New York State Department of Civil Service & New York State Insurance Fund Workers' Compensation Technical Proposal

MAY 2012

Section I Technical Proposal Requirements

Section II Additional Requested Exhibits

SECTION IV: TECHNICAL PROPOSAL REQUIREMENTS

The Procuring Agencies seek to award two separate Agreements to a qualified Offeror to provide Pharmacy Benefit Services for the respective agencies prescription drug programs. The Department is seeking to secure the services of a qualified Offeror to administer The Empire Plan, Excelsior Plan, and Student Employee Health Plan Prescription Drug Programs (collectively referred to as DCS Program(s)). NYSIF is seeking to secure the services of a qualified Offeror to administer the NYS Workers' Compensation Prescription Drug Program (referred to as NYSIF Program). The purpose of this section of the RFP is to set forth the programmatic duties and responsibilities required of the Offeror and to pose questions concerning those duties and responsibilities. The Offeror's Technical Proposal must contain responses to all questions (i.e. Required Submissions) in the format requested. Each Offeror may submit only one Technical Proposal. The proposals will be evaluated based on the Offeror's responses to the questions contained in this section. Therefore, it is critical that Offerors fully respond to each of the questions presented in this section. Evaluation of all Proposals and the selection of the Successful Offeror shall be based only upon the Offeror's Proposal regarding the duties and responsibilities set forth in the RFP, and shall not be based upon any supplemental material.

Notes:

1. Unless otherwise stated, all of the requirements contained in this section pertain to both the DCS and NYSIF Programs.
2. Numbers, data, or statistics which may appear in the Exhibits referenced throughout this RFP are for informational purposes only and should not be used or viewed by prospective Offerors as guarantees or representations of any levels of past or future performance or participation.

The Procuring Agencies will accept Proposals only from qualified Offerors and will consider for evaluation and selection purposes only those Offeror Proposals that it determines to meet the Minimum Mandatory Requirements in Section III and are responsive to the duties and responsibilities set forth in Section IV of this RFP.

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

A. Program Administration

1. EXECUTIVE SUMMARY

The Offeror must describe its capacity to administer the DCS and NYSIF Prescription Drug Programs (also hereafter collectively referred to as the "Programs").

A. REQUIRED SUBMISSION

The Offeror must submit an Executive Summary that describes its capacity to administer the DCS and NYSIF Prescription Drug Programs. The Executive Summary must include:

(1) The name and address of the Offeror's main and branch offices and the name of the senior officer who will be responsible for this account;

Office	Function	Addresses
CVS Caremark Corporation	CVS Caremark Headquarters	One CVS Drive Woonsocket, Rhode Island 02895
Caremark	Operations Centers	2211 Sanders Road Northbrook, Illinois 60062 9501 E. Shea Boulevard Scottsdale, Arizona 85260 750 West John Carpenter Freeway Suite 1200 Irving, Texas 75039

Executive Sponsor

Jon C. Roberts
Executive Vice President & Chief Operating Officer
CVS Caremark
One CVS Drive
Woonsocket, Rhode Island 02895

(2) A description demonstrating its understanding of the requirements presented in the RFP, and how the Offeror can assist the Procuring Agencies in accomplishing their objectives;

CVS Caremark understands the requirements presented in the RFP, and our proposal and offer reflects our commitment to honor all RFP requirements and deliver valuable pharmacy benefit management services that align with the objectives of the procuring Agencies.

Our high level of service is achieved by providing:

- A business model that is aligned with the financial interests of the Procuring Agencies, which offers financial protections for the State and is transparent within all business relationships relating to the Programs
- A Workers' Compensation strategy that accommodates NYSIF requirements and designed to achieve higher success rates in capturing first fill claims and accurate application of plan design parameters

- Consultative Account management approach, staffed with a dedicated team from our Government Business Unit, who are knowledgeable and experienced in servicing public sector contracts
- Dedicated customer care unit
- Robust clinical program deployment to maximize safety, cost containment, and coordination with physicians and other health care professionals
- Sound underwriting support, through developing and implementing stable and realistic premium rate structure
- The ability to exceed the minimum mandatory pharmacy network requirements
- Member access to all prescriptions through the retail and mail service benefit
- High-touch Specialty Pharmacy Management program that addresses the evolving needs of the specialty pharmacy landscape
- Adherence to mandatory generic substitution requirements in order to maximize generic utilization and discount savings to the Program
- Full pass through of all pharma revenue
- Proactive pharmacy network management that maximizes cost containment and provides a superior network of pharmacies
- Formulary management based on clinical effectiveness and a lowest net cost approach
- Aggressive performance guarantees.

(3) A statement explaining previous experience managing the Prescription drug plans of other state governments or large public entities or any other organizations with over 100,000 covered lives, as well as any previous experience managing a Self-Funded Prescription Drug Program. Detail how this experience qualifies the Offeror and, if applicable, the experience of its Key Subcontractors to undertake the functions and activities required by this RFP;

(4) An explanation of how the following administrative and operational components will be performed by the Offeror. Include an organizational chart explicitly detailing responsibility for the following functions:

(a) Network Management

Our retail network strategy takes both the client and the member into consideration. We build our networks with a focus on providing broad access, choice, and convenience – to maintain and enhance member satisfaction, along with competitive pricing – to help reduce total costs for our clients.

The scope of our retail network management strategy provides the following benefits:

- Aggressively negotiated discounts on drug pricing
- Member convenience, choice, and confidence
- Flexibility to control plan design, eligibility, and dispensing
- Maximum allowable cost (MAC) plan design options
- Accurate analysis and reporting for clients
- Pharmacy Education programs to promote accuracy at the point of sale
- Comprehensive audit services.

(b) Specialty Pharmacy Program

[redacted]

(c) Mail Service Pharmacy Process

[redacted]

(d) Claims Processing

(e) Retrospective Coordination of Benefits

We use eligibility information and other insurance indicators to identify pharmacy claims not properly coordinated with members' other commercial carrier or Medicare coverage which is primary. The following is an overview of our process:

- Claims, eligibility data, and COB indicator files are received and loaded into our proprietary databases.
- Data is evaluated for 30 days to verify subsequent adjustments. Accumulated claims are continuously mined and enriched through internal and external resources to identify potential overpayments.
- Audits are generated and distributed to analysts who are experts in applicable NAIC and Medicare regulations, and pharmacy benefit administration.
- Using gathered information, the primacy determination is made.
- For commercial other insurance, based on information obtained and applicable NAIC guidelines, primacy for the patient is determined and claims paid incorrectly are accumulated.
- For Medicare eligibility, based on information obtained and applicable Medicare Secondary Payer regulations, primacy for the patient is determined, Part B coverage and situational drug coverage is confirmed. Claims paid incorrectly are accumulated.
- Claims accumulated for each audit scenario above are individually evaluated for coverage through the correct primary commercial insurance or Medicare coverage for the respective dates of fill to confirm ability for pharmacy to re-bill.
- Claim overpayment notices are generated internally and subject to a final quality review.
- Approved claim overpayment notices are sent monthly to the dispensing pharmacy or appropriate corporate office, or other insurance carrier providing notice of the overpayment. Notice provides the proper insurance billing information and claim-level data for each member.
- A dispute or appeal period is allowed to address any questions or disputes from the dispensing pharmacy. Any issues are resolved prior to submitting claims for reversal.
- A reversal file is produced monthly containing all confirmed overpayments beyond the dispute period that have not already been refunded by the insurance carrier or reversed by the dispensing pharmacy.

(e) Customer Service

[redacted]

(g) Enrollee Communication Support

CVS Caremark offers a package of standard communication materials that have been enhanced over time to improve engagement, clarity, and response. The Programs will be able to review these communications for approval, and we will assign a Communications Specialist to assist in the customization of these materials. CVS Caremark Account Team members will assist in presentation development and be present for benefit fairs and other member-facing events.

Examples of pertinent enrollee communications during the implementation period include formulary communications to mitigate disruption; plan design materials to inform about new coverage rules; specialty pharmacy communications to assist transition to new program; and general transition communications to introduce the new program.

CVS Caremark will support the programs with ongoing communications and support to develop customized materials as needed, with final approval to be provided by the Department.

(h) Enrollment Management

Our Eligibility Administration department is responsible for the implementation of new client eligibility. This group works with the eligibility provider to determine format and medium; obtain test and production files; provide error reports and feedback; and create labels for mailing purposes. A checklist is maintained and completed by the Enrollment Analyst to confirm that all tasks are completed prior to the client start date.

Eligibility Administration is also responsible for ongoing monitoring of client eligibility files and problem resolution. Eligibility Administration works closely with the Eligibility Verification unit, IT, Customer Care, and the provider of eligibility data to help identify trends and work towards a resolution.

CVS Caremark has developed several service and quality-based tools that are used to monitor the automated eligibility load process and maintain the integrity of the eligibility data.

(i) Reporting

CVS Caremark offers a wide range of standard, optional, and ad hoc reporting capabilities to address the Programs' requirements and help fulfill our commitment to provide consultative account management support and provide the Programs the information you need to make fact-based decisions.

We offer a comprehensive portfolio of flexible financial and utilization reports. Many reports are flexible and provide the necessary information at a carrier, product (i.e., account), and/or group level. Establishing the carrier, account, and group hierarchy is critical to enable us to report to the Programs at a meaningful level. Fields exist on individual member eligibility files in which the Programs can report specific information, such as section or medical group numbers. Reporting is feasible at this subgroup level as well, provided that the information is available on the member eligibility files.

The Programs will also have access to our ad hoc reporting system for virtually unlimited clinical ad hoc reporting capabilities. Using our user-based ad hoc reporting tools, we can produce reports that include drug category/specific drugs, information on chains vs. independent pharmacies, formulary compliance, and brand/generic usage. With this ad hoc reporting system we can break out reports for groups or sections within the plan.

(j) Clinical Management/ Prior Authorization

Our fully-functional prior authorization program alerts pharmacists with hard stops at the point of service to ensure that all medications flagged with PA rules are subjected to case review and appeals process. While we recommend the most appropriate drugs for prior authorization, to achieve the best return on investment, while mitigating disruption, we offer consultative services allowing the programs to customize PA criteria to optimize the approach.

In addition, we have successfully rolled out electronic prior authorization, leveraging the Surescripts (formerly known as RxHub) network as a means of bi-directional communication, which enables user-friendly PA processes for physicians and decreases the administrative burden on their practices. This approach also decreases member disruption as case reviews can be completed in a more timely, efficient manner.

(k) Drug Utilization Review (concurrent, retrospective and narcotics)

Our suite of DUR programs, and the proprietary clinical rules engine that supports the retrospective function, enables us to review 100% of claims against evidenced-based clinical guidelines, to ensure that members receive safe and appropriate medications. Our programs are backed by targeted member and physician engagement strategies that enable interventions for the most cost-effective medications; interventions that identify and address medication misuse, fraud, and abuse; and interventions that target member-specific opportunities to close gaps and care as well as address adherence issues.

(l) Flexible Formulary and Preferred Drug List Development and Management

CVS Caremark's PDL development and management approach aligns with the Programs objectives identified in the scope RFP. For example, as we developed a customized PDL for DCS Flexible and Enhanced Flexible Formulary designs, our approach fostered a solution where we can achieve lower net costs, while minimizing member disruption. Our strategy behind this approach is to achieve a better return on the Department's health care investment and provide desirable access to clinically-effective medications as well as maintain compliance with the outlined requirements and State & Federal regulations.

(m) Rebate Administration

Rebates for eligible claims are coordinated and administered by CVS Caremark's Industry Analysis team through our proprietary vendor rebate system. This system enables CVS Caremark to track each contract independently, generate rebate invoices, and compile reporting. CVS Caremark invoices for rebates from manufacturers on a quarterly basis, based on current terms and conditions as well as market performance.

CVS Caremark has an aggressive collection and reconciliation process related to rebate payments. All payments are fully reconciled to the original invoiced amount, and any differences are documented and escalated appropriately to ensure that payment is made on all valid claims submitted to the drug manufacturers. The average turnaround time for manufacturers to pay their rebates is 60 to 120 days after the end of the quarter; however, the payment timing of the rebates depends upon the Programs' contract.

CVS Caremark will determine the rebates due to the Programs by matching the payment information detailed in the manufacturer reconciliation data against the invoiced claims. The CVS Caremark proprietary reconciliation system then applies the rebate payment to the individual claims. The aggregate dollar amount is determined and monies distributed per the terms of the client contract.

(n) Account Management

CVS Caremark's Account Team structure and philosophy is organized to benefit clients by assigning individuals that have the appropriate expertise and acumen in the client's business segment. In this case, team members from our Government Business Unit, who have experience managing similar accounts will consult with the Programs to help design a benefit strategy that aligns with all objectives within the scope of the RFP. Our Government Business Unit works as a cohesive team, which enables lateral communication to share best practices specific to the government business segment as well as ensure continuity on our overarching focus to build lowest net cost benefit designs for our clients, while maintaining accessibility to quality care for members.

The following individuals will comprise your Account Service team:

ACCOUNT SERVICE TEAM	
Executive Sponsor	Jon Roberts
Strategic Account Executive	Lisa Stover
EGWP Strategic Account Executive	Tina Goldenberg
Account Manager	Araceli Flores
Account Manager	Amy Hammerschlag
EGWP Account Manager	Virna Rodriguez
Clinical Advisor	James Dennis
Analytics Consulting Services	Jay Blomquist
EGWP Implementation Manger	Anita Degge

(o) Consulting

CVS Caremark offers a consultative Account Management approach, which leverages the expertise of the various roles of the team members and their ability to work within our organization on behalf of clients to gain valuable insights from experts across our organization. In this case, the proposed Strategic Account Executive, Lisa Stover, is a current member of our Government Business Unit and has valuable experience working with similar clients. Also, the proposed Clinical Advisor, James Dennis, and Analytic Consultant, Jay Blomquist, will be dedicated to supporting the Programs' needs and will be able to provide recommendations and ad hoc analyses to support decision-making and strategic planning.

(p) Mandatory Generic Substitution & Generic Appeals Process

CVS Caremark's online claims adjudication system is fully-integrated among retail, mail, and specialty claims, which enables CVS Caremark to ensure compliance with the Mandatory Generic Substitution parameters as all claims adjudicated by CVS Caremark's system are verified against the Programs' plan design. When prescriptions written for brand-name drugs are adjudicated under a plan design that requires generic substitution, a message is sent back to the retail pharmacist designating that a generic equivalent is available. The CVS Caremark claims adjudication system will automatically indicate when a generic equivalent is available for substitution.

In addition, retail network pharmacies are audited for accurate generic substitution dispensing. During these audits, CVS Caremark confirms that the physician has ordered "Dispense as Written" (DAW) on the brand prescription. We also verify that DAW was not arbitrarily added to the claim form or rejection form in order to obtain payment for the brand-name prescription where a generic substitution should have been made.

CVS Caremark employees a licensed pharmacy staff to oversee the generic appeals process, and our current process is aligned with current DCS requirements.

(q) Pharmacy Audit and Responses to NYS Audits

The standard audit process involves three levels of review: the daily review of high-dollar claims to identify erroneous billings, the more detailed on-site review, and the in-depth investigational audit. These audit processes confirm that claims were billed accurately – in accordance with the physician's directions and client plan guidelines – and that the billed drugs were provided to our clients' participants.

Our proactive audit process ensures that all pharmacies are subject to daily review, and that potential problems are identified and controlled before they can have any significant adverse effects on our clients or their members. Pharmacies with an indication of noncompliance may be subject to on-site or investigational audits. We monitor the pharmacy performance each time a claim is submitted electronically.
System edits applied at the point of service act as an automated management tool to ensure compliance with program parameters before a prescription is dispensed.

CVS Caremark is in compliance with all audit requirements as set forth by the Programs.

(r) Drug Lawsuits/Settlements

CVS Caremark provides assistance to clients when CVS Caremark has knowledge of class action lawsuits for third party payors. CVS Caremark will provide clients with the necessary drug spend information that is required for the client to submit a claim to the fund administrator. CVS Caremark's Analytics and Outcomes department sets up a database that can be accessed by the appropriate Account Managers for this purpose. If the Programs file their own claims, we will provide the Program with the same level of assistance. If the Programs request CVS

Caremark to directly file claims on their behalf or otherwise directly pursue recoveries, to the extent permitted by the settlement or award, CVS Caremark will do so.
CVS Caremark will coordinate with the Programs on the approach, depending on the circumstances of the particular situation, and may utilize the resources of a third-party consultant or legal counsel, as appropriate.

(s) Medicare Part D Prescription Drug Program Administration

(t) Half Tablet Program

CVS Caremark is not proposing to implement the optional Half-Tablet program as more than half of the brand drugs on the current list are expected to lose patent protection before 2014. CVS Caremark offers a soft edit Dose Optimization program that can achieve cost savings for the program and members by coordinating with physicians during the retrospective review. Unlike a similar program with a hard edit, our proposed approach would mitigate any member disruption.

(u) Drug Recall Notification

With a routine-level recall, our pharmacies are notified immediately and given instructions on how to segregate and return the affected product to the manufacturer.

A member-level recall requires that any product "in-house" be segregated for return and that a notification process be launched immediately. The member is instructed *via a phone call or letter*, depending upon the type of recall/withdrawal, on what to do with the product and how it is to be replaced. This instruction is at the direction of the manufacturer or distributor.

In either case, communication with our pharmacies is immediate through e-mail. The pharmacy takes whatever action is necessary and responds on the status within 24 hours. If not all of the information is available on the issuance of the recall, a call is placed immediately to the manufacturer for verification.

(v) Financial Support Services

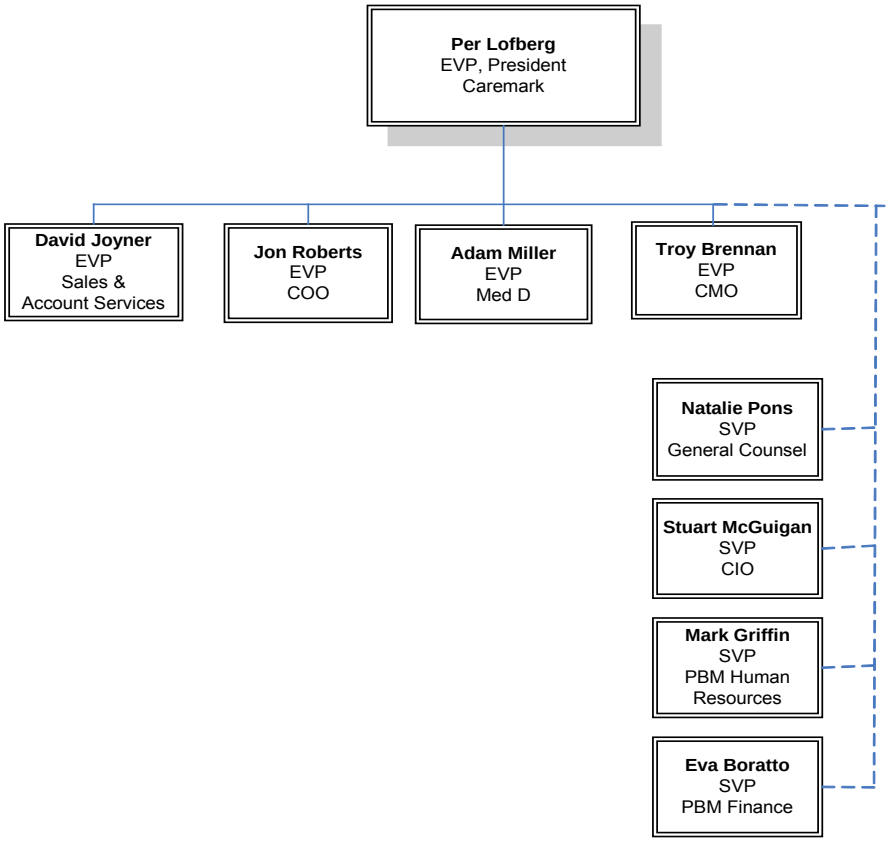
CVS Caremark is supporting DCS Program financial services by offering access to key individuals from our underwriting and actuarial services department, as well as analytic support from the assigned Account Team. CVS Caremark will work with the Department and its contracted actuarial consultant on the annual rate renewal recommendation and our availability to present such recommendation to the Department, Division of the Budget, and GOER.

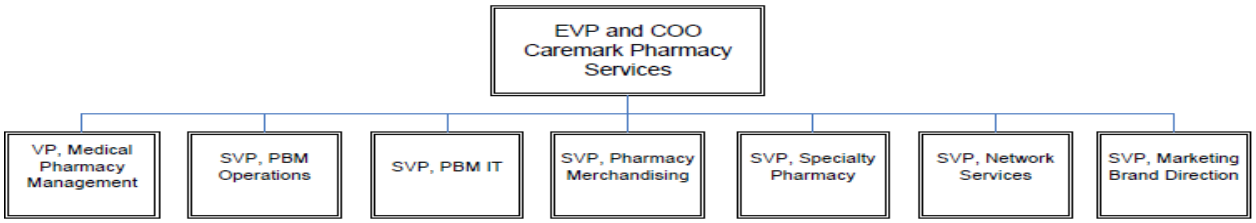
(w) Transition and Termination of Contract

CVS Caremark maintains NCPDP standard processes for inbound and outbound transitions. We maintain a Vendor Transition analyst for outgoing transitions, to maintain the integrity of our clients' programs and support the incoming vendor by providing necessary information (e.g. files and data) required for a seamless transition.

If the proposed organizational structure has been used in administering the program of another client, provide the client's name and include the client as a reference as required in Exhibit I.V.

CVS Caremark confirms. Please refer to references in Exhibit I.V. Below is CVS Caremark's functional PBM Operations Organizational Structure.





2. GENERAL QUALIFICATIONS OF THE OFFEROR

The DCS Prescription Drug Programs cover over one million lives and incur costs in excess of $1.5 billion annually. Over 50,000 NYSIF Workers' Compensation claimants fill approximately 700,000 prescriptions annually and incur costs in excess of $75 million annually.

The Offeror must have the experience, reliability and integrity to ensure that each Program member's health care needs are addressed in a clinically appropriate and cost effective manner. The terms of the Offeror's proposal must demonstrate explicit acceptance of and responsiveness to the Programs duties and responsibilities set forth in this RFP, ensuring full compliance with the respective Programs Services.

A. REQUIRED SUBMISSION

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

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

(2) Explain how the Offeror's account team will be prepared to actively manage the administrative, operational, and clinical aspects of the Programs?

CVS Caremark's Account Team structure and philosophy is organized to benefit clients by assigning individuals that have the appropriate expertise and acumen in the client's business segment. In this case, team members from our Government Business Unit, who have experience managing similar accounts, will consult with the Programs to help design a benefit strategy that aligns with all objectives within the scope of the RFP.

CVS Caremark understands that each client is unique; therefore, we take a consultative team approach to address client needs. The goal of this approach is to furnish each client with extensive resources in an efficient, well-coordinated manner. We will work with you to develop an appropriate account management structure and strategy, using this proven method as the foundation.

Establishing a Foundation

The first goal of the consultative team approach is to minimize disruption during the transition from your current vendor. The team will work closely with sales and project management professionals thought program implementation so that your Account team is involved right from the start, and so that meaningful relationships can begin to grow.

Delivering Service

Your CVS Caremark team will be an extension of your organization and will serve as a professional and experienced consultative and educational resource. We know that our clients hire us to be their pharmacy benefit experts, and that is what we will be to the Programs. The Account team that provides the client with ongoing support services after implementation will include a Strategic Account Executive, an Account Manager, an Analytic Consultant, and a Clinical Advisor.

The Strategic Account Executive coordinates the collaboration between our staff and the client's staff to ensure that all client requirements are met in a consistent, effective, and timely manner. The Strategic Account Executive assumes overall accountability for client satisfaction.

The assigned Clinical Advisor will be responsible for managing the clinical and formulary aspects of your prescription benefit program. The clinical advisor will collaborate with your benefits team, as well as the other members of your account team to support your pharmacy benefit goals,, implement clinical programs, provide utilization management recommendations and update you on actionable marketplace issues, such as brand/generic pipeline management.

The Account Managers oversee the client's benefit design and plan performance, coordinating day-to-day account administration and ensuring the client's satisfaction with the services provided by CVS Caremark. The Account Managers also work closely with the client and the Strategic Account Executive to recommend benefit programs and monitor the quality of daily benefit program operations.

The Analytic Consultant is responsible for applying analytical expertise to benefit design and trend management initiatives. The Analytic Consultant works with the Account team to provide recommendations and solutions based on advanced analytic methodology, as well as a thorough knowledge of the data and the overall health care landscape.

The Account team will be able to draw upon resources from a wide range of CVS Caremark operational areas to handle your needs more effectively. Our integrated approach enables ready access to support from such areas as retail network management, mail service management, eligibility and coordination of benefits, information technology, governmental affairs, member-level customer service, clinical services, and financial reporting. On an ongoing basis, we will monitor and staff based on meeting the needs of the Programs.

(3) What internal systems or procedures does the Offeror have in place to provide financial, legal, and audit oversight of the Programs?

An SSAE 16 (formerly SAS 70) report is prepared to provide information on CVS Caremark's controls that may be relevant to user organizations of CVS Caremark and their auditors as it relates to an audit of financial statements and is prepared in accordance with the guidance contained in the American Institute of Certified Public Accountants' Standards for Attestation Engagements (SSAE) No. 16, "Service Organizations," as amended.

An independent external audit firm is hired each year to perform the audit of CVS Caremark's controls. This external audit is performed twice a year, resulting in a yearly report that is available to clients upon request.

CVS Caremark processes prescription claims in an online, real-time and paperless environment. Our primary applications are reviewed on a periodic basis internally, and by the external auditors to ensure that users are in compliance with CVS Caremark's information asset policies, procedures and standards.

Additionally, to maintain compliance with the International Standardization Organization's (ISO's) certification requirements, our data center is subject to annual surveillance audits conducted by NSF, Inc. In addition, NSF, Inc. performs recertification audits every three years.

CVS Caremark has real-time intrusion detection monitoring on our networks. In addition, quarterly external vulnerability scans also are conducted to ensure that our Internet presence is secured.

Annual Payment Card Industry Data Security Standard (PCI-DSS) audits are performed to ensure compliance with the PCI-DSS. CVS Caremark is currently compliant with this standard.

CVS Caremark IT Compliance and Audit Support conducts the following audit reviews on a periodic basis as part of the SOX compliance effort:

1. Periodic Access Review occurs semi-annually for all applications, systems, and databases.
2. Access to critical files, libraries, and directories occurs annually.
3. High privileged users' review occurs on a quarterly basis.
4. Segregation of duties analysis occurs on a semi-annual basis for SOX-related systems.
5. Security patch audits are conducted on a periodic basis.
6. Termination reviews are conducted on a continuous basis.

In addition, across all CVS Caremark business lines, we have corporate officers with responsibility and oversight regarding the compliance with and deployment of financial, legal, and regulatory requirements through their individual departments. These officers include: a Chief Legal Officer (health care law oversight); a Chief Financial Officer (financial management oversight); a Chief Privacy Officer (information governance, including privacy and information security, oversight); and a Chief Compliance Officer (compliance and integrity, including internal audit, oversight).

B. DCS and NYSIF Prescription Drug Program Services

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

1. ACCOUNT TEAM

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

A. DUTIES AND RESPONSIBILITIES

(1) The Offeror must maintain an organization of sufficient size with staff that possesses the necessary skills and experience to administer, manage, and oversee all aspects of the Programs during implementation and operation.

(a) The account team(s) must be comprised of qualified and experienced individuals who are acceptable to the Procuring Agencies and who are responsible for ensuring that the operational, clinical, and financial resources are in place to operate the Programs in an efficient manner;
(b) The Offeror must ensure that there is a process in place for the account team(s) to gain immediate access to appropriate corporate resources and senior management necessary to meet all Programs requirements and to address any issues that may arise during the performance of the separate resultant Agreements.

(2) The Offeror's dedicated account team(s) must be experienced, accessible (preferably in the New York State Capital Region district) and sufficiently staffed to:

(a) provide timely responses (within 1 to 2 Business Days) to administrative and clinical concerns and inquiries posed by the Department, or other staff on behalf of the Council of Employee Health Insurance, or NYSIF, or union representatives regarding member-specific claims issues for the duration of the separate Agreements to the satisfaction of the Procuring Agencies;
(b) immediately notify the Procuring Agencies in writing of actual or anticipated events impacting Program costs and/or delivery of services to Enrollees (for example, drug recalls and withdrawals, class action settlements, and operational issues).

(3) The Offeror's dedicated account team(s) must ensure that the Programs are in compliance with all legislative and statutory requirements. If the Offeror is unable to comply with any legislative or statutory requirements, the Procuring Agencies must be notified in writing immediately. The Offeror is required to work with the Department to develop accurate Summary Plan Descriptions (SPDs) and/or Program material.

B. REQUIRED SUBMISSION

(1) Provide an organizational chart and narrative description illustrating how you propose to administer, manage, and oversee all aspects of the Programs. Include the names, qualifications, and job descriptions of the key individuals selected to comprise the account management team(s) for the Offeror. Complete Exhibit I.B of this RFP, Biographical Sketch Form, for all key members of the proposed account management team(s); where key individuals are not named, include qualifications of the individuals that you would seek to fill the positions. Include the following:

(a) Reporting relationships and the responsibilities of each key position of the account management team(s); how the team will interact with other departments such as customer service, clinical services, reporting, auditing, and network management, within your organization.

[redacted]

[redacted]

[redacted]

(b) Describe how the dedicated account management team(s) interfaces with senior management and ultimate decision makers within your organization to ensure that all Program requirements are met and to address any issues that may arise during the performance of the resultant Agreements;

In addition to our dedicated Strategic Account Management team members, and to further ensure a cooperative and effective working relationship with the Programs, CVS Caremark proposes an executive sponsorship arrangement with the Programs. CVS Caremark has found that for key customers, executive sponsorships can be invaluable in enabling representation of corporate strategies and aiding the development of innovative approaches. Our ongoing executive sponsorship programs have also helped leverage the existing resources and assets of both CVS Caremark and our clients.

We propose Jon Roberts, Executive Vice President and Chief Operating Officer, as the executive sponsor for the Programs. Jon Roberts has been named as the successor President over Caremark Pharmacy Services effective as of September 1, 2012. Mr. Robert's primary focus as executive sponsor for the Programs will be to establish an environment of executive-level engagement and collaboration. He will:

- Gain knowledge of the Programs' health care goals, strategies, and current initiatives, validated through collaboration with the Programs strategic decision-makers
- Act as "executive liaison" to align various CVS Caremark resources to accomplish key initiatives in support of the program, and establish priorities, as needed
- Appoint task forces or special action committees as needed to implement agreed-upon solutions to meet the Programs' health care purposes and objectives
- Speed resolution for any critical issues that the Account team is unable to resolve through other channels.

(2) Please confirm that the account team(s) will be readily accessible to the Programs. State where the account team will be based. Describe:

[redacted]

(a) How will you ensure that timely responses (1 to 2 Business Days) are provided to administrative concerns and inquiries?

As a standard operating procedure, and given the nature of this contract, the CVS Caremark Account team will respond to inquiries within one business day. For those inquiries that cannot be resolved immediately, the assigned Account Manager will within 1 business day of receipt of the inquiry, provide an estimated time of resolution via electronic or verbal communication to requestor.

(b) The protocols in place to ensure the Procuring Agencies will be kept abreast of actual or anticipated events impacting Program costs and/or delivery of services to Enrollees. Provide a representative scenario.

The roles of our Account team structure are to ensure that the Programs are managed proactively, and so that we can maintain rigorous oversight of the entire benefit, day-to-day. Our Account Services staff members are supported by internal communications departments that deliver timely industry news, market trends, health care updates (e.g. drug recall notification), and more. As a standard operating procedure, Account teams translate this information to clients and provide solutions based on how the new information impacts the health care benefit. In addition, our Account teams are tasked to understand unique client objectives, values, and benefit design parameters. Below is an example of a scenario where the CVS Caremark Account team provided a proactive, consultative recommendation to help the client avoid a costly change to their benefit design.

The following cost impact issue was resolved as a result of our Account Services team's productive relationship with the client:

- The client proposed a plan design change that ultimately would have been more costly. We were able to identify the cost impact, consult with the client, and recommend an alternative plan design that proved to be more cost effective.

The CVS Caremark Account Services team identified any potential causes of disruption and took preventive measures, while frequently recommending cost saving strategies to the client. This was possible because each member of the dedicated Account Services team interacted regularly with the client to consult about every aspect of their pharmacy benefit program.

(3) Describe the Corporate resources available to the account team(s) to ensure compliance with all legislative and statutory requirements. Confirm your commitment to notify the Procuring Agencies immediately if you are unable to comply with any legislative or statutory requirements and to work with the Procuring Agencies to take the appropriate remedial action(s) to come into compliance as soon as practicable. Confirm your commitment to work with the Department to develop accurate SPDs and/or Program material.

Our Government Affairs and Legal departments continuously monitor federal and state laws to ensure that we are in compliance with all applicable laws. CVS Caremark is in compliance with all federal and state laws applicable to the services performed and the products provided to the Programs. Additionally, CVS Caremark requires all participating retail pharmacies and key subcontractors to agree in writing to comply with all applicable federal and state laws and regulations.

CVS Caremark confirms our commitment to notify the Procuring Agencies immediately if we are unable to comply with any legislative or statutory requirements and will work with the Procuring Agencies to take the appropriate remedial action(s) to come into compliance as soon as practicable. Furthermore, CVS Caremark confirms our commitment to work with the Department to develop accurate SPDs and/or Program material.

2. PREMIUM DEVELOPMENT SERVICES (EXCLUSIVE TO DCS)

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

A. DUTIES AND RESPONSIBILITIES

The Offeror will be responsible for assisting and supporting the Department with all aspects of the premium rate development including, but not limited to:

(1) Providing a team of qualified and experienced individuals who are acceptable to the Department and who will assist and support the Department in developing premium rates consistent with the financial interests and goals of the DCS Program and the State;

(2) Development of claim, trend and administrative fee projections for each DCS Program Year. Analysis of all DCS Program components impacting the DCS Program cost shall be performed including, but not limited to claims, trend factors, administrative fees, projected Pharma Revenue, changes in enrollment, changes in the Specialty Pharmacy Drug list, as well as changes in the formularies including the Empire Plan's Specialty Drug list, Flexible Formularies and the Traditional PDL; and

(3) Working with the Department and its contracted actuarial consultant through the annual rate renewal process to further document and explain any premium rate recommendation. This process includes presenting the premium rate recommendation to staff of the Department, Division of the Budget and GOER.

B. REQUIRED SUBMISSION

(1) Provide the names, qualifications and job descriptions of those key individuals who will provide premium rate development services for the DCS Programs. Describe their experience in providing financial assistance and support to other large health plans. Complete Exhibit I.B of this RFP, Biographical Sketch Form, for all key staff involved in the premium rate development.

[redacted]

[redacted]

(2) Describe the general steps that you will follow to develop the annual premium renewal recommendation for submission to the Department. Include any different steps that will be employed to develop the first year premium vs. the premium for subsequent years of the Agreement. Include a description and source of the data you will utilize, assumptions you will use and how these assumptions will be developed, as well as any resources you will utilize.

The process to develop annual premium renewal recommendation will be as follows:

CVS Caremark will conduct a comparison of Expected outcomes of the previous year's premium development key assumptions and metrics to Actual outcomes.

Pharmacy Assumptions for the Rating Period will be developed using the latest intelligence we have for current and future pharmacy pipeline and economic conditions.

The Rating Period forecast will also account for any changes in demographic makeup of the population as well as changes in the pharmacy or medical plan designs that may impact the Rating Period.

CVS Caremark staff will work closely with the Department and its contracted actuarial consultants when developing and sharing assumptions and outcomes.

The Rating Period forecast will take into account any changes in CMS Guidance, Regulations, or required benefit designs.

(3) Confirm your commitment to work with the Department and its contracted actuarial consultant on the annual rate renewal recommendation and your availability to present such recommendation to the Department, Division of the Budget and GOER.

CVS Caremark confirms our commitment to work with the Department and its contracted actuarial consultant on the annual rate renewal recommendation and our availability to present such recommendation to the Department, Division of the Budget, and GOER.

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

3. IMPLEMENTATION

The Offeror must ensure that the Programs are fully functional on January 1, 2014. The Offeror's must propose two implementation plans, one for the Department and one for NYSIF. The plans must be detailed and comprehensive and exhibit a firm commitment by the Offeror to complete all implementation activities by December 31, 2013.

A. DUTIES AND RESPONSIBILITIES

(1) The Offeror must commence an implementation period beginning on or around October 1, 2012 upon approval of the resultant separate Agreements by OSC. During the implementation period, the Contractor must undertake and complete all implementation activities, including but not limited to those

specific activities set forth below. Such implementation activities must be completed no later than December 31, 2013 so that the Programs are fully operational on January 1, 2014.

(2) Implementation and Start-up Guarantee: The Offeror guarantees that all Implementation and Start-up activities will be completed no later than December 31, 2013 so that, effective January 1, 2014, the Offeror can assume full operational responsibility for the Programs. For the purpose of this guarantee, the Offeror must, on January 1, 2014, have in place and operational:

(a) A contracted Retail Pharmacy Network that meets the access standards set forth in Section IV.B.11.b. of this RFP, under the subheading "Retail Pharmacy Network." Additionally, in order to meet the Offeror's implementation guarantee, the network implemented on January 1, 2014 must include all chain pharmacies with more than 20 locations and all groups of 20 or more independent pharmacies utilizing the same third party organization to collectively negotiate network participation agreements, as identified in the Offeror's Proposed Retail Pharmacy Network File, to the extent the subject chains and/or independent Pharmacy groups continue in operation on and after January 1, 2014.

The Program requires that all chain pharmacies with less than 20 locations, groups of less than 20 independent pharmacies utilizing the same third party organization to collectively negotiate network participation agreements, and all independent pharmacies, as identified in the Offeror's Proposed Retail Pharmacy Network File, be included in the Offeror's Retail Pharmacy Network implemented on January 1, 2014. Acceptable reasons for non-participation of independents, smaller chains or groups of individual pharmacies contracting collectively on January 1, 2014 include, and are limited to: a Pharmacy's violation of state and/or federal laws;

A Pharmacy's failure to meet the Offeror's credentialing criteria; or a Pharmacy's failure to fulfill its contractual obligations and no remedy can be achieved. On January 1, 2014, the Retail Pharmacy Network must meet all requirements set forth in Section IV.B.11. of this RFP, under the subheadings "Retail Pharmacy Network," "Pharmacy Credentialing" and "Pharmacy Contracting" and be available to fill Enrollee Prescriptions for all Covered Drugs including Specialty Drugs/Medications(for those Enrollees that do not participate in the Specialty Pharmacy Program);

(b) A fully operational Mail Service Pharmacy Process utilizing facilities as necessary to ensure that Enrollees have access to all Covered Drugs, including Specialty Drugs/Medications (for those Enrollees that do not participate in the Specialty Pharmacy Program) as set forth in Section IV.B.11. of this RFP, under the subheading "Mail Service Pharmacy Process." The Offeror must have a plan in place to facilitate the transfer of Prescription information, including open refills, prior authorizations and generic appeals from the previous Program administrators and outline the procedures that will be utilized to ensure a smooth mail service transition for Enrollees;

(c) A fully operational Specialty Pharmacy Program utilizing facilities as necessary to ensure that Enrollees have access to all covered Specialty Drugs/Medications (for those Enrollees that participate in the Specialty Pharmacy Program) as set forth in Section IV.B.11. of this RFP under the sub heading "Specialty Pharmacy Program." The Offeror must have a plan in place to facilitate the transfer of specialty Prescription information, including open refills and prior authorizations, from the previous Program administrator and outline the procedures that will be utilized to assure a smooth Specialty Pharmacy Program transition for affected Enrollees;

(d) A fully operational call center providing all aspects of customer support and services as set forth in Section IV.B.4. of this RFP;

(e) An on-line claims processing system that applies the Procuring Agencies' approved edits and point of service edits, including drug utilization review edits, as set forth in Section IV.B.12. of this RFP;

(f) An on-line claims processing system with real time access to the most updated, accurate enrollment and eligibility data provided by the Procuring Agencies to correctly pay claims for eligible Enrollees/Dependents consistent with the Programs benefit designs and contractual obligations; and

(g) (Exclusive to DCS) A fully functioning customized Program website with a secure dedicated link from the Department's website able to provide Enrollees with on-line access to the specific website requirements as set forth in Section IV.B.4.a.(7) of this RFP.

B. REQUIRED SUBMISSION

(1) Provide separate implementation plans (narrative, diagram, and timeline) upon each Agreement's approval, on or around October 1, 2012 that results in the implementation of all Program Services by the required date of December 31, 2013, indicating: roles, responsibilities, estimated timeframes for individual task completion, testing dates and objectives, and areas where complications may be expected. Include key activities such as member and Pharmacy communications, training of customer service staff, report generation, Flexible Formulary and Preferred Drug List development, mail service and specialty Pharmacy transition, customized website design, eligibility feeds, claims testing, and EGWP approval and transition.

Please see Section II, Tab 1 for the completed implementation timeline and narrative for the DCS program and Section II, Tab 2 for the completed implementation timeline and narrative for the NYSIF program. Please see Section II, Tab 3 for the completed implementation timeline for the EGWP program.

SilverScript has vast experience in transitioning clients from a Retiree Drug Subsidy Program or another EGWP vendor to our EGWP. In regards to implementation, SilverScript follows a detailed and methodical implementation process that has been used successfully for years at CVS Caremark and adapted for Medicare Part D. It is a collaborative process that uses input from our clients and includes frequent interaction in order to properly define requirements and share regular status reports. Project tracking in the form of timeline management and issues/action items/resolution logging is one key to the successful setup of client programs. Weekly meetings are held to review project status and resolve outstanding questions.

The implementation process is broken down into four distinct phases: Discovery, Development, Deployment and post-Implementation Support. Substantial time is spent in the Discovery phase defining and documenting the requirements of the various Medicare D programs. As mentioned before this is a collaborative effort between the SilverScript Implementation Team (which includes representatives from all required functional areas) and the client subject matter experts. Not until the Discovery phase is complete with the final, signed requirements documentation, does the Development phase begin. Benefits and enrollment/ eligibility file development takes place at this time as long as additional program and communication setup. The Deployment phase is when final testing and training of frontline staff takes place. After the effective date, SilverScript personnel will monitor claims to proactively identify any issues not discovered in testing. Meetings with the client to review post-implementation status will be scheduled. In these meetings, claim statistics will be reviewed as well as any enrollee level concerns that have been identified.

