of MBEs and WBEs). A separate MWBE participation goal of 0 percent has been established for the performance of the NYSIF contract. Please confirm that the MWBE goal is measured as a percent of net claims cost after copay and net of rebates and CMS subsidies and inclusive of administrative fees.

Question	Section	Question and Answer
A6		**Confirmed. MWBE goals are measured as a percent of net claims cost after copay and net of rebates and CMS subsidies and inclusive of administrative fees.**
Q7	**Section II.B.8**	Regarding the redaction process: • For the redacted electronic copies of each Proposal, Offeror understands redactions are to be marked using the Adobe "Mark for Redaction" function and should not be "Applied", thereby leaving a clear indication of requested redactions. Per Exhibit I.A, Section 6.A.2, please confirm Offerors are to combine the entirety of each proposal (Admin/Technical/Cost) into 3 separate pdf files for inclusion on the redacted CD? • For the physical copies of each Proposal, in Section II.B.8, please clarify the meaning of "marked" within the statement *"…the Offeror must provide a separately bound hardcopy of each of the three (3) Proposal documents with redactions marked that are included on the CDs."* Section II.B.8 requests that Offerors do not use the "Apply Redactions" function. Does this extend to the physical copies? Exhibit I.A, Section 6.A.1 states Offerors should provide physical copies with redacted items highlighted in yellow. We request the ability to use the Adobe "Mark for Redaction" function follow by the "Apply Redactions" function in place of the yellow highlighting.
A7		**Confirmed, Offerors should submit proposal redactions as three (3) separate .pdf files (Administrative, Technical, and Cost), with redactions marked in the manner outlined in Section II.B.8 of the RFP.** **When submitting physical copies of the Offeror's proposal with marked redactions, it is acceptable for the Offeror to use the "marked for redaction" function in lieu of yellow highlights. This method would be preferred by the Department.**
Q8	**Section III.B.5**	Are bidders required to provide only one, single Retail Pharmacy Network that covers all three components of the program (DCS Commercial, DCS EGWP, and NYSIF Workers' Compensation) and that the one network must have identical composition for all three components. We understand that New York does not allow for direction of care for Workers' Compensation programs. Would this require a separate, completely open network for the NYSIF program?
A8		**Offerors may, but are not required to, propose a single Retail Pharmacy Network that covers all three components of the program (DCS Commercial, DCS EGWP and NYSIF Workers' Compensation). Offerors must meet the minimum access guarantees specified in the RFP. All three programs will be evaluated to ensure these guarantees are met independently. NYSIF requires a broad network that does not exclude any pharmacy that is willing to accept our reimbursement rates, i.e. "Any Willing Pharmacy."**
Q9	**Section III.B.5**	The RFP notes that Offerors may not exclude chain pharmacies in their Retail Pharmacy Network. Please define chain pharmacy. Is this applicable to large, national chains only? Does this apply to local and/or regional chain pharmacies, even those with fewer than 10 stores?
A9		**The intent of the RFP requirement is that large national chain pharmacies may not be excluded. In addition, local and/or regional chain pharmacies with ten or more locations in New York State may not be excluded.**

