

# New York State Department of Civil Service & New York State Insurance Fund Workers' Compensation Cost Proposal MAY 2012

Section I Cost Proposal Requirements

Section II Exhibit V Items

- Tab 1 Exhibit V.A Proposed Claim Reimbursement Quote
- Tab 2 Exhibit V.B Re-Pricing Instructions for Offerer's Re-Priced Claims File
- Tab 3 Exhibit V.B.1 File Layout Specifications for Offerer's Re-Priced Claims File
- Tab 4 Exhibit V.B.2 Offerer's Re-Priced Claims File
- Tab 5 Exhibit V.C Retail and Mail Service Generic Drugs – MAC List Costs per GPI
- Tab 6 Exhibit V.D Specialty Pharmacy Program Dispensing Fee
- Tab 7 Exhibit V.E Pharma Revenue Guarantee Quote
- Tab 8 Exhibit V.E.1 Documentation to Support Pharma Revenue Guarantee Quote
- Tab 9 Exhibit V.F Claims Administration Fee(s) Quote

Section III Additional Requested Exhibits

- Tab 1 Mail Service Pharmacy Process – House Generics



## SECTION V: COST PROPOSAL REQUIREMENTS

### A. INTRODUCTION

The purpose of this section of the RFP is to set forth the duties and responsibilities required of the Offeror as regards to its cost quotes and to pose questions (i.e., the information and documentation required under the Confirmations and Required Submissions sections) concerning those duties and responsibilities. The Offeror's Cost Proposal must contain responses to all questions in the format requested, as well as, the cost exhibits required in Section C.1., below. The Cost Proposal evaluation will analyze the relative impact of each Offeror's Cost Proposal on the Programs' claims costs and administration costs and net savings that will result for the Offeror's Pharma Revenue Guarantee. Each Offeror may submit ONLY ONE Cost Proposal. Each Cost Proposal will be evaluated with the following goal in mind: the lowest possible total combined Program cost over the term of the Agreements resulting from this RFP while meeting Program clinical requirements, Pharmacy access requirements, and service standards.

### B. EVALUATION PROCESS – GENERAL

The evaluation of Cost Proposals will be conducted by applying each Offeror's cost quotes to normalized claim data. In particular, the evaluation will involve the following:

1. Analysis of the impact of proposed Guaranteed Discounts and dispensing fees, and the Offeror's per final paid claim Pharma Revenue Guarantee on combined Program claim costs; and
2. Analysis of the impact of the Offeror's proposed Claims Administration Fees for administering the Programs.

### C. ANALYSIS OF COST COMPONENTS

#### 1. Summary of Cost Exhibits

The Offeror must complete the following cost exhibits in strict accordance with the directions set forth in this RFP and submit them as part of their Cost Proposal:

|               |   |
|---------------|---|
| Exhibit V.A.  | Offeror's Proposed Claim Reimbursement Quotes   |
| Exhibit V.B.  | Re-pricing Instructions for Exhibit V.B.2 entitled "Offeror's Re-Priced Claims Files" to be submitted in Support of the Offeror's Proposed Claim Reimbursement Quotes |
| Exhibit V.B.1 | Layout Specifications for Exhibit V.B.2 entitled "Offeror's Re-Priced Claims Files to be submitted in Support of the Offeror's Proposed Claim Reimbursement Quotes    |
| Exhibit V.B.2 | Offeror's Re-priced Claims Files  |
| Exhibit V.C.  | Retail and Mail Service Generic Drugs – MAC List Costs Per GPI (for Offerors proposing to use Medi-Span as the claims adjudication platform)                          |
| Exhibit V.C.1 | Retail and Mail Service Generic Drugs – MAC List Costs Per GCN (for Offerors proposing to use First Data Bank as the claims adjudication platform)                    |
| Exhibit V.D.  | Specialty Pharmacy Program Dispensing Fee   |
| Exhibit V.E.  | Pharma Revenue Guarantee Quote  |
| Exhibit V.E.1 | Documentation to Support Pharma Revenue Guarantee Quote   |
| Exhibit V.F.  | Claims Administration Fees Quote  |



CVS Caremark confirms. The above exhibits are located in the sections noted below.

|               |                   |
|---------------|-------------------|
| Exhibit V.A   | Section II, Tab 1 |
| Exhibit V.B   | Section II, Tab 2 |
| Exhibit V.B.1 | Section II, Tab 3 |
| Exhibit V.B.2 | Section II, Tab 4 |
| Exhibit V.C   | Section II, Tab 5 |
| Exhibit V.C.1 | (Not applicable)  |
| Exhibit V.D   | Section II, Tab 6 |
| Exhibit V.E   | Section II, Tab 7 |
| Exhibit V.E.1 | Section II, Tab 8 |
| Exhibit V.F   | Section II, Tab 9 |

## 2. Instructions for Submitting Offeror's Re-priced Claims Files: Exhibit V.B.2

It has been the Procuring Agencies' experience that the submission of Exhibit V.B.2, Offeror's Re-Priced Claims Files, has presented difficulties for some Offerors. The Procuring Agencies will make every effort to assist Prospective Offerors in resolving issues in advance of the submission of an Offeror's actual Cost Proposal. To assure an accurate interpretation of the requirements for completing Exhibit V.B.2, the Department strongly recommends Prospective Offerors take advantage of the opportunity to submit a Re-Priced Claims Test File with sample data as referenced in Section III.G. of this RFP. (Note: Do not include actual cost data in the Re-Priced Claims Test File).

In support of the Offeror's proposed claim reimbursement quotes, Offerors are required to provide their Re-priced Claim Files, Exhibit V.B.2 in strict accordance with the Re-pricing Instructions and Layout Specifications found in Exhibits V.B and V.B.1 of this RFP.

For use in preparing Exhibit V.B.2, the Department has produced a Claims Data File containing claims paid for the period 11/12/10 – 10/28/11 for the DCS Programs for Prospective Offerors that can be obtained by following the instructions and meeting the requirements specified in Section III.G. of this RFP. The NYSIF Program claims data is for informational purposes only and will not be used in the Repricing Exercise. The Procuring Agencies make no guarantee that any Offeror will be granted an opportunity to submit a corrected Exhibit V.B.2 after the Proposal Due Date in Section II.A. of this RFP and encourages Offerors to take all steps necessary to provide accurate data in its Proposal. In addition, the Procuring Agencies reserve the right to reject any or all Proposals in which Exhibit V.B.2 is not submitted in accordance with the instructions in Exhibit V.B. and V.B.1.

Please see Section II, Tab 4 for the completed Exhibit V.B.2.

## 3. Claim Ingredient Cost – General

The Procuring Agencies require full transparency of claim ingredient costs in the Retail Pharmacy Network. The Offeror is required to propose an overall Guaranteed Minimum Discount off the aggregate AWP of all Brand Drugs dispensed through the Retail Pharmacy Network. The Offeror is required to propose overall Guaranteed Minimum Discounts off the aggregate AWP of all Generic Drugs dispensed through the Retail Pharmacy Network and Mail Service Pharmacy Process. In addition, the Offeror is required to propose a



Guaranteed Discount off Brand Drugs dispensed to Enrollees/Claimants through the Mail Service Pharmacy Process and a Guaranteed Discount off Specialty Drugs/Medications dispensed to Enrollees/Claimants through the Specialty Pharmacy Program. The Offeror must also propose a pricing methodology for Compound Drugs dispensed to Enrollees/Claimants that will be utilized for both retail claims and Mail Service Pharmacy Process claims. This section sets forth the Program requirements related to those guarantees.

#### A. DUTIES AND RESPONSIBILITIES – CLAIM INGREDIENT COST - GENERAL

- (1) All proposed discounts and dispensing fees for Brand and Generic Drugs must be guaranteed for the entire term of the Agreements without qualification or condition. In addition, the selected Offeror's proposed Compound Drug pricing methodology must be guaranteed for the entire term of the Agreements without qualification or condition.
- (2) All proposed discounts and dispensing fees for Specialty Drugs/Medications apply only to Enrollees/Claimants who participate in and have drugs dispensed through the Specialty Pharmacy Program and must be guaranteed for the entire term of the Agreements without qualification or condition.
- (3) The Contractor shall utilize the Medi-Span field coded R028 entitled "AWP unit price" or Red Book as the source of Average Wholesale Price (AWP) information for purposes of calculating Ingredient Cost.
- (4) During the term of the Agreements, in the event the national reporting service, as identified by the Contractor in its Proposal, changes its methodology related to any of the information fields used in the Procuring Agencies' classification of Brand and Generic Drugs, or its methodology for coding drugs in connection with these information fields, the Contractor shall be obligated to inform the Procuring Agencies in writing of such changes within 30 Days of learning of such changes. Upon written notification, the Contractor and the Procuring Agencies will meet and agree in writing to any Brand and/or Generic Drug classification changes that may be necessary to enable each to maintain the same economic position and obligations as are set forth in the Agreements.
- (5) If, during the term of the Agreements, industry events have caused the Contractor's source of AWP to become obsolete or no longer available, the Procuring Agencies and the Contractor shall agree on revised pricing terms. In no event shall the Programs' actual costs for drugs increase as the result of new pricing terms. The Contractor shall notify the Procuring Agencies in writing as soon as any information indicating a problem with the future use of the Contractor's AWP source is received. Within two weeks of the initial notification, the Contractor shall submit a detailed written proposal to the Procuring Agencies for effectively revising pricing terms including but not limited to a file containing the Contractor's pricing for all drugs dispensed during the prior six months utilizing the current AWP source and the Contractor's revised pricing for such drugs using the proposed methodology. The Contractor's Proposal should ensure continued alignment of the Contractor's interests with those of the Programs.
- (6) To protect Enrollees/Claimants from disruption due to reclassification of drugs, during the term of the Agreements, and to assure that Offeror's Proposals are evaluated consistently, drugs shall be classified for pricing purposes in accordance with current Program Brand /Generic Drug classifications and in accordance with the definitions in the Contract Provisions, Section VII, (see Article I, entitled "Definition of Terms") of this RFP.



- (7) Offerors ~~must use the Programs current Brand/Generic classification methodology which is based on a particular set of not capable of utilizing Medi-Span indicators to determine Brand /Generic classification of drugs, for example Offerors utilizing First Data Bank or Red Book indicators, must submit for Procuring Agency review and written approval an alternative automated or manual process intended to replicate the results of the Programs' methodology for determining the Brand /Generic classification of drugs dispensed to Program Enrollees/Claimants. To assist such Offerors, the Procuring Agencies have created Exhibit III.G to provide~~ presents a listing of the NDC's dispensed to Enrollees/Claimants in 2011 and the required brand name/generic drug classification assigned to each NDC.

The following methodologies shall be used by Offerors and will be used by the Procuring Agencies in their evaluation of Offerors' Proposals to determine the appropriate Brand /Generic Drug classification so as to comply with the contractual definitions set forth in the Contract Provisions, Sections VII.A. and VII.B. (see Articles I, entitled "Definition of Terms") of this RFP.

(a) Brand Name Drug Determination Methodology

A drug labeled with the identifier "M" or "O" in the Medi-Span Multi-Source code shall be processed as a Brand Drug unless the same drug is identified as "G" in the Medi-Span Brand-Name code. In addition to drugs identified as "M" or "O" in the Medi-Span Multi-Source code, a drug that is identified as "N" in the Medi-Span Multi-Source code shall be designated a Brand Drug if the drug is identified as "T" in the Medi-Span Brand- Name code.

(b) Generic Drug Determination Methodology

A drug identified as "Y" in the Medi-Span Multi-Source code shall be designated as a Generic Drug. In addition to drugs identified as "Y" in the Medi-Span Multi-Source code, a drug identified as "N" in the Medi-Span Multi-Source Code shall be designated as a Generic Drug if the corresponding Medi-Span Brand-Name code for such drug is "B" or "G."

In addition, a drug identified as "G" in the Medi-Span Brand-Name Code shall be designated as a Generic Drug, regardless of the identifier designated in the Medi-Span Multi-Source code. As stated in the definition, as set forth in the Contract Provisions, Sections VII.A. and VII.B., (see Articles I, entitled "Definition of Terms") of this RFP, no drug approved through an FDA Generic Drug approval process, including any FDA approval process established for approving generic equivalents of biologic drugs, shall be processed as a Brand Drug regardless of the assigned Medi-Span indicators or the result of the Offeror/Contractor's proposed methodology for determining the appropriate classification of a drug.

Offerors not capable of utilizing Medi-Span to determine Brand /Generic classification of drugs, for example Offerors utilizing First Data Bank or Red Book indicators must submit for Procuring Agency review and written approval an alternative automated or manual process intended to replicate the results of the Programs' methodology for determining the Brand /Generic classification of drugs dispensed to Program Enrollees/Claimants.

(c) Compound Drug Determination Methodology

A Compound Drug is a drug with two or more ingredients (solid, semi-solid or liquid), where the primary active ingredient is an FDA approved covered drug with a valid NDC requiring a Prescription for dispensing, combined together in a method specified in a Prescription issued by a medical professional.



The end result of this combination must be a Prescription medication for a specific patient that is not otherwise commercially available in that form or dose/strength from a single manufacturer. The Prescription must identify the multiple ingredients in the Compound, including active ingredient(s), diluent(s), ratios or amounts of product, therapeutic use and directions for use. The act of compounding must be performed or supervised by a licensed Pharmacist. Any commercially available product with a unique assigned NDC requiring reconstitution or mixing according to the FDA approved package insert prior to dispensing will not be considered a Compound Prescription by the Programs.

- (8) The selected Offeror shall be required to submit a file containing the NDC's dispensed to Enrollees/Claimants in 2011 and the resulting brand/generic classification of each NDC derived from application of the contractor's electronic classification process. If, at that time, the Procuring Agencies determine that the selected Offeror's proposed classification methodology does not replicate the results of the Programs' methodology for determining the brand name/generic classification of drugs, the selected Offeror must modify its classification methodology to replicate the results of the Programs' methodology, either automatically through the claims adjudication system or through an annual claims reconciliation process. The Procuring Agencies determination shall be final.
- (9) The Programs' Lesser of Logic, as defined in Section VIII (Glossary of Terms), shall apply to all claims processed under the Programs.

#### **B. CONFIRMATION – CLAIM INGREDIENT COST - GENERAL**

- (1) Offerors must confirm their agreement to perform/fulfill and comply with the Duties and Responsibilities contained within "Claim Ingredient Cost - General" section above including, but not limited to:
  - (a) The guarantee that all discounts and dispensing fees shall remain in effect during the entire term of the Agreements, without qualification or condition;  
  
CVS Caremark confirms.
  - (b) Pricing for Specialty Drugs/Medications, shall apply only to Enrollees/Claimants who participate in and fill a prescription through the Specialty Pharmacy Program. Specialty Drugs/Medications for all other Enrollees/Claimants and/or claims shall be priced using the Offeror's proposed pricing for retail and mail service drugs;  
  
CVS Caremark confirms.
  - (c) AWP will be determined by Medi-Span utilizing the field coded R028 entitled "AWP unit price" or by Red Book, as proposed by the Offeror;  
  
CVS Caremark confirms.



- (d) Confirmation that if the Procuring Agencies determine that industry events have caused the Contractor's proposed source of AWP to become inflated against new industry standards, obsolete, or unavailable, the Contractor agrees to negotiate revised pricing terms ensuring that the Programs' actual costs for drugs in no event increase as the result of new pricing terms, in accordance with Section V.C.3.a.(5) above.

CVS Caremark confirms.

- (e) Drugs will be classified as brand name, generic, or compound consistent with Section V.C.3.a.(7) above;

CVS Caremark confirms.

For the EGWP, brand name, generic, or compound drugs will be defined in accordance with CMS regulations and guidance.

- (f) Prescriptions shall be processed consistent with the Programs' classification of drugs on an NDC basis. Confirmation that, if selected, the Offeror agrees to submit a file containing the NDC's dispensed to Enrollees/Claimants in 2011 and the resulting brand/generic classification of each NDC utilizing the Offeror's proposed methodology for determining the brand name/generic classification of drugs. Confirmation that, if the Procuring Agencies determine that the Offeror's proposed classification methodology does not replicate the results of the Programs' methodology for determining the brand name/generic classification of drugs, the Offeror shall agree to modify its classification methodology to replicate the results of the Programs' methodology either automatically through the claims adjudication system or through an annual claims reconciliation process; and

CVS Caremark confirms.

For the EGWP, brand name, generic, or compound drugs will be defined in accordance with CMS regulations and guidance and process as such.

- (g) Applying the Programs' Lesser of Logic to all claims.

CVS Caremark confirms.

#### C. REQUIRED SUBMISSION – CLAIM INGREDIENT COST – GENERAL

- (1) The Offeror is required to specify whether they are utilizing the Medi-Span field coded R028 entitled "AWP unit price" or Red Book as the source of AWP information for calculating Ingredient Cost.

CVS Caremark currently utilizes Medi-Span field coded R028 entitled "AWP unit price" as the source of AWP information for calculating ingredient cost.

#### 4. MANDATORY GENERIC SUBSTITUTION AT RETAIL AND MAIL



Encouraging utilization of cost-effective clinically equivalent Generic Drugs is an integral component of the Programs' benefit design. To promote the use of Generic Drugs, the Programs have a mandatory generic substitution requirement that mandates that FDA approved A-rated Generic Drugs and authorized Generic Drugs be substituted for equivalent Brand Drugs or the Enrollee/Claimant pays the applicable Level 3 Drug Copayment plus an "Ancillary Charge." Under the NYSIF Program, there are no Copayments or Ancillary Charges collected from the Enrollee/Claimant. The Offeror must apply this requirement on a consistent basis at the retail network pharmacies and through the Mail Service Pharmacy Process.

#### A. DUTIES AND RESPONSIBILITIES

To ensure strict adherence to the Programs' Mandatory Generic Substitution Requirement and protect the financial interests of the Programs, the Contractor shall be required to:

- (1) Apply mandatory generic substitution to all specific NDC's of Brand Drugs for which there is an FDA approved A-rated Generic Drug (including but not limited to, Generic Drugs rated AA, AB, AN, AO, AT, etc) or an authorized Generic Drug as permissible by NYS law. Retail network pharmacies shall comply with all state laws related to mandatory generic substitution. The Programs' mandatory generic substitution provisions shall apply to any claim where the A-rated or authorized Generic Drug is required or permitted to be substituted under state law. Mandatory generic substitution provisions will not apply to B-rated or unrated Generic Drugs or in the unlikely event that state law prohibits dispensing of the A-rated or authorized Generic Drug.
- (2) (Exclusive to DCS) Establish the Ancillary Charge by calculating the difference in the Discounted Ingredient Cost of the Brand Drug and the Discounted Ingredient Cost of the equivalent A-rated Generic Drug or authorized Generic Drug based on the Programs' MAC List price assigned when a Brand Drug for which an A-rated or authorized Generic Drug has been introduced in the market is dispensed to the Enrollee. In such cases, the Enrollee shall be responsible for paying the applicable Level 3 Drug Copayment plus Ancillary Charge not to exceed the cost of the drug to the DCS Program. The Ancillary Charge shall be assessed even in the event a doctor has specifically directed a Pharmacist to dispense the Brand Drug rather than the A-rated or authorized Generic Drug through DAW notation.
- (3) Monitor the pharmaceutical industry on behalf of the Procuring Agencies to identify Generic Drugs expected to enter the market. Prior to the actual introduction of the Generic Drug to market, the Contractor shall inform the Procuring Agencies of anticipated shipping dates of the first generic introduced into the market for one or more strengths of a particular Brand Drug.
- (4) (Exclusive to DCS) Following the first shipment of a first Generic Drug for one or more strengths of a particular Brand Drug, the Contractor shall be required to:
  - (a) Inform the Department as soon as practicable but in no event later than fourteen (14) Days after the first date of shipment, (from manufacturer to wholesaler or retailer) of the financial impact of enforcing mandatory generic substitution via the "MAC Alert Notice" detailed in Section IV of this RFP under "Reporting";
  - (b) For those drugs that will result in a lower net cost to the Programs by enforcing mandatory generic substitution, the Contractor shall provide the "MAC Alert Notice" as described in (a) above. The Contractor shall add the GPI/GCN to the Programs' MAC List and begin enforcement as soon as practicable but in no event later than fourteen (14) Days after the first date of shipment provided that the participating retail network pharmacies are able to obtain the Generic Drug;





- (c) For those drugs that could potentially result in a higher net cost to the Programs by enforcing mandatory generic substitution, the Contractor shall provide the "MAC Alert Notice" as described in (a) above. The Contractor shall also notify the Department whether the drug should be included in the Brand for Generic strategy. The Department, in its sole discretion, may determine that enforcement is contrary to the best financial interests of the Programs and shall inform the Contractor whether Mandatory Substitution shall be applied. If the Contractor does not receive a formal response to the information provided via the "MAC Alert Notice," enforcement shall commence and the GPI/GCN shall be added to the Programs' MAC List effective on the 21<sup>st</sup> day after shipment of the first A-rated generic equivalent drug or authorized Generic Drug provided that the pharmacies are able to obtain the Generic Drug. In the event the Department decides to exercise its discretion not to enforce mandatory generic substitution, the Contractor shall apply MAC pricing to the Generic Drug when dispensed;
- (d) To assist the Department in determining whether or not mandatory generic substitution should be enforced within 21 Days, the Contractor shall survey its Retail Pharmacy Network to identify the pharmacies that are unable to obtain the new Generic Drug within 21 Days. The Contractor shall submit this information to the Department and provide any additional information as required by the Department to reach a determination. The DCS, in its sole discretion, shall determine based on such evidence how the Programs' mandatory generic substitution provisions will be applied. The Programs will not consider and the Contractor shall not act on availability information provided by 3<sup>rd</sup> party sources, including but not limited to Medi-Span, Red Book and First Data Bank;
- (e) For preferred Brand Drugs for which an A-rated or authorized Generic Drug has been introduced into the market for one or more strengths of a Brand Drug, the status of the Brand Drug shall be changed from preferred to Non-Preferred status concurrent with the commencement of the enforcement of mandatory generic substitution. Enrollees prescribed strengths of the Preferred Brand Drug for which an A-rated or authorized Generic Drug has been introduced shall receive the Generic Drug and be charged the Level 1 Copayment. If the prescribing Physician requires that the Brand Drug be dispensed, the Enrollee will be charged the applicable Level 3 Drug Copayment and Ancillary Charge. Enrollees prescribed strengths of the preferred Brand Drug for which no A-rated or authorized Generic Drug has been introduced shall continue to receive the prescribed drug at the applicable Level 2 Copayment and mandatory generic substitution provisions shall not apply;
- (f) For Non-Preferred Brand Drugs for which an A-rated or authorized Generic Drug has been introduced into the market for one or more strengths of a Brand Drug, the status of the Brand Drug shall remain Non-Preferred for all strengths. Concurrent with enforcement of mandatory generic substitution, Enrollees prescribed strengths of the Non-Preferred Brand Drug for which an A-rated or authorized Generic Drug has been introduced shall receive the Generic Drug and be charged the Level 1 Copayment. If the prescribing Physician requires that the Brand Drug be dispensed, the Enrollee will be charged the applicable Level 3 Drug Copayment and Ancillary Charge. Enrollees prescribed strengths of the Non-Preferred Brand Drug for which no A-rated or authorized Generic Drug has been introduced shall continue to receive the prescribed drug at the applicable Level 3 Drug Copayment and mandatory generic substitution provisions shall not apply;
- (g) The Contractor shall cause the dispensing Network Pharmacy to inform the Enrollee prior to dispensing the Brand Drug, that an Ancillary Charge would be applied in addition to the applicable Level 3 Drug Copayment. If the prescribing Physician requires the Brand Drug be dispensed, the Contractor shall cause the dispensing Network Pharmacy to collect the applicable Level 3 Drug Copayment plus the calculated Ancillary Charge. However, under no circumstances shall the



Enrollee's total cost exceed what the actual cost of the Brand Drug would have been to the DCS Program after application of the Programs' Lesser of Logic provisions;

- (5) Charge the Programs based on the Programs' MAC List price assigned to the GPI/GCN of the dispensed Brand Drug plus the applicable dispensing fee as set forth in "Programs' Claims Reimbursement" of the Contract Provisions, Sections VII.A and VII.B of this RFP;
- (6) Receive written approval from the Procuring Agencies for any and all exceptions to the Programs' mandatory substitution provisions, beyond the approval of specific generic appeals. Following commencement of mandatory generic substitution, the Contractor must receive Procuring Agencies' written approval prior to suspending enforcement of the Programs' mandatory generic substitution provisions; and
- (7) Maintain an electronic claims processing system capable of obtaining information from Network Pharmacies to ensure consistent enforcement of the Programs' mandatory generic substitution provisions. In particular, the claims processing system must be capable of capturing information concerning the availability of the Generic Drug at the Network Pharmacy submitting the electronic claim. If a Generic Drug is available to be dispensed by the Network Pharmacy, the Programs' mandatory generic substitution rules shall be applied. If the Network Pharmacy does not have the A-rated or authorized Generic Drug in stock, mandatory generic substitution provisions will not apply and the Enrollee/Claimant shall receive the Brand Drug, be charged the applicable Generic Drug Copayment and the Plan charged based on Generic Drug pricing. Currently, the Programs reject, with appropriate messaging, claims for Brand Drugs subject to mandatory generic substitution that are submitted with a DAW 0-code and require resubmission of the claim (since a DAW 0-code provides no indication of Generic Drug availability in the Network Pharmacy). Similar rules can be applied to other DAW submission codes as necessary to ensure consistent, accurate application of the Programs' mandatory generic substitution requirements.

## **B. CONFIRMATION - MANDATORY GENERIC SUBSTITUTION AT RETAIL AND MAIL**

Confirm the Offeror's agreement to perform/fulfill and comply with the Duties and Responsibilities contained within "Mandatory Generic Substitution at Retail and Mail" section above.

CVS Caremark confirms.

For the EGWP, a mandatory generics program is not allowed for a Medicare Part D program per CMS guidance.

## **5. RETAIL PHARMACY NETWORK CLAIMS**

The cost of all Covered Drugs dispensed at network pharmacies shall be charged to the Programs consistent with the requirements set forth in this RFP, including but not limited to the Lesser of Logic set forth in Section V.C.3.a.(9) above and Pass-through Pricing.

### **General Provisions**

The following general provisions apply to all claims submitted by Retail Pharmacy Networks:



**A. DUTIES AND RESPONSIBILITIES - RETAIL PHARMACY NETWORK CLAIMS - GENERAL**

- (1) The Contractor shall ensure that the Network Pharmacy collects the appropriate Copayment specified in Exhibit II.C (plus Ancillary Charge, if applicable) from the Enrollee/Claimant and will charge the Programs the Discounted Ingredient Cost as determined through the application of the Lesser of Logic detailed in Section V.C.3.a.(9) above plus the Contractor's applicable pharmacy contracted dispensing fee minus the applicable Copayment for all drugs dispensed through a Network Pharmacy.
- (2) (Exclusive to DCS) If the current Discounted Ingredient Cost plus the dispensing fee or the submitted cost is less than the applicable Copayment, then the Contractor shall ensure that the Network Pharmacy charges the Enrollee the lesser amount.
- (3) The Contractor shall implement a control process at point of service intended to protect the Programs from any inflated AWP costs associated with "repackaged" drugs charged to the Programs.

**B. CONFIRMATION – RETAIL PHARMACY NETWORK CLAIMS - GENERAL**

Confirm the Offeror's agreement to perform/fulfill and comply with the Duties and Responsibilities in Section V.C.5. of this RFP, under subheading "General Provisions."

CVS Caremark confirms.

**C. REQUIRED SUBMISSION – RETAIL PHARMACY NETWORK CLAIMS - GENERAL**

- (1) The Offeror is required to provide the Offeror's Re-priced Claim Files, Exhibit V.B.2 in strict accordance with the Re-Pricing Instructions and Layout Specifications found in Exhibits V.B and V.B.1 of this RFP.

CVS Caremark confirms. Please see Section II, Tab 4 for the completed Exhibit V.B.2.

- (2) The Offeror is required to describe the process it proposes to utilize to ensure that the Programs' financial interests are protected from any inflated AWP costs associated with "repackaged" drugs charged to the Program.

The package size basis for retail prescriptions is the AWP of the submitted NDC. CVS Caremark does not repack drugs at retail and is offering actual package size at mail.



## Retail Pharmacy Network Brand Name Drug Pricing

### A. DUTIES AND RESPONSIBILITIES – BRAND NAME DRUG PRICING

- (1) The Contractor shall charge the Program utilizing Pass-through Pricing for all Brand Name Drugs dispensed to Enrollees/Claimants through the Network Pharmacies. The Contractor's pharmacy contracted discount off of AWP and pharmacy contracted dispensing fee(s) for Brand Drugs shall be applicable to all individual Prescriptions for Brand Drugs dispensed to Enrollees/Claimants from a Network Pharmacy.
- (2) Guarantee an overall minimum discount off of the aggregate AWP for all Brand Drugs dispensed at Retail Network Pharmacies as defined in the RFP. The Contractor shall guarantee the Programs that its management of Brand Drug costs dispensed by pharmacies shall result in each Program achieving the Contractor's overall Guaranteed Minimum Discounts during each Program Year as proposed by the Contractor in its Proposal. The discounts achieved off of the aggregate AWP for all Brand Drugs as a result of Pass-through Pricing will be calculated utilizing the following formula:  $1 \text{ minus } (\text{Sum of Ingredient Costs of dispensed Brand Drugs divided by sum of AWP of dispensed Brand Drugs})$ . The aggregate discount calculation will be based on Pharmacy Prescriptions filled with a Brand Drug where the Program was the primary payer (including Enrollee submitted claims for the DCS Program). Claims submitted for secondary payer consideration, Compound Drug claims, NYSIF Program non-network claims and claims submitted by governmental entities must be excluded from the aggregate discount calculation. In addition, claims with a calculated AWP discount greater than 50% will be excluded pending receipt of supporting documentation by the Offeror and verification by the Procuring Agencies as to the validity of the calculated discount; and
- (3) If the overall aggregate discounts obtained, as calculated utilizing the formula set forth in the prior paragraph, are less than the Guaranteed Minimum Discounts proposed, the Contractor shall reimburse each Program the difference between the Ingredient Cost each Program was charged utilizing Pass-through Pricing and the Ingredient Cost the Programs would have been charged if the Guaranteed Minimum Discount off of the aggregate AWP had been obtained. The Programs will be credited annually for this difference in Ingredient Cost. The Programs shall retain the benefit of any cost savings, in excess of the Contractor's Guaranteed Minimum Discounts off the aggregate AWP for all Brand Drugs dispensed by pharmacies.

This calculation shall be performed for each Program Year based on claims paid for each incurred year. Specifically, the Contractor shall perform a reconciliation to include claims incurred in each Program Year and paid through June of the following Program Year. The reconciliation shall be submitted to the Procuring Agencies on July 31<sup>st</sup>. If the Procuring Agencies' review of the Contractor's calculations indicates an adjustment to the calculation is required, then the Procuring Agencies reserve the right in their sole discretion to make an adjustment to the Contractor's calculations. The calculations must be completed by July 1<sup>st</sup> of the following year. Upon approval by the Procuring Agency, the Contractor shall pay/credit each Program the applicable amount, if any, within 30 (thirty) Days following the February 15<sup>th</sup> calculations. If the Procuring Agencies' review of the Contractor's calculations indicates an adjustment to the calculation is required, then the Procuring Agencies reserve the right in their sole discretion to make an adjustment to the Contractor's calculations. The Contractor shall also reflect the adjustments, if any, in the Offeror's Annual Financial Summary Report. ~~On July 31<sup>st</sup> following each Program Year, the Contractor shall perform a reconciliation to include claims incurred in each Program Year and paid through June of the following Program Year. Based on this reconciliation, the Procuring Agencies shall receive an adjustment, if necessary, within 30 Days following the date of the reconciliation and the adjustment shall be included in the following year's Annual Financial Summary~~



~~Report.~~ The Programs shall retain the benefit of any cost savings, in excess of the Contractor's Guaranteed Minimum Discount off the aggregate AWP set forth in duties and responsibilities of Section V.C.5 entitled "Retail Pharmacy Network Claims." Any shortfall in the Guaranteed Minimum Discount set forth in Section V.C.5. cannot be recovered by the Contractor in subsequent years.

## B. CONFIRMATION – BRAND NAME DRUG PRICING

- (1) Confirm the Offeror's agreement to perform/fulfill and comply with the Duties and Responsibilities Section V.C.5. of this RFP, under subheading "Retail Pharmacy Network Brand Name Drug Pricing."

CVS Caremark confirms.

- (2) The Offeror agrees that it has an obligation to maximize the discount achieved on behalf of the Program for Brand Drugs dispensed by network pharmacies.

CVS Caremark agrees and will fulfill this obligation by consistently monitoring the marketplace and, where appropriate and reasonable, attempting to negotiate lower Network Pharmacy discount rates, and more effective Plan design and network composition strategies.

## C. REQUIRED SUBMISSION – BRAND NAME DRUG PRICING

The Offeror is required to provide its Guaranteed Minimum Discount in Exhibit V.A as a percent off of the aggregate AWP for all Brand Drugs dispensed at Network Pharmacies in Exhibit V.A.

### Retail Pharmacy Network Generic Pricing

## A. DUTIES AND RESPONSIBILITIES – GENERIC PRICING

- (1) The Contractor shall charge the Programs utilizing Pass-through Pricing for all Generic Drugs dispensed to Enrollees/Claimants through the Network Pharmacies. For purposes of the RFP and the Agreements, Pass-through Pricing is defined to mean the Programs are charged the same Ingredient Cost paid to the dispensing Network Pharmacy for the Generic Drug dispensed.
- (2) To maximize savings for the Programs on Generic Drugs dispensed through a Network Pharmacy, the Contractor is required to:
  - (a) Create and maintain a single, Programs-specific Maximum Allowable Cost (MAC) List called the Programs MAC List for Retail and Mail Service Pharmacies, setting the Ingredient Cost maximum price the Programs will be charged, and the amount the dispensing Network Pharmacy will be paid, for the Ingredient Cost for the drugs required to be included on the Programs MAC List. The MAC price assigned shall not exceed the Discounted Ingredient Cost to the Programs achieved ~~through Pharmacy submitted pricing or pricing achieved by using the highest contracted~~ Retail and Mail Service Pharmacy Brand Guaranteed Minimum Discount off of AWP applied to the AWP of the dispensed Generic Drug, ~~as proposed by the Contractor in its Proposal.~~
  - (b) Assign a MAC price to all NDCs of drugs included within a GPI/GCN, including NDCs of all Brand Drugs, containing an A-rated or authorized Generic Drug form of the original Brand Drug in the



GPI/GCN. The Contractor shall add the GPI/GCN to the Programs MAC List and set a MAC price for the GPI/GCN in accordance with Section V.C.4.a.(3)-(4). The provisions of these paragraphs require that MAC pricing be applied in no event later than 21 Days after the first shipment of the first Generic Drug from the manufacturer to a wholesaler or retailer. All A-rated or authorized Generic Drugs shall be MAC'd in all instances including, but not limited to circumstances in which the Department in its sole discretion decides not to enforce mandatory generic substitution of the Brand Drug in that GPI/GCN. There shall be one MAC price applicable to all NDCs included in the GPI/GCN on the Programs MAC List. However, depending on particular market factors, it may be in the best interests of the Programs, and therefore appropriate, for more than one MAC price to be assigned within a GPI/GCN. Such situations would require that the Contractor provide any information the Procuring Agencies deem necessary to support such action and obtain prior written approval from the Procuring Agencies.

- (d) Assign a MAC price to the NDCs of B-rated or unrated Generic Drugs included within a GPI/GCN that does not include an A-rated or authorized Generic Drug. The Offeror shall add the GPI/GCN to the Programs MAC List and set a MAC price for the Generic Drug NDCs included in the GPI/GCN as soon as practicable, but in no event later than 14 Days after the first shipment of the first Generic Drug from the manufacturer to a wholesaler or retailer concurrent with transmission of the MAC alert notice. The Contractor shall not apply the MAC price to the NDC(s) for Brand Drugs dispensed in the GPI/GCN and shall not enforce the Programs' mandatory generic substitution provisions for Brand Drugs dispensed in this GPI/GCN. There shall be one MAC price applicable to all Generic Drug NDCs included in the GPI/GCN on the Programs' MAC List. However, depending on particular market factors, it may be in the best interests of the Programs, and therefore appropriate, for more than one MAC price to be assigned within a GPI/GCN. Such situations would require that the Contractor provide any information the Procuring Agencies deem necessary to support such action and obtain prior written approval from the Procuring Agencies.
- (e) Charge the Programs for non-MAC'd Generic Drugs dispensed, utilizing pass-through pricing at the Contractor's pharmacy contracted discount applied to the AWP of the dispensed Generic Drug as proposed by the Contractor in its Proposal. The only Non-MAC'd Generic Drugs will be Generic Drugs included in GPIs/GCNs required to be on the Programs MAC List but which have not yet been assigned a MAC price within the required time frame;
- (f) The Contractor shall inform the Department of any market based condition which makes the strict compliance with paragraphs (a)-(d) above contrary to the financial interests of the Programs. The Contractor shall agree that, in cases where the Department, at its sole discretion, determines that the above requirements are contrary to the best financial interests of the Programs, the Department may waive such requirements;
- (g) Monitor the Programs MAC List pricing to ensure that NDCs contained in GPIs/GCNs subject to MAC pricing are paying at the MAC price after application of the Programs' Lesser of Logic provisions. The Contractor shall notify the Programs of any GPIs/GCNs subject to MAC pricing in which the majority of claims are processing at a basis other than the MAC price;
- (h) Agree that there shall be no increases to Programs MAC List prices where such adjustment is intended to limit the discount achieved on behalf of the Programs to the Guaranteed Minimum Discounts off of the aggregate AWP for all Generic Drugs dispensed by Network Pharmacies during the Plan Year as proposed in Exhibit V.A;



- (i) Provide to the Department full access to the Programs MAC List used to price Generic Drugs dispensed by Network and Mail Service Pharmacies for the Programs. The Programs MAC List provided in the Offeror's proposal as Exhibit V.C and V.C.1 must support the Contractor's Guaranteed Minimum Discounts off of the aggregate AWP for all Generic Drugs dispensed by Retail and Mail Service Pharmacies for the Program as proposed by the Contractor in its Proposal.

(Note: Offerors must be prepared to provide valid documented market rationale to support their Programs MAC pricing should the Procuring Agencies request this information. In order to protect the Programs' financial interests from the date of the award until the termination date of the Agreements, the selected Offeror must agree that any increases to the proposed Programs MAC pricing must be justified to the Procuring Agencies with valid documented market rationale. Following selection, the successful Offeror shall manage the content of the Programs MAC List consistent with the requirements of the RFP. Prices assigned to required new additions to the Programs MAC List shall be equivalent to the selected Offeror's most aggressive MAC price for that drug. To ensure compliance with these requirements, the successful Offeror shall notify the Department on a monthly basis of all changes, additions, and deletions made to the Programs MAC List in the format specified in Exhibit II.F.4 and the requirements specified in Section IV, entitled "Reporting." Compliance with these requirements as noted herein shall be a condition of contract award. Should the selected Offeror fail to comply with the requirements noted herein, the State reserves the right to deem the selected Offeror non-responsive and withdraw said conditional award. Throughout the term of the Agreements, the Contractor shall commit to use its best efforts to maintain the aggregate effectiveness of the Programs' MAC List. The Contractor must ensure that MAC pricing is reduced to an appropriate level based on any change in market conditions such as increased competition within a GPI/GCN.

- (j) The Contractor shall strictly enforce all requirements of the Programs' mandatory generic substitution provision as detailed in the duties and responsibilities of Section V.C.4. entitled "Mandatory Generic Substitution at Retail and Mail."
- (k) The Contractor must guarantee an overall minimum discount off of the aggregate AWP for all Generic Drugs dispensed at Retail and Mail Service Pharmacies as defined in the RFP. The Contractor shall guarantee the Programs that its management of Generic Drug costs dispensed by pharmacies, including maintenance of the Programs MAC List, and application of pricing provisions related to Generic Drugs that do not meet the requirements for inclusion on the Programs MAC List, shall result in the Programs achieving the Contractor's overall Guaranteed Minimum Discounts during the Program Year as proposed in the Contractor's Proposal. The discount achieved off of the aggregate AWP for all Generic Drugs as a result of Pass-through Pricing will be calculated utilizing the following formula:  $1 - \frac{\text{Sum of Ingredient Costs of dispensed Generic Drugs at Retail and Mail Service Pharmacies}}{\text{sum of AWP of dispensed Generic Drugs}}$ . The aggregate discount calculation will be based on Pharmacy Prescriptions filled with a Generic Drug where the Program was the primary payer (including Enrollee submitted claims). Claims submitted for secondary payer consideration, Compound Drug claims, NYSIF Program non-network claims and claims submitted by governmental entities must be excluded from the aggregate discount calculation. In addition, claims with a calculated AWP discount greater than 90% and a total AWP greater than \$500 will be excluded pending receipt of supporting documentation by the Contractor and verification by the Procuring Agencies as to the validity of the calculated discounts. The setting of an overall minimum discount off of the aggregate AWP for all Generic Drugs dispensed at Network Pharmacies shall in no way modify the Contractor's contractual obligation to maximize the



NYSIF Program's aggregate discount above the Contractor's overall Guaranteed Minimum Discount off of the aggregate AWP;

- (l) If the overall aggregate discount obtained, as calculated utilizing the formula set forth in the prior paragraph, is less than the Contractor's Guaranteed Minimum Discounts, the Contractor shall reimburse the Programs the difference between the Ingredient Cost the Programs were charged utilizing Pass-through Pricing and the Ingredient Cost the Programs would have been charged if the Guaranteed Minimum Discount off of the aggregate AWP had been obtained. The Programs will be credited annually for this difference in Ingredient Cost. The Programs shall retain the benefit of any cost savings, in excess of the Contractor's Guaranteed Minimum Discounts off the aggregate AWP for all Generic Drugs dispensed by Retail and Mail Service Pharmacies.

These calculations shall be performed for each Program Year based on claims paid for each incurred year. Specifically, the Contractor shall perform a reconciliation to include claims incurred in each Program Year and paid through June of the following Program Year. The reconciliation shall be submitted to the Procuring Agencies on July 31<sup>st</sup>. If the Procuring Agencies' review of the Contractor's calculations indicates an adjustment to the calculation is required, then the Procuring Agencies reserve the right in their sole discretion to make an adjustment to the Contractor's calculations. The calculations must be completed by July 1<sup>st</sup> of the following year. Upon approval by the Procuring Agency, the calculations must be completed by February 15<sup>th</sup> of the following year. The Contractor shall pay/credit each Program the applicable amount, if any, within 30 (thirty) Days, following the February 15<sup>th</sup> calculations. If the Procuring Agencies' review of the Contractor's calculations indicates an adjustment to the calculation is required, then the Procuring Agencies reserve the right in their sole discretion to make an adjustment to the Contractor's calculations. The Contractor shall also reflect the adjustments, if any, in the Contractor's Annual Financial Summary Report. On July 31<sup>st</sup> following each Program Year, the Contractor shall perform a reconciliation to include claims incurred in each Program Year and paid through June of the following Plan Year. Based on this reconciliation, the Procuring Agencies shall receive an adjustment, if necessary, within 30 Days following the date of the reconciliations and the adjustments shall be included in the following year's Annual Financial Summary Report. The Programs shall retain the benefit of any cost savings, in excess of the Contractor's Guaranteed Minimum Discount off the aggregate AWP set forth in duties and responsibilities of Section V.C.5. entitled "Retail Pharmacy Network Claims." Any shortfall in the Guaranteed Minimum Discount set forth in Section V.C.5. cannot be recovered by the Contractor in subsequent years.