(2) The Offeror must guarantee that all of the Implementation and Start-Up requirements listed above in Section B.3.a.(2) will be in place on or before December 31, 2013. The Offeror shall propose, separately for each Program, the forfeiture of a percentage of the 2014 Claims Administration Fee (prorated on a daily basis) for each day that all Implementation and Start-Up requirements are not met.

The Standard Credit Amount for each day that all Implementation and Start-Up requirements for the DCS or NYSIF Program are not met is fifty percent (50%) of the 2014 Claims Administration Fees (prorated on a daily basis). However, Offerors may propose higher or lesser percentages.

The Offeror's quoted percent to be credited for each day that all Implementation and Start-up requirements are not met is [redacted] percent [redacted] of the 2014 Claims Administration Fee (prorated on a daily basis) for the DCS Program and [redacted] percent [redacted] of the 2014 Claims Administration Fee (prorated on a daily basis) for NYSIF's Program.

4. CUSTOMER SERVICE

The Programs require that the Offeror provide quality customer service to Enrollees/Claimants. The DCS Program provides access to customer service representatives through The Empire Plan's consolidated toll-free number. Through this toll-free number members access representatives who respond to questions, complaints and appeals regarding DCS Program benefits, mail order services, Network Pharmacies, the Specialty Pharmacy Program, processing point of sale Prescriptions, drug status, claim status, etc. NYSIF's Program provides 24 hour, 7 day a week telephone support via a toll-free number, to assist its claimants with locating participating pharmacies, eligibility and benefit verification. The Offeror is required to agree to customer service performance guarantees that reflect strong commitments to quality customer service. Exhibit II.L of this RFP illustrates the current Pharmacy Benefit Manager's call center volume for the DCS Program. Exhibit II.K.1 provides the number of members who have utilized the current DCS customized Program website from October 2010 through October 2011.

A. DUTIES AND RESPONSIBILITIES

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

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

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

(3) Maintaining separate ~~Dedicated~~ ~~C~~call ~~C~~centers for the Programs located in the United States staffed by fully trained customer service representatives and supervisors available 24 hours a day 365 Days a year. The Offeror must maintain separate Dedicated Call Centers for the Programs between the hours of 7:00am and 7:00pm ET. During off hours, calls may be routed to a designated call center(s) located in the United States staffed by fully trained customer service representatives and supervisors. The ~~Dedicated~~ Ccall ~~C~~centers must also provide immediate access to Pharmacist(s) 24 hours a day 365 days a year. The ~~Dedicated~~ ~~C~~call ~~C~~centers must meet the Offeror's proposed customer service telephone guarantees set forth in Section.IV.4.b.(8)(a) through (d) of this RFP.

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

(5) Customer service representatives must be trained and capable of responding to a wide range of questions, complaints and inquiries including but not limited to: Program benefit levels, refills, order status, prices and billing, point of service issues, prior authorization, eligibility, generic appeals, Mail Service Pharmacy Process, Specialty Pharmacy Process services, and Flexible Formulary and Preferred Drug List alternatives.

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

(7) (Exclusive to DCS) Maintaining and timely updating a secure online customized website accessible by Enrollees, which is available 24 hours a Day, 7 Days a week, except for regularly scheduled maintenance, which will provide, at a minimum, access to information regarding: DCS Program benefits, Network Pharmacy locations, eligibility, mail service order status, Copayment information, claim status, comparative drug check functionality, Prescription drug history for both retail and mail claims, and the Flexible Formulary and Preferred Drug Lists (including alternatives for Non-Preferred Brand Name and excluded drugs). The Department shall be notified of all regularly scheduled maintenance at least one Business day prior to such maintenance being performed. The Offeror must establish a dedicated link to the customized website for the DCS Program from the Department's website with content subject to the approval of the Department and limited to information that pertains to the DCS Program. Any links should bring a viewer back to the Department website. No other links are permitted without the written approval of the Department. Access to the online Network Pharmacy locator must be available to Enrollees without requiring them to register on the website. Any costs associated with customizing and updating the website or establishing a dedicated link for the DCS Program shall be borne by the Offeror. Also, the Offeror shall fully cooperate with any Department initiatives to use new technologies, processes, and methods to improve the efficiencies of the customized website including development of an integrated Enrollee portal;

(8) Call Center Telephone Guarantees: The Offeror must provide separate guarantees for the DCS and NYSIF Programs for the following four (4) measures of service on the toll-free customer service numbers:

(a) Call Center Availability: The Programs' service level standard requires that the Offeror's telephone line will be operational and available to Enrollees, Claimants, Dependents, and pharmacies at least

ninety-nine and five-tenths percent (99.5%) of the Offeror's Call Center Hours. The call center availability shall be reported monthly and calculated quarterly;

(b) Call Center Telephone Response Time: The Programs' service level standard requires that at least ninety percent (90%) of the incoming calls to the Offeror's telephone line will be answered by a customer service representative within sixty (60) seconds. Response time is defined as the time it takes incoming calls to the Offeror's telephone line to be answered by a customer service representative.

(c) Telephone Abandonment Rate: The Programs' service level standard requires that the percentage of incoming calls to the Offeror's telephone line in which the caller disconnects prior to the call being answered by a customer service representative will not exceed three percent (3%). The telephone abandonment rate shall be reported monthly and calculated quarterly; and

(d) Telephone Blockage Rate: The Programs' service level standard requires that not more than three percent (3%) of incoming calls to the customer service telephone line will be blocked by a busy signal. The telephone blockage rate shall be reported monthly and calculated quarterly.

B. REQUIRED SUBMISSION

(1) Confirm that you will provide Enrollees access to Programs information on Claimants through separate consolidated toll-free numbers 24 hours a day 365 Days a year, as described above.

CVS Caremark confirms.

(2) (Exclusive to DCS) Confirm you will enter into a shared service agreement with the Empire Plan Medical Insurer and AT&T. Confirm you will provide 24 hours a day 365 Days a year access to a TTY number for callers utilizing a TTY device because of a hearing or speech disability.

CVS Caremark confirms.

(3) Confirm that you will maintain separate ~~Dedicated~~ ~~C~~call ~~C~~centers for each Program located in the United States, employing ~~a staff of Pharmacists and~~ a staff of fully trained customer service representatives (CSR's) and supervisors available 24 hours a day 365 Days a year. The Offeror must maintain separate Dedicated Call Centers for the Programs between the hours of 7:00am and 7:00pm ET. During off hours, calls may be routed to a designated call center(s) located in the United States staffed by fully trained customer service representatives and supervisors. The call centers must also provide immediate access to Pharmacist(s) 24 hours a day 365 days a year.

CVS Caremark confirms.

(4) Describe the information, resources and system capabilities that are available for the customer service representatives to address and resolve member inquiries. Include:

(a) Whether any Interactive Voice Response (IVR) system is proposed.

Yes. CVS Caremark's Interactive Voice Response (IVR) application offers prescription services 24 hours a day, 7 days a week. By simply dialing their client-specific, toll-free number, members can choose from many options (depending on client set-up), some of which include:

- Order prescription refills
- Check the status of an order
- Check the cost of a particular drug
- Request plan balance information (OOP, MAB, etc.)
- Check eligibility
- Request a new ID card
- Locate a convenient retail network pharmacy
- Obtain an order form or claim form
- Request to speak to a live representative.

The caller is authenticated by speaking or entering their date of birth along with the prescription number or their member ID.

Ordering Refills

Our user-friendly application enables the caller to select a prescription for refill by entering the prescription number or by speaking the prescription drug name. If the prescription cannot be filled on the date the member calls, the caller is reminded it is "too soon to refill," and the system speaks the available refill date. The caller is also informed if the prescription has expired or if no refills remain, and they are asked to call the physician to renew the prescription. This feature helps members manage their prescription needs within the plan requirements.

After each prescription is added to an order, the IVR system will advise the member of the remaining refills. If the medication requested is out of refills or if the prescription is expired, the IVR will still add them to that order but will advise the caller "we will be contacting the doctor to request a new prescription on your behalf. This may extend the normal processing time."

Methods of payments include: Credit Card, Invoice, Bill Me Later™, and Electronic Check. These payment types are conditional upon client approval. Refills can be charged to the credit card on file, or the caller can elect to enter an alternative credit card number. Plan members will hear the estimated cost of their refill prescription order prior to its completion. Any debit or credit amounts on file are stated to the member and calculated as part of the estimated cost. A confirmation number is provided with each refill order and can be used when checking the order status.

Other Features

- Check order status – To check order status, the caller can enter an Rx number or confirmation number, request status by drug name, or request status by most recent order. If the order has shipped, the caller will be provided with the Rx numbers, drug names, ship date, address, shipping method, any associated shipping tracking numbers and Web site, and the total cost of the prescription order.

- Find a network pharmacy – Retail network pharmacy locations can be provided for either the member's address on file or zip code for any zip code entered. The caller can hear a list of pharmacy locations, or elect to have a list forwarded to a fax number entered by the caller.

- Request a form – Order forms and claim forms can be requested by mail or faxed to the fax number entered. On a client-specific basis, the presented menu can change to offer only selections appropriate to the member's plan; for example, the Find a Pharmacy option can be removed from menus for clients without retail benefits, or the claim order form option can be removed for clients without paper claim benefits.

More useful features include:

- If the member needs additional assistance, the option is available to speak to a representative at any point in the session. S/he doesn't have to wait until the current module is completed.

- The member can return to the Main Menu after placing his/her order. This feature enables members to complete multiple transactions with one call to the system.

- Plan members can select from available addresses prior to placing their refill orders or requesting forms, and addresses are presented early in the order placement process. As a result, the potential for misdirected orders is reduced.

(b) A sample of the IVR script and a description of customizable options, if any, you propose for the Programs.

IVR continues to grow as a preferred method of accessing information and resolving inquiries, and CVS Caremark invests in the necessary technology and resources to accommodate this growing demand. Customizable options give the Programs the choice to select any or all of the following IVR topics – refill, order status, drug price, payment registration, forms, pharmacy locator, balances, address, eligibly, ID Card, plan Info, and speak to a pharmacist

Please see Section II, Tab 4 for a sample IVR script.

(c) A description of the management reports and information available from the system including the key statistics you propose to report.

With the Program's custom toll-free number, call metrics reports can be generated. These include number of calls answered, average speed of answer, abandonment rate, and more. The reports are also broken out by IVR contacts and Customer Service Representative touches and metrics. The reports can be furnished to the client on a monthly basis, or otherwise. Standard reporting is provided through the Account Services Team at no additional cost.

(d) A description of the capabilities of your phone system to track call types, reasons and resolutions.

Our Customer Care Representatives track 100% of member calls within our customer relationship management application, regardless of inbound contact method. This system captures inquiry type, pending action(s), representative name, and resolution for each call received.

- Tracking Categories
- The call reasons and tracking categories available to our representatives include the following:

- Billing/Payment
- Order Placement
- Order Status
- Fulfillment of forms, cards, etc.
- Paper Claims
- Eligibility
- CVS Caremark Programs
- Retail Pharmacy
- Plan Design/Plan Benefits
- Prescription Verification
- CVS Caremark Information
- Medicare
- Pharmacist Consultation
- Training
- Voice Response System or Website
- Appeals.

(5) Describe the training that is provided to CSR and Pharmacist staff before they go "live" on the phone with Enrollees. Include:

(a) A description of the internal reviews that are performed to ensure quality service is being provided to Enrollees;

CVS Caremark Customer Care utilizes several tools to assess the delivery of quality service to our members. We believe achieving quality in servicing member needs is a combination of overall communication delivery, accuracy, and efficiency.

In an effort to further establish CVS Caremark as a pre-eminent service provider in the health care industry, CVS Caremark Customer Care searched for the most advanced and effective customer interaction management tool available. Based on our extensive research of the leading systems in the industry, the Behavioral Analytics tool from Mattersight™ stood out among the competition with its sophisticated linguistics application. Behavioral Analytics allows us to record, analyze, and interpret unstructured call content into structured, usable call data, which is then used for coaching and training opportunities.

The Behavioral Analytics application also provides an objective view of our service levels. We are able to analyze our member interactions based on substantial data, resulting in reduced service escalations through proactive servicing. We can also leverage data from calls to enhance the member's experience and improve the Customer Care Representative's performance.

The Quality Assurance Team

The Quality Team and Customer Care Supervision conduct ongoing call audits across the Enterprise targeting behaviors and performance relative to our goals which are based on our vision, mission, and values. Representatives are provided coaching and development based on trends that may be discerned from either the Supervisor or Quality observations.

The Quality definitions shown below not only represent the behavioral expectations but include the essential elements of the consultative call flow model. They are:

- Ease of Doing Business – The ability to resolve or satisfy the caller's inquiry without creating additional work or difficulty for the caller.
- First Contact Resolution – The ability to resolve the inquiry on the first contact, avoiding a repeat contact on the same issue.
- Proactive Education – The ability to educate and influence members about maximizing their plan benefit.
- Courtesy and Professionalism – The ability to prevent and alleviate distress while resolving inquiries.
- Empathy – The ability to identify with the member and understand his or her unique situation.
- Accuracy – The ability to provide accurate and complete information in response to all inquiries.
- Authentication – The ability to comply with HIPAA regulations based on CVS Caremark's Authentication Policy.

Each call element is assessed with a possible rating of “Fully Meets,” “Exceeds,” or “Did Not Meet.”, with Accuracy and Authentication only having “Fully Meets” or “Did Not Meet”. The Overall rating is assessed by taking into consideration the above 7 elements along with the impact they had on the member experience. Through the performance review process, a Customer Care Representative’s performance is linked to various goals and expectations that support CVS Caremark’s quality, member satisfaction, and Customer Care metrics. Quality assurance performance tracking is also an important element in coaching and development for the individual representative. Daily, weekly, monthly, and quarterly data are disseminated to enable ongoing assessment and intervention. This data also helps identify customer and client trends.

(b) The first call resolution rate for the proposed call centers;

[redacted]

(c) The call center locations, average staff and turnover rate for call center employees;

[redacted]

(d) Ratio of management and supervisory staff to customer service representatives and;

The ratio of Customer Care Representatives to Supervisors is 15:1.

(e) Proposed staffing levels including the logic used to arrive at the proposed staffing levels.

(6) Describe the back-up systems for your primary telephone system which would be used in the event the primary telephone system fails, is unavailable or at maximum capacity. If a back-up system is needed, explain how and in what order calls from Enrollees will be handled. Confirm that backup staff will have DCS Program and NYSIF Program specific training. Indicate the number of times the back-up system has been utilized over the past two (2) years. Confirm that calls will be handled exclusively by your Dedicated Call Centers and that the backup call center would only be used in case of system failure or call overflow.

CVS/Caremark's Avaya Telephone system is setup as an active PBX system with capability to route calls through either backup site and have done that during scheduled maintenance as well as during any outages. Calls are routed to designated primary/backup call centers using an ICM (Intelligent Call Management) system.

We maintain redundant customer care call center capabilities to ensure that client support functions are not interrupted in the event of a disaster or when the main lines are at capacity. CVS Caremark operates five networked customer care call centers, which are capable of transitioning calls seamlessly – whether to adjust for continuous call management or to address an emergency situation at a site.

CVS Caremark confirms that backup staff will have DCS Program and NYSIF Program specific training. Additionally, CVS Caremark confirms that calls will be handled exclusively by our Dedicated Call Centers and that the backup call center would only be used in case of system failure or call overflow.

Aside from routine scheduled maintenance, the backup system has not been utilized within the past 2 years.

(7) (Exclusive to DCS) Describe the information and capabilities your website provides to members and describe the process you will utilize to develop it. Confirm that you will develop a customized website for the DCS Program. Also, confirm that the following information, at a minimum, will be available on the website: DCS Program benefits, Network Pharmacy locations, eligibility, mail service order status, Copayment information, claim status, Prescription drug history for both retail and mail claims, and the Flexible Formulary and Preferred Drug List (including alternatives for Non-Preferred Brand Name and excluded drugs). Provide the URL of your main website and provide a dummy ID and password so that the Department may view the capabilities and user-friendliness of your website.

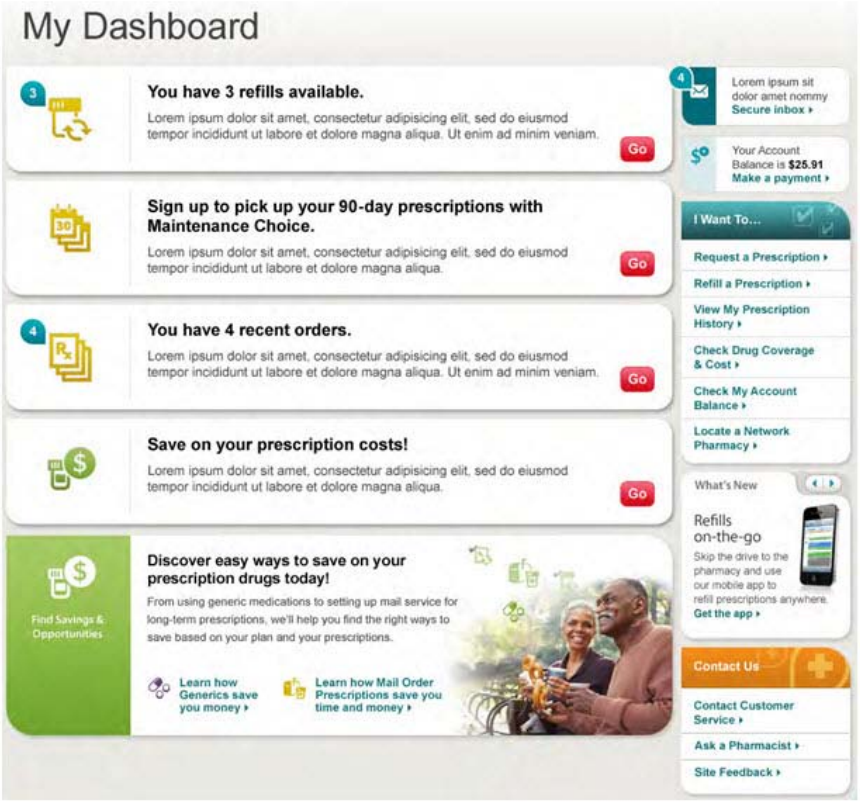
CVS Caremark's main Web site, www.caremark.com, is the portal through which clients, members, clinicians, and investors can obtain detailed information about our organization and the services and programs we offer.

Members-specific online tools

CVS Caremark redesigned our member Web site, Caremark.com, to support our goals of enhancing member engagement and empowering members to take an active role in their health care. Our focus is on improving how members use the site by enhancing the look and feel, simplifying registration, improving navigation, clarifying descriptions and overall language, and offering better customer support. We use icon-based graphics to highlight tools and functionality that help empower members and we provide members a personalized dashboard, which offers actionable information for members, tailored to their prescriptions and plan design. Using their personalized dashboard, members are able to:

- Learn how to start a new prescription with CVS Caremark Mail Service
- Order mail service refills online
- Check drug coverage and price, including therapeutic alternatives
- View benefit information and an online drug list
- Check TrOOP status for EGWP members
- Check mail service status
- Check drug interactions and search drug information (Gold Standard Multimedia)
- View 24-month drug history
- Find a local pharmacy (client network-specific) and access maps/driving directions
- Gain e-mail access to Customer Care Center
- View secured member messaging via the member's online Message Center
- Set e-mail alerts
- Read e-mail alerts regarding available refills, expiring refills, and shipped prescription refills
- Download forms (claim and mail order forms)
- Print ID cards
- Access CVS Caremark's "Ask A Pharmacist" interactive feature and hundreds of frequently asked questions
- Find savings and opportunities to price and compare brand-name drugs, preferred drugs, and generic drugs and locate plan-specific lower cost channels.
- View the Caremark.com Site Tour.

Our member Web site can also help increase savings for members and the Program by reaching members when they are more receptive to making positive behavior changes and by influencing behavior change through valuable savings opportunities.



Caremark.com on the go

As an organization that is focused on finding innovative ways to engage and communicate, we know members are looking for opportunities to utilize new technologies to manage their prescriptions and keep them connected. To increase convenience and help improve the experience of the Program's members, we can now provide a faster and easier experience on Caremark.com for mobile phone users as well as a free application for Apple® iPhone® and Android® users. These upgrades provide a mobile view of the homepage and select key tools so your members can spend less time waiting to view information and begin their transactions.

For iPhone and Android users, the free application allows them to do even more, including enrolling in FastStart and locating a nearby network pharmacy using their smart phone's GPS locator function. Additionally, any iPhone or Android user can use the Drug Information function, which will connect users to the Drug Information Database where they can research particular prescription medications, get information about how to take them, learn about available generic drug alternatives, see an image of the drug, learn about side effects and precautions, and much more.

*Some mobile device users may need to reset or delete their cache to access the new mobile-friendly upgrade. Please refer to your device instructions on deleting Internet history for more information.
**The application is available for Android, Apple iPhone, iPad®, and iPod Touch® users.

Demo Web Site

Following are a temporary login and password that will enable the Programs to access CVS Caremark's Web site:

- Login: cmktest
- Password: common1
- For challenge questions, please use the following:
- Favorite Color: answer1
- Mother's Maiden Name: answer2
- College: answer3
- CVS Caremark's eBusiness group is available to conduct a walkthrough of the site via live meeting. In addition, the Caremark.com site tour can be accessed at www.caremark.com/sitetour.
- CVS Caremark confirms that we will develop a customized website for the DCS Program and that the information outlined above, at minimum, will be available on the website.

(8) Call Center Telephone Guarantees: For each of the four (4) Call Center Telephone Guarantees above, the Offeror shall propose, separately for each Program, the forfeiture of a specific dollar amount of the Claims Administration Fees, for failure to meet the Offeror's proposed guarantee.

(a) Call Center Availability:

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

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

[redacted]

(b) Call Center Telephone Response Time:

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

The Offeror's quoted amount to be credited against the Claims Administration Fee for each .01 to 1.0% of incoming calls to the Offeror's telephone line below the standard of ninety percent (90%) (or the Offeror's proposed guarantee) that is not answered by a customer service representative within sixty (60) seconds, calculated on a quarterly basis, is $ ____per quarter for DCS and $ _____per quarter for NYSIF;

[redacted]

(c) Telephone Abandonment Rate:

The Standard Credit Amount for each .01 to 1.0% of incoming calls to the Offeror's telephone line in which the caller disconnects prior to the call being answered by a customer service representative in excess of the standard of three percent (3%) is $25,000 per each quarter for DCS and $7,500 for NYSIF, respectively. However, Offerors may propose higher or lesser amounts.

The Offeror's quoted amount to be credited against the Claims Administration Fee for each .01 to 1.0% of incoming calls to the Offeror's telephone line in which the caller disconnects prior to the call being answered by a customer service representative in excess of the standard of three percent (3%) (or the Offeror's proposed guarantee), calculated on a quarterly basis, is $ ___per quarter for DCS and $ ____per quarter for NYSIF; and

[redacted]

(d) Telephone Blockage Rate:

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

The Offeror's Quoted amount to be credited against the Claims Administration Fee for each .01 to 1.0% of incoming calls to the Offeror's telephone line that is blocked by a busy signal, in excess of the standard of three percent (3%) (or the Offeror's proposed guarantee), calculated on a quarterly basis, is $ per quarter for DCSand $ per quarter for NYSIF.

[redacted]

5. MEDICARE PART D – EMPLOYER GROUP WAIVER PLAN PDP (EXCLUSIVE TO DCS)

A. DUTIES AND RESPONSIBILITIES

The Offeror will be responsible for implementing and administering a Center for Medicare and Medicaid Services (CMS)-approved and compliant Employer Group Waiver Plan (EGWP) and Medicare D supplemental wrap Prescription Drug Plan (PDP) for the Empire Plan's Medicare-eligible retirees beginning on January 1, 2014. Such services shall include at least the following tasks and such other tasks as may be added in guidance and further regulation by CMS:

(1) Disclosing to CMS, on a timely basis and on behalf of the Department, any filings, applications, reports, formularies, and other DCS Program material necessary for the Department to comply with the requirements of an "800-series" Medicare PDP EGWP, plus Medicare D supplemental wrap;

(2) Fully supporting the Department with all operational aspects of a fully compliant Medicare PDP EGWP, plus Medicare D supplemental wrap including but not limited to:

(a) Medicare PDP EGWP premium development
(b) Enrollment
(c) Enrollee Opt-Out process
(d) Health Insurance Claim Number (HICN) administration
(e) Formulary management
(f) Issuing of Medicare PDP EGWP member identification cards
(g) Member Communications, including required explanation of benefits statements
(h) Claims Processing
(i) Administration of a Medicare D supplemental wrap with the goal of providing Medicare primary Enrollees with a prescription drug benefit replicating as closely as possible the prescription drug benefit design for non-Medicare primary retirees in The Empire Plan;
(j) Timely administration of catastrophe re-insurance claims
(k) Administration of Low Income Subsidy requirements

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

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

(5) The Department acknowledges and agrees that it shall be responsible solely (1) for providing creditable coverage notices required with respect to the EGWP; and (2) for determining whether enrolled individuals are qualifying covered retirees. The Offeror will work with the Department to obtain HICNs for all eligible Medicare-primary members enrolled in the EGWP.

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

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

(8) The Offeror is required to act as consultant to the Department in analyzing its experience with the Medicare PDP EGWP, and recommending as well as implementing other permitted options under Medicare Part D which may be of advantage to the Department, agencies participating in NYSHIP and NYSHIP Enrollees;

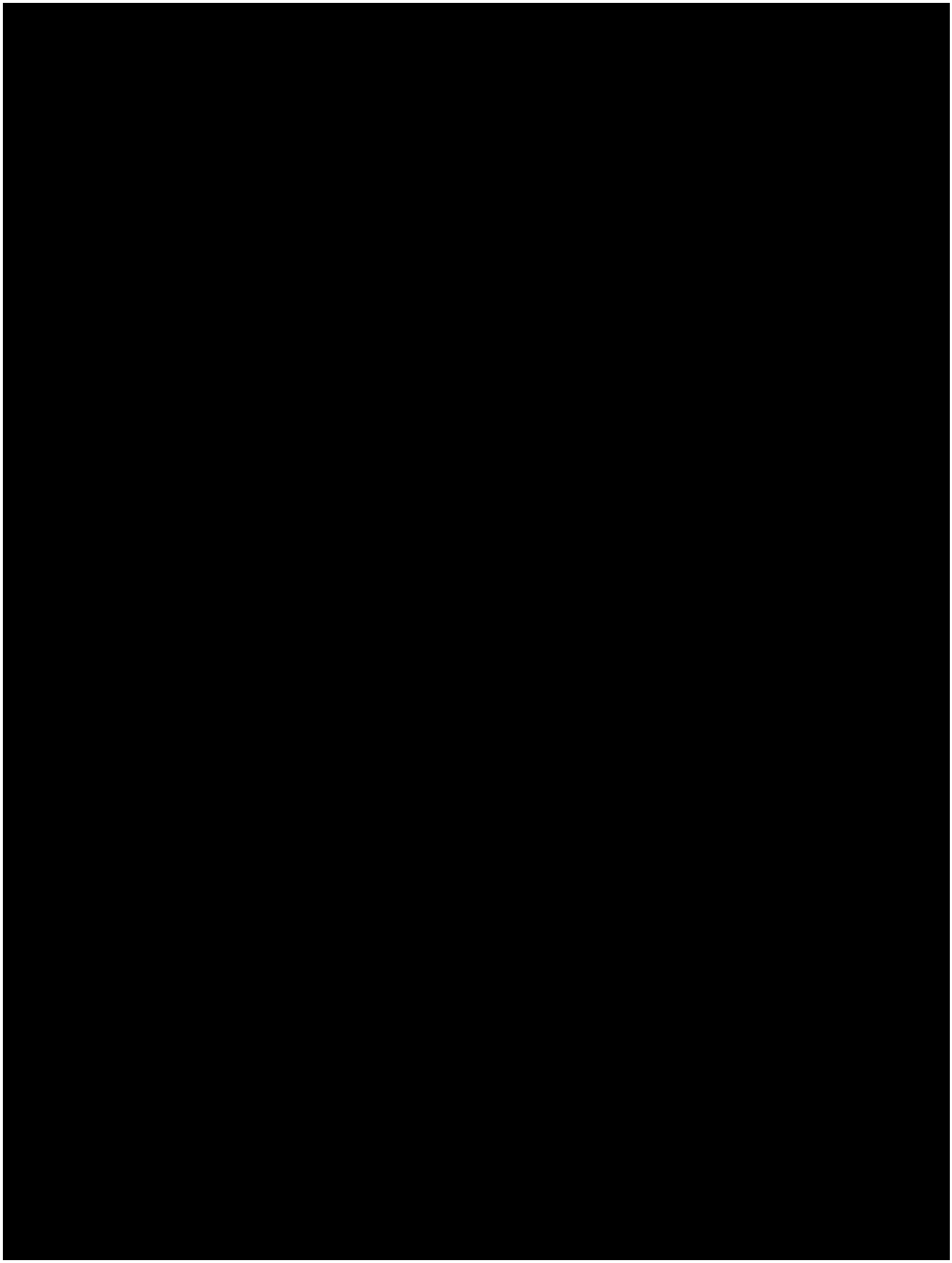
(9) Upon finalization of a subrogation process by CMS, the Offeror will be required to identify and recover claim payments made by the DCS Program from other plans that should have been the primary payor.

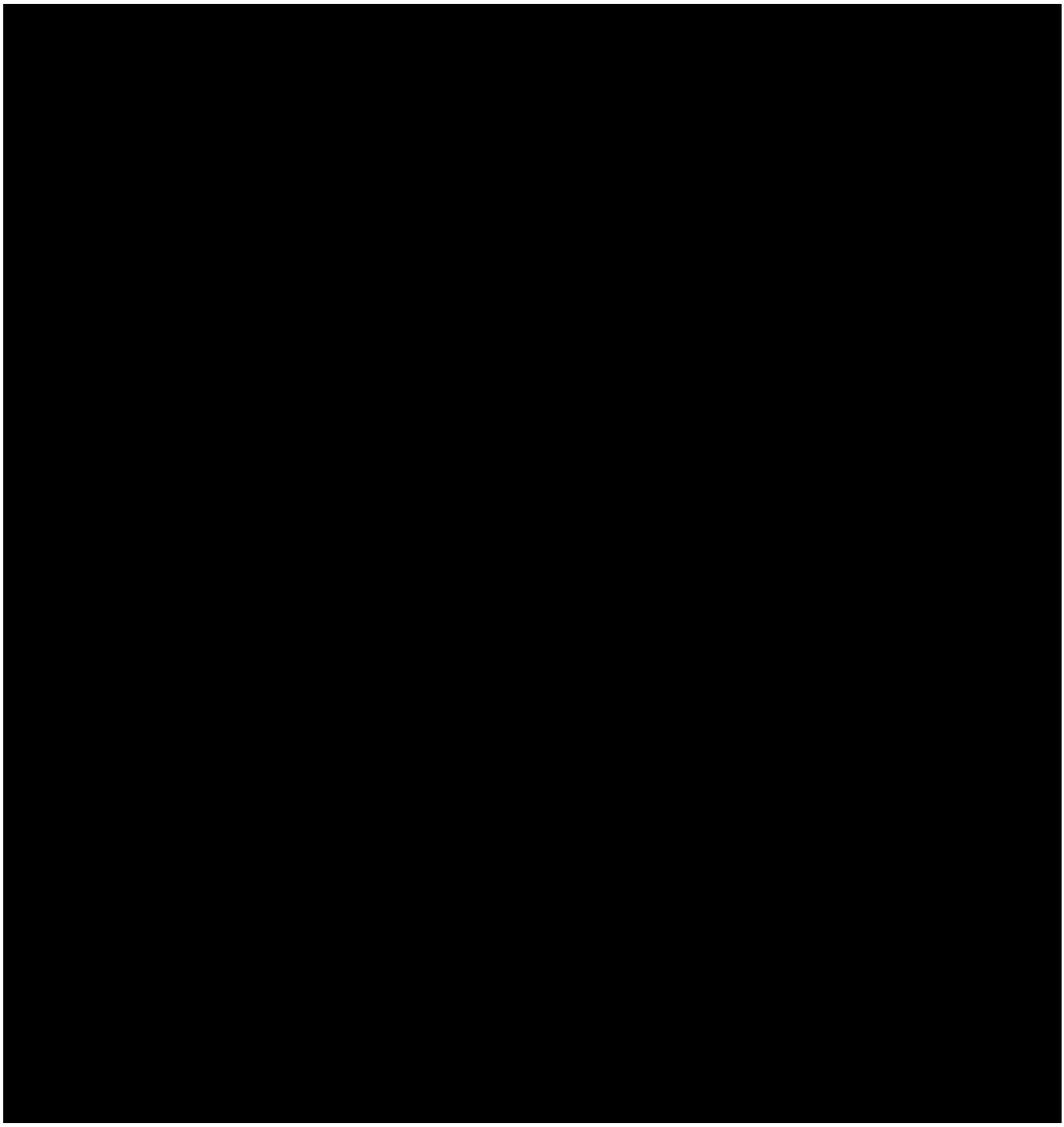
B. REQUIRED SUBMISSION

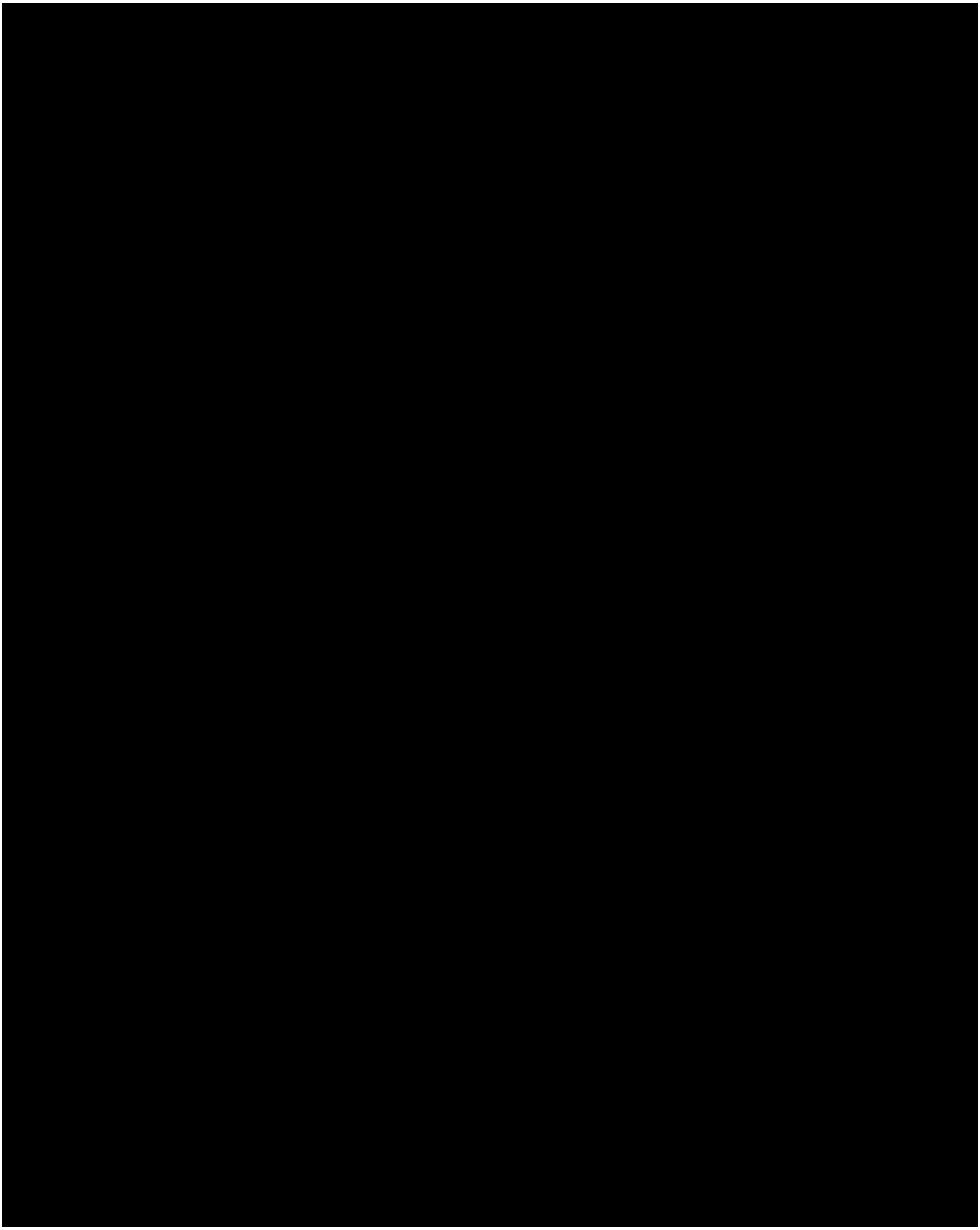
(1) Describe your experience in implementing and administering a Medicare PDP EGWP plus Medicare D supplemental wrap for customers of similar scope and size to The Empire Plan.

[redacted]

[redacted]







(2) Confirm your understanding of the requirements to support the implementation and administration of a Medicare PDP EGWP plus Medicare D supplemental wrap for The Empire Plan on behalf of the Department, including the Offeror's proposed approach for the following:

CVS Caremark confirms SilverScript's understanding of the all of the requirements provided below.

(a) Medicare PDP EGWP premium development

We will provide the Program with an actuarial team to work with the Department and its contracted actuarial consultant. CVS Caremark staff would do a comparison of Actual to Expected of the previous year's premium development key assumptions and metrics to what actually occurred. Pharmacy Assumptions for the Rating Period would be developed using the latest intelligence we have regarding current and future pharmacy pipeline and economic conditions. The Rating Period forecast will take into account any changes in CMS Guidance, Regulations or required benefit designs. The Rating Period forecast would also take into account any changes in Demographic makeup of the population and or changes in the pharmacy or medical plan designs that may impact the Rating Period. The CVS Caremark staff would work closely with the Department and its contracted actuarial consultants when developing and sharing assumptions and outcomes.

(b) Enrollment

CVS Caremark follows all CMS guidance around Medicare Part D enrollment. The following lists the enrollment application processing and eligibility management services that we provide for our Medicare Part D EGWP +Wrap clients:

- Electronic receipt of application records from client, distribution of letters acknowledging receipt of applications;
- Review of application and outreach to applicants as needed to address missing or incomplete information;
- Processing of enrollment records with CMS for approval/eligibility;
- Resolution of records rejected by CMS, including required applicant outreach;
- Notification of enrollment/eligibility outcome to applicants, as well as to client;
- Standardized web based admin tool for monitoring enrollment production / status;
- Submission of 4Rx files and resolution of 4Rx discrepancies;
- Receipt and processing of disenrollments, including acknowledgements, reject resolution and confirmations;
- Print and mailing the appropriate enrollment and disenrollment letters and enrollment packets to the beneficiaries;
- Receipt and processing of TRR and MMR files from CMS;
- Resolution of eligibility related PDE rejects;
- PDP Returned Mail Processing:
  - Includes receipt, sorting, and opening of all returned mail
- Researching / contacting the beneficiary for updated information.
- Re-mailing returned items to corrected addresses, plus postage at cost incurred by weight.

Pre-enrollment EGWP +Wrap Member Communication Materials

SilverScript creates, submits for CMS approval, prints, and mails all the CMS required member materials using the CMS model format, as available, During pre-enrollment, SilverScript will provide a group enrollment opt out notification with Summary of Benefits.

Pre-enrollment Call Center Support

SilverScript's specialized call center staff is adept at handling pre-enrollment calls from beneficiaries to help understand their plan. The staff is trained on the plan design(s) and has a variety of tools available to them to help potential beneficiaries, look up their drugs, pharmacy.

Standard PDP Pre-Enrollment Website

SilverScript can create a CMS compliant standard website for the client based on the clients benefit. The website has information to help the beneficiary understand the employer's plan including pharmacy locator, and other documents.

(c) Enrollee Opt-Out process

For the Opt-Out process, the Program's Medicare Part D eligibles would be enrolled into the EGWP+ Wrap plan and per CMS guidance have 30 days to opt-out of the plan.

(d) Health Insurance Claim Number (HICN) administration

We can assist clients to obtain missing HICNs for all their Medicare eligible members. the Program would just need to provide us with the enrollment file containing their Medicare eligibles information such as, full name (both retirees and spouses listed separately), DOB, Sex, Primary Address. Should a member's HINC change we will be notified by CMS, and will immediately update the members info with the updated HICN. We will report back to the Program any member updates or HICN change received by CMS.

(e) Formulary management

SilverScript develops and provides clinically appropriate, cost-effective, CMS compliant formularies. SilverScript's EGWP formulary is one of the broadest Medicare Part D EGWP formularies in the industry. Any drugs that the Program currently provides coverage for that are not on our EGWP formulary, can be covered under the secondary wrap plan. The Wrap would alleviate any formulary disruption for their retirees. Overall, we will work with the Program on an EGWP formulary and UM edits to meet your needs within CMS guidance.

(f) Issuing of Medicare PDP EGWP member identification cards

SilverScript will create and mail ID cards to the EGWP+Wrap members, upon receipt from CMS of enrollment approval.

(g) Member Communications, including required explanation of benefits statements

SilverScript creates, submits for CMS approval, prints, and mails all the CMS required member materials for the EGWP +Wrap plan. Upon CMS enrollment approval we will provide acknowledgement letters, Evidence of Coverage (EOC), abridged formulary, pharmacy listing, ID cards, Explanation of Benefits (EOBs) for utilizing EGWP members and ANOCs, as well as other correspondence associated as needed with the receipt and processing of enrollment.

(h) Claims Processing

The advantage of using SilverScript for your EGWP + Wrap plan, is our industry-leading single-transaction coordination of benefits (ST-COB) processing technology which provides a virtually seamless combined plan to your retiree members – all with a single pharmacy card. As the only Medicare Part D plan to offer ST-COB since 2007, the Program will benefit from our experience with this capability and proven and tested technology of adjudicating EGWP plus Wrap claims.

In STCOB, a member enrolls in both a primary and a secondary plan. The member is issued a single ID card. At point of sale, the member presents their ID card. SilverScript's STCOB model is unique to the PBM industry, in that on our ID card we only use one PCN and one BIN number for the EGWP with Wrap plan. This allows the

pharmacist to enter in one set of numbers versus the traditional two sets of numbers on the ID card (one for the primary plan and one for the Wrap plan), and avoids the possibility of claims being processed out of order and the need for members to have to submit a paper claim. The pharmacy then submits a single claim transaction, and SilverScript adjudicates the prescription against both the primary and secondary benefit, in the proper order. A single response is returned to the pharmacist, who collects the appropriate cost share from the member.