Question	Section	Question and Answer
Q10		Please confirm the claims associated with the EGWP plan can be identified using the Medicare Indicator field and represents the following based on the detailed claims file provided: total record count of 17,375,252. Please also provide the total EGWP lives count (enrollee plus dependents) and total commercial lives count (employee plus dependents).
A10	**Section III.F**	**The Medicare Indicator field in the Department's informational claims file reports the Medicare primacy status of the person associated with the claim (Enrollee or Dependent). In most instances, claims with indicator of Y are associated with the EGWP plan; however, a small number of claims for certain Medicare primary Enrollees/Dependents may be processed as a non-EGWP claim if the Enrollee/Dependent was not enrolled timely in EGWP. Of the 17.4 million total claims included in the informational file, approximately 7.5 million are EGWP plan claims.** **Commercial Plan (non-Medicare):** **Enrollees: 340,157; Dependents: 475,782; Total: 815,939** **EGWP (Medicare):** **Enrollees: 203,533; Dependents: 70,476; Total: 274,009** ***represents the covered dependents enrolled in the EGWP** **Note: The provided enrollment counts are as of June 2018. Due to timing, the total Commercial + EGWP counts do not perfectly reconcile to the numbers presented in Exhibit II.B.2.**
Q11	**Section III.F**	Please provide guidance for breaking claims data out by individual program populations. The RFP includes benefit program codes with values listed below. Please advise how the populations can be split out using these values. Alternatively, please advise if there is an indicator in the claims file we should use to separate each of the DCS populations. **Benefit Program Code** A01, A02, A03, A04, A05, A09, A10, A11, A12, A13, A14, A15, A17, A19, A20 A21, A22, A23, A24, A25, A27, A28, A29, A33, A34, A36, A37, A39, A40, A41 A47, A48, A50, A52, A53, A60, A61, A63, A64, A65, C01, C02, C03, C04, C05 C07, C09, C13, C14, C15, C17, C20, C27, C29, C30, C31, C37, C39, C47, C48 C52, D01, D02, D03, D04, D10, D16, D17, D18, D19, E01, E02, G01, G03, G04 G05, G06, G07, G08, G09, G11, G14, G15, G16, G17, G21, G23, G24, G59, G78, G80, G84, G85, L19, M03, M04, M05, M07, M11, N00, PA7, PA9, PC7, PC9, PD7, PE7, PE9, PF7, PF9, PR7, PR9, PS7, PS9, PV7, ~, R01, R03, R05, R06, R07, R08, R09, R10, R11, R13, R16, R20, R21, R23, R25, R26, R27
A11		**See new Appendix 1: Account Structure.**

Question	Section	Question and Answer
Q12	**Section III.G.4**	Section III.G.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?
A12		**Yes, the RFP requires one MAC List. Yes, if a second MAC List is implemented, guarantees related to the second MAC List would be subject to negotiation. Yes, there is a second MAC List in place today. Currently, 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.**
Q13	**Section IV.B.4**	Would you provide a report of the total PBM call volume in 2017 for Commercial?
A13		**See Exhibit II.Z: Call Statistics in the RFP.**
Q14	**Section IV.B.4**	Would you provide a report of the total PBM call volume in 2017 for EGWP?
A14		**See Exhibit II.Z: Call Statistics in the RFP.**
Q15	**Section IV.B.4**	Would you provide a report of the total PBM call volume in 2017 for after-hours support for Commercial?
A15		**In 2017, there were 7,759 total after hour calls between the hours of 7pm-7am for the Commercial Plan.**
Q16	**Section IV.B.4**	Would you provide a report of the total PBM call volume in 2017 for after-hours support for EGWP?
A16		**In 2017, there were 9,036 total after hour calls between the hours of 7pm-7am for the EGWP Plan.**
Q17	**Section IV.B.4**	Would you provide a report of the total PBM call volume in 2017 for weekend support for Commercial?
A17		**In 2017, there were 10,120 total weekend calls for the Commercial Plan.**
Q18	**Section IV.B.4**	Would you provide a report of the total PBM call volume in 2017 for weekend support for EGWP?
A18		**In 2017, there were 17,126 total weekend calls for the EGWP Plan.**
Q19	**Section IV.B.4**	Would you provide a reporting of the total PBM warm transfer Workers Comp. total calls in 2017 from PBM to NYSIF program?
A19		**There were no warm transfers completed from the current PBM to the NYSIF program in 2017.**
Q20	**Section IV.B.4**	How many onsite or client owned pharmacies are available to SoNY employees?
A20		**There are three onsite/client-owned pharmacies available to New York State employees: the Student Health Pharmacy at SUNY Buffalo; the SUNY Stony Brook University Student Health Service Pharmacy; and, the SUNY Upstate Outpatient Pharmacy.**
Q21	**Section IV.B.4**	Are there defined timelines for open enrollment that are provided to CMS? If so, what are the dates?