## B. CONFIRMATION – GENERIC PRICING

- (1) Confirm the Offeror's agreement to perform/fulfill and comply with the duties and responsibilities listed in the Retail Pharmacy Network Generic Pricing in Sections V.C.5. of this RFP, under subheading "Retail Pharmacy Network – Generic Pricing."

CVS Caremark confirms.

There may be rare instances when pricing will be applied at the NDC level. CVS Caremark is able to provide examples if requested by the Programs.





- (2) The Offeror agrees that it has an obligation to maximize the discount achieved on behalf of the Program for Generic Drugs dispensed by Retail and Mail Service pharmacies.

CVS Caremark agrees and will fulfill this obligation by consistently monitoring the marketplace and, where appropriate and reasonable, attempting to negotiate lower Network Pharmacy discount rates, and more effective Plan design and network composition strategies.

- (3) The Offeror agrees that it will develop a Program's MAC List for Retail and Mail Service Pharmacies in order to maximize the discount achieved on behalf of the Programs for Generic Drugs.

CVS Caremark agrees. Our proposed MAC List is Programs-specific and is not the same as the MAC list published by the Centers for Medicare and Medicaid Services (formerly known as the Health Care Financing Administration, or "HCFA MAC"). For a copy of our proposed MAC list for the Programs, please see the completed Exhibit V.C in Section II, Tab 5.

### C. REQUIRED SUBMISSION – GENERIC PRICING

- (1) The Offeror is required to provide its Program's MAC list unit cost information in Exhibit V.C -- Retail Generic Drugs – MAC List Costs Per GPI (for Offerors proposing Medi-Span as the claims adjudication platform) or Exhibit V.C.1 -- Retail Generic Drugs – MAC List Costs Per GCN (for Offerors proposing First Data Bank as the claims adjudication platform) in accordance with the instructions provided in the files.

CVS Caremark confirms. Please see Section II, Tab 5 for the completed Exhibit V.C.

- (2) The Offeror is required to provide its Guaranteed Minimum Discount as a percent off of the aggregate AWP for all Generic Drugs dispensed by Retail and Mail Service Pharmacies in Exhibit V.A.

CVS Caremark confirms. Please see Section II, Tab 1 for the completed Exhibit V.A.

### Retail Pharmacy Network Compound Drug Pricing

Compound Drugs must be classified as compounds consistent with the definition in the Contract Provisions, Section VII, (see Article I, entitled "Definition of Terms"). Drugs assigned a unique NDC that require reconstitution and/or mixing prior to dispensing do not meet the Programs' definition of a Compound Drug and shall be processed in accordance with the requirements set forth in this RFP.

### A. DUTIES AND RESPONSIBILITIES – COMPOUND DRUG PRICING

The Contractor shall be required to:

- (1) Utilize its pricing methodology for Compound Drugs utilizing Pass-through Pricing, as proposed by the Contractor in its Proposal in Exhibit V.A, for the entire term of the Agreements. (Note: If an Offeror has multiple methods of pricing, the Offeror may propose each pricing method in Exhibit V.A for Procuring Agency consideration and selection.) The proposed pricing methodology(ies) for Compound Medications must be the same for retail and Mail Service Pharmacy Process claims.



- (2) (Exclusive to DCS) Charge Enrollees the applicable Level 2 Drug Copayment for all Compound Medications;
- (3) Process Compound Drug claims in a manner that verifies the validity of the claim as a Compound Medication according to the Programs' definition of a Compound Drug and provides appropriate claim Level control procedures to protect the financial interests of the Programs; and
- (4) Conduct due diligence as well as audit Network Pharmacies to ensure that drugs are being properly classified as Compound Drugs consistent with the Programs' definition of a Compound Drug and to ensure that compound claims are priced in accordance with the Contractor's pricing methodology for Compound Medications, as proposed by the Contractor in its Proposal, selected by the Procuring Agencies.

#### **B. CONFIRMATION – COMPOUND DRUG PRICING**

Confirm the Offeror's agreement to perform/fulfill and comply with the Duties and Responsibilities in Section V.C.5. of this RFP, under subheading "Retail Pharmacy Network Compound Drug Pricing."

CVS Caremark confirms.

For the EGWP, compound drug will be defined as noted in CMS regulations. The NCPDP D.0 standard for multi-ingredient compounds will be required for compound claims in 2012. This new functionality captures each ingredient used in the compounded prescription. The claims adjudication system will determine whether the compound is considered to be a Part D compound. A Part D compound must contain at least one ingredient that independently meets the definition of a Part D drug and cannot contain a Part B drug component. The system will then determine an allowable ingredient cost for each covered Part D NDC using lesser of logic comparing the AWP discount, MAC (if applicable), and the submitted ingredient cost for each individual component in the recipe. These individual allowable ingredient costs by NDC are then combined to create an Allowable Final Ingredient Cost.

#### **C. REQUIRED SUBMISSION – COMPOUND DRUG PRICING**

The Offeror is required to provide its pricing methodology(ies) utilizing Pass-through Pricing for Compound Drugs dispensed by Network Pharmacies in Exhibit V.A.

CVS Caremark confirms. Please see Section II, Tab 1 for the completed Exhibit V.A.

### **6. MAIL SERVICE PHARMACY PROCESS CLAIMS**

The current Programs include a Mail Service Pharmacy Process by which Enrollees/Claimants can obtain all Covered Drugs through the mail including any and all drugs that could be classified as Specialty Drugs/Medications for Enrollees/Claimants who do not participate in the Specialty Pharmacy Program. Enrollees are entitled to fill Prescriptions for up to a ninety (90) day supply with refills up to one year at a cost savings to the Enrollee and the DCS Program.



## General Provisions

The following provisions shall apply to all claims submitted through the Mail Service Pharmacy Process.

### A. DUTIES AND RESPONSIBILITIES – GENERAL

The Contractor shall be required to:

- (1) Consistently enforce and administer all provisions of the Program (including but not limited to mandatory generic substitution, drug utilization review, prior authorization, refill too-soon edits, etc.) to the claims dispensed through the Mail Service Pharmacy Process, consistent with the processing of claims through the Retail Pharmacy Network process;
- (2) Charge the Programs for those drugs dispensed to the Enrollee/Claimant in original manufacturer packaging, based on the Contractor's source of AWP as proposed by the Contractor in its Proposal for the 11 digit NDC of the package size dispensed through the Mail Service Pharmacy Process, subject to MAC pricing for Generic drugs. If the drug is not dispensed to the Enrollee/Claimant in original manufacturer packaging (i.e., dispensed from bulk), the Programs shall be charged based on the Contractor's source of AWP as proposed by the Contractor in its Proposal for the 11 digit NDC of the package size from which the drug was originally dispensed by the Mail Service Pharmacy Process Facility, subject to MAC pricing for Generic drugs. If the drug is dispensed from a bulk package size for which no AWP is reported in the Contractor's proposed AWP source as proposed by the Contractor in its Proposal, the Programs will be charged based on the reported AWP for the NDC of the largest package size contained in the Contractor's AWP source as proposed by the Contractor in its Proposal. The Programs shall not be charged based on an NDC assigned to repackaged drugs or based on package sizes prepared by special arrangement with the original manufacturer, unless such packaging offers a net savings to the Programs;
- (3) Charge the Programs based on the Contractor's pricing terms and dispensing fees (if any) applicable to Brand, Generic, and Compound Drug claims as set forth in Exhibit V.A of the Contractor's Proposal for all prescriptions submitted through the Mail Service Pharmacy Process. If multiple Compound Drug pricing methodologies were proposed by the Contractor in its Proposal, the Programs must be charged according to the methodology selected by the Procuring Agencies for Compound Drug claims. The Programs' Lesser of Logic shall be applied;
- (4) (Exclusive to DCS) Ensure that the Mail Service Pharmacy Process Facilities collect the appropriate Copayment specified in Exhibit II.C (plus Ancillary Charge, if applicable) from the Enrollee and charge the Programs the balance of the Discounted Ingredient Cost as determined through the application of the Lesser of Logic detailed in Section V.C.3.a.(9) plus the Contractor's applicable proposed Guaranteed Dispensing Fee minus the applicable Copayment for all drugs dispensed through the Mail Service Pharmacy Process; and
- (5) (Exclusive to DCS) Inform the Enrollee prior to shipping if the total amount for a new Prescription order submitted through the Mail Service Pharmacy Process exceeds \$100 and Enrollee has payment information (e.g. credit card) on file or Enrollee's total balance is over \$100 and Enrollee has no payment information (e.g. credit card) on file. The Mail Service Pharmacy Process Facility will not be required to inform Enrollees if there is a consistent history of the acceptance of shipments that exceed the maximum amount specified for the same medications. If the Brand Drug is dispensed, the Contractor shall cause the dispensing facility to collect the applicable Level 3 Drug Copayment plus the calculated



Ancillary Charge, if any. Under no circumstances shall the Enrollee's total cost exceed what the actual cost of the Brand Drug would have been to the Program.

## **B. CONFIRMATION – GENERAL PROVISIONS**

Confirm the Offeror's agreement to perform/fulfill and comply with the Duties and Responsibilities in Section V.C.6. of this RFP, under subheading "General Provisions."

CVS Caremark confirms.

## **C. REQUIRED SUBMISSION – GENERAL PROVISIONS**

The Offeror is required to provide the Offeror's Re-priced Claim Files, Exhibit V.B.2 in strict accordance with the Re-pricing Instructions and Layout Specifications found in Exhibits V.B and V.B.1 of this RFP.

CVS Caremark confirms. Please see Section II, Tab 4 for the completed Exhibit V.B.2.

### **Mail Service Pharmacy Process Brand Name Drug Pricing**

The Contractor must classify Brand Drugs in accordance with the definition in the Contract Provisions, Sections VII.A. and VII.B., (see Articles I, entitled "Definition of Terms") as well as the methodology outlined in Section V. of the RFP entitled "Brand Drug Determination Methodology."

## **A. DUTIES AND RESPONSIBILITIES – BRAND DRUG PRICING**

The Contractor shall be required to:

- (1) Utilize the Contractor's fixed contracted Guaranteed Discount off of Average Wholesale Price (AWP) as proposed by the Contractor in its Proposal to determine the Ingredient Cost of the Prescription to charge the Programs. The Contractor's fixed contracted Guaranteed Discount shall be applicable to all individual Prescriptions for Brand Drugs dispensed to Enrollees/Claimants through the Mail Service Pharmacy Process; and
- (2) Ensure that the Mail Service Pharmacy Process dispensing facility collects the appropriate Brand Drug Copayment (plus Ancillary Charge if applicable) from the Enrollee and charges the Programs the balance of the Discounted Ingredient Cost plus the Contractor's guaranteed dispensing fee, if any, for Brand Drugs dispensed through the Mail Service Pharmacy Process, as proposed by the Contractor in its Proposal. If the current Discounted Ingredient Cost plus the dispensing fee (if applicable) or the submitted cost is less than the applicable Level 2 or Level 3 Drug Copayment then the Contractor shall ensure that the Enrollee/Dependent is charged the lesser amount.



## B. CONFIRMATION – BRAND NAME PRICING

Confirm the Offeror's agreement to perform/fulfill and comply with the Duties and Responsibilities Section V.C.6. of this RFP, under subheading "Mail Service Pharmacy Process Brand Name Drug Pricing."

CVS Caremark confirms.

## C. REQUIRED SUBMISSION – BRAND NAME PRICING

The Offeror is required to provide the Offeror's fixed contracted Guaranteed Discount off of AWP for Brand Drugs dispensed through the Mail Service Pharmacy Process on Exhibit V.A. The Offeror shall assume in its pricing that the Procuring Agencies will not allow promotion of the Mail Service Pharmacy Process. However, the Procuring Agencies reserve the right during the term of the Agreements to allow promotion of the Mail Service Pharmacy Process provided such promotion is in the best financial interests of the State and complies with all applicable state laws and regulations.

CVS Caremark confirms. Please see Section II, Tab 1 for the completed Exhibit V.A.

### Mail Service Pharmacy Process – Generic Drug Pricing

The Contractor shall classify Generic Drugs in accordance with the definition in the Contract Provisions, Sections VII.A. and VII.B., (see Articles I, entitled "Definition of Terms") as well as the methodology outlined in Section V. of the RFP entitled "Generic Drug Determination Methodology."

## A. DUTIES AND RESPONSIBILITIES – GENERIC DRUG PRICING

The Contractor shall be required to:

- (1) Utilize the Programs MAC list for Retail and Mail Service Pharmacies to determine the Ingredient Cost of each Prescription charged to the Programs. The Contractor's Programs MAC list for Retail and Mail Service Pharmacies shall be applicable to all individual Prescriptions for Generic Drugs dispensed to Enrollees/Claimants through the Mail Service Pharmacy Process;
- (2) Ensure that the Mail Service Pharmacy Process dispensing facility collects the Level 1 Drug Copayment from the Enrollee and charges the Programs the balance of the Discounted Ingredient Cost plus the Contractor's guaranteed dispensing fee for Generic Drugs dispensed through the Mail Service Pharmacy Process, if any, as proposed by the Contractor in its Proposal. If the current Discounted Ingredient Cost plus the dispensing fee (if applicable) or the submitted cost is less than the applicable Level 1 Drug Copayment then the Contractor shall ensure that the Enrollee is charged the lesser amount; and
- (3) Guarantee an overall minimum discount off of the aggregate AWP for all Generic Drugs dispensed through the Mail Service Pharmacy as defined in the RFP. The Contractor shall guarantee the Programs that its management of Generic Drug costs dispensed by the Mail Service Pharmacy, including maintenance of the Programs MAC List for Retail and Mail Service Pharmacies, and application of pricing provisions related to Generic Drugs that do not meet the requirements for inclusion on the Programs MAC List, shall result in the Plan achieving the Contractor's overall Guaranteed Minimum Discounts during the Plan Year, as proposed by the Contractor in its Proposal.



The discounts achieved off of the aggregate AWP for all Generic Drugs dispensed at Retail and Mail Service Pharmacies as a result of Pass-through Pricing will be calculated utilizing the following formula: 1 minus (Sum of Ingredient Costs of dispensed Generic Drugs dispensed at Retail and Mail Service Pharmacies divided by sum of AWP of dispensed Generic Drugs). The aggregate discount calculations will be based on Pharmacy Prescriptions filled with a Generic Drug where the Program was the primary payer (including Enrollee submitted claims). Claims submitted for secondary payer consideration, Compound Drug claims, house generic claims, NYSIF Program non-network claims and claims submitted by governmental entities must be excluded from the aggregate discount calculations. In addition, claims with a calculated AWP discount greater than 90% and a total AWP greater than \$500 will be excluded pending receipt of supporting documentation by the Contractor and verification by the Procuring Agencies as to the validity of the calculated discounts; and

- (4) If the overall aggregate discounts obtained, as calculated utilizing the formula set forth in the prior paragraph, are less than the Guaranteed Minimum Discounts as proposed by the Contractor in its Proposal, the Contractor shall reimburse the Programs the difference between the Ingredient Cost the Programs were charged utilizing Pass-through Pricing and the Ingredient Cost the Programs would have been charged if the Guaranteed Minimum Discount off of the aggregate AWP had been obtained. The Programs will be credited annually for this difference in Ingredient Cost. The Programs shall retain the benefit of any cost savings, in excess of the Contractor's proposed Guaranteed Minimum Discounts off of the aggregate AWP for all Generic Drugs dispensed by pharmacies.

#### **B. CONFIRMATION – GENERIC PRICING**

Confirm the Offeror's agreement to perform/fulfill and comply with the Duties and Responsibilities in Section V.C.6. of this RFP, under subheading "Mail Service Pharmacy Process - Generic Drug Pricing."

CVS Caremark confirms.

#### **C. REQUIRED SUBMISSION – GENERIC PRICING**

- (1) The Offeror is required to provide its Guaranteed Minimum Discount as a percent off of the aggregate AWP for all Generic Drugs dispensed through the Mail Service Pharmacy Process on Exhibit V.A.

CVS Caremark confirms. Please see Section II, Tab 1 for the completed Exhibit V. A.

- (2) The Offeror is required to provide a listing of the Offeror's proposed house generics to be dispensed through the Mail Service Pharmacy Process.

CVS Caremark confirms. Please see Section III, Tab 1 for a listing of house generics dispensed through the Mail Service Pharmacy Process.

#### **Mail Service Pharmacy Process – Compound Drug Pricing**

The Contractor must classify Compound Drugs in accordance with the definition in the Contract Provisions, Sections VII.A. and VII.B., (see Articles I, entitled "Definition of Terms"). Drugs assigned a unique NDC that require reconstitution and/or mixing prior to dispensing do not meet the Programs' definition of a Compound Drug and shall be processed in accordance with the requirements set forth in the RFP.



#### A. DUTIES AND RESPONSIBILITIES – COMPOUND DRUG PRICING

The Contractor shall be required to:

- (1) Utilize its pricing methodology for Compound Drugs utilizing Pass-through Pricing, as proposed by the Contractor in Exhibit V.A of its Proposal, for the entire term of the Agreement. (Note: If an Offeror has multiple methods of pricing, the Offeror may propose each pricing method in Exhibit V.A for Procuring Agency consideration and selection.) The Contractor's pricing methodology(ies) for Compound Medications, as proposed by the Contractor in its Proposal, must be the same for retail and Mail Service Pharmacy Process claims.
- (2) Charge Enrollees the applicable Level 2 Drug Copayment for all Compound Medications. If the current Discounted Ingredient Cost or the submitted cost is less than the applicable Level 2 Drug Copayment then the Contractor shall ensure that the Enrollee is charged the lesser amount;
- (3) Process Compound Drug claims in a manner that verifies the validity of the claim as a Compound Medication according to the Programs' definition and provides appropriate claim control mechanisms to protect the financial interests of the Programs; and
- (4) Conduct due diligence to ensure that drugs are being properly classified as Compound Drugs consistent with the Programs' definition of a Compound Drug and ensure that compound claims are priced in accordance with the Contractor's pricing methodology for Compound Medications, as proposed by the Contractor in its Proposal, selected by the Procuring Agencies.

#### B. CONFIRMATION – COMPOUND DRUG PRICING

Confirm the Offeror's agreement to perform/fulfill and comply with the Duties and Responsibilities in Section V.C.6. of this RFP, under subheading "Mail Service Pharmacy Process – Compound Drug Pricing."

CVS Caremark confirms.

For the EGWP, compound drug will be defined as noted in CMS regulations. The NCPDP D.0 standard for multi-ingredient compounds will be required for compound claims in 2012. This new functionality captures each ingredient used in the compounded prescription. The claims adjudication system will determine whether the compound is considered to be a Part D compound. A Part D compound must contain at least one ingredient that independently meets the definition of a Part D drug and cannot contain a Part B drug component. The system will then determine an allowable ingredient cost for each covered Part D NDC using lesser of logic comparing the AWP discount, MAC (if applicable), and the submitted ingredient cost for each individual component in the recipe. These individual allowable ingredient costs by NDC are then combined to create an Allowable Final Ingredient Cost.

#### C. REQUIRED SUBMISSION – COMPOUND DRUG PRICING

The Offeror is required to provide the Offeror's proposed pricing methodology(ies) utilizing Pass-through Pricing for Compound Drugs dispensed through the mail service pharmacy in Exhibit V.A.

CVS Caremark confirms. Please see Section II, Tab 1 for the completed Exhibit V.A.



## 7. ENROLLEE SUBMITTED CLAIMS (EXCLUSIVE TO DCS)

The cost to the Program for Prescriptions for which Enrollees submit direct claims for reimbursement will be charged to the DCS Program at the actual amount reimbursed by the Contractor. For the DCS Programs, such reimbursement shall be based on the lesser of the submitted cost, minus the applicable Copayment; or the Discounted Ingredient Cost, plus the applicable (brand/generic) Guaranteed Maximum Dispensing Fee, minus the applicable Copayment. In the case of an Enrollee who has dual Empire Plan coverage, the applicable copayment will not be subtracted from the reimbursement for the secondary claim.

### A. DUTIES AND RESPONSIBILITIES – ENROLLEE SUBMITTED CLAIMS

The Contractor shall be required to utilize the following methodology to charge the Programs:

- (1) Brand Drugs, including Specialty Drugs/Medications, must be charged to the Programs utilizing the Guaranteed Minimum Discount off of AWP for Brand Drugs dispensed at the Retail Pharmacy Network and retail brand Guaranteed Maximum Dispensing Fee for Brand Drugs, minus the applicable Copayment;
- (2) Generic Drugs, including Specialty Drugs/Medications, must be charged to the Program utilizing the Contractor's assigned MAC price for the Retail and Mail Service Pharmacies, plus the Guaranteed Maximum Dispensing Fee for Generic Drugs, minus the applicable Copayment. Generic Drugs without a MAC price must be charged to the DCS Program using the Contractor's Guaranteed Minimum Discount for Brand Drugs, as proposed by the Contractor in its Proposal, off of AWP of the dispensed Generic Drug, plus the Guaranteed Maximum Dispensing Fee for Generic Drugs, minus the applicable Copayment;
- (3) Compound Drugs must be charged to the DCS Program by applying the Contractor's pricing methodology for Compound Drugs as defined in Section V,C.5. of the RFP, under the subheading "Retail Pharmacy Compound Drug Pricing," as proposed by the Contractor in its Proposal, plus the Guaranteed Maximum Dispensing Fee for Compound Drugs minus the applicable Level 2 Drug Copayment.
- (4) The Program's Lesser of Logic must be applied to all Enrollee Submitted Claims; and
- (5) For the NYSIF Program, all Enrollee/Dependent Submitted Claims must be charged to the Program at the submitted cost, (i.e., Enrollees/Dependents must be reimbursed 100% of their actual cost).

### B. CONFIRMATION – ENROLLEE SUBMITTED CLAIMS

Confirm the Offeror's agreement to perform/fulfill and comply with the duties and responsibilities listed in the Enrollee Submitted Claims section above.

CVS Caremark confirms.

For the EGWP, compound drug will be defined as noted in CMS regulations. The NCPDP D.0 standard for multi-ingredient compounds will be required for compound claims in 2012. This new functionality captures each ingredient used in the compounded prescription. The claims adjudication system will determine whether the compound is considered to be a Part D compound. A Part D compound must contain at least one ingredient that independently meets the definition of a Part D





drug and cannot contain a Part B drug component. The system will then determine an allowable ingredient cost for each covered Part D NDC using lesser of logic comparing the AWP discount, MAC (if applicable), and the submitted ingredient cost for each individual component in the recipe. These individual allowable ingredient costs by NDC are then combined to create an Allowable Final Ingredient Cost.

## **8. NON-NETWORK PHARMACY SUBMITTED CLAIMS (EXCLUSIVE TO NYSIF)**

The cost to the NYSIF Program for Prescriptions for which Non-Network Pharmacies submit direct claims for reimbursement will be charged to the NYSIF Program in accordance with New York State Worker's Compensation Board laws and regulations, specifically, Section 440 of Chapter V. of Title 12 NYCRR (New York Codes Rules and Regulations).

### **A. DUTIES AND RESPONSIBILITIES – NON-NETWORK PHARMACY SUBMITTED CLAIMS**

The Contractor shall be required to utilize the following methodology to charge the Programs:

- (1) Brand Drugs, including Specialty Drugs/Medications, must be charged to the NYSIF Program at the New York State Workers' Compensation Board rates, currently a twelve percent (12%) discount off of AWP, plus a \$4 Dispensing Fee;
- (2) Generic Drugs, including Specialty Drugs/Medications, must be charged to the NYSIF Program at the New York State Workers' Compensation Board rates, currently a twenty percent (20%) discount off of AWP, plus a \$5 Dispensing Fee;

### **B. CONFIRMATION – NON-NETWORK PHARMACY SUBMITTED CLAIMS**

Confirm the Offeror's agreement to perform/fulfill and comply with the duties and responsibilities listed in the Non-Network Pharmacy Submitted Claims section above.

CVS Caremark confirms.

## **9. DISPENSING FEE**

A Dispensing Fee is the amount of money, if any, paid to the pharmacies in compensation for the services rendered for filling a Prescription under the Agreements. The level of dispensing fees should encourage appropriate dispensing and compliance with the Programs' mandatory generic substitution requirements.

### **A. DUTIES AND RESPONSIBILITIES – DISPENSING FEES**

- (1) Dispensing fees at Retail Network Pharmacies shall be subject to Pass-through Pricing, up to a Guaranteed Maximum Dispensing Fee applied to aggregate claims. Dispensing fees for claims filled at the Specialty Pharmacy(ies), may be variable commensurate with the level of clinical services offered through the Specialty Pharmacy Program. (Note: Offerors may propose a different Guaranteed Maximum Dispensing Fee at Retail Network Pharmacies for Brand Drugs vs. Generic Drugs. Offerors shall propose a single contracted dispensing fee for the Mail Service Process.)



- (2) The Contractor shall be required to guarantee its dispensing fee(s), as proposed by the Contractor in its Proposal, for the entire term of the Agreements.
- (3) No dispensing fee shall be charged to the Programs for any claim that is paid on the basis of the Pharmacy's Usual and Customary price.
- (4) The Contractor must guarantee the overall maximum dispensing fee for Brand, Generic and Compound claims, respectively, dispensed at Retail Network Pharmacies, as proposed by the Contractor in its Proposal. The level of dispensing fees achieved as a result of Pass-through Pricing at Retail Pharmacies will be calculated utilizing the following formula: Total Retail Network Dispensing Fees paid by each Program on an annual basis divided by the number of Final Paid Claims at Retail Network Pharmacies for each of Generic, Brand, and Compound claims.
- (5) If the overall aggregate dispensing fees paid, as calculated utilizing the formula set forth in the prior paragraph, are more than the Guaranteed Maximum Dispensing Fee proposed for each of Brand, Generic, and Compound claims at Retail Network Pharmacies, the Contractor shall reimburse each Program the difference between the Dispensing Fee the Programs were charged utilizing Pass-through Pricing and the Dispensing Fee the Programs would have been charged if the Guaranteed Maximum Dispensing Fee had been obtained. The Contractor shall perform a reconciliation to include claims incurred in each Program Year and paid through June of the following Program Year. The reconciliation shall be submitted to the Procuring Agencies on July 31<sup>st</sup>. If the Procuring Agencies' review of the Contractor's calculations indicates an adjustment to the calculation is required, then the Procuring Agencies reserve the right in their sole discretion to make an adjustment to the Contractor's calculations. Upon approval by the Procuring Agency, the Contractor shall pay/credit each Program the applicable amount, if any, within 30 (thirty) Days. The Programs will be credited annually for this difference by February 15<sup>th</sup>. The Contractor shall also reflect the adjustment, if any, in the Contractor's Annual Financial Summary Report. The Programs shall retain the benefit of any cost savings in excess of the Guaranteed Maximum Dispensing Fees set forth in Section V.C.9. Any shortfall in the Guaranteed Maximum Dispensing Fees set forth in Section V.C.9. cannot be recovered by the Contractor in subsequent years.

#### **B. CONFIRMATION – DISPENSING FEES**

Confirm the Offeror's agreement to perform/fulfill and comply with the duties and responsibilities listed in the dispensing fee section above.

CVS Caremark confirms.

#### **C. REQUIRED SUBMISSION – DISPENSING FEES**

- (1) The Offeror is required to provide the Offeror's proposed Guaranteed Maximum Dispensing Fees for retail Brand and Generic claims on Exhibit V.A.

CVS Caremark confirms. Please see Section II, Tab 1 for the completed Exhibit V.A.



- (2) The Offeror is required to provide the Offeror's proposed fixed dispensing fees for mail order Brand and Generic claims on Exhibit V.A.

CVS Caremark confirms. Please see Section II, Tab 1 for the completed Exhibit V.A.

- (3) The Offeror is required to complete Exhibit V.D listing the Offeror's proposed dispensing fees for each drug proposed to be included in the Offeror's Specialty Pharmacy Program.

CVS Caremark confirms. Please see Section II, Tab 6 for the completed Exhibit V.D.

## 10. SPECIALTY PHARMACY PROGRAM PRICING

Certain Employee groups participate in the Specialty Pharmacy Program, whose goal is to provide an enhanced level of clinical management for Enrollees/Claimants taking Specialty Drugs/Medications in exchange for lower Copayments and restricted access. Under the current plan design for The Empire Plan and SEHP, after the first Specialty Drug/Medication Prescription is filled through Retail, future fills are subject to a Hard Edit, meaning that Enrollees are required to obtain the drug through the Specialty Pharmacy Process. In addition to the first fill at Retail, certain Specialty Drugs/Medications available through the Specialty Pharmacy Program as well as all Specialty Medications covered under the NYSIF Program are also available through the Retail Pharmacy Network, because of their clinical requirements and/or urgent dispensing timeframe or NYS laws and regulations. All drugs filled at a Retail Pharmacy Network are subject to the Retail Network Pharmacy pricing and guarantees. For those drugs available only through the Specialty Pharmacy Program, the Offeror may propose dispensing fees on a drug by drug basis, commensurate with the clinical services provided for each. All drugs shall be classified as either Brand Name, Generic, or Compound for pricing purposes based on the classification methodologies set forth in Section V. of this RFP. The Programs shall be entitled to all manufacturer revenue derived from Specialty Drugs/Medications Drugs to be included in the Specialty Pharmacy Program, Specialty Drugs/Medications are:

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

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



#### A. DUTIES AND RESPONSIBILITIES – SPECIALTY PHARMACY PROGRAM PRICING

- (1) Consistently enforce and administer all provisions of the Program (including but not limited to mandatory generic substitution, drug utilization review, prior authorization, refill too-soon edits, etc.) to the claims dispensed through the Specialty Pharmacy Process, consistent with the processing of claims through the Retail and Mail Service Pharmacy Network processes.
- (2) Charge the Programs for those drugs dispensed to Enrollees/Claimants in original manufacturer packaging, based on the Contractor's source of AWP for the 11 digit NDC of the package size dispensed through the Specialty Pharmacy Process. If the drug is not dispensed to the Enrollee/Claimant in original manufacturer packaging (i.e., dispensed from bulk), the Programs shall be charged based on the Contractor's source of AWP for the 11 digit NDC of the package size from which the drug was originally dispensed by the Designated Specialty Pharmacy. If the drug is dispensed from a bulk package size for which no AWP is reported in the Contractor's AWP source, the Programs shall be charged based on the reported AWP for the NDC of the largest package size contained in the Contractor's AWP source. The Programs shall not be charged based on an NDC assigned to repackaged drugs or based on package sizes prepared by special arrangement with the original manufacturer unless such packaging offers a net savings to the Programs.
- (3) Charge the Programs based on the Contractor's pricing terms and dispensing fees (if any) applicable to Brand and Generic, Specialty Drug/Medication claims as set forth in Exhibit V.A and V.D for all prescriptions submitted through the Specialty Pharmacy Program.
- (4) Ensure that the Designated Specialty Pharmacy(ies) collects the appropriate Copayment specified by the Department (plus Ancillary Charge, if applicable) from the Enrollee and will charge the Programs the balance of the Discounted Ingredient Cost plus the Offeror's applicable guaranteed dispensing fee set forth in Section V.C.9. of the RFP, minus the applicable Copayment for all drugs dispensed through the Specialty Pharmacy Process.
- (5) Classify Brand Drugs consistent with the definition in the Contract Provisions, Sections VII.A and VII.B, (see Articles I, entitled "Definition of Terms") as well as the methodology outlined earlier within Section V of the RFP entitled "Brand Drug Determination Methodology."
- (6) Classify Generic Drugs consistent with the definition in the Contract Provisions, Sections VII.A and VII.B, (see Articles I, entitled "Definition of Terms") as well as the methodology outlined earlier within Section V of the RFP entitled "Generic Drug Determination Methodology."
- (7) Propose a fixed contracted Guaranteed Discount off of Average Wholesale Price (AWP) that will be utilized to determine the Ingredient Cost of the Prescription to charge the Programs. The Offeror's Guaranteed Discount shall be applicable to all individual Prescriptions for Brand Drugs and Generic Drugs dispensed to Enrollees/Claimants through the Specialty Pharmacy Process.
- (8) Act in the interests of the Programs when dispensing Generic Drugs through the Specialty Pharmacy Process by avoiding the dispensing of NDC's with higher AWP's unless market conditions exist making dispensing the more cost effective NDC impractical or impossible.



## B. CONFIRMATION – SPECIALTY PHARMACY PROGRAM PRICING

Confirm the Offeror's agreement perform/fulfill and comply with to the Duties and Responsibilities – Section V.C.10. of this RFP, under the subheading "Specialty Pharmacy Program Pricing."

CVS Caremark confirms.

For the EGWP, members of a Medicare Part D plan must be able to obtain their Specialty drugs through any willing Specialty pharmacy provider, including through a retail provider when applicable. Also under the Medicare Part D benefit, Specialty drugs are determined and defined based upon CMS guidance.

## C. REQUIRED SUBMISSION – SPECIALTY PHARMACY PROGRAM PRICING

The Offeror is required to provide the Offeror's fixed contracted Guaranteed Discount off of Average Wholesale Price (AWP) as set forth in Exhibit V.A of the RFP.

CVS Caremark confirms. Please see Section II, Tab 1 for the completed Exhibit V.A.

## 11. 100% PHARMA REVENUE GUARANTEE

The Empire Plan is one of the largest health insurance plans in the country. The DCS Program has adopted a three-level drug benefit structure for Enrollees to enhance the ability of the DCS Program to obtain direct discounts from manufacturers. The Contractor is required to manage the DCS Program's Preferred Drug List, Flexible Formulary and NYSIF Program Drug List and to negotiate, on the Programs' behalf, agreements with manufacturers for direct discounts off of the cost of drugs dispensed to Program Enrollees/Claimants. Manufacturer discounts related to Programs utilization can make a drug with a higher AWP competitive with clinically comparable drugs with lower AWP's. However, the Contractor's receipt of revenue related to the Programs' utilization can create a potential conflict of interest in the decision to classify a drug as Preferred, Non-Preferred or excluded.

Full transparency is critical to protecting the interests of the State, Participating Agencies and Enrollees/Claimants and ensuring alignment of the Programs' financial interests with those of the Contractor. This section details the Contractor's duties and responsibilities with regard to management of Pharma Revenue on the Programs' behalf.

### Definitions

Pharma Revenue is defined as set forth in the "Glossary of Terms" Section VIII. Pharma Revenue is any and all revenues generated from agreements between the pharmaceutical manufacturers and the Contractor and/or its Key Subcontractor or any Affiliate of the Contractor or its Key Subcontractor which relate to Program utilization and/or Pharmacy benefit management services provided under the Agreements. Such revenues include, but are not limited to revenues described as: formulary rebates; market share rebates; administrative fees, AWP caps; or by any other name.

A Final Paid Claim is defined as set forth in the "Glossary of Terms" Section VIII. A Final Paid Claim is a claim processed and paid by the Contractor for a Prescription drug provided to an Enrollee/Claimant, including but not limited to, claims for Prescriptions filled at a retail Pharmacy or through the Mail Service Pharmacy Process or Specialty Pharmacy Program. A claim that is denied prior to processing is not



considered a Final Paid Claim. In addition, a claim that is processed and paid but is subsequently voided, reversed, or otherwise adjusted is not a Final Paid Claim. Zero balance claims are considered Final Paid Claims. Consistent with the definition of a Final Paid Claim, the Pharma Revenue guarantee per Final Paid Claim quoted applies to rebateable and non-rebateable claims.

#### A. DUTIES AND RESPONSIBILITIES – PHARMA REVENUE GUARANTEE

The Contractor agrees to and shall:

- (1) Negotiate Pharma Revenue agreements with manufacturers that maximize savings to the Programs, leveraging the significant enrollment of the Programs for each individual drug. The Contractor agrees that any Programs 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;
- (2) Pay the Programs quarterly within 150 Days of the end of each quarter, the greater of 100% Pharma Revenue received or the minimum guaranteed amount attributable to the Programs' combined utilization;
- (3) Calculate and distribute Pharma Revenue to the Programs in a fully transparent and verifiable process. The Contractor agrees that all direct and indirect revenue arrangements with manufacturers, suppliers, or other vendors shall be disclosed and the revenue generated related or attributable to the Programs' utilization shall be credited to the Programs. The Contractor acknowledges and agrees that the records, methods, and calculations utilized to total and distribute these amounts to the Programs are subject to audit by the State under the audit authority set forth in Contract Provisions, Sections VII.A and VII.B, of the RFP and Appendices A and B thereto. In addition, the Contractor shall provide all agreements as necessary for the Programs to evaluate Preferred Drug List, Flexible Formulary and NYSIF Program Drug List decisions including direct access to any manufacturer contracts in unredacted form, under which the Programs is entitled to derive Pharma Revenue pursuant to the terms of the Agreements;
- (4) Not enter into any agreement that has the effect of diverting, shortchanging, or trading off any form of Pharma Revenue that would otherwise be due the Programs for other consideration. There shall be no fees charged to the Programs or received from a manufacturer, separate from the Claims Administration Fees as described and authorized in the RFP, by the Contractor for rebate or other Pharma Revenue administration. The Contractor agrees that it shall not divert, shortchange, or trade off Pharma Revenue that would otherwise inure to the Programs' financial benefit for Enrollee/Claimant drug utilization in return for reduced drug acquisition costs or other monetary or non-monetary consideration from manufacturers;
- (5) Upon selection of the successful Offeror and as a condition of contract award and throughout the term of the Agreements, the successful Offeror/Contractor shall provide, upon the request of the State, all information and documentation related to Pharma Revenue agreements, including but not limited to, full direct access by the Procuring Agencies staff or their agents to complete unredacted Pharma Revenue agreements pursuant to which the Programs derives Pharma Revenue;
- (6) Utilize manufacturer agreements for the Programs that meet or exceed the Contractor's best existing Pharma Revenue agreements for all individual drugs. If the Contractor's business model allows for more than one Pharma Revenue agreement with manufacturers, the Contractor agrees that in no instance will the Programs receive less Pharma Revenue in any therapeutic class than other clients of the Contractor with a comparable benefit design and consistent preferred drug designations in the class, provided the



Programs' utilization of the drugs generating Pharma Revenue in the class is equal to or greater than those of other clients. The Contractor, as part of its Proposal, must propose a process satisfactory to the Procuring Agencies to confirm compliance with this provision and must implement and administer said satisfactory process under the Agreements. The Programs shall receive full pass-through of 100% of Pharma Revenue derived from any agreement with a pharmaceutical manufacturer. Where any Pharma Revenue contracts allow for higher Pharma Revenue for Mail Service Pharmacy or Specialty Pharmacy Program claims, the Programs will receive the full financial benefit of those higher rates receiving 100% of the Pharma Revenue derived from those agreements on mail order claims. If manufacturer agreements provide less Pharma Revenue for Mail Service Pharmacy or Specialty Pharmacy Program claims than retail claims for the same drug, the terms of the manufacturer agreement applicable to retail claims shall be applied to Program Mail Service Pharmacy and Specialty Pharmacy Program claims for purposes of calculating the amount of Pharma Revenue due the Programs;

- (7) The Contractor, as part of its Proposal, must propose a Minimum Per Final Paid Claim Pharma Revenue Guarantee that will be utilized by the Contractor in calculating the minimum annual amount due to the Programs for Pharma Revenue. The Minimum Pharma Revenue amount due the Programs on an annual basis will be calculated according to the formula: Contractor's Minimum Per Final Paid Claim Pharma Revenue Guarantee multiplied by the number of Final Paid Claims incurred for the DCS Program and the NYSIF Program for the respective Program Year;
- (8) Ensure the Contractor's Minimum Per Final Paid Claim Pharma Revenue Guarantee is not contingent upon the Programs' participation in any of the Contractor's formulary management or intervention programs. Nor shall the Contractor's Minimum Per Final Paid Claim Pharma Revenue Guarantee be contingent or dependent on the timing of any patent expirations and/or introduction of generic equivalent drugs, including but not limited to early and/or at risk Generic Drug launches. The Programs will review the guaranteed amount only in the event of legislative, regulatory, or judicial action excluding patent litigation not specific to the Contractor's business practices that serves to void existing Pharma Revenue agreements materially compromising the Contractor's ability to obtain contracted Pharma Revenue necessary to meet the Contractor's Minimum Per Final Paid Claim Pharma Revenue Guarantee;
- (9) Calculate and perform an annual reconciliation of the Pharma Revenue credit to the Pharma Revenue earned. As part of this annual reconciliation the Contractor shall be required to:
  - (a) Calculate the Pharma Revenue guarantee on all Final Paid Claims, incurred for the respective Program Year. The Pharma Revenue guarantee shall be on the aggregate level, not separated for each therapeutic class;
  - (b) Credit the Programs an amount calculated based on the following formula: if in any Program Year, the Pharma Revenue realized and credited to the Programs by the Contractor is less than the amount due the Programs as determined utilizing the minimum Pharma Revenue credit set forth above in (7) of this Section, the amount of the credit shall be equal to the difference between the reported Pharma Revenue credited to the Programs and the Contractor's Minimum Per Final Paid Claim Pharma Revenue Guarantee;
  - (c) Submit calculations and documentation supporting the amount of Pharma Revenue reported and credited to the Programs for the Procuring Agencies' review and written approval. The Contractor shall provide all information and documentation deemed necessary by the Procuring Agencies to verify the Programs were credited with all Pharma Revenue due it under the terms of the Agreements;



- (d) If at the close of any Plan Year, the Pharma Revenue credited to the Programs is greater than the higher of the amount derived through application of the Pharma Revenue guarantee formula or the actual Pharma Revenue realized by the Programs, upon notice and verification by the Procuring Agencies, the DCS Program and the NYSIF Program shall pay the Contractor the difference between the amount previously credited to each Program and the higher of the minimum Pharma Revenue guaranteed amount or actual Pharma Revenue realized during the Program Year;
- (e) If at the close of any Program Year, the Pharma Revenue credited to the Programs is less than the actual Pharma Revenue realized by the Programs, the Contractor shall credit each Program the difference between what was previously credited and the full amount due to the Programs;
- (f) Include such reconciliations as part of the Contractor's annual financial summary report. The Procuring Agencies require the Contractor's Minimum Per Final Claim Paid Pharma Revenue Guarantee be credited to the claims experience on the annual financial reports regardless of the amount of Pharma Revenue that has been received by the Contractor; and
- (g) Administer the Procuring Agencies' Pharma Revenue Program in accordance with the Contract Provisions, Sections VII.A and VII.B of the RFP. In this regard, the Contractor agrees to the terms set forth in Contract Provisions, Sections VII.A and VII.B, of the RFP (see Articles XIII, entitled "100% Pharma Revenue Guarantee" and Articles XV "Payments/(Credits) to/(from) the Contractor."

**B. CONFIRMATION – PHARMA REVENUE GUARANTEE**

Confirm the Offeror's agreement to the definitions and the Offeror's agreement to perform/fulfill and comply with the duties and responsibilities listed in the Pharma Revenue guarantee section above.

[Redacted]

[Redacted]

**C. REQUIRED SUBMISSION – PHARMA REVENUE GUARANTEE**

- (1) The Offeror is required to provide its proposed Minimum Per Final Paid Claim Pharma Revenue Guarantee in Exhibit V.E. Offerors may provide a different Minimum Per Final Paid Claims Pharma Revenue Guarantee for each year of the Agreements. The minimum credit to the Programs for Pharma Revenue shall be the Offeror's Minimum Per Final Paid Claim Pharma Revenue Guarantee (as submitted on Exhibit V.E) times the number of Final Paid Claims paid for each Program for the respective Program Year as defined in the "Glossary of Terms," Section VIII."

Please see Section II, Tab 7 for the completed Exhibit V.E.





- (2) The Offeror is required to provide adequate documentation as determined by the Procuring Agencies, to support the Offeror's offer relative to Pharma Revenue. Said documentation is to be provided as Exhibit V.E.1 of the Offeror's Proposal.