STCOB is advantageous to clients and members for several reasons:

- The beneficiary has a single ID card and the pharmacist submits a single claim transaction. This eliminates member and pharmacy confusion around submitting all claims in the proper order.
- Claims are always processed in the proper order (primary then secondary), reducing payer out of order corrections.
- Members receive the full advantage of both the primary and secondary benefit at point of sale, and do not have to wait for reimbursement as a result of a paper claim.

(i) Administration of a Medicare D supplemental wrap with the goal of providing Medicare primary Enrollees with a prescription drug benefit replicating as closely as possible with the prescription drug benefit design for non-Medicare primary retirees in The Empire Plan;

For the Program we are proposing a Self Funded EGWP + Wrap solution for your Medicare eligible retirees. The primary EGWP plan carries the standard defined Part D plan design that excludes brands in the Gap and the self-funded secondary plan wraps around the primary EGWP plan and can mirror your current retiree plan coverage and copayments. The Self Funded EGWP + Self funded Wrap retiree combination provides equivalent drug coverage at similar copayments from your current retiree plan coverage while leveraging the funding available from Health Care Reform.

(j) Timely administration of catastrophe re-insurance claims

For a self funded EGWP plan, the client 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.

(k) Administration of Low Income Subsidy requirements

During the enrollment process, CMS notifies SilverScript of any Low Income Subsidy (LIS) eligibility. SilverScript uses this information to properly mark the individual for the appropriate level of Low Income Copay Subsidy and the Low Income Premium Subsidy. As CMS notifies SilverScript of any LIS changes, the updates are made to both the claim adjudication and premium billing systems. CMS sends a TRR to update the LIS values. SilverScript send letters to members notifying of their status as the time of enrollment and anytime their enrollment status changes. For EGWP clients, an enrollment report detailing LIS-eligible individuals can be created.

For a Self funded EGWP plan, the client 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 PBM and EGWP administrative fees.

(3) Confirm that you will develop, and timely submit to, CMS and /or Enrollees all required filings and DCS Program material related to the implementation and administration of a Medicare PDP EGWP plus Medicare D supplemental wrap on behalf of the Department.

CVS Caremark confirms SilverScript's understanding of the above requirements.

(4) Provide a copy of your proposed Medicare Part D formulary and provide a side by side comparison to the proposed Empire Plan flexible formularies included in this RFP. Comment on reasons for variances.

Please refer to Section II, Tab 5 for our proposed SilverScript EGWP formulary. In addition, please refer to Section II, Tab 6, for the EGWP formulary disruption based upon the EGWP claims data provided with the RFP compared against our proposed SilverScript formulary.

(5) Provide a sample member communications package, including proposed benefit card, for the EGWP PDP plus Medicare D supplemental wrap.

Please refer to Section II, Tab 7, for the sample EGWP member communications package.

(6) Describe in detail the transition services you will utilize to assist members who are newly eligible for the EGWP plus Medicare D supplemental wrap, including formulary disruption, prior authorization, mail order and retail pharmacy refills, Specialty Program medications, and quantity limits.

When transitioning clients and their members to our EGWP +Wrap plans, we try to allow provide the least amount of disruption as possible. However, there are some program differences between which a client and their members may be used to when in a commercial plan verses and Medicare Part D EGWP plan due to the Part D plan regulations and the nature of the program.

Formulary Disruption

SilverScript's EGWP formulary is one of the broadest Medicare Part D EGWP formularies in the industry. Any drugs that the Program currently provides coverage for that are not on our EGWP formulary, can be covered under the secondary wrap plan. The Wrap would alleviate any formulary disruption for their retirees. Overall, we will work with the Program on an EGWP formulary and UM edits to meet your needs within CMS guidance.

SilverScript also adheres to the CMS guidelines to allow Transition Fill (TF) for non-formulary drugs and formulary drugs with prior authorization, step therapy and quantity limit requirements in both retail and long term care settings.

- Retail & Mail: Cumulative supply up to 30 days within first 90 days of coverage in new Plan, or defaults to greater benefit set-up;
- Long Term Care (LTC): 31 days' supply (unless prescription written for less) with multiple refills up to cumulative 93 days' supply within first 90 days of coverage in new Plan; or defaults to greater benefit set-up. Effective no later than January 1, 2012, the allowed new beneficiary LTC TF days supply is: 14-day supply (unless prescription written for less) with multiple cumulative refills as needed to at least 91 days supply and up to 98 days supply.
- LTC TF days' supply is allowed for qualified transition fill claims submitted with patient location code designating LTC and/or beneficiary has LICS level III status when the drug is set up as transition fill eligible via the benefits set up process.

New Members

At retail, members new to the plan are eligible for a cumulative transition fill days supply of a non-formulary drug (or formulary drug w/ PA, Step therapy, and/or Quantity Limit requirements) for up to a 30 day's supply - at retail during the first 90 days of enrollment; or defaults to greater Plan set-up. Members in long term care are eligible for 31 days supply of a non-formulary medication (or formulary drug w/ PA, Step therapy and/or Quantity Limit requirements) with multiple refills as necessary up to cumulative 93 days supply during the first 90 days of enrollment; or defaults to greater Plan set-up. Transition notices are sent to the member within three business days, explaining the process for obtaining a formulary drug or exception.

Renewing Members

Renewing beneficiaries impacted by negative formulary change across contract years are eligible for transition fills:

- Retail & Mail: Cumulative supply up to 30 days within first 90 days of the calendar year for Calendar and Non-CY Plans with CY formularies; or defaults to greater benefit set-up.
- Long Term Care (LTC): 31 day supply (unless prescription written for less) with multiple refills 93 days supply within first 90 days of the calendar year (Calendar and Non-CY Plans with CY formularies); or defaults to greater benefit set-up.

Additional, Ad Hoc Transition Fill

In the long-term care setting, after New Member transition fill days supply is exhausted, or the transition period has expired, our policy provides transition fills for:

- LTC Admission/Level of Care Change
- 31 day's supply with multiple fills allowed (unless written for less); or defaults to greater client-defined benefit set-up
- LTC Emergency Supply
- 31 day's supply (unless prescription written for less); or defaults to greater client-defined benefit set-up.

Additionally, transition fills are available via the Pharmacy Help Desk on ad hoc basis for:

- Non-LTC beneficiary level of care changes
- Retail & Mail: up to a 30 day supply unless prescription is written by a prescriber for less than 30 days, in which case multiple fills up to a cumulative 30-day supply are allowed.
- Available through manual overrides via Pharmacy Help Desk on case by case basis

- Beneficiaries requesting exceptions and for whom decisions are not issued by the end of the Transition Fill period, or allowed days supply:
- Retail & Mail: up to a 30 day cumulative supply via manual override (additional as needed as long as exception or coverage determination decision is pending.
- LTC: 31 day's supply (unless prescription written for less) with multiple refills allowed.

Mail Vendor Transition

We can transfer prescription information electronically from the incumbent mail service provider to our company. With this approach, the Program would support us in working with the incumbent mail service provider. This approach results in a seamless transition for members and captures their complete mail service prescription history.

Success of electronic transfers depends on the data provided by the Program's current mail service provider.

Provided the incumbent mail service vendor utilizes the industry standard layout for electronically transferring open refills, we have had great success in moving nearly all open refills into our system within 24-48 hours of receipt. We have extensive experience in mail service transitions and will analyze all transferred data closely to pinpoint potential problems and issues (e.g., date of birth transpositions, prescriber identifiers, etc.) we have faced historically with electronic transfers. Because of differences in the data obtained, patients still may, in rare situations, need to obtain new prescriptions for remaining refills.

Additionally, due to electronic transmission constraints and legal regulations and restrictions, when refills are transferred electronically from the current mail service provider, certain prescriptions are exempt from that transfer, such as:

- Controlled substances
- Compounded prescriptions
- Expired prescriptions
- Prescriptions with zero refills remaining.

However, we will work with the Program to outline these limitations in any of our standard or customized communication letters that will be provided to the members.

We will work also with the Program to advise members of a change in mail service providers 30 to 60 days prior to the transition date to give them ample time to understand the transfer process or obtain new prescriptions if they choose.

Retail Pharmacy Refills and UM Disruption

When a member become eligible for Medicare Part D and transfers from a commercial plan to the EGWP, claims history and clinical qualifications do not transfer with them member. Since they will be starting a Medicare Part D plan, the claims history begins over again in order to accurately calculate the Medicare Part D benefit levels for the members. EGWP members would also follow any step-therapy and prior authorizations applicable for Medicare Part D and approved by CMS. Overall, we will work with the Program on an EGWP formulary and UM edits to meet your needs within CMS guidance.

(7) Describe the member termination process under the EGWP PDP, including the timing of termination after the termination date is received by the Department.

Upon receipt of a disenrollment request from a Group sponsor, the following process is initiated:

- Receive a client batch files with disenrollments via secure connectivity. There are two types of disenrollments
- Voluntary Disenrollment (member initiated, must receive written copy of request) - Part D Services will be submitted completed request to CMS without delay.

a. Involuntary Disenrollments (plan/group initiated) - beneficiary will receive notification 21 days prior to the effective date while disenrollment is simultaneously submitted to CMS with a prospective effective date.

b. Voluntary - Once the Client file is loaded into the Enrollment System, it will automatically:

- Generate Group Disenrollment Notification letter within 10 days
- The Enrollment system will transmit a disenrollment transaction code to CMS
- An Eligibility File is transmitted to the claim adjudication system which terminates access to care for the member.
- Upon CMS approval, a disenrollment confirmation letter is issued to the member within 10 days.

c. Involuntary - Once the Client file is loaded into the Enrollment System, it will automatically:

- Disenrollment effective date is adjusted prospectively to provide the member 21 days advance notice
- Generate Group Disenrollment Notification letter with adjusted effective date within 10 days
- The Enrollment system will transmit a disenrollment transaction code to CMS
- An Eligibility File is transmitted to the claim adjudication system which terminates access to care for the member.
- Upon CMS approval, a disenrollment confirmation letter is issued to the member within 10 days.

(8) Describe your capability to provide the consulting and accounting services necessary to support and assist the Plan Sponsor in determining what Medicare Part D option the Department should select so that the DCS Program realizes maximum savings.

CVS Caremark and its affiliates have over five (5) years of experience in providing EGWP forecasts that optimize the desired outcomes that our Plan Sponsor Clients desire.

(9) Confirm your understanding and describe your ability to identify and recover claim payments made by the DCS Program from other Medicare Part D plans that should have been the primary payor, upon finalization of the subrogation process by CMS.

For situations where the State paid supplemental to Med D, our method to identify this scenario, would be via their usage of an MSP code. Once the indicator is set, we would go back and reprocess the incorrect claims that paid Med D primary, as primary under State.

6. ENROLLEE COMMUNICATION SUPPORT

The Department regularly provides information regarding DCS Program benefits to members through various publications, the Department's website and attendance at various meetings. The successful Offeror will be required to assist the Department with the creation, review and presentation of DCS Program materials that will enhance a member's understanding of DCS Program benefits. Please see Exhibit II.N for a summary of DCS Program presentations that took place in the past 12 month period. The Offeror will also be required to assist NYSIF with various Claimant communications including the issuing of ID cards, information packets, forms and letters, as requested.

A. DUTIES AND RESPONSIBILITIES

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

(2) (Exclusive to DCS) The Offeror will be responsible for providing Enrollee communication support and services to the Department including, but not limited to:

(a) Developing language describing the DCS Program for inclusion in the NYSHIP General Information Book and Empire Plan SPD, subject to the Department's review and approval;
(b) Developing articles for inclusion in Empire Plan Reports and other publications on an "as needed" basis, detailing DCS Program benefit features and/or highlighting trends in drug utilization;
(c) Timely reviewing and commenting on proposed DCS Program communication material developed by the Department;

(3) (Exclusive to DCS) Upon request, subject to the approval of DCS, on an "as needed" basis, the Offeror agrees to provide staff to attend Health Benefit Fairs, select conferences, and benefit design information sessions, etc. in NYS and elsewhere in the United States. The Offeror agrees that the costs associated with these services are included in the Offeror's Claims Administration Fee.

(4) The Offeror must work with the Procuring Agencies to develop appropriate customized forms and letters for the Programs, including but not limited to mail order forms, Enrollee claim forms, prior authorization letters, generic appeal letters, Flexible Formulary and Preferred Drug List, disruption letters, etc. All such communications must be approved by the Procuring Agencies.

(5) (Exclusive to NYSIF) The Offeror must assist NYSIF in developing a customized Claimant information packet that will include information on available prescription drug services as well as a permanent ID card to be used when filling injury-related prescriptions. See sample ID card in Exhibit II.E.2d.

B. REQUIRED SUBMISSION

(1) Please describe the organizational resources currently dedicated to Enrollee communications including any changes that would occur if you were awarded the resultant Agreements. Please detail the process that will be utilized to develop Enrollee communications including, but not limited to the role of the Offeror's legal department. Provide several examples of the Programs communications you have developed for Enrollees. Confirm your understanding that all Programs communications developed by the Offeror are subject to the Procuring Agencies final approval.

Note: (Exclusive to DCS) There are specific requirements for Flexible Formulary and Preferred Drug List communications set forth in Preferred Drug List Development and Management within Section IV.B.16.a. of this RFP.

CVS Caremark employs experienced marketing teams that focus on crafting communications for internal CVS Caremark employees, external (clients, members, physicians, etc.) audiences, strategic initiatives, and public relations.

As part of our marketing professionals, we established a dedicated member engagement team that develops and executes member-facing programs to educate members about their benefit and to promote behavior change. These types of educational pieces inform members about the following:

- The use of low cost medications (e.g. generic medications)
- The use of low cost channels (e.g. CVS Caremark Mail Service Pharmacy)
- Adherence to medications and enrollment in automatic refill programs
- Use of self-service tools such as Caremark.com.

We also employ communications professionals within specific departments (i.e., marketing, disease management, specialty pharmacy, Customer Care, implementations, etc.) to best meet the unique needs of our internal and external customers. These personnel are responsible for formulary communications (Drug List notifications), our Member Education program (therapeutic class-specific newsletters), our mail service pharmacies, our FastStart® program, and many other informative member communications.

Development Process

CVS Caremark's marketing communication process starts with the business or clinical subject matter expert working with an appropriate communications expert to draft the content. All communications and their content then undergo clinical, HIPAA, and legal reviews prior to release for design and print production. If the Programs request significant content adjustments to our templates, our Member Engagement team assists with the creative development. Content is then submitted to Brand Compliance for review and approval prior to production/implementation.

For the EGWP program, we offer flexible support and will work the Program to tailor the EGWP + Wrap communication materials to meet Program needs within CMS guidelines.

Program Communication Examples

Please see Section II, Tab 8 for program communication examples for DCS and Section II, Tab 9 for program communication examples for NYSIF.

Final Approval

CVS Caremark confirms that all program communications developed by CVS Caremark are subject to the Procuring Agencies final approval.

(2) (Exclusive to DCS) Describe the resources that will be available to the Department to support the Department's development of various Enrollee communications and your ability to provide input into such communications quickly.

The Department will receive assistance from our Communication Specialists during implementation to determine flexible strategies for employer group and member communications.

As part of the implementation planning process, your account services team − including an Implementation Manager and a Communications Professional − will discuss the various options. Our team approach helps to ensure as smooth and seamless a transition to our company as possible. After implementation, your account team will provide continued support in evaluating the program's effectiveness over time.

CVS Caremark intends to deliver high quality and consistent messages to Program members throughout the life of the contract. Member communications take many forms, including letters, Web site materials and postings, and responses from our Customer Care Representatives. Your dedicated account team will monitor all member communications to ensure that they comply with Department requirements and that they are consistent across all communication channels.

For ongoing communications that require extensive customization, the Account team will interface with our marketing department and Member Engagement team to design an approach that meets Program needs. All communications will be subject to the Department's approval.

(3) (Exclusive to DCS)Confirm that staff will be available to attend Health Benefit Fairs, select conferences, and benefit design information sessions, etc. in NYS and elsewhere in the United States. Describe the experience and qualifications of staff that will be attending these events.

CVS Caremark confirms that staff will be available to attend health benefit fairs, select conferences, and benefit design information sessions, etc. in NYS and elsewhere in the United States. Biographies of our Account team members are included with our proposal submission.

(4) Confirm your commitment to work with the Procuring Agencies to develop appropriate customized forms and letters for the Programs. Provide examples of how you have worked with other large clients to produce customized communications.

CVS Caremark confirms. CVS Caremark works with many large clients to develop customized communications that suit client-specific needs. As a common offering, we help clients brand communications to include their personalized logo and colors, and we also enlist subject matter experts and marketing professionals to provide insight and recommendations for customized communications. A real-world example of our support is working with a large health plan to develop a marketing communication to promote clinical programs. We enlisted the help of a marketing director, who manages clinical products, to review and enhance the communication strategy.

For the EGWP program, will work the Department to tailor the EGWP + Wrap Communication Materials to meet your needs within CMS guidelines.

(5) (Exclusive to NYSIF) Confirm your commitment to develop a customizable information packet that will include a permanent ID card and other prescription drug information for the NYSIF Program. Provide samples of information packets developed and customized for other clients.

CVS Caremark confirms. Please see Section II, Tab 9 for a sample ID card and information packet for the CVS Employee Program. Please note, the actual ID card created for NYSIF claimants will match the current ID card format in place today. In addition, we can include your formulary list to help educate claimants on the preferred drugs.

7. ENROLLMENT MANAGEMENT

The Programs require the Offeror to ensure the timely addition of enrollment data as well as cancellation of benefits in accordance with each of the Programs' eligibility rules.
The Employee Benefits Division of the Department of Civil Service utilizes a web-based enrollment system for the administration of Employee benefits known as the New York Benefits Eligibility & Accounting Systems (NYBEAS). NYBEAS is the source of eligibility information for all Empire Plan, Excelsior Plan, and SEHP Enrollees and Dependents. Enrollment information is set forth in Exhibits II.B through II.B.2.

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

When a person enrolls in The Empire Plan, Excelsior Plan, or SEHP, the Department's card contractor issues an Employee Benefit Card. An Enrollee with individual coverage will receive one card containing the Enrollee's 9-digit alternate identification number and name. An Enrollee with family coverage will receive two cards containing the Enrollee's alternate identification number and name, as well as Dependents' names.

This universal card is used by Enrollees and Dependents for all components of The Empire Plan. An example of The Empire Plan Employee Benefit Card is provided in Exhibit II.E.2a. An example of the Excelsior Plan Employee Benefit Card is provided in Exhibit II.E.2c. The Department will not accept an alternative approach to ID cards, with the exception of ID cards required for the EGWP. It is the responsibility of the Offeror to ensure that the Retail Pharmacy Network accepts The Empire Plan Employee Benefit Card as evidence of coverage and is capable of submitting claims when presented with The Empire Plan Employee Benefit Card. These cards include The Empire Plan consolidated toll free number that pharmacies may use to contact the DCS Program if they need claim submission assistance. The Offeror should not expect any modification of the current identification card as part of implementation. Separate Prescription drug cards will not be issued, with the exception of ID cards required for the EGWP.

The SEHP Employee Benefit Card displays the Enrollee's 9-digit alternate identification number and name and the expiration date of coverage. The SEHP Employee Benefit Cards are issued annually by a Department contractor and have an expiration date of August 31st of each year. An example of this card is provided in Exhibit II.E.2b.

NYSIF's Claim Eligibility process ensures that Claimants receive convenient prescription filling services and that Network Pharmacy bill the NYSIF Program with the proper Carrier Case Number (i.e. Claim Number). A sample ID card is provided in Exhibit II.E.2d.

A. DUTIES AND RESPONSIBILITIES

The selected Offeror will be responsible for the maintenance of accurate, complete, and up-to-date enrollment files, located in the United States, based on information provided by the Department and NYSIF. These enrollment files shall be used by the Offeror to process retail, mail order and specialty pharmacy claims, provide customer service, identify individuals in the enrollment files who are enrolled in the EGWP or another Medicare Part D plan, and produce management reports and data files. The Offeror is required to provide enrollment management services including but not limited to:

(1) Initial Testing:

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

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

(2) (Exclusive to DCS) Providing an enrollment system capable of receiving secure enrollment transactions (Monday through Friday) and having all transactions fully loaded to the claims processing system within twenty-four (24) hours of release of a retrievable file by the Department. The Offeror shall immediately notify the Department of any delay in loading enrollment transactions.

In the event the Offeror experiences a delay due to the quality of the data supplied by the Department, the Offeror shall immediately load all records received (that meet the quality standards for loading) within twenty-four (24) hours of their release, as required. The Department will release enrollment changes to the Offeror in an electronic format daily (Monday through Friday). On occasion, the Department will release more than one enrollment file within a 24-hour period. The Offeror must be capable of loading both files within the twenty-four (24) hour performance standard. The format of these transactions will be in an EDI Benefit Enrollment and Maintenance transaction set, utilizing an ANSI x.12 834 transaction set in the format specified by the Department. The latest transaction format is contained in Exhibit II.G and II.G.1. The Offeror must also have the capability to receive alternate identification numbers and any special update files from the Department containing eligibility additions and deletions, including emergency updates, if required;

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

(4) Ensuring the security of all enrollment information as well as the security of a HIPAA compliant computer system in order to protect the confidentiality of Enrollee/Dependent data contained in the enrollment file. Any transfers of enrollment data within the Offeror's system or to external parties must be completed via a secured process;

(5) Providing a back-up system or have a process in place where, if enrollment information is unavailable or not current at the point of service, Enrollees can obtain Prescriptions without interruption, at the point of service. Short fill policies should be included in the Pharmacy Provider manual;

(6) Cooperating fully with any State initiatives to use new technologies, processes, and methods to improve the efficiencies of maintaining enrollment data including any enrollment file conformance testing requested during the course of the Agreement resulting from this RFP;

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

(8) (Exclusive to DCS) Meeting the administrative requirements for National Medical Support Notices. A child covered by a Qualified Medical Child Support Order (QMCSO), or the child's custodial parent, legal guardian, or the provider of services to the child, or a NYS agency to the extent assigned the child's rights, may file claims and the Offeror must make payment for covered benefits or reimbursement directly to such party.

An Offeror will be required to store this information in their system so that any claim payments or any other plan communication distributed by the Offeror, including access to information on the Offeror's website would go to the person designated in the QMCSO;

(9) Ability to manually load/correct an enrollment record and to contact the Pharmacy to allow the adjudication of a Prescription in an urgent or emergency situation. Occurrences of these situations are very rare; and,

(10) (Exclusive to NYSIF) The Offeror must provide an instant enrollment or "short fill" service to injured workers of NYSIF policyholders. This service should allow immediate acceptance by any pharmacy in the Offeror's Retail Pharmacy Network in order to provide a limited number of cost-effective medication benefits to the injured worker.

(11) Enrollment Management Guarantee: The Offeror must propose a performance guarantee. The Programs' service level standard requires that one hundred percent (100%) of all Program enrollment records that meet the quality standards for loading will be loaded into the Offeror's enrollment system within twenty-four (24) hours of release by the Department and within twelve (12) hours of releases by the NYSIF.

B. REQUIRED SUBMISSION

(1) Describe your testing plan to ensure that the initial enrollment loads for the DCS and NYSIF Programs are accurately updated to your system and that they interface correctly with your claims system.

(a) What quality controls are performed before the initial and ongoing enrollment transactions are loaded into the claims adjudication system?

CVS Caremark visually inspects all eligibility test files for any formatting errors. This visual test determines any errors that inhibit a system test to complete. All fields on the file are inspected to confirm that valid values are sent and all data are in the correct positions.

After a successful visual test, the test and production files are system tested. The system test validates the file in a production environment.

An integral part of the eligibility system test is Error Tolerance quality edits. These edits may be customized to your data and are systematically applied to all eligibility files during the test/load process to:

- Identify and quantify data problems
- Safeguard employee enrollment records
- Preserve data integrity.

With Error Tolerance, any file that is "over tolerance" in any one of the edits will be sent to a holding queue. Any errors found are communicated back to the eligibility provider in writing. A copy of the validation report is included. The Eligibility Analyst will review this information with the provider, answer any questions, and decide on next steps.

Test File

A test file is created by pulling data from the same source that will be used for the production file. It contains member and dependent records, using examples of plan/group codes, coverage codes, effective dates, and Coordination of Benefit effective dates (if used). It includes examples for any problematic areas, such as surviving spouse data. More specific content for the test file will be discussed and decided in the implementation process.

(b) How does your system identify transactions that will not load into your enrollment system? What exceptions will cause enrollment transactions to fail to load into your enrollment system? What steps are taken to resolve the exceptions, and what is the turnaround time for the exception records to be added to your enrollment file?

The CVS Caremark load process is a 3-step automated process containing a set of profile options that customizes the client's loading of eligibility data. The first step validates the formatting of each field based on the field specifications within the standard layout. The second step includes additional data content verification based on profile settings. These profile settings allow fields to either be required, optional, or conditional, and also validate against specific values, thresholds etc. In addition, a third level of validation will be made to the data hierarchy to ensure the member data is loaded to the correct hierarchy (carrier/account/group), plan information. All exceptions are reported electronically in report format (via secure email or SFTP) or via electronic file (error exception code & original transaction) to the client for resolution. We expect clients will then make any necessary changes within their system based on the exceptions and resubmit the transactions to CVS Caremark, either the same day or the following day (depending on a client's capabilities). Member exceptions can also be manually entered into the system by the Account team or Eligibility Analyst for emergency purposes if members require prescriptions quickly.

(2) Describe your system capabilities for retrieving and maintaining enrollment information within twenty-four (24) hours of its release by the Department and within twelve (12) hours of its release by NYSIF as well as:

CVS Caremark confirms our ability to retrieve and maintain enrollment information within twenty-four (24) hours of its release by the Department and within twelve (12) hours of its release by NYSIF.

CVS Caremark receives and processes files 24 hour per day, 7 days per week, 365 days per year. All files are processed through automated tool in near real time, as soon as files are received. Files are not held for later processing unless a HOLD has been established by the Eligibility Analyst for reasons presented and agreed upon by the client or Account team. All files that are processed are monitored internally by our operations staff and if any load jobs are interrupted due to system or program issues, they are reported directly to the Eligibility Analyst for immediate notification and resolution. In rare cases, issues may not be resolved until the next business day (e.g., if the issues were the result of incomplete or corrupt data and the client is not available during non-business hours to address).

CVS Caremark will work closely with the Programs to ensure that their unique needs are met.

(a) How your system maintains a history of enrollment transactions and how long enrollment history is kept online. Is there a limit to the quantity of history transactions that can be kept on-line?

CVS Caremark uses a "stacking" application method for tracking and storing historical eligibility:

Eligibility is sent with one record for each beneficiary. This record represents the most current eligibility status for a member.

The eligibility load program builds history by adding the new eligibility information based on the new effective date of coverage. The previous coverage row is terminated as of one day prior to the new effective date.
CVS Caremark maintains a complete eligibility history for each the Programs member throughout the life of the Programs' integrated prescription drug program.

(b) How your system handles retroactive changes and corrections to enrollment data;

For retroactive eligibility updates, claims that already have been processed must be adjusted manually and reprocessed. Readjudication data, along with manual adjustments, are stored with the original claim history. Retroactive updates, and all other changes to member eligibility, are tracked and stored in the same member eligibility file and can be viewed by the Programs online and in real time.

Updates to member records will be matched according to the Programs' specific business rules and then edited for valid field content. Multiple active spans of coverage or multiple types of terminations can be allowed or rejected depending on the business rules established by the Programs.

Same-day terminations – Same-day terminations result in one day of coverage and can be used in conjunction with timely filing rules to prevent current claims submission.

Future-effective date – A future-effective date allows for a member to be posted to the system but denies claims submitted before the effective date.
Future-terminated date – A future-terminated date allows for payment of claims for valid prescriptions filled before the termination date is posted to the system. Any claims submitted after that date will be rejected.

Terminations prior to an effective date (one-day negative) – One-day terminations result in no coverage. We can work with the Programs to map same-day terminations to one-day negative terminations if this is a business requirement.
In addition to the updating processes described above, we will provide the Programs with tools, as well as proper authorization, controls, and audit trails, to terminate or cancel coverage for a specific member.

For the EGWP, we follow CMS guidelines for enrollment and disenrollment. The following describe our process.

Receive a client batch files with new adds, changes and disenrollments via secure connectivity.

- Process Group Sponsor Medicare Part D Batch files
- Opt Out Option - beneficiary will be on hold for 21 days (Opt Out Period) before releasing the transaction to CMS.
- Opt In Option – Part D Services will be released to CMS without 21 days hold
- Transmit Enrollment Request to CMS

Once the Opt-Out Client file is loaded into the Enrollment System, it will automatically:

- Transmit a BEQ request to CMS; CMS response will provide the beneficiary match found with flag "Y" or not found with flag "N" along with other parameters like Part A, B and D Eligibility Effective and Term dates, Co-Payment levels, Part D Premium Subsidy Percent, Employer Subsidy Effective and Term dates, Number of uncovered months for LEP determination, etc.
- Beneficiary will be on hold for 21 days (Opt Out Period) before releasing the transaction to CMS.
- Generate Group Enroll Notification letter.

- After 21 days, the Enrollment system will transmits an enrollment transaction code (60) batch file to CMS

Once the Opt-in Client file is loaded into the Enrollment System, it will automatically:

- Transmit a BEQ request to CMS; CMS response will provide the beneficiary match found with flag "Y" or not found with flag "N" along with other parameters like Part A, B and D Eligibility Effective and Term dates, Co-Payment levels, Part D Premium Subsidy Percent, Employer Subsidy Effective and Term dates, Number of uncovered months for LEP determination, etc.
- Transmits an enrollment transaction code (60) batch file to CMS.
- Process CMS Enrollment Response
- CMS will process and send the response file back to the Part D services.
- When a TRR accepting an enrollment is received.
- For Group Sponsor Enrollments, the Enrollment System prompts distribution of an enrollment packet to the beneficiary within 10 calendar days of receipt of the accepted TRR. The enrollment packet contains a Confirmation of Enrollment Packet which includes Confirmation of Enrollment letter, Coordination of Benefits Survey, Evidence of Coverage, Formulary list, Pharmacy Directory, Summary of Benefits and Mail Order Form.
- An Eligibility File is transmitted to the claim adjudication system which generates an ID Card and is sent to the enrollee.
- If the beneficiary is subject to LEP, the LEP process is invoked.
- When a TRR rejecting an enrollment is received,
- Part D Services Exception team representative will work on the data discrepancies between the MARx application and Part D Enrollment System as follows:
- If the MARx application show the same beneficiary and in Enrollment System show the last name and first name reversed, or incorrect date of birth or gender mismatch, then representative will update and resubmit the transaction to CMS.
- Rejects that cannot be resolved by inquiry to the Enrollment system or unable to reach out the beneficiary, Part D Services Team will trigger a letter for seeking additional information and also notify to the corresponding Account Manager.

Upon receipt of a TRR 127, for enrollees who are part of an employer group, sends a notification letter to the beneficiary requesting that s/he confirm intent to enroll with SilverScript. The enrollee will have 30 days to respond to the letter. The letter will advise the enrollee of consequences to his/her employer/union coverage as result of enrolling in a Part D plan.

If the enrollee responds to the letter and confirms their intent to enroll, the transaction is updated to mark the employer subsidy override flag and then re-submitted to CMS.

If the enrollee fails to respond to the letter, it will be interpreted as a lack of intent to enroll and the enrollment request will be processed as a denial of enrollment.

Group Sponsor may submit their beneficiaries' enrollment for the current month (CPM) or future active and retroactive dates, but not exceeding 90 days. Retroactive transactions that have processing dates outside of these parameters require special handling.

Disenrollment

Upon receipt of a disenrollment request from a Group sponsor, the following process is initiated:

- Receive a client batch files with disenrollments via secure connectivity. There are two types of disenrollments
- Voluntary Disenrollment (member initiated, must receive written copy of request) - Part D Services will be submitted completed request to CMS without delay.
- Involuntary Disenrollments (plan/group initiated) - beneficiary will receive notification 21 days prior to the effective date while disenrollment is simultaneously submitted to CMS with a prospective effective date.

Voluntary - Once the Client file is loaded into the Enrollment System, it will automatically:

- Generate Group Disenrollment Notification letter within 10 days
- The Enrollment system will transmit a disenrollment transaction code to CMS
- An Eligibility File is transmitted to the claim adjudication system which terminates access to care for the member.
- Upon CMS approval, a disenrollment confirmation letter is issued to the member within 10 days.

Involuntary - Once the Client file is loaded into the Enrollment System, it will automatically:

- Disenrollment effective date is adjusted prospectively to provide the member 21 days advance notice
- Generate Group Disenrollment Notification letter with adjusted effective date within 10 days
- The Enrollment system will transmit a disenrollment transaction code to CMS
- An Eligibility File is transmitted to the claim adjudication system which terminates access to care for the member.
- Upon CMS approval, a disenrollment confirmation letter is issued to the member within 10 days.

(c) (Exclusive to DCS) Detail how your enrollment system captures the information necessary to produce the reports entitled “Claims and Credits Paid by Agency” and “Quarterly Participating Agency Claims” required in the Reporting Section of this RFP.

CVS Caremark’s system is coded according to hierarchy (Carrier, Account, Group, Member), which enables detailed reporting at the agency level Claim files are created using elements from the claim extract file to report the data as it was adjudicated for each claim. Each file will contain all paid records adjudicated within the specified reporting period as well as any out of cycle reversals (reversal of a previously paid claim from a prior reporting period).

On a nightly basis, adjudicated clams are fed into the claims extract file, which is the source for all back end reporting and billing. Claims are also fed to the CVS Caremark Data Warehouse, which allows us to accommodate a variety of reporting options and information sharing with our clients. Our experience in supporting clients of all sizes, across all business segments has led us to develop the flexibility to adhere to report types and formats, including the current format used by the Programs.

(d) Confirm your enrollment and claims processing system has the capacity to administer a social security number, Employee identification number and an alternate identification number assigned by the Department or NYSIF. Does your system have any special requirements to accommodate these three identification numbers? Explain how Dependents are linked to the Enrollee in the enrollment system and claims processing system (DCS Only).

CVS Caremark confirms. We can accommodate all three ID's; however, simply supplying the SSN will not allow the member to adjudicate a claim against that number, unless the SSN is identified as either the Employer Number or the Alternate ID Number. We encourage our clients to move away from using a member's SSN as either the primary or alternate ID. There are no special requirements to accommodate the Primary (Employer ID) or Alternate ID fields within the CVS Caremark system; however, we do ask that clients supply a 2-3 digit "person code" affixed to the end of the Primary and Alternate ID fields to help identify each member within a family. Typically, we ask the client to supply a core base ID number (the same number used for each family member), followed by the 2- 3 digit Person Code field. This, in addition to the relationship code field, will help identify the cardholder, spouse, and any dependents that make up a family.

(3) Describe how your enrollment system, data transfers, and procedure for handling enrollment data are HIPAA compliant.

CVS Caremark is HIPAA-compliant. We have met every required compliance standard by the dates specified under the law.

The CVS Caremark Client Care Access system is fully accessible through remote browsers over standard and secure Web-based protocols, including http, xml, and SOAP/Web services. This feature is a subset of the functionality provided by Client Care Access that can be made available to the Programs. Our portal provides a secure e-mail exchange between CVS Caremark and our clients. Our HIPAA office reviews and certifies all systems.

CVS Caremark can limit security access and functionality with respect to Client Online Services® features by means of specific data restrictions and permission. We can turn off certain functions completely and limit others to "read only" access versus "write" access.

the Programs will receive a user manual as well as an online demonstration of our Client Online Services tools during training with your Account Manager.

(4) Describe the backup system, process or policy that will be used to ensure that Enrollees receive needed Prescription drugs in the event that enrollment information is not immediately available at the point of service;

System edits applied to each claim at the point of service ensure that the submitting member is entitled to benefits according to the eligibility data provided by the Programs. To confirm eligibility, the system will compare the information submitted by the pharmacy to the Programs' eligibility file. Ineligible claims will be denied, so the Programs will be protected from the processing of claims for those members who are ineligible.

If eligibility is denied but the member insists that s/he is eligible, the pharmacist can call the toll-free Pharmacy Help Desk – available 24 hours a day, 7 days a week – to verify eligibility. The Pharmacy Help Desk representative will compare the member information submitted by the pharmacy to the Programs' eligibility file. If eligibility is confirmed, the representative can override the ineligible message and advise the pharmacist of the approval.

If coverage cannot be confirmed at the time of the inquiry, the pharmacist will offer the member the following options:

- Contact the Programs' benefits or customer service unit to clarify eligibility status
- Have the member pay the full cost of the prescription at the pharmacy, and submit a paper claim form to CVS Caremark for reimbursement.

(5) Exclusive to DCS) Confirm that you will maintain a read only connection to the NYBEAS enrollment system, and that Offeror's staff will be available to access enrollment information through NYBEAS during the required hours, Monday through Friday, from 9:00 a.m. to 5:00 p.m., with the exception of NYS holidays.

CVS Caremark confirms.

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

CVS Caremark confirms our ability to meet the administrative requirements for National Medical Support orders and dependents covered by a QMCSO, including storage of information about dependents and only releasing information to the individual named in the QMCSO. If the primary insured produces the court order and demonstrates that they are the custodial provider, then the Program will be able to identify the dependent in the eligibility file, and we will be able to process claims and maintain records for the dependent as we would through our standard process.

(7) Describe your ability and the process to manually load/correct an enrollment record and to contact the Pharmacy to allow the adjudication of a Prescription in an urgent or emergency situation.

CVS Caremark can accept eligibility changes from the Programs via phone call, fax, and/or e-mail. Also, CVS Caremark's online tool system enables plan sponsors to manage pharmacy benefits proactively, at an individual level, for the member population. Real-time additions and updates enter directly into the online tool and are effective immediately. the Programs can access the Web-enabled system from any PC with an Internet connection and work with real-time data.

For the EGWP program, the Program would have access to our online tools consistent with our obligations to CMS as the PDP plan sponsor. Real-time additions and updated are not applicable to the Medicare Part D business as a member is not actually considered enrolled into the EGWP plan until we receive an enrollment confirmation back from CMS.

(8) (Exclusive to NYSIF) Describe in detail how you will administer the instant enrollment or "Short Fill" service to allow immediate acceptance by any pharmacy in the Offeror's Retail Pharmacy Network in order to provide a limited number of cost-effective medications to the injured worker.

[redacted]

(9) Enrollment Management Guarantee: The Programs service level standard requires that one hundred percent (100%) of all Program enrollment records that meet the quality standards for loading will be loaded into the Offeror's enrollment system within twenty-four (24) hours of release by the Department and within twelve (12) hours of release by NYSIF. The Offeror shall propose, separately for each Program, the forfeiture of a specific dollar amount of the Claims Administration Fee for failure to meet the standards.

The Standard Credit Amount for each 24 hour period beyond twenty-four (24) hours from the release by the Department that one hundred percent (100%) of the Program enrollment records that meet the quality standards for loading is not loaded into the Offeror's enrollment system is $5,000. However, Offerors may propose higher or lesser amounts.

The Standard Credit Amount for each 24 hour period beyond twelve (12) hours from the release by the NYSIF that one hundred percent (100%) of the Program enrollment records that meet the quality standards for loading is not loaded into the Offeror's enrollment system is $375. However, Offerors may propose higher or lesser amounts.

The Offeror's quoted amount to be credited against the Claims Administration Fee for each 24 hour period beyond twenty-four (24) hours from the release by the Department, and for each 24 hour period beyond twelve (12) hours from the release by the NYSIF, that one hundred percent (100%) of the Program enrollment records that meet the quality standards for loading is not loaded into the Offeror's enrollment system, is $_ ____for DCS and $ ___ for NYSIF.

[redacted]

[redacted]

8. REPORTING

(Exclusive to DCS)

Reporting must be structured to provide assurances that member, network and account management service levels are being maintained and that claims are being paid and billed according to the terms of the agreements with pharmacies and the terms of the Agreements resulting from this RFP. The selected Offeror may on occasion be requested to provide ad-hoc reporting and analysis within very tight time frames. In order to fulfill its obligations to enrolled members and ensure contract compliance, the Program requires that the Offeror provide accurate claims data information on a claim processing cycle basis as well as specific summary reports concerning the DCS Program and its administration.

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

A. DUTIES AND RESPONSIBILITIES

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

(1) Ensuring that all financial reports including cycle claim reports are generated from amounts billed to the DCS Program, and tie to the quarterly and annual financial experience reports, and Rebate reports;

(2) Developing, in conjunction with the Department, standard electronic management, financial, and utilization reports required by the Department for its use in the review, management, monitoring and analysis of the DCS Program. These reports must tie to the amounts billed to the DCS Program. The final format of reports is subject to the Department review and approval;

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

(4) Providing direct, secure access to the Offeror's claims system and any online and web-based reporting tools to the Departments' offices;

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

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

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

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

Annual Reports

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

Offeror must submit an Annual Premium Renewal no later than September 1st of each Calendar Year. This renewal package must detail all assumptions utilized to back up the rate renewal request, including, but not limited to: paid claim amounts, administrative fees, projected Pharma Revenue, COB recoveries, changes in enrollment, changes in the Specialty Pharmacy drug list as well as changes in the Flexible Formularies and the Traditional PDL;

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

Annual Summary Reporting: The Offeror must prepare and present an annual report that details DCS Program performance, industry trends and anticipated market developments including the introduction of generics and potential new product developments. This presentation should include comparisons of the DCS Program to book of business statistics, and other similar plan statistics. Clinical, financial and service issues as well as strategies and opportunities for plan savings are to be comprehensively addressed. In

addition, the Offeror should be proactive by reporting any areas that need improvement, potential problem areas, and any solutions that can be implemented. The annual presentation and report is due each August after the end of each complete Calendar Year;

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

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

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

Catastrophe Reinsurance Reconciliation Report: The Offeror is required to submit an annual reconciliation of the Catastrophe Reinsurance receipts for the EGWP by December 31st of the year following year of incurral.