Question	Section	Question and Answer
A21		**There are no defined timelines for open enrollment provided to CMS. With the exception of the Student Employee Health Plan (SEHP), NYSHIP does not have open enrollment. SEHP open enrollment periods are managed by SUNY and CUNY.** **Eligible retirees who are not enrolled in the New York State Health Insurance Program (NYSHIP) may reenroll at any point, but are subject to a three-month late enrollment period. This late enrollment period is waived for eligible retirees who experience a qualifying event.** **In addition, retirees enrolled in NYSHIP coverage may change their Empire Plan or HMO option once in a rolling 12-month period.** **More information regarding retirees' eligibility to enroll in coverage can be found in the 2018 NYSHIP Retiree General Information Book: https://www.cs.ny.gov/employee-benefits/hba/shared/publications/general-information-book/2018/ny-retiree-gib-2018.pdf.**
Q22	**Section IV.B.4**	Will the PBM be required provide technical support to members for troubleshooting access issues to the PBM portal?
A22		**Yes, the PBM is required to provide technical support to members for troubleshooting access issues to the PBM portal.**
Q23	**Section IV.B.4**	Will PBM be required to reconcile member address information for DCS for changes or differences between eligibility files in RxClaim and the member's mailing address for orders from our Home Delivery Pharmacy?
A23		**Yes. The Mail Service Pharmacy may need to make outbound calls to verify information prior to filling an order, in the event a physician-submitted order conflicts with member information. Additionally, the Offeror should have an integrated computer system that can accommodate multiple delivery addresses, so an enrollee may call Customer Care to request that the order is mailed to an alternate address (for example, if an enrollee has a permanent address in addition to a vacation home).**
Q24	**Section IV.B.4**	Regarding Patient Education of cost effective drugs, will DCS want the vendor to offer Lower Cost Alternatives (LCA) and Retail to Mail Order (RMO) programs via the call center?
A24		**No.**
Q25	**Section IV.B.5.b.8**	Is the State open to considering plan design changes in response to Question 8 or should the permitted options be limited to programs and other offerings?
A25		**No, the State is not open to considering plan design changes.**
Q26	**Section IV.B.7.a(2)**	What will be the indicator(s), flag(s) or data element(s) used and sent to the PBM from DCS' ANSI x.12 834 transaction set and NYBEAS' EGWP Enrollment Record Layout that would advise the PBM which participants on the eligibility feed meets the condition of Dual Enrollment and QMCSO?
A26		**There is not an indicator for NMSO. The process will be done manually. There is not an indicator for Dual Enrollment. Discussion around this topic will occur during implementation.**
Q27	**Section IV.B.7.a.2(g)**	Will the DCS send a flag on the eligibility file to determine which members they can attest to as living in the service area (when only a PO Box is provided), or will the DCS attest that all members sent on the file reside within the EGWP plan vendor service area?

Question	Section	Question and Answer
A27		**The format of the EGWP Eligibility file is coded to indicate which members currently reside in the EGWP service area when only a P.O. Box is provided as the place of permanent residency. Please refer to Exhibit II.G.2, NYBEAS EGWP Enrollment Record Layout – Detail File, for further information.**
Q28	**Section IV.B.7.a.2(j)(v)**	Please confirm if this requirement should actually read as "unable to POST" rather than "load". Please clarify.
A28		**Confirmed. The intent is to notify the Department if an error occurs during file transmission, preventing the Department from downloading a Feedback file properly.**
Q29	**Section IV.B.10.a(4)**	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.
A29		**Confirmed.**
Q30	**Section IV.B.10 Pharmacy Contracting**	This Section states that all Network Pharmacy contracts include a provision prohibiting the use of pharmacy manufacturer coupons that reduce or waive Enrollee Copayments. Network Pharmacy means a Pharmacy, other than those Pharmacies meeting the definition of Mail Service Pharmacy Process Facilities or a Designated Specialty Pharmacy. With the understanding that manufacturer coupons or copay card programs cannot be used at Retail, please confirm manufacturer coupons or copay card programs cannot be used at Mail or Specialty pharmacies or included in the calculation of the Pharma Revenue guarantees.
A30		**Confirmed. The DCS Program prohibits the use of manufacturer coupons at all pharmacies, including Retail, Mail and the Designated Specialty Pharmacy.** **In the event a coupon is used to reduce or waive an Enrollee copayment, the claim would only be excluded from the Pharma Revenue Guarantee if it was not considered a Final Paid Claim, as defined in Section VIII of the RFP.**
Q31	**Section IV.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?