Please see Section II, Tab 8 for the completed Exhibit V.E.1.

## 12. CLAIMS ADMINISTRATION FEES

The Claims Administration Fees are the fees, quoted by the Contractor in its Proposal that the Contractor shall charge the Programs to cover all of the administrative services provided by the Contractor. Three separate Claims Administration Fees must be developed and quoted by Offerors for the Programs: DCS Program Primary; EGWP Medicare Primary; and NYSIF Program. The DCS Program Primary Claims Administrative Fee covers the Contractor's administration of The Empire Plan for non-Medicare primary Enrollees, as well as the SEHP and the Excelsior Plan, as may be modified from time to time. The Contractor's EGWP Medicare Primary Claims Administrative Fee covers the Contractor's administration of The Empire Plan for Medicare primary Enrollees. The Contractor's NYSIF Program Claims Administrative Fee covers the Contractor's administration of the NYSIF Program.

### A. DUTIES AND RESPONSIBILITIES – CLAIMS ADMINISTRATION FEES

The Contractor shall be required to:

- (1) Be bound by its Claims Administration Fees, as proposed in the Contractor's Proposal for the entire term of the Agreements;
- (2) Implement any changes necessary to accommodate Programs modifications resulting from collective bargaining, legislation or within the statutory discretion of the State within 60 days of notice, or as soon as practicable;
- (3) Agree not to request higher Claims Administration Fees, and the Procuring Agencies will not consider any increases to the Claims Administration Fees, that are not based on a material changes to the Programs requiring the Contractor to incur additional costs. The determination of what constitutes a material change will be at the sole discretion of the Procuring Agencies Implementation of an alternate formulary or multiple formularies shall not constitute a material change and the Contractor agrees to implement, if required, all alternative formularies at the Claims Administration Fees proposed;
- (4) Manage all Programs Enrollees/Claimants based on the Contractor's associated Claims Administration Fees as proposed by the Contractor in its Proposal;
- (5) Submit detailed documentation of additional administrative/clinical costs, over and above existing administrative/clinical costs, with any request for an increase in the Claims Administration Fee(s) resulting from a material change in the benefit structure of the Programs. The Procuring Agencies reserve the right to request and the Contractor agrees to provide any additional information and documentation the Procuring Agencies deem necessary to verify that the request for an increase to a Claims Administration Fee(s) is warranted. The Procuring Agencies' decision to modify the Claims Administration Fees to the extent necessary to compensate the Contractor for documented additional costs incurred shall be at the sole discretion of the Procuring Agencies, subject to the approval of a



formal amendment to the Agreement(s) by the New York State Attorney General and New York State Office of State Comptroller;

- (6) Implement all benefit designs as required by the Department with or without final resolution of any request for a Claims Administration Fee(s) adjustment. Refusal to implement changes will constitute a material breach of the Agreement(s) and the Procuring Agencies will seek compensation for all damages resulting; and
- (7) Agree that Claims Administration Fees shall be payable only for Final Paid Claims and that the Programs will not pay a Claims Administration Fee or other charge or fees for any claim that is denied prior to processing or any claim that is subsequently voided, reversed, or otherwise modified.

#### **B. CONFIRMATION – CLAIMS ADMINISTRATION FEES**

Confirm the Offeror's agreement to perform/fulfill and comply with the duties and responsibilities listed in the Claims Administration Fees section above.

CVS Caremark confirms.

#### **C. REQUIRED SUBMISSION – CLAIMS ADMINISTRATION FEES**

The Offeror is required to provide the Offeror's Claims Administration Fees in Exhibit V.F on a fee per Final Paid Claim basis.

CVS Caremark confirms.

Please see Section II, Tab 9 for the completed Exhibit V.F.

### **13. PAYMENTS/ (CREDITS) TO/ FROM THE CONTRACTOR**

This section presents details regarding the financial structure and timing of financial transactions related to the Agreements and the specific items Offerors must submit with their Cost Proposal and questions related to those requirements.

The following information is presented for use by Offerors in developing their Cost Proposal. Additional detail regarding each of these provisions may be found in Contract Provisions, Sections VII.A. and VII.B. of the RFP.

As of December 2011, there were 232,213 individual contracts and 291,008 family contracts with Empire Plan prescription drug coverage. Within the aforesaid contracts, there are 233,729 Empire Plan Enrollees and Dependents that have Medicare Primary coverage and would be eligible for the EGWP coverage. In addition to the Empire Plan contracts, there are 32 individual contracts and 20 family contracts with the Excelsior Plan and 4,891 individual contracts and 775 family contracts with the Student Employee Health Plan (SEHP) benefits. Under NYSIF's Program, the agency was servicing approximately 50,000 Claimants with NYSIF Program benefits. The enrollment mix and benefit characteristics are presented in Exhibits II.B through II.B.2 and Exhibits III.B through III.E4 of this RFP; however, the Procuring Agencies cannot guarantee that,



during the term of the Agreements, the same enrollment mix and benefit characteristics as those set forth in Exhibit II.B through Exhibit II.B.2 and Exhibits III.B through III.E.4 of this RFP will exist;

#### A. DUTIES AND RESPONSIBILITIES – FINANCIAL STRUCTURE AND TIMING OF FINANCIAL TRANSACTIONS

- (1) Each Procuring Agency will separately reimburse the Contractor for claim payments and associated Claims Administration Fees no sooner than two (2) Business Days and no later than five (5) Business Days after receipt of an accurate invoice, following each claims processing cycle (weekly for the NYSIF Program and bi-weekly for the DCS Programs).

The Offeror is required to submit a detailed claim file concurrent with each invoice (for the NYSIF Program) and within fifteen (15) Days after the end of each claims processing cycle (for the DCS Programs) to support the submitted invoices. The data file layout and file transmission protocol will be mutually agreed upon by the Contractor and the Procuring Agencies during Implementation, in accordance with the Contractor's Proposal.

- (2) Any credit amounts due from the Contractor to the Procuring Agencies for failure of the Contractor to meet the performance guarantees set forth in the Agreements shall be applied as a credit against the Claims Administration Fees charged separately to the Programs in the ~~next~~ first invoice(s) processed after the performance guarantee has been calculated and agreed to by the Program(s).
- (3) Upon final audit determination by the Procuring Agencies, any audit liability amount assessed by the Procuring Agencies shall be paid/credited to the Programs within thirty (30) Days of the date of the Procuring Agencies' final determination.
- (4) (Exclusive to DCS) Coordination of Benefit recoveries collected by the Contractor shall be aggregated and paid/credited to the DCS Program within fifteen Days after the end of the month.
- (5) Drug litigation recoveries and settlements shall be paid/credited to the Programs within fifteen (15) Days of receipt by the Contractor.
- (6) One hundred and fifty (150) Days after the end of the first quarter, the Contractor shall pay/credit the Program the greater of (1) the actual Pharma Revenue received on behalf of the Programs or (2) the minimum Per Final Paid Claim Pharma Revenue Guarantee, set forth in the Contract Provisions, Sections VII.A. and VII.B. Articles 13.9.7, multiplied by the number of Final Paid Claims incurred for the first quarter.
  - (a) For each subsequent quarter of the Program Year the calculations shall be performed on a cumulative Program Year-to-Date basis. The Contractor shall pay/credit the Programs the greater cumulative amount less the amount previously paid for the Program Year.
  - (b) The Contractor shall perform a reconciliation by May 31st of each year and the incremental Pharma Revenue amount shall be paid/credited to the Programs within thirty (30) Days of May 31st.
  - (c) At the May 31st Pharma Revenue reconciliation, to the extent that any amount is owed by the Contractor, the Contractor shall pay/credit the Programs within thirty (30) Days after the Final Pharma Revenue reconciliation for the amount owed.



## B. CONFIRMATION – FINANCIAL STRUCTURE AND TIMING OF FINANCIAL TRANSACTIONS

- (1) The Offeror is required to confirm the Offeror's agreement to perform/fulfill and comply with the duties and responsibilities listed in the Details on the Financial Structure and Timing of Financial Transactions section above.

CVS Caremark confirms.

With respect to item number 3 above in Duties and Responsibilities, CVS Caremark confirms any audit liability amount shall be paid or credited to the Programs within thirty (30) days of the date of the Procuring Agencies' final determination, made consistent with paragraph 19.6.0 of Section VIIA of the RFP and paragraph 17.6.0 of Section VIIB of the RFP, respectively.

## C. REQUIRED SUBMISSION – FINANCIAL STRUCTURE AND TIMING OF FINANCIAL TRANSACTIONS

- (1) Describe in detail the Contractor's proposed invoicing process, including the timing for invoice preparation and supporting detail claims files at the end of each cycle, required payment timeframes and whether this structure is in effect for any other self-funded customers.

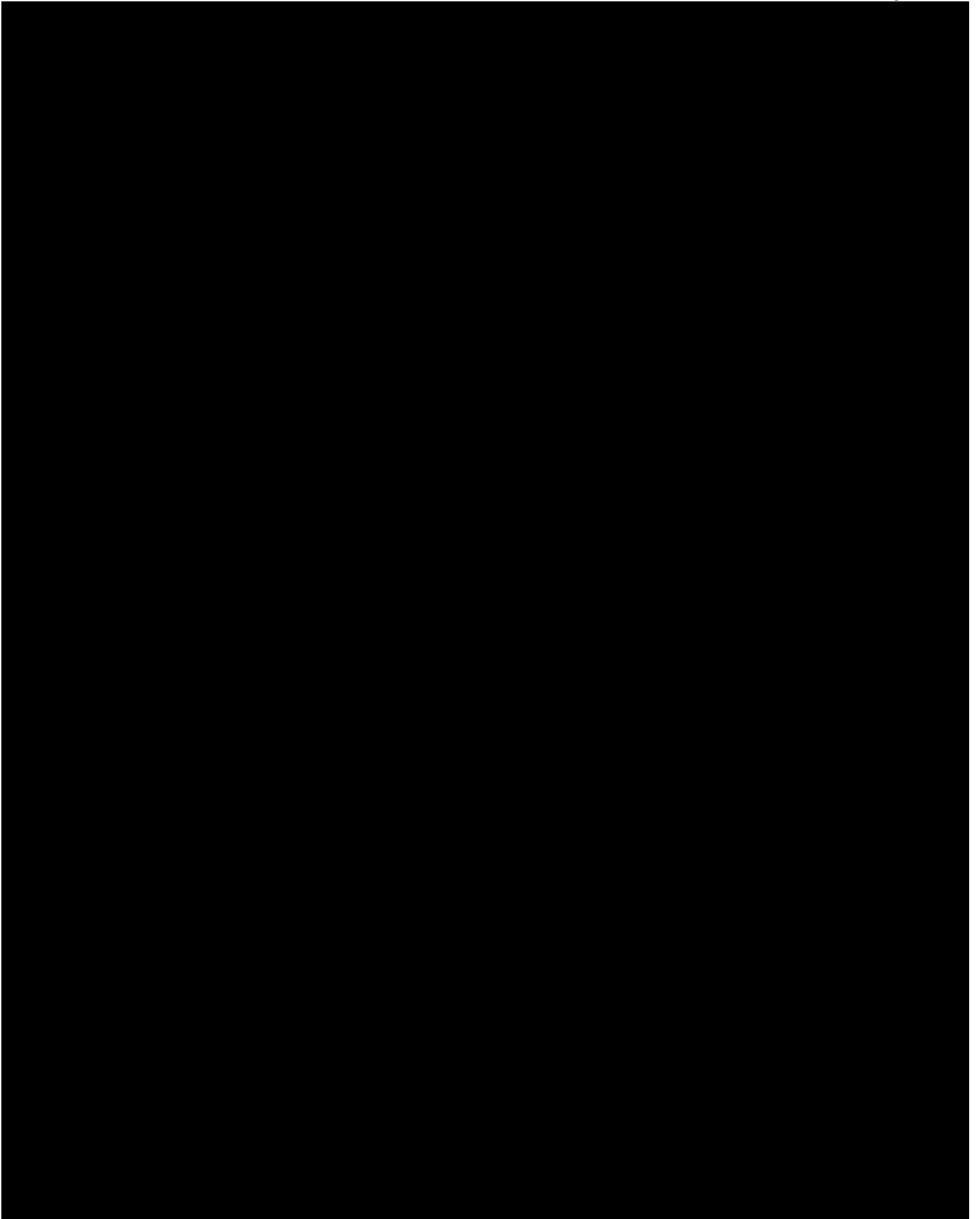
CVS Caremark confirms to the billing and invoicing requirements in section 13.A.1 (Payments/(CREDITS) to/from the contractor) and that this structure is in place for other self-funded customers.

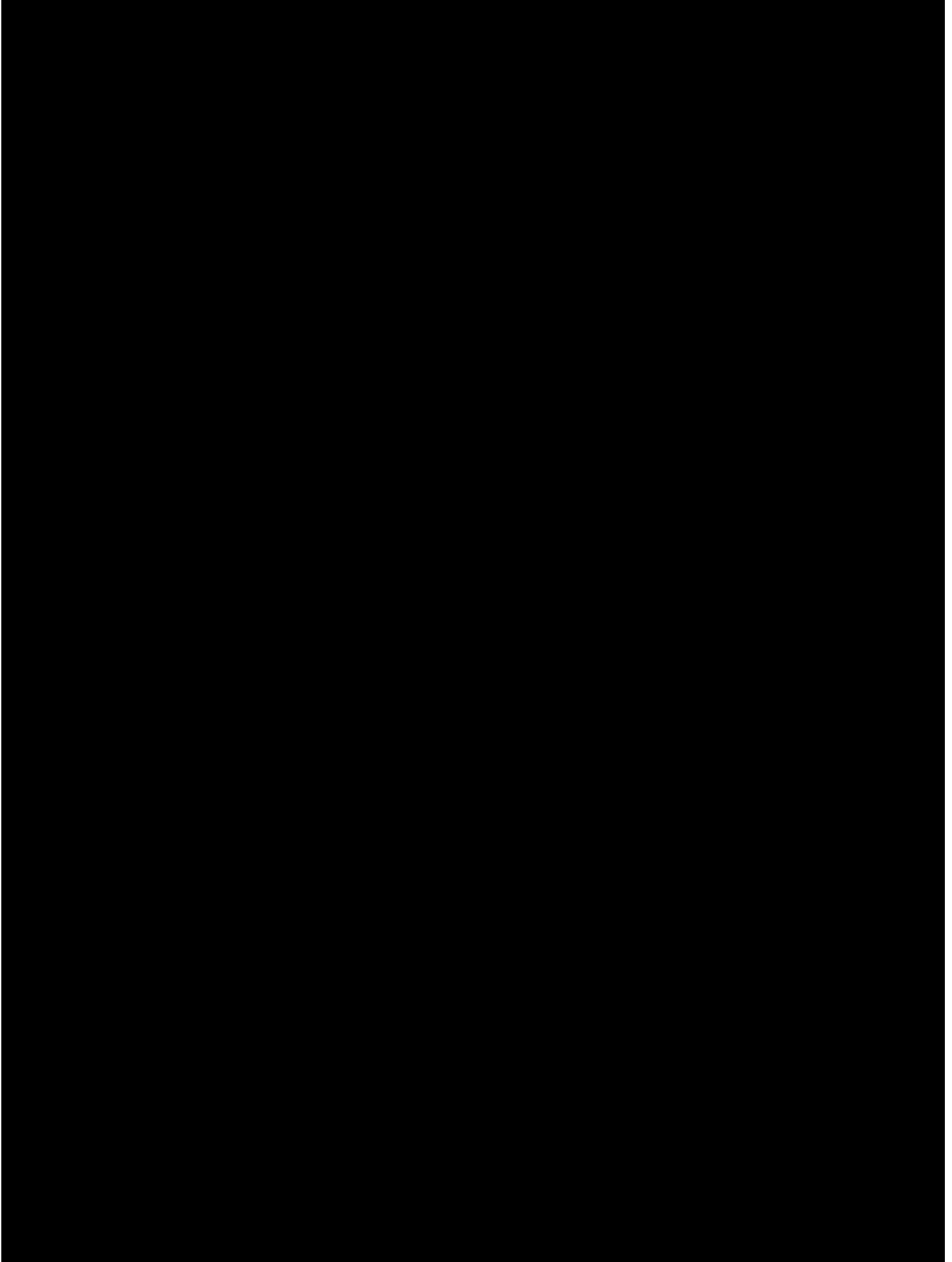
For the EGWP, the Programs will pay for all claims, and will receive the full value of the CMS direct subsidy, CMS low-income subsidy, and any CMS reinsurance received by SilverScript Insurance Company. The client will be responsible for the administrative fees, based on the services elected.

SilverScript's invoices are divided into two categories - claims costs and administrative fees – and may be reported at the group level based on the client's specifications.

**Claim Costs** – With respect to processing frequency, the invoicing of claim costs occurs four times a month (date driven with cut-offs on the 7th, 15th, 23rd, and the last day of the month). Invoices are prepared for delivery by the second business day following the close of the processing period. Delivery and assembly standards depend on the medium and the method of delivery.

**Administrative Fees** – Per claim administrative fees are billed four times a month (date driven with cut-offs on the 7th, 15th, 23rd, and the last day of the month). Administrative fee transactions are included on the same invoice as the claim ingredient costs. Invoices are prepared for delivery by the second business day following the close of the processing period. Delivery and assembly standards depend on the medium and the method of delivery.





**DCS and NYSIF Prescription Drug Programs**  
**Re-pricing Instructions for Offeror's Re-Priced Claims File**

In support of the Offeror's proposed claim reimbursement quote presented in Exhibit V.A and V.D and in accordance with Section V of the RFP, each Offeror is required to present the effect of the Offeror's proposed AWP discount and dispensing fees on **DCS Program** drug claims paid during the period 11/12/2010 through 10/28/2011. Use the claim data file available to Offerors in accordance with Section III. PART G of this RFP (containing 1 record for each DCS Program drug claim paid during the 12 month period ending 10/28/2011), to re-price each prescription using your proposed reimbursement formula(e) for the Programs. In doing so, please assume:

1. All prescriptions are filled February 1, 2012; therefore, the AWP in effect on February 1, 2012 should be used;
2. All prescriptions are filled for the same enrollee type with the same drug, dosage, strength and quantity identified by the NDC and claim data file; do not assume any changes;
3. All prescriptions are filled at the same pharmacy indicated by the NPI; do not assume any changes, with the exception of prescriptions filled at the Mail Service Pharmacy or the Specialty Pharmacy; and
4. All re-priced claims should not be adjusted for sales tax or coordination of benefit savings.

**Note: In order to simplify this re-pricing request, we have eliminated all the records associated with reversals, compound drugs, zero quantity claims, coordination of benefits claims, VA hospital claims and NYS Medicaid Program claims.**

The Offeror is required to submit a re-priced claims file with their Cost Proposal using the Layout Specifications detailed in Exhibit V.B.1. The re-priced claims file should report the claims data originally provided by the Department along with the following nine additional fields at the end of each record:

**Field 1 Pharmacy Type:** Based on the Offeror's proposed Pharmacy Network and composition of drugs included in the Specialty Pharmacy Program, as well as the Pharmacy NPI and Specialty Program Participation Indicator included in the claims data file, code each record with one of the five pharmacy types: R = Retail Network Pharmacy, M = Mail Service Pharmacy, D = Direct Submit (Enrollee) Claim, N = Non-network Pharmacy), S = Specialty Pharmacy.

First, for all drugs proposed for the Specialty Pharmacy Program, the Offeror should enter "S" if the Specialty Program Participation Indicator (SPPI) is coded with "Y"; if SPPI is coded with N, then enter "M" in Field 1 if the NPI is one of the numbers below or "R" if the pharmacy is a participating retail pharmacy in your proposal.

For all other prescriptions (non-specialty), the Offeror should enter "M" in Field 1 if the NPI is one of the codes of the numbers below. For Direct Submit claims as indicated by the code "E" in the Provider\_Class field, the Offeror should enter "D."

**DCS Program and NYSIF Program PRESCRIPTION DRUG PROGRAM**  
**Re-pricing Instructions for Offeror's Re-Priced Claims File**

- Field 1 (continued) For the remaining prescriptions, the Offeror should enter "R" if the pharmacy is a participating retail network pharmacy proposed by the Offeror or enter "N" if the pharmacy is not a participating retail network pharmacy proposed by the Offeror.
- Claims with the following Pharmacy NPI numbers are considered to be Mail Service Pharmacy Claims if the claim is not a Specialty Pharmacy Claim: 1275740474, 1346208949, 1417915653, 1528275724, 1548282510, 1972710176, 1184672883, 1184675910, 1205885175, 1407807191, 1710933007.
- Field 2 **Drug Type:** Based on the Offeror's proposed composition of the Flexible Formulary and the NDC of the drug included in the claims data file, code each record with one of the four drug types: 1 = Generic Rx, 2 = Preferred Brand Rx, 3 = Non Preferred Brand Rx, 4 = Excluded Rx.
- Field 3 **Therapeutic Category For Formulary:** For each claim record, enter the therapeutic category for the drug. The therapeutic category should be consistent with the category used in the development of the submitted formulary.
- Field 4 **AWP:** For each claim record, enter the AWP for the dispensed drug as of February 1, 2012, using the Offeror's proposed source of AWP (Redbook or MediSpan).
- Field 5 **Ingredient Cost:** Based on the Offeror's proposed Pharmacy Network and composition of drugs included in the Specialty Pharmacy Program, as well as the Pharmacy NPI and Specialty Program Participation Indicator included in the claims data file, enter the Offeror's proposed Ingredient Cost for the dispensed drug, following the instructions below:
- For proposed Pharmacies in your Retail Network, price all Brand drugs using the proposed pass-through pricing contracted with the Pharmacy. For Mail Service Pharmacy, price all Brand drugs using the proposed guaranteed AWP discounts for Brands. For Specialty Pharmacy, price all Brand drugs using the proposed guaranteed AWP discounts for Specialty Drugs.
- For proposed Pharmacies in your Retail Network, price all Generic drugs using the pass-through pricing in the Offeror's proposed Program MAC list, or if the Generic drug is not MAC'd, the contracted AWP discount for Brands. For Mail Service Pharmacy, price all Generic drugs using the pass-through pricing in the Offeror's proposed Program MAC list, or if the Generic Drug is not MAC'd, the proposed guaranteed AWP discount for Brands. For Specialty Pharmacy, price all Generic drugs using the proposed guaranteed AWP discount for Specialty Drugs.



**DCS Program and NYSIF Program PRESCRIPTION DRUG PROGRAM**  
**Re-pricing Instructions for Offeror's Re-Priced Claims File**

- Field 5 (continued) For Pharmacies that are not in your proposed Retail Network, price all Generics using the Minimum Guaranteed Discount proposed for all retail Generics. Price all Brands using the Minimum Guaranteed Discount proposed for all retail Brands.
- Field 6 **Dispensing Fee:** Based on the Pharmacy Type identified in Field 1 (above) as well as the NYS Generic Brand Code and NDC of the drug included in the claims data file, enter the Offeror's proposed dispensing fee, following the instructions below:
- For Pharmacy Type R, enter the Offeror's proposed pass-through dispensing fee contracted with the Pharmacy. For Pharmacy Type M, enter the Offeror's proposed guaranteed dispensing fee applicable to Brand or Generic drugs. For Pharmacy Type D or N, enter the Offeror's proposed Maximum Guaranteed Dispensing Fee applicable to Brand or Generic drugs. For Pharmacy Type S, enter the Offeror's proposed guaranteed dispensing fee applicable to the specific Specialty Drug.
- Field 7 **Co-payment:** Based on the Pharmacy Type identified in Field 1 and the Drug Type identified in Field 2 (above) as well as the three level benefit design of the Program specified in Exhibit II.C, enter the applicable co-payment. If the Total Claim Cost [Ingredient Cost (Field 5) plus Dispensing Fee (Field 6)] for any claim is less than the Plan co-payment amount, enter the Total Claim Cost. When the drug dispensed meets the criteria for generic enforcement as set forth in the RFP, enter the Level 3 (non-preferred) copayment amount, excluding any ancillary charge.
- Field 8 **Therapeutic Category For Pharma Revenue Agreements:** Enter the therapeutic Pharma Revenue classification system for negotiating pharma revenue agreements for each drug.
- Field 9 **GPI:** Offerors proposing to use Medispan as the source of AWP in Field 4 (above), enter the Medispan Generic Product Indicator (GPI) associated with the NDC dispensed. If proposing to use Redbook as the source of AWP in Field 4 and FDB for other prescription drug classification indices, leave this Field 9 blank.

**(Amended April 27, 2012)**

**DCS and NYSIF Prescription Drug Programs**  
**Layout Specifications for Exhibit V.B.2 Offeror's Re-Priced Claims Files**

**Purpose:** To define data layout specifications for Offerors' Re-Priced Claims Files (based on DCS Program claim data only), submitted with their Cost Proposal as Exhibit V.B.2. This layout contains the claims data fields originally provided by the Procuring Agencies, along with the following nine additional fields at the end of each record that are to be filled out by the Offeror in accordance with the Re-pricing Instructions set forth in Exhibit V.B:

- Field 1: Pharmacy Type
- Field 2: Drug Type
- Field 3: Therapeutic Category For Formulary
- Field 4: AWP
- Field 5: Ingredient Cost
- Field 6: Dispensing Fee
- Field 7: Co-payment
- Field 8: Therapeutic Category for Pharma Revenue Agreements
- Field 9: Generic Product Indicator (GPI)

Note: The last 9 fields listed in this layout contain the required field format, field length, and definitions of field values for Fields 1 through 9 above.

**Media:** Data files should be provided on CD and labeled as Exhibit V.B2 with the Offeror's name.

**Format:** Flat file format; (text file, ~~comma delimited pipe delimited~~) **(Comma delimited criteria deleted 4/27/12 and pipe delimited criteria added 4/27/12)**

NOTE: As specified in Section III.G, a data file of NYSIF Program claims for the period November 1, 2010 through November 1, 2011 in the following format is provided for informational purposes to those Offeror's that request said file. Do not submit a Re-Price claims file for the NYSIF Program claims data.

| <i>NYS Dept of Civil Service<br/>Field Name</i> | <i>Name of Field</i>         | <i>Field<br/>Format</i> | <i>Field<br/>Length</i> | <i>Definition of Field Value/Comments</i>  |
|---|------------------------------|-------------------------|-------------------------|--|
| <b>DATE_OF_SERVICE</b>                          | <b>Date of service (DOS)</b> | Text                    | 8                       | Date of Service for the dispensed drug. Format = CCYYMMDD                                      |
| <b>NDC</b>                                      | <b>NDC</b>                   | Text                    | 11                      | NDC for the drug dispensed   |
| <b>PRODUCT_NAME</b>                             | <b>Product name</b>          | Text                    | 70                      | The name for the drug dispensed based on the manufacturing code, product code and package code |

**(Amended April 27, 2012)**

| <i>NYS Dept of Civil Service<br/>Field Name</i>  | <i>Name of Field</i>               | <i>Field<br/>Format</i> | <i>Field<br/>Length</i> | <i>Definition of Field Value/Comments</i>   |
|--|------------------------------------|-------------------------|-------------------------|---|
| <b>NEW_REFILL_CD</b>   | <b>New/Refill code</b>             | Text                    | 2                       | Indicator that identifies if the prescription was new or a refill on the drug dispensed.<br><b>00</b> = New script<br><b>01 -99</b> = Refill Number   |
| <b>QUANTITY_DISPENSED</b>  | <b>Quantity Dispensed</b>          | Number                  | (13,3)                  | Metric quantity for the drug dispensed. Format is a right-justified numeric field up to 13 total positions including a decimal point and up to 3 characters after the decimal point.<br>Examples:<br>Value of 180 will show as <b>180</b><br>Value of 30.5 will show as <b>30.5</b><br>Value of 1.258 will show as <b>1.258</b> |
| <b>DAYS_SUPPLY</b>   | <b>Days Supply</b>                 | Number                  | (4,0)                   | Days supply for the drug dispensed. Format is right-justified numeric field.<br>Examples:<br>Value of 120 will show as <b>120</b><br>Value of 90 will show as <b>90</b><br>Value of 2 will show as <b>2</b>   |
| <b>DATE_OF_BIRTH</b>   | <b>Date of Birth</b>               | Text                    | 8                       | Date of birth for the member. Format = <i>CCYYMMDD</i>  |
| <b><u>MEMBER_SUBSCRIBER_ID</u></b><br><br><b>(Field deleted on 3-8-12 – DCS file only)</b> | <b><u>Member Subscriber Id</u></b> | <b><u>Text</u></b>      | <b><u>9</u></b>         | <b><u>Nine character encrypted member subscriber id.</u></b>  |
| <b><u>PART_B_INDICATOR</u></b><br><br><b>(Field added on 3-8-12 - DCS file only)</b>       | <b><u>Part B Indicator</u></b>     | <b><u>Text</u></b>      | <b><u>1</u></b>         | <b><u>Y = Member had Medicare Part B primary coverage on claim adjudication date</u></b><br><b><u>N = Member did not have Medicare Part B primary coverage on claim adjudication date (“N” added on 3-9-12)</u></b>   |
| <b>PERSON_CD</b>   | <b>Person Code</b>                 | Text                    | 2                       | Person code that claim processed against  |
| <b>BENEFIT_PROGRAM</b>   | <b>Benefit Program</b>             | Text                    | 3                       | Member’s Benefit Program indicator  |

**(Amended April 27, 2012)**

| <i>NYS Dept of Civil Service<br/>Field Name</i>  | <i>Name of Field</i>                             | <i>Field<br/>Format</i> | <i>Field<br/>Length</i> | <i>Definition of Field Value/Comments</i>  |
|--|--|-------------------------|-------------------------|--|
| <b>SPECIALTY PROGRAM PARTICIPATION INDICATOR</b> | <b>Specialty Program Participation Indicator</b> | Text                    | 1                       | <b>Y</b> = Member participates in the Specialty Pharmacy Program<br><b>N</b> = Member does not participate in Specialty Pharmacy Program   |
| <b>PRODUCT_SELECTION_DAW_CD</b>                  | <b>DAW code</b>                                  | Text                    | 1                       | Drug Dispensed As Written<br><b>0</b> = None indicated<br><b>1</b> = Physician prescribed brand<br><b>2</b> = Physician allowed substitution, patient selected brand<br><b>3</b> = Physician allowed substitution , pharmacist substituted brand<br><b>4</b> = No generic available<br><b>5</b> = Brand was dispensed as generic<br><b>6</b> = Override<br><b>7</b> = Substitution not allowed - brand drug mandated by law<br><b>8</b> = Substitution allowed - generic drug not available in marketplace<br><b>9</b> = Other |
| <b>PHARMACY_NPI</b>                              | <b>Pharmacy NPI</b>                              | Text                    | 10                      | Unique number assigned to the dispensing pharmacy from the National Council for Prescription Drug Programs.  |
| <b>GCN</b>                                       | <b>Generic Code Number</b>                       | Text                    | 5                       | The (First Data Bank) generic code number associated with the NDC dispensed.   |
| <b>PROVIDER_CLASS</b>                            | <b>Provider Class</b>                            | Text                    | 3                       | Provider Class:<br><b>E</b> = Direct Member Submit<br><b>F</b> = Retail<br><b>P</b> = Mail Order   |
| <b>CLAIM_STATUS</b>                              | <b>Claim Status</b>                              | Text                    | 1                       | Claim status for the claim<br><b>P</b> = Paid  |
| <b>NYS_GENERIC_BRAND_CD</b>                      | <b>NYS Generic Brand Code</b>                    | Text                    | 1                       | The NYS brand/generic product indicator for the pharmacy submitted drug<br><b>0</b> = Brand<br><b>1</b> = Generic  |

**(Amended April 27, 2012)**

| <i>NYS Dept of Civil Service<br/>Field Name</i> | <i>Name of Field</i>                      | <i>Field<br/>Format</i> | <i>Field<br/>Length</i> | <i>Definition of Field Value/Comments</i>  |
|---|---|-------------------------|-------------------------|--|
| <b>PROVIDER_ZIP_CD</b>                          | <b>Provider Zip Code</b>                  | Text                    | 5                       | Pharmacy Zip Code  |
| <b>BILL_DATE</b>                                | <b>Bill Date</b>                          | Text                    | 8                       | Date that the claim was billed to the client. Format = <i>CCYYMMDD</i>   |
| <b>ROW_NUMBER</b>                               | <b>Row Number</b>                         | Number                  | (8,0)                   | Row number assigned sequentially. Format is right-justified numeric field.<br>Example: Value of 234567 will show as <b>234567</b>  |
| <b>PHARMACY_TYPE (Field 1)</b>                  | <b>Pharmacy Type</b>                      | Text                    | 1                       | <b>R</b> = Retail Network Pharmacy<br><b>M</b> = Mail Service Pharmacy<br><b>D</b> = Direct Submit (Enrollee) Claim<br><b>N</b> = Non-network Pharmacy<br><b>S</b> = Specialty (See Instructions)  |
| <b>DRUG_TYPE (Field 2)</b>                      | <b>Drug Type</b>                          | Text                    | 1                       | <b>1</b> = Generic Rx<br><b>2</b> = Preferred Brand Rx<br><b>3</b> = Non Preferred Brand Rx<br><b>4</b> = Excluded Rx  |
| <b>THER_CAT_FORM (Field 3)</b>                  | <b>Therapeutic Category For Formulary</b> | Text                    | 100                     | For each drug, provide the same level of therapeutic classification detail used in the development of the submitted formulary.   |
| <b>AWP (Field 4)</b>                            | <b>AWP</b>                                | Number                  | (13,5)                  | AWP for dispensed Rx as of 4/1/11.<br>Format is right-justified numeric field, totaling 13 positions including a decimal point and up to 5 positions after the decimal point. Examples:<br>Value of \$1.22095 should be coded as <b>1.22095</b><br>Value of \$288.50 should be coded as <b>288.5</b><br>Value of \$30.12345 should be coded as <b>30.12345</b> |

**(Amended April 27, 2012)**

| <i>NYS Dept of Civil Service<br/>Field Name</i> | <i>Name of Field</i>                                      | <i>Field<br/>Format</i> | <i>Field<br/>Length</i> | <i>Definition of Field Value/Comments</i>   |
|---|---|-------------------------|-------------------------|---|
| <b>INGREDIENT_COST (Field 5)</b>                | <b>Ingredient Cost</b>                                    | Number                  | (11,2)                  | Ingredient cost of the dispensed drug, as calculated using the re-pricing instructions included in Exhibit V.B. Format is right-justified numeric field totaling 11 positions including a decimal point and up to 2 positions after the decimal point. Examples:<br>Value of \$1028.61 should be coded as <b>1028.61</b><br>Value of \$131.00 should be coded as <b>131</b><br>Value of \$22.69 should be coded as <b>22.69</b><br>Value of \$1.55 should be coded as <b>1.55</b><br>Value of .85 should be coded as <b>.85</b> |
| <b>DISPENSING_FEE (Field 6)</b>                 | <b>Dispensing Fee</b>                                     | Number                  | (8,2)                   | Dispensing fee of the dispensed drug, as calculated using the re-pricing instructions included in Exhibit V.B. Format is right-justified numeric totaling 8 positions including a decimal point and up to 2 positions after the decimal point.<br>Examples:<br>Value of \$16.50 should be coded as <b>16.50</b><br>Value of \$1.65 should be coded as <b>1.65</b><br>Value of .65 should be coded as <b>.65</b>   |
| <b>CO_PAYMENT (Field 7)</b>                     | <b>Co-Payment</b>   | Number                  | (8,2)                   | Copayment of the dispensed drug, as calculated using the re-pricing instructions included in Exhibit V.B. Format is right-justified numeric field totaling 8 positions, including a decimal point and up to 2 positions after the decimal point.<br>Examples:<br>Value of \$30.00 should be coded as <b>30</b><br>Value of \$17.31 should be coded as <b>17.31</b><br>Value of \$5.00 should be coded as <b>5</b><br>Value of zero should be coded as <b>0</b>  |
| <b>THER_CAT_PHARMA (Field 8)</b>                | <b>Therapeutic Category for Pharma Revenue Agreements</b> | Text                    | 100                     | Therapeutic classification system used for negotiating pharma revenue agreements for each drug.   |
| <b>GPI (Field 9)</b>                            | <b>Generic Product Indicator</b>                          | Text                    | 14                      | If proposing to use Medispan as the source of AWP in Field 4, fill in the Generic Product Indicator associated with the NDC dispensed. If using Red Book as the source of the AWP in Field 4, leave this field blank.   |