Semi-Annual Reports

Top 100 Brand Name and Generic Drugs – Retail Pharmacy Report: The Offeror is required to submit a semi-annual report that details the top 100 brand name and top 100 Generic Drugs dispensed to Enrollees of the DCS Program through the Offeror's Retail Pharmacy Network sorted by drug spend and script count. The report should include fields such as: drug name, indication of use (i.e. cholesterol, diabetes, etc), preferred drug indicator, number of Rx's, number of Enrollees utilizing the drug, Rx cost, average cost per script, average Copayment, and average Days supply. The Offeror should closely follow the current format specified by the Department in Exhibit II.F.7. The numbers should be submitted on a year-to-year comparison basis. Any trends or abnormalities should be submitted in a narrative. The report is due sixty (60) Days after the end of the second and fourth quarter;

Top 20 Therapeutic Categories Report: The Offeror is required to submit a semi- annual report that details the top 20 therapeutic categories by drug spend on the Offeror's Flexible Formularies and Preferred Drug List (broken down by drug) utilized by Enrollees of the DCS Program (combined Retail, Mail Service and Specialty Pharmacy). The report should include fields such as: drug name, number of Rx's, number of members utilizing the drug, Rx cost, average cost per script, preferred drug indicator, average Copayment, and average Days supply. The Offeror should closely follow the current format specified by the Department in Exhibit II.F.8. The numbers should be submitted on a year-to-year comparison basis. Any trends or abnormalities should be submitted in a narrative. The report is due sixty (60) Days after the end of the second and fourth quarter;

Top 100 Brand Name and Generic Drugs – Mail Service Pharmacy Report: The Offeror is required to submit a semi-annual report that details the top 100 brand name and top 100 Generic Drugs dispensed to Enrollees of the DCS Program through the Offeror's Mail Service Pharmacy sorted by drug spend and script count. The

report should include fields such as: drug name, indication of use (i.e., cholesterol, diabetes, etc), preferred drug indicator, number of Rx's, number of members utilizing the drug, Rx cost, average cost per script, preferred drug indicator, average Copayment, and average Days supply. The Offeror should closely follow the current format specified by the Department in Exhibit II.F.9. The numbers should be provided on a year-to- year comparison basis. Any trends or abnormalities should be provided in a narrative. The report is due sixty (60) Days after the end of the second and fourth quarter;

Top 100 Specialty Drugs – Specialty Pharmacy Report: The Offeror is required to submit a semi-annual report that details the top 100 Specialty Drugs dispensed to Enrollees of the DCS Program through the Offeror's Designated Specialty Pharmacy sorted by drug spend and script count. The report should include fields such as: drug name, indication of use (i.e., cholesterol, diabetes, etc) , preferred drug indicator, number of Rx's, number of members utilizing the drug, Rx cost, average cost per script, preferred drug indicator, average Copayment, and average Days supply. The Offeror should closely follow the current format specified by the Department in Exhibit II.F.6. The numbers should be provided on a year-to-year comparison basis. Any trends or abnormalities should be provided in a narrative. The report is due sixty (60) Days after the end of the second and fourth quarter;

Quarterly Reports

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

- annual financial performance;
- assessment of DCS Program costs;
- incurred claim triangles;
- Pharma Revenue;
- coordination of benefit recoveries;
- audit recoveries;
- drug settlement and litigation recoveries;
- administrative expenses;
- trend statistics; and
- such other information as the Department deems necessary.

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

Quarterly Performance Guarantee Report: The Offeror must submit quarterly the DCS Program's Performance Guarantee report that details the Offeror's compliance with all of the Offeror's proposed

Performance Guarantees. The report should include the areas of: Implementation; system availability; customer service (telephone availability, response time, blockage rate, abandonment rate); claims processing; management reports and claim files; enrollment; mail service turnaround; and, Pharmacy composition and access.
The Offeror should closely follow the current format specified by the Department in Exhibit II.F.11. Documentation of compliance should be included with this report. The report is due thirty (30) Days after the end of the quarter;

Quarterly Network Access: The Offeror must submit a measurement of the Network access (using Exhibit I.Y.4) based on a "snapshot" of the network taken on the last day of each quarter. The report is due thirty (30) Days after the end of the quarter;

Quarterly Audit Report: The Offeror must submit a quarterly audit report detailing audits planned, audits initiated, audits in progress, audits completed, audit findings, audit recoveries, and any other enforcement action by the Offeror. The report should include fields such as: Pharmacy name, NABP number, recovery amounts, audit method or type, and basis for and method of recovery. The Offeror should closely follow the current format specified by the Department in Exhibit II.F.12. The report is due thirty (30) Days after the end of the quarter;

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

Quarterly Rebate and Other Pharma Revenue Report: The Offeror is required to submit a quarterly rebate and other Pharma Revenue report detailing the amount of rebates and other Pharma Revenue received from the Offeror during the quarter. The report must include breakdowns by each manufacturer and drug with quarterly and year-to-date numbers, as well as any adjustments that are performed. The Offeror should closely follow the current format specified by the Department in Exhibit II.F.13. The Offeror's process for documenting rebates and other Pharma Revenue by manufacturer and issuing the payment of rebates and other Pharma Revenue to the DCS Program should not exceed one hundred fifty (150) Days from the end of the quarter in which the initial claims were processed. This report is due at the time the rebates and other Pharma Revenue are paid to the Program;

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

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

Rebate File: The Offeror is required to transmit a computerized file via secure transfer containing prescription rebate information for all earned rebates in a format specified by the Department. The pharmacy rebate records in the Rebate File must match all prescriptions billed to the Department by the Offeror. The report is due one hundred fifty (150) Days after the end of the quarter; and

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

Monthly Reports

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

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

Monthly Report of DCS Program MAC List: Each month the Offeror is required to submit an updated DCS Program MAC List that details all the drugs included on the DCS Program MAC List and the corresponding prices used to charge the DCS Program. The following information shall be included: GCN, drug name, form, strength, reference product, FDA rating, date the product was initially MAC'd, initial MAC price, previous MAC price, current MAC price, effective date of current MAC price and the change in price from the previous DCS Program MAC List. Drugs that are added or deleted from the DCS Program MAC List shall be clearly marked or highlighted. The Offeror is required to submit this report in the current format specified by DCS in Exhibit II.F.4 unless otherwise specified by the Department. The report is due thirty (30) Days after the end of the month;

MAC Saving Reports: Each month is required to submit a year-to-date and annualized savings projections of the MAC price increases and decreases based on expected utilization. The following information shall be included: GCN, Drug Name, Strength, Initial MAC Price, Current Price, Quantity Filled, Actual Savings, Annual Savings.

The Offeror is required to submit this report specified by the Department in Exhibit II.F.14 unless otherwise specified by the Department. The report is due thirty (30) Days after the end of the month; and
Program Customer Service Monthly Reports: Each month the Offeror is required to submit a customer service report that measures the Offeror's customer service performance including customer service availability, customer service telephone response time, the telephone abandonment rate, the telephone blockage rate, claims processing, enrollment, and mail service turnaround. The Offeror is required to work out the final format of these reports with the Department. The reports are due fifteen (15) Days after the end of the month. For the first two months of the Agreement resulting from this RFP, these reports will be due on a weekly basis. After two months, the Department will re-examine the required frequency of these reports and establish due dates with the Selected Offeror.

Bi-Weekly Reports

Detailed Claim File Data: The Offeror must transmit to the Department and/or its Decision Support System (DSS) Vendor a computerized file via secure transfer, containing detailed claim records in the format specified by the Department in Exhibit II.F.1 unless otherwise specified by the Department, to support the bi-weekly invoice. The Department requires that all claims processed, reversed and adjusted be included in claims data. The file must facilitate reconciliation of claim payments to amounts charged to the DCS Program and include the current status of the claim (i.e. fields identifying claims as paid, adjusted, reversed).

A rejected claim file is also required upon request by the Department. The Offeror is required to securely forward the required claims data on a claims processing cycle basis to the Department and/or its DSS vendor within fifteen (15) Days after the end of each claims processing cycle, and submit a summarized report by claims processing cycle broken down by drug type (generic/brand) utilizing the fields and the format specified by the Department in Exhibit II.F.5. Based upon the analysis of the information contained in the report any important programmatic information, trends or abnormalities should be provided in a narrative.

Reports Required at Other Frequencies

Mac Alert Notice: The Offeror is required to submit a report of the financial impact of enforcing mandatory generic substitution via a "Mac Alert Notice" utilizing the current format specified by the Department in Exhibit II.F.10. This report must be submitted in accordance with the time frames specified in Section IV.B.14.a.(4) of this RFP, under the subheading "Mandatory Generic Substitution at Retail and Mail."

B. REQUIRED SUBMISSION

(1) How will reversed, rejected, and adjusted claims be reflected in the reconciliation of the cycle claim reports to the quarterly and annual financial experience statements? Will this process be the same for claims billed within the cycle or outside of the cycle? Please describe in detail how reversed or modified claims are identified within your claims data. Please describe how your system allows the Department to identify only Final Paid Claims within your claims data. Explain how a claim reversed in a different billing cycle would be identified in your claims data.

CVS Caremark populates a "Claim Status Code" on each transaction. This field identifies a claim as either Paid, Reversed, Rejected, or Adjusted. Each claim is assigned a numeric claim and sequence number in the adjudication process. A paid and reversed claim will have the same claim and sequence number but each will be identified as either Paid or Reversed via the Claim Status Code. This allows our clients to easily tie the two transactions together. Subsequent resubmissions of the claim will have the same claim number as the original but the Sequence number incrementally decreases by one.

CVS Caremark has the ability to "wash" or drop Paid and Reversed claims that occur within the same reporting period or to report all transactions.

(2) The Offeror must submit examples of the financial and utilization reports that have been listed without a specified format in the reporting requirements above as well as any other reports that the Offeror is proposing to produce for the Department to be able to analyze and manage the DCS Program. Provide an overview of your reporting capabilities with the value you believe this will bring to the DCS Program.

[redacted]

(3) Confirm that you will provide reports in the specified format (paper and/or electronic – Microsoft Access, Excel, Word), as determined by the Department.

CVS Caremark confirms.

(4) Confirm that you will provide direct, secure access to your claims system and any online and web-based reporting tools to the Department's offices. Include a copy of the data sharing agreement you propose for Department staff to execute in order to obtain systems access.

CVS Caremark confirms. Please see Section II, Tab 11 for a sample data sharing agreement/non-disclosure agreement.

(5) Confirm that your ability and willingness to provide Ad Hoc Reports and other data analysis. Provide examples of Ad Hoc reporting that you have performed for other clients.

[redacted]

[redacted]

(6) Management Reports and Claim File Guarantees: The DCS Program's service level standard requires that accurate management reports and claims files will be delivered to the Department no later than their respective due dates. For the management reports and claim files listed in Section IV.B.8.a.(7) of this RFP, the Offeror must propose a performance guarantee. The Offeror shall propose the forfeiture of a specific dollar amount of the Claims Administration Fee for failure to meet this standard.

The Standard Credit Amount for each management report or claim file that is not received by its respective due date is $1,000 per report per each Business Day. However, Offerors may propose higher or lesser amounts.

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

[redacted]

Reporting (Exclusive to NYSIF)

Reporting must be structured to provide assurances that Claimant, network and account management service levels are being maintained and that claims are being paid and billed according to the terms of the agreements with pharmacies and the terms of the separate Agreements resulting from this RFP. The selected Offeror may on occasion be requested to provide ad-hoc reporting and analysis within very tight time frames.

In order to fulfill its obligations to enrolled members and ensure contract compliance, the NYSIF Program requires that the Offeror provide accurate claims data information on a claim processing cycle basis as well as specific summary reports concerning the NYSIF Program and its administration.
All electronic files received by NYSIF are first validated for compliance with the specified file structure. Files that fail to adhere to this structure are rejected in their entirety.

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

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

A. DUTIES AND RESPONSIBILITIES

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

(1) Generating and submitting monthly, quarterly, semi-annual and annual reports per NYSIF specification. Specifications will be provided upon contractor selection;
(2) Capturing and providing NYSIF with electronic files of eligibility and authorization on the GC3, or similar code level. The Offeror should have the capability to capture drug denials on the GCN and NDC code levels;
(3) Providing direct, secure access to the Contractor's claims system and any online and web-based reporting tools to NYSIF's offices;
(4) Providing NYSIF with an on-line decision support tool with ad-hoc query capability;
(5) Providing Ad Hoc Reports and other data analysis at no additional cost. The exact format, frequency, and due dates for such reports shall be specified by NYSIF. Information required in the Ad Hoc Reports may include but is not limited to providing:
    (a) Forecasting and trend analysis data;
    (b) Data necessary to track drug pricing;
    (c) Utilization data on the Mail Order Pharmacy and the Special Pharmacy Program;
    (d) Utilization review savings;
    (e) Benefit design modeling analysis;
    (f) Reports to meet clinical program review needs;
    (g) Reports segregating claims experience for specific populations; and
    (h) Reports to monitor Agreement compliance.
(6) The Offeror must work with NYSIF to resolve reporting issues according to the timeframes described in Section IV.B.8.a.(8) (NYSIF Reporting) of this RFP;
(7) Management Reports and Claim File Guarantees: The Offeror must propose a performance guarantee. The NYSIF's Program service level standard requires that accurate management reports and claim files as specified in Section IV.B.8.a.(8) (NYSIF Reports) of this RFP will be delivered to NYSIF no later than their respective due dates inclusive of the date of receipt;
(8) Supplying reports in paper format and/or in an electronic format (Microsoft Access, Excel, Word) as determined by NYSIF. The primary reports and data files are listed in this section of the RFP under Annual, Semi-Annual, Quarterly, Monthly, Weekly, and Daily Reports and include the time frames for submittal to NYSIF;

Annual Reports

Rebate True-up File: The Offeror is required to transmit a computerized file via secure transfer containing a yearly true-up of rebate records in a format specified by NYSIF. The true-up rebate file must match all of the billing records provided by the Offeror in the weekly pharmacy billing files. The report is due one hundred fifty (150) Days after the end of the Calendar Year. Issue resolution timeframe: within 1 week of the original submission.

Quarterly Reports

Rebate File: The Offeror is required to transmit a computerized file via secure transfer containing prescription rebate information for all earned rebates in a format specified by NYSIF. The pharmacy rebate records in the Rebate File must match all prescriptions billed to NYSIF by the Offeror. The report is due one hundred eighty (180) Days after the end of the quarter. Issue resolution timeframe: within 1 week of the original submission.

Monthly Reports

Card Issuance File: The Offeror is required to submit a computerized file via secure transfer with the names of all NYSIF Claimants who have been issued a permanent ID card that is used when filing their injury-related prescriptions. The Offeror is required to submit this report in the current format specified by NYSIF in Exhibit II.E.2d unless otherwise specified by NYSIF. The report is due no later than fifteen (15) calendar Days after the end of the month being reported. Issue resolution timeframe: within 1 week of the original submission.

Weekly Reports

Established Claim Billing File: The Offeror is required to transmit a computerized file via secure transfer containing only those pharmacy bills that are in accordance with the defined NYSIF business rules for pharmacy bill submission and contains only those pharmacy bills that have been successfully matched to an established NYSIF claim. Upon Offeror selection, NYSIF will provide a comprehensive list of edit rules and rejection codes that are based on the structure or content of a pharmacy bill record, as well as the specified file format. The report is due on the Monday following the week reported. Issue resolution timeframe: prior to the next scheduled submission;

Weekly Invoice: The Vendor Invoice submission consists of two parts:

- Hard copy of the Vendor Invoice submitted to NYSIF via USPS.
- Electronic submission of a Vendor Invoice Detail file supporting the charges on the Vendor Invoice.

The Offeror must submit the Vendor Invoice Detail file in the form an ASCII text file. The purpose of the detailed invoice file is to provide NYSIF with the information needed in order to programmatically reconcile the Vendor Invoice. The report is due on the Monday following the week reported. Issue resolution timeframe: within 1 week of the original submission;

Aging Bill Report File: The Offeror is required to submit a computerized pharmacy billing file via secure transfer with bills previously submitted in the Instant Enrollment/"Short Fill" file that remain unmatched to an established NYSIF claim. In the event there are not records meeting the above criteria, an empty file should be transmitted. The report is due each Monday. Issue resolution timeframe: prior to the next scheduled submission.

Daily Reports

Short Fill Report File: The Offeror is required to submit a computerized file via secure transfer with pharmacy bills for those injured workers of NYSIF policy holders where the bill cannot be matched to an established NYSIF claim. The report is due daily. Issue resolution timeframe: prior to the next scheduled submission.

B. REQUIRED SUBMISSION

(1) Confirm your agreement to generate and submit all daily, weekly, monthly, quarterly, semi-annual, and annual reports per NYSIF specification;

CVS Caremark confirms.

(2) Confirm you will provide NYSIF with electronic file of eligibility and authorization on the GC3, or similar code level. Indicate your capability for capturing drug denials on the GCN and NDC code levels. If unable to capture denials on the GC3 code level, provide a detailed description of your denial coding system;

CVS Caremark confirms and has the capability to capture drug denials at the GCN and NDC code levels.

(3) Confirm that you will provide reports in the specified format (paper and/or electronic – Microsoft Access, Excel, Word), as determined by NYSIF;

CVS Caremark confirms.

(4) Confirm that you will provide NYSIF with an on-line decision support tool with ad- hoc query capability;

CVS Caremark confirms.

(5) Confirm that your ability and willingness to provide Ad Hoc Reports and other data analysis. Provide examples of Ad Hoc reporting that you have performed for other clients.

CVS Caremark confirms. Please see Section II, Tab 10 for Ad Hoc reporting samples.

(6) Describe how your proposed system will accept pharmacy bills from the Offeror's network pharmacies;

When prescriptions are filled at a CVS Caremark network pharmacy, they will be identified and processed using the CVS Caremark electronic BIN number and the NYSIF assigned group number provided in the claimant information packet.

(7) Describe how your proposed system will edit these pharmacy bills in accordance with NYSIF business rules;

CVS Caremark offers an integrated solution for retail and mail order prescription adjudication processes, maintaining continuity of care and the ability to detect potential fraud when patients attempt to fill medications using both retail and mail order distribution channels. In addition, internally developed systems monitor and enforce generic substitution requirements as customized by the client. For both retail and mail, prescription claims for brand drugs are accepted only when the physician requires brand dispensing.

Prescription control occurs at the point of fill according to client-specific business rules. Business rules can be customized by:

- Plan
- Employer
- Physician
- Claim / case status
- Individual patient
- Injury
- Drug
- Dollar amount
- Quantity
- Days supply
- Refill frequency

In addition, CVS Caremark supports formulary customization and monitoring at the plan level and allows for customization at the injury level as well.

(8) Describe how the proposed system will reject, with reason, any pharmacy bills that do not adhere to NYSIF business rules;

Prescriptions are screened for approval at the point of fill, using table-driven, client approved edits; patient restrictions and physician restrictions; and drug dosage, quantity, and duration restrictions. This process results in an electronic notification to the pharmacy of a potentially inappropriate medication.

(9) Describe the method for notification of your network pharmacy in the event of rejection;

CVS Caremark will provide immediate electronic feedback to network pharmacy providers when medications are reject against client business rules or formulary rules. When formulary restrictions are in place at the plan level, as well as profile restrictions at the patient level, any medication not listed in the patient's profile, or stopped due to a drug coverage rule, requires pre-authorization before the system will authorize.

(10) Describe how the pharmacy bills submitted will validate against the claim eligibility information provided by NYSIF;

Claim eligibility provided by the client is validated by matching the Cardholder ID and Date of Injury, received from the pharmacy as part of the NCPDP version D.0 data standard for pharmacy claims submission, against a system database of claimant injuries created from client eligibility files. When a match is found and the claim status is verified to be 'Active,' the claim is considered as eligible.

(11) Identify the format of your pharmacy billing file, i.e. national standard, proprietary, etc;

An electronic billing file utilizing the ANSI 837 National Standard will be provided.

(12) Describe the encryption and secure transmission protocol for the pharmacy billing files;

Electronic bills will be provided utilizing a secure FTP transfer option, and/or public/private key encryption (PGP) technologies.

(13) Describe how the system will be monitored for performance;

We support an enhanced monitoring and management capability associated with the pharmacy network, client network, claims processing, and back-end systems. This includes telecommunications interfaces, as well as systems and application-level management and reporting (ad hoc and scheduled). The pharmacy network – which includes pharmacy chains, value-added network providers, and independent pharmacies – is monitored proactively and managed by internally developed software.

(14) Describe how NYSIF will be notified in the event of a system and/or transmission failure;

In the event of a system or transmission failure, the CVS Caremark Account Management Team will contact key personnel as specified by NYSIF having responsibilities related to program network management.

(15) Describe how it will be determined into which file Established Claim or Instant Enrollment/"Short Fill," the pharmacy bill will be placed;

An injury not found in the system Injury Database when matched by Cardholder ID and Date of Injury will be processed against NYSIF's 'Instant Enrollment' matrix. If the injury meets the client-specific criteria for instant enrollment, it is then edited against client specific 'New Injury' edits. If successful, it is added to the Injury Database.

Once added, the claim will be set as 'Pended' (Pending will limit future fills without preauthorization until compensability is established) per the client's requirements. In either situation a 'First Report of Injury' (FROI) electronic notification will be delivered to NYSIF, and a link will be provided to allow the adjustor and/or nurse case manager to review the new claim and to customize the future treatment protocol as needed.

Injuries that do not meet the employer's eligibility requirements and the new injury 'auto-add' criteria will generate a message directing the pharmacy to contact CVS Caremark for verification and preauthorization.

(16) Describe the process for tracking Aging Bills and how it will be determined whether or not a bill is to be placed in the Aging Bill files;

We have payment terms that require payment 30 days or less after the invoice date. Claims that have not been paid within this time frame are considered past due and placed in the Aged Bill File to be worked for collection.

(17)Describe how card issuance information is tracked in your system;

Upon receipt of a client's eligibility file, CVS Caremark will verify the claimant's address for accuracy using QAS software and the eligibility file is loaded into the claims processing system. All new claimant's with an 'Active" claim status are flagged for card production. Each business day program identification cards are processed and mailed. The claimant record is updated with the date that the card was processed. Any manual card reprint request is processed and mailed the next business day after the request is received.

(18)Describe your encryption and secure transmission protocol for your electronic files;

EDI exchanges for electronic invoicing, payment remittance advice, and eligibility registration are transferred utilizing secured FTP transfer options, and/or public/private key encryption (PGP) technologies.

(19)Confirm your agreement to create specified electronic files in the form of an ASCII text file;

CVS Caremark confirms.

(20) Describe how rebate information is tracked in your system; and

(21) Describe the process that determines when a rebate is included in the quarterly rebate and annual true-up files.

CVS Caremark has an aggressive collection and reconciliation process related to rebate payments. All payments are fully reconciled to the original invoiced amount, and any differences are documented and escalated appropriately to ensure that payment is made on all valid claims submitted to the drug manufacturers.

CVS Caremark will determine the rebates due to the Programs by matching the payment information detailed in the manufacturer reconciliation data against the invoiced claims. The CVS Caremark proprietary reconciliation system then applies the rebate payment to the individual claims. The aggregate dollar amount is determined and monies distributed per the terms of the client contract.

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

The Standard Credit Amount for each management report or claim file that is not received by its respective due date is $75 per report per each Business Day. However, Offerors may propose higher or lesser amounts.

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

[redacted]

9. CONSULTING

The Procuring Agencies require the selected Offeror to be an expert in the Prescription drug industry. Thus, the Procuring Agencies may request the advice and recommendations of the selected Offeror to provide the Procuring Agencies with up-to-date developments in the prescription drug field. The Procuring Agencies expect the selected Offeror to proactively provide advice and recommendations that are related to the clinical quality and cost management of the Programs. Such recommendations must include preliminary analysis of financial, therapeutic and Enrollee impact of proposed and contemplated benefit design changes.

A. DUTIES AND RESPONSIBILITIES

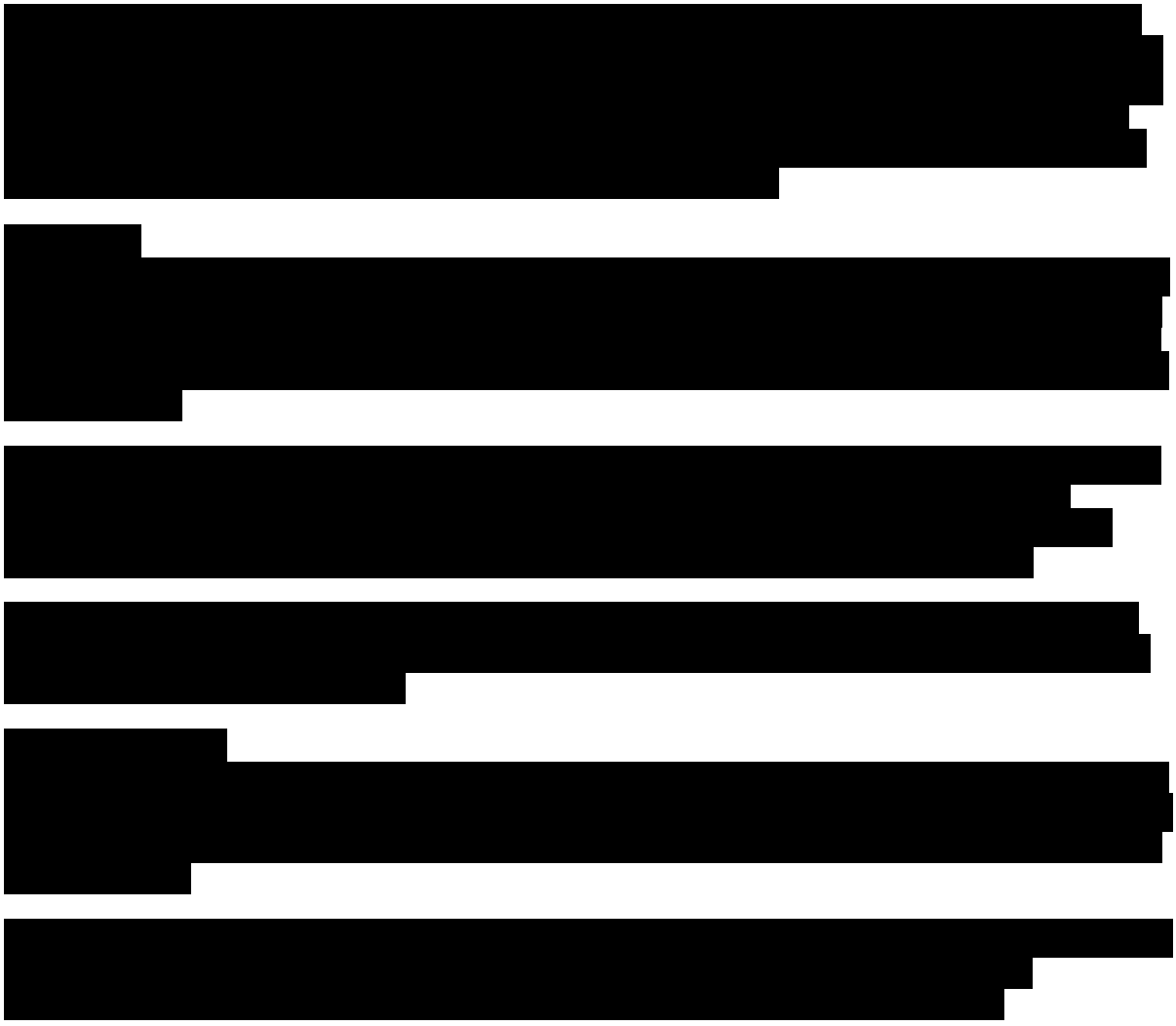
The selected Offeror will be responsible for providing advice and recommendations regarding the Programs. Such responsibility shall include, but not be limited to:

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

(2) Assisting the Procuring Agencies with recommendations and evaluation of proposed benefit design changes and implementing any changes necessary to accommodate Program modifications resulting from collective bargaining, legislation, or within the statutory discretion of the State. Recommendations must include a preliminary analysis of all associated costs, a clinical evaluation, and the anticipated impact of proposed Program modifications and contemplated benefit design changes on Enrollees. In the event of a design change and the Offeror requests any change in compensation such change will be in accordance with Section V.C.12.a. of this RFP.

B. REQUIRED SUBMISSION

(1) What resources will you utilize to ensure the Programs are kept abreast of the latest developments in the Prescription drug field? How do you propose to communicate trends, pending legislation and industry information to the Programs?



10. TRANSITION AND TERMINATION OF AGREEMENTS

The Offeror shall ensure that upon termination of the separate Agreements, any transition to another organization be done in a way that provides Enrollees with uninterrupted access to their Prescription drug benefits and associated customer services through the final termination of the respective Agreements resulting from this RFP. This includes, but is not limited to: ensuring Enrollees/Claimants can continue to fill their Prescriptions through network pharmacies, the Mail Service Pharmacy Process and the Specialty Pharmacy Program; the processing of all non-network claims; verification of enrollment; and, providing sufficient staffing to ensure Enrollees continue to receive good customer service even after the termination date of the Agreements resulting from this RFP. It is also imperative that the Programs continue to have

dialogue with key personnel of the Offeror, maintain access to online systems and receive data/reports and other information regarding the Programs after the effective end date of the Agreements.
In addition, the Offeror and the selected successor shall fully cooperate with the Department and NYSIF to create and establish separate transition plans in a timely manner for each Program.

A. DUTIES AND RESPONSIBILITIES

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

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

(a) Transition of Program data, including but not limited to a minimum of one year of historical Enrollee claim data, detailed COB data, report formats, Mail Service Pharmacy, Specialty Pharmacy and retail scripts with available refills, prior authorization approved through dates, generic appeal approved through dates and exceptions that have been entered into the adjudication system on behalf of the Enrollee, as well as other data the successor contractor may request and the Procuring Agencies approve during implementation of the Programs in the format acceptable to the Procuring Agencies. The transition of open refill prior authorization and generic appeal files should include but not be limited to the following:
  (i) Providing a test file to the successor contractor in advance of the implementation date to allow the new contractor to address any potential formatting issues;
  (ii) Providing one or more pre-production files at least four 4 weeks prior to implementation that contains Enrollee Prescription refill availability, one year of claims history and prior authorization and appeal approved-through dates as specified by the Procuring Agencies working in conjunction with the successor contractor;
  (iii) Providing a second production file to the new Contractor by the close of business January 2nd (or 2 days after the Agreements resulting from this RFP terminate) that contains all Enrollee Prescription refill availability as specified by the Procuring Agencies, working in conjunction with the selected successor contractor; and
  (iv) Providing a lag file due seven (7) Days after the implementation date to capture any refills that may have been in process but not yet shipped at the Offeror's Mail Service and Designated Specialty Pharmacy(ies) after the end of the year.

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

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

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

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

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

(a) Provide all Contractor-provided services associated with claims incurred, as applicable to the respective Programs, on or before the scheduled termination date of the Agreements resulting from this RFP, including but not limited to paying network claims, Mail Service Pharmacy claims, Specialty Pharmacy claims, manual submit claims including but not limited to: Medicaid, VA , Skilled Nursing Facility claims, out-of-network claims, foreign claims, in-network claims, COB claims, Student Health Center Claims, and Medicare, reimbursing late filed claims if warranted, reimbursing customer credit balance accounts, resolution of Mail Service Pharmacy process and Specialty Pharmacy Process issues, repaying or recovering monies on behalf of the Program for Medicare claims, retaining NYBEAS access, continuing to provide updates on pending litigation and settlements and claims/rebate data for class action litigation that the Contractor or the NYS Attorney General's Office has/may file on behalf of the Programs. In addition, the Offeror must continue to provide the Procuring Agencies access to any online claims processing data and history and online reporting systems through the final settlement dates, unless the Procuring Agencies notify the Offeror that access may be ended at an earlier date;
(b) Complete all required reports in the reporting Section IV.B.8. of this RFP;
(c) Provide the Programs with sufficient staffing in order to address State audit requests and reports in a timely manner;
(d) Agree to fully cooperate with all the Department, NYSIF or Office of the NYS Comptroller (OSC) audits consistent with the requirements of Article XIX of the resulting Agreements and Appendices A and B;
(e) Perform timely reviews and responses to audit findings submitted by the Department, NYSIF and the Comptroller's audit unit in accordance with the requirements set forth in Article XIX "Audit Authority," Section VII, Contract Provisions;
(f) Remit reimbursement due the Program within fifteen (15) days upon final audit determination consistent with the process specified in Article XIX "Audit Authority" and Article XV "Payments/(credits) to/from the contractor" of Section VII, Contract Provisions and Appendix B; and
(g) (Exclusive to DCS) Assist the Department in all activities necessary to ensure the correct and adequate interface between NYSHIP and the Centers for Medicare and Medicaid Services (CMS) with respect to the administration of the EGWP in accordance with Subpart R of 42CFR423 and the Medicare Prescription Drug Improvement and Modernization Act (P.L. 108-173). Such assistance includes, but is not limited to the provision of accurate data within the Offeror's control.

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

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

(9) If the selected Offeror does not meet all of the Transition Plan requirements in the time frame stated above, the selected Offeror will permanently forfeit 100% of all Claims Administration Fees (prorated on a daily basis) from the due date of the Transition Plan requirement(s) to the date the Transition Plan requirement(s) are completed to the satisfaction of the Procuring Agencies.

B. REQUIRED SUBMISSION

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

CVS Caremark maintains NCPDP standard processes for inbound and outbound transitions. We maintain a Vendor Transition analyst for outgoing transitions, to maintain the integrity of our clients' programs and support the incoming vendor by providing necessary information (e.g. files and data) required for a seamless transition.

CVS Caremark will conduct similar activities to support the incoming vendor such as transferring open refills, prior authorization statuses, member claim histories, etc.

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

CVS Caremark will provide the level of customer care and support for the amount of time that we process run-out claims, as agreed upon in the contract. We are committed to fulfilling our obligation to the Programs, and that includes such services as phone-based member services and claim inquiries.

11. NETWORK MANAGEMENT

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

Retail Pharmacy Network

The current Programs include a nationwide Retail Pharmacy Network through which Enrollees can obtain all Covered Drugs including any and all drugs that could be classified as Specialty Drugs/Medications as required by Section IV.B.11. of this RFP, under the subheading "Specialty Drugs/Medications." The Offeror must propose a Retail Pharmacy Network that meets or exceeds the Programs' minimum access guarantees at the time of proposal submission that is credentialed and contracted for participation in the Programs' Retail Pharmacy Network commencing on January 1, 2014. The Offeror may choose to enter into Program-specific Pharmacy contracts that are contingent on award and/or utilize existing Pharmacy agreements that can be made applicable to the Programs to meet the Programs' requirement that the Offeror have executed contracts with all the Network Pharmacies included in the Offeror's Proposed Retail Pharmacy Network File upon the submission date of their Proposal.

(Note: Because the Procuring Agencies provide significant purchaser volume, the Department and NYSIF expect each Offeror will present a Proposal with network contracts at reimbursement rates more favorable than the Offeror's standard pharmacy contracts.)

All Brand Drug Retail Pharmacy Network claims shall be charged to the Programs at Pass- through Pricing subject to the Offeror's proposed overall Guaranteed Minimum Discount off of AWP for all Brand Drugs dispensed, as set forth in Exhibit V.A, plus the applicable brand dispensing fee. All Generic Drug Retail Pharmacy Network claims shall be charged to the Program at Pass-through Pricing subject to the Offeror's proposed overall Guaranteed Minimum Discount off of AWP for all Generic Drugs dispensed, as set forth in Exhibit V.A plus the applicable generic dispensing fee. Retail and Mail Service Pharmacy Process claims meeting the Programs' definition of Compound Drugs shall be charged to the Programs utilizing Pass-through Pricing in accordance with the Offeror's proposed (and Procuring Agencies' approved) methodology plus the applicable compound dispensing fee. Do not include any cost information in the technical proposal.

A. DUTIES AND RESPONSIBILITIES

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

(2) The Programs require that the Offeror have available to Enrollees on January 1, 2014 its proposed Retail Pharmacy Network in accordance with the requirements set forth in Section IV.B.3.a.(2)(a) guaranteeing effective implementation of their proposed Retail Pharmacy Network.

(3) The Offeror is required to include Independent Pharmacies in its Proposed Retail Pharmacy Network. In developing its proposed Retail Pharmacy Network, the Offeror is expected to use its best efforts to substantially maintain the composition of independent Network Pharmacies included in the Programs' current Retail PharmacyNetwork provided such Pharmacies meet the requirements of Pharmacy Credentialing and Pharmacy Contracting of this RFP, and are willing to accept the proposed aggressive reimbursement rates.

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

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

(6) Prior to January 1, 2014, the selected Offeror must ensure that their Network Pharmacies have the correct claim identification information (i.e. RX BIN #, RXPCN, RXGRP, effective date, phone number for questions, etc.) to facilitate accurate claims submission and uninterrupted access for Enrollees.

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

(8) Network Pharmacy Access Guarantee: The selected Offeror must propose a Retail Pharmacy Network that throughout the term of the Agreements resulting from this RFP meets or exceeds the Procuring Agencies' minimum access guarantees as follows:
   (a) Ninety percent (90%) of Enrollees in urban areas will have at least one (1) Network Pharmacy within two (2) miles;
   (b) Ninety percent (90%) of Enrollees in suburban areas will have at least one (1) Network Pharmacy within five (5) miles; and
   (c) Seventy percent (70%) of Enrollees in rural areas will have at least one (1) Network Pharmacy within fifteen (15) miles.

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

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

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

B. REQUIRED SUBMISSION

(1) Propose access guarantees for the Programs' Retail Pharmacy Network that meet or exceed the minimums set forth above. The access guarantee must be provided in terms of actual distance from Enrollees' residences and must meet or exceed the minimum access guarantees stipulated above.

(2) Complete Exhibit I.Y.1 to indicate whether certain chain pharmacies will or will not participate your Retail Pharmacy Network on January 1, 2014. The completion of Exhibit I.Y.1 must be consistent with the contents of the Offeror's Proposed Retail Pharmacy Network File, Exhibit I.Y.3.

   Please see Administrative Proposal, Section C, Tab 22 for the completed Exhibit I.Y.1.

(3) Please compare the current DCS Program network pharmacies that have submitted claims in 2010/2011 with your Proposed Retail Pharmacy Network File. Identify whether each of the Program's current network pharmacies will or will not participate in the Offeror's proposed Retail Pharmacy Network in accordance with the instructions provided in Exhibit I.Y.5, entitled "Comparison of Current Program Network Pharmacies and the Offeror's Proposed Retail Pharmacy Network."

The file containing the DCS Program's current network pharmacies and instructions for completing the exhibit can be obtained by following the instructions included in Exhibit I.Y.5 and meeting the requirements specified in Section III.B.5. of this RFP.

Please see Administrative Proposal, Section C, Tab 26 for the completed Exhibit I.Y.5.

(4) Please confirm that if selected, you will provide an updated Exhibits I.Y.1, I.Y.3, I.Y.4 and I.Y.5 on December 1, 2013 confirming that the Offeror's proposed Retail Pharmacy Network will be implemented as required on January 1, 2014. If necessary, the selected Offeror shall submit a second file affirmatively identifying any deviations from the proposed Retail Pharmacy Network along with a detailed explanation for all deviations.

CVS Caremark confirms.

(5) Describe the approach(es) you would use to solicit additional pharmacies to enhance your proposed Retail Pharmacy Network or to fulfill a request to add an individual independent Pharmacy.

CVS Caremark monitors our network coverage and demographic data on a continuing basis to identify areas in which additional pharmacies are needed. In areas identified as having inadequate pharmacy access levels, we recruit additional pharmacies for participation in a particular network by phone, fax, or direct mail solicitation. In addition, the Programs and your members can request that nonparticipating pharmacies be solicited to join a network.

Solicitation Process

Initially a solicitation packet, containing a contract and a full description of network requirements, is mailed or faxed to targeted independent pharmacies. We contact chain pharmacy executives who operate stores in desired locations by phone, and then either mail or fax a contract with a full description of network requirements for their consideration. Our network enrollment staff will also follow up with solicited pharmacies by phone to discuss unresolved issues and answer questions.

When the pharmacy returns the signed agreement (typically within 3 to 10 business days), it is entered into CVS Caremark's system. Once we have the signed agreement in-house, the pharmacy effectively becomes part of the network within 24 to 48 hours.

All pharmacies must comply with our criteria for network membership. We work with clients and pharmacy providers to ensure that all of our networks comply with any willing provider and freedom of choice legislation in each state, and we monitor changes in legislation to ensure that our recruitment activities stand in full accord with the most current requirements in the respective states.

(6) Please identify Limited Distribution Drugs and indicate the authorized distributors that will participate in the Retail Pharmacy Network proposed for the Programs. If you are unable to secure the participation of the authorized distributors in your Retail Pharmacy Network, describe the process you will utilize to provide Enrollees with access to these drugs placing no additional steps or burdens on the Enrollee.

[redacted]

(7) Network Pharmacy Access Guarantees: You must guarantee that throughout the term of the Agreements resulting from this RFP, Enrollees living in urban, suburban and rural areas will have access, as proposed by the Offeror, to a Network Pharmacy.

The Offeror must propose an access guarantee that meets or exceeds the minimum access guarantees set forth in the "Retail Pharmacy Network" Section of this RFP. The Offeror shall propose, separately for each Program, the forfeiture of a specific dollar amount of the Claims Administration Fee for failure to meet these guarantees.

The Standard Credit Amount for each .01 to 1.0% below the ninety percent (90%) minimum access guarantee, for any quarter, in which the Network Pharmacy Access for Urban Areas is not met by the Offeror, is $100,000 per each quarter for DCS and $7,500 for NYSIF. However, Offerors may propose higher or lesser amounts.

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

[redacted]

[redacted]

The Standard Credit Amount for each .01 to 1.0% below the ninety percent (90%) minimum access guarantee for any quarter in which the Network Pharmacy Access for Suburban Areas is not met by the Offeror, is $100,000 per each quarter for DCS and $7,500 for NYSIF. However, Offerors may propose higher or lesser amounts.

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

[redacted]

[redacted]

The standard credit amount for each .01 to 1.0% below the seventy percent (70%) minimum access guarantee for any quarter in which the Network Pharmacy Access for Rural Areas is not met by the Offeror, is $100,000 per each quarter for DCS and $7,500 for NYSIF. However, Offerors may propose higher or lesser amounts.

The Offeror's quoted amount to be credited against the Claims Administration Fee is $ _for DCS and $ ___for NYSIF for each .01 to 1.0% below the seventy percent (70%) minimum access guarantee (or the Offeror's proposed guarantee) for any quarter in which the Network Pharmacy Access-for Rural Areas Guarantee, is not met by the Offeror.

[redacted]

[redacted]

Measurement of compliance with each access guarantee will be based on a "snapshot" of the Retail Pharmacy Network taken on the last day of each quarter within the current plan year. The results must be provided in the format contained in Exhibit I.Y.4. The report is due thirty (30) Days after the end of the quarter.

Pharmacy Credentialing

Offerors must ensure that their Network Pharmacies meet the licensing standards required by the state in which they operate. Network pharmacies are also required to meet the credentialing criteria established by the Offeror. This criteria should be designed to ensure quality pharmaceutical care.