<table>
<tr><th>Question</th><th>Section</th><th>Question and Answer</th></tr>
<tr><td>A31</td><td></td><td>The expectation is that the successful Offeror will require all third-party recipients of the State's claims data to execute an appropriate confidentiality agreement to protect the confidentiality of the claims data, including the PHI contained in the claims records. It is also expected that the successful Offeror will not unreasonably deny access to such data. DCS and NYSIF reserve the right to determine if a confidentiality agreement is appropriate, which will not be unreasonably withheld. <u>Note that while pricing data is not a listed field in Exhibit V.B or Exhibit V.B.1, the successful Offeror is required to share a larger file that contains pricing information for the claims records with the Department's or NYSIF's Decision Support System (DSS) vendor.</u> To the extent that the successful Offeror already has agreements in place with DCS' or NYSIF's third-party vendors which are acceptable to DCS and/or NYSIF, DCS and/or NYSIF will not require the execution of separate, new agreements.

Any assertions for trade secret protection or request for exemption from the NYS Freedom of Information Law must be made in accordance with RFP Section 2.B.8 and RFP Exhibit I.C. No determination regarding the trade secret protection or FOIL exemption is made within the context of the questions and answers.</td></tr>
<tr><td>Q32</td><td rowspan="2">Section IV.B.12.a(1)</td><td>Please confirm the DCS is requiring the Offeror to collect money from Enrollees who have primary Prescription drug coverage through another carrier. If so, please describe to what extent the Offeror is to pursue collection.</td></tr>
<tr><td>A32</td><td>Confirmed. The Offeror will be responsible for the collection process that will consist of:

- Identification of claims with a primary payer.
- Contact within primary payer's organization.
- Primary payer is educated on Medicare recovery rights
- Files are sent to primary payer to establish recoveries, and payment is requested.
- Payment is collected and returned to DCS.</td></tr>
<tr><td>Q33</td><td rowspan="2">Section IV.B.12</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>A33</td><td>See table below, as well as accompanying footnotes, for information available.

<table>
<tr><th></th><th>2016</th><th>2017</th><th>Total*</th></tr>
<tr><td>Members</td><td>138</td><td>158</td><td>296</td></tr>
<tr><td>Unrecovered Claims**</td><td>8,623</td><td>9,949</td><td>18,572</td></tr>
<tr><td>Recovered Claims</td><td>1,742</td><td>1,910</td><td>3,652</td></tr>
<tr><td>Invoicing***</td><td>$407,700</td><td>$917,183.15</td><td>$1,324,883.15</td></tr>
<tr><td>Recoveries</td><td>$354,500</td><td>$889,967.19</td><td>$1,244,467.19</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>Q34</td><td>Section IV.B.13</td><td>Does the Mandatory Generic Substitution Program apply to all the Flexible Formularies and the Excelsior Plan Drug List?</td></tr>
</table>

Question	Section	Question and Answer
A34		**Yes, Mandatory Generic Substitution is required under NYS Law and applies to all the Flexible Formularies and the Excelsior Plan Drug List.**
Q35	**Section IV.B.14**	The 2018 RFP eliminated references to the "New To You" program. Please confirm that the New to You program will not be in place for 2019. Also, does the State plan to make any other significant plan changes or implement any new plan design or clinical programs for 2019?
A35		**Confirmed. The New to You program has been eliminated for all enrollees, effective January 1, 2019. A significant plan change in 2019, for ratified groups, is adoption of List 2 which may expand the number of drugs that can be excluded from the Formulary. In addition, ratified groups have agreed to copay increases that are listed in Exhibit II.C. No other benefit changes are expected.**
Q36	**Section IV.B.15**	Sections 1.34.0, 1.35.0, and 6.6.1i requires that the Medicare Part D Drug List and Medicare Part D Supplemental Wrap Drug List replicates the non-Medicare- primary Empire Plan prescription drug benefit structure as closely as possible; however Section IV – 15 references that effective January 1, 2019, roughly 124,000 enrollees and dependents have collective bargaining agreements that allow for drug exclusions under a separate list (List 2). Please confirm that Offerors must submit only one Medicare Part D Drug List and Medicare Part D Supplemental Wrap Drug List that replicates either List 1 or List 2. Alternately, please confirm that offerors may propose two separate formularies for the Empire Plan Medicare Rx program, following criteria under (1) List 1 and (2) List 2.
A36		**Confirmed. Offerors should propose one Medicare Part D Drug List that follows the List 1 criteria for exclusion.**
Q37	**Section IV.B.15**	Regarding the requirements indicated in Section IV.B.15: 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?
A37		**For List 1, 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.** **For List 2, 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, can be excluded.** **Additionally, when an active ingredient of a Prescription Drug Product is available in an over-the-counter version, that Prescription Drug Product would be eligible for exclusion on List 1 and List 2 even if the over-the-counter product does not have the same indications as the prescription product.**