**Exhibit V.B.2**

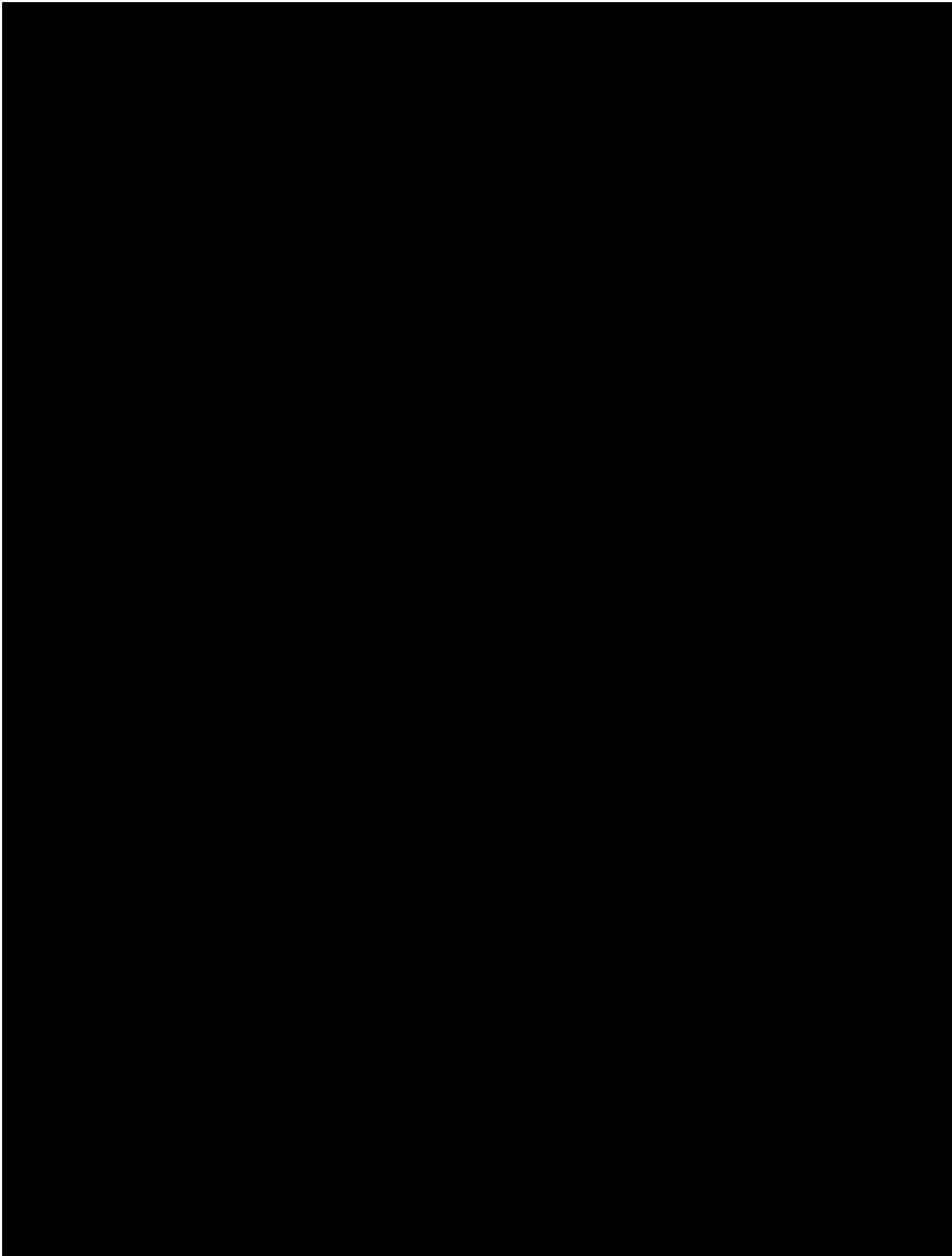


EXHIBIT V.C

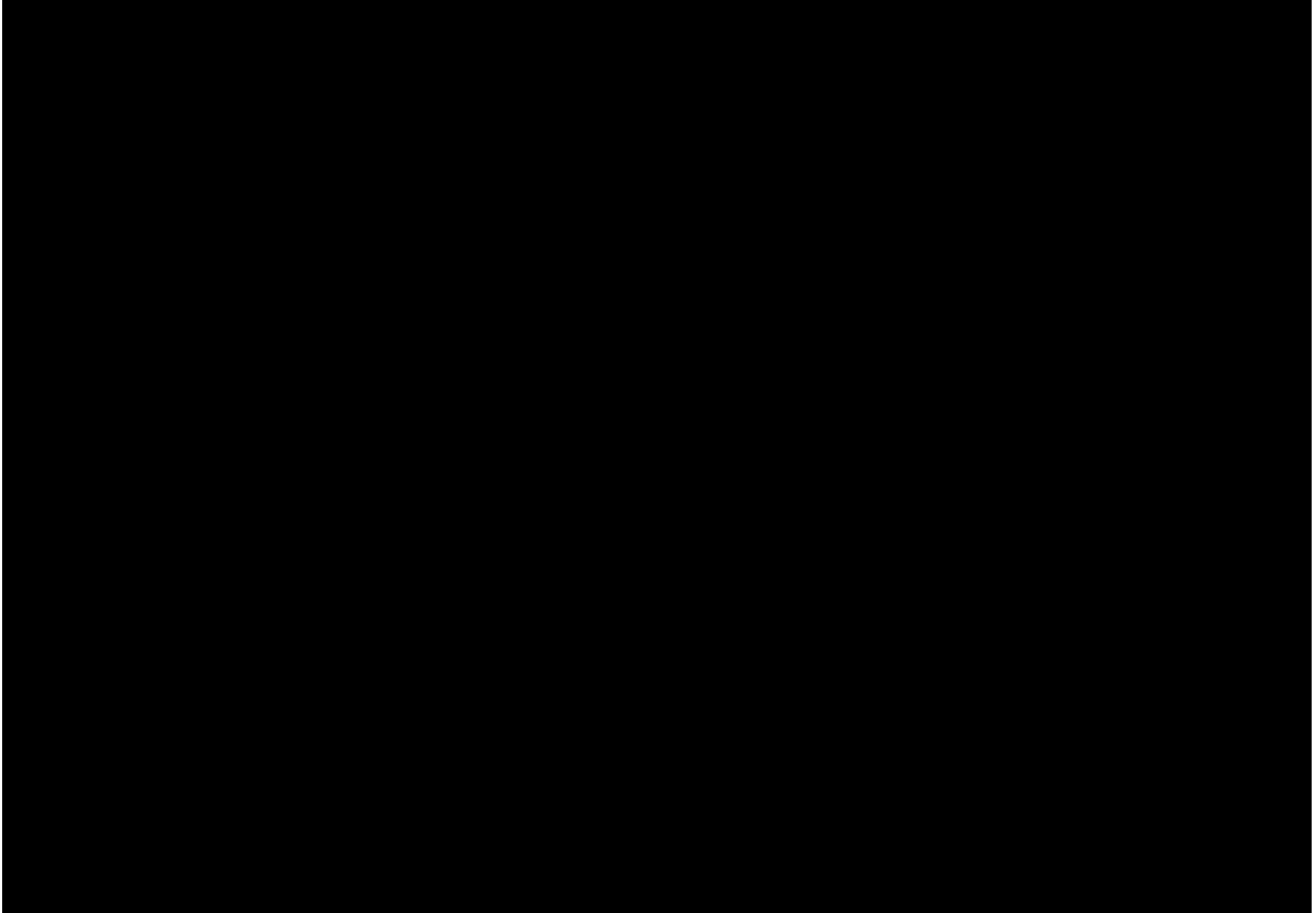




EXHIBIT V.C

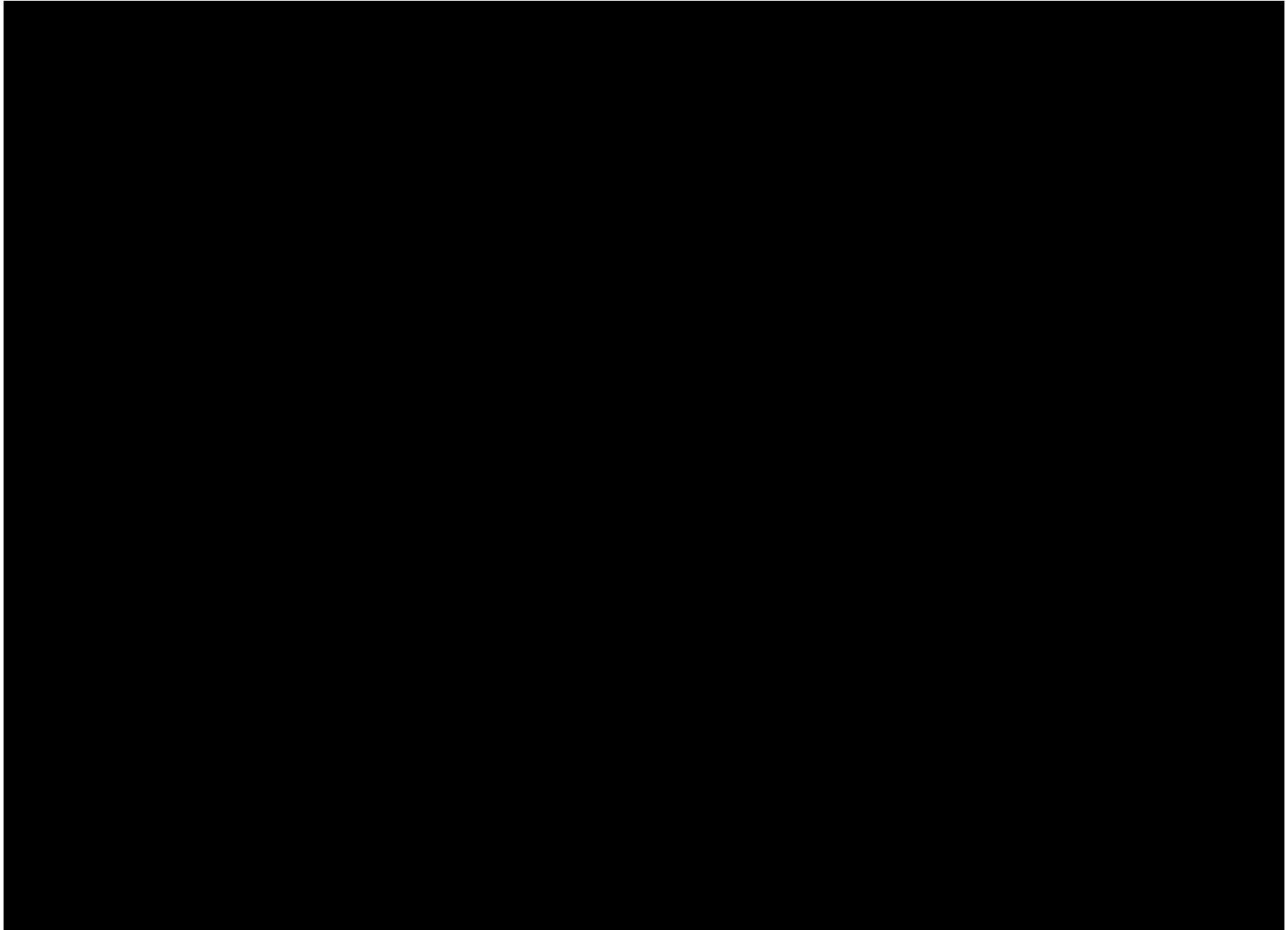


EXHIBIT V.C

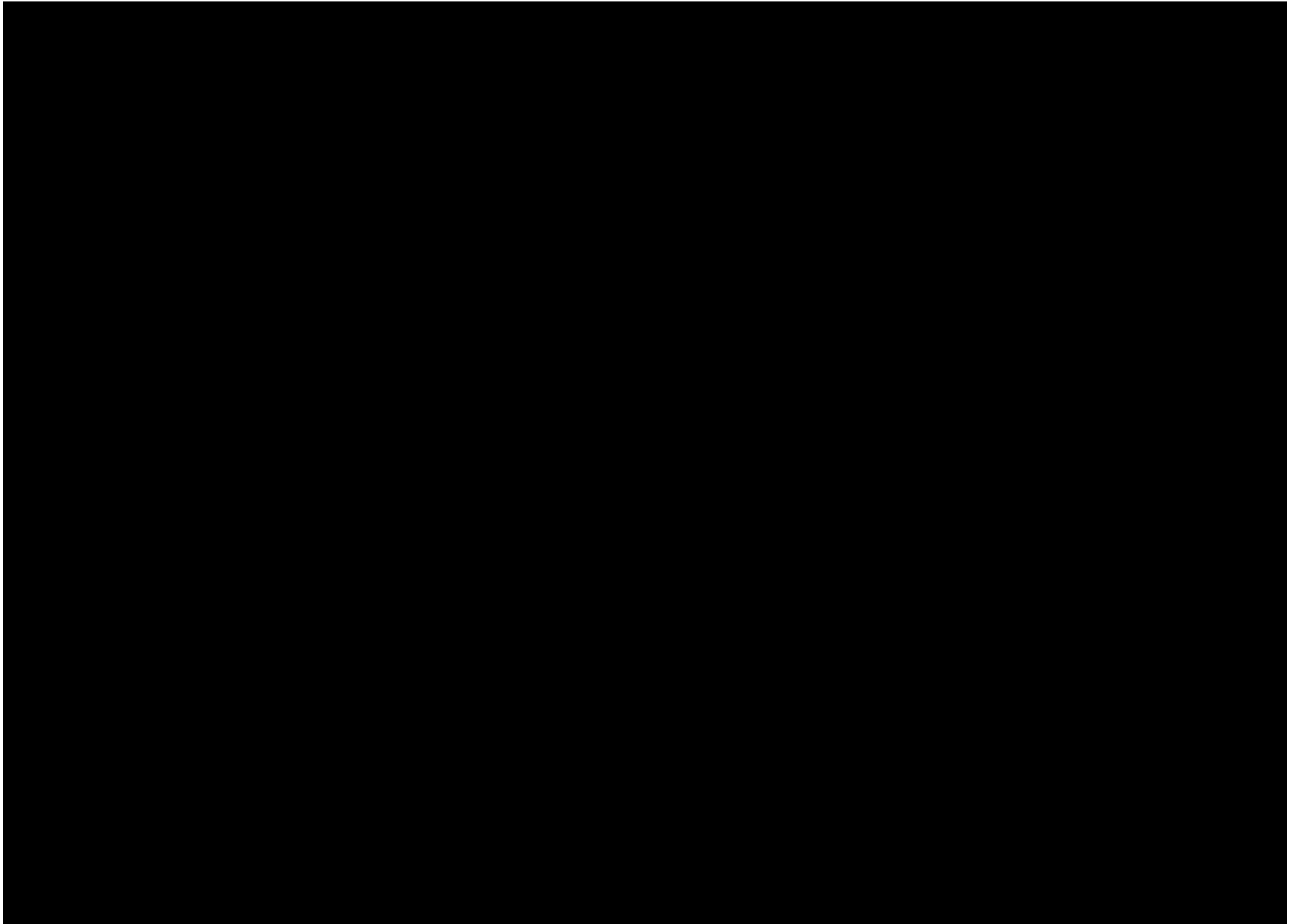


EXHIBIT V.C

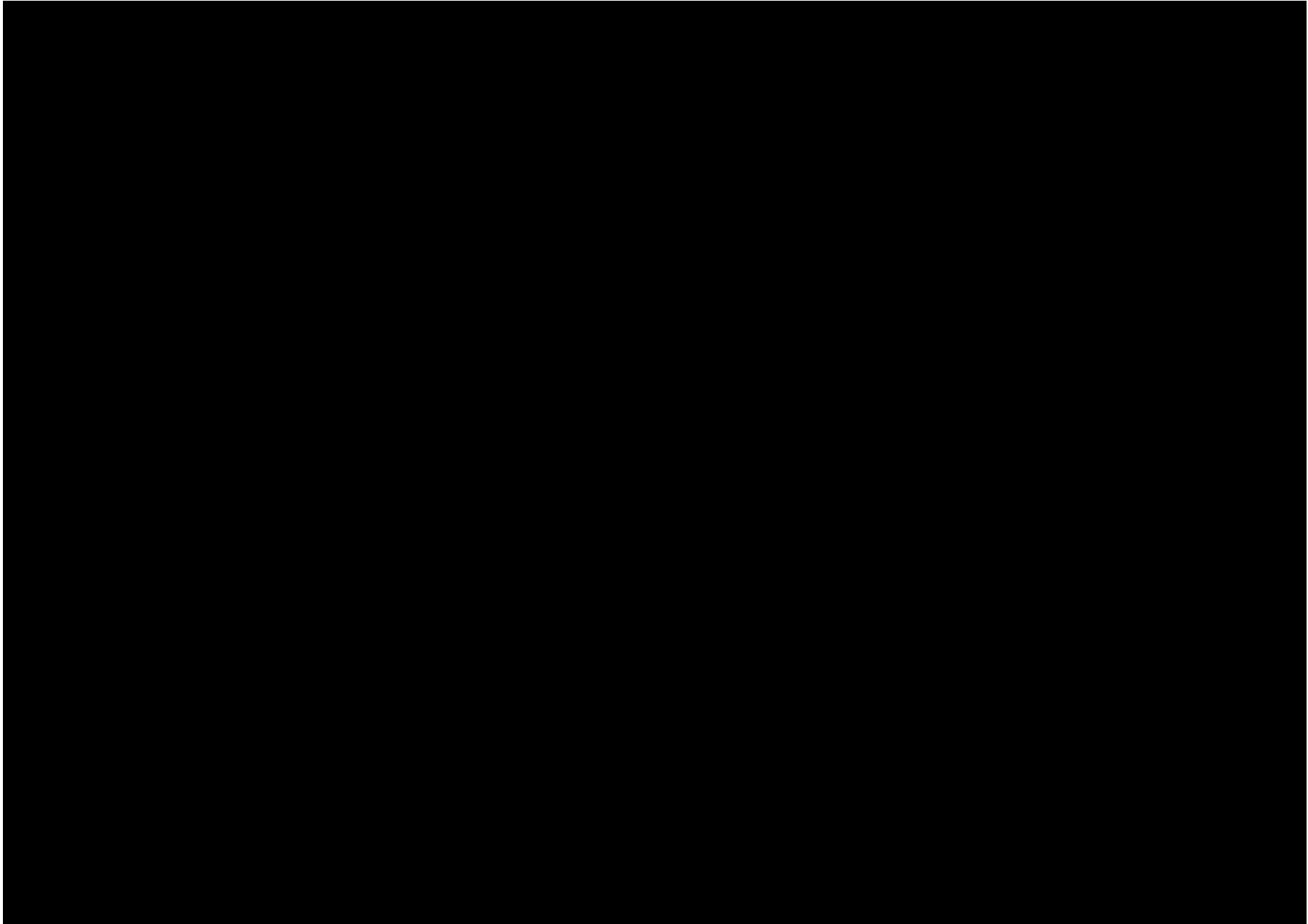


EXHIBIT V.C

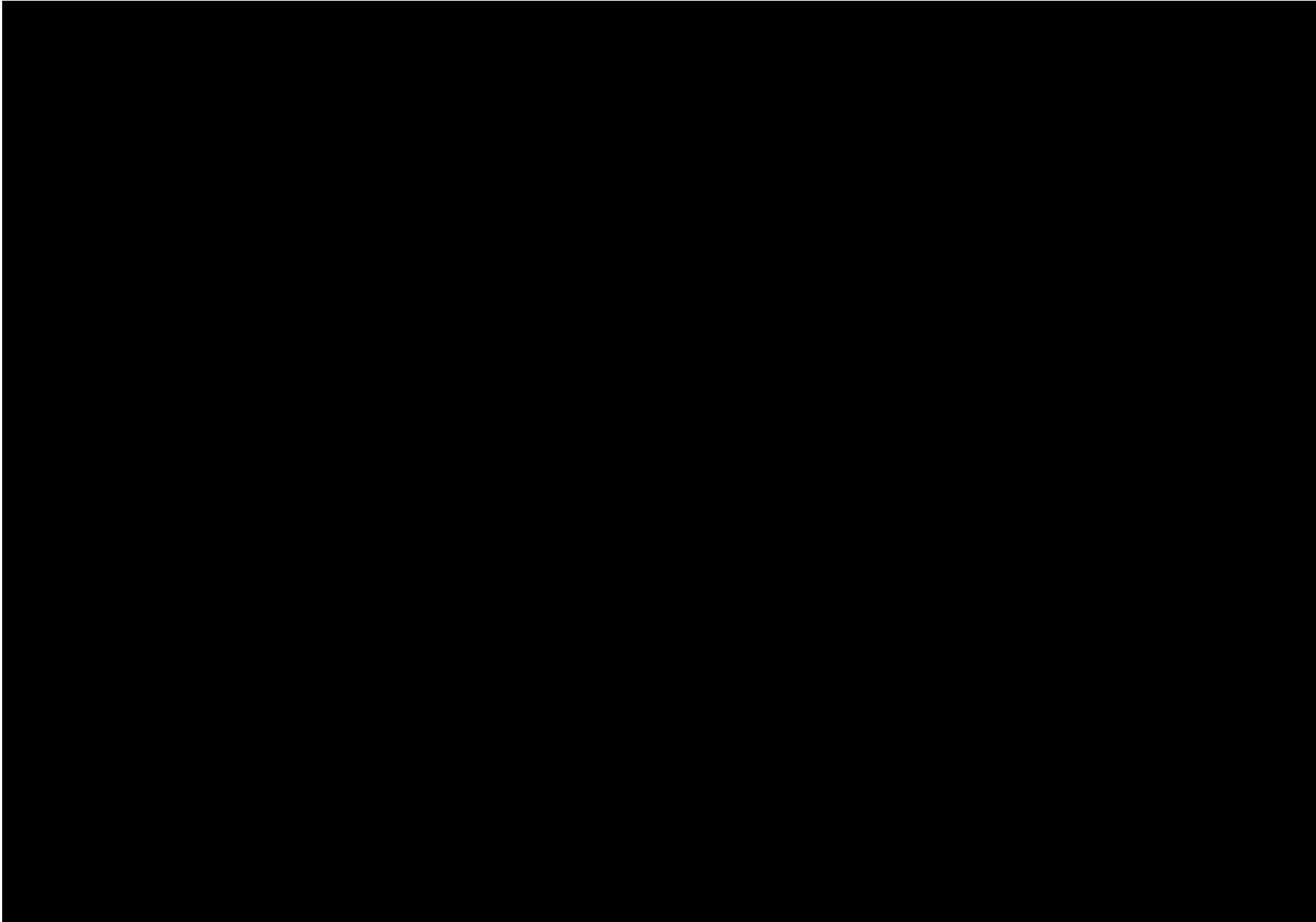


EXHIBIT V.C

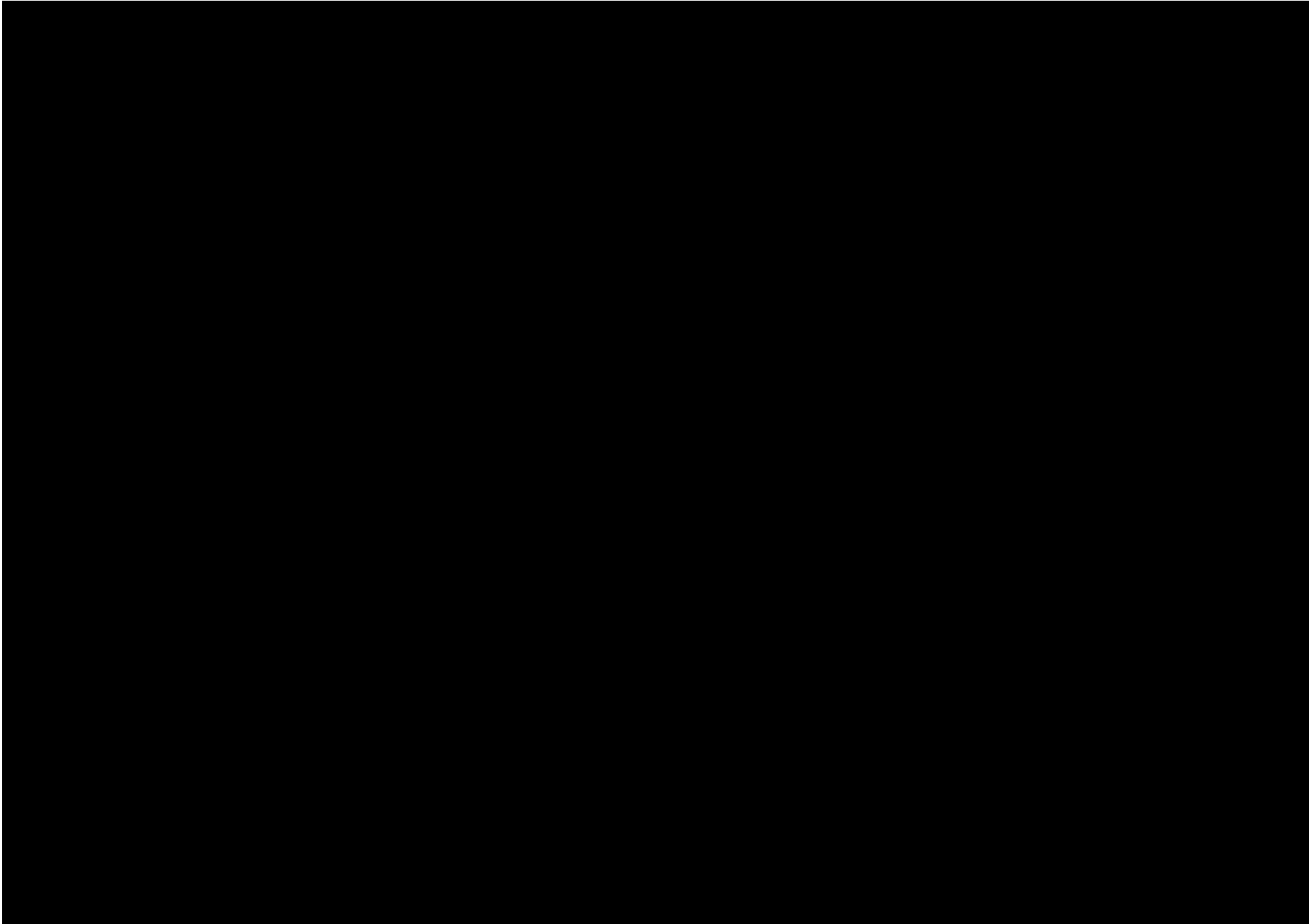


EXHIBIT V.C

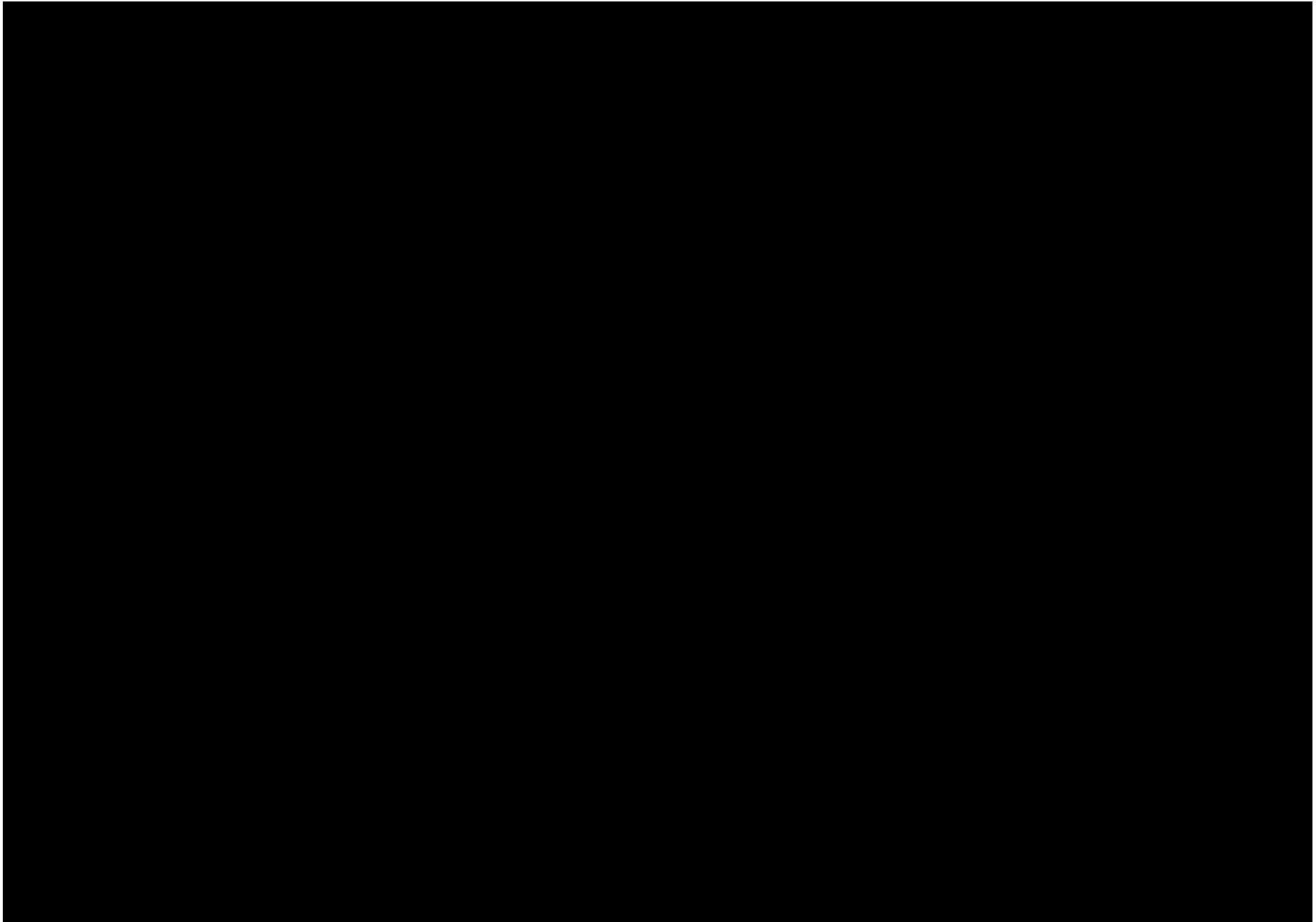


EXHIBIT V.C

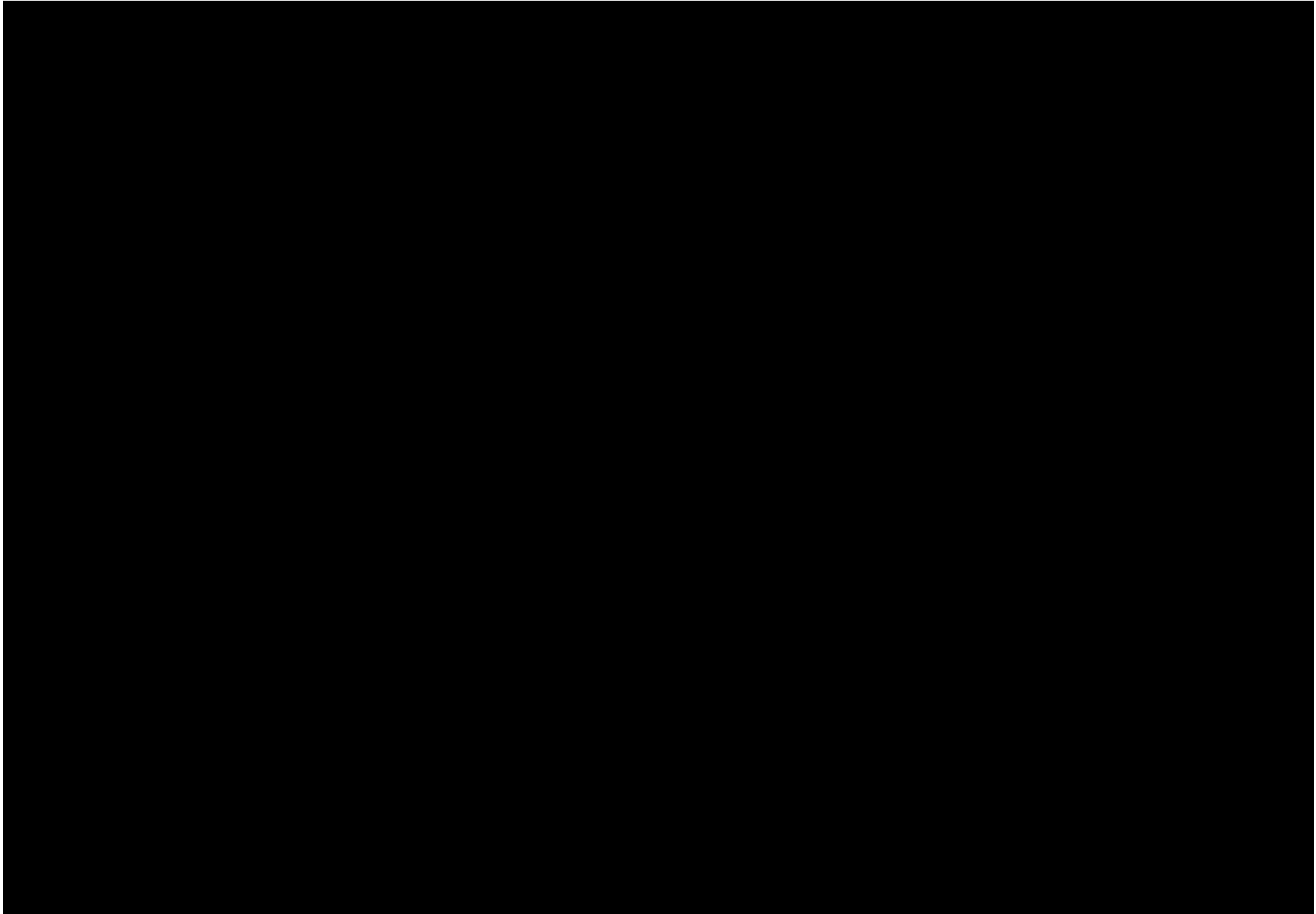


EXHIBIT V.C

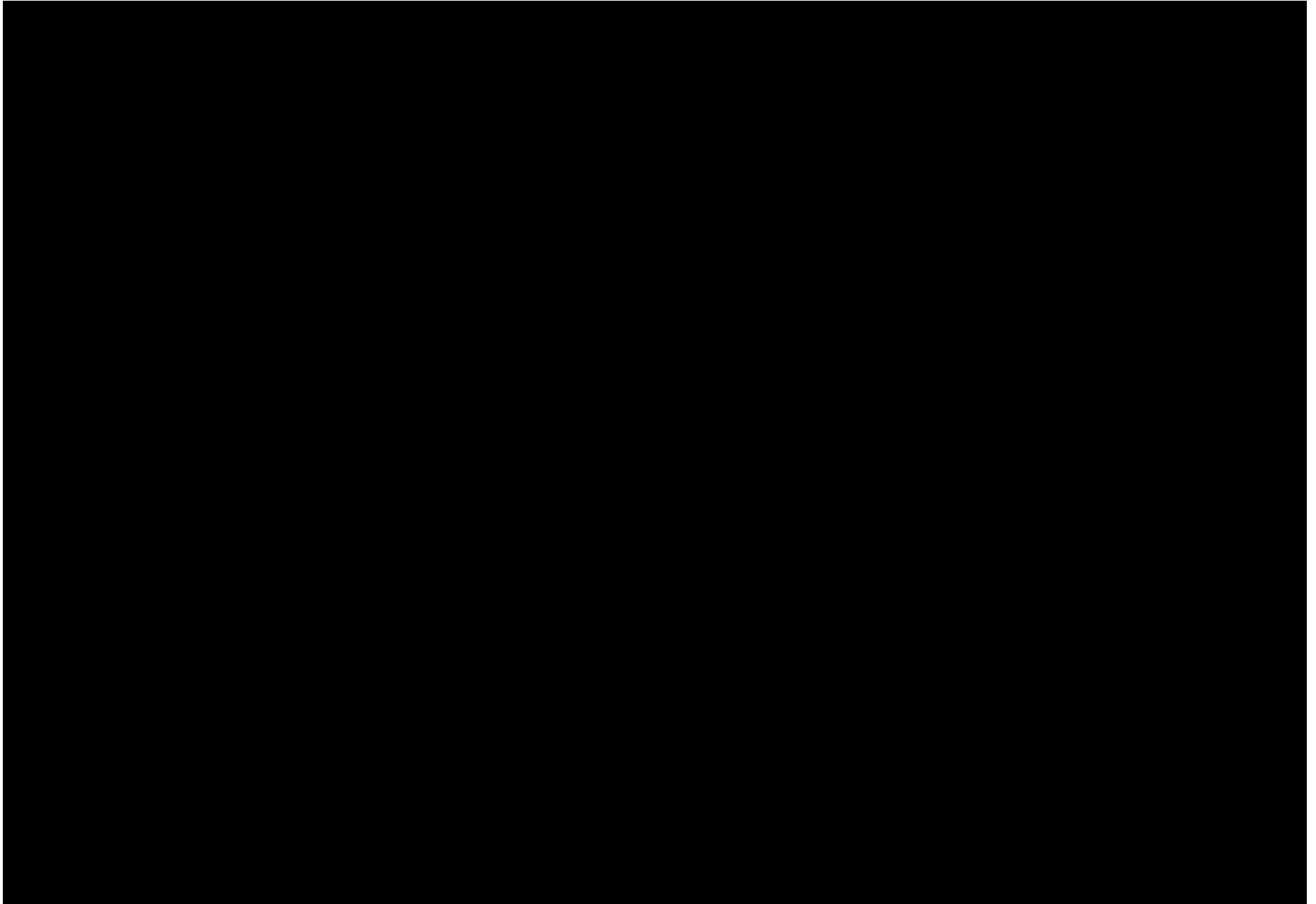




EXHIBIT V.C

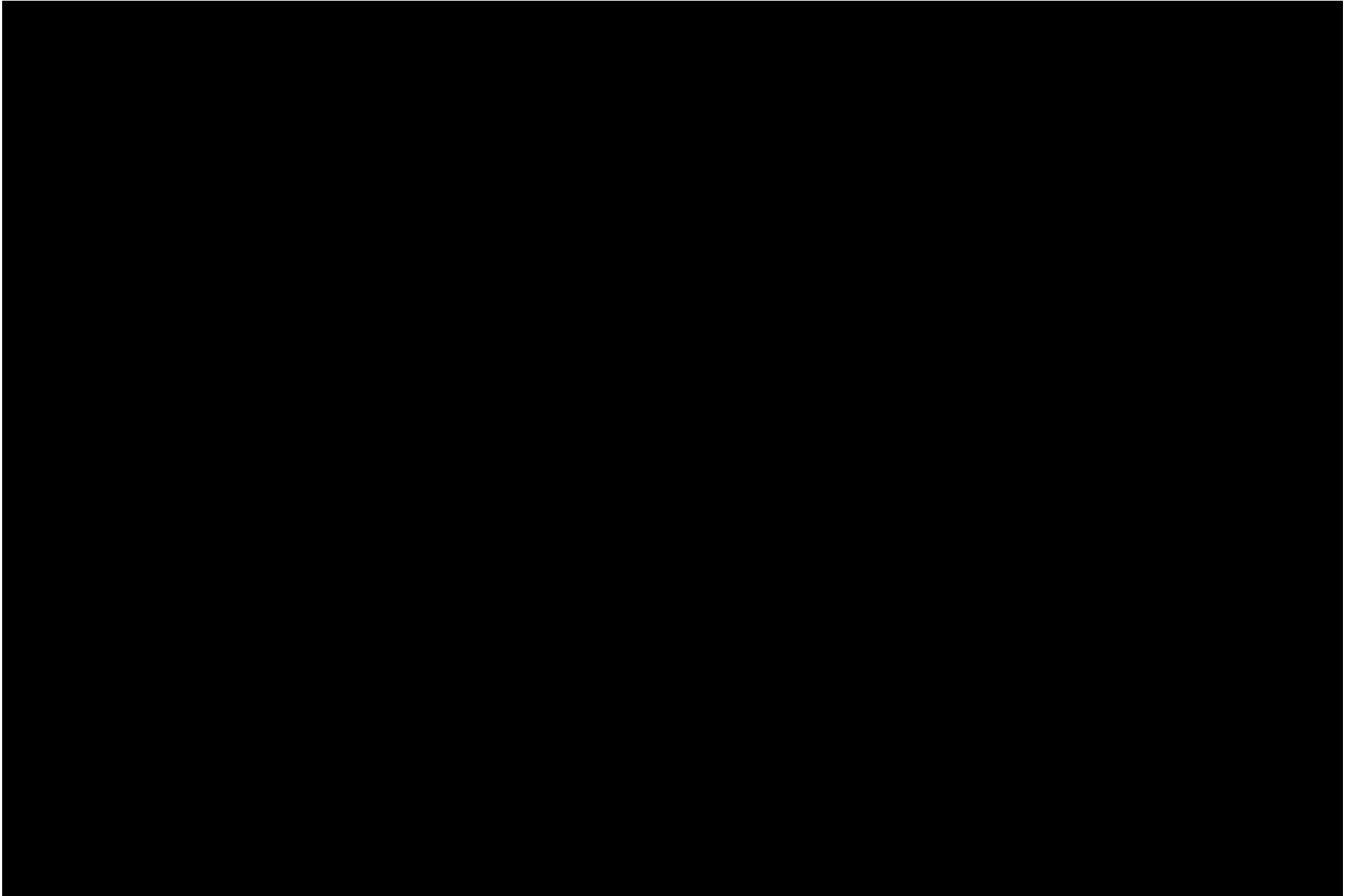


EXHIBIT V.C