A. DUTIES AND RESPONSIBILITIES

(1) The selected Offeror must ensure its Retail Pharmacy Network is credentialed in accordance with all applicable federal and state laws, rules and regulations.

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

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

B. REQUIRED SUBMISSION

(1) Describe the Offeror's process to ensure that network pharmacies meet the applicable state licensing requirements and are in compliance with all other federal and state laws, rules and regulations. What is the resource, data base, or other information used by your organization to verify this information?

CVS Caremark requires that all participating retail pharmacies agree, in writing, to meet all state and federal licensing requirements. Prior to enrollment, the pharmacy must provide evidence of an active state license and DEA number.

On a monthly basis, CVS Caremark reviews and investigates information from the Office of the Inspector General (OIG) and General Service Administration (GSA) related to sanctioned entities. If we learn from this review about a CVS Caremark network pharmacy that is not in good standing with the OIG, we terminate that pharmacy's membership in all CVS Caremark networks. In addition, we frequently contact state board of pharmacy Web sites and personnel to verify pharmacy status when it appears that a given pharmacy may be under review by a regulatory body.

(2) Describe your approach for credentialing Network Pharmacies.

Each pharmacy applicant requesting membership in CVS Caremark's network must have specific credentials and must meet specific contractual standards, including, but not limited to:

- Active membership in the National Council for Prescription Drug Programs (NCPDP) and compliance with HIPAA regulations (e.g. NPI Number, etc.).
- Appropriate state licensure
- An active Drug Enforcement Agency (DEA) number
- Evidence that all prescriptions are dispensed as dictated by applicable state laws

The ability to meet all of the contractual and professional obligations for participation in a network, including:

- Mandatory requirements for electronic transmission of claims
- Submission of U&C charges

- Submission of accurate claims data
- Evaluation of concurrent drug utilization review alerts, along with other online claims processing messaging
- Compliance with contract and MAC pricing
- Valid tax ID number
- Proof of insurance and compliance with malpractice liability requirements
- Submission of the pharmacy's customary service levels (e.g., delivery services, language accommodations, emergency hours).

To contract with CVS Caremark, an independent retail pharmacy must complete all pages of the Membership Enrollment Form and comply with all data and licensing requirements. The Membership Enrollment Form includes the pharmacy's demographic and ownership information. In addition, the following documentation must be returned by the pharmacy:

- A signed provider contract
- A completed Provider Service Levels form
- A copy of the pharmacy's DEA Certificate
- A copy of the State Provider License
- A copy of the Liability Insurance Policy.

To enroll a new chain store, CVS Caremark must receive a request from the chain headquarters. We do not require hard copies of DEA, insurance policy, and state license certificates for members of a chain pharmacy upon enrollment. The chain headquarters is responsible for ensuring that each store has this information.

(a) Specify if you utilize an external credentialing verification organization. When was the credentialing verification process last completed? What is your process for confirming continuing compliance with credentialing standards? How often do you conduct a complete review?

Currently, all credentialing and re-credentialing is performed in-house. Periodically, we conduct follow-up activities with contracted network pharmacies to verify the accuracy of the data on the master pharmacy database. In addition, we conduct a biennial survey requesting that each targeted pharmacy verify the data CVS Caremark has on file for that pharmacy. Data on the returned survey are entered into a database and compared to the current data on file. Once the comparison has been completed, changes are loaded to the master pharmacy database. The last biennial survey was completed in September 2011.

(b) What steps do you take between credentialing periods to ensure that Network Pharmacies that are officially sanctioned, disciplined, or had their licenses revoked are removed from the Retail Pharmacy Network as soon as possible? What steps, if any, do you take to advise members when a Pharmacy has been removed from the Retail Pharmacy Network?

On a monthly basis, we review information from the Office of the Inspector General (OIG) and the General Service Administration (GSA) related to sanctioned entities. If we learn from this review about a CVS Caremark network pharmacy that is not in good standing with the OIG, we terminate that pharmacy's membership in all CVS Caremark networks. In addition, we frequently contact state board of pharmacy Web sites and personnel to verify pharmacy status when it appears that a given pharmacy may be under review by a regulatory body. Members can receive updated information on pharmacy availability by calling CVS Caremark Customer Care, or by logging on to Caremark.com. Information regarding new pharmacies in our networks is updated to the CVS Caremark pharmacy locator on a weekly basis, enabling members to receive up-to-date information regarding newly opened pharmacies in their area.

Upon request to the Account team, we will produce a current network directory via email, in Excel format.

Pharmacy Contracting

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

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

A. DUTIES AND RESPONSIBILITIES

The Offeror will be responsible for providing Pharmacy contracting services including but not limited to:
(1) Ensuring that all Network Pharmacies contractually agree to and comply with all of the Programs' requirements and benefit design specifications;
(2) (Exclusive to DCS) Ensuring all Network Pharmacy contracts include a provision prohibiting the use of pharmacy manufacturer coupons that reduce or waive Enrollee Copayments;
(3)(Exclusive to DCS) Recruiting licensed Pharmacies affiliated with home care agencies that are participating providers under The Empire Plan's Home Care Advocacy Program administered by The Empire Plan's medical carrier. These licensed pharmacies are provided in Exhibit II.E.3 of this RFP;
(4) Ensuring that Network Pharmacies accept as payment-in-full the Offeror's reimbursement for all claims processed based on the Program's Lesser of Logic detailed in Section VII of the RFP, Article 12.6.0.
(5) Notifying the Department and NYSIF in writing of any plan to renegotiate the financial terms of any Network Pharmacy contract utilized by the Programs for any Pharmacy that is located in the State of New York, or for any such Pharmacy located outside the NYS that accounts for more than 0.25% of total Program final paid claim Ingredient Costs;
(6) Notifying the Procuring Agencies in writing within one (1) Business day of any changes to contracts with Retail Pharmacy Network chain Pharmacies or independent Pharmacies negotiating collectively with the Offeror, including but not limited to, those identified as participating in the Offeror's proposed network;
(7) (Exclusive to DCS) Upon the request of the Department, resoliciting the entire Pharmacy Network to obtain more aggressive reimbursement rates that would pass- through to the Program in exchange for a smaller, select network that meets proposed access guarantees, as modified;
(8) Committing to administering Pharmacy contracts consistent with all representations made in the Offeror's cost proposal, including all representations regarding the administration of generic pricing and maintenance of MAC list(s); and
(9) (Exclusive to NYSIF) Ensuring there are mechanisms in place to circumvent the referral of bills by participating pharmacies to third party billers for collection.

B. REQUIRED SUBMISSION

(1) Confirm that your agreements with Network Pharmacies require their compliance with all the Programs' requirements and benefit design specifications. Provide a copy of the Offeror's proposed Pharmacy contract, rate sheet, and provider manual.

CVS Caremark confirms. Please see Section II, Tab 12 for our sample contract for the Programs.

(2) Exclusive to DCS) Confirm that licensed Pharmacies affiliated with home care agencies that are participating providers under The Empire Plan's Home Care Advocacy Program are, or will be, recruited into your Retail Pharmacy and Specialty Pharmacy network, if applicable.

CVS Caremark confirms.

(3) Please confirm that your Network Pharmacy contracts require the Pharmacy to apply the Program's Lesser of Logic to all the Programs' claims.

CVS Caremark confirms.

(4) Please confirm that you will notify the Procuring Agencies in writing of any changes to the Network Pharmacy contracts or any plans to renegotiate the financial terms of the contracts utilized by the Programs for any New York State Pharmacy or significant out-of-state Pharmacy.

CVS Caremark confirms in accordance with paragraphs 5 and 6 in the duties and responsibilities section above.

(5) (Exclusive to NYSIF) Describe in detail the mechanisms you will put in place to circumvent the referral of bills by participating pharmacies to third party billers for collection.

[redacted]

Pharmacy Audit

The protection of the Programs' assets must be a top priority of the selected Offeror. The selected Offeror must have a strong audit presence throughout its organization. The Offeror is responsible for the oversight and audit of pharmacies that dispense drugs for Enrollees. Staff should be well-trained and experienced. Claims systems should have logic programmed which help to focus audit resources.

A. DUTIES AND RESPONSIBILITIES

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

(1) Providing ample audit resources including access to the Offeror's on-line claims processing system to the Department, NYSIF and OSC at their respective offices through the date of the final financial settlement of the Agreement resulting from this RFP;

(2) Providing the Procuring Agencies with access and monthly updates to the Prescription Drug industry pricing source material (e.g. Red Book, Medispan, other) that the Offeror will be utilizing for the Programs;

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

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

(5) The capability and contractual right to effectively audit the Programs' Retail Pharmacy Network, including the use of statistical sampling audit techniques and the extrapolation of errors;

(6) Agreement to fully cooperate with all Department, NYSIF and/or OSC audits consistent with the requirements of Appendices A and B as set forth in Section VII, Contract Provisions including provision of access to protected health information and all other confidential information when required for audit purposes as determined by the Department and/or OSC as appropriate. The Offeror must respond to all State (including OSC) audit requests for information and/or clarification within fifteen (15) Business Days. The Offeror must perform timely reviews and respond in a time period specified by the Department or NYSIF to preliminary findings submitted by the Department, NYSIF or the Comptroller's audit unit in accordance with the requirements of Article XIX "Audit Authority" in Section VII, Contract Provisions. Such audits may include, but are not limited to: mail order claims; Enrollee-submitted paper claims; and on-line Pharmacy claims. Use of statistical sampling of claims and extrapolation of findings resulting from such samples shall be acceptable techniques for identifying claims errors. The selected Offeror shall facilitate audits of network pharmacies, including on-site audits, as requested by the Department, NYSIF and/or OSC;

(7) Remitting 100% of pharmacy audit recoveries to DCS and/or NYSIF as applicable within thirty (30) Days upon final audit determination consistent with the process specified in Section V, "Payments/ (credits) to/from the Contractor" and Appendix B of Section VII, Contract Provisions;

(8) Utilizing the auditing tools and performance measures proposed by the Offeror to identify fraud and abuse by Network Pharmacies and/or Enrollees; and,

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

B. REQUIRED SUBMISSION

(1) Confirm that ample audit resources will be made available to Department, NYSIF and OSC staff to conduct audits, including access to the Offeror's on-line claims processing system.

[redacted]

(2) Confirm that current Prescription Drug industry pricing source material (e.g. Red Book, Medispan, other) will be made available for the duration of the Agreement resulting from this RFP by the Offeror for access up to 3 (three) Department Staff.

CVS Caremark confirms.

(3) Describe the Pharmacy audit program you would conduct for the Programs including a description of the criteria you use to select pharmacies for audit and a description of the policy that you follow when a Pharmacy audit detects possible fraudulent activity by the Pharmacy or an enrollee. Include all types of audits performed and offered by your organization.

[redacted]

[redacted]

[redacted]

(4) Describe the corrective action, monitoring and recovery efforts that take place when you find that a Pharmacy is billing incorrectly or otherwise acting against the interests of your clients. Please indicate whether you have a fraud and abuse unit within your organization and its role in the Pharmacy audit program. In the extreme case of potentially illegal activity, what procedures do you have in place to address illegal or criminal activities by the Pharmacy?

[redacted]

[redacted]

(5) Provide a copy of the audit language that is contained in your standard contract(s) for Network Pharmacies.

[redacted]

(6) Confirm that the Offeror will fully cooperate with all Department, NYSIF and/or Office of the NYS Comptroller (OSC) audits, as described in RFP Section IV.B.11.a.(6) and (7) of this RFP, under the subheading "Pharmacy Audit."

CVS Caremark confirms.

(7) Confirm that the Offeror will remit 100% of pharmacy audit recoveries to DCS and/or NYSIF as applicable within thirty (30) Days upon final audit determination consistent with the process specified in Section V, "Payments/ (credits) to/from the Contractor" and Appendix B of Section VII.

CVS Caremark confirms and will return 100% of any recoveries to Client once those funds are recovered.

(8) Describe the Offeror's proposed auditing tools and performance measures for identifying fraud and abuse by Network Pharmacies and/or Enrollees.

(9) Confirm that you will permit the Department, NYSIF, or a designated third party to audit pharmacy bills and drug company revenues.

CVS Caremark confirms. the Programs, or its independent designated third party, may conduct an annual claims audit to ensure accuracy by CVS Caremark in processing claims, compliance with financial obligations, performance guarantees, business operations, and other contractual obligations.

CVS Caremark can provide a reporting of a reasonable sample of the Programs' claims demonstrating that the amount billed to the Programs is the same amount that is paid to the pharmacy. In addition, CVS Caremark can provide a pharmacy remittance advice to be compared to the client invoice for purposes of demonstrating a transparent retail network.

The Department, NYSIF (including the State Comptroller or Attorney General on their behalf), or an independent designated third party who executes a Non-Disclosure Agreement may conduct an annual audit of the formulary rebate program, including accounting for rebates earned and allocation of rebate payments to the Programs.

Please note, any independent designated third-party would need to execute a confidentiality agreement reasonably acceptable to the Department or NYSIF, and CVS Caremark.

Mail Service Pharmacy Process

The current Programs include a Mail Service Pharmacy Process by which Enrollees can obtain all Covered Drugs through the mail including any and all drugs that could be classified as Specialty Drugs/Medications or require special preparation or handling for enrollees who do not have the Specialty Pharmacy Program benefit. To fulfill this requirement, the Offeror may use compounding or specialty pharmacies provided that they meet all Mail Service pricing provisions and service standards with no additional steps or burdens placed on the Enrollee. Enrollees are entitled to fill Prescriptions for up to a ninety (90) day supply with refills up to one year. The Mail Service Copay (DCS only) shall apply when the Enrollee utilizes the Mail Service Pharmacy Process to obtain medications. Exhibit II.K of this RFP presents the mail service Prescription volume from October 1, 2010 through October 28, 2011.

A. DUTIES AND RESPONSIBILITIES

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

(1) Having a fully staffed and fully operational Mail Service Pharmacy Process throughout the term of the resultant Agreements, utilizing one or more Mail Service Pharmacy Process Facilities meeting all New York State legal requirements. The Mail Service Pharmacy Process must be capable of dispensing all covered, FDA approved medications including any drug that could be classified as Specialty Drugs/Medications or requires special preparation or handling for up to a 90-day supply. Offerors must establish a process to provide Enrollees with access to Limited Distribution Drugs placing no additional steps or burdens on the Enrollee. Prescriptions are considered to be "submitted through the Mail Service Process" if they are submitted by phone, fax, internet, e-prescribing or mail to any Mail Service Pharmacy Process Facility, regardless of how the Prescription is filled. All covered Prescriptions, except for Limited Distribution Drugs, submitted through the Mail Service Pharmacy Process or through a Mail Service Pharmacy Process Facility shall be charged to the Program based on the Offeror's mail service pricing terms and dispensing fees (if any) applicable to Brand Name, Generic, and Compound Drug claims as set forth in Exhibit V.A, including Specialty Drugs/Medications for certain enrollees. Limited Distribution Drugs submitted through the Mail Service Pharmacy Process shall be charged to the Program based on the Offeror's Retail Network pricing terms and dispensing fees (if any) applicable to Brand Name, Generic and Compound Drug claims as set forth in Exhibit V.A. The Mail Service Pharmacy Process shall apply the same Programs' benefit design features as the Network Pharmacies, including but not limited to Mandatory Generic Substitution, DUR, Prior Authorization, Flexible Formulary and Preferred Drug List, and application of appropriate Copayments;

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

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

(4) Providing a simple, user friendly method(s) of ordering, reordering, or transferring Prescriptions from retail to mail. Maintaining a Dedicated Call Center located in the United States employing a staff of Pharmacists, and a staff of fully trained customer service representatives, and supervisors available 24 hours a day 365 Days a year that must meet the Offeror's proposed Mail Service Pharmacy Process guarantees set forth in Section IV.B.11.b.(19) and (20) of this RFP, under the subheading "Mail Service Pharmacy Process."
   (a) The Offeror must have an integrated system for customer service staff to utilize to respond to, log and track all Enrollee inquiries. The system must create a record of the Enrollee contacting the call center, the call type and all customer service actions and resolutions.
   (b) Customer service representatives must be trained and capable of responding to a wide range of questions, complaints, and inquiries including but not limited to: Programs' benefit levels, refills, order status, prices and billing, point of service issues, prior authorization, eligibility, generic appeals, Mail Service Pharmacy Process, Specialty Pharmacy Process services and complaints, and Flexible Formulary and Preferred Drug List alternatives. Callers must be able to reorder and check order status through both the customized website (DCS only) and the consolidated telephone line. Enrollees must also have access to their Prescription drug history file (both retail and mail) via the customized website;

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

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

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

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

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

(10) Maintaining a system that notifies Enrollees/Claimants about potential health and safety issues with their Prescriptions;

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

(12) Providing prompt notification to Enrollees regarding out of stock items, partial fill orders, and changes to Prescriptions (e.g., approved or required dispensing of generics instead of Brand drugs). In out of stock situations, the Offeror must have a system in place to ensure that Prescriptions are filled in the most efficient manner whether it be through an alternate facility(ies) or obtaining a re-stock from a supplier. If necessary, the Offeror shall call the Enrollee first to obtain permission to contact their Physician to offer alternative medications, or to offer to return the prescription. If the Physician

authorizes use of an alternative medication, a letter notifying the Enrollee of the change must be sent to the Enrollee before the medication is shipped or must accompany the Prescription;

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

(14) (Exclusive to DCS) Informing the Enrollee prior to shipping if the total amount for a new Prescription order submitted through the Mail Service Pharmacy Process exceeds $100 and Enrollee has payment information (e.g. credit card) on file or Enrollee's total balance is over $100 and Enrollee has no payment information (e.g. credit card) on file. The Mail Service Pharmacy Process Facility will not be required to inform Enrollees if there is a consistent history of the acceptance of shipments of the same medication that exceed the maximum amount specified. If the brand name drug is dispensed, the Offeror shall cause the dispensing facility to collect the applicable Brand Drug Copayment plus the calculated Ancillary Charge, if any. Under no circumstances shall the Enrollee's total cost exceed what the actual cost of the Brand Drug would have been to the Program.

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

(16) Notifying the Procuring Agencies of nationwide out of stock issues, including information from the manufacturer or wholesaler regarding the anticipated date that the drug will resume shipment;

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

(18) Ensuring that the consent of the Enrollee is obtained prior to calling the prescribing Physician with the exception of calls made for purposes of clarification, verification, settlement of other intervention claim issues or DAW-1 confirmations;

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

(20) Having a back-up mail order facility(ies) to handle any overflow and/or situations where the primary mail order facility is unavailable;

(21) Promoting the utilization of the Mail Service Pharmacy Process through targeted mailings, Physician communications, etc., if the Department determines that such promotions are in the best financial

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

(22) The Offeror shall act in the best interests of the Programs when dispensing Generic Drugs through the Mail Service Pharmacy Process by avoiding the dispensing of NDC's with higher AWPs unless market conditions exist making dispensing the more cost effective NDC impractical or impossible;

(23) Turnaround Time for Non-Intervention Mail Service Prescriptions Guarantee: Offerors must propose, separately for each Program, a Turnaround Time for Non- Intervention Mail Service Prescriptions performance guarantee. The Program's service level standard requires at least ninety-five percent (95%) of all non- intervention mail service Prescriptions will be turned around in two (2) Business Days (not including the date of Prescription receipt). Turnaround time is measured from the day after the Prescription is received by the Mail Service Pharmacy to the date the Prescription is received by the mailing agent. For example, a Prescription order received on Monday, January 6, 2014, by the Mail Service Pharmacy, must be received by the mailing agent no later than Thursday, January 9, 2014; and

(24) Turnaround Time for Intervention Mail Service Prescriptions Guarantee: Offerors must propose, separately for each Program, a Turnaround Time for Intervention Mail Service Prescriptions performance guarantee. The Programs service level standard requires at least ninety-five percent (95%) of all intervention mail service Prescriptions will be turned around in five (5) Business Days (not including the date of Prescription receipt). Turnaround time is measured from the day after the Prescription is received by the Mail Service Pharmacy to the date the Prescription is received by the mailing agent. For example, a Prescription order received on Monday, January 6, 2014, by the Mail Service Pharmacy, must be received by the mailing agent no later than Tuesday, January 14, 2014.

B. REQUIRED SUBMISSION

(1) Identify and describe the facility(ies) that the Offeror will use in the Mail Service Pharmacy Process for the Programs including the following:

(a) Location(s) of all facilities owned, operated, or subcontracted by the Offeror that are capable of filling Prescriptions through the Mail Service Pharmacy Process including, but not limited to, any compounding or Specialty Pharmacies that fill or dispense Prescriptions through the mail;

CVS Caremark's mail service pharmacies are located at the following addresses:

1. 800 Biermann Court
   Mt. Prospect, Illinois 60056

2. 7034 Alamo Downs Parkway
   San Antonio, Texas 78238

3. 15800 S.W. 25th Street

Miramar, Florida 33027

4. Number 1 Great Valley Boulevard
   Wilkes-Barre, Pennsylvania 18702

5. 1780 Wall Street
   Mount Prospect, IL 60056

Specialty mail service pharmacies are located at the following addresses:

1. 180 Passaic Avenue
   Fairfield, New Jersey 07004

2. 25 Birch St, Building B, Suite 100
   Milford, Massachusetts 01757-9901

3. 105 Mall Boulevard
   Monroeville, Pennsylvania 15146

4. 800 Biermann Court, Suite B
   Mount Prospect, Illinois 60056

5. 7930 Woodland Center Boulevard. Suite 500
   Tampa, Florida 33614

6. 11162 Renner Boulevard
   Lenexa, Kansas 66219-9621

7. 1127 Bryn Mawr Avenue, Suite A
   Redlands, California 92374

8. 1307 Allen Dr., Suite H
   Troy, Michigan 48083*

9. 8370 Wolf Lake Drive, Suite 107
   Bartlett, Tennessee 38133-7108*

10. 10700 World Trade Blvd, Suite 110
    Raleigh, North Carolina 27617*

* The Specialty pharmacy locations in Michigan, Tennessee, and North Carolina are not licensed in the State of New York and will not be used to perform or support any services under this proposal.

(b) Location(s) of all other facilities including, but not limited to, any compounding or Specialty Pharmacies that the Offeror is proposing to utilize in the normal course of the Mail Service Pharmacy Process to dispense all mail order Prescriptions to Enrollees;

Not applicable.

(c) Confirmation that the facilities listed in b.(1)(a) or (b) above that are utilized to fill any Enrollee Prescriptions submitted through the Mail Service Pharmacy Process will be priced in accordance with the Offeror's Guaranteed Mail Order Pharmacy Process pricing as proposed in Exhibit V.A;

CVS Caremark confirms.

(d) The total capacity of all facilities identified in response to question (a) including, but not limited to the total number of scripts dispensed in 2011 and customers serviced. Describe any technology changes and/or staffing changes that would be necessary to service the Mail Service Pharmacy Process Prescription volume of the Programs;

[redacted]

(e) Describe the backup mail order process facility(ies) that you would utilize to handle any overflow, out of stock situations and/or situations where the primary mail order facility is unavailable. Provide any other alternative methods you would utilize to meet the mail service Prescription drug delivery requirements of the Programs; and

CVS Caremark's mail service fulfillment operation mitigates delays that can occur from overflow, out of stock situations, and other occurrences that cause disruption. Rather than designating a primary facility, CVS Caremark's full-service regional mail pharmacies are networked to serve as a virtual service operation across the U.S., with unparalleled technical and physical redundancy.

Our regional distribution model operates in an automated, paperless environment with efficiencies to allow dispensing and shipping from the mail facility that is most appropriate for the Programs' members based on a number of factors, including most efficient prescription order processing time and proximity to a member's desired shipping destination (allowing for a reduced total transit time).

Each pharmacy can review, process, and fill prescriptions in one location and dispense from that location or any other location in our network of mail pharmacies – a process we routinely practice and one that is transparent to members. This is a critical part of the disaster recovery plan that enables us to deal with all natural disasters, minimizing member disruption.

Value-Added Alternative Services

Another advantage of our vertically-integrated business model is our innate ability to broaden accessibility to lower cost medications for both members and plan sponsors. Maintenance Choice combines two primary components:

- The cost savings and convenience of mail and the option of using CVS/pharmacy for a 90-day supply of maintenance medications, giving members more choices and accessibility to medication.
- A transformative, industry-leading member experience that differentiates CVS Caremark in the marketplace with regards to how we connect with members and influence patient behavior, ultimately leading to greater healthcare outcomes.

By adopting the Maintenance Choice plan design*, the Programs will enable members to fill a 90-day supply of medication at any CVS retail pharmacy, at the mail copay and cost – increasing convenience and access to the lowest cost channels.

* Client qualifications include, but are not limited to, allowing CVS Caremark to communicate with members regarding the benefits of moving to a 90-day supply per their plan design, 90-day prescriptions being limited to CVS/pharmacy retail locations and CVS Caremark Mail Service as well as having a plan design that offers a minimum financial incentive to move to a 90-day supply.

(f) Identify the facilities listed in b.(1)(a) or (b) above that have a commercial compounding license and indicate if they compound all drugs covered by the Programs. If there are any drugs that your facilities are unable to compound or do not compound, please detail the process you will utilize to provide Enrollees with access to all Compound Drugs through the Mail Service Pharmacy Process when the Prescription is submitted through the Mail Service Pharmacy Process.

All of our mail service facilities have a commercial compounding license and have the ability to compound nearly any medication as long as it does not have sterile requirements.

(2) Provide a flow chart describing each step in the Mail Service Pharmacy Process taken prior to dispensing the medication. Describe the system edits for eligibility, prior authorization, utilization, including refill too soon and duplicate therapy utilized to ensure Enrollee safety and Programs' cost control.

[redacted]

(3) (Exclusive to DCS) What steps would a member need to follow to establish their initial order and set up their billing account, when transitioning from the previous contractor's Mail Service Pharmacy? Describe the process that a member must follow when ordering, reordering Prescriptions via mail or moving Prescriptions from a retail Pharmacy to the Mail Service Pharmacy Process. How do you assist the Enrollee with this process?

CVS Caremark's comprehensive approach allows for a member-friendly experience when transitioning to mail service from an incumbent vendor as well as transitioning from retail to mail.

The key to mitigating disruption from the beginning is having a strong mail implementation process to transition open refills, claims history, and active prior authorizations, which is a critical step in setting up your current mail users. Cooperation between the outgoing and incoming PBMs is important, and CVS Caremark and Medco have a mutually beneficial relationship and standard processes in place to optimize efficiency during the transitions.

CVS Caremark offers convenient methods for incoming mail users. We offer a self-service option via the web, which we redesigned in order to create a more user-friendly navigation system. In addition, we assist members through our FastStart® program. When a member contacts a FastStart representative, we make all of their mail service arrangements.

FastStart is also effective as a means to transition retail users to the mail service. Under this approach, members are contacted by phone or direct mail explaining the convenience, cost effectiveness, and other benefits of mail service and are offered our "FastStart" program. This encourages members to contact us to receive their first mail service pharmacy prescription. The phone calls and letters explain the benefits of mail service and how a greater days' supply, an easy refill option (by telephone or Internet) and convenient delivery are available. We also contact the prescribing physician on the member's behalf to write and send the prescription to our mail service pharmacy. Otherwise the member can provide their prescribing physician a toll-free number to call the FastStart Customer Care representative directly.

When ordering, reordering, or shifting from retail to mail, we offer multiple mediums to suit individual member preferences, including:

Mail: Members complete an Order Form and send it, along with their new or refill prescription and copay. All correspondence will be electronically imaged and will route to our network of mail service pharmacies for further processing.

Internet: Members can use our Web site to order refills or check the status of mail service prescriptions at any time. Additionally, members can register for our electronic check or Bill Me Later® payments options. CVS Caremark offers co-branding and single sign-on services to simplify access for members.

Customer Care: Members can contact our Customer Care Center to order a new prescription, obtain a refill, or request that a prescription transfer from a retail pharmacy to our mail service pharmacy.

Interactive Voice Response System: For added convenience, 24 hours a day, 7 days a week, CVS Caremark provides toll-free Touch-Tone and voice integration telephone access to prescription services.

Physician Submitted: Physicians may submit prescriptions to CVS Caremark mail pharmacies via electronic prescribing, phone, and solicited or un-solicited fax.

(4) Describe the capabilities of the Mail Service Pharmacy call tracking system.

Our Customer Care Representatives track 100% of member calls within our customer relationship management application, regardless of inbound contact method. This system captures inquiry type, pending action(s), representative name, and resolution for each call received.

Tracking Categories

The call reasons and tracking categories available to our representatives include the following:

- Billing/Payment
- Order Placement
- Order Status
- Fulfillment of forms, cards, etc.
- Paper Claims
- Eligibility
- CVS Caremark Programs
- Retail Pharmacy
- Plan Design/Plan Benefits
- Prescription Verification
- CVS Caremark Information
- Medicare
- Pharmacist Consultation
- Training
- Voice Response System or Website
- Appeals.

Our call metrics reports include number of calls answered, average speed of answer, abandonment rate, etc. The reports can be furnished to the client on a monthly basis, or otherwise. Standard reporting is provided through the Account Services Team at no additional cost.

(5) Confirm that you will supply sufficient quantities of mail order forms and pre-paid envelopes to encourage mail service utilization.

CVS Caremark confirms.

(6) Describe the process to be utilized to handle the following types of Prescriptions including any instructions provided to the Enrollee:

(a) Urgent Prescriptions; will there be additional handling or delivery costs for these Prescriptions?

The member can request expedited shipping of their orders once the processing is complete. Both overnight and second-day delivery options are available. If a member's order is in the pharmacy processing phase, he/she can contact Customer Care to alert the representative to the urgency of the situation. The Customer Care representative will expedite the order, and CVS Caremark will absorb the cost of shipment. In the rare case that a reshipment is required, CVS Caremark absorbs the costs.

(b) Prescriptions that require "special" handling (i.e., temperature control, special preparation, controlled substances, limited shelf life, etc.);

CVS Caremark has a program in place that determines the appropriate shipping procedures for mail service medications based on the temperature in the destination zip code. Using a program from the National Weather Service, we download the five day forecast for every ZIP code in the United States into our shipping system. The automated shipping system provides the forecast to the shipper, along with information on the appropriate packaging materials and delivery timetable required.

For drugs requiring protection from freezing, the following protocol is used:

- For "average" winter temperatures (no sub-zero temperatures), the drug is wrapped with bubble pack wrapping and placed in a 1.25" foam envelope inside a cardboard box to ship.
- For "extreme" winter temperatures (sub-zero temperatures), the drug is wrapped with bubble pack, and a room-temperature gel pack is placed next to it; it is then placed in a 1.25" foam envelope inside a cardboard box to ship.

Forecasted Destination	Shipping Method
Greater than 85 degrees	Next-day delivery with a cold gel pack: Medication will be packed inside an expander pack (insulated plastic bag) next to a three-pound cold gel pack and shipped in a cardboard box. Typically, the medication will be bubble wrapped to protect it from moisture.
85 degrees or less	Second-day delivery with a cold gel pack: Medication will be packed inside an expander pack (insulated plastic bag) next to a three-pound cold gel pack and shipped in a cardboard box. Typically, the medication will be bubble wrapped to protect from moisture.

(c) Narcotics for the original fill for an Enrollee; and

All Schedule II narcotics and all orders with a total value exceeding $1,500 are shipped for two- or three-day delivery. All Schedule II narcotics require an adult signature for delivery. Recurring incidents of lost or stolen prescriptions also may result in a signature requirement for subsequent deliveries.

(d) Prescriptions requested to be mailed in easy open caps;

As required by pharmacy regulations, all outgoing bottle caps are in the childproof position. CVS Caremark uses a dual purpose cap, that once removed can be converted to “easy-open” by the recipient.

(7) Please detail the system in place to track Prescriptions received through the Mail Service Pharmacy Process. Include the time from the receipt of the order until the delivery agent picks up the package. Specifically, detail how the actual date of receipt of the Prescription and the date the delivery agent picks up the package are recorded.

Each order received receives an electronic time stamp that is captured and used to monitor processing time throughout the fulfillment cycle. Orders are tracked until the end date, which is when the mail carrier picks up the package for delivery. Each order received by Mail is time-stamped upon receipt from the USPS. If the order is received by fax, electronic prescribing, or web, the time begins when received into the processing system. When Customer Care initiates the request, the time starts when the Customer Care Representative submits the order. Regardless of the start time, the outbound package is always date-stamped according to the time that it is provided to the delivery agent.

(8) Please describe how your system tracks mail service fill accuracy rates including all error types tracked by the system. In addition, detail the error types your system reports and include a mail service fill

accuracy report for 2011. How are member reported errors tracked and reported? What type of investigations and process modifications would you undertake to address accuracy errors that have the potential to critically impact the Enrollee's health and safety?

[redacted]

(9) Please detail when a Prescription is designated as requiring intervention, and how the system tracks the point at which an intervention is deemed necessary. Describe how your system tracks these Prescriptions and calculates turnaround times for intervention claims. What is the definition of a Prescription that requires external intervention? Would that ever include a Prescription for a medication that is out of stock or a Prescription that has simply aged in the processing system?

Each time a prescription is entered into the system, the online, real-time Drug Utilization Review automatically performs more than 500 edits. The order is screened against the member's integrated prescription history for potential interactions with prescriptions previously dispensed at CVS Caremark's Mail Service Pharmacies and retail network pharmacies, as well as any out-of-network pharmacies where the member has submitted a paper claim reimbursement. Prescriptions are checked for therapeutic duplicates, potential drug-to-drug and drug-to-allergy interactions, plan design compliance, and evidence of overutilization, such as early refill requests or an unusual delay between the date of the prescription and the date it was received by CVS Caremark.

The length of time a prescription is in-house is monitored by a state-of-the-art scanning system that tracks each prescription throughout the dispensing process. A unique bar code identifier is assigned to each order to provide constant monitoring for that prescription order.

CVS Caremark leverages a highly sophisticated Mail processing system, including automated and manual interventions. For example, during the initial Rx entry, the technician may not be able to read/understand the prescription. They have the ability to route the order to a call unit for prescriber contact. Others may systematically transfer to a physician call based on a DUR message received during on-line adjudication.

Claim turnaround is determined after the order has been completed. The system reviews each of the processing steps, and if the order is diverted for either a physician or member contact, it will be considered diverted. Currently about 40% of all orders require intervention or divert. The others are considered "clean" and are counted separately from those that diverted. The majority of those are refills, which met all of the diverted requirements with the initial order.

If a medication is out of stock, the member is contacted and provided options. Options include holding the order, obtaining an alternative, returning the prescription, or to split the order (if applicable). In that case, the system will track TAT for the processed order. If requested to hold, the turnaround time measurement would start when the medication becomes available.

If the medication is on hold waiting for member or prescriber contact, the TAT is stopped and restarted when the information is proved and an order can be processed.

If any drug safety concern or clinical opportunity is indicated, the system will flag the prescription. Prescriptions in question are forwarded to the physician consultation area, where a registered pharmacist will consult with the

prescribing physician. No prescription is allowed to enter the pharmacy for dispensing until this comprehensive screening process is completed.

A prescription that requires intervention is defined as one that is subject to clinical review, utilization review, accounts receivable review, or therapeutic interchange.

(10) Describe the process that you will utilize to provide Enrollees with access to Limited Distribution Drugs when the Prescription is submitted through the Mail Service Pharmacy Process.

There are a very limited number of products that CVS Caremark cannot dispense, due to a pharmaceutical manufacturer's exclusive relationship with another provider (other providers). If necessary, CVS Caremark has a system in place to transfer the prescription and other referral information to the designated provider, to minimize inconvenience to the member and to minimize delays in initiating therapy.

Should we receive a prescription in our pharmacy for an item we do not dispense, we will forward the prescription and other necessary information to the provider to facilitate a member's access to the medication. Also, our Customer Care representatives have access to instructions regarding limited distribution medications and will be able to help members should an applicable situation arise.

(11) Please describe/present the process in place to ensure that Enrollees receive all necessary clinical information and support related to Prescriptions dispensed through the Mail Service Pharmacy Process. Please detail the role of licensed Pharmacists in the Mail Service Pharmacy Process clinical program. Is the process for providing clinical support to Enrollees utilizing the Mail Service Pharmacy Process integrated with or independent of the customer service call center?

Each outgoing order contains customized product descriptions and patient care information for each of the medications shipped. For any additional questions, licensed pharmacists are available 24 hours per day for consultation. Members can initiate pharmacist contact through the Customer Care call center, which is integrated with pharmacist support. Internal pharmacists also conduct clinical reviews on targeted claims, to identify cases of fraud, waste, and abuse as well as other clinical programs that revolve around safety and cost containment.

(12) Describe the process and channels (web, phone access, hard copy, etc.) you utilize to collect the information necessary to develop and maintain an Enrollee safety profile.

Each time a member fills out an order form, they are provided space to list any allergies, preferences, etc. These are captured in the Mail processing system and used in a Drug Utilization Review process that ensures patient safety. This information is updated through a seamless process as refills are ordered over the Web, IVR, or through a Customer Service representative.

(13) Describe your drug purchasing and inventory philosophy including:

(a) What are the time frames as they relate to back orders or shipment from an alternate mail order facility;

Rather than assigning a designated primary mail facility, our virtual mail service fulfillment process leverages all of our mail pharmacies, which are networked together to best accommodate members, improve efficiency, and reduce turnaround times. While a large volume of prescriptions may be dispensed from one facility, our system

identifies the best pharmacy to dispense the medication, and the system logic considers inventory supply, shipment, and current volume/capacity. Prior to putting the medication on backorder, inventory at all Mail pharmacy locations will be depleted. As long as the stock is available at one of our facilities, the order will be transferred to the available facility for processing. All transfers of this nature occur electronically, through automated processes and do not hinder mail service performance.

(b) What are the time frames as they relate to backorders or shipments that are from your primary supplier;

Manufacturer back-orders and out-of-stock drugs affect less than 1% of the total prescription volume processed by our facilities. We will make every attempt to fill all prescriptions within five days. However, in a situation in which we are unable to contact the physician or in a back-order situation, this process requires us to return the prescription to the member. Our standard policy is to hold the prescription and contact the member to notify him or her of the situation.

(c) What is the percentage of Prescriptions that are filled when initially submitted to the primary mail service pharmacy facility you are proposing; and

CVS Caremark leverages a virtual mail fulfillment process by filling prescriptions at any of our mail pharmacies that best suits the member's needs at the time the prescription is submitted. Our proprietary technology enables automation, and the system can determine the most suitable pharmacy based on current volume, capacity, and inventory.

Therefore, nearly100% of prescriptions are filled through our primary means of fulfillment, without having the need for manual processes to transition prescriptions to back-up pharmacies.

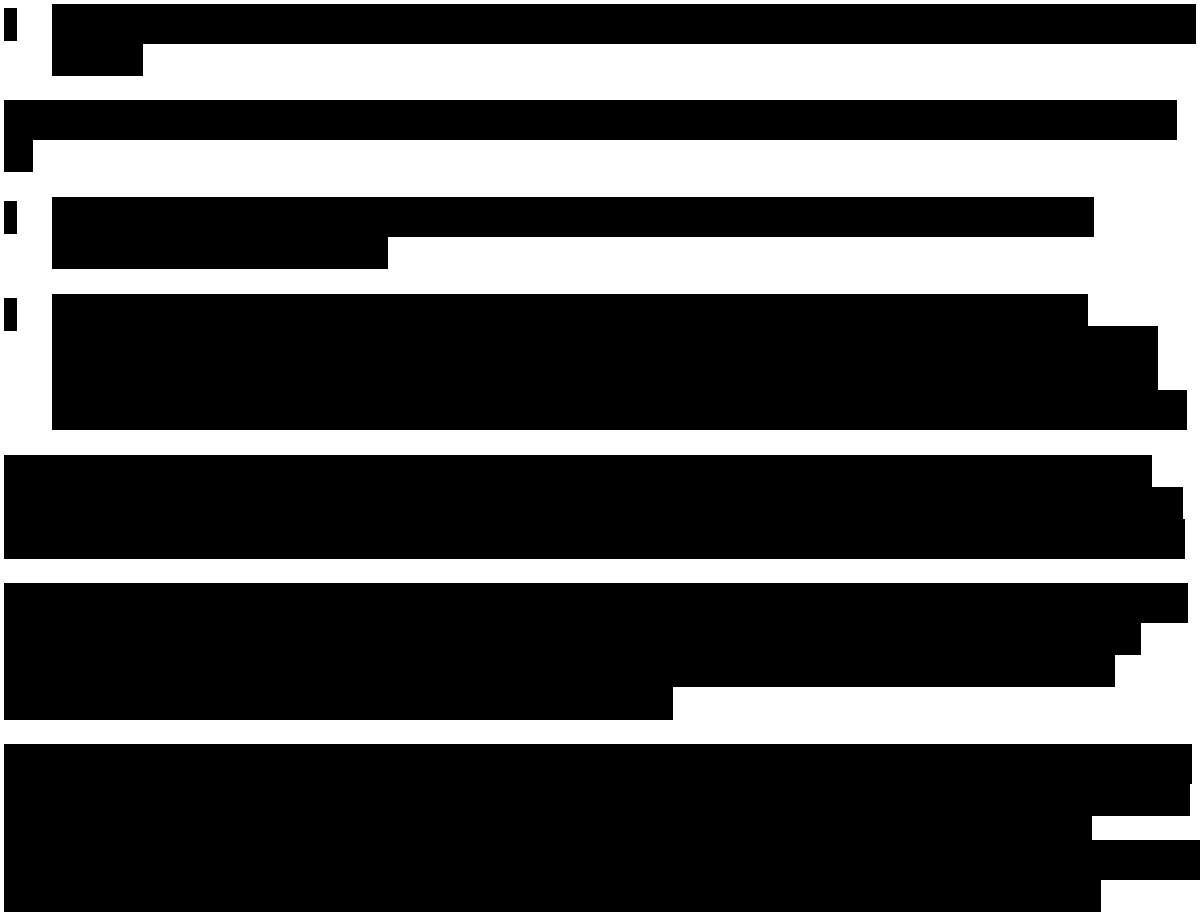
(d) How are backorders and out of stock situations handled with members?

In the rare occurrence that an order is delayed due to a manufacturer's back order or out-of-stock situation, our member services unit at the pharmacy contacts the affected member by phone and provides several options, including:

- Having one of our pharmacists contact the member's physician for an alternative medication
- Holding the prescription if the back-order situation is soon to be resolved by the manufacturer
- Transferring the prescription to the member's local retail pharmacy if a back-ordered item may be unavailable for an extended period of time.