Question	Section	Question and Answer
Q38	**Section IV.B.15**	The RFP mentions that approximately 124,000 enrollees and dependents are currently eligible for List 2. Can those members be identified on the utilization data? If not, can the State provide a crosswalk on the census allowing for identification of the utilization for those specific members
A38		**Yes, please see Appendix 1 to this Q&A document entitled "Account Structure", which will provide the Benefit Programs that are "Ratified" and are therefore eligible for List 2. All other Benefit Programs fall under List 1. Benefit Programs are a field in the Informational Claims Data File.**
Q39	**Section IV.B.15**	Are there other groups/bargaining units that will likely be eligible for utilization of List 2?
A39		**There may be other Benefit Programs that will be added to List 2 throughout the term of the contract awarded from this procurement. Another union, United University Professions (UUP), whose employees are enrolled in Benefit Programs: A03; A53; A63; A65; C03; C53; C62; C64; D04; D14; D23; D27; D29; M02; M03; M13; and M14 have tentatively agreed to, but not yet finalized, this change, effective January 1, 2019. This decision will be accepted or rejected in a ratification vote to be announced on September 5, 2018. The Benefit Programs identified as "Ratified" in Appendix 1: Account Structure, are currently eligible for List 2.**
Q40	**Section IV.B.15**	As shown on page 4-133, "The Flexible Formularies 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." Please describe how the financial evaluation will account for generic drugs placed on Level 3, or excluded for the initial offer. Please confirm the State will require proof that these flexible formularies will provide an advantage to the plan? How is the Plan evaluating "advantageous" from a financial perspective?
A40		**The financial evaluation does not account for generic drugs placed on Level 3, or excluded in the Offeror's proposal. If during the resultant contract term, the selected Offeror (Contractor) intends to utilize a Brand for Generic strategy, the Department would require the Contractor to show the clinical rationale and the cost/benefit calculation of the net cost of brand drugs after rebates versus the discounted ingredient cost of generic drugs, and the Department would ultimately have to approve.** **Please note that Offerors must not include any cost information in the Technical Proposal.**
Q41	**Section IV.B.15**	Please provide the current Generic Dispensing Rate by list 1 and list 2. Is there any expectation of a materially change over the term of the Agreement?

Question	Section	Question and Answer
A41		**There is only one List currently in effect (List 1).** **APSU 86.5%** **CSEA 86.9%** **Council 82 85.8%** **DC-37 85.1%** **Excelsior 86.6%** **M/C 85.1%** **NYSCOPBA Correction 86.8%** **NYSCOPBA Law Enforcement 86.2%** **NYSCOPBA Law Enforcement UUP Lifeguards 94.1%** **PBA State Police Supervisors 86.4%** **PBA State Police Troopers 86.0%** **PEF 85.5%** **PIA State Police 86.6%** **Participating Agency 84.3%** **Participating Employers 84.3%** **Retirees Vestees Survivors Preferred 85.6%** **SEHP 85.5%** **UCS (CSEA) 84.7%** **UCS (DC-37) 83.3%** **UCS (Judges Justices) 82.3%** **UCS (Various Unions) 84.0%** **UUP 84.6%** **Total 85.0%**
Q42	**Section IV.B.15**	Please provide a detailed list of the current exclusions and utilization programs for both List 1 and List 2
A42		**There is only one List currently in effect (List 1). List 2 will not be in effect until 2019. See Exhibit II.I.1 of the RFP for the 2018 Flexible Formulary Drug List, with indications for drugs that have associated utilization programs (e.g., Quantity Limits, Prior Authorizations). See Exhibit II.I.3 of the RFP for the 2018 Empire Plan Excluded Drug List.**
Q43	**Section V.C.5.b(2)**	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?
A43		**Confirmed.**
Q44	**Section V.C.5.c(1)**	Exhibit V.C, Retail and Mail Service Pharmacy Generic Drugs - MAC List Costs per GPI is listed in the Cost Proposal as "Informational" however, the cost proposal also lists this Exhibit as a "required submission". Please clarify if we are to complete and provide with our submission.
A44		**Exhibit V.C is a required submission.**
Q45	**Section V.C.11**	Several claims are not eligible for rebates (i.e. vaccines, 340B, VA, discount cards, compounds, etc.). Please confirm the State requires the rebates minimums to be paid on these and other non-eligible claims.
A45		**Confirmed. The per Final Paid Claim Pharma Revenue guarantee applies to both rebatable and non-rebatable claims.**