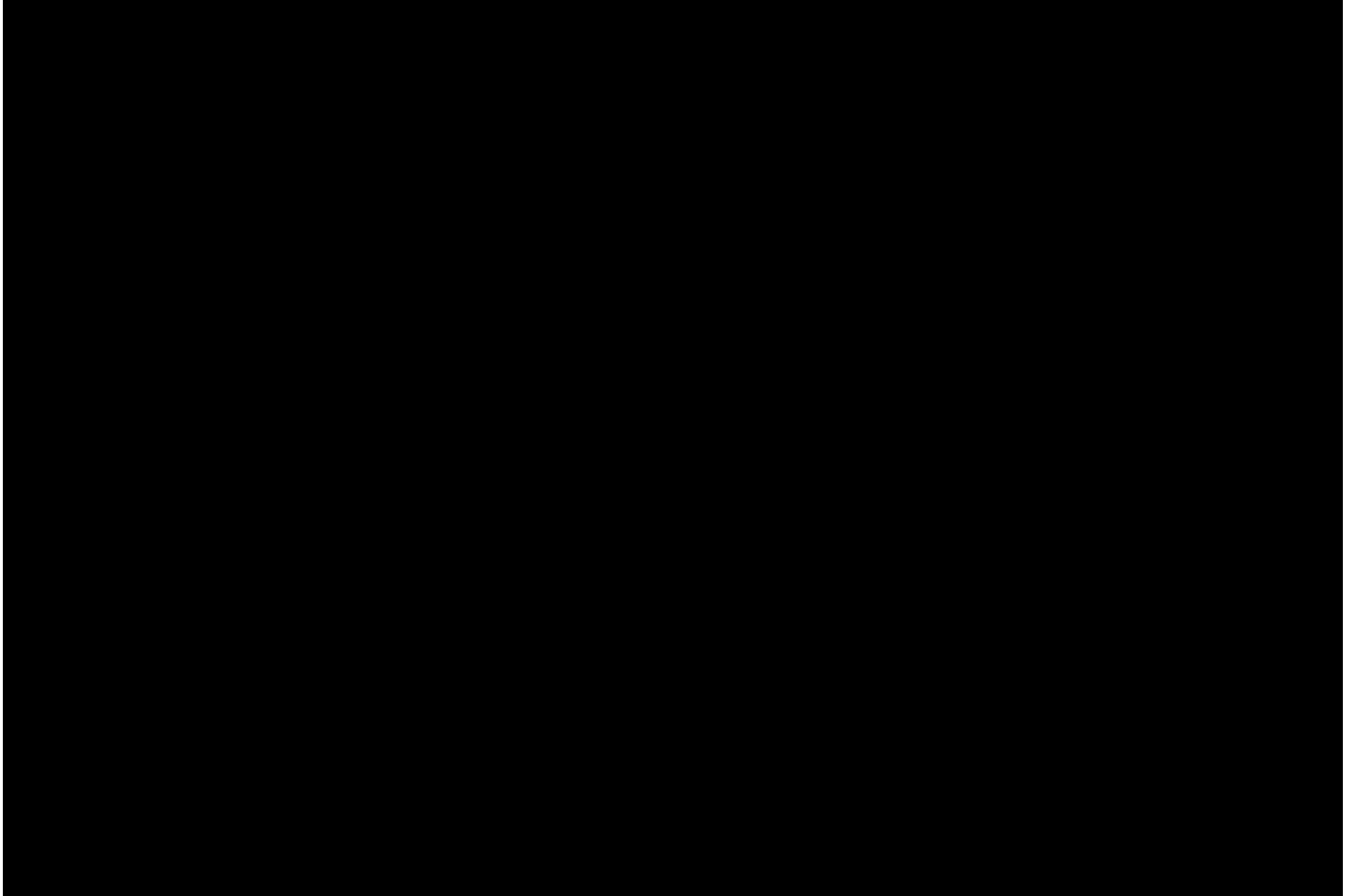


EXHIBIT V.C

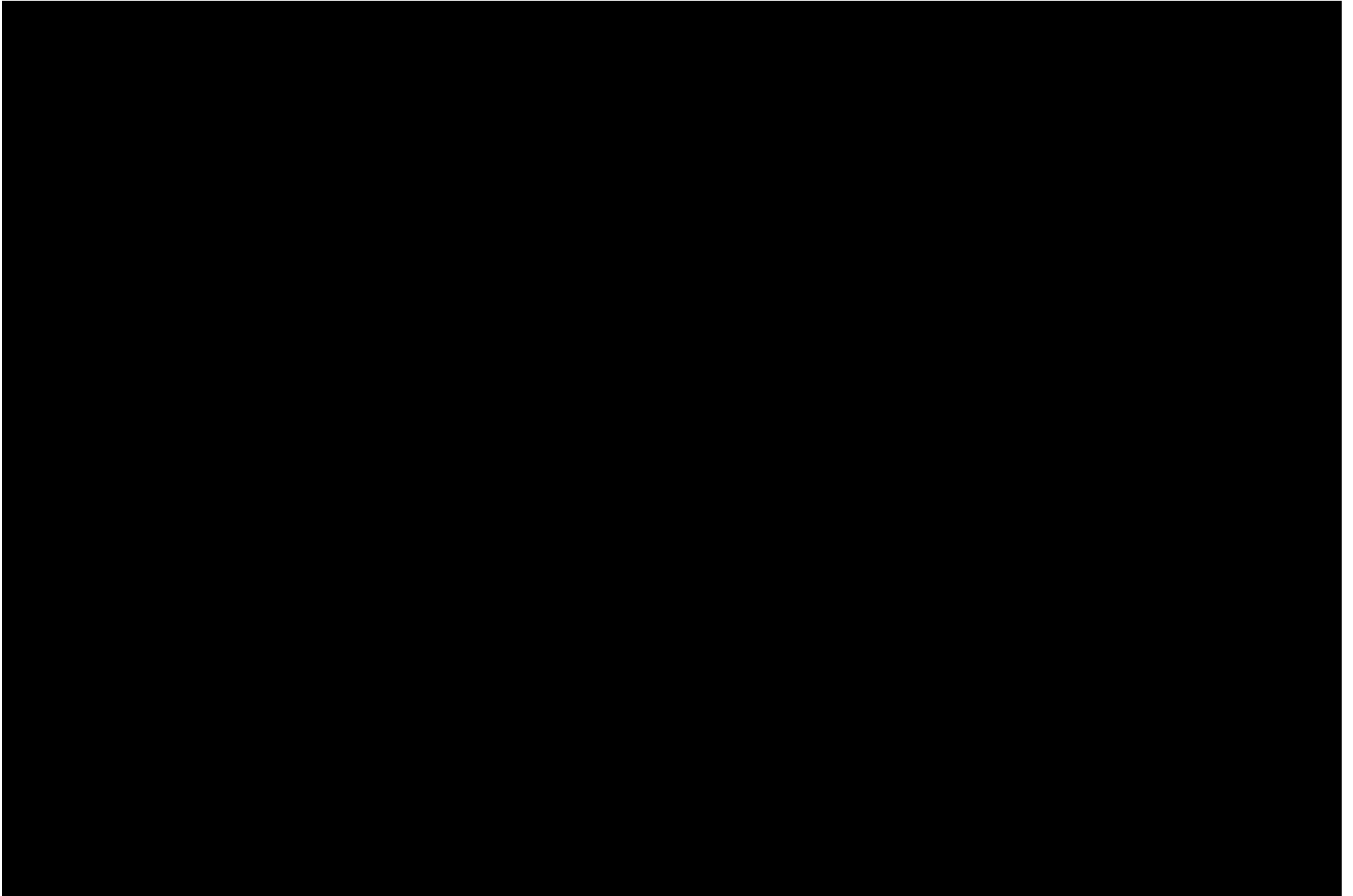


EXHIBIT V.C

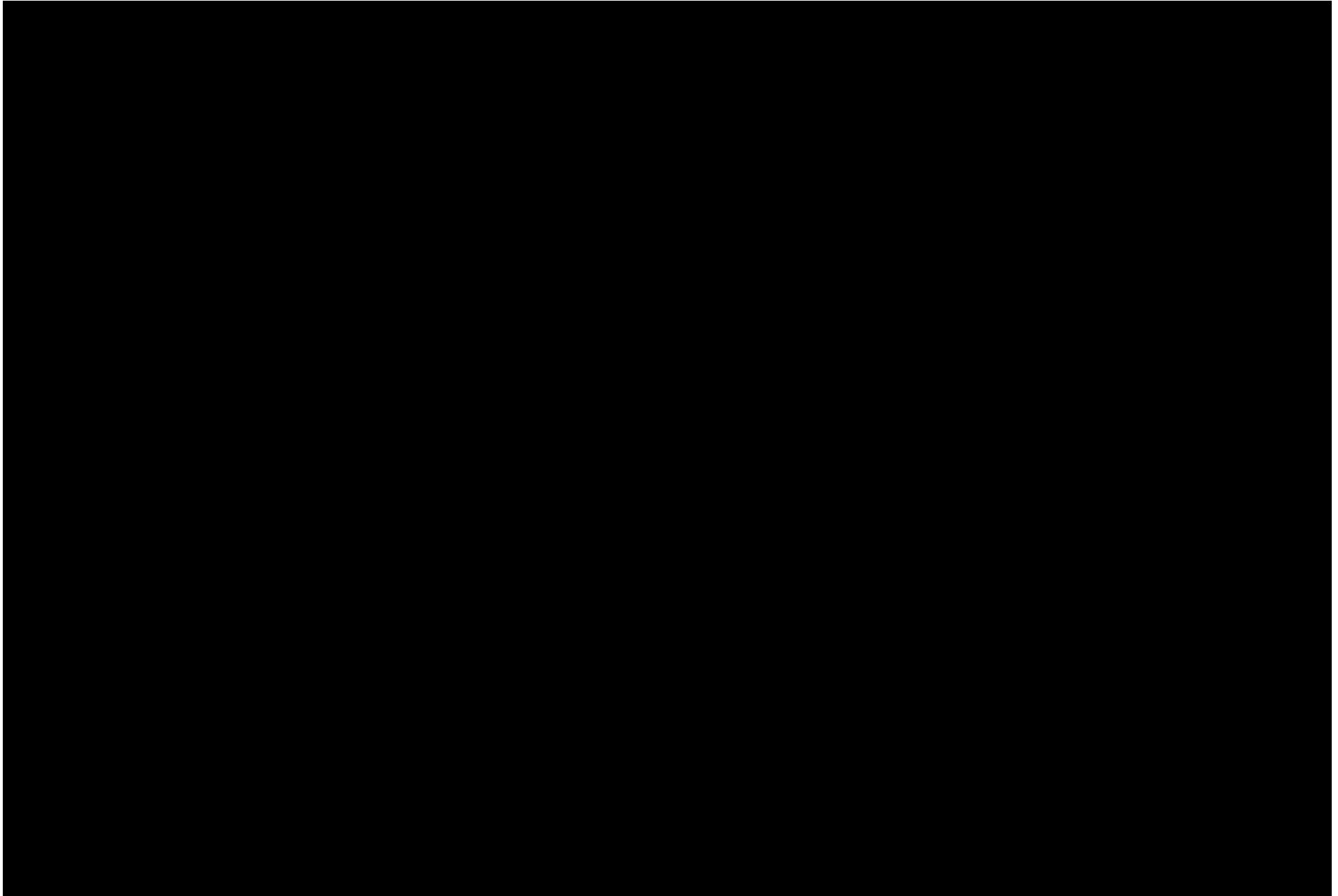


EXHIBIT V.C

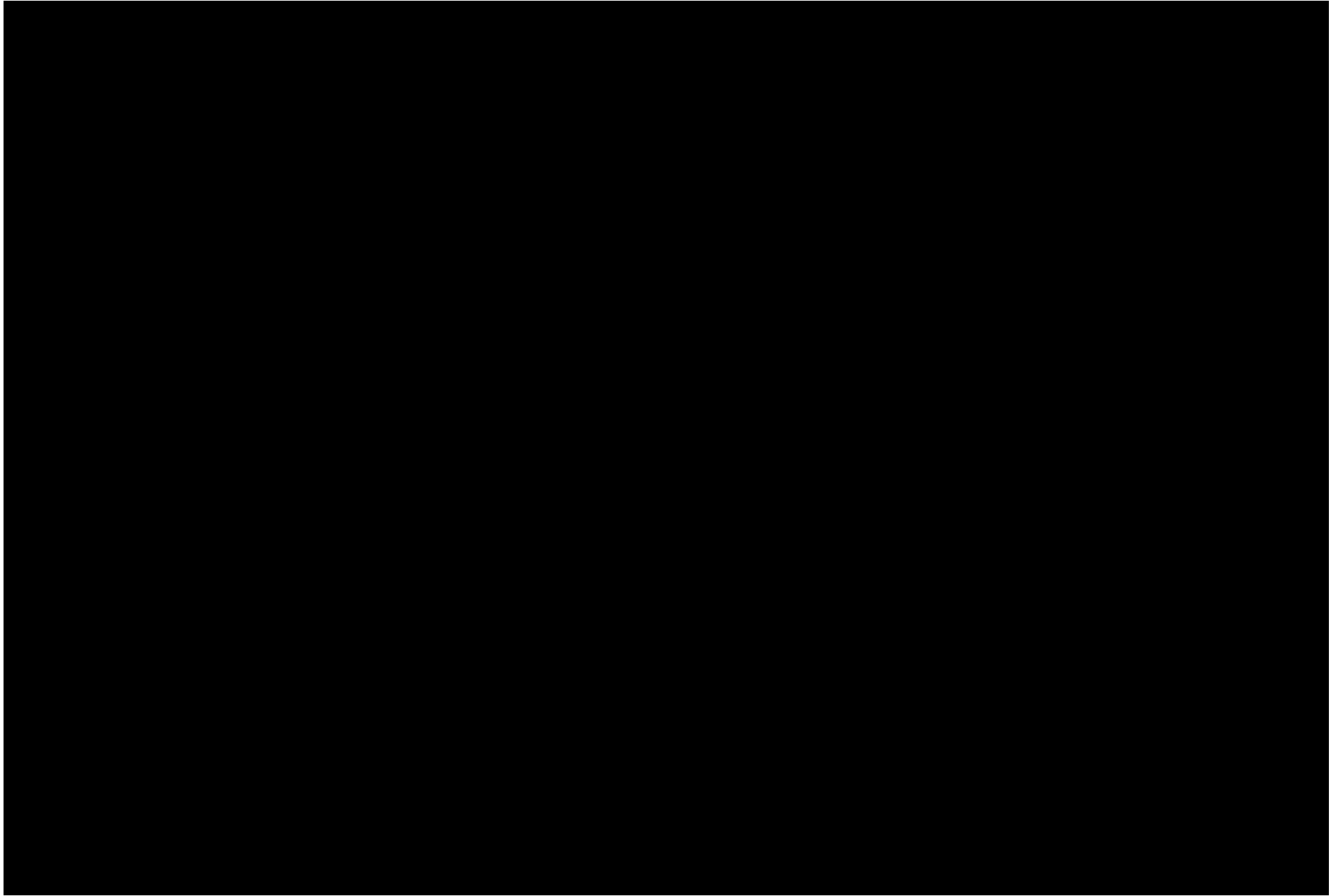


EXHIBIT V.C

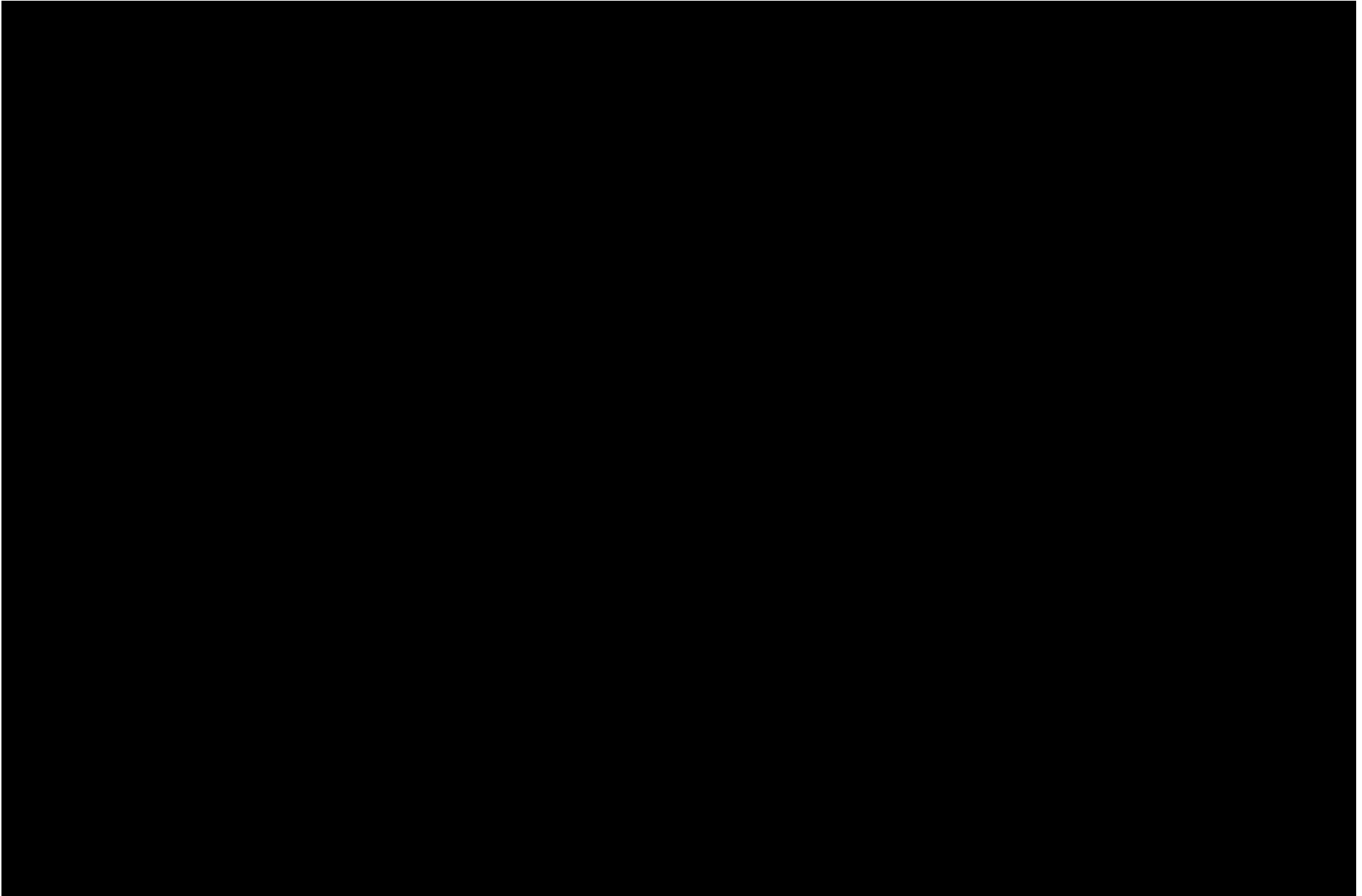


EXHIBIT V.C

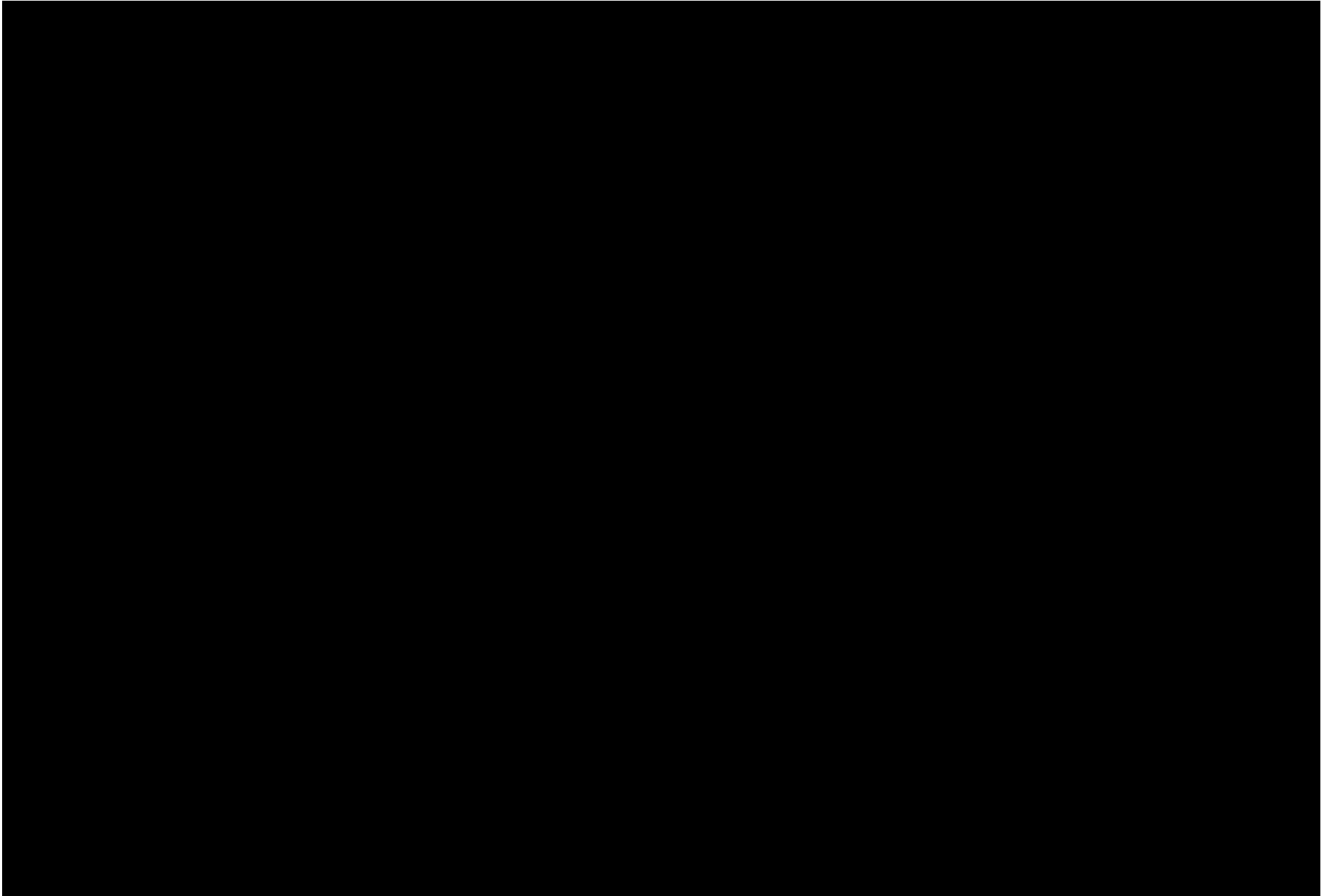


EXHIBIT V.C

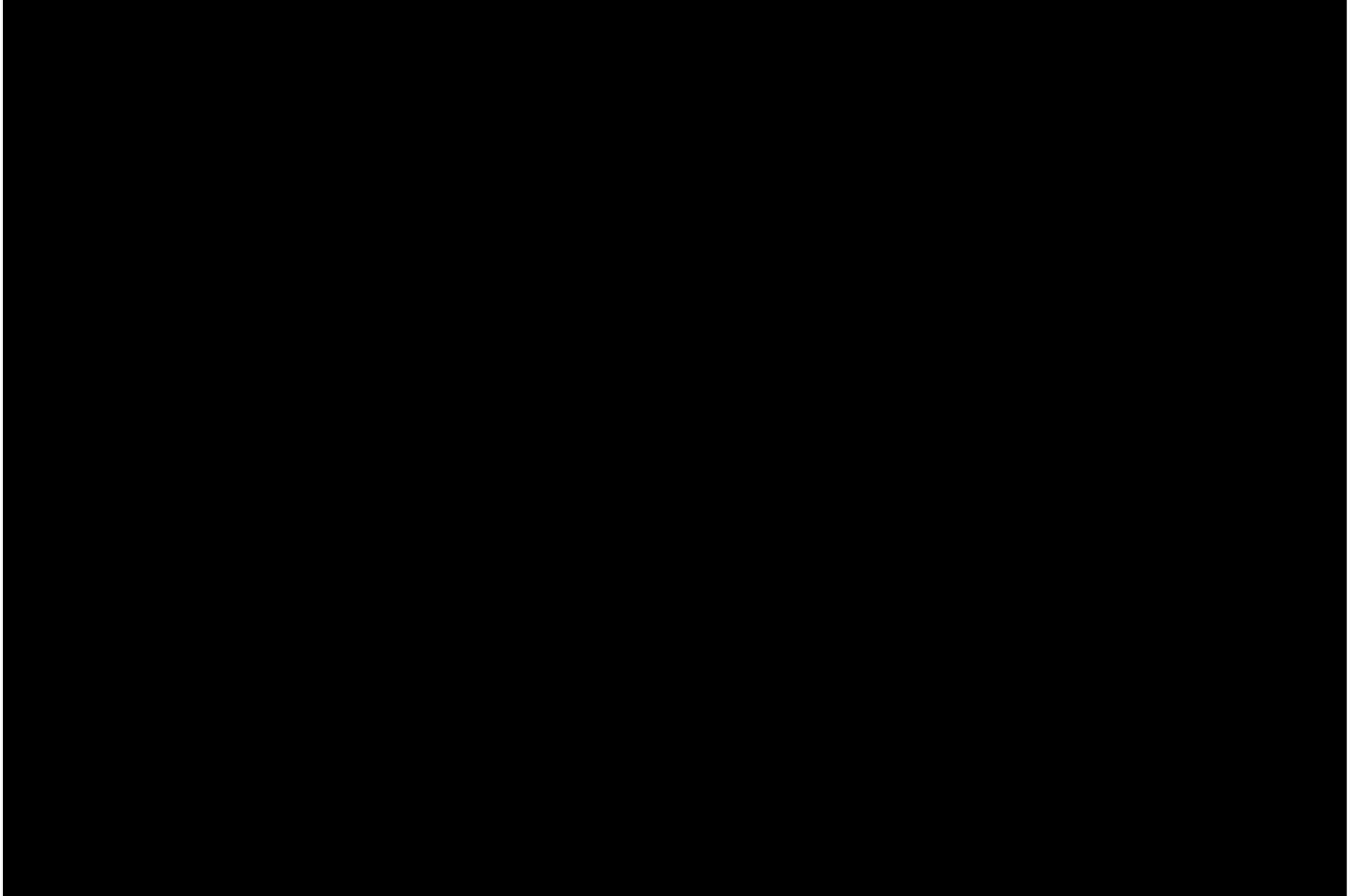




EXHIBIT V.C

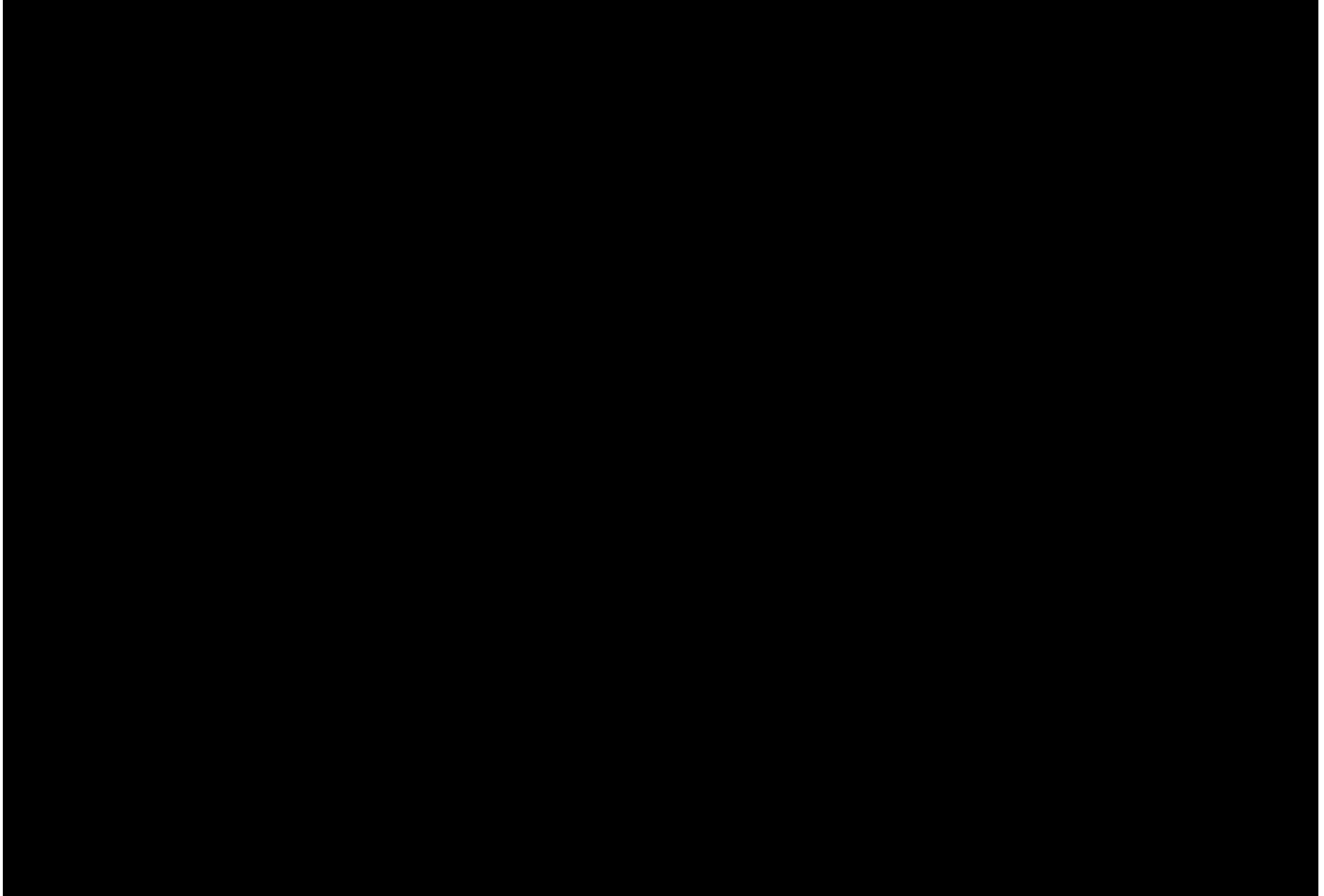


EXHIBIT V.C

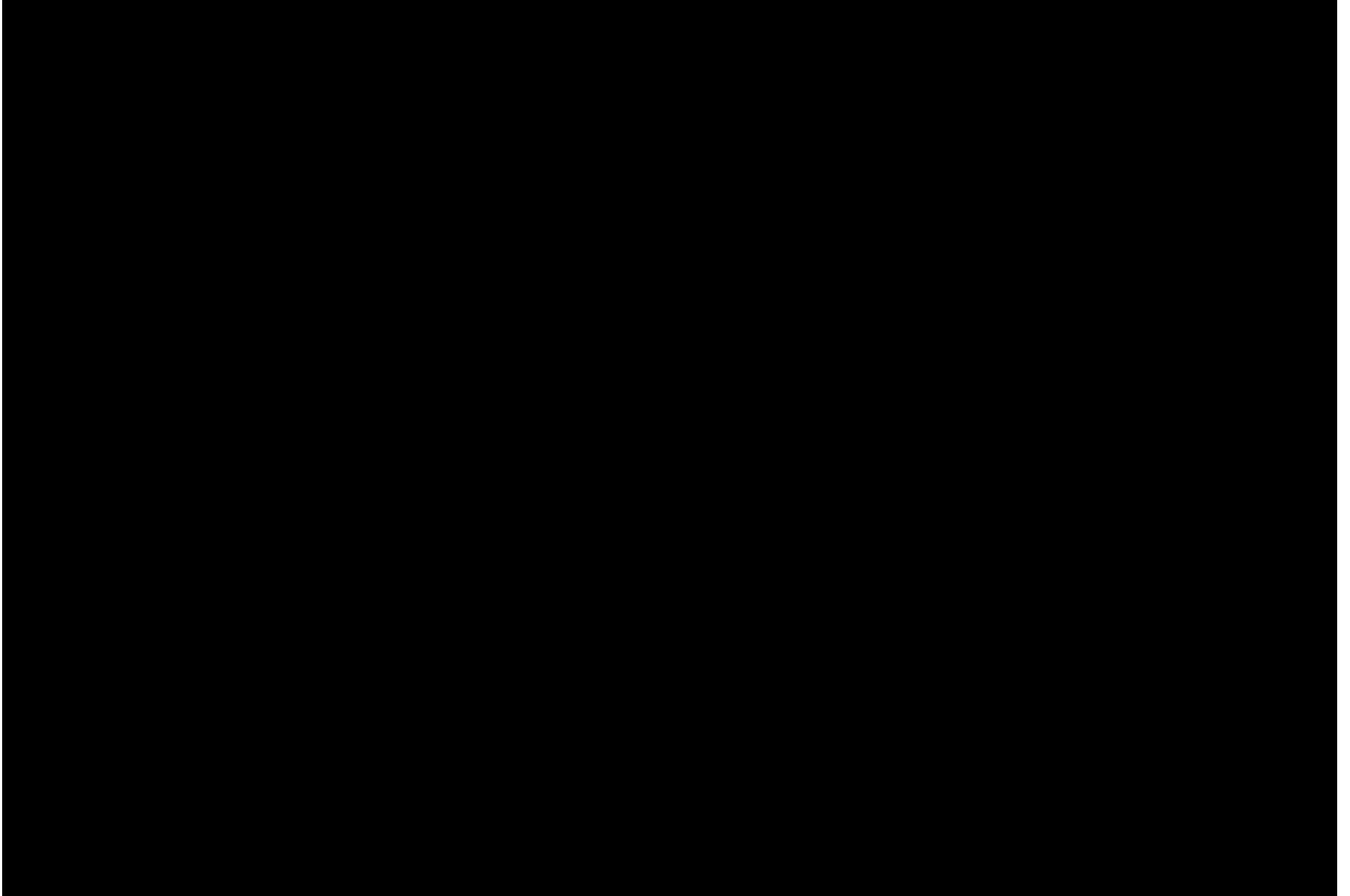


EXHIBIT V.C

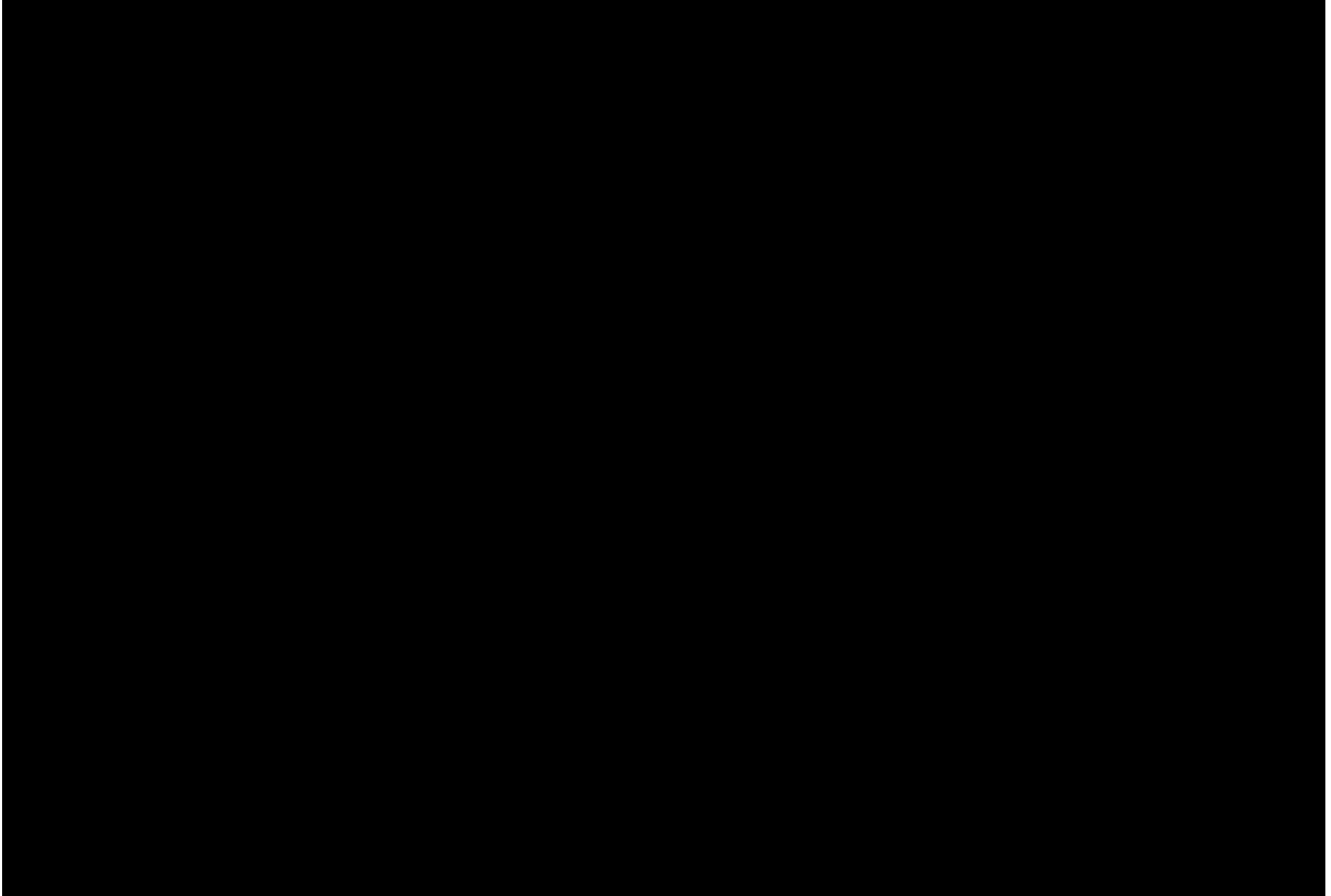


EXHIBIT V.C

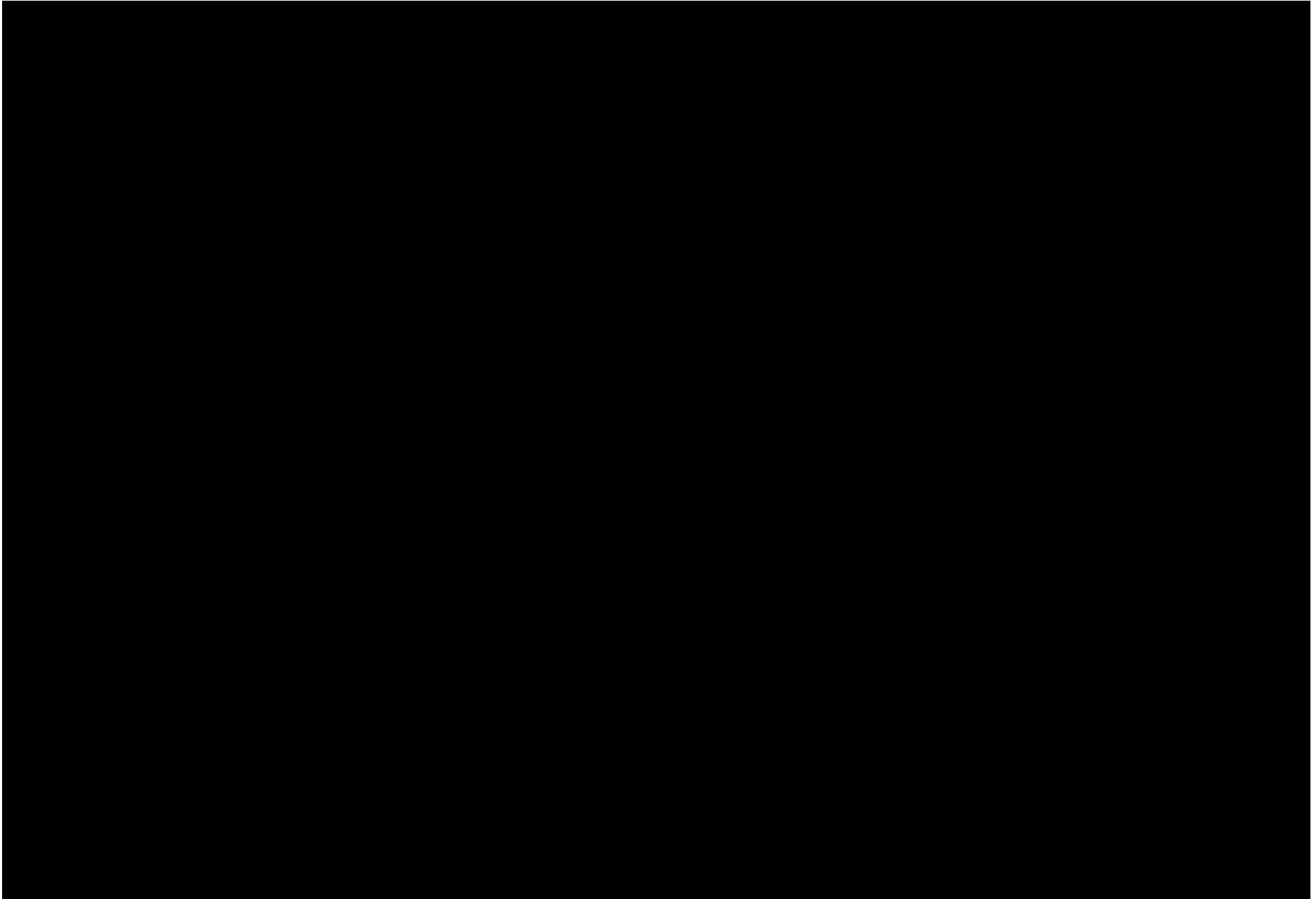


EXHIBIT V.C

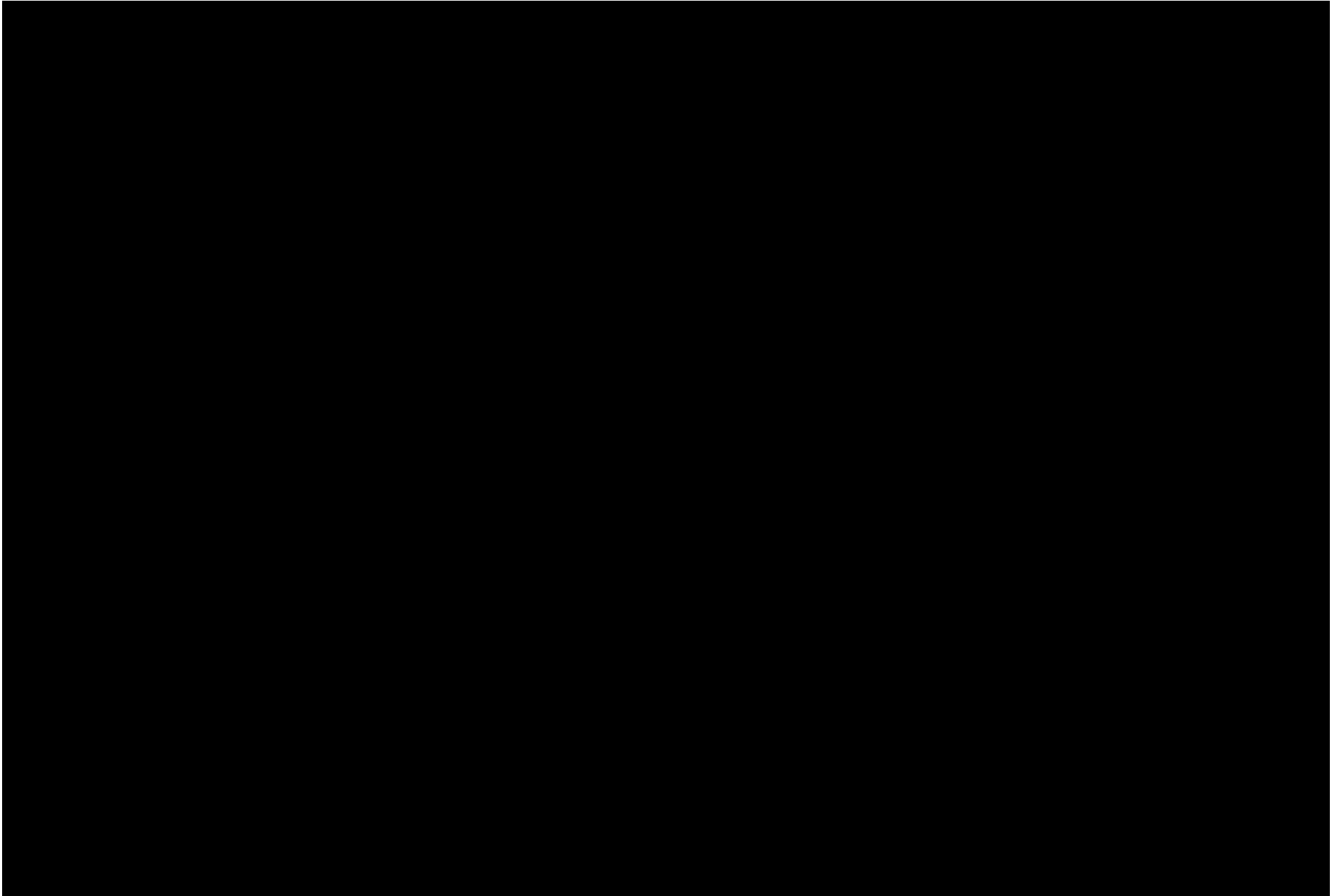