(14)(Exclusive to DCS) Describe your Enrollee communication process for out-of-stock items, partial fill orders, when an Enrollee appears to be ineligible, when there are changes to a Prescription that would result in Ancillary Charges, and when there are billing issues that prevent a Prescription from being immediately shipped. Confirm that the Offeror will arrange payment plans with Enrollees, on request.

[redacted]



(15) New York State Law does not require, but permits substitution of B-rated or unrated generics. Will the Mail Service Pharmacy Process facilities utilized for the Programs fill a Prescription written for a Brand Drug with a B-rated or unrated Generic Drug or will the Enrollee have to obtain a Prescription from the prescribing Physician written for the B-rated or unrated Generic Drug in order to avoid receiving the Brand Drug and paying the higher Brand Drug Copayment?

We currently only stock and perform generic substitution with FDA-approved A-rated generic medications. If a prescriber writes a medication for a B or non-rated generic and designates it as medically necessary, we are generally able to obtain stock for the individual member's order. If there is no indication, the order would be filled with an A-rated generic.

(16) Are there any situations where a Prescription written for a Brand Drug is submitted through the Mail Service Pharmacy Process and the Mail Service Pharmacy Process facilities utilized for the Programs are prevented from substituting an A-rated or authorized Generic Drug in accordance with the Programs' benefit design?

At all times, applicable law and the Programs' benefit design will govern the medication that is dispensed, including, but not limited to, the Mandatory Generic Substitution Program rules (e.g. Brand NTI will not be substituted with a generic equivalent).

(17)Please describe how the Days supply is determined for the following forms of Prescription Drugs, dispensed by the Mail Service Pharmacy:

Eye/Ear Drops

For Eye/Ear Drops, we assume 15 drops per mL.

Lotions and Ointments

According to general manufacturer packaging, we assume one box is a 30 day supply.

Syrups

We calculate the days supply based upon the directions. For example, if the directions read “Take 5 mL daily”, then 450 mL would equate to a 90-day supply.

(18) Please describe what proposed strategies you would implement with your Mail Service Pharmacy to compete with Low-Cost 30 and 90 Day programs offered by Retail Pharmacies?

[redacted]

(19) Turnaround Time for Non-Intervention Mail Service Prescriptions Guarantee: The Programs' service level standard requires that at least ninety-five percent (95%) of all non-intervention mail service Prescriptions will be turned around in two (2) Business Days (not including the date of Prescription receipt). Turnaround time is measured from the day after the Prescription is received by the Mail Service Pharmacy to the date the Prescription is received by the mailing agent. The Offeror shall propose, separately for each Program, the forfeiture of a specific dollar amount of the Claims Administration Fee, for failure to meet this guarantee.

The standard credit amount for each .01 to 1.0% below the ninety-five percent (95%) of all non intervention mail service Prescriptions not turned around within two (2) Business Days, is $25,000 per each quarter for DCS and $375 for NYSIF. However, Offerors may propose higher or lesser amounts.

The Offeror's quoted amount to be credited against the Claims Administration Fee for each .01 to 1.0% below ninety-five percent (95%) (or the Offeror's proposed guarantee) of all non-intervention mail service Prescriptions not turned around within two (2) Business Days, calculated on a quarterly basis, is $ ___for DCS and $__for NYSIF.

[redacted]

(20) Turnaround Time for Intervention Mail Service Prescriptions Guarantee: The Programs' service level standard requires that at least ninety-five percent (95%) of all intervention mail service Prescriptions will be turned around in five (5) Business Days (not including the date of Prescription receipt). Turnaround time is measured from the date the Prescription is received by the Mail Service Pharmacy to the date the Prescription is received by the mailing agent. The Offeror shall propose, separately for each Program, the forfeiture of a specific dollar amount of the Claims Administration Fee for failure to meet this guarantee.

The standard credit amount for each .01 to 1.0% below the ninety-five percent (95%) of all intervention mail service Prescriptions not turned around within five (5) Business Days is $25,000 per each quarter for DCS and $375 for NYSIF. However, Offerors may propose higher or lesser amounts.

The Offeror's quoted amount to be credited against the Claims Administration Fee for each .01 to 1.0% below ninety-five percent (95%) (or the Offeror's proposed guarantee) of all intervention mail service Prescriptions not turned around within five (5) Business Days, calculated on a quarterly basis, is $ ___for DCS and $ __for NYSIF.

[redacted]

Specialty Drugs/Medications

The Programs provide coverage for Medically Necessary Drugs including Specialty Drugs/ Medications. Specific to the DCS Program, drugs dispensed and billed by a Physician's office or drugs dispensed in a

hospital setting are not the responsibility of the DCS Program and are covered under the Medical or Hospital portion of The Empire Plan.

Enrollees in most Employee groups receive Specialty Drugs/Medications benefits through the Specialty Pharmacy Program. All other Enrollees receive Specialty Drugs/Medications through the Retail Pharmacy Network or the Mail Service Pharmacy Process. See Exhibit II.C for a breakdown of groups that participate in the Specialty Pharmacy Program and those that receive Specialty Drugs/Medications through the Retail Pharmacy Network or the Mail Service Pharmacy Process.

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

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

A. DUTIES AND RESPONSIBILITIES

(1) The Offeror must provide Enrollees with access to all Medically Necessary Specialty Drugs/Medications covered by the Programs through its proposed Retail Pharmacy Network and through the Mail Service Pharmacy Process in accordance with each Enrollee group benefit design as set forth in Exhibit II.C. In the case of Limited Distribution Drugs, the Offeror shall provide Enrollees with access in accordance with the following:

(a) Retail Pharmacy Network Access

The Offeror shall secure the participation of the authorized distributor in its Retail Pharmacy Network and bill the Programs consistent with the Offeror's contracted discount off of AWP for the Limited Distribution Drug, plus any dispensing fee.

~~If the Offeror is unable to secure the participation of the authorized distributor, the Offeror agrees to facilitate the Enrollee's receipt of the Limited Distribution Drug and bill the Program consistent with its Minimum overall Guaranteed Discounts applicable to Brand Drugs for network pharmacies. The Enrollee shall be charged the applicable retail Copayment.~~

(b) Mail Service Pharmacy Process Access

The Offeror must facilitate the Enrollee's receipt of the Limited Distribution Drug. The Offeror shall secure the participation of the authorized distributor in its Retail Pharmacy Network and bill the Programs consistent with the Offeror's contracted discount off AWP for the Limited Distribution Drug, plus any dispensing fee. ~~by obtaining the drug from an authorized distributor and billing the~~

~~Programs consistent with its Guaranteed Discounts applicable to Brand Drugs. for the mail service pharmacy~~. The Enrollee shall be charged the applicable mail order Copayment.

(2) (Exclusive to DCS) Individuals receiving home infusion services through the Home Care Advocacy Program (HCAP), a component of The Empire Plan's Medical/Surgical Program, have their home infusion drugs covered under the Prescription Drug Program.

Currently the DCS Program has a network of licensed pharmacies affiliated with home care agencies participating in The Empire Plan's HCAP Program administered by The Empire Plan's medical carrier. The Offeror is expected to secure contracts with the licensed pharmacies provided in Exhibit II.E.3 of this RFP to ensure continued utilization of a network Prescription drug benefit for those Enrollees utilizing the HCAP Program. An Offeror may propose to utilize entities owned by or affiliated with the Offeror to serve as an HCAP Provider. The Department at its sole discretion shall determine whether it is in the best interests of the DCS Program to allow the entity to participate in the HCAP Program. The Prescription drugs dispensed to Enrollees via the entities or pharmacies owned by or affiliated with the Offeror must be charged to the DCS Program based on the Offeror's mail service pricing terms and dispensing fees applicable to brand name, generic, and Compound Drug claims as proposed in Exhibit V.A.

B. REQUIRED SUBMISSION

(1) Explain how your proposed network provides access to all medically necessary covered Specialty Drugs/Medications.

CVS Caremark serves as the PBM for many large employers and health plans, and its specialty pharmacy also works directly with external PBMs, employers, and health plans to provide services. We have extensive experience in directing physicians, members, and prescriptions to our internal specialty pharmacy and external specialty pharmacies when necessary.

We have proven interfaces and protocols in place that render the connection to specialty services streamlined and efficient.

Specialty services can be accessed easily by phone, fax, e-mail, internet, and mail. Easy-to-use enrollment forms also are available to further streamline the process.

When written correspondence is received by our internal PBM, the information and desired products are entered promptly into the system. The system recognizes specialty products at GPI and NDC levels, which immediately queues the order to the specialty pharmacy for fulfillment of products and services. When verbal correspondence is received by our PBM Customer CareTeam, the representative will query the product in the system, and the system will prompt the representative to connect the caller with the specialty pharmacy.

When the exception occurs that our specialty pharmacy cannot provide services because we are not contracted or do not have access to a product, we have established relationships and protocols in place to connect that member with the specialty pharmacy that can provide those services within the same business day.

(2) Explain the mechanisms in place to facilitate the delivery of Limited Distribution Drugs to Enrollees. Confirm that Enrollees will be charged the Mail Service copayment for Limited Distribution Drugs submitted to the Mail Service Pharmacy (DCS only).

Across our book of business, CVS Caremark is consistently able to to provide specialty medications to 99.98% of specialty utilizers and we continuously pursue access to all specialty products to offer the broadest portfolio to our clients. Our broad access to specialty medications allows us to provide a comprehensive level of service to clients, members and physicians.

CVS Caremark has access to 97% of all specialty products in the marketplace. There are a very limited number of specialty products that CVS Caremark cannot dispense, due to a pharmaceutical manufacturer's exclusive relationship with another provider (other providers). If necessary, CVS Caremark has a system in place to transfer the prescription and other referral information to the designated provider, to minimize inconvenience to the member and the physician and to minimize delays in initiating therapy.

CVS Caremark confirms that members (under DCS Programs) will be charged the mail service copayment for Limited Distribution Drugs submitted to the Mail Service Pharmacy.

(3) (Exclusive to DCS) Confirm that you will solicit participation in the Retail Pharmacy Network all licensed pharmacies affiliated with the Empire Plan Home Care Advocacy Program. Describe the capability of the Offeror to coordinate and/or integrate services with The Empire Plan's medical insurer.

CVS Caremark confirms. When appropriate, we will coordinate infusion services with the medical carrier and the HCAP provider by working with their respective case management functions or in situations where we may receive nursing orders directly from physicians.

(4) (Exclusive to DCS) For those HCAP providers that do not have affiliated pharmacies, how do you propose coordinating with HCAP and supplying the medication to the Enrollee? Will you utilize the Mail Service Pharmacy Process?

CVS Caremark will use our Specialty mail service process to receive prescriptions directly from the physician or infusion provider and then coordinate delivery of the medications to the provider for their nurses to administer to the patient. We would bill the Program for the medications and the provider would bill through the medical plan for the infusion services.

(5) Confirm that necessary ancillary supplies that accompany certain Specialty Drugs/Medications will be delivered to the Enrollee at no additional cost to the Programs or Enrollee.

CVS Caremark confirms.

(6) Indicate the licensed pharmacies in Exhibit II.E.3 with whom you have a current Network Pharmacy contract.

[redacted]

Specialty Pharmacy Program

NYSIF Claimants and most DCS Program Employee groups participate in the Specialty Pharmacy Program, which provides an enhanced level of clinical management for Enrollees taking Specialty Drugs/Medications. Under the current plan design, after the first Specialty Drug/Medication Prescription is filled through either the Retail or Mail Service Pharmacy, future fills are subject to a Hard Edit (DCS only), meaning that Enrollees are required to obtain the drug through the Specialty Pharmacy Process, subject to the mail service copayment (DCS only) when dispensed by the designated Specialty Pharmacy. In addition to the first fill at Retail, certain Specialty Drugs/Medications available through the Specialty Pharmacy Program are also available through the Retail Pharmacy Network, because of their clinical requirements and/or urgent dispensing timeframe. All Specialty Drugs/Medications filled at a Retail Pharmacy Network are subject to the Retail Network Pharmacy Pass-through Pricing and Copayments (DCS only). For those drugs available only through the Specialty Pharmacy Program, the Offeror may propose dispensing fees on a drug by drug basis, commensurate with the clinical services provided for each. All drugs shall be classified as either Brand name, Generic, or Compound for pricing purposes based on the methodologies set forth in Section V of this RFP. The Program shall be entitled to all manufacturer revenue derived from Specialty Drugs/Medications Drugs to be included in the Specialty Pharmacy Program, Specialty Drugs/Medications are:

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

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

A. DUTIES AND RESPONSIBILITIES

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

(1) Developing a listing of the Specialty Drugs/Medications proposed for inclusion in the Specialty Pharmacy Program;

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

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

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

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

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

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

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

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

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

(11) Ensuring that all Designated Specialty Pharmacies utilized in the Offeror's Specialty Pharmacy Program meet all Prescription drug packaging regulatory requirements. The Offeror must ensure that Specialty

Drugs/Medications are shipped to Enrollees in appropriate packing materials so that Specialty Drugs/Medications are safe and effective and delivered on time.

(12) Providing a simple, user friendly method(s) of ordering, reordering, and transferring Prescriptions from the retail and mail setting to the Designated Specialty Pharmacy(ies) including pre-addressed postage paid Specialty Pharmacy Program envelopes. The Offeror must send a Specialty Pharmacy Program letter to Enrollees who have received a First Fill of a Specialty Drug/Medication through a Network Pharmacy. The letters must be sent within seven (7) Days of the Prescription being filled to Enrollees who have received a Specialty Drug/Medication subject to the Designated Specialty Pharmacy Hard Edit (DCS Only) and within thirty (30) Days of the Prescription being filled to Enrollees who have received a Specialty Drug/Medication subject to the Designated Specialty Pharmacy Passive Edit. Enrollees are allowed one Grace Period for Specialty Drugs/Medications.

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

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

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

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

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

(18) (Exclusive to DCS) Informing the Enrollee prior to shipping if the total amount for a new Prescription order submitted through the Specialty Pharmacy Process exceeds $100 and Enrollee has payment information (e.g. credit card) on file or Enrollee's total balance is over $100 and Enrollee has no payment information (e.g. credit card) on file. The Designated Specialty Pharmacy will not be required to inform an Enrollee if there is a consistent history of the acceptance of shipments of the same medication that exceed the $100 amount specified.

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

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

(21) Having back-up Designated Specialty Pharmacies to handle any overflow and/or situations where the primary Specialty Program facility is unavailable.

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

(23) Recommending newly launched Specialty Drugs/Medications for inclusion in the Specialty Pharmacy Program based on the established criteria/definition of Specialty Drug/Medications, in a format to be approved by the Procuring Agencies. Prior to inclusion in the Programs, or if not accepted by the Procuring Agencies to be included in the Programs, the Offeror must bill the Programs for these Prescriptions consistent with the Offeror's contracted discount off of AWP at the dispensing Network Pharmacies or the Guaranteed Discount at the Mail Service Pharmacy Process, based on where each Prescription was actually dispensed. Inclusion of new Specialty Drugs/Medications shall have a cost-neutral or positive financial impact on the Program, and in no case shall the Ingredient Cost of a newly added Specialty Drug/Medication charged to the Program exceed the Guaranteed Discount on Specialty Pharmacy Drugs.

B. REQUIRED SUBMISSION

(1) Provide a listing of the Specialty Drugs/Medications that you propose for inclusion in the Specialty Pharmacy Program, along with an indication of how they meet the minimum criteria. Also, please state if you propose additional criteria. Please state whether the Designated Specialty Pharmacy(ies) you propose regularly dispense any other Specialty Drugs/Medications which you are not proposing for the Programs.

[redacted]

(2) Provide a detailed description of your proposed Specialty Pharmacy Program. Include the following:

(a) Customer service call center

All specialty pharmacy members, regardless of therapy or location, are provided with a toll-free number to our Specialty Customer Care organization. This centralized organization is designed to receive inbound specialty pharmacy calls and triage them to the appropriate parties. Inbound calls can be connected to any one of our specialty pharmacies. Customer Care is staffed by representatives who answer all incoming inquiries from physicians and members, and manage new member enrollment.

A CVS Caremark pharmacist is available 24 hours a day, 365 days a year to respond to questions and medical emergencies as appropriate to the member's therapy. CVS Caremark utilizes an on-call service and pagers to respond to member or customer calls and inquiries. All calls are returned promptly to address questions regarding therapy, administration of medication, shipment status, or any other questions or concerns. In addition, a nurse is available to respond to questions from members or other nursing agencies. Finally, each member is asked, every time an order is placed, whether s/he would like to speak to the pharmacist with any questions or information regarding the therapy.

(b) Administration of REMS

CVS Caremark Specialty Pharmacy is uniquely positioned to provide members with access and clinical oversight to limited distribution drugs and those requiring a REMS strategy. CVS Caremark Specialty Pharmacy has been managing and dispensing medications under FDA-mandated drug safety programs for approximately since the early 1990's. In fact, we were the exclusive provider of Clozaril (Sandoz) – an antipsychotropic drug – that was subject to specific drug therapy management and dispensing requirements for the first drug safety program. Our involvement in FDA RiskMAPS, and now Risk Evaluation Mitigation Strategies (REMS) programs, has continued to grow since the introduction of Thalomid (Celgene) and dozens of others, including Tracleer, Revlimid, Tysabri, and Letairis. We anticipate REMS programs to be applied as a condition of new drug approvals and that the FDA will retrospectively assign REMS requirements to currently marketed products with known serious adverse effects.

To meet this evolving demand made by the FDA and pharmaceutical companies, CVS Caremark has established a department of drug safety management with oversight responsibility for all FDA-mandated programs. We have built infrastructure and information systems to support safe and effective drug therapy management and dispensing processes in accordance with these RiskMAPS/REMS programs.

Additionally, program-specific business processes and documentation are developed based on their respective requirements. Where applicable, process controls are instituted to prevent medication dispensing when all requirements of the program are not met. Each RiskMAP/REMS is implemented by specially-trained pharmacists and technicians, certified by the drug safety management department. Program performance is continuously monitored and periodic audits are conducted to ensure RiskMAP/REMS compliance.

(c) (Exclusive to DCS) Whether Specialty Drugs/Medications administration will be through HCAP or a Specialty Pharmacy Program contracted network

When an HCAP provider is administering the medications, they would bill directly to the medical carrier for the administration charges. CVS Caremark can also administer medications through our contracted nursing network, and in those situations, we would bill the medical carrier directly.

Home Infusion

CVS Caremark pioneered the infusion therapy market over 30 years ago starting with hemophilia and then expanded into other conventional therapies. Our heritage is deeply imbedded within the care of these very complex diseases and is unique in the industry and backed by our accreditation by the Joint Commission as a home care provider.

Over the next year, we will continue to expand our infusion capabilities to support patient access, increase clinical effectiveness and reduce total cost. Our new program will provide more robust, comprehensive and consistent clinical protocols; all of which will be supported by certified infusion nurses and expanded access to infusion suites. We are focusing on avoiding hospitalizations and coordinating the transition from hospital to home when a patient is hospitalized. Payers will benefit from the rich clinical data capture at the time of infusion, less costly infusion center alternatives and the resulting improvement in patient outcomes and lower health care costs.

(d) Clinical management, including demonstration of outcomes improvement

[redacted]

[redacted]

(e) Fulfillment process, including cold-chain supply and shipping logistics

Once CVS Caremark receives a referral, the member is enrolled into our system and the Programs is contacted to verify eligibility and coverage. During the verification process, a CVS Caremark Customer Care Representative determines whether the product is covered, whether a prior authorization is needed, how to obtain the prior authorization, and what financial obligation the family may have.

Once the benefit verification is complete, the Customer Care Representative contacts the member to inform him/her of the findings regarding coverage. After the physician and the member have been contacted and agreed to accept CVS Caremark's service, the pharmacy is notified to arrange a shipment.

CVS Caremark Specialty Customer Care provides the intake function for referrals from physicians, nurses, and case managers as well as member self-referral. In addition, this group will interface with all the Programs organizations (regional plans, the Programs' mail service, etc.), as well as the Programs retail pharmacy network, to bring self-injectable members into the CVS Caremark program.

Initial and refill orders are received in one of three ways:

- Mail/Fax
- Telephone by Service Representative
- Online using CVS Caremark's Specialty Web site.

The Specialty Customer Care line is staffed Monday through Friday from 6:30 a.m. to 8:00 p.m. Central Time. During this time, incoming calls are answered by a Customer Care Representative. At times of high volume, a recorded announcement assures the caller that s/he has reached the intended destination and that we will be with him/her shortly. Normal hours of operation at the pharmacies are from 8:00 a.m. to 5:00 p.m., Monday through Friday. Larger pharmacies have extended operational hours to accommodate our customers.

CVS Caremark has a pharmacist available 24 hours a day, 365 days a year to respond to questions and medical emergencies as appropriate to the member's therapy. CVS Caremark utilizes an on-call service and pagers to respond to member or customer calls and inquiries. All calls are returned promptly to address member questions regarding therapy, administration of medication, shipment status, or any other questions or concerns. In addition, a nurse is available to respond to questions from members or other nursing agencies. Finally, members are asked, each time an order is placed, whether they would like to speak to the pharmacist regarding any questions or information about their therapy.

Members are provided with information regarding after-hour calls during their initial training. An informational packet for all new members or caregivers is provided for future reference. In addition, each member is provided with a back-up phone number from another CVS Caremark pharmacy in the unlikely event that the member cannot reach the on-call pharmacist in the primary branch.

PHARMACY MANAGEMENT SYSTEM

CVS Caremark's pharmacy management system calculates the next expected shipment date based on the quantity dispensed and the prescription information. Members are contacted 5 to 7 days prior to the next shipment to encourage compliance with the treatment plan. At the time of subsequent refills, the remaining quantity of medication is verified for potential compliance issues related to under- or over-utilization. When refills remaining have expired for chronic, self-administered injectable medications, a CVS Caremark pharmacist contacts the physician for a new prescription.

PRODUCT DELIVERY

Because of the high-cost and stability requirements for the specialty medications dispensed by CVS Caremark, the primary method of product delivery is by UPS. This method is highly reliable, with consistent results for deliveries. Each morning, an "Exception Report" is generated to determine the status of packages and to identify situations in which delays are expected. Members are contacted in the event of delays or lost packages. CVS Caremark absorbs the cost for product that does not arrive.

All shipping packages are unmarked as to contents or other confidential information. The outside package is marked only with a shipping label, with the member's name and address and instructions for handling (e.g., "Refrigerate immediately upon arrival").

PROACTIVE CONTACT AND SUPPORT

Our standard procedures are to contact members proactively in advance regarding the expected shipment date, to minimize situations in which existing product is consumed prior to the arrival of additional product.

In addition to being contacted on a proactive basis, members are assigned an acuity level based on their individual clinical status. In the event of a natural disaster, members with the highest acuity are contacted on a priority basis to ensure product levels. Each CVS Caremark branch also has the ability to access another branch's database to allow for dispensing to a member in an emergency.

CVS Caremark maintains agreements with national carriers and local couriers for circumstances in which members have an immediate medical need for product. Regarding the long-term service to members with chronic illnesses, service options/limitations for remote areas are noted in the member's clinical chart. In the unlikely event that a member has an immediate need for product that cannot be met by proactive shipment scheduling, overnight service, or a combination of national carrier and local courier, the member is advised to obtain treatment at the nearest emergency room or hospital.

CVS CAREMARK COUNSELING AND SUPPORT

At initiation of therapy, members and caregivers are counseled about the medical condition as well as the therapy they are about to undertake. This education includes the provision of various written materials, therapy-specific videotapes for the member and caregiver, and one-on-one interaction with various members of the clinician-led CareTeam to ensure understanding of the therapy. To maintain the member's continued education, with all subsequent contacts we offer the caller an opportunity to speak with a pharmacist regarding any questions the caller may have about his/her medications or therapy, including issues of product storage, expected side effects, etc.

In addition, in response to the growing trend to have the member receive training on self-administration of the injectable medication in his or her home, CVS Caremark has established a network of home health agencies and registered nurses who will be available to provide training in the member's home on a prior authorization basis, in keeping with treatment guidelines outlined by the Programs.

CVS Caremark can provide the distribution of a New Member Packet to familiarize the member and the family with CVS Caremark, its services, its people, the drug therapy that the member is about to begin, and support organizations available to the member.

Adhering to therapy is a challenge for many. One of the keys to CVS Caremark's success has been to tailor the compliance-with-therapy program to a person's lifestyle and schedule. The Customer Care Representative works with the prescribing physician and the member to ensure optimal therapeutic outcomes in a program customized for each person's therapy success.

SPECIAL HANDLING

The majority of specialty medications handled by CVS Caremark require special handling. CVS Caremark works closely with manufacturers to determine the most cost-effective method of shipping product, given the FDA-approved storage tests, etc., that have been performed on products to determine their stability at various temperatures. The ambient temperature of the shipping and receiving destinations, along with the manufacturer's recommendation, determine the method and supplies for special handling.

(f) Transition process from First Fill at Retail or Mail

CVS Caremark is currently building a formal process to transition members from first fill retail to the Specialty Pharmacy program. This process will enable us to proactively engage members upon identifying their first fill outside of the Specialty Pharmacy Program and educate them on how the program works as well as how to obtain future fills and access information/resources.

(3) Do you propose to use one dedicated Specialty Pharmacy or several different Specialty Pharmacies? What are the advantages to this approach? Indicate which of the licensed Pharmacy(ies) in Exhibit II.E.3 will participate in the Specialty Pharmacy Program.

CVS Caremark intends to leverage multiple Specialty Pharmacies to dispense medications to deliver the most efficient, convenient, and reliable benefit to members. The advantage of the CVS Caremark Specialty Pharmacy network is that we have the geographical scope and physical capacity to meet the client and member needs.

For those therapies and/or disease states that are low-incidence, require specially trained staff, and/or have other unique service requirements, CVS Caremark has established Centers of Excellence (COE) to consolidate those members in a limited number of locations that are organized to meet their unique needs. Through the COEs, we are

able to dispense limited therapies from any CVS Caremark Specialty Pharmacy location by leveraging our expertise as well as our national pharmacy network.

As an example of our COE model, a member on the East coast needed a blood modifier (for the next day) in time to continue chemotherapy for an aggressive form of breast cancer. Our Benefit Verification Team worked diligently to determine coverage and secured billing approval. Our CareTeam located at our COE for oncology provided the member with the therapy and member-level training, and then transferred the prescription to a West coast CVS Caremark Specialty Pharmacy open at that hour, to ensure timely dispensing and overnight shipping. The member received the medication by 10 a.m. the next day, which allowed treatment to take place later that afternoon.

Additionally, our national network of pharmacies can support natural disaster and emergency plans to provide continued service to your members. Our disaster recovery efforts allow affected members to receive their specialty medications. We are able to do so by:

- Responding immediately to incoming calls by rerouting the phone line and member data to an alternate facility
- Dispensing and delivering specialty medications to members' new or temporary addresses, including shelters and hotel rooms
- Transferring prescriptions to accessible retail pharmacies
- Providing additional staffing support to our alternate facility.

Please note, for the EGWP program the member must be allowed to obtain a Specialty drug through any willing Specialty pharmacy provider.

(4) Detail the mechanisms in place to ensure the prompt, safe, and effective delivery of all Specialty Drugs/Medications in the Specialty Pharmacy Program to Enrollees. Describe the mechanisms the Offeror proposes to facilitate delivery of Limited Distribution Drugs to Enrollees. Describe override procedures the Offeror proposes to facilitate urgent or same-day delivery of Specialty Drugs/Medications in the Specialty Pharmacy Program as well as override procedures proposed when the Designated Specialty Pharmacy is precluded from shipping the medications, i.e. to an Enrollee residing in a skilled nursing facility or foreign country.

With our network of specialty pharmacies, CVS Caremark and its affiliates have the infrastructure and the expertise to deliver even the most sensitive pharmaceuticals overnight directly to members in all 50 states and Puerto Rico. We can also offer specialty pharmacy clients a delivery choice. Members can have their medication shipped to their home, work, doctor's office, or the location of their choice, including select CVS/pharmacy locations. Regardless of where the medication is shipped, the member will receive personalized pharmacy care management through the CVS Caremark Specialty Pharmacy CareTeam.

Temperature and Confidentiality Controls

Our carrier relationships mean safe, appropriate handling and storage of a member's drug under temperature-controlled conditions to assure integrity of the medications, as appropriate to the specific medication being shipped. All shipping packages are unmarked (e.g., as to contents or other confidential information), and include only a shipping label with the member's name and address and instructions for handling (e.g., "Refrigerate immediately upon arrival").

Shipping Carriers and Tracking

Because of the high-cost and stability requirements for specialty medications dispensed by CVS Caremark, the primary method of product delivery is overnight by UPS. This primary carrier is highly reliable, with consistent results

for deliveries. Each morning, an "Exception Report" is generated to determine the status of packages and identify situations in which delays are expected. Intended recipients, such as members or physician's offices, are contacted before day's end in the event of delays or lost packages. CVS Caremark works with the mail carrier to identify the reason for non-delivery, schedule for re-routing of the package if applicable, or return for destruction if necessary. CVS Caremark absorbs the cost for product that does not arrive.

Contingency and Emergency Plans

CVS Caremark maintains contracts with our primary carrier and has put contingency plans and procedures in place, should the carrier encounter service issues. CVS Caremark also maintains agreements with national carriers and local couriers for circumstances in which members have an immediate medical need for product. With respect to the long-term service required by members with chronic illnesses, service options and limitations for remote areas are noted in the member's clinical chart. In the unlikely event that a member has an immediate need for product that cannot be met by proactive shipment scheduling, overnight service, or local courier, the member is advised to obtain treatment at the nearest emergency room or hospital.

CVS Caremark's standard procedures are to contact members proactively, in advance, regarding the expected shipment date, to minimize situations in which existing product is consumed prior to the arrival of additional product. Each CVS Caremark facility also has the ability to coordinate with another facility to dispense for members in emergency situations.

Limited Distribution Drugs

CVS Caremark has access to 97% of all specialty products in the marketplace. There are a very limited number of specialty products that CVS Caremark cannot dispense, due to a pharmaceutical manufacturer's exclusive relationship with another provider (other providers). If necessary, CVS Caremark has a system in place to transfer the prescription and other referral information to the designated provider, to minimize inconvenience to the member and the physician and to minimize delays in initiating therapy.

Override procedures

Situations that preclude the Specialty Pharmacy from dispensing a medication are handled on a case by case basis. Our flexible business model enables us to customize solutions for these situations, and we will work the Programs to determine the best approach, based on program parameters and patient needs.

(5) (Exclusive to DCS) Describe the capability of the Offeror to coordinate and/or integrate services with The Empire Plan's medical insurer in providing HCAP services. For those HCAP providers that do not provide medications, how do you propose supplying the medication?

When appropriate, we will coordinate infusion services with the medical carrier and the HCAP provider by working with their respective case management functions or in situations where we may receive nursing orders directly from physicians.

For HCAP providers who do not provide medications, we would use our specialty mail service process to receive prescriptions directly from the physician or infusion provider and then coordinate delivery of the medications to the provider for their nurses to administer to the patient. We would bill the Program for the medications and the provider would bill through the medical plan for the infusion services.

(6) How does your system provide the ancillary supplies that accompany some of the Specialty Drugs/Medications?

The types of ancillary supplies required differ between therapy classes and are dependent on the administration setting, the member, and drug utilized. CVS Caremark is able to coordinate the provision of ancillary supplies for all therapies dispensed.

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

We look at each drug or combination of drugs used in the treatment of a medical condition, the primary medical condition and co-morbidities, the drug's safety profile, dosing guidelines, and the learning needs of the members to optimize drug use. In addition, we consider the need for member support and monitoring to ensure appropriate utilization and compliance − both key features of a specialty pharmacy program.

Specifically, our PTEC committee reviews the attributes of all new and existing drugs, which may include:

- Possible high cost medication
- Evaluation of drug's risk profile
- Produced through DNA technology or biological processes
- Targets a chronic or complex disease
- Route of administration could be inhaled, infused, oral, or injected
- Unique handling, distribution and/or administration requirements
- Requires a customized medication management program that includes medication use review, member training, coordination of care and adherence management for successful use such that more frequent monitoring and training may be required
- Medication is only available via Limited Distribution Model to Specialty Pharmacy provider(s), per manufacturer requirements.

12. CLAIMS PROCESSING

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

The claims processing system shall include controls to identify questionable claims, prevent inappropriate payments, and ensure accurate reimbursement of claims in accordance with the applicable benefit design, Programs' provisions and negotiated agreements with pharmacies. All Program provisions for drug utilization review, benefit design and other utilization or clinical management programs must be adhered to for all prescriptions. Enrollee Submitted Claims (DCS Only) are required to be submitted to the Offeror no later than one hundred twenty (120) Days after the end of the Calendar Year in which the drugs were dispensed, or one hundred twenty (120) Days after another plan processes the claim, unless it was not

reasonably possible for the Enrollee to meet this deadline. The DCS Program count of Enrollee Submitted Claims can be found in Exhibit III.B of this RFP.

A. DUTIES AND RESPONSIBILITIES

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

(a) Verifying that the Programs benefit designs have been loaded into the system appropriately to adjudicate and calculate cost sharing and other edits correctly;
(b) Accurate and timely processing of all claims submitted under the Programs in accordance with the benefit design applicable to the Enrollee at the time the claim was incurred as specified to the Offeror by the Procuring Agencies;
(c) Charging the Programs consistent with the Offeror's proposed pricing quotes;
(d) Developing and maintaining claim payment procedures, guidelines, and system edits that guarantee accuracy of claim payments for covered expenses only, utilizing all edits as proposed and approved by the Procuring Agencies. The Offeror shall utilize refill too soon edits and duplication of therapy edits for all claims unless exceptions are specifically approved in advance by the Procuring Agencies. The Offeror's system must ensure that refilling Prescriptions prior to use of the minimum prescribed Days supply does not result in over dispensing;
(e) Managing Flexible Formulary (two Flexible Formularies – Original and Enhanced) and Preferred Drug List placement of drugs consistent with the Programs' design and ensuring application of appropriate Copayments based on level assignment (Copayments do not apply NYSIF's Program);
(f) Maintaining claims histories for 24 months online and archiving older claim histories for 6 years and the balance of the calendar year in which they were made with procedures to easily retrieve and load claim records;
(g) Maintaining the security of the claim files and ensuring HIPAA compliance;
(h) Reversing all attributes of claim records, e.g. AWP, quantity, Days supply, etc., processed in error ~~or due to fraud~~ including the reversal of any Claims Administration Fee associated with the original claim and crediting the Programs for all costs associated with the claim processed in error ~~or due to fraud~~ including but not limited to the Claims Administration Fee; and
(i) Agreeing that all claims data is the property of the State. Upon the request of the Department, the Offeror shall share appropriate claims data with other DCS Program carriers and consultants for various programs (e.g. Disease Management, Centers of Excellence) and the Department's DSS vendor (DCS only). The Offeror cannot share, sell, release, or make the data available to third parties in any manner without the prior consent of the Procuring Agencies. The Procuring Agencies understand that the selected Offeror will be required to share certain claims data with pharmaceutical manufacturers for purposes of obtaining for the Programs all Pharma Revenue due it under the Agreements resulting from this RFP. The Offeror shall inform the Procuring Agencies of the types of data being shared for these specific authorized purposes.
(j) Maintaining a back-up system and disaster recovery system for processing claims in the event that the primary claims payment system fails or is not accessible;
(k) Maintaining a claims processing system capable of integrating and enforcing the various utilization review components of the Programs, including, but not limited to: Mandatory Generic Substitution, Prior Authorization, messaging capability in the current NCPDP format, and a concurrent DUR program to aid the Pharmacist at the point of sale.
(l) Maintaining an electronic claims processing system capable of obtaining information from Network Pharmacies to ensure consistent enforcement of the Programs mandatory generic substitution

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

Pharmacy	Enrollee	Ancillary	
1	Brand	Yes	Generic
2	Brand	Yes	Generic
3	Generic	No	Generic
4	Generic	No	Generic
5	Generic	No	Generic
6	Generic	No	Generic
7	Brand	No	Brand
8	Generic	No	Generic
9	Generic	No	Generic

(m) Maintaining a claims processing system capable of ensuring that claims are consistently processed with the appropriate brand name/generic/compound classification in accordance with the requirements set forth in Section V.C.3.a.(6);
(n) Maintaining a Programs' MAC List for Pharmacies;
(o) (Exclusive to DCS) Processing Enrollee Submitted Claims in accordance with the following:

(i) For Prescriptions filled with a Brand Drug with no generic equivalent, the Enrollee will be reimbursed using the Offeror's Minimum overall guaranteed Discounted Ingredient Cost for the Retail Pharmacy Network and dispensing fee for Brand Drugs not to exceed the submitted charges, less the applicable Copayment;
(ii) For Prescriptions filled with a Brand Drug that has a generic equivalent, the Enrollee will be reimbursed up to the amount the DCS Program would reimburse the Retail Pharmacy Network for filling the Prescription with that drug's generic equivalent; not to exceed the submitted charges, less the applicable Copayment;
(iii) For Prescriptions filled with a Generic Drug the Enrollee will be reimbursed up to the amount the DCS Program would reimburse the Retail Pharmacy Network for that Prescription, not to exceed the submitted charges, less the applicable Copayment;
(iv) For Prescriptions filled with a Compound Drug the Enrollee will be reimbursed up to the amount the DCS Program would reimburse the Retail Pharmacy Network for that Prescription, not to exceed the submitted charges, less the applicable Copayment; and
(v) If the Enrollee has two Empire Plan coverages, the DCS Program will reimburse 100% of the copay upon submission of a paper claim form prepared by the Enrollee. For specific methodology on how the DCS Program must be charged for Enrollee Submitted Claims, see Section V.C.7. of this RFP entitled "Enrollee Submitted Claims."

(p) (Exclusive to NYSIF) Processing Non-Network Pharmacy claims submitted to the Offeror in accordance with Chapter V of title 12 NYCRR.

(q) (Exclusive to DCS) Processing claims for Employees enrolled in the SEHP who fill Prescriptions at the SUNY Stony Brook Student Health Service Pharmacy, and other SUNY pharmacies as may be requested by the Department during the term of the Agreement resulting from this RFP. Prescriptions under this arrangement must be dispensed according to the Plan design for the SEHP (see Exhibit II.C), including required prior authorizations and, where applicable, Days supply limits. The Offeror must monitor the submission of SEHP claims and inform the Department if the SUNY Pharmacies submit charges in excess of the amounts that are paid to the Program's Retail Network Pharmacies for the same NDC's;

(r) Processing all manually submitted claims including but not limited to Medicaid, VA, Skilled Nursing Facility claims, out-of-network claims (DCS and NYSIF), foreign claims, in-network manual claims, COB claims, and Medicare B primary claims in accordance to the Offeror's proposed Claims Adjudication Guarantee;

(s) Analyzing and monitoring claim submissions to promptly identify errors, fraud and abuse and reporting to the State such information in a timely fashion in accordance with a State approved process. The Programs shall be charged only for accurate (i.e., the correct dollar amount) claims payments of covered expenses. The Programs will be charged a Claims Administration Fee only for Final Paid Claims. The Offeror will credit the Programs the amount of any overpayment regardless of whether any overpayments are recovered from the Pharmacy and/or Enrollee in instances where a claim is paid in error due to Offeror error, or due to fraud or abuse, without additional administrative charge to the Programs. The Offeror shall report fraud and abuse to the appropriate authorities. In cases of overpayments resulting from errors only found to be the responsibility of the State, the Offeror shall use reasonable efforts to recover any overpayments and credit 100% of any recoveries to the Programs upon receipt; however, the Offeror is not responsible to credit amounts that are not recovered.

(t) Establishing a process where Pharmacies can verify eligibility of Enrollees and Dependents during Call Center Hours;

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

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

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

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

(y) (Exclusive to DCS) Processing claims pursuant to Enrollees covered under the Disabled Lives Benefit. DCS agrees to reimburse the selected Offeror for claims processed under the Disabled Lives Benefit in accordance with Section V.13 of this RFP.

(2) Program Claims Processing System Availability Guarantee: The Offeror must propose separate performance guarantees for the respective Programs. The Programs service level standard requires that the claims processing system will be available at least ninety-nine and five-tenths percent (99.5%) of the time excluding periods of scheduled down time, which shall be reported to the Department in advance

and kept to a minimum, based on a 24 hours a day, 7 Days a week availability, calculated on a quarterly basis.

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

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

B. REQUIRED SUBMISSION

(1) Provide a flow chart and step-by-step description of your proposed claims processing methodology for adjudicating each of the following claim types: Mail Order, Specialty Pharmacy, Network Pharmacy, Enrollee-submitted claims, and Non- Network Pharmacy claims for the NYSIF Program. Provide a description of the comprehensive edits you propose at the point of service to ensure proper claim adjudication, including a detailed description and example of how your proposed refill-too-soon (RTS) edit will operate to ensure cost effective dispensing of Drugs under the Programs. Confirm that you will implement your proposed full RTS edit on January 1, 2014.