Question	Section	Question and Answer
Q46	**Section V.C.11.c(2)**	Section V.C.11.c(2) specifies that Offerors are to provide adequate documentation to support the Pharma Revenue Guarantee quoted in Exhibit V.E.1. Could the Procuring Agencies provide a description of what the documentation requested would be expected to consist of? Please confirm that the Procuring Agencies do not desire or permit additional conditions or terms in Exhibit V.E.1 related to the Pharma Revenue Guarantee that would modify, condition or otherwise impact the valuation of the guarantee to be provided in Exhibit V.E.
A46		**Adequate documentation may include, but would not be limited to, written justification to support the guarantees quoted. For example, if the Offeror is proposing substantial year-over-year increases, the Procuring Agencies expect a comprehensive narrative in support of those increases.** **Confirmed – the Procuring Agencies do not desire and will not permit additional conditions or terms in Exhibit V.E.1 related to the Pharma Revenue Guarantee that would modify, condition or otherwise impact the valuation of the guarantee to be provided in Exhibit V.E.**
Q47	**Section V.C.14.a(1)**	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.
A47		**Generally speaking, payments are made to the vendor 4 business days following receipt of invoice.**
Q48	**Section VI.A.1.c**	For consistency in review and evaluation, please provide the State's definition for "overhead costs" in relation to M/WBE expenditures under the Diversity Practices questions. Is this specific to overhead costs in New York State only? Please also provide a definition of overhead.
A48		**The term "overhead" refers to those expenditures that are not directly related to the provision of goods or services to an Offeror's clients or customers (e.g., janitorial services, office supplies).** **These questions relate specifically to New York State certified MWBE suppliers.**

Question	Section	Question and Answer
Q49	**Section VI.C.1.a**	Drugs that are commonly classified as Specialty Drugs are generally priced and procured under different terms than non-specialty drugs due to significant variations in the competition within a given therapeutic class, lower levels of utilization, manufacturer-imposed restrictions on which pharmacies may dispense certain Specialty Drugs, and/or other characteristics and factors not typically associated with drugs not commonly considered to be Specialty Drugs. Accordingly, through inclusion or exclusion of certain drugs in its proposed Specialty Drug list, an Offeror can materially impact the overall effective Specialty Drug discount it can propose to the Procuring Agencies. Section VI.C.1.a states that the Procuring Agencies will make adjustments based on the Offeror's Specialty Drug List compared to the list currently in place with DCS. Because of the disproportionate impact of Specialty Drug spend on a pharmacy benefit program, it is very important for Offerors to understand the scoring of the Specialty Drug component of their offers. Accordingly, will the Procuring Agencies please provide a more detailed description of the calculations that will be used to evaluate Offerors' Specialty Drug Lists and compare them to other Offerors?