EXHIBIT V.C

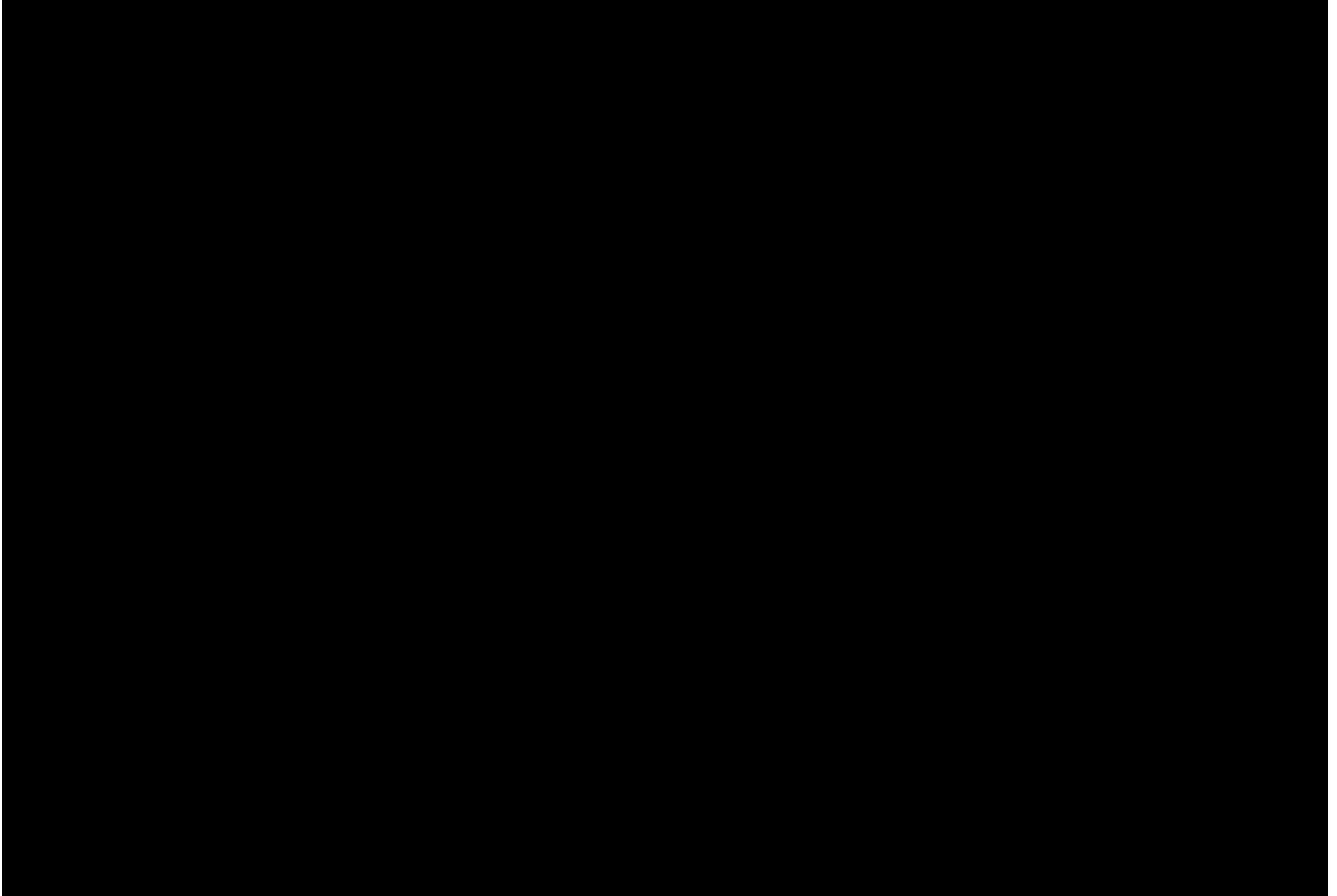


EXHIBIT V.C

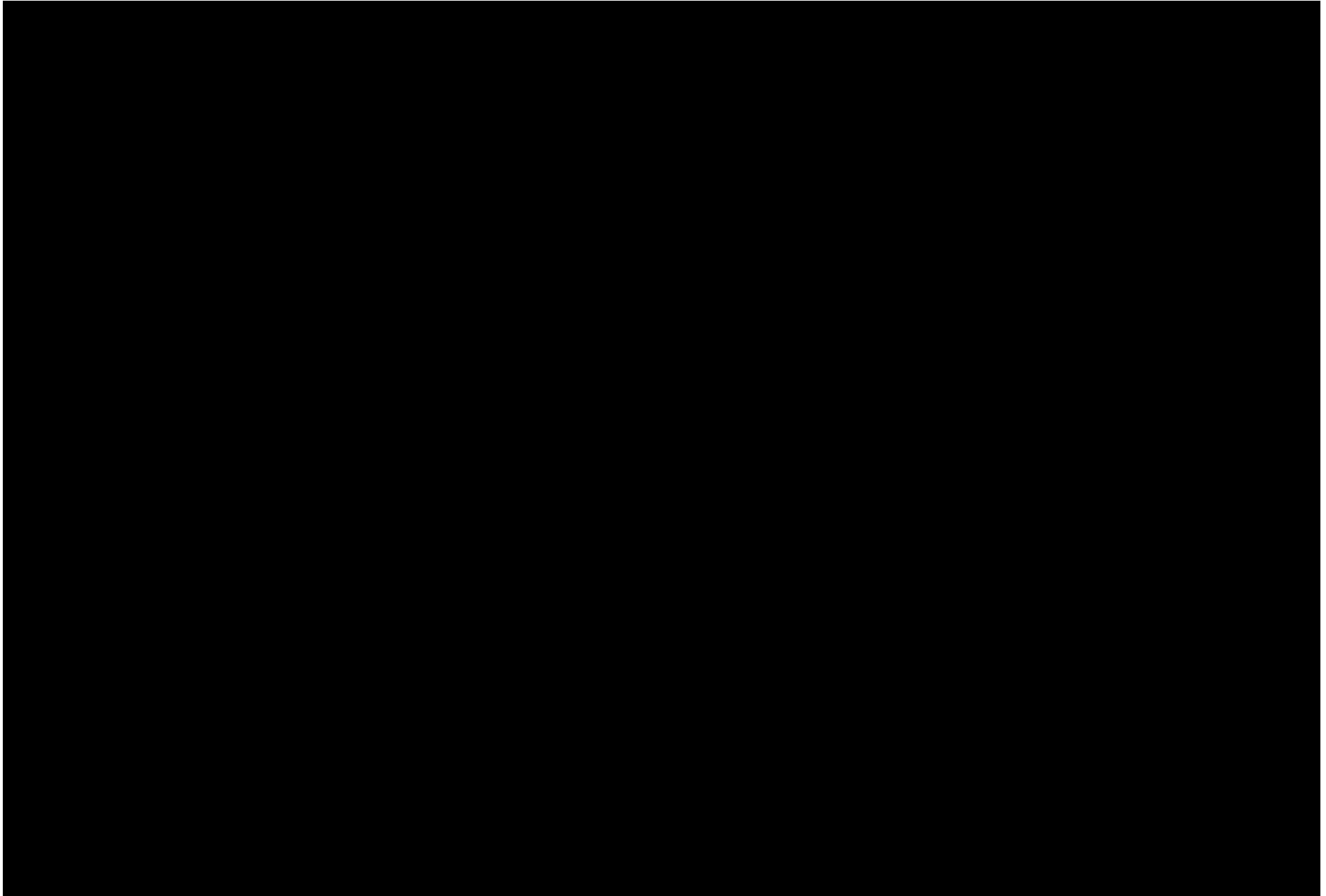


EXHIBIT V.C

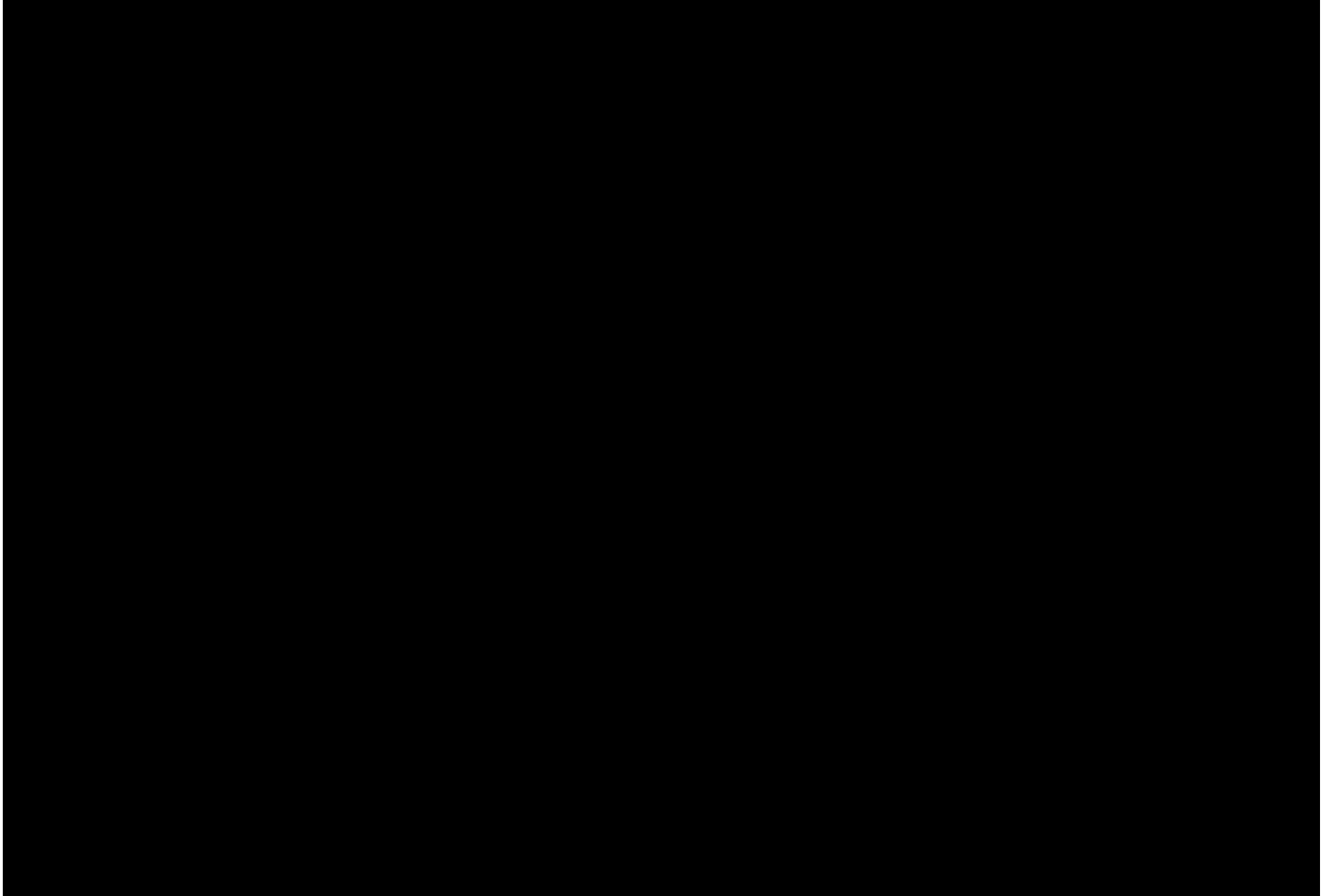




EXHIBIT V.C

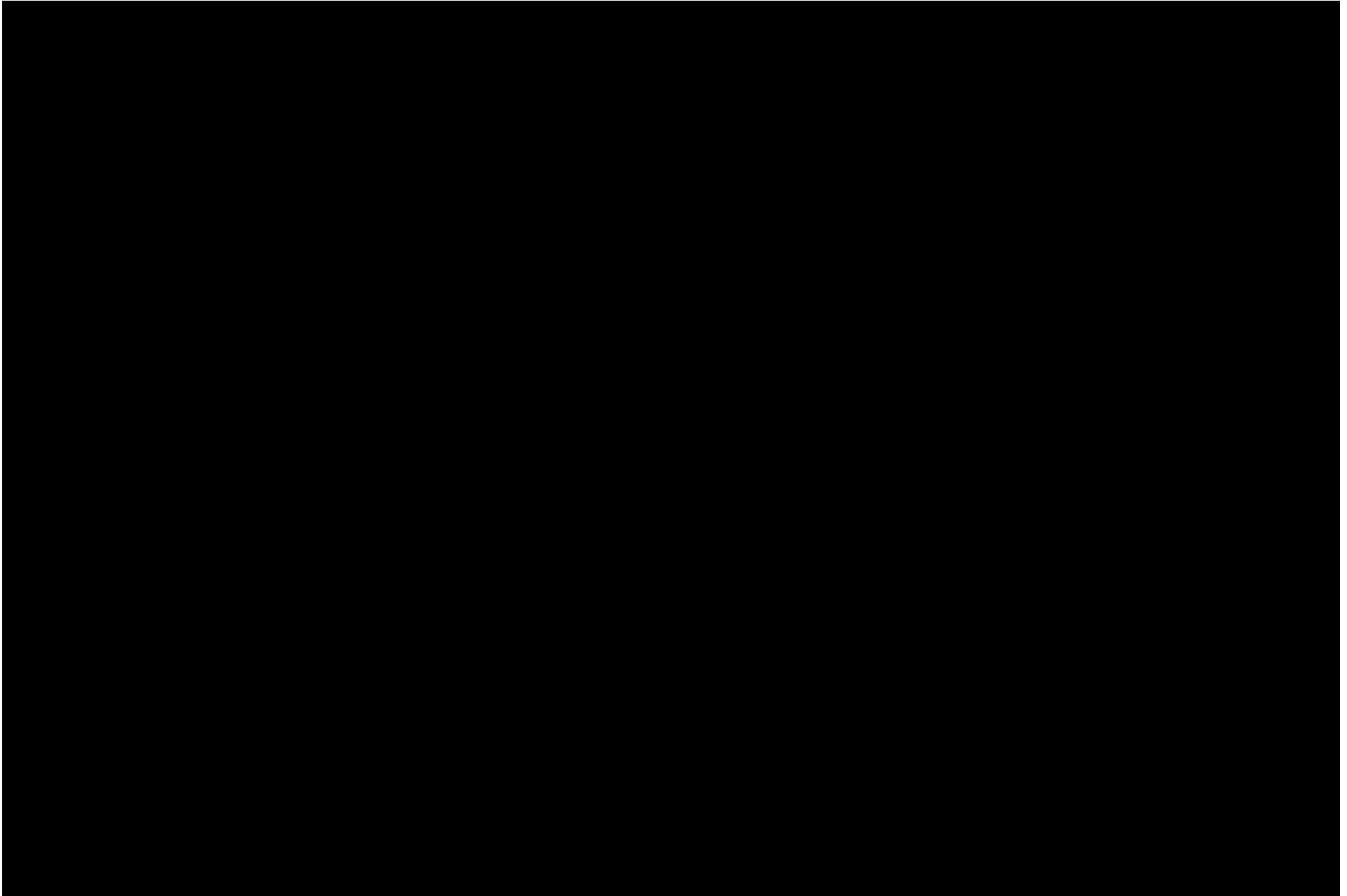


EXHIBIT V.C

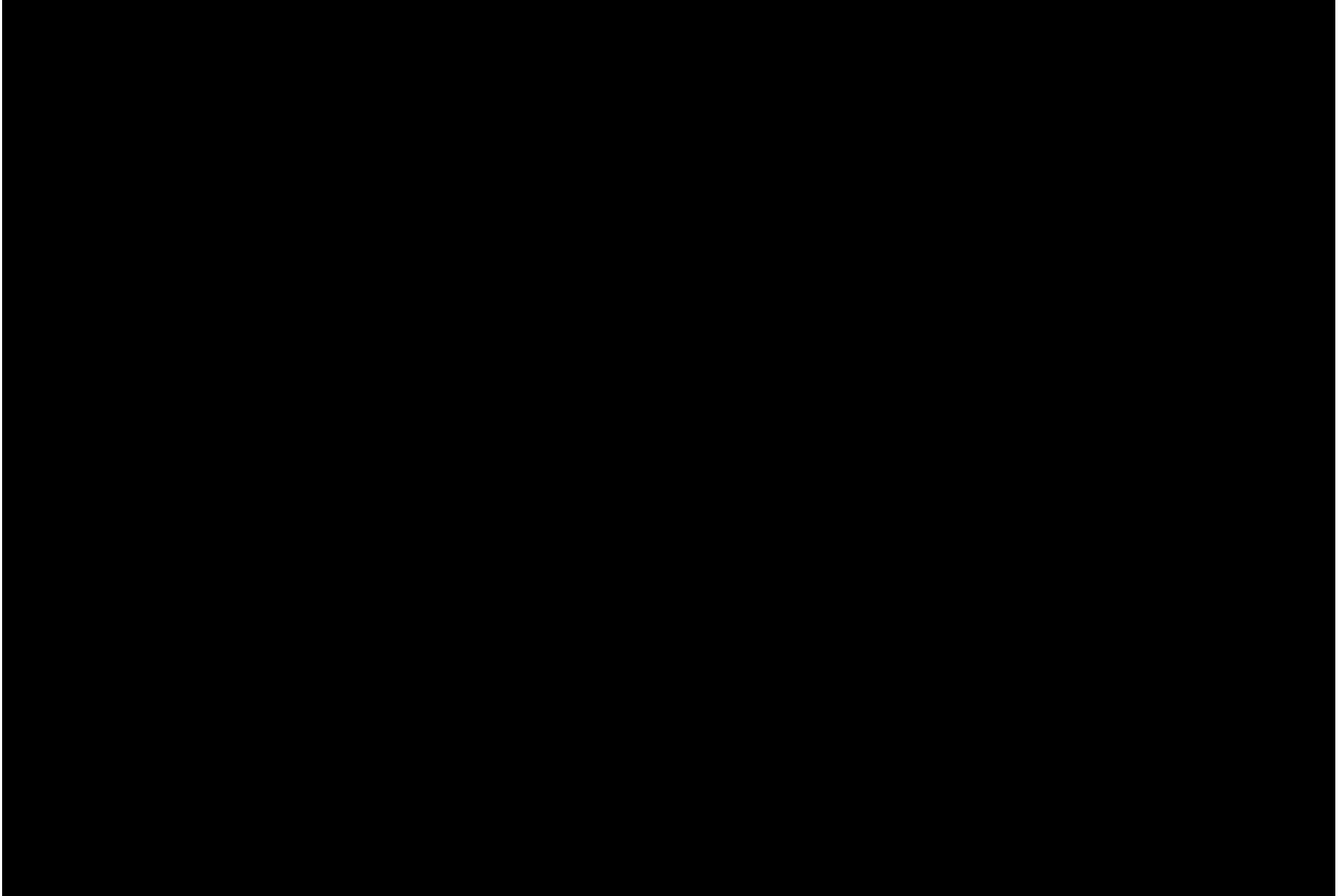


EXHIBIT V.C

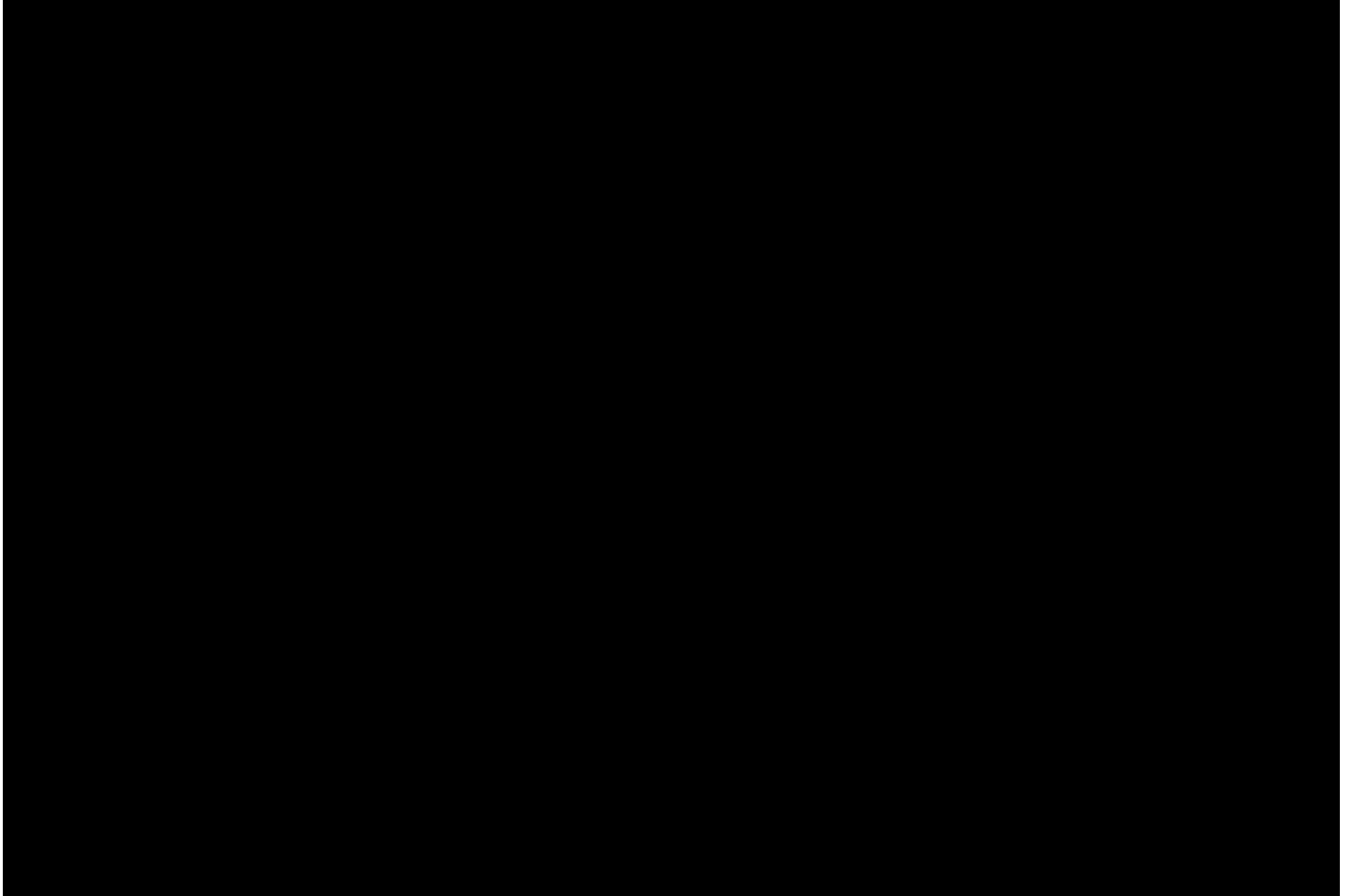


EXHIBIT V.C

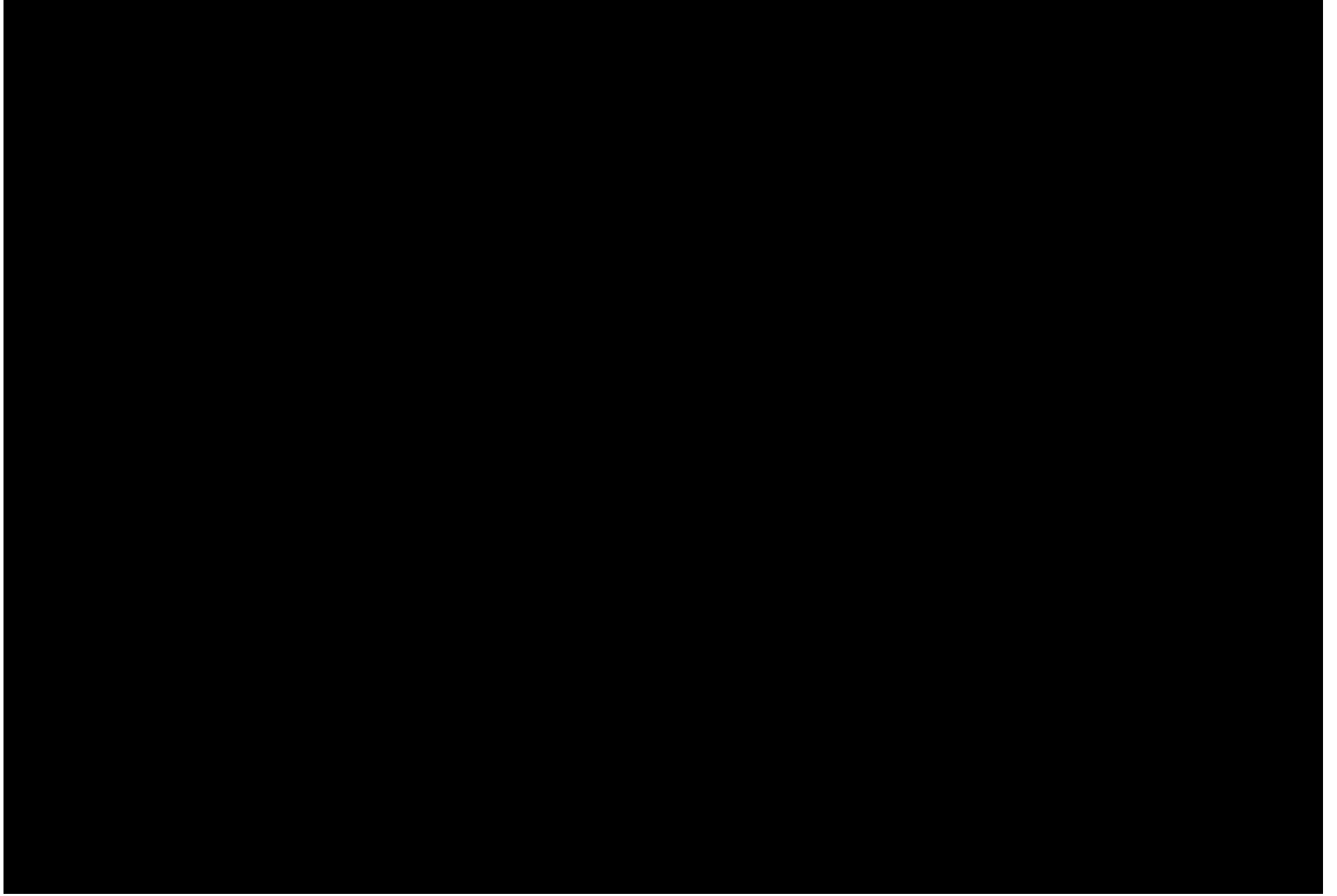


EXHIBIT V.C

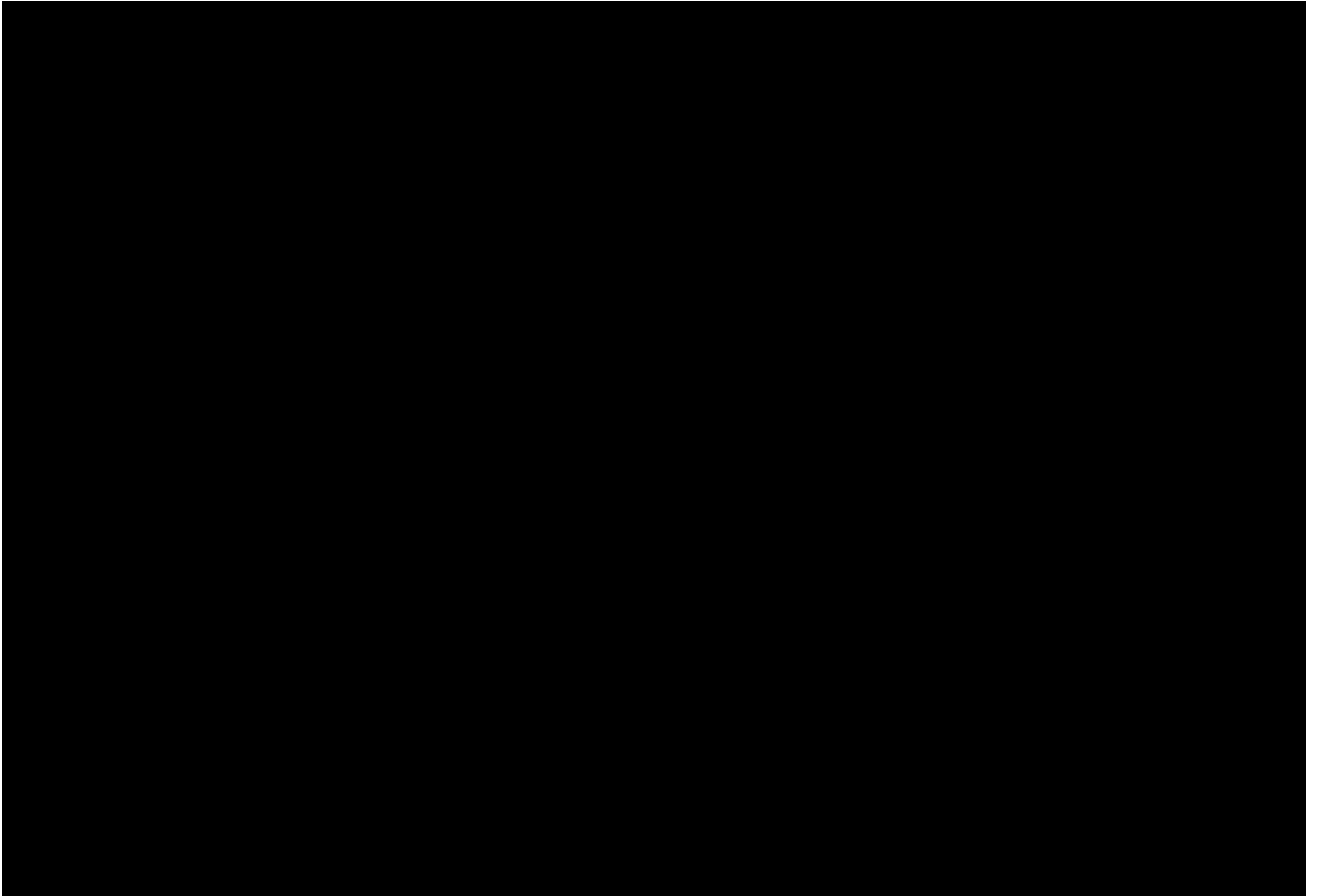


EXHIBIT V.C

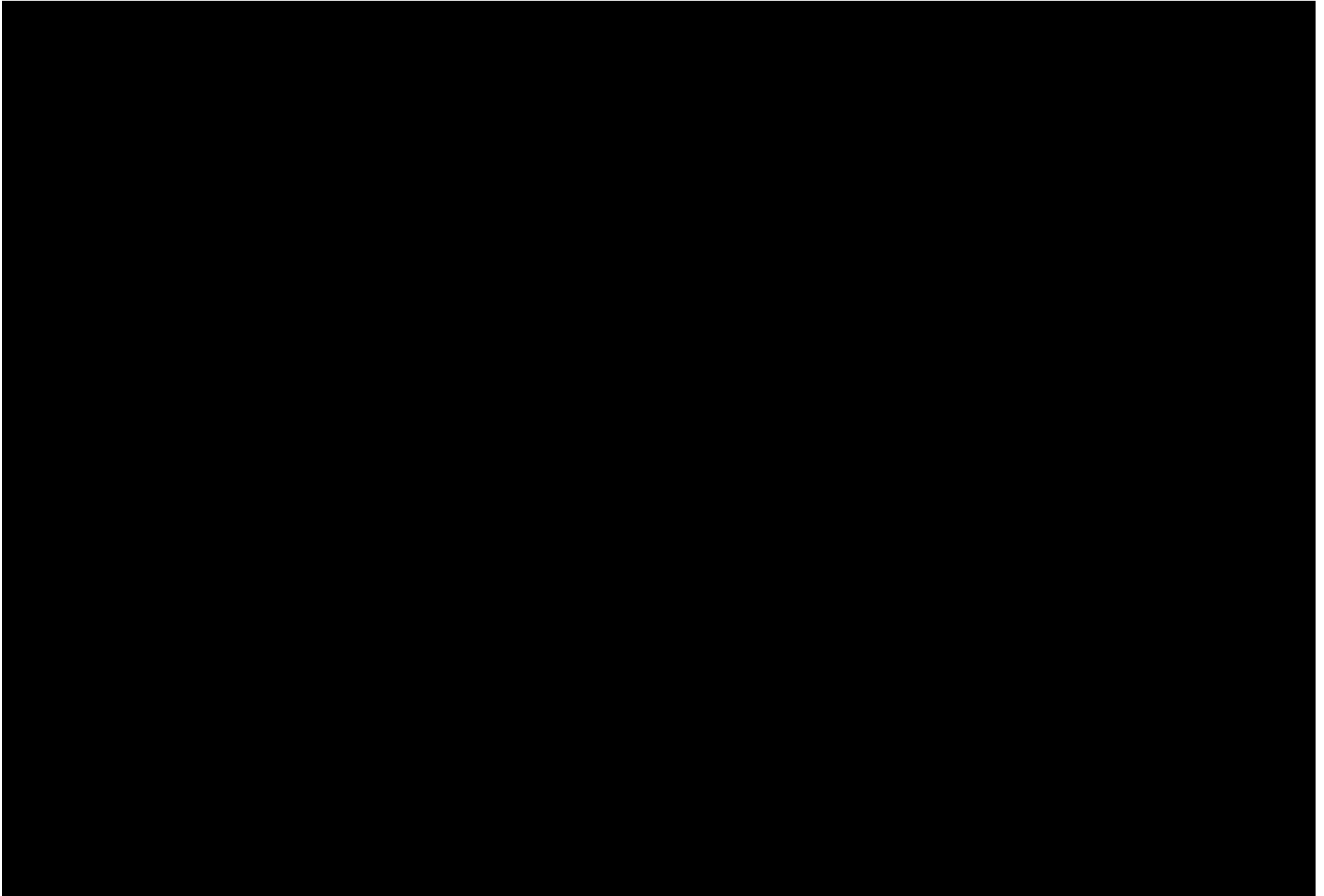


EXHIBIT V.C

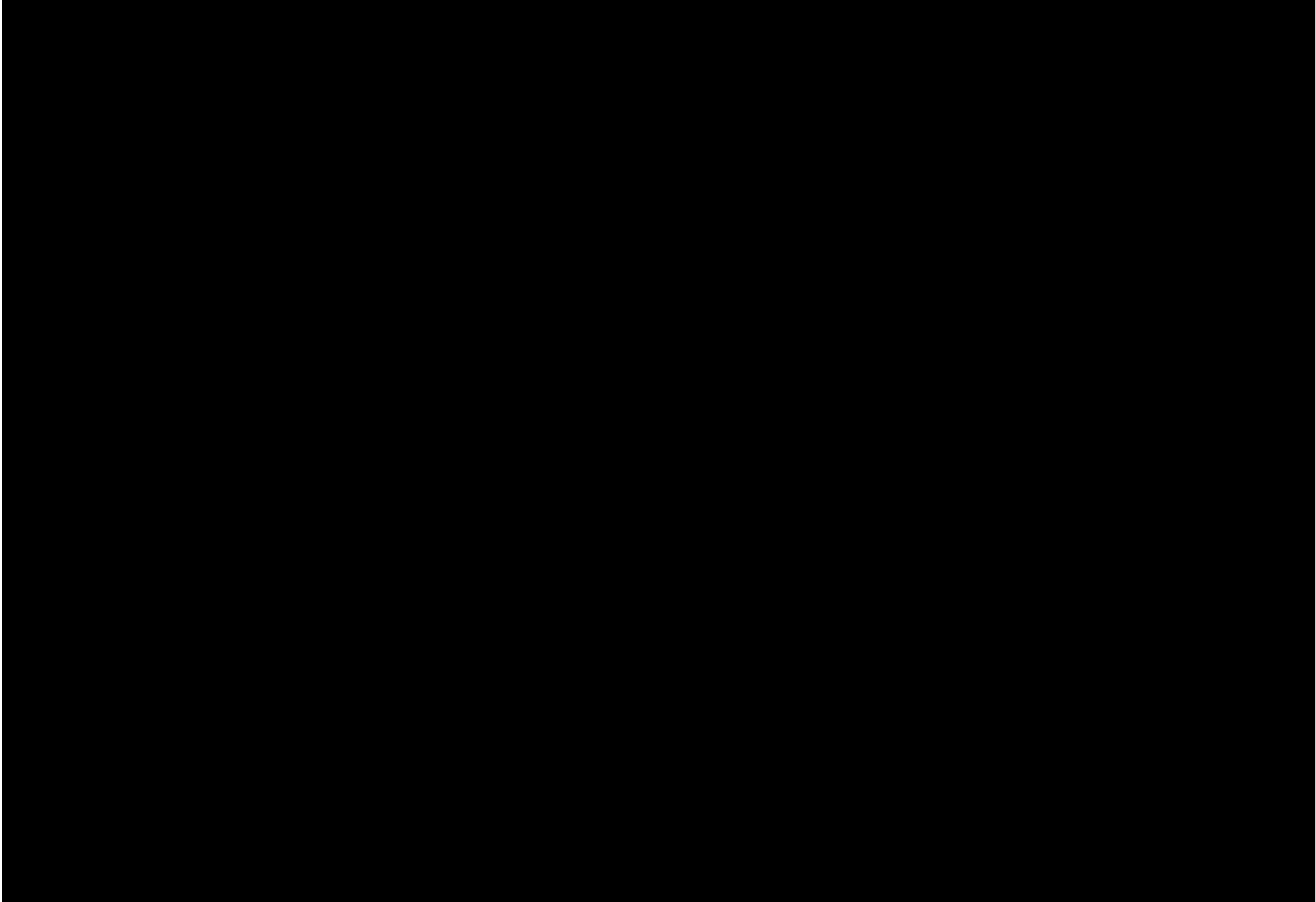


EXHIBIT V.C

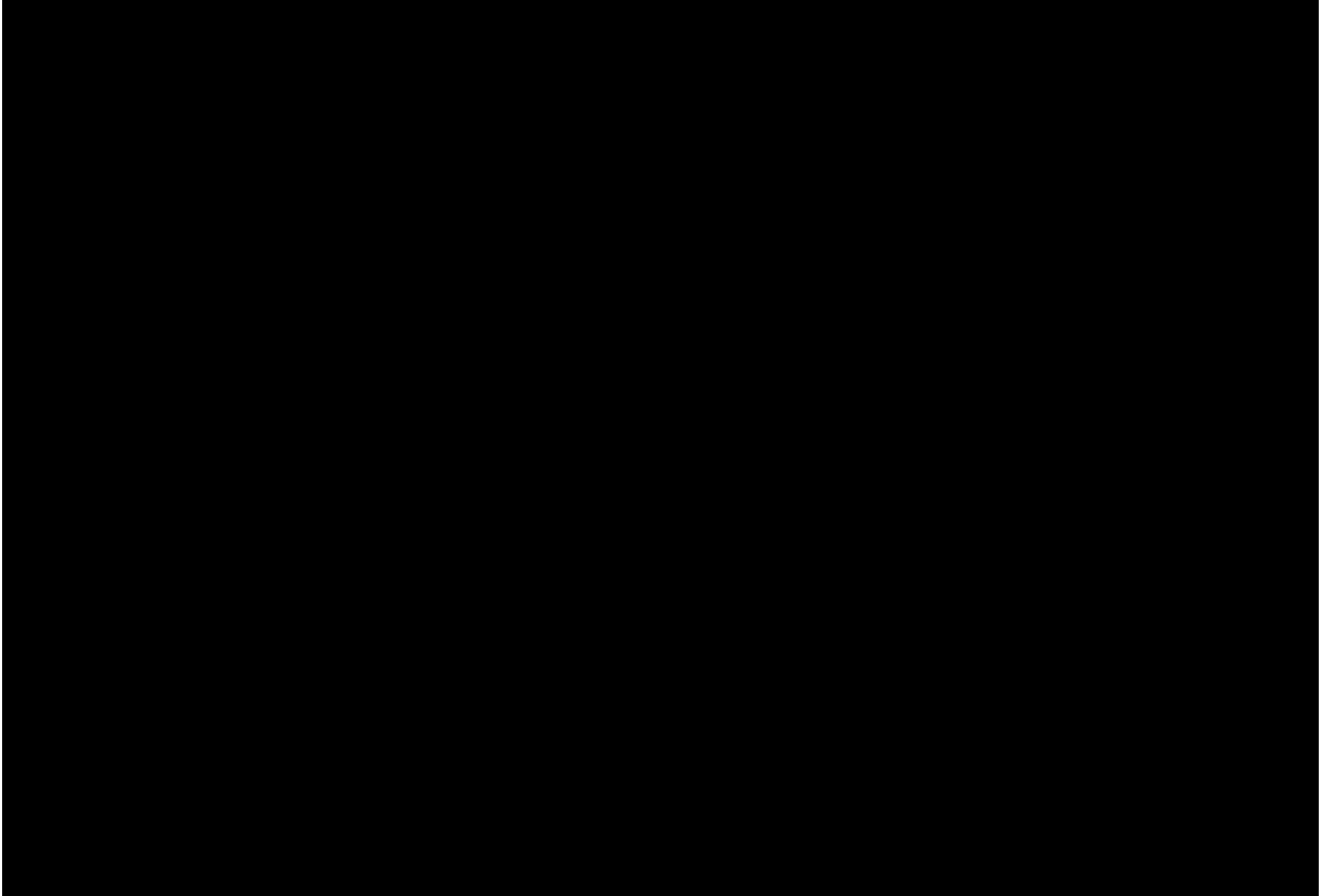