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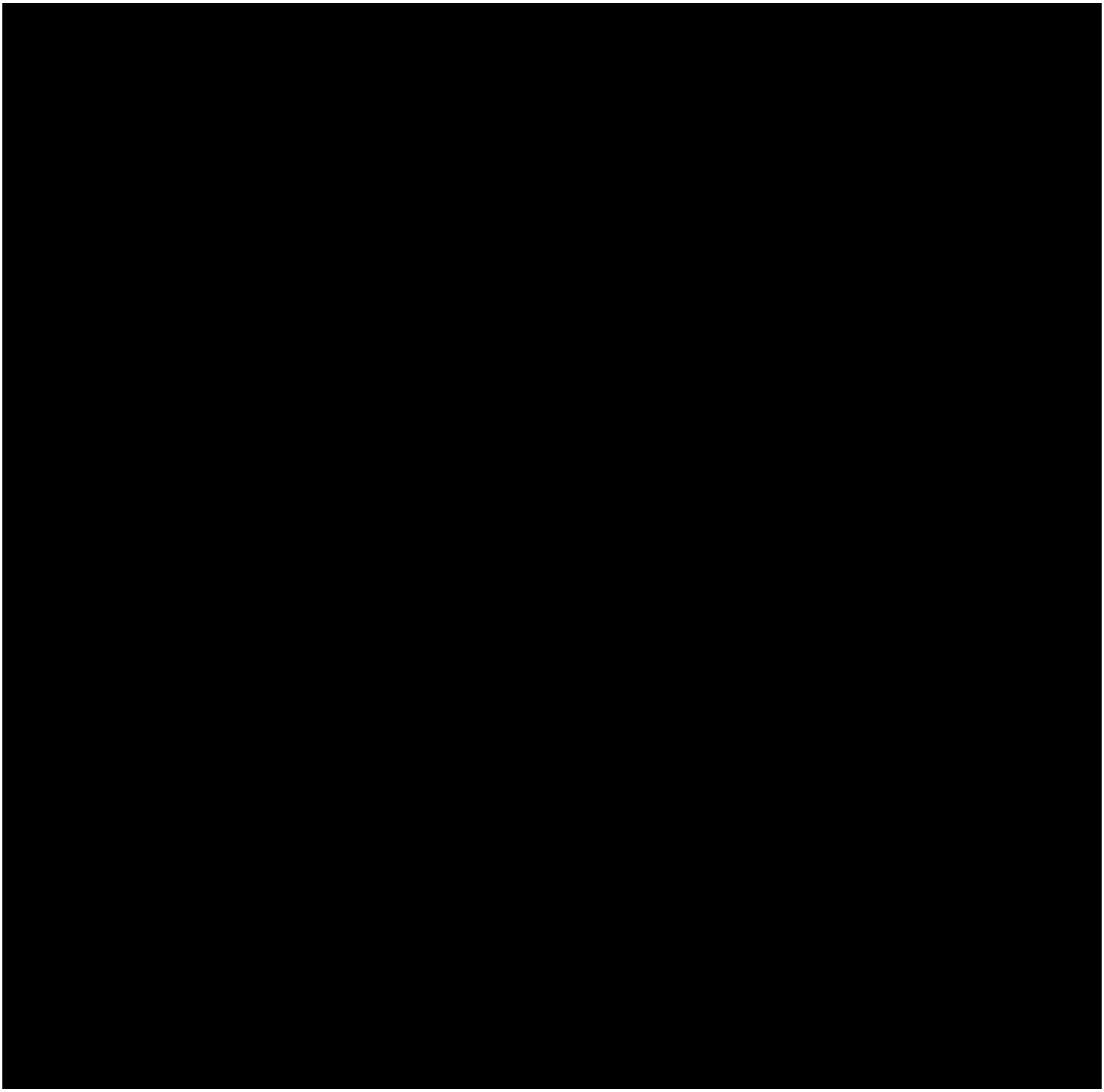


(2) Please describe your claims processing system platform including any backup system utilized. Describe your disaster recovery plan and how Enrollee disruption will be kept to a minimum during a system failure. What is the process for Enrollees trying to get a Prescription when the claims payment system is down or is not accessible?

[redacted]

[redacted]

[redacted]

(3) Describe the capabilities of your claim processing system to perform, at the point of service, for each of the following required Programs' components:

(a) The Programs generic substitution requirements based on the Programs' definition of a Generic Drug as set forth in Section VIII of this RFP;

Mandatory generic substitution will be applied 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. We will not include drugs that the Program chooses to exempt, such as NTI drugs.

CVS Caremark abides by all applicable State and Federal laws when dispensing generic products, closely monitoring any changes in generic laws in the states in which we dispense, and updating drug files accordingly. CVS Caremark follows the guidelines from Approved Drug Products with Therapeutic Equivalence Evaluations (an FDA publication, also known as the Orange Book) and will substitute only those products the FDA has classified as therapeutically equivalent. We also comply with specific substitution rules in states with more restrictive rules than those in the FDA Orange Book.

CVS Caremark confirms the ability to process claims according to the brand and generic drug definitions as set forth in the contract, and adjudicate claims according to the current plan design parameters of the Mandatory Generic Substitution program. The below criteria align with the Program's requirements.

(c) A Prior Authorization Program for specific drugs that have an increased risk of inappropriate utilization;

Drugs that require prior authorization are set up systematically in our online claims processing system; a message (for example, *Prior Authorization Required*) is sent to the pharmacist at the point-of-service. A drug is considered covered only when the prior authorization request meets established criteria.

Specific to the NYSIF population, CVS Caremark supports formulary customization and monitoring at the plan level and allows for customization at the injury level. The processing system provides immediate feedback to providers when medications outside the formulary are dispensed. The client will have the ability to restrict any drugs that have an increased risk of inappropriate utilization. When formulary restrictions are in place at the plan level, as well as profile restrictions at the patient level, any medication not included in the formulary, or listed in the patient's profile, requires pre-authorization before the processing system will authorize.

(c) A concurrent DUR program identifying Enrollee drug therapy safety edits and Programs' benefit edits;

Our system can perform up to 500 concurrent DUR edits on every prescription – in real time, at mail and retail – to ensure that the prescription meets both administrative and member safety criteria. Our system has been improved to reduce wait time and help eliminate disruption for the Programs' members.

Our concurrent DUR program reviews the following areas:

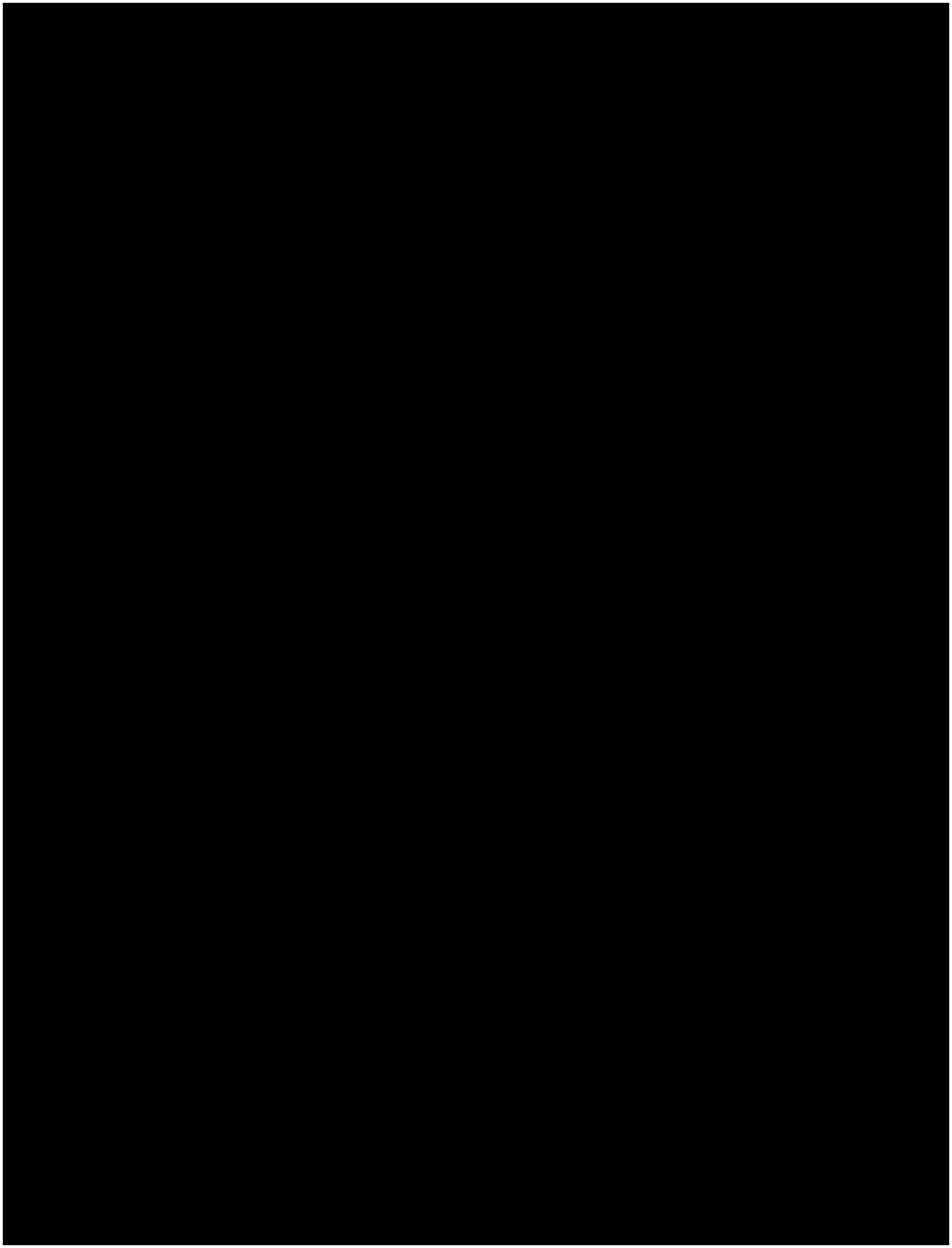
- Conformity with plan design
- Member eligibility
- Formulary compliance
- Refill limits
- Dosage limits
- Dispensing accuracy and consistency
- Potential drug safety issues (e.g., drug-drug, drug-allergy, drug-gender and drug-pregnancy interactions; inferred drug-disease interactions; high dose and low dose alerts; and therapeutic duplications)

Our concurrent DUR program edits ensure that your members are conforming to prescription safety standards, and the program also protects your plan design by ensuring that each mail and retail prescription conforms to the established parameters set by the plan.

For the NYSIF population, at the time of dispense, medications are compared against the patient's profile, the patient's medical condition and specific patient demographic features to assess the appropriateness of the medication for the injury. Edits may be hard or soft and include incorrect dosage, incorrect duration, member eligibility, formulary compliance, duplicate prescription, dollar limit edits, quantity edits, days supply edits, and generic utilization edits.

(d) Messaging capabilities to the Network Pharmacy;

[redacted]



[redacted]

(e) Eligibility verification;

All delivery systems verify against the eligibility data provided by the programs, using the eligibility rules established. Eligibility rules, such as dependent age constraints, can be specific to the delivery system.

CVS Caremark uses a "stacking" application method for tracking and storing historical eligibility:

- Eligibility is sent with one record for each beneficiary. This record represents the most current eligibility status for a member.

- The eligibility load program builds history by adding the new eligibility information based on the new effective date of coverage. The previous coverage row is terminated as of one day prior to the new effective date.

For established injuries under the Workers' Compensation program, eligibility is determined by matching the Cardholder ID and the Date of injury received from the pharmacy as part of the NCPDP version D.0 data standard for pharmacy claim submission against the system Injury database created from the client's eligibility files. When a match is found and the claim status is verified to be 'Active', the claim is considered as eligible.

(f) Customized edits for individual Enrollees;

Our system has the flexibility to apply customized member-level edits if requested by DCS/NYSIF. These edits include, but are not limited to, specific pharmacy, physician, or drug restrictions.

For the NYSIF program, formularies can be customized at the patient level to include medications not normally covered under workers' compensation, or to exclude medications for a specific patient that would otherwise be included in the standard workers' compensation formulary.

(g) Utilization of some medications intended to treat conditions limited to one sex;

Using plan design, CVS Caremark can set up gender-specific edits for specific drugs according to the Programs' preferences. At a mail service pharmacy, the DUR system would flag the prescriptions for these drugs when appropriate and divert them to a clinical pharmacist for review. At a retail network pharmacy, an electronic message would be sent back to the pharmacist. In addition, select serious drug-gender interactions will be sent as alerts to pharmacists through the POS DUR system.

(h) Historic claims look up capability to reduce Enrollee disruption at the point of sale;

Historic claims are maintained in the system to allow for online real-time adjudication of certain plan edits, such as prior authorization, step therapy, deductibles, and DUR to prevent disruption to enrollees. Also, our Customer Care representatives have desktop access to integrated real-time electronic claims data to better serve the Programs, their enrollees, and network pharmacies.

(i) (Exclusive to DCS) Multi-level cost sharing;

CVS Caremark's diverse client base requires us to accommodate any combination of plan designs, formularies, and utilization management functions. For designs with multi-level cost sharing, a common approach in today's market, messages are immediately transmitted at the point of service, advising the pharmacy of claim status (pay or deny), claim payable amount, member cost-share amount, and applicable DUR messages. The entire process occurs within seconds.

(j) Identification and pricing of compounded Prescriptions consistent with the Programs' definitions and requirements set forth in this RFP; and

The industry-wide NCPDP D.0 standard for multi-ingredient compounds is required for compound claims and CVS Caremark supports this functionality. This new functionality captures each ingredient used in the compounded prescription.

The claims adjudication system will determine an allowable ingredient cost for each 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. At this point, there is a final check to compare the Allowable Final Ingredient Cost plus dispensing fee and Level of Effort (LOE) Fee to the pharmacy submitted total Usual & Customary price for determination of the overall final charge.

For the EGWP program, compound drugs will be defined in accordance with CMS regulations and guidance.

(k) Recognition of Pharmacy submitted cost and ensuring the Programs receive the Lesser of Logic for all Prescriptions filled at a network and Non-Network Pharmacy or through the Mail Service and Specialty Pharmacy Processes.

Our system would process the pricing as follows:

1. Compare the lesser of AWP and MAC
2. Add the dispensing fee
3. Compare the result of the lesser of the AWP or MAC plus dispensing fee against Usual & Customary and return the lesser as the price of the claim.

For the NYSIF program, we will pay non-network pharmacies per Section 8 (Non-Network Pharmacy Submitted Claims (Excusive to NYSIF) in the cost proposal.

(4) Please describe how your claims processing system will reject Network Pharmacy claims submitted with a DAW-0 code and send appropriate messaging to Pharmacists to ensure submission of a code that provides an indication of the Generic Drug's availability in the Pharmacy to facilitate consistent and accurate application of the Programs' mandatory generic substitution provisions.

Claims for brand name drugs that have both an A-rated generic available and are submitted with a DAW 0 are coded to reject, and a message is returned to indicate invalid DAW code and that generic substitution is available.

For the EGWP program, a Mandatory Generics program is not allowed per CMS guidance.

(5) Describe how your adjudication system feeds the reporting and billing systems and any claim update data delays.

Our claim files are built directly on our adjudication platform. The claim files are created using elements from the claim extract file to report the data as it was adjudicated for each claim. Each file contains all paid records adjudicated within the specified period as well as any out of cycle reversals (reversal of a previously paid claim from a prior reporting period). On a nightly basis, adjudicated clams are fed into the claims extract file, which is the source for all back end reporting and billing.

StoneRiver Pharmacy Solutions will provide a daily Transaction File to feed to CVS Caremark's reporting and billing systems for NYSIF.

(6) Do you own the adjudication system, license the software or contract out this service?

CVS Caremark owns the adjudication system.

Workers compensation claims are processed under StoneRiver Pharmacy Solutions, our technical partner, to deliver best in class claim processing for NYSIF.

(7) How quickly are your systems brought into compliance when a new version or capability of the standard NCPDP format for claims transmission is released?

CVS Caremark is not permitted to modify the NCPDP vD.0 Telecom Standard. The U.S. Department of Health & Human Services (HHS) is the legal entity authorized to make such changes. Typically, HHS initiates these modifications by issuing a Notice of Proposed Rule Making (NPRM) that requires interested parties to respond with comments by a certain date, which is defined by HHS. Once HHS reviews all comments received, it issues a final ruling that requires all covered entities, as defined by the NPRM, to comply with the terms outlined in the ruling by a certain date, which also is defined by HHS.

The process outlined above dictates all timeframes for changes to the NCPDP vD.0 Telecom Standard.

(8) Describe the current Network Pharmacy available overrides to your claims adjudication system. How would overrides from the Retail Pharmacy Network and messaging to the retail Pharmacy network be tracked and reported to the Procuring Agencies? Describe the loading of an override within your claims processing system and confirm whether it over-rides your client's program benefit design? If so, provide the circumstances where you would load an override edit at the point of service. If applicable, describe the circumstances where you would approve the dispensing of quantities in excess of the benefit design amounts within your concurrent DUR program.

CVS Caremark's Concurrent DUR provides online utilization review for appropriate drug use and drug interactions. A potential drug interaction is identified online, in real time, through our Integrated Claims Adjudication System at both the mail and retail pharmacies.

If any problems in these areas are indicated, a registered pharmacist will contact the prescriber for authorization prior to filling the prescription.

The dispensing pharmacy is notified of Level 1 or "Very Severe" drug interactions where there is a high risk of potential harm to the member. This message rejects the claim at mail service and sends an alert to retail pharmacies.

The drug interaction alert provides messages to the pharmacist, explaining that the prescription being filled can or will harmfully interact with another medication. The message includes the name, strength, and quantity of the interacting medication.

PHARMACIST OVERRIDE

For a pharmacist to override DUR messages, an authorization override code must be utilized. This code is entered only after the pharmacist has discussed the detected clinical concern with the prescriber or exercised his/her professional judgment. The retail pharmacist can then dispense a different drug with the prescriber's approval, not dispense the prescribed drug at all, or override the rejection and fill the prescription as written.

CVS Caremark's override codes become part of the permanent record, providing an audit trail if questions regarding dispensing arise in the audit process.

For the NYSIF program, formularies can be customized at the patient level. Individual injuries may be customized by adjustors and nurse case managers to define a customized treatment protocol to include or to exclude specific medications. In these cases, the system will override the client's normal program benefit design and use the individual claim customization to authorize or reject a medication.

(9) Describe how the Mail Service Pharmacy Process, Specialty Pharmacy Program and Network Pharmacy Claims will be subjected to the same prior authorization/quantity limitations, Point of Service and DUR edits and how a common Enrollee profile is maintained for each Enrollee? Is this process on-line for both systems?

Our claims processing system works from a single database that ensures complete integration of all retail and mail service claims data. Our single platform system technology incorporates online capabilities that are mirrored in both the retail and mail service environments. This point-of-service technology helps ensure maintenance of a completely integrated member history, with updates to eligibility and plan specifications available instantaneously for both retail and mail service pharmacies. Total database integration between our retail program and mail service dispensing facilities is achieved through the transmission and adjudication of both retail and mail service claims via our online system, and clinical/UM rules such as concurrent DUR, retrospective DUR, Prior Authorization, and the DCS Mandatory Generic program are applied consistently across pharmacy touch-points.

Member profile information is captured and stored in the computer system each time a prescription is submitted through either the mail service pharmacy or a retail network pharmacy. Each time a medication is dispensed through CVS Caremark, the transaction is entered and integrated for use within the claims processing suite of systems. Member history profiles are maintained online throughout the member's eligibility, and the ship date and method of shipment of each prescription is stored on the original prescription record for seven years. When processing paper claims, CVS Caremark adds and updates member addresses in addition to capturing diagnosis information, if provided.

(10) Describe how any changes to the benefit design would be monitored, verified and tested for the Programs, and the quality assurance program to guarantee that changes to other client benefit programs do not impact the Programs.

Once a benefit request is received, the change is submitted by the Benefits Relationship Manager (BRM) or the Account Manager for setup in our adjudication system. Once the change is completed with the appropriate effective date, test claims are run to ensure client intent is met. These changes are completed in a pre-production environment. Once test results are reviewed and approved, the changes will be promoted to our production environment.

Monitoring Benefit Changes

The Salesforce.com (SFDC) system is a comprehensive tracking tool to monitor end to end benefit changes across all operational platforms. SFDC tracks all Benefit Administration Request (BARs) submitted to the Client Benefits Department from Account Managers, BRM, Clinical or Implementation Managers. SFDC has the ability to track all changes at different stages of the request (who made the change, automated date/time stamp, and capture all documentation associated with that change under a unique number, improving audit functionality, consistency and quality). Requests are submitted directly to a resource for assignment and do not need to go through a 'gatekeeper' process.

Quality Assurance and Testing

CVS Caremark stages all new plans and plan changes within a pre-production environment. Within the pre-production environment, plans are tested extensively before they are moved to production. Once the plans are tested and reviewed, the plans are moved to production, thus allowing claims to process against the new/modified plans.

The Quality Assurance process involves a review of the system setup and testing outcomes against client documentation to ensure the setup is accurate and complete. Initial testing is performed by the coders, who then send a formal testing request to Quality Assurance staff.

The testing process involves running test claims for the affected groups in a pre-production environment. The number of scenarios and plans tested depends on the complexity of the changes. For example, if a quantity change is requested for a particular drug, the testing will be performed using the NDC of that drug with a quantity below, at, and above the new quantity limit.

Errors are corrected as soon as possible. Once corrected, the Account Manager submits the documentation to the Service Warranty department within 3 days of correction to begin the process of determining the financial reimbursement. Errors are tracked and trended in order to provide coaching and identify training needs.
Specific to the NYSIF program, StoneRiver Pharmacy Solutions employs a Quality Assurance Department, which verifies and tests all program changes on a dedicated development system prior to releasing program changes onto the live production system. In addition, client data is logically separated via database controls and are indexed/filtered by Client ID to prevent unauthorized changes to the client's benefit program.

(11) Identify the resources that are available to a Pharmacist who is having difficulty processing a claim at the point of service. How do you ensure that the Pharmacist is able to get through to a person to resolve the issue?

(12)(Exclusive to DCS) Confirm that your claims processing system has the capability to: stop claims at the point of service for Enrollees who are enrolled in a Medicare Part D; plan other than the DCS Program EGWP and send messaging to the Pharmacy to instruct the Pharmacist to submit the claim to the Enrollee's Medicare Part D Plan.

CVS Caremark confirms. When a participant enrolls in a Part D plan, when they indicate that other coverage exists, the CMS COB Contractor will collect this information and send to the Part D plan on a file. The CVS Caremark system will accept and store this information and message back to the pharmacy (often referred to as ADDINS or Additional insurance messaging) 4Rx processing information as provided on the COB file from CMS. The ADDINS messaging will provide processing information to the pharmacy indicating the payor order of all insurance coverage in order to enable them to process the claims to each payor. Additionally, if the eligibility is flagged on the Part D plan as secondary coverage, the claim will reject at the point of sale and provide information about payors that would pay before the Part D plan, as indicated on the COB file from CMS.

(13)Explain how your claims processing system collects overpayments from your Retail Pharmacy Network.

Overpayments and underpayments resulting from system errors are rare. If an error occurs, CVS Caremark's Service Warranty team is notified and appropriate steps are taken to immediately correct the effected system. The steps followed by our Service Warranty team include:

- Identifying the impacted claims
- Quantifying the financial impact
- Remitting/billing monies owned to the member and/or the client.

(14) Confirm the Offeror will reverse all attributes of claim records, e.g. AWP, quantity, Days supply, etc., processed in error or due to fraud including the reversal of any Claim Administration Fee associated with the original claim and crediting the Programs for all costs associated with the claim processed in error, including but not limited to the Claim Administration Fee;

CVS Caremark's claim adjudication system enables the ability to code Programs-specific rules to conform to the desired benefit design parameters and accurately adjudicate claims according to various PDL strategies. In addition, CVS Caremark's multi-faceted Fraud, Waste, and Abuse program comes with Point of Service edits that aim to identify potential fraudulent claims (e.g. missing information, cardholder not covered, refill too soon, etc.)

CVS Caremark confirms, as specified in Section IV.B.12.a.(1)(h) above, that it will reverse all attributes of claim records processed in error, including the reversal of any Claims Administration Fee associated with the original claim and credit the Programs in the amount of any overpayment, whether recovered from the pharmacy and/or Enrollee, in instances where a claim is paid as a result of a system error, including instances of erroneous application of those edits that intend to detect fraud and abuse as well as any other point of service edits that govern the Programs' coverage rules and benefit design.

(15)Describe how the Offeror will analyze and monitor claim submissions to promptly identify errors, fraud and abuse and report such information in a timely fashion to the State in accordance with a State approved process. Confirm the Programs shall be charged only for accurate (i.e., the correct dollar amount) claims payments of covered expenses and will be charged a Claims Administration Fee only for Final Paid Claims. Confirm the Offeror will credit the Programs the amount of any overpayment regardless of whether any overpayments are recovered from the Pharmacy and/or Enrollee in instances where a claim is paid in error due to Offeror error, or due to fraud or abuse. In cases of overpayments resulting from errors only found to be the responsibility of the Department, the Offeror shall use

reasonable efforts to recover any overpayments and credit 100% of any recoveries to the Programs upon receipt; however the Offeror, is not responsible to credit amounts that are not recovered.

We monitor each pharmacy on all claims submitted via the online claims processing system. System edits applied at the point of service act as an automated management tool to monitor and ensure compliance with program parameters before the prescription is dispensed. Few other vendors can provide the Programs with as stringent a set of online electronic claims verification and authorization edits, combined with extensive pharmacy desk audit and field audit capabilities. More than 85 categories of clinical and qualitative edits are performed automatically by our claims processing system to verify the accuracy and appropriateness of all online claims submitted to CVS Caremark, including member eligibility, formulary verification, and prior authorization. In addition to the audits conducted by the Claims Analysis group, our Quality Assurance staff will conduct claims administration audits based on the Programs' benefit plan designs. Claims audit results are utilized to assess the overall performance of our online and paper claims processing procedures, as well as to provide recommended operational enhancements where needed, resulting in optimal processing performance.

CVS Caremark's comprehensive audit process is designed to identify discrepancies; prevent and detect fraud, waste, and abuse; and provide a deterrence message to pharmacies – all of which help us fulfill our commitment to reducing total health care costs for our clients. When fraud, waste, or abuse involving a network pharmacy is identified, CVS Caremark works closely with the impacted clients to communicate the issues and provides the necessary support to correct any future problems.

Our audit process encompasses sophisticated tools, which include:

- Pharmacy Exceptional Activity Report (PEAR)
- Daily Review and Compound Review
- Member-Submitted Review - Tracking and Escalations
- Payment trending analysis
- Late night claims analysis
- Aberrant dosing reviews
- Member tracking
- Pharmacy data mining for fraudulent pattern recognition
- Education efforts
- External tips and follow-up.

Our comprehensive approach includes daily and compound review processes, onsite process, and intensive investigational audits.

CVS Caremark confirms, as specified in Section IV.B.12.a.(1)(h) above, that it will reverse all attributes of claim records processed in error, including the reversal of any Claims Administration Fee associated with the original claim and credit the Programs in the amount of any overpayment, whether recovered from the pharmacy and/or Enrollee, in instances where a claim is paid as a result of a system error, including instances of erroneous application of those edits that intend to detect fraud and abuse as well as any other point of service edits that govern the Programs' coverage rules and benefit design.

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

Yes. On behalf of our clients, CVS Caremark works with leading debit card companies to support FSA, HRA, and HSA plans. The data that can be provided is typically used to support real-time substantiation at retail and mail service, or a retrospective audit of debit card transactions. With the IIAS guidelines that were set forth, technology

has been put into place by pharmacies to substantiate transactions at the point of service. CVS Caremark can provide claims data in real time or via batch feed.

CVS Caremark communicates with medical integrators either in real-time or in batch mode. We have established electronic connections with over 165 medical integrators and continue to add new medical integrators throughout the year.

Debit cards are not applicable to NYSIF program.

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

The industry-wide NCPDP D.0 standard for multi-ingredient compounds is required for compound claims and CVS Caremark supports this functionality. This new functionality captures each ingredient used in the compounded prescription. In D.0 format, the pharmacist would submit the following elements:

- Compound Indicator
- The NDC, Quantity, Submitted Ingredient Cost for each individual component in the recipe
- Total Quantity and total Usual & Customary price
- Level of Effort value

The claims adjudication system will determine an allowable ingredient cost for each 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. At this point, there is a final check to compare the Allowable Final Ingredient Cost plus dispensing fee and Level of Effort (LOE) Fee to the pharmacy submitted total Usual & Customary price for determination of the overall final charge.

The NCPDP D.0 standard for multi-ingredient compounds provides an allowance for professional services called Level of Effort, or LOE. The following table lists the LOE values and descriptions.

Level of Effort values	Description
1	Single ingredient batched capsule; any combination of commercially available products
2	Two or three ingredient batched capsule; transdermal gel
3	Four or more ingredient batched capsule; three or less ingredient cream/ointment/gel: suppository; two or less ingredient capsule: noncomplex suspension; tablet triturate
4	Topical containing controlled ingredient; three or more ingredient troche; four or more ingredient capsule; complex suspensions (i.e., pediatric); custom capsule (includes rapid dissolution preparations); chemotherapy cream/ointment/gel; hormone therapy (capsules, troches, and suppositories)
5	Sterile product

Additional adjudication edits may apply based on plan design parameters (e.g., Prior Authorization, managed drug limits) and CMS requirements for Part D plans (e.g., Part D excluded drugs, transition fills).

In addition to the electronic controls though CVS Caremark's electronic claims processing system that assist evaluation of compound pricing, CVS Caremark will utilize its comprehensive, dedicated audit unit to review compounds claims for the Programs. This team is supervised by a pharmacist with significant experience in

compound audits and the unit has the appropriate experience and education (e.g., prior compound pharmacy experience, CPhT).

The audit team will review compound prescription claims submitted online. Each component of the audit process: daily review (desk audits), on-site audits, and investigational audits include compound medication reviews and include compound claims in the audit process.

(18) Programs' Claims Processing System Availability Guarantee: The Programs service level standard requires that the Programs' online claims processing system be available at least ninety-nine and five-tenths percent (99.5%) of the time excluding periods of scheduled down time which shall be reported in advance to the Department and kept to a minimum, based on a 24 hours a day, 7 Days a week availability (or the Offeror's proposed guarantee). The Offeror shall propose, separately for each Program, the forfeiture of a specific dollar amount of the Claims Administration Fee for failure to meet this guarantee.

The standard credit amount for each .01 to .25% below the ninety-nine and five- tenths percent (99.5%) that the Offeror's online claims processing system for the Programs are not available, is $100,000 per each quarter for DCS and $7,500 for NYSIF. However, the Offeror may propose higher or lesser amount.

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

[redacted]

(19) (Exclusive to DCS) Turnaround Time for Claims Adjudication Guarantee: The DCS Program's service level standard requires that at least ninety-nine and five- tenths percent (99.5%) of Enrollee-submitted claims that require no additional information in order to be properly adjudicated that are received by the Offeror and not turned around within ten (10) Business Days from the date the claim is received in the Department's Designated Post Office Box to the date the Explanation of Benefits is received by the mailing agent. The Offeror shall propose the forfeiture of a specific dollar amount of the Claims Administration Fee for failure to meet this guarantee.

The standard credit amount for each .01 to .25% of the DCS Program's Enrollee- submitted claims that require no additional information in order to be properly adjudicated that are received by the Offeror and not turned around within ten (10) Business Days from the date the claim is received in the Department designated Post Office Box to the date the Explanation of Benefits is received by the mailing agent

below the standard of ninety-nine and five-tenths (99.5%) is $5,000 per each quarter for DCS. However, the Offeror may propose higher or lesser amounts.

The Offeror's quoted amount to be credited against the Claims Administration Fee for each .01 to .25% of Enrollee-submitted claims that require no additional information in order to be properly adjudicated that are received by the Offeror and not turned around within ten (10) Business Days from the date the claim is received in the Department designated Post Office Box to the date the Explanation of Benefits is received by the mailing agent, below the standard of ninety-nine and five-tenths percent (99.5%) as calculated on a quarterly basis, is $ _for DCS.

(20) (Exclusive to NYSIF) Turnaround Time for Claims Adjudication Guarantee: The NYSIF Program's service level standard requires that at least ninety-nine and five- tenths percent (99.5%) of Non-Network Pharmacy claims that require no additional information in order to be properly adjudicated that are received by the Offeror and not turned around within thirty (30) Calendar Days from the date the claim is received in NYSIF's Designated Post Office Box to the date the Explanation of Benefits is received by the mailing agent. The Offeror shall propose the forfeiture of a specific dollar amount of the Claims Administration Fee for failure to meet this guarantee.

The standard credit amount for each .01 to .25% of the NYSIF Program's Non- Network Pharmacy submitted claims that require no additional information in order to be properly adjudicated that are received by the Offeror and not turned around within thirty (30) Calendar Days from the date the claim is received in the FUND's designated Post Office Box to the date the Explanation of Benefits is received by the mailing agent below the standard of ninety-nine and five-tenths (99.5%) is $375 per each quarter for NYSIF. However, the Offeror may propose higher or lesser amounts.

The Offeror's quoted amount to be credited against the Claims Administration Fee for each .01 to .25% of Non-Network Pharmacy submitted claims that require no additional information in order to be properly adjudicated that are received by the Offeror and not turned around within thirty (30) Calendar Days from the date the claim is received in NYSIF's designated Post Office Box to the date the Explanation of Benefits is received by the mailing agent, below the standard of ninety-nine and five-tenths percent (99.5%) as calculated on a quarterly basis, is $ for NYSIF.

13. RETROSPECTIVE COORDINATION OF BENEFITS (EXCLUSIVE TO DCS)

The selected Offeror must be capable of administering a retrospective coordination of benefits (COB) recovery program. The DCS Program's current COB process is administered on a retrospective basis. A claim is not stopped at the point of service nor is there any current plan to have Prescriptions stopped at the point of service to verify COB coverage unless it is indicated that the Enrollee has enrolled in a Medicare Part D Plan other than the DCS Program EGWP. The DCS Program allows members to receive Prescriptions and have the selected Offeror seek COB recoveries after the Prescription is dispensed.

A. DUTIES AND RESPONSIBILITIES

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

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

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

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

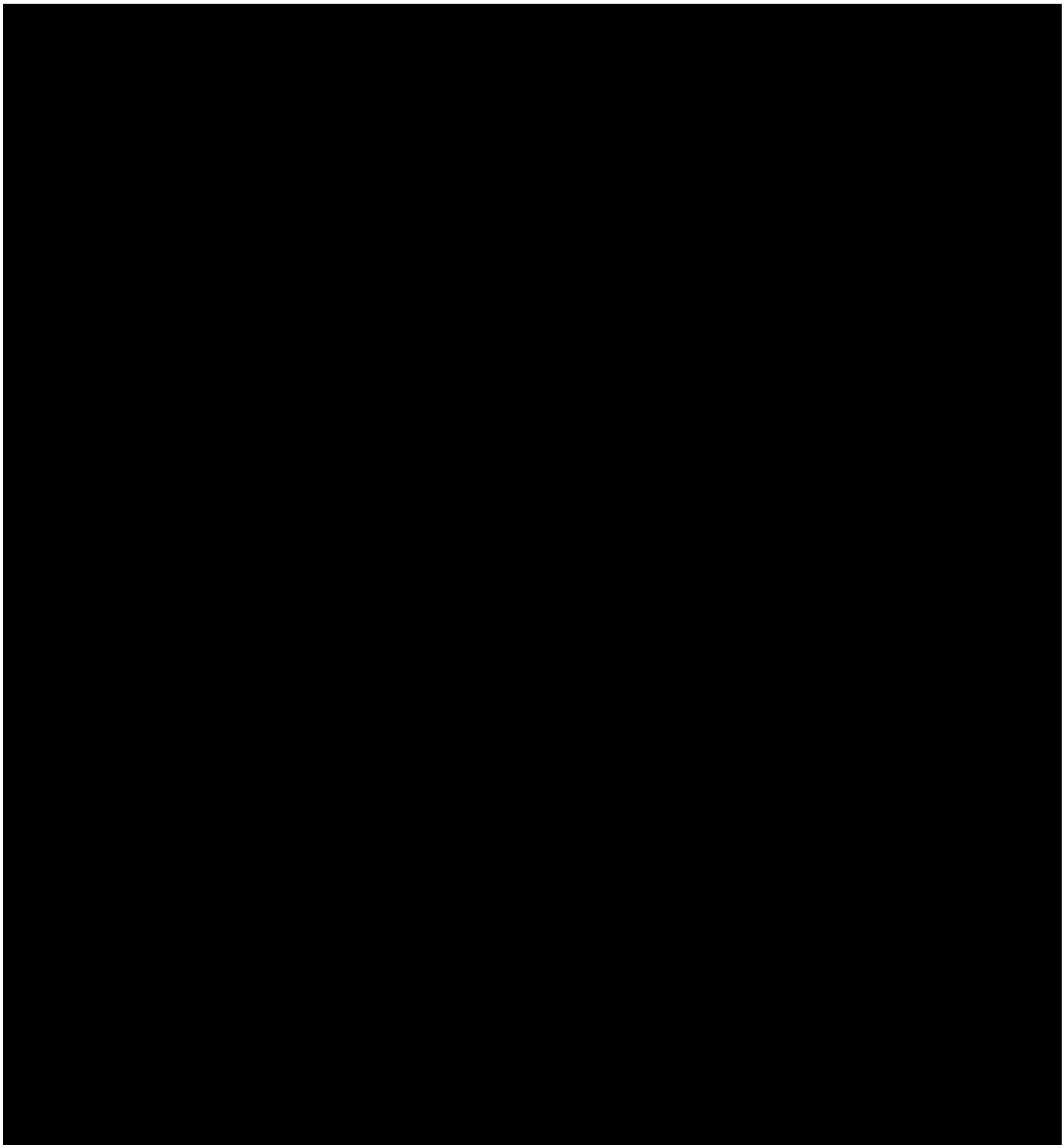
Note: Offerors may choose to enter into a Key Subcontract for the provision of these services; however, the cost of this service must be included in the Offeror's proposed Claims Administration Fee with all gross recoveries credited to the DCS Program (no carve-out of Key Subcontractor fees will be permitted).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

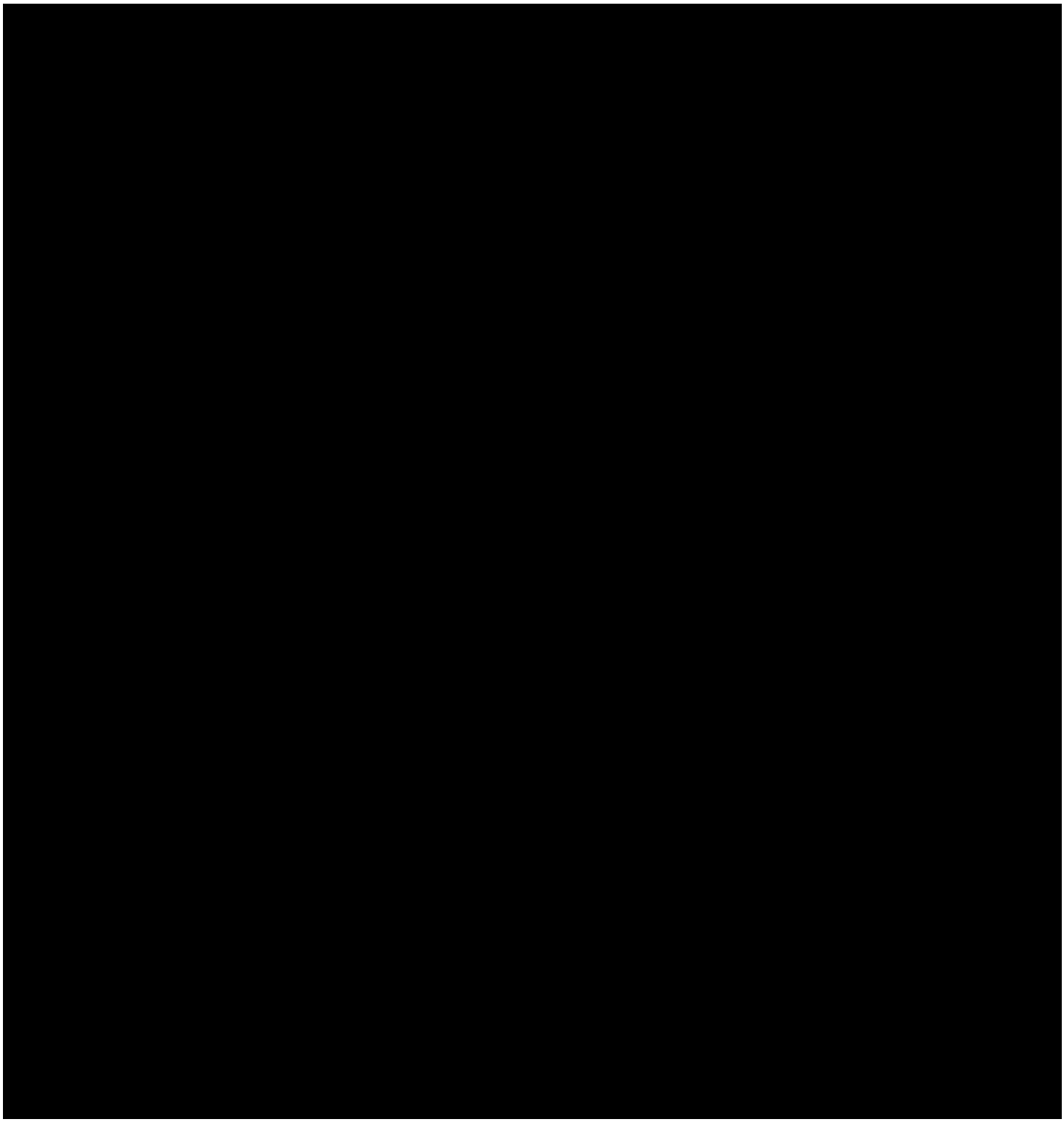
B. REQUIRED SUBMISSION

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

[redacted]

[redacted]





14. UTILIZATION MANAGEMENT

Mandatory Generic Substitution at Retail and Mail

Appropriate utilization of cost-effective clinically equivalent Generic Drugs is an integral component of the Programs benefit design. To promote the use of Generic Drugs, the Programs have a mandatory generic substitution requirement that mandates that FDA approved generic equivalents be substituted for the equivalent Brand Drug or the Enrollee pays the Non-Preferred Brand Drug Copayment plus an Ancillary Charge (DCS only) equal to the difference in the Ingredient Cost of the Brand Drug and the Ingredient Cost of the Generic equivalent, not to exceed the cost of the drug, unless otherwise directed by the Department. Mandatory generic substitution will be applied to all specific NDC's of Brand Drugs for which there is an FDA approved A-rated Generic Drug (including but not limited to, Generic Drugs rated AA, AB, AN, AO, AT, etc) or an authorized Generic Drug, as permissible by NYS law. Network Pharmacies shall comply with all state laws related to mandatory generic substitution. The Programs' mandatory generic substitution provisions shall apply to any claim where the A-rated or authorized Generic drug is required or permitted to be substituted under state law. Mandatory generic substitution provisions will not apply to B-rated or unrated Generic drugs or in the unlikely event that state law prohibits dispensing of the A-rated or authorized Generic Drug. Mandatory generic substitution provisions shall apply if a Physician writes a Prescription with a Dispense as Written (DAW) code for a Brand Drug that has an A-rated or authorized Generic Drug available. The Enrollee should be informed that an Ancillary Charge (DCS only) will be applied and the Pharmacist should offer to contact the prescribing Physician for approval to dispense the Generic Drug. Enrollees who receive a multi-source Brand Name drug because of a DAW notation are still required to pay both the applicable Brand Drug Copayment and the Ancillary Charge (DCS only). Mandatory generic substitution does not apply to the strength of a particular drug for which there is no approved Generic Drug.
The Department's Program currently has the following exceptions to the mandatory generic substitution requirement: Coumadin, Dilantin, Lanoxin, Levothroid, Mysoline, Premarin, Synthroid, Tegretol and Tegretol XR. Because the drugs are exceptions to the mandatory generic substitution requirement, no Ancillary Charge can be imposed. The drug placement on the Offeror's proposed PDL will determine the Copayment (DCS only) for these drugs subject to the Program's benefit design which requires that a Brand Drug with a Generic equivalent be placed on the third level of the Preferred Drug List. An appeal cannot change the level status of these drugs on your proposed PDL.