Question	Section	Question and Answer
A49		**The cost evaluation will include the following steps:** **1. Establish an estimate of Average Wholesale Price (AWP) and claim counts for retail, mail, and specialty prescriptions in 2019 based on the Empire Plan's actual 2017 utilization and specialty drug list.** **2. Compare each Offeror's proposed specialty drug list to the Empire Plan's actual 2017 specialty drug list.** **3. An adjustment will be made for drugs that appear on the Offeror's proposed specialty drug list, but are not on the actual Empire Plan 2017 specialty drug list. This adjustment will be made by determining the 2017 actual AWP and claim counts for these drugs, adjusting these totals for projected cost and utilization trend changes, adjusting for the location (specialty or retail) where specialty drugs are filled, subtracting them from the estimated 2019 retail and mail totals, and adding them to the estimated 2019 specialty totals.** **4. An adjustment will be made for drugs that do not appear on the Offeror's proposed specialty drug list, but are on the actual Empire Plan 2017 specialty drug list. This adjustment will be made by determining the 2017 actual AWP and claim counts for these drugs, adjusting these totals for projected cost and utilization trend changes, subtracting them from the estimated 2019 specialty totals, and adding them to the estimated 2019 retail and mail totals. An assumption of the split between retail and mail totals will be used based on the Empire Plan's aggregate 2017 experience.** **Also, please note that if Offerors do not achieve the Guaranteed Discounts for Brand Drugs and Generic Drugs dispensed to Enrollee/Claimants through the Specialty Pharmacy, they shall reimburse the Programs the difference between the Ingredient Cost the Programs were charged and the Ingredient Cost of what the Programs would have been charged if the Guaranteed Discount off aggregate AWP had been obtained. This difference, if any, will be credited to the Programs annually.**
Q50	**Section VI.C.1.a**	Given the potential impact to the cost evaluation, please explain in detail how "adjustments to the AWP and Final Paid Claim counts" are calculated, based on the listing of Specialty Drugs proposed by each Offeror.
A50		**Please see answer to Question 49.**
Q51	**Section VI.C.1.a**	Please explain in detail how "the projected distribution of the proposed Specialty Drugs at mail, retail, and the Designated Specialty Pharmacy" is calculated.
A51		**Please see answer to Question 49.**

Question	Section	Question and Answer
Q52	**Section VI.C.1.d**	Because PBMs are, historically, able to negotiate escalating rebate payments over a period of time, the value of an Offeror's Pharma Revenue Guarantee can be materially impacted by evaluator's projection of paid claim volume over time. Section VI.C.1.d states that the Procuring Agencies will normalize the Pharma Revenue Guarantee for the full period 1/1/19 through 12/31/23 based on the projected Final Paid Claim count for the 2019 Plan Year. Please (i) provide this projected Final Paid Claim count and (ii) confirm the same Final Paid Claim count will be used for all five years. If the same Final Paid Claim count will not be used for all five years, please advise what counts will be used for the latter four years.
A52		**In the cost evaluation of the RFP, a projected 2019 Final Paid Claim count of 17,747,500 will be used for the DCS Programs. A projected 2019 Final Paid Claim count of 373,247 will be used for the NYSIF program.** **As noted in Section VI.C.1.d of the RFP, the Pharma Revenue Guarantee will be calculated by multiplying the Offeror's average Pharma Revenue Guarantee quote(s) presented in Exhibit V.E for the period 1/1/2019 – 12/31/2023 times the normalized Final Paid Claim count projected for the 2019 Plan Year.**
Q53	**Section VI.C.2**	This section highlights the "normalization of specific factors among Offerors shall result in a more accurate and fair comparison of the Offeror's Cost Proposal as applied to the normalized claim base." Please provide an example of ways in which the data may be normalized to account for inconsistences between Specialty fee schedules, how Pharma revenue guarantees are calculated or how Limited Distribution Drugs are treated when certain PBM's don't have access.
A53		**The Procuring Agencies are "normalizing" the Offerors' proposals by changing the baseline AWP to account for the Offerors' unique mixes of drugs proposed in an effort to evaluate all proposals on a level playing field. As noted in A49, the Procuring Agencies will make adjustments based on drugs that appear on the Offerors' proposed specialty drug lists. Please refer to A52 for more information on how the Procuring Agencies will evaluate Pharma Revenue Guarantees.**
Q54	**Section VII 1.81.0**	1.81.0 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.