EXHIBIT V.C

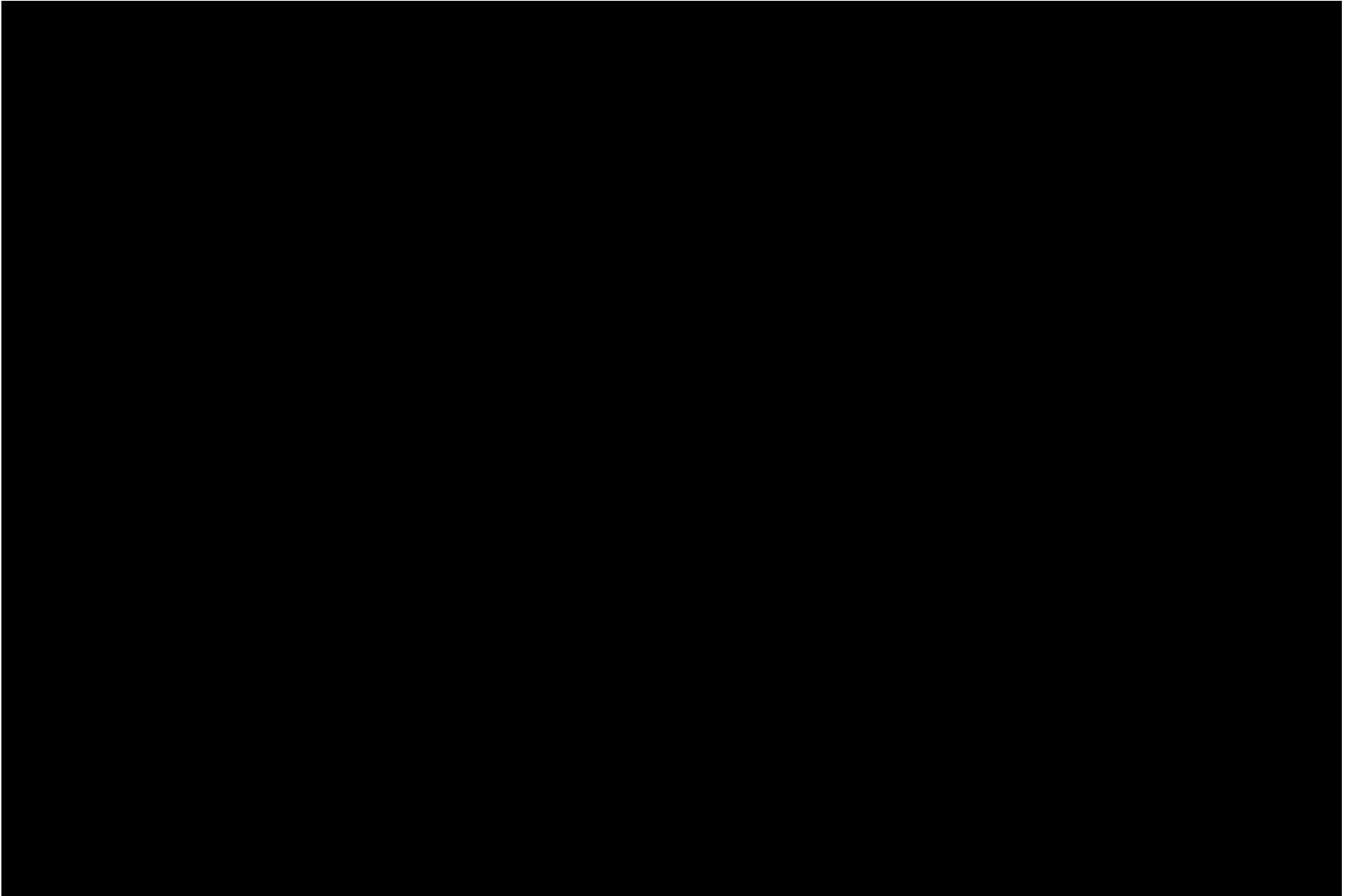


EXHIBIT V.C

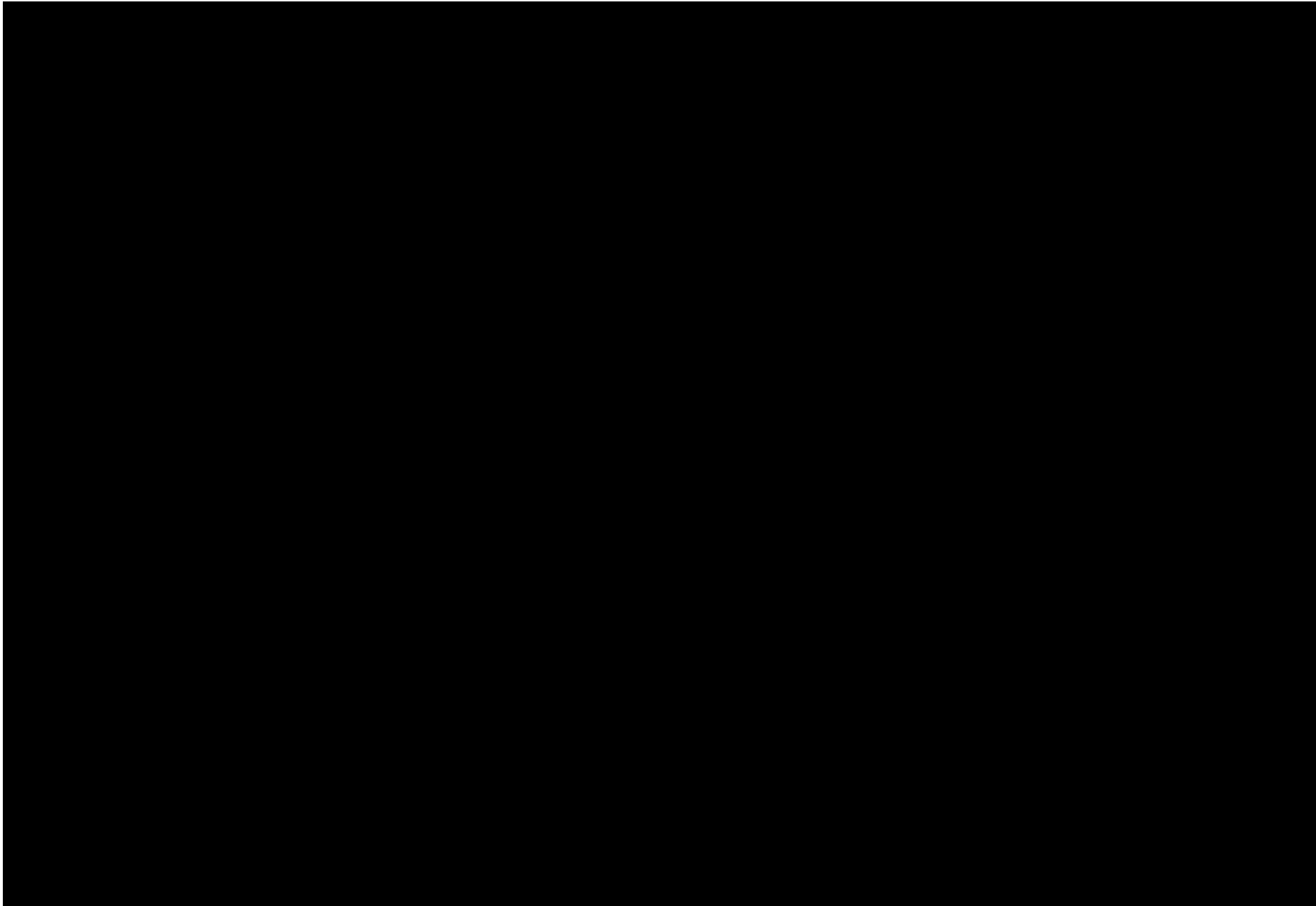


EXHIBIT V.C

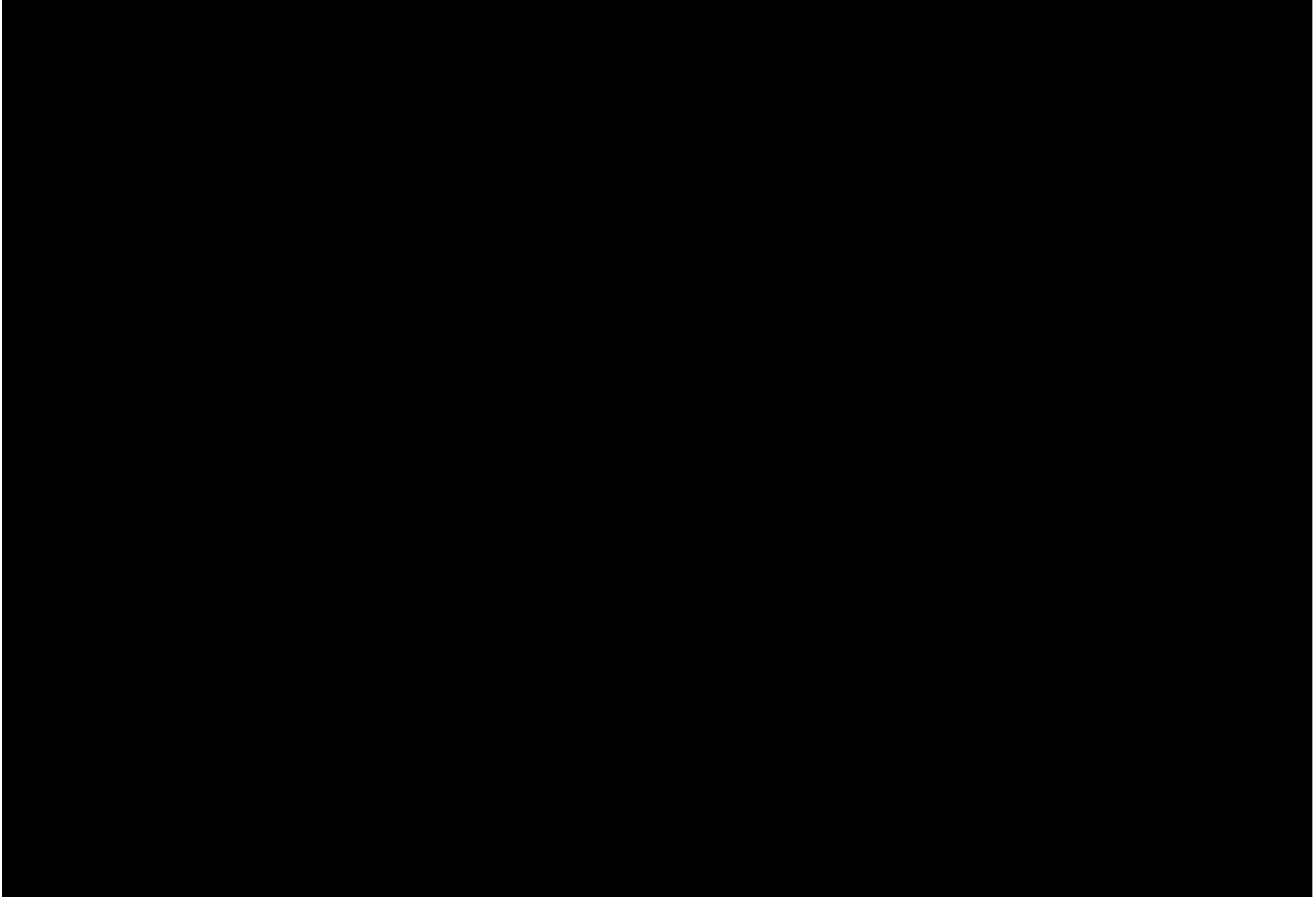


EXHIBIT V.C

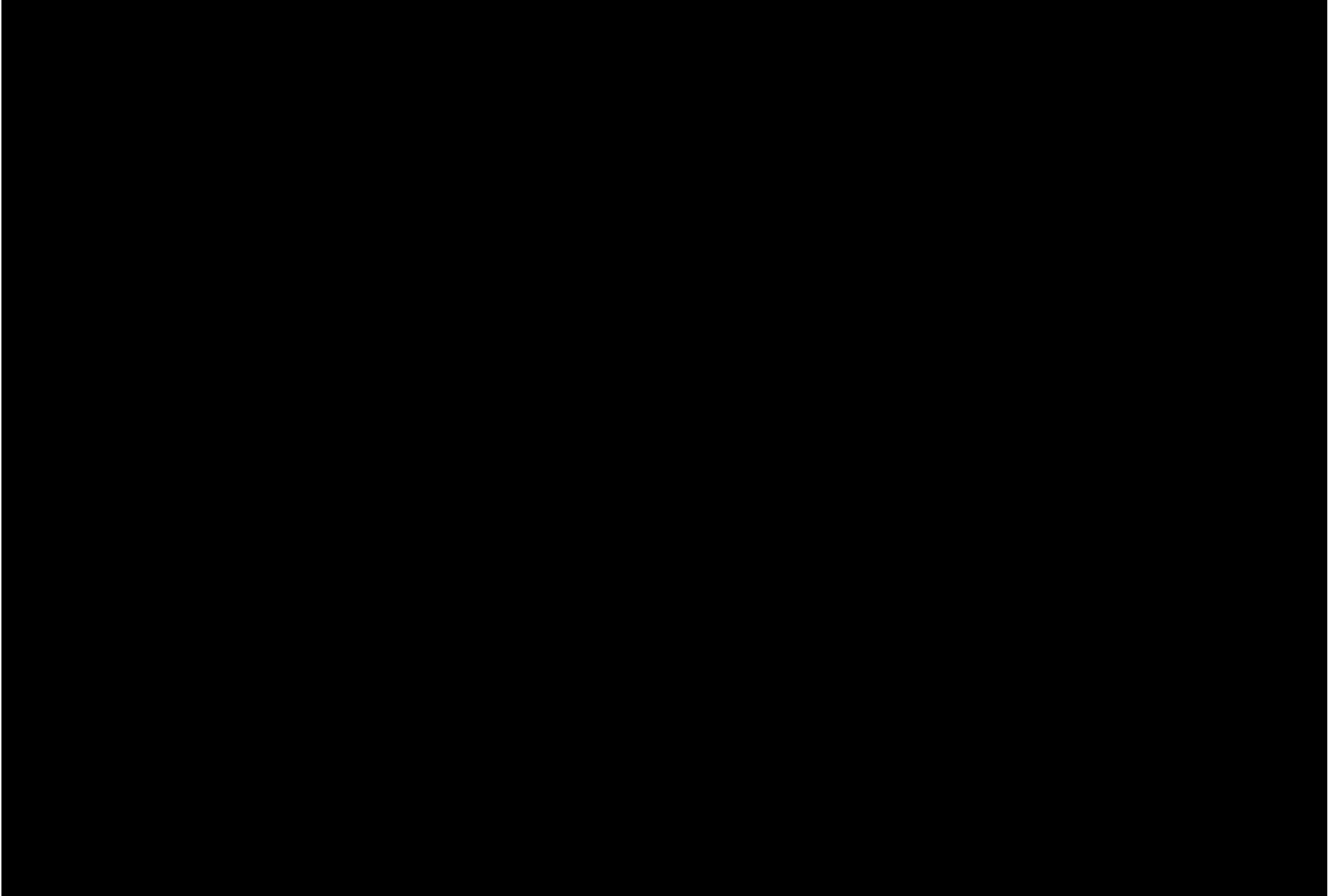


EXHIBIT V.C

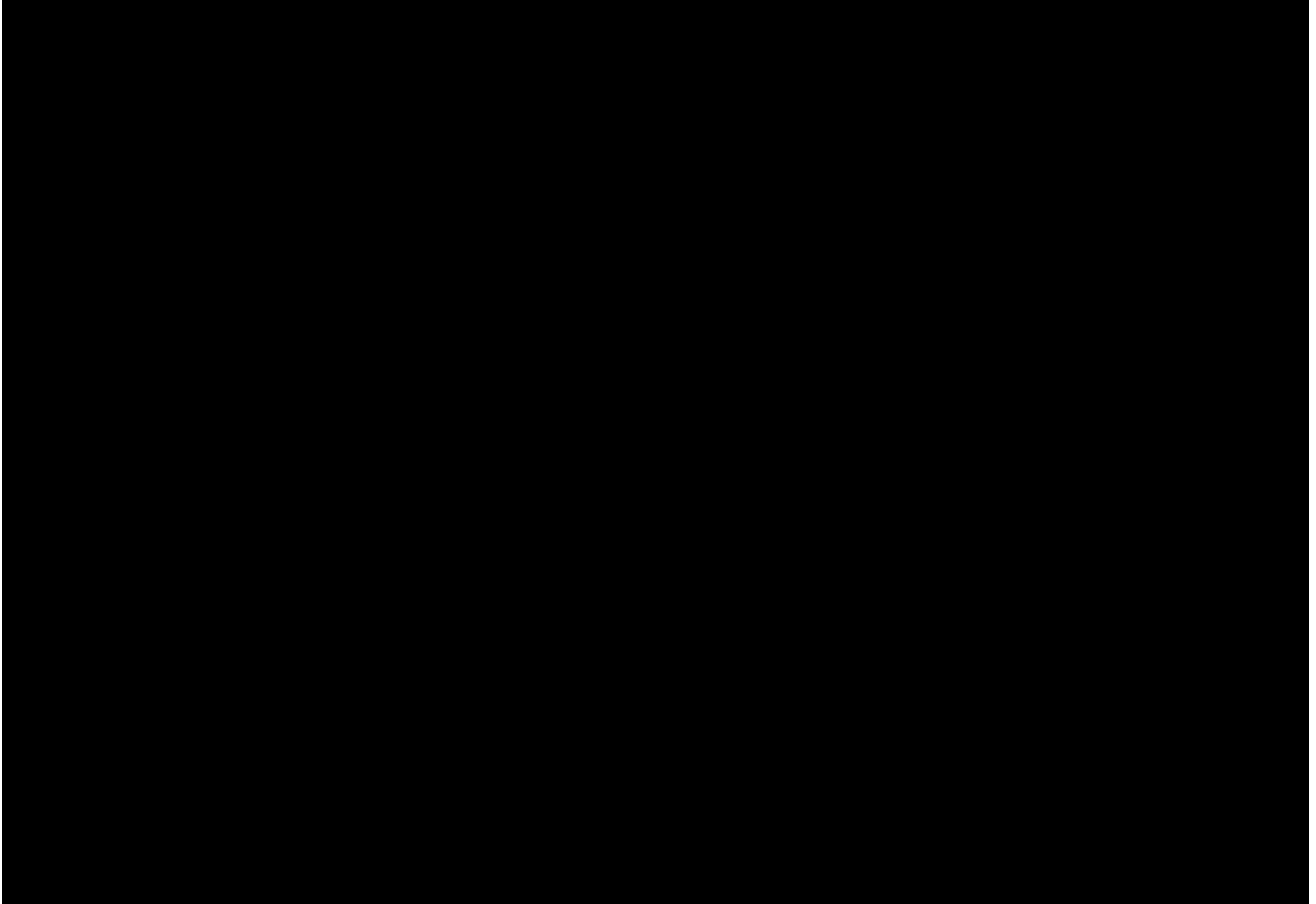


EXHIBIT V.C

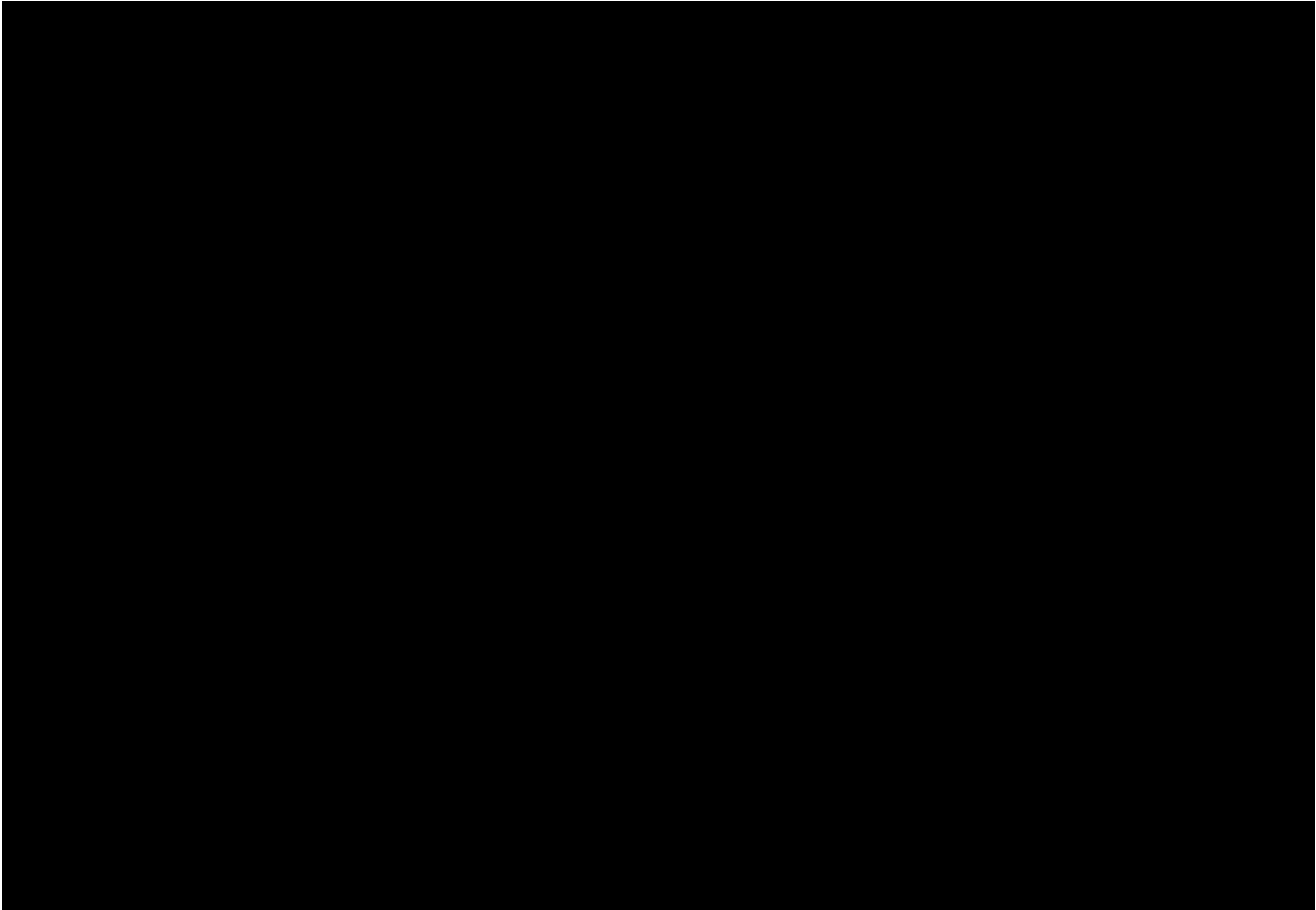
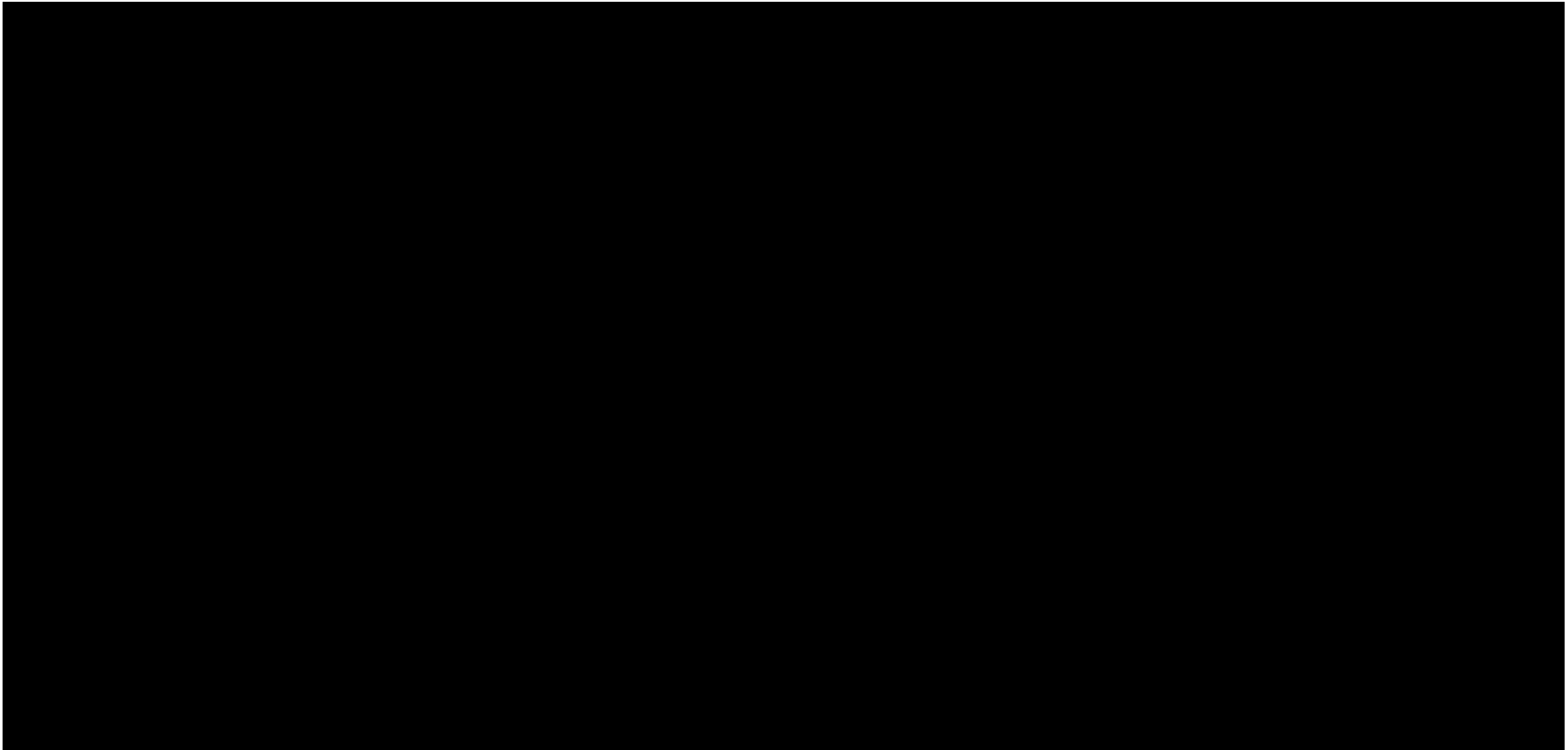
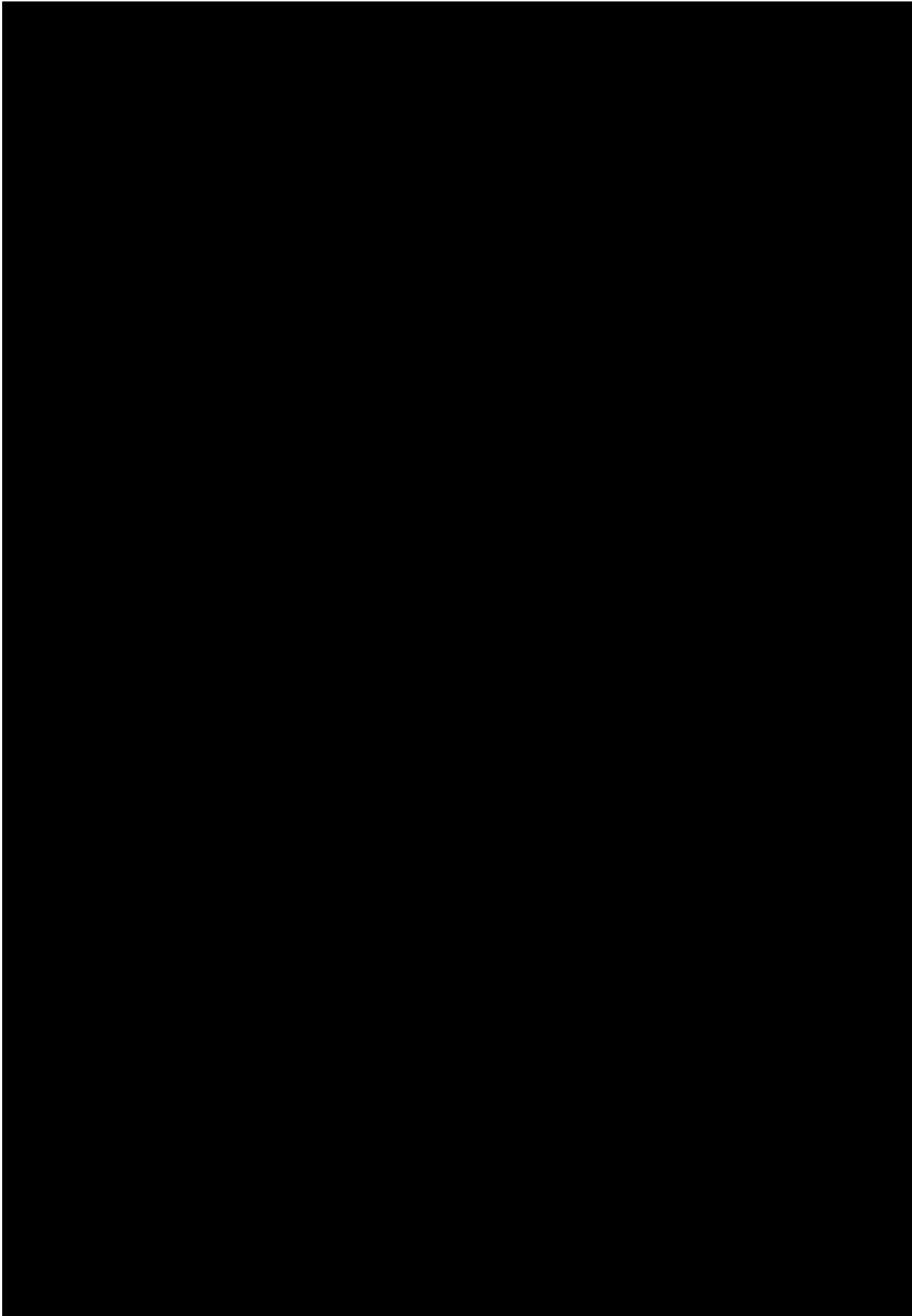


EXHIBIT V.C







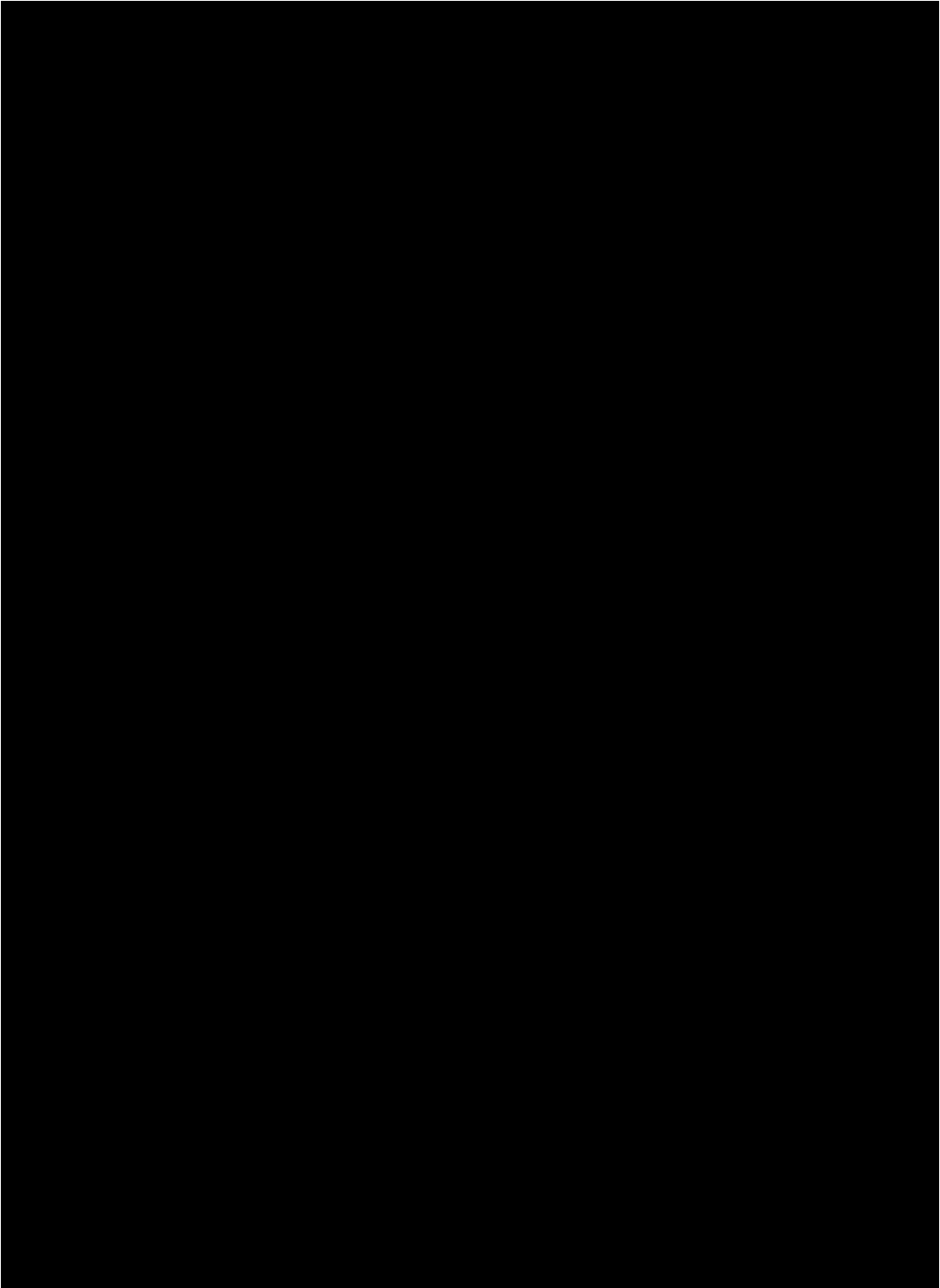
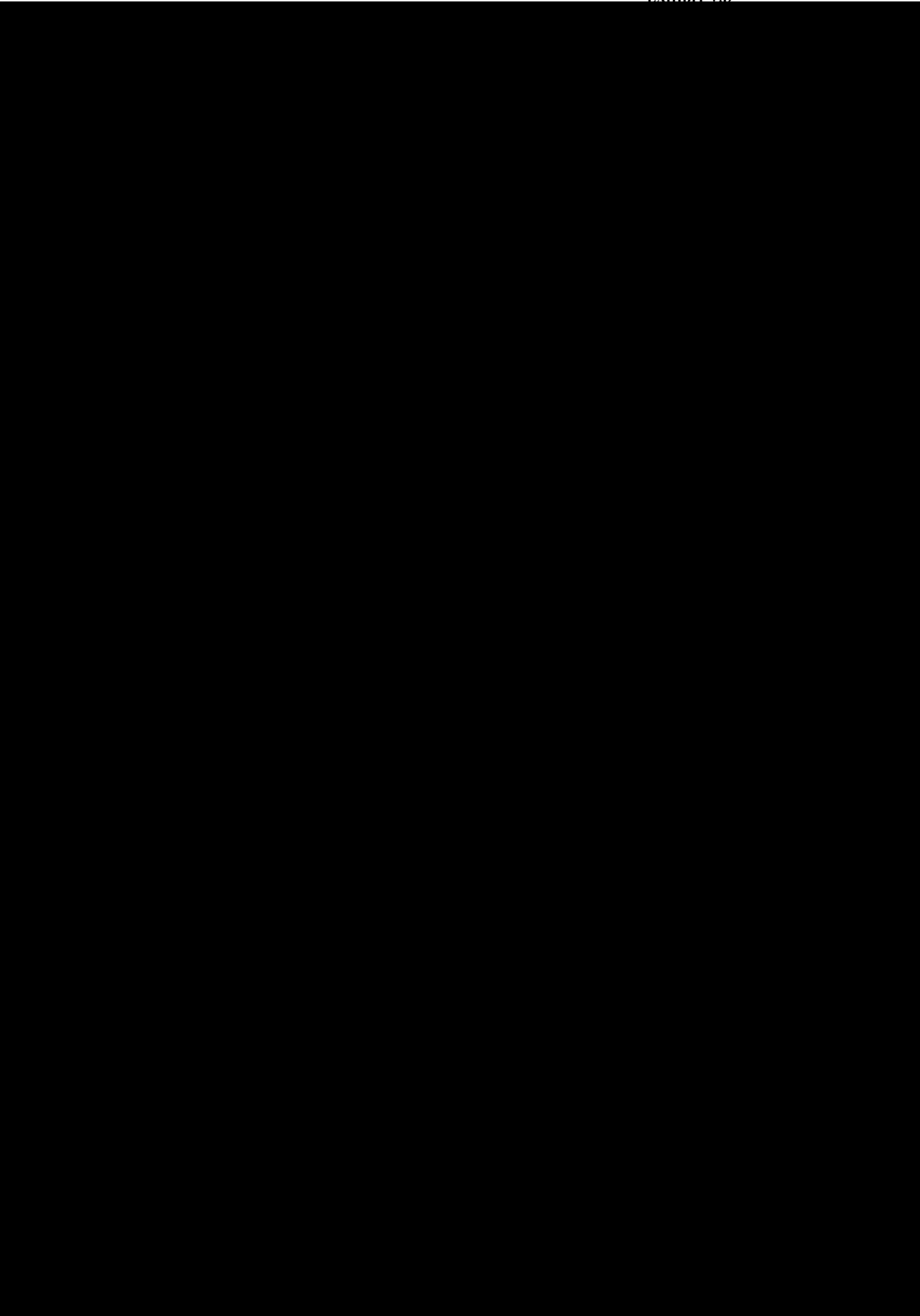
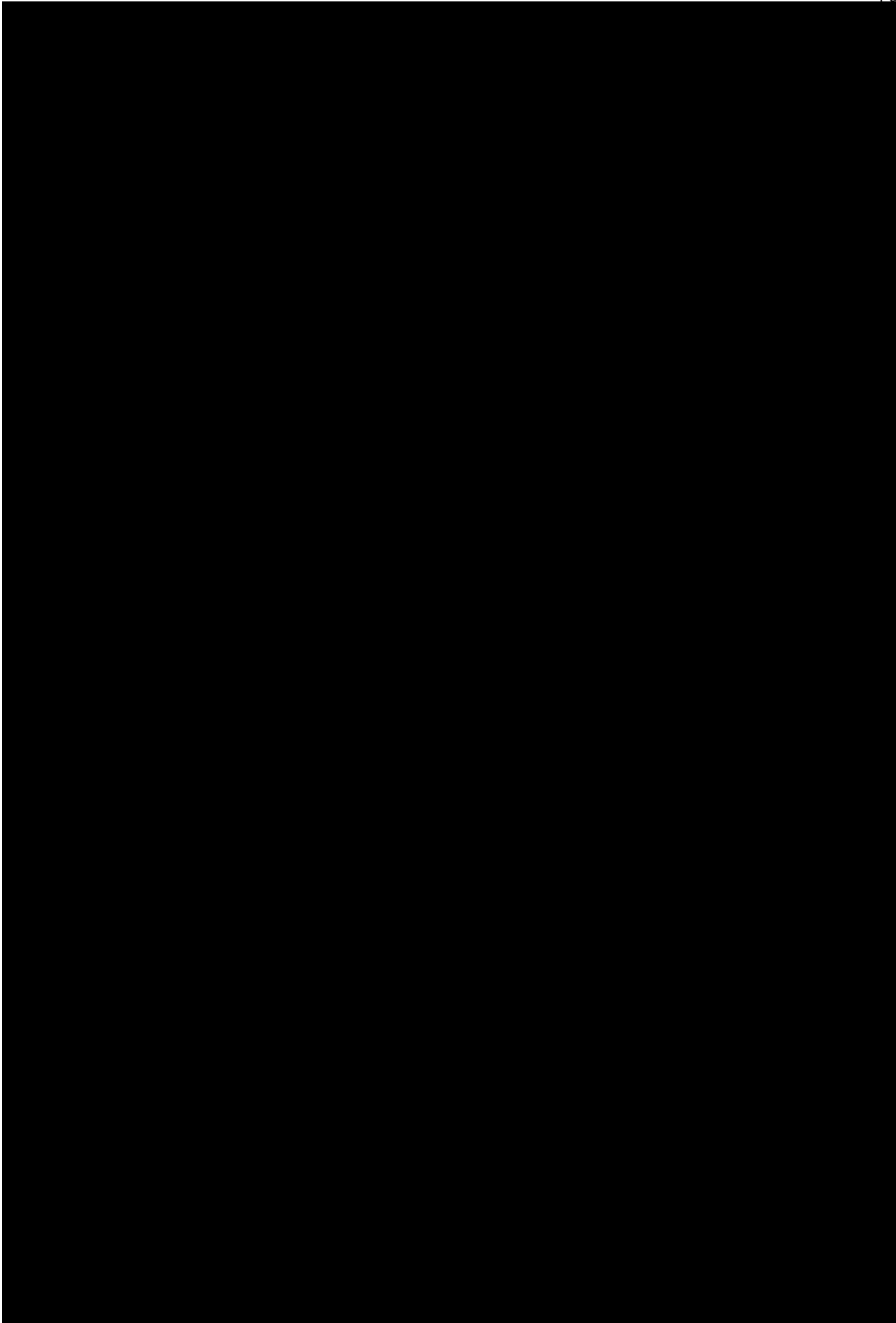
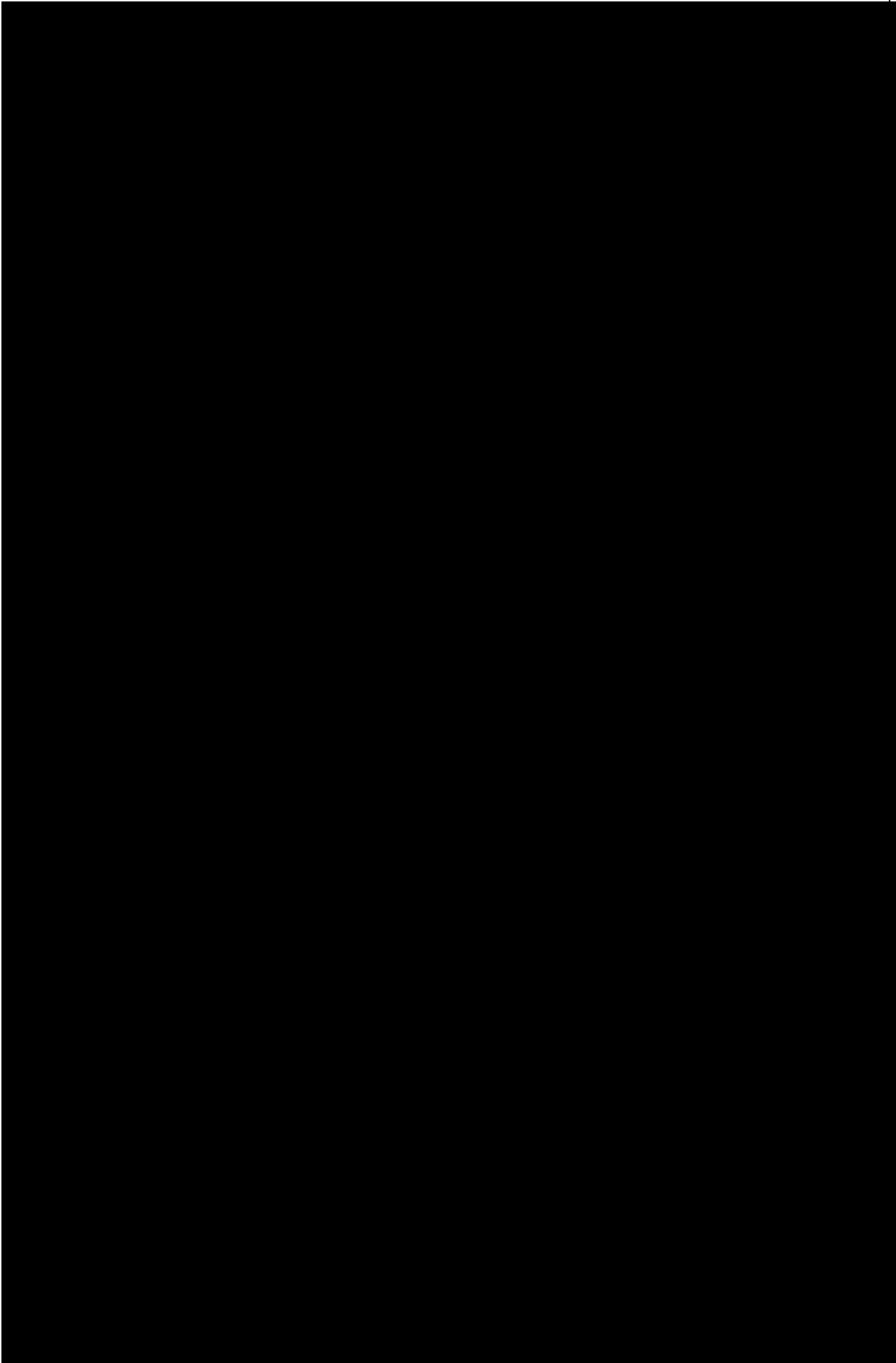
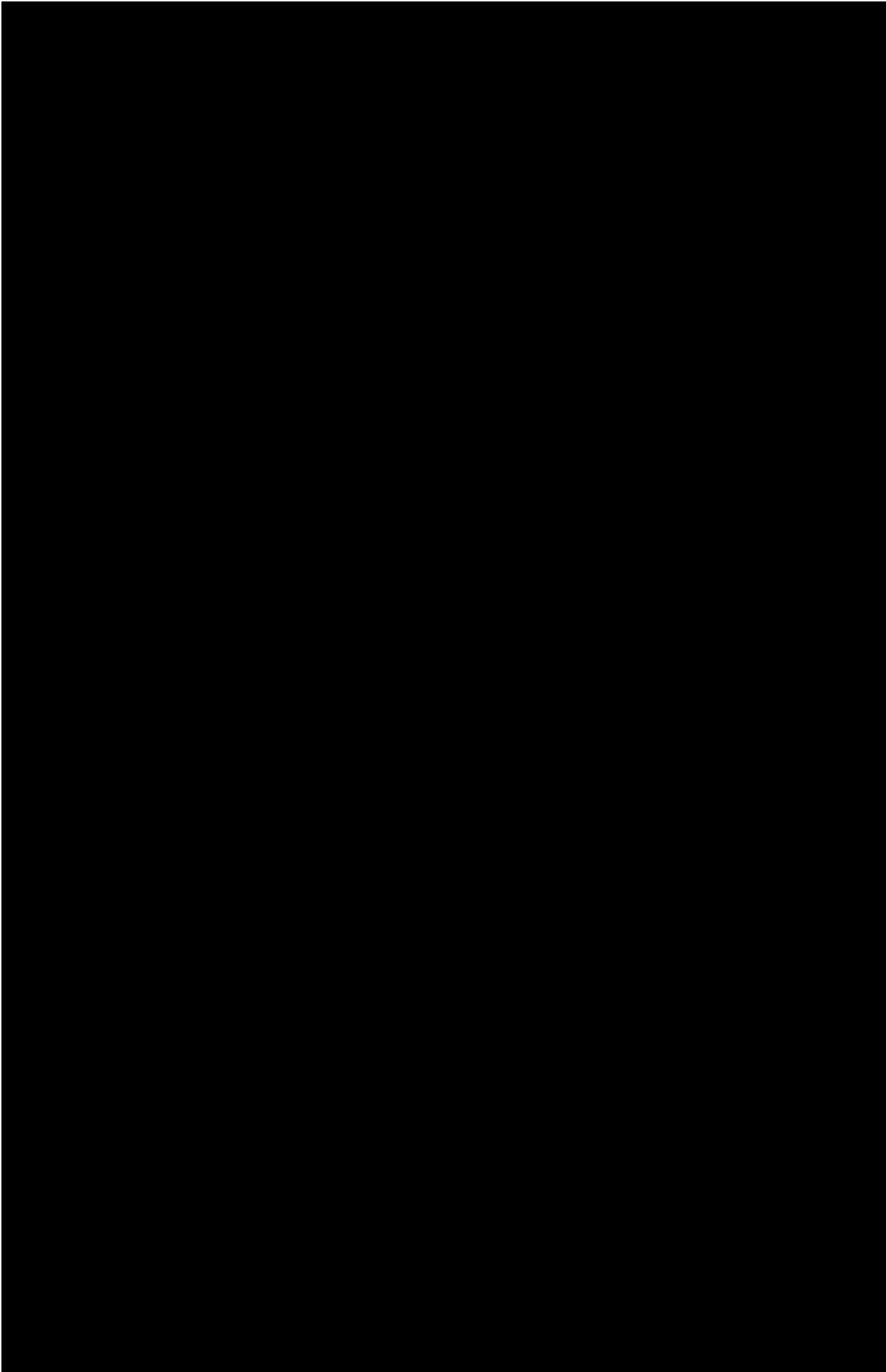