Question	Section	Question and Answer
A54		**The reference to Mail Service Pharmacy in the Pass-through Pricing definition applies only if the PBM does not own the Mail Service Pharmacy.** **Also, please note that Offerors are required to propose a Guaranteed Discount off all individual prescriptions for <u>Brand Drugs</u> dispensed to Enrollees/Claimants through the <u>Mail Service Pharmacy</u>, <u>not</u> a Guaranteed Discount off the aggregate AWP.** **<u>Lastly, please note the Offerors' Guaranteed Discount quotes for Generic Drugs dispensed at the Mail Service Pharmacy in Exhibit V.A are to be the same as their Guaranteed Discount quotes for Generic Drugs dispensed at Retail Network Pharmacies.</u>**
Q55	**Section VII 1.86.0**	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.
A55		**Pharma Revenue guarantees should not include the impact of copay assistance programs or copay offset programs.**
Q56	**Section VII 6.5.2 & 6.4.1**	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 and Section 6.4.1?
A56		**Yes, the approach described would be compliant with the language in Section 6.5.2 and Section 6.4.1. 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.**

Question	Section	Question and Answer
Q57	**Section VII 6.8.2d**	Please confirm that the date transmitted by the Department is to be utilized as the primary desired date and should be deemed a prospective enrollment if submitted as such.
A57		**The date transmitted by the Department on the EGWP eligibility file shall be used as the desired effective date of coverage. If the Offeror is unable to enroll a member with the desired effective date, the Offeror shall submit the enrollment to CMS with the earliest EGWP effective date CMS allows. The Offeror is also required to not only submit the enrollment to CMS for the member, but to also extend Commercial coverage until such point when the member is enrolled in the EGWP plan.**
Q58	**Section VII 6.15.0 & 12.7.0 – 12.8.6**	The New York State Workers' Compensation Board proposed the adoption of Part 441 of 12 NYCRR and amendment of Section 440.2 of 12 NYCRR to establish a drug formulary that includes high-quality and cost-effective preauthorized medication. The proposed formulary and related rules classify drugs as "preferred" (does not require prior authorization) or "non-preferred" (requires prior authorization), while also providing certain exemptions for "special fill" and "perioperative fill" medications (similar to California). In addition – brand name drugs with a generic available, compounds and drugs not listed on the formulary will all require prior authorization. Please confirm that Pharma Revenue guarantees may be adjusted in the event there is a significant change in the composition of the New York State Worker's Compensation formulary.
A58		**Article VIII of Section VII.B of the RFP, allows for the modification of program services in the event laws or regulations enacted by the Federal government and/or the State of New York have an impact upon the conduct of the Agreement. This Article provides a mechanism for the Contractor to request a review of the guarantees and fees.**
Q59	**Section VIII 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.
A59		**Please see answer to Question 55.**

Question	Section	Question and Answer
Q60	**Appendix D**	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 under "II. Contract Goals": For purposes of this Contract, the Department hereby establishes an overall goal of .05 percent for MWBE participation, 0.25 percent for New York State-certified minority- owned business enterprise ("MBE") participation and 0.25 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. Because the vast majority of the value of this contract will flow through retail pharmacies, the selection of which is controlled by the plan members, not the Offeror, please confirm that the goal is 0.025 percent for New York State-certified minority- owned business enterprise ("MBE") participation and 0.025 percent for New York State certified women-owned business enterprise ("WBE") participation, and not 0.25 percent.
A60		**The MWBE participation goal for this solicitation is 0.025 percent for Minority-owned Business Enterprise ("MBE") and 0.025 percent for Women-owned Business Enterprise ("WBE"), respectively. The overall MWBE participation goal is 0.05 percent.**
Q61	**Exhibit V.E**	Exhibit V.E Pharm Revenue Guarantee Quote allows for only 1 entry to list a blended minimum rebate guarantee for all prescriptions. Without a clear understanding of the membership that will be eligible for List 1 versus List 2 throughout the 5-year contract term, will the State provide for separate List 1 and List 2 all prescription minimum rebate guarantees?
A61		**Offerors must list a single blended minimum rebate guarantee for all prescriptions.**
Q62	**General**	Can the State please provide excel versions of all PDF formularies?
A62		**Excel versions of the Formularies have been added to the RFP website.**