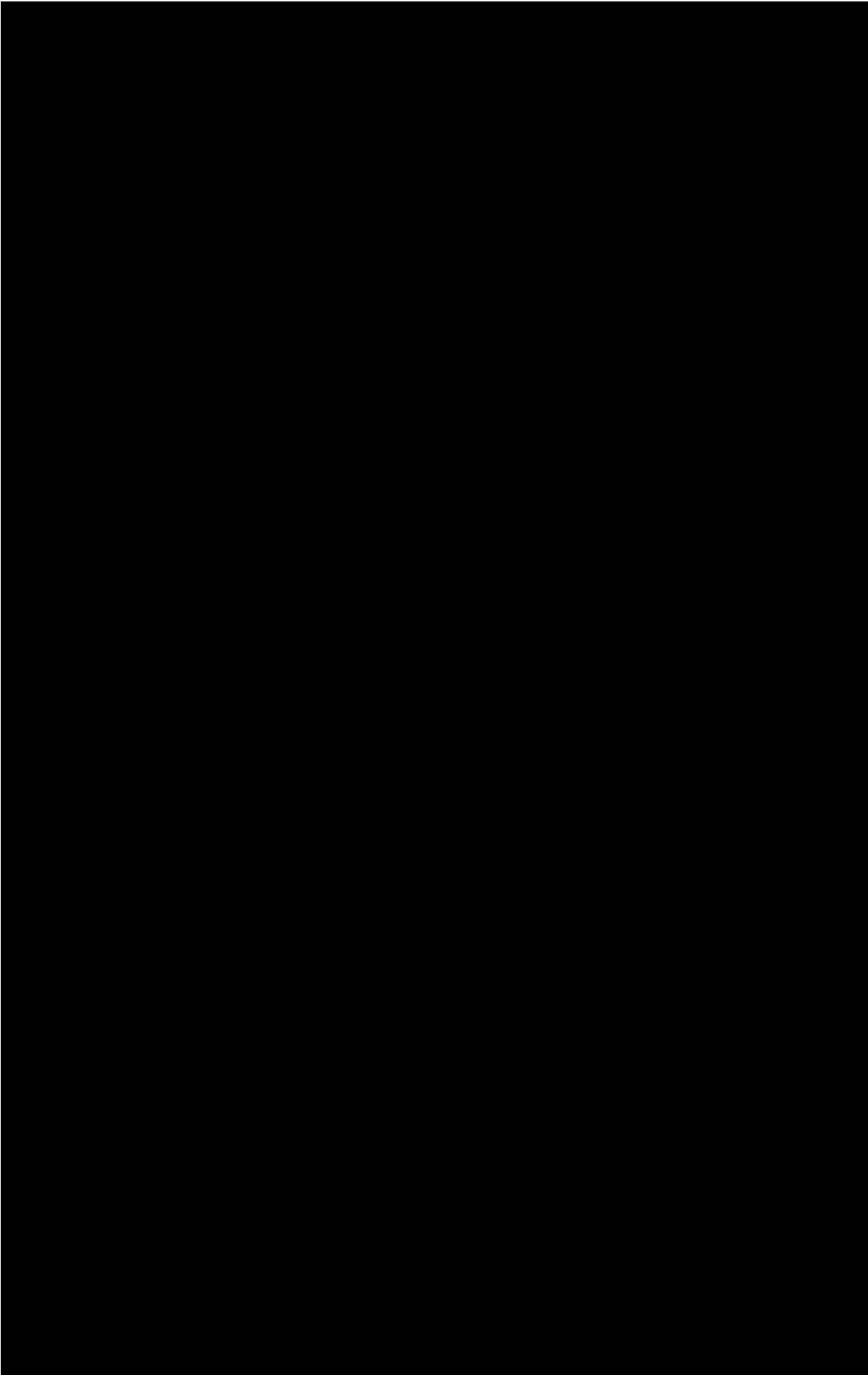
EXHIBIT V.D

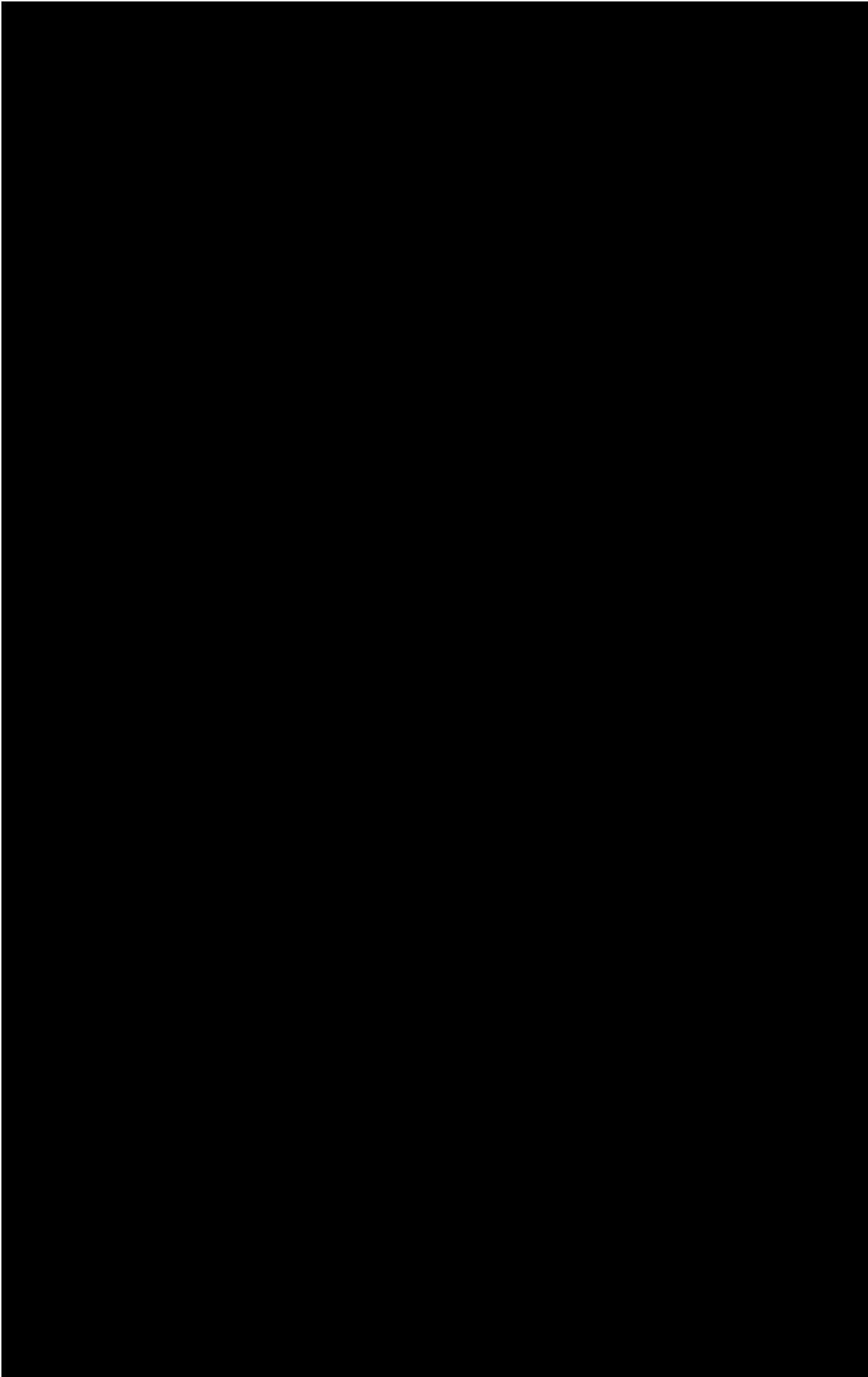


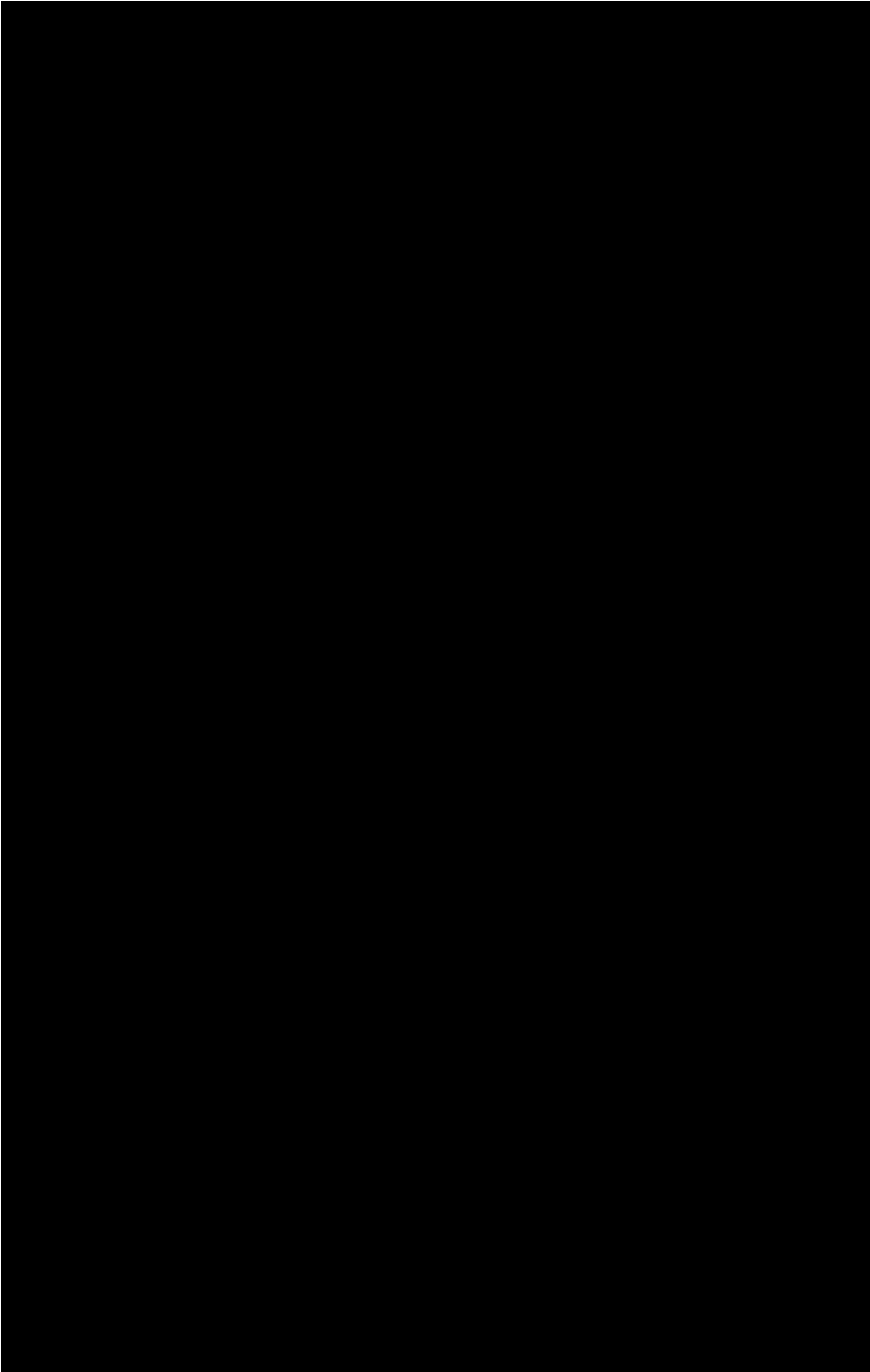




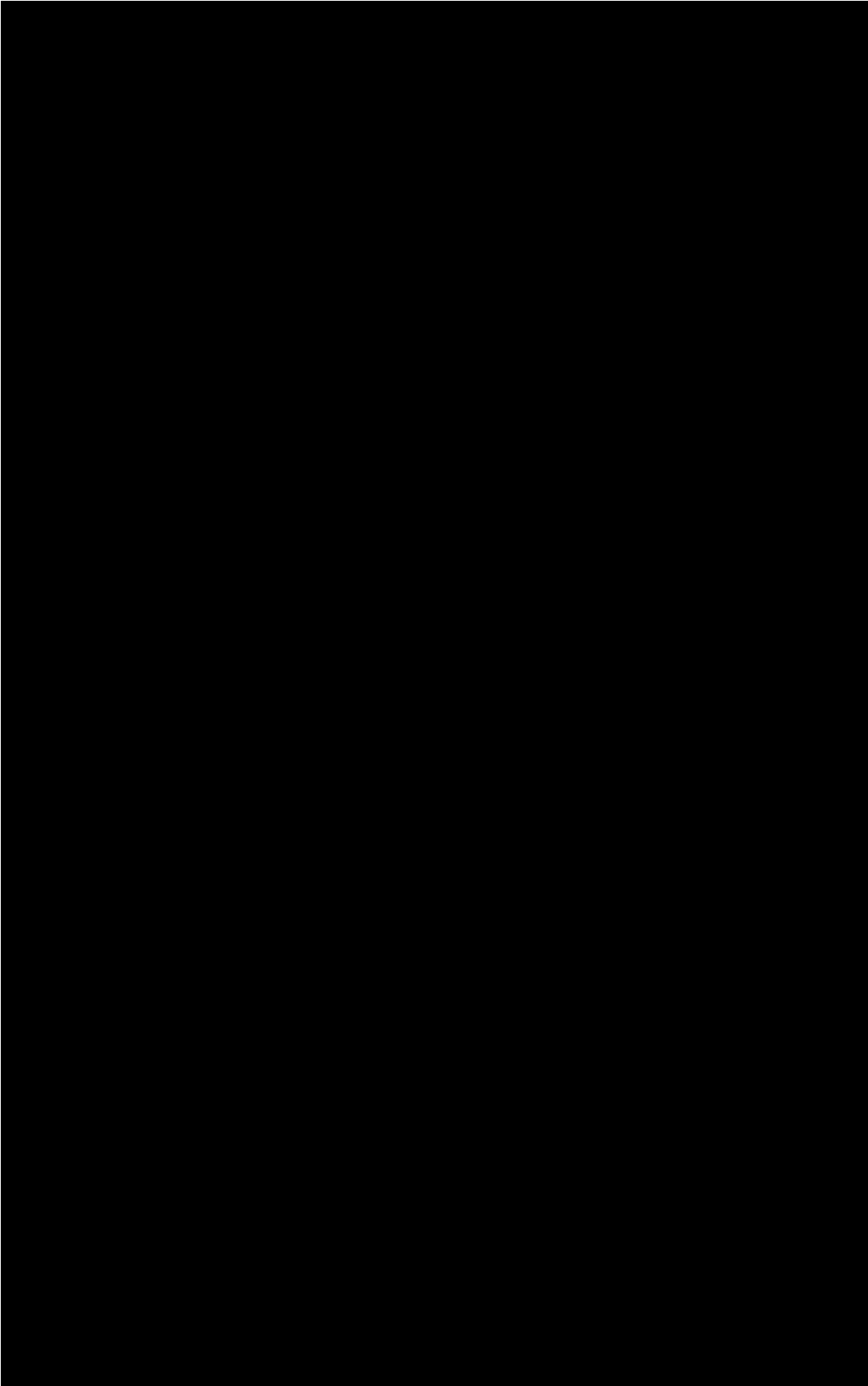


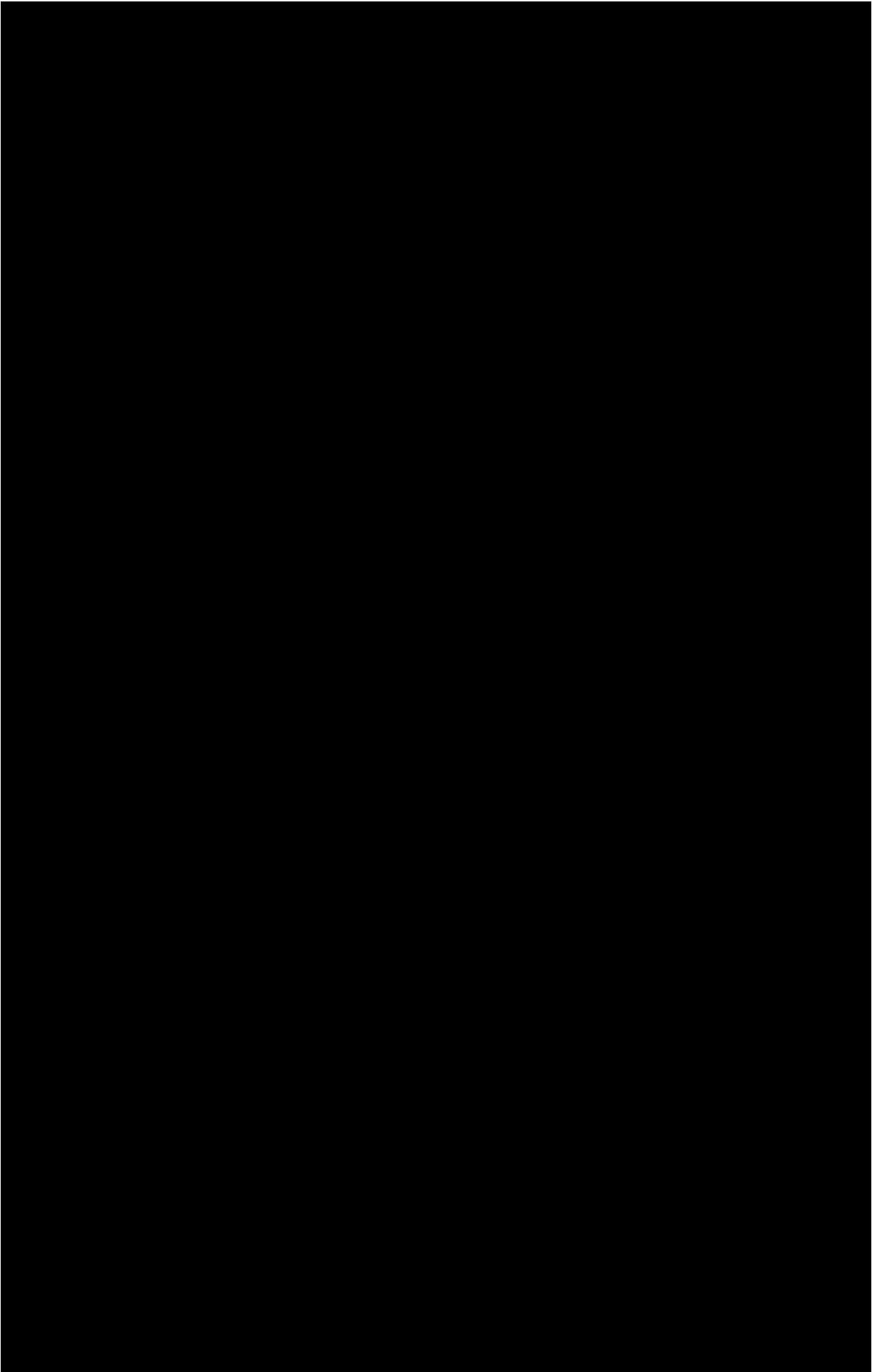


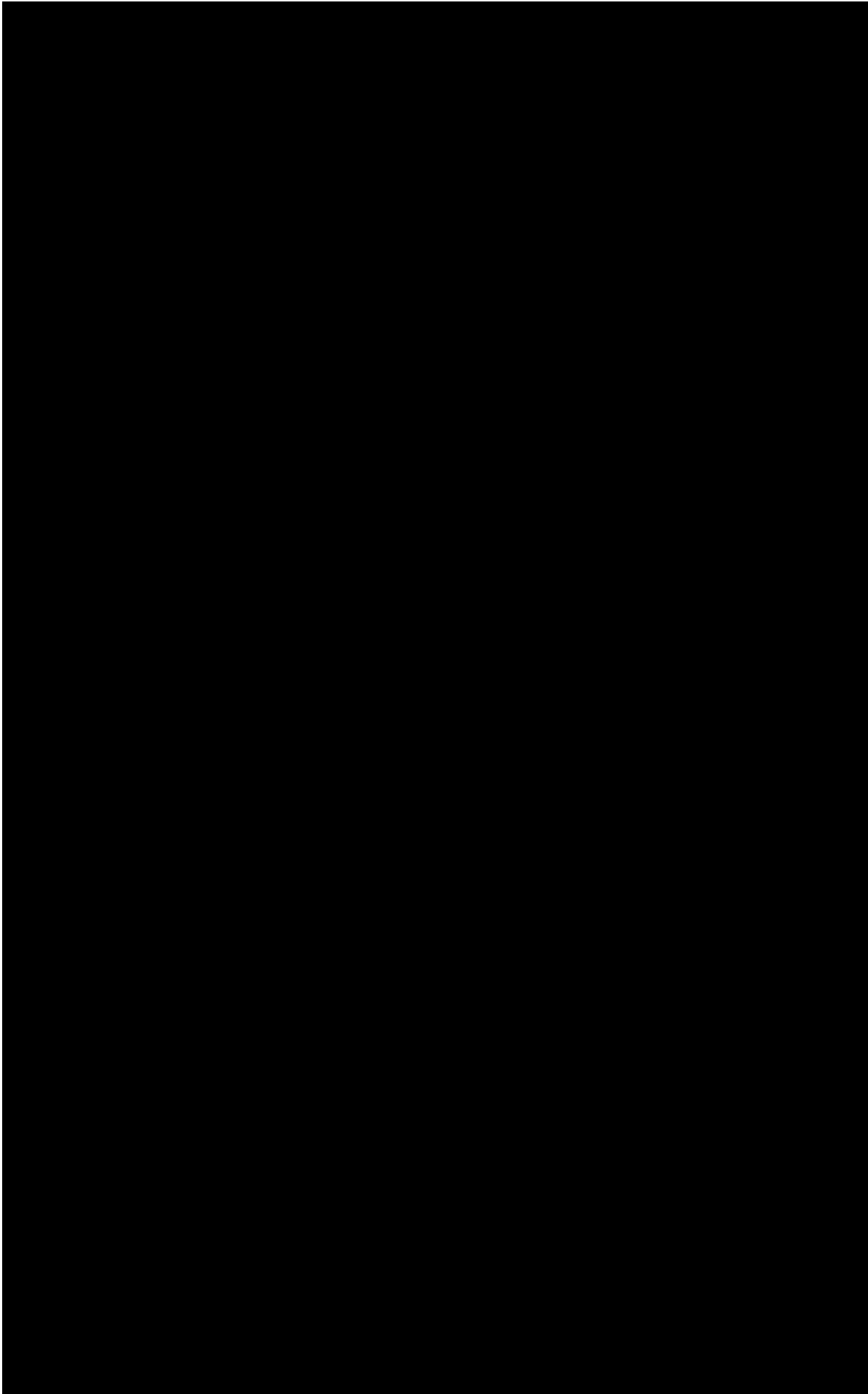


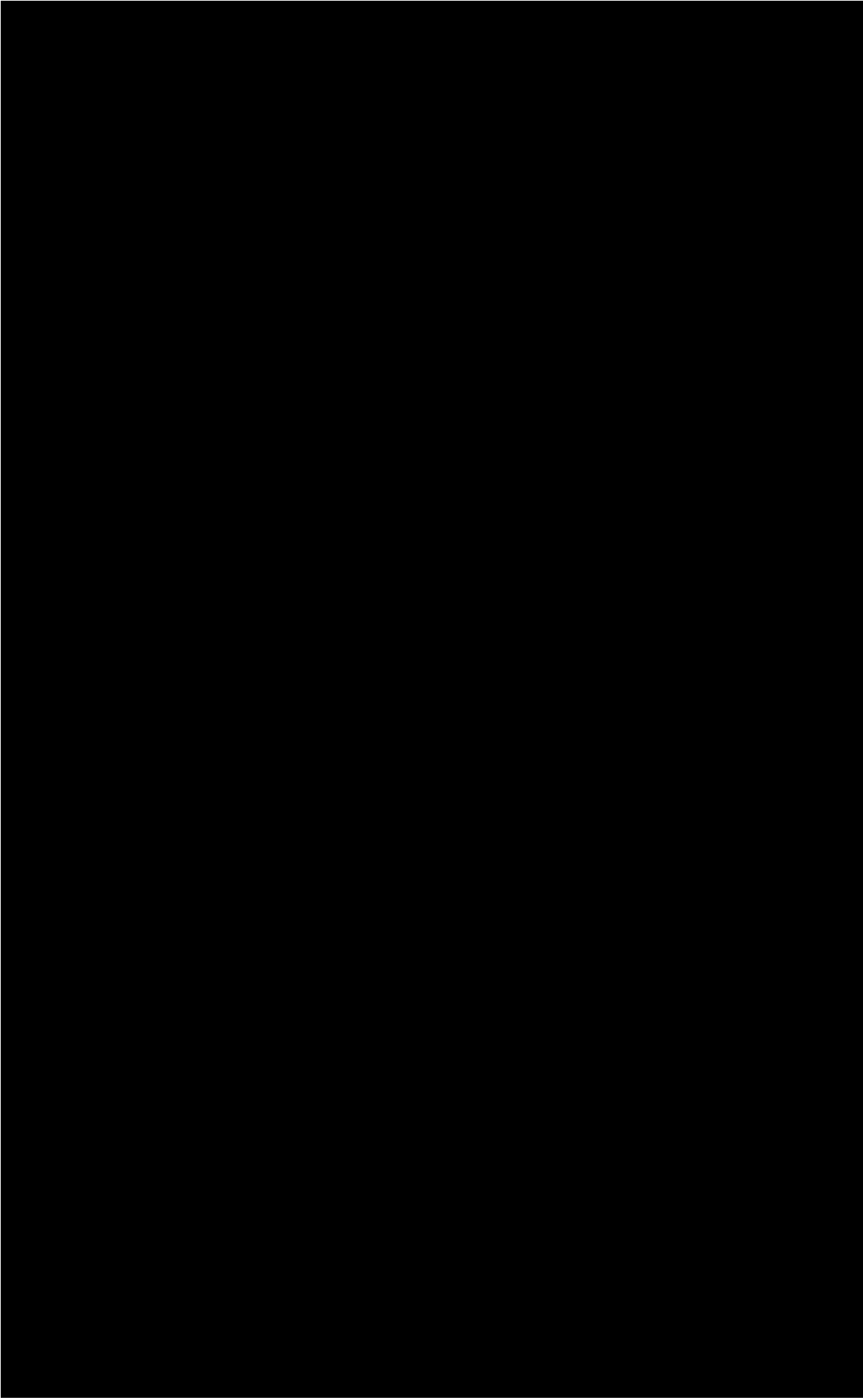


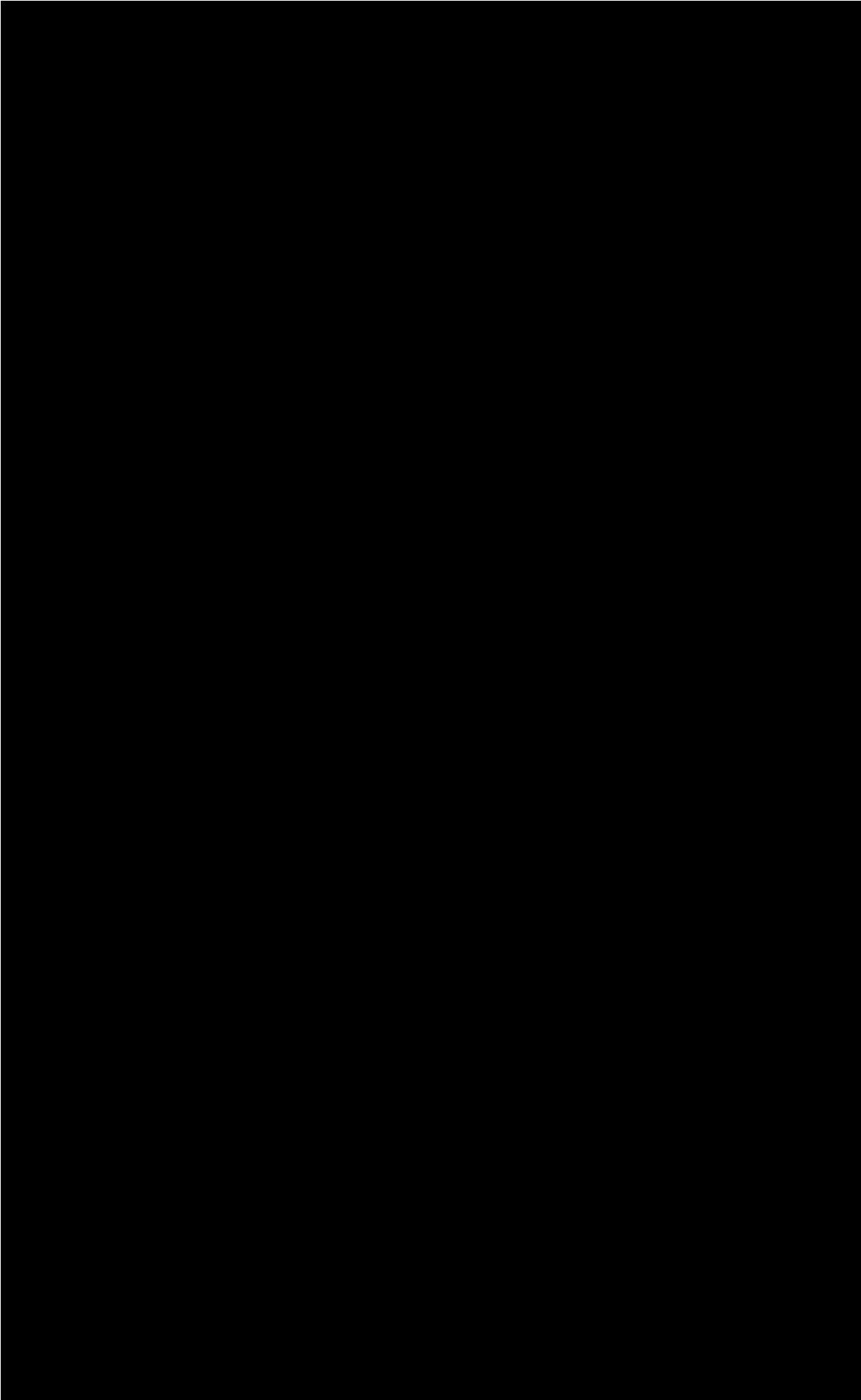


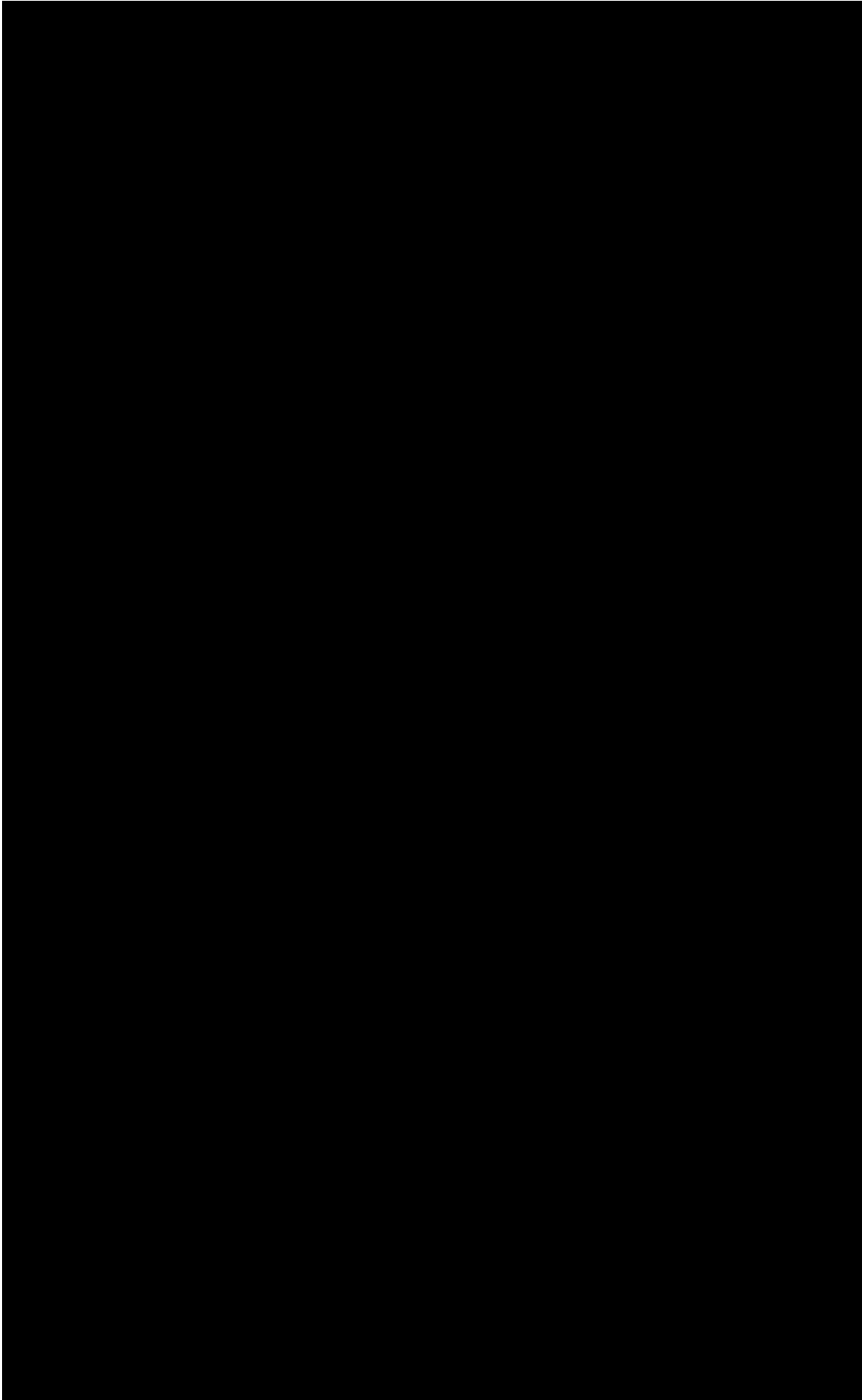


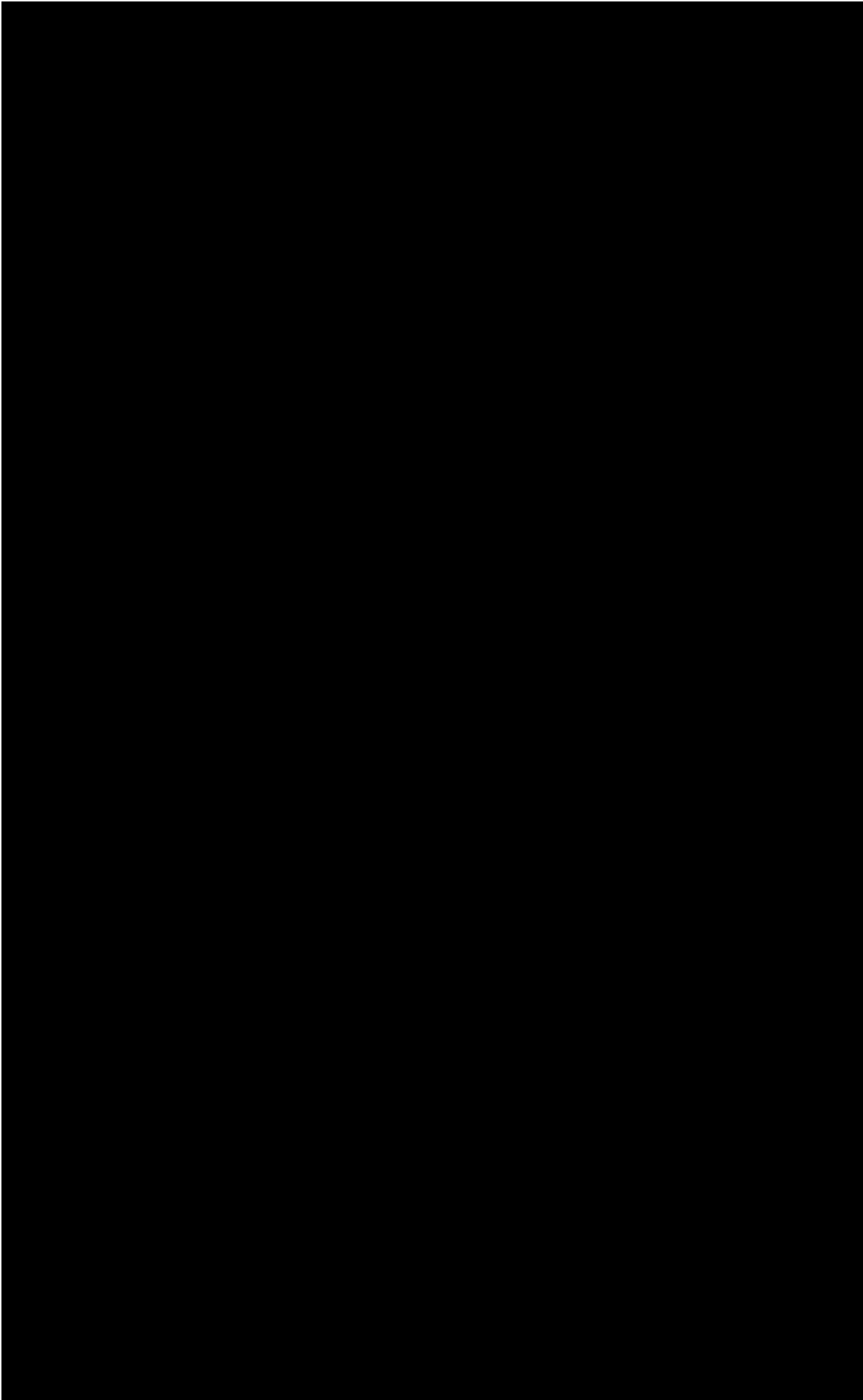


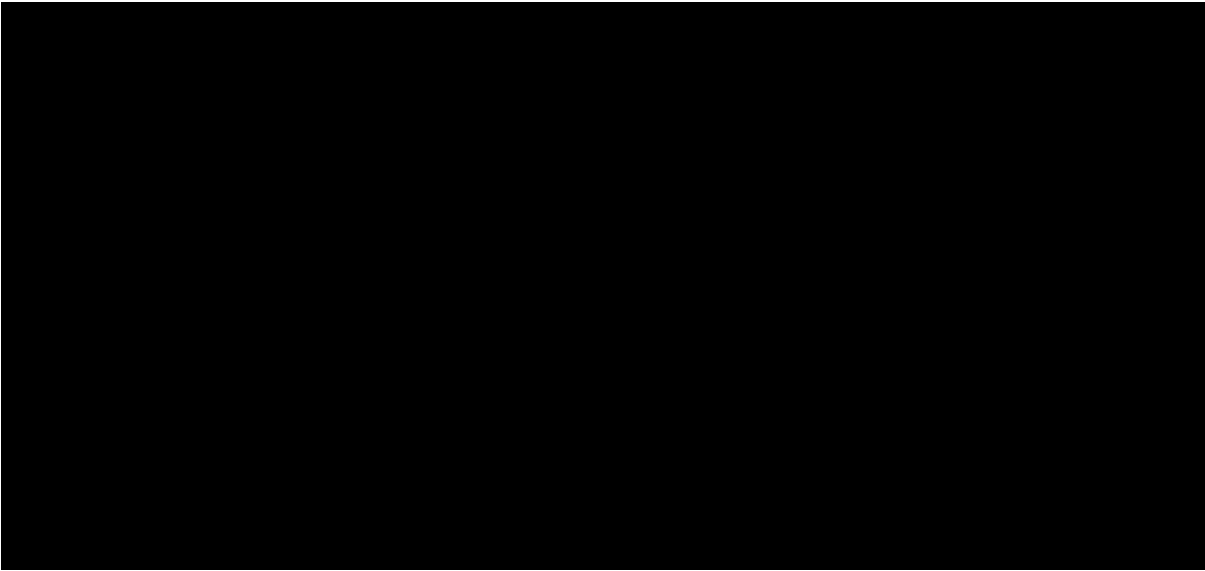














**DCS & NYSIF PRESCRIPTION DRUG PROGRAMS**  
**Pharma Revenue Guarantee Quote**  
Period 1/1/2014 - 12/31/2018

| Pharma Revenue Guarantee (1) | Per Final<br>Paid Claim (DCS Program) | Per Final<br>Paid Claim (NYSIF) |
|------------------------------|---------------------------------------|---------------------------------|
| ████████                     | █ ██████                              | █ ██████                        |
| ████████                     | █ ██████                              | █ ██████                        |
| ████████                     | █ ██████                              | █ ██████                        |
| ████████                     | █ ██████                              | █ ██████                        |
| ████████                     | █ ██████                              | █ ██████                        |
| ████████                     | █ ██████                              | █ ██████                        |

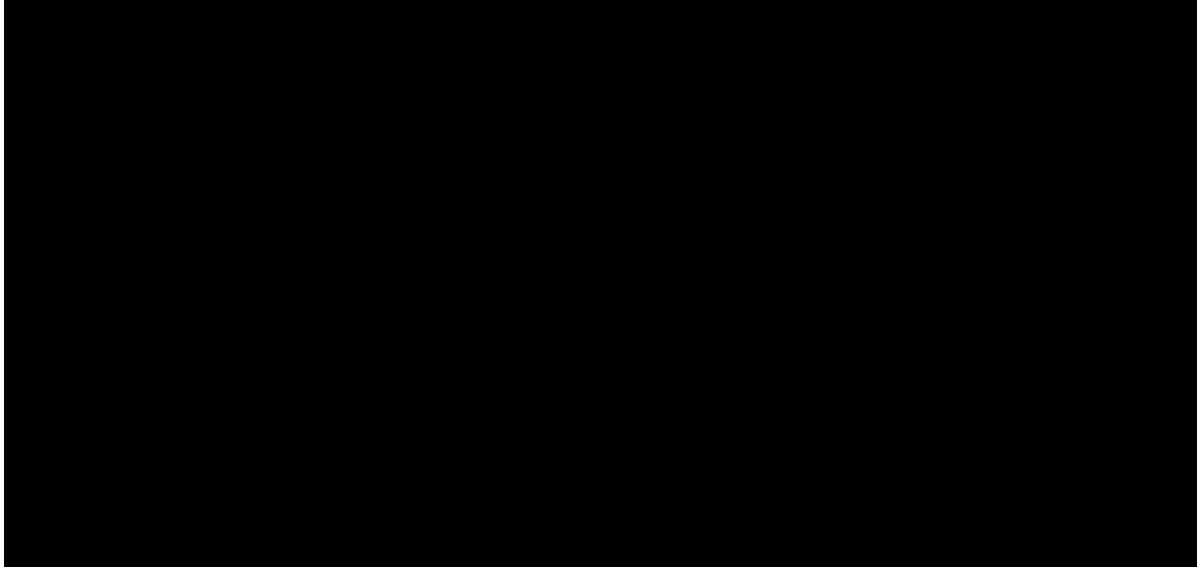
- (1) The quote above represents the guaranteed minimum amount due the Programs.
- The State shall receive all (100%) of pharma revenue as defined in this RFP.
  - The amount must be quoted on a per final paid claim basis as defined in the glossary; Section VIII
  - No separate administrative fee to manage the pharma revenue process shall apply.

Note: Offerors must provide adequate documentation as determined by the Department, to support the Offeror's proposal relative to pharma revenue. Documentation should be provided as Exhibit V.E.1 of the Offeror's proposal.

**The Offeror's Minimum Per Final Paid Claim Pharma Revenue Guarantee Quote is not contingent upon the Programs' participation in any of the Offeror's formulary management or intervention programs. Nor shall the Offeror's Minimum Per Final Paid Claim Pharma Revenue Guarantee Quote be contingent or dependent on the timing of any patent expirations and/or introduction of generic equivalent drugs, including but not limited to early and/or at risk generic launches.**

**Exhibit V.E1**  
Page 1 of 1

**DCS and NYSIF PRESCRIPTION DRUG PROGRAMs**  
**Documentation to Support Pharma Revenue Guarantee Quote**  
**Period 1/1/2014 - 12/31/2018**





**DCS and NYSIF PRESCRIPTION DRUG PROGRAMS**  
**Claims Administration Fee(s) Quotes (1)**  
**Period 1/1/2014 - 12/31/2018**

**Claims Administration Fees (2)**

**DCS Program Primary**

Total DCS Program Primary Claims Admin Fee

| <u>Quote</u>  | <u>Basis of Charge</u>  |
|---|---|
|  |  |

**EGWP Medicare Primary**

Total EGWP Medicare Primary Claims Admin Fee

|   |   |
|---|---|
|  |  |
|---|---|

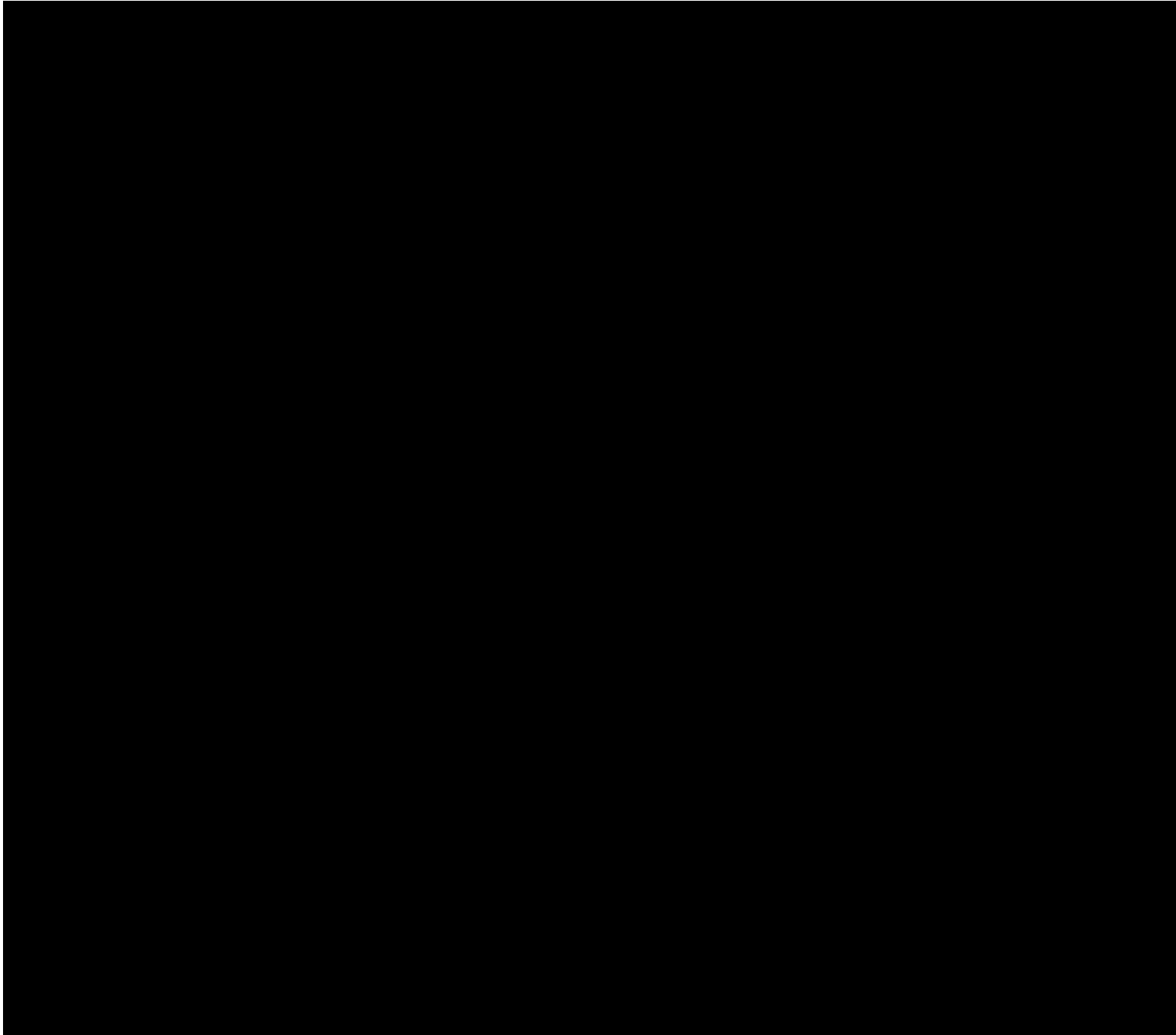
**New York State Insurance Fund Program**

Total NYSIF Program Claims Admin Fee

|   |   |
|---|---|
|  |  |
|---|---|

- (1) These quotes are made in accordance with the requirements of Sections IV and V of the RFP.  
 The quotes must be guaranteed for the period 1/1/2014 -12/31/2018.  
 Changes to these quotes not under the control of the Offeror may be negotiated solely at the Procuring Agencies' discretion.
- (2) Refer to Exhibit IV.A for a listing of Program Services applicable to each Claims Administrative Fee component.

Brand as Generics



Brand as Generics