A. DUTIES AND RESPONSIBILITIES

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

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

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

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

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

(a) Inform the Department as soon as practicable but in no event later than 14 Days after the first date of shipment, (from manufacturer to wholesaler or retailer) of the financial impact of enforcing mandatory generic substitution via the "MAC Alert Notice" detailed in Section IV.B.8.a. of this RFP, under the subheading "Reports Required at Other Frequencies."
(b) For those drugs that will result in a lower net cost to the Program by enforcing mandatory generic substitution, the Offeror shall provide the "MAC Alert Notice" as described in (a) above. The Offeror shall add the GCN to the Programs' MAC List and begin enforcement as soon as practicable but in no event later than 14 Days after the first date of shipment provided that the majority of Retail Network Pharmacies are able to obtain the Generic Drug. In the case where a GCN is already subject to MAC pricing the Offeror is required to immediately apply the MAC price and mandatory generic substitution to any NDC added to the GCN following the first date of shipment.
(c) For those drugs that could potentially result in a higher net cost to the Programs by enforcing mandatory generic substitution, the Offeror shall provide the "MAC Alert Notice" as described in (a) above. The Department, in its sole discretion, may determine that enforcement is contrary to the best financial interests of the DCS Program and shall inform the Offeror whether mandatory substitution shall be applied. If the Offeror does not receive a formal response to the information provided via the "MAC Alert Notice," enforcement shall commence and the GCN shall be added to the Programs' MAC List effective on the 21st day after shipment of the first A-rated generic equivalent drug or authorized Generic Drug provided that the majority of pharmacies are able to obtain the Generic Drug. In the event the Department decides to exercise its discretion not to enforce mandatory generic substitution, the Offeror shall apply MAC pricing to the Generic Drug.
(d) To assist the Department in determining when mandatory generic substitution should be enforced based on an adequate supply of Generic drug being available in the market, the Offeror shall survey its Retail Pharmacy Network to identify the Pharmacies that are unable to obtain the new Generic Drug within 21 Days and weekly thereafter until the shortage resolves. The Offeror shall submit this information to the Department and provide any additional information as required by the Department to reach a determination. The Department, in its sole discretion, shall determine based on such evidence how the DCS Program's mandatory generic substitution provisions will be applied. The DCS Program will not consider and the Offeror shall not act on availability information provided by 3rd party sources, including but not limited to Medi-Span, Red Book, First Data Bank or wholesalers.
(e) For Preferred Brand Drugs for which an A-rated or authorized Generic Drug has been introduced into the market for one or more strengths of a Brand Drug, the status of the Brand Drug shall be

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

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

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

(5) Charge the Programs based on the Programs' MAC List price assigned to the GCN of the dispensed Brand Drug subject to the Programs' Lesser of Logic plus the applicable dispensing fee as set forth within "Program Claims Reimbursement" of the Contract Provisions, Section VII of this RFP;

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

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

submission codes as necessary to ensure consistent, accurate application of the Programs' mandatory generic substitution requirements;

(8) Immediately notify the Procuring Agencies of changes (from brand to generic or generic to brand) in the NDC classification submitted by the Offeror, subject to the Programs' definitions of Brand and Generic Drugs contained in Section VIII of the RFP.

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

B. REQUIRED SUBMISSION

(1) Please explain in detail the process you will utilize to administer the Programs' mandatory generic substitution provisions in accordance with the requirements set forth in this RFP including, but not limited to, how your claims processing system will enforce the Programs' generic substitution requirement for a Generic Drug within the time limits specified above.

Promoting the use of generic medications, when available and clinically appropriate, is a cornerstone of CVS Caremark Clinical Solutions as well as our industry-leading service model of improving health and reducing total costs.

CVS Caremark's online claims adjudication system is fully-integrated among retail, mail, and specialty claims, which enables CVS Caremark to maximize the rate of generic substitution for the Programs. All claims adjudicated by CVS Caremark's system are verified against the Programs' plan design. When prescriptions written for brand-name drugs are adjudicated under a plan design that requires generic substitution, a message is sent back to the retail pharmacist designating that a generic equivalent is available. The CVS Caremark claims adjudication system will automatically indicate when a generic equivalent is available for substitution.

In addition, retail network pharmacies are audited for accurate generic substitution dispensing. During these audits, CVS Caremark confirms that the physician has ordered "Dispense as Written" (DAW) on the brand prescription. We also verify that DAW was not arbitrarily added to the claim form or rejection form in order to obtain payment for the brand-name prescription where a generic substitution should have been made.

We only perform generic substitution with FDA-approved A-rated generic medications. When a prescription enters one of our mail service pharmacies with "DAW", we can call the physician's office (if DAW1) or the member (if DAW2), prior to the dispensing of the prescription, to ask if s/he will approve a generic substitution.

For the EGWP program, a Mandatory Generics program is not allowed per CMS guidance.

(2) How do your Retail Pharmacy Network contracts protect the financial interests of the Programs in the event a network Pharmacist does not have a required generic in stock when presented with a Prescription requiring dispensing of the generic under law or pursuant to the provisions of the Programs' mandatory generic substitution program after the maximum twenty-one (21) day period?

[redacted]

[redacted]

(3) Explain in detail the process you intend to follow to ensure that drugs meeting the definition of generic as set forth in this RFP are identified in your system as Generic Drugs subjecting them to the generic pricing requirements set forth in Section V and mandatory generic substitution for A-rated or authorized Generic Drugs.

Mandatory generic substitution will be applied 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. We will not include drugs that the Program chooses to exempt, such as NTI drugs.

CVS Caremark abides by all applicable State and Federal laws when dispensing generic products, closely monitoring any changes in generic laws in the states in which we dispense, and updating drug files accordingly. CVS Caremark follows the guidelines from Approved Drug Products with Therapeutic Equivalence Evaluations (an FDA publication, also known as the Orange Book) and will substitute only those products the FDA has classified as therapeutically equivalent. We also comply with specific substitution rules in states with more restrictive rules than those in the FDA Orange Book.

CVS Caremark considers a drug to be a generic if a majority of the following conditions is true: (1) non-innovator product, (2) pharmaceutical equivalent products are available from multiple marketplace sources, (3) not protected by Patent(s), Exclusivity, or cross-licensure, (4) product identified as the holder of an Abbreviated New Drug Application (ANDA), which is an application to market a duplicate drug that has already been approved under the full NDA; however, not all generic drugs have an associated ANDA.

CVS Caremark confirms the ability to process claims according to the brand and generic drug definitions as set forth in the contract, and adjudicate claims according to the current plan design parameters of the Mandatory Generic Substitution program. The below criteria align with the Program's requirements.

- If FDA App Type = ANDA then B/G status = G
- If Medispan Brand Name Code = G then B/G status = G
- If Medispan MONY Code = Y then B/G status = G
- If Medispan MONY Code = N and Brand Name Code = B then B/G status = G
- B/G status for all remaining NDC's = B

(4) Please detail how your system will distinguish between A-rated and authorized Generic Drugs requiring generic substitution, A-rated generics not requiring substitution including, but not limited to Narrow Therapeutic Index (NTI) drugs (DCS only), and non-A-rated Generic Drugs. Please describe the capability of your system to apply MAC pricing but not enforce generic substitution for non-A-rated Generic Drugs, NTI drugs, or for available A-rated Generic Drugs that the Department has directed the Offeror not to enforce the Programs' mandatory generic substitution requirement.

A-rated generics not requiring substitution are considered NTI drugs specifically by the Programs or are considered NTI drugs by a particular State pharmacy substitution law. The corresponding DAW code 7 provides for the pharmacist submission of the claim, making it exempt from mandatory generic substitution with no ancillary fee applied. Specifically for the Programs, the NTI list will be set up at the plan-design level so all of these agents are exempt from mandatory generic substitution.

With respect to authorized generics, in the instances that these drugs are considered to be co-licensed, CVS Caremark will set the MAC list to read both the Generic Indicator for Multi-Source brand and the Generic Indicator of

the co-licensed product. This will capture the brand drug and generic drug that are offered by the same manufacturer and are present on the CVS Caremark MAC list.

(5) Please detail the process for updating your claims processing system upon distribution of a new Generic Drug to ensure prompt application of MAC pricing and/or mandatory generic substitution.

New brand and generic NDC's are added to the drug file by an update tape that Medi-Span or any other nationally approved source provides on a daily basis (Monday – Friday). Manual drug entries can be implemented, if necessary; however, prescription coverage depends on plan design parameters.

(6) (Exclusive to DCS) Please describe how you will manage the NTI list for the DCS Program including the parties responsible for making NTI recommendations.

CVS Caremark has the capability to exempt or exclude certain NTI (narrow therapeutic index) generics from the mandatory generic substitution edit. The Program's assigned Clinical Advisor will advise on NTI products as guided by our Formulary Review Committee as well as ongoing publications of evidence-based guidelines.

Mandatory Generic Substitution Appeal Process (Exclusive to DCS)

An Enrollee may appeal the requirement to pay the Ancillary Charge. Generic appeal review is based upon the demonstrated need for the Brand Drug on an individual Enrollee basis. It is not related to the specific drug as much as it is to the ability of the Enrollee to tolerate the Generic Drug. The criteria may include: previous clinical issues with the Generic Drug, reported allergy to an inert ingredient, co-morbid conditions that require multiple drug therapies, etc. The Offeror is expected to develop a generic appeals process that would allow for exceptions based upon compelling evidence provided by the treating Physician. Each individual case should be decided upon its own merits. For the DCS Program, there must be at least one level of appeal. If an appeal is unsuccessful, an Enrollee may request an external appeal as required by the NYS Insurance Law. Exhibit II.J.1 of this RFP provides the number of generic appeals reviewed for the period of January 1, 2008 through September 17, 2010.

A. DUTIES AND RESPONSIBILITIES

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

(1) Administering a clinically sound generic appeal process at no additional cost to the DCS Program or to the Enrollee. The process must include developing an appeal form and criteria for establishing medical necessity, reviewing appeals for medical necessity, preparing communications to notify Enrollees (subject to Department review and approval) of the outcome of appeals within five (5) Business Days, and integrating the decisions into the claims processing systems including reimbursing the Enrollee for any Ancillary charge paid up to 30 Days prior to receipt of the approved generic appeal; and
(2) Reporting the results of the generic appeal process for the DCS Program to the Department on a drug by drug basis in the format and frequency required in the "Reporting" section of this RFP.
(3) Following a successful generic appeal, charging the Enrollee for the Brand Drug at the Level 3 Copayment with no Ancillary Charge.

(4) Loading into your claims processing system one or more files from the incumbent contractor of the previously approved Generic Appeal requests by the January 1, 2014 implementation date, once an acceptable file is received.
(5) Interfacing with the New York State Department of Financial Services External Appeals Process that provides an opportunity for Enrollees and Dependents to appeal denied coverage on the basis that a prescription drug is not medically necessary or is an experimental or investigational drug.

B. REQUIRED SUBMISSION

(1) Describe in detail how you would administer the required generic appeal processes for the DCS Program including:

To help our clients comply with the Patient Protection and Affordable Care Act (ACA), which generally requires non-grandfathered plans to offer members external review of final internal adverse benefit determinations, CVS Caremark offers an external review service.

The following provides an overview of the optional IAROS process:

- Each member will be notified in any final internal denial notices s/he receives that the ACA-mandated external review process is available. The denial notices will also include information on how to initiate the review.
- The member can mail or fax in his/her request for federal external review and any supporting documentation to CVS Caremark. The member's request must generally be in writing, and must be submitted not later than 4 months after the final determination on appeal is issued.
- Requests for external review of urgent care claims may be made by calling the CVS Caremark Customer Service toll-free telephone number on the member's ID card.
- CVS Caremark will confirm member eligibility for external review, and will comply with all requirements mandated by the ACA, including timelines for review and guidelines for submitting case information to the assigned IRO.
- Upon receipt of a request for an external IRO review of an appeal decision CVS Caremark will, within five days, conduct the preliminary review (more quickly for eligible urgent review requests) to determine eligibility. CVS Caremark will, within an additional 5 business days (24 hours for an urgent review) from the date the IRO is assigned, provide the assigned IRO with all required documents and important information.
- CVS Caremark's contracted IROs will provide a written notice of the final external review decision as required under the ACA.
- CVS Caremark will retain records of all member requests for external review conducted under the IAROS.

(a) The turnaround time;

Upon receipt of a request for an external IRO review of an appeal decision CVS Caremark will, within five days, conduct the preliminary review (more quickly for eligible urgent review requests) to determine eligibility. CVS Caremark will, within an additional 5 business days (24 hours for an urgent review) from the date the IRO is assigned, provide the assigned IRO with all required documents and important information.

(b) Qualifications of the staff that would conduct the review;

External Review requests are reviewed by an external review organization. An independent physician with the same or similar medical specialty will conduct a review for medical necessity of the denial.

(c) A description of the criteria that would be used to determine whether the brand name medication is medically necessary. Are there any dollar thresholds within your criteria? Do you require generic appeals to be updated after a specific time period? If so, what is the process?

CVS Caremark will adhere to the criteria that are currently in place today.

(d) Do you currently administer a generic appeals process? If yes, provide the number of appeals you review annually and the approval and denial rates for a client similar to the Program (for the most recent Calendar Year); and for the following list of drugs:
Prilosec
Fosamax
Topamax
Keppra
Cellcept

Yes. We conduct an exceptions program for generic medications. The volume of appeals is significantly lower than that of the exceptions.

(d) How the Enrollee's claim will be handled during the appeal processing. In the event of a successful appeal, confirm that you will retroactively adjust claims incurred within 30 Days from the date of receipt of a completed appeals form. Describe how member refunds will be handled.

During the generic appeal process, the patient would be required to pay the applicable non-preferred copayment, plus the ancillary charge (the cost difference between the generic and brand products). If the generic appeal request is approved, the patient is allowed reimbursement for ancillary charges paid up to 30 days prior to the receipt of the completed generic appeal request. The patient is instructed of the reimbursement procedure for the ancillary charges during the verbal and written notification provided upon approval. The patient may be reimbursed upon submission of a paper claim.

(2) Confirm that you will load previously approved Generic Appeals data into your claims adjudication system.

CVS Caremark confirms.

15. CLINICAL MANAGEMENT/DRUG UTILIZATION REVIEW (DUR)

Clinical management and drug utilization review programs help to control costs and attempt to ensure that Enrollees are receiving safe effective drug treatment. The Procuring Agencies require the selected Offeror to have clinical management/drug utilization programs including a mandatory generic substitution program, a prior authorization program, a concurrent review program and retrospective review programs. The selected Offeror is required to provide these programs; however, an Offeror is not prevented from offering other value oriented programs. No clinical management and drug utilization review programs can be funded by Pharmacy manufacturers. The Procuring Agencies reserves the right to not participate in any program offered by the selected Offeror and the right to opt out of any program at any time. The Offeror is required to administer and enforce a comprehensive clinical management and DUR program that integrates the various Programs' components, which include at a minimum:

A Prior Authorization Program: to determine the medical appropriateness of Prescription drugs that have an increased risk of inappropriate utilization;
A Concurrent DUR Program: to aid the dispensing Pharmacist in identifying potential drug therapy problems at the point of sale; and

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

Note:The cost of all the programs listed above is required to be in your claims administration fee.

Prior Authorization

The Programs current Prior Authorization Program determines the medical appropriateness of Prescription drugs that have an increased risk of inappropriate utilization or a high cost. Drugs currently subject to prior authorization have been recommended by the current contractor and reviewed by the Department. Exhibit II.H provides a current list of the drugs subject to prior authorization. The DCS Program allows Enrollees to appeal denied coverage on the basis that a Prescription drug is not medically necessary or is an experimental or investigational drug. Exhibit II.H.2 provides the number of Program prior authorizations reviewed and certified for the period January 1, 2008 through September 16, 2011.

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

A. DUTIES AND RESPONSIBILITIES

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

(1) A Prior Authorization Program for high cost Prescription drugs that are prescribed for very specific medical indications. Only medications that have been identified by the Offeror as appropriate for Prior Authorization and reviewed by the State shall be included in the Prior Authorization Program. The Prior

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

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

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

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

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

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

(7) (Exclusive to DCS) Interfacing with the New York State Department of Financial Services' External Appeals Process that provides an opportunity for Enrollees and Dependents to appeal denied coverage on the basis that a Prescription drug is not medically necessary or is an experimental or investigational drug.

(8) Loading one or more files of Prior Authorization approved-through dates from the incumbent contractors, prior to the January 1, 2014 implementation date, once acceptable files are received.

B. REQUIRED SUBMISSION

(1) Referring to the drugs or the drug categories subject to Prior Authorization, describe in detail how you would propose to administer Prior Authorizations including:

(a) The process and criteria you utilize to identify drugs that the Programs should consider for prior authorization;

CVS Caremark prior authorization criteria are developed to ensure safe, effective, and appropriate utilization of selected drugs. Our standard criteria also assist clients in meeting any applicable regulatory requirements when they provide conditional drug coverage.

The drugs suitable for the prior authorization program include those products that are:

- Subject to significant safety concerns
- Subject to overuse, misuse, or off-label use
- Limited to a specific patient population

- Sometimes used for conditions that are exempt from the pharmacy benefit (e.g., cosmetic use).

CVS Caremark's clients determine which drugs they wish to place in their prior authorization program. CVS Caremark develops standard criteria on the basis of sound clinical evidence and to fit our system capabilities. Our standard criteria are maintained per the following:

- The latest FDA-approved product labeling, authoritative drug compendia (e.g., American Hospital Formulary Service [AHFS], and Micromedex), relevant findings of nationally accepted practice guidelines, government agencies, and peer-reviewed journals
- Internal review by one CVS Caremark physician
- External review by practicing clinical experts
- Update at least yearly, or sooner if the drug indication or safety information changes
- Update with the release of new drugs in an existing class or new dosage strengths to quantity limits, as appropriate
- Conformance with applicable standards of the National Committee for Quality Assurance (NCQA), the Utilization Review Accreditation Commission (URAC), CMS and state or Federal agencies.

For NYSIF, under the direction of the StoneRiver Pharmacy Solutions Clinical Review Committee, a standard Workers' Compensation Formulary has been established. This standard formulary can be customized to the client's specific requirements.

(b) The qualifications of each level of staff making decisions with regard to the pre- authorization process, denial, and appeal. Based on the DCS Program's number of prior authorizations, what is your projected staffing level for this unit?

[redacted]

(c) A description of any current prior authorization programs you manage including the list of drugs subject to prior authorization and the number of cases reviewed, approved and declined for a client similar to the DCS Program (for the most recent Calendar Year);

[redacted]

[redacted]

[redacted]

(d) The process you utilize to contract and collect the appropriate information from Physicians in order to make a determination. Provide a timeline for completion of approvals and denials;

The following steps describe our prior authorization process:

- The member submits a prescription to the pharmacy, which processes the prescription online and receives a message that prior authorization is required.
- The pharmacist telephones the physician to request that a prior authorization call be made to our Prior Authorization unit.
- At his or her convenience, the physician or physician's representative telephones our Prior Authorization unit with the patient information.
- The prior authorization representative, who is a pharmacy technician, evaluates the medication request online, in real time, according to criteria set by the plan sponsor or the client.
- If the request is approved, the prior authorization representative informs the physician/representative during the telephone call and updates the online system to reflect the approval.
- The physician's office calls the patient, who then can go to the pharmacy to pick up the medication.
- If the request is denied, the prior authorization representative forwards the request to an in-house pharmacist, who sends out denial notification and appeal information to the physician and the member.
- Both physician and member are notified in writing of the outcome of their request.

Our turnaround time for this process is within 24 hours for urgent requests and within 72 hours for non-urgent requests.

Prior Authorization Innovation

CVS Caremark introduced new electronic Prior Authorization (ePA) capabilities that provide physicians and their representatives access to real-time submission and response for PAs, within both electronic prescribing and a portal system. Through ePA, the physician can request and complete an ePA via the secure electronic prescribing or portal channel. After completing the ePA, the prescriber will receive an immediate response – either an approval based on client's criteria or a pending response, indicating pharmacist and/or Medical Director review prior to a denial, which will be communicated through ePA as well.

The CVS Caremark ePA program is integrated into e-prescribing tools currently used by prescribers, allowing an efficient workflow. This integrated approach utilizes the growing e-prescribing and electronic health record channel to provide for a better patient and provider experience. Caremark is excited to have launched this industry-leading ePA program, which provides efficient online, real-time access to ePA for providers, improves provider satisfaction and reduces member disruption and helps allow patients faster access to medications.

(e) The methods you utilize to measure program effectiveness (Do not include any reference to specific monetary savings).

Prior Authorization savings are calculated by taking a longitudinal view of the member experience. The reporting captures net savings, gross savings, and ROI by class and brand-name drug. A one-time savings is taken for walk-aways or the gatekeeper effect (members who do nothing after rejecting at the pharmacy). Prior Authorization calls (first calls and subsequent appeals), which are denied without a paid claim, are also counted toward savings with an additional assumed refill rate that was deflected. The costs of alternative therapies used by the member are also considered in calculating the actual client savings.

(f) How you will transition Enrollees with current prior authorizations and their Prescriptions into your system. Specifically address whether your system has the flexibility to grandfather benefits for Enrollees currently taking drugs that would require pre-authorization.

CVS Caremark transfers active prior authorizations as a standard implementation practice, and our system has the flexibility to grandfather benefits for Enrollees currently taking drugs that would require pre-authorization. During implementation, CVS Caremark's Vendor Transition Analyst and Implementation Project Manager manage the vendor transition process. Because prior authorization coding differs among vendors, we thoroughly review the prior authorization information from the incumbent vendor in order to determine the most appropriate translation method for loading the other vendor's prior authorization data into the CVS Caremark system. This is typically done by either identifying a one-to-one match of the prior authorization codes or by analyzing the drug categories supplied on the file to determine which benefit structures need to be overridden under the new plan design. This will help ensure the prior authorizations load correctly into our system. The approved prior authorizations will be transferred to our company's prior authorization system. This requires loading member data, such as name and demographics; the drug for which the prior authorization was approved; the date of approval; and the number of remaining refills.

(2) For each of the drugs currently subject to Prior Authorization under the DCS Program, please list the time period of the authorizations that you would apply to each. Also, please confirm what steps the Offeror will perform to re-authorize at the end of the authorization period.

Standard prior authorization approval time frames are one year, and the Programs have the discretion to adjust the time frame as necessary. The Programs can also consider increasing the approval time frame to reduce member disruption.

For the re-authorization process, we would implement an "expiring" notification on appropriate prior authorization criteria.
Members will receive notification of their expiring Prior Authorization and instructions on how to renew their prior authorization, if needed. This option may not be available for all criteria based on clinical need or appropriateness and approval timeframe.

(3) Confirm that you will send notification letters, subject to the approval of the Department, to the Enrollee and/or Physician to advise of the outcome of the Prior Authorization review and their appeal rights.

CVS Caremark confirms.

Concurrent Drug Utilization Review (DUR)

The Programs current Concurrent DUR program aids the dispensing Pharmacist in identifying potential drug therapy safety issues at the point of sale, as well as various other point of sale edits that are related to benefit design such as "refill too soon," and Preferred/Non-Preferred Drug designation.

A. DUTIES AND RESPONSIBILITIES

To safeguard Enrollee health and ensure adherence with the Programs' benefit design, the selected Offeror must administer a concurrent DUR program which includes at a minimum:

(1) A point of service system at all Retail Pharmacy Network locations, Mail Service Pharmacy Process Facilities and Specialty Pharmacies which is continually updated with the latest patient safety edits with the capacity to "message" Pharmacists related to safety issues prior to the dispensing of the Prescription drug; and
(2) A fully integrated point of service system capable of enforcing the Programs' benefit design features.

B. REQUIRED SUBMISSION

(1) Please detail the full scope of the Concurrent DUR program that you are proposing to utilize for the Programs. Include the qualifications of the staff responsible for oversight of your Concurrent DUR program.

CVS Caremark leverages concurrent DUR to automatically evaluate prescriptions in the context of the member's complete drug history, regardless of the channels they use to fill their prescriptions. When appropriate, real-time alerts are issued to the dispensing pharmacist regarding potential issues.

All prescriptions are first checked for member eligibility and plan design features. They are then compared against previous histories of prescriptions filled by the same pharmacy, by other participating retail network pharmacies, by the mail service pharmacies, and submitted paper claims. All drug conflicts are detected online when the prescription is entered into the computer system. If a conflict is identified, the pharmacist reviews the member's history and may contact the prescriber to make any adjustments prior to filling the prescription. Our program enables the pharmacist to override an edit when they have reviewed the data with the member or prescriber and have determined that the prescription is safe to dispense.

CVS Caremark's concurrent DUR program includes key edits such as drug-drug interactions, drug-allergy interactions, drug-age alerts, and therapeutic duplication.

(2) Describe the software you will utilize to administer the Concurrent DUR program that you will implement for the Programs. Please specify if you have developed this software, purchased it from a third party source, or is it a system you purchased and have adapted for your use.

CVS Caremark uses the industry-standard POS DUR edits provided by Medi-Span.

(3) Program Safety Edits

(a) Within your Concurrent DUR program describe all safety edits currently enforced through your claims processing system including, but not limited to the safety edits below:
(i) Drug-drug interaction including OTC drugs and herbal supplements, if applicable;
(ii) Drug-allergy interaction;
(iii) Drug-medical condition interaction;
(iv) Minimum daily dosage;
(v) Exceeding maximum dosage;
(vi) therapeutic duplication;
(vii) drug-gender interaction;
(viii) Drug-age interaction;
(vix) Drug-pregnancy interaction; and

(x) Compliance with FDA approved drug utilization guidelines.

Our system can perform up to 500 concurrent DUR edits on every prescription – in real time – to ensure that the prescription meets both safety and administrative criteria. Our system has been improved to reduce wait time and help eliminate disruption for the Programs' members.

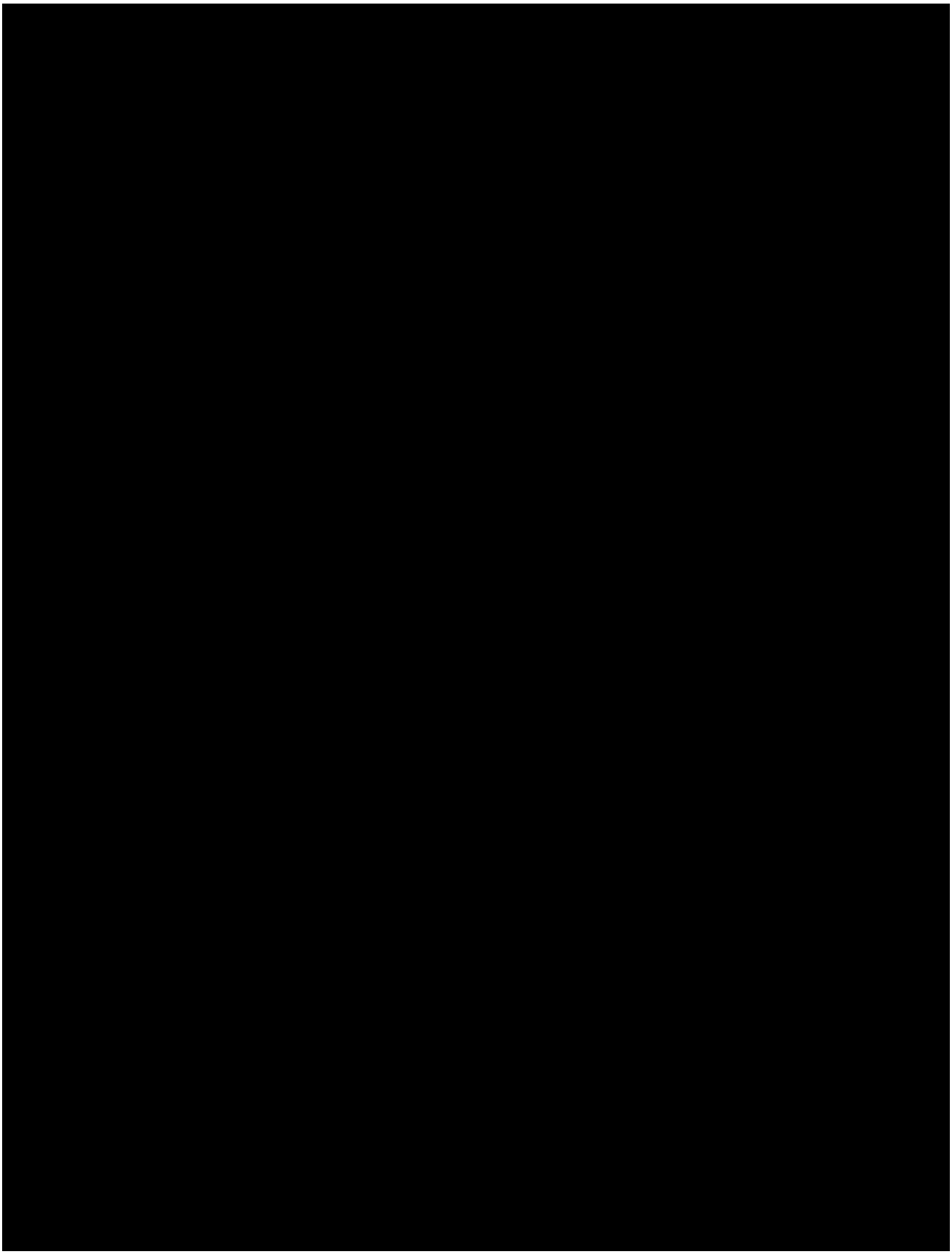
Our concurrent DUR program targets potential drug safety issues (e.g., drug-drug, drug-allergy, drug-gender and drug-pregnancy interactions; inferred drug-disease interactions; high dose and low dose alerts; and therapeutic duplications)as well as the following areas:

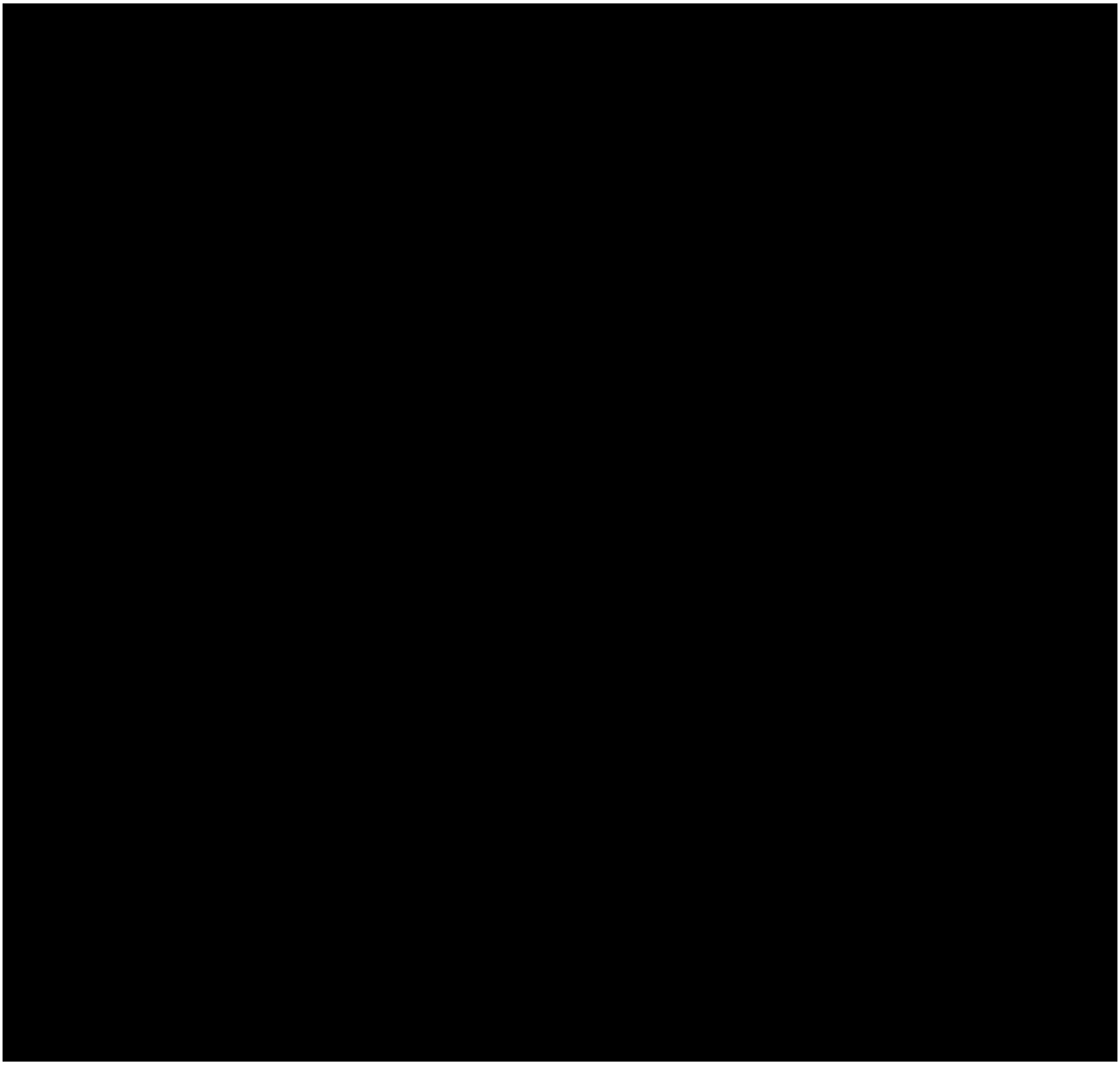
- Conformity with plan design
- Member eligibility
- Formulary compliance
- Refill limits
- Dosage limits
- Dispensing accuracy and consistency

Our concurrent DUR program edits ensure that your members are conforming to prescription safety standards, and the program also protects your plan design by ensuring that each mail and retail prescription conforms to the established parameters set by the plan.

In addition, the CVS Caremark concurrent DUR program provides early screening for potential abuse of all controlled substances, including high dosage and duplicate therapy in Schedule II to Schedule V drugs. CVS Caremark clinical pharmacists are trained to identify all aspects of potential abuse patterns when reviewing a member's drug history.

(b) Please describe for each edit the messaging sent to the Pharmacist including whether the edit is classified as a soft or hard edit. Describe the type of actions required by the Pharmacist at the point of service following receipt of these alerts. How do you monitor the effectiveness of the safety alerts program?





(4) Program Benefit Edits

(a) Within your Concurrent DUR program describe how your program monitors the following at the point of service, including whether the edits are hard edits or soft edits, and whether the Program monitors overrides at the Pharmacy Level:

CVS Caremark can apply the Programs' specific business rules regarding overrides. CVS Caremark's CustomerCare department utilizes the Client Information Form for client's plan design highlights, including prior authorizations and overrides. Within the override section, the client authorized parameters are listed. This Client Information Form is accessed by Customer Care through the CVS Caremark intranet site.

(i) refill too soon, including a description of the methodology utilized;

The refill-too-soon edit is a hard edit and will occur when a prescription is submitted *before* a given percentage of the previously filled prescription's days' supply has elapsed. This edit identifies early refills for members who are using multiple network pharmacies and notifies the dispensing pharmacy if a different pharmacy or prescriber was involved in the previous prescription. It also identifies early refills regardless of whether the prescription is for a brand or a generic.

the Programs can determine whether the edit results in a rejected claim and sets the parameters for determining the early-refill window. The flexibility of the system allows for different percentage parameters to be set for different days' supplies (e.g., 70% for greater than a 10-day supply and 50% for a 10-day supply or less).

(ii) prior authorization; and

Prior Authorization is a hard edit. Claims that do not meet prior authorization screen out criteria will reject with a message to the pharmacist that a PA is required, including instructions for the prescriber to call an appropriate 800 number.

(iii) drug exclusions or limitations.

Claims for drugs that are excluded from coverage will reject with a hard edit. For drugs with quantity limitations on them, a reject will occur for quantities greater than permitted by plan design. The pharmacist will be informed that the quantity limit has been exceeded.

(5) Describe the methods you utilize to measure Program effectiveness (Do not include any reference to specific monetary savings).

CVS Caremark tracks DUR messaging to pharmacists and related activity resulting from the messaging as a means of monitoring the effectiveness of the program and identifying areas for improvement/intervention. Savings are reported based on the cost of those claims that are rejected or not filled after DUR edits are processed and evaluated.

(6) Describe any other programs the Offeror proposes to provide to administer utilization management on behalf of the Programs.

Additional programs that CVS Caremark offers as part of our utilization management approach include Step Therapy and Quantity Limits.

Step Therapy

Step therapy ensures that members utilize the most therapeutically appropriate and cost-effective drugs first. This solution is offered as part of our core POS Utilization Management tools, provided at no additional cost to the Programs.

The step therapy protocol optimizes appropriate drug therapy while controlling costs by defining how and when a particular drug or drug class should be used, based on a member's drug history. It requires the use of one or more prerequisite drugs that meet specific conditions prior to the use of another drug or drugs. Many of the step therapy protocols have a Post-Step Prior Authorization available to allow for the use of the medication in clinically appropriate

circumstances if the member fails to meet the step therapy criteria (e.g., is intolerant or allergic to the primary therapy). If the Programs chooses to implement Post-Step Prior Authorization criteria, standard PA fees apply.

Quantity Limits

Our Quantity Limits program is available as an alternative or a supplement to our Prior Authorization program. This solution is offered as part of our core POS Utilization Management tools, provided at no additional cost to the Programs. Clients that wish to maintain control over drugs with the potential for abuse, misuse, or member safety concerns – without eliminating coverage – can do so by means of the Quantity Limits program. Through our online system, the Programs can modify its benefit plan structure by placing limitations on covered drugs for specified drug categories, *without eliminating coverage or establishing prior authorization criteria.*

Using this program, the client can define a set of drugs it wishes to limit. Physicians can prescribe the medications without having to request prior authorization. If the coverage limit is exceeded, the claim is rejected at the pharmacy and the member can assume responsibility for the cost of the prescription.

A client that elects to allow coverage for higher quantities under specific circumstances can institute a prior authorization once the predetermined limit has been exceeded. The prior authorization criteria applied after this limit has been met allow for additional quantities of the drug to be covered under appropriate circumstances. These criteria – defined as *Post-Limit PA* criteria – are designed to address actual or potential overuse or inappropriate use, which could be of clinical concern, economic concern, or both. The prior authorization criteria are determined and approved by the client. If the Programs chooses to implement Post-Limit Prior Authorization criteria, standard PA fees apply.

The Programs can modify the parameters and drugs covered by the program to suit its individual needs.

Retrospective DUR Program (Exclusive to DCS)

The DCS Program's current Retrospective DUR Program reviews Enrollee presciption profiles for drug therapy complications. In the event a potential drug complication is identified, alert letters are sent to the prescribing Physician. The DCS Program is designed to safeguard the Enrollee's health and help Physicians make more informed decisions about Prescription drugs.

A. DUTIES AND RESPONSIBILITIES

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

(1) Using the Offeror's standards, evaluates the Enrollee's Prescription drug utilization against the Enrollee's profile using FDA and other evidence based guidelines to identify potential safety related concerns. The Offeror shall alert the prescribing Phyicians to drug specific, Enrollee-specific health, safety and utilization issues including potential overuse of narcotics; and
(2) Identifies potential drug therapy complications for Enrollees, develops Physician alerts (subject to Department review and approval) and sends the alerts to the prescribing Physician; and
(3) Reports the results of its Retrospective DUR Program initiatives, including outcomes, to the Department on a quarterly basis in a mutually agreed upon format.

B. REQUIRED SUBMISSION

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

(1) The qualifications of the staff that would perform these reviews;

Clinical reviews associated with CVS Caremark's Retrospective DUR program are conducted by licensed pharmacists.

(2) How you identify and select areas for retrospective review and the methods utilized to inform and educate Physicians;

The CVS Caremark retrospective DUR programs are based on criteria-driven clinical algorithms. These intervention algorithms are developed by CVS Caremark clinicians (i.e., clinical pharmacists, physicians, and nurses) and are evidenced-based, utilizing the latest FDA-approved product labeling and national clinical guidelines to identify opportunities that improve prescribing practices. Communications are sent to any prescribers who do not meet these clinical criteria with suggestions for improvement.

Safety Net

Our retrospective DUR solutions are geared toward safety and cost containment. The first component is our Retrospective Safety Review, which spans all drug classes to identify the most serious drug-drug interactions. Physicians are alerted via fax and phone.

Identifying Fraud, Waste, and Abuse

We also incorporate evidence-based rules to detect potential cases of fraud, waste, and abuse through our retrospective efforts. Our Safety and Monitoring Solution currently targets the following drug classes:

- Narcotic/narcotic combination drugs
- Anti-anxiety and sedative/hypnotic agents
- Non-benzodiazepine sedatives/hypnotics
- Muscle relaxants
- CNS stimulants
- Other controlled substances.

When cases of fraud, waste, and abuse are identified, we send the physician the patient's full medication profile to provide them with the necessary information to intervene.

Condition Management Support

Our intuitive clinical rules engine runs claims on a daily basis to identify patients with prevalent chronic conditions, and further, to identify potential gaps in care and adherence issues. Such health care opportunities, when not addressed, can lead to unnecessary adverse medical events such as hospitalizations, which significantly impact total health care costs. We continually monitor claims activity for gaps/adherence issues and leverage our vertically-integrated business model to offer more personalized, high-touch care to members who live with the challenges associated with managing chronic/complex conditions and comorbidities.

(3) A timeline for these reviews.

The CVS Caremark retrospective DUR solution provides a daily, almost-real-time retrospective review of the client's prescription activity and intervention with the prescriber within 72 hours after claim adjudication.

(4) What type of follow-up you conduct after communicating the information to the Physician;

In order to maintain efficient coordination with physicians, the type of follow-up is dependent on the nature of the intervention, actions taken, and the urgency of the situation. For example, if the intervention is for medication fraud or abuse, CVS Caremark will work with physicians and other appropriate resources to ensure that the case is addressed and closed. Another example is a gap in care alert for a patient with a chronic condition – once identified, we work with physicians until the gap is properly addressed and closed, rather than treating this type of scenario as an episodic occurrence.

(5) How you measure the effectiveness of your Retrospective DUR Program including any statistical measures of the success of your efforts (Do not include any reference to specific monetary savings);

The effectiveness of our clinical interventions is routinely tracked and measured. We monitor for desired changes in prescribing behavior and the persistence of that change in order to measure success. Clients are provided quarterly activity reports and annual outcomes reports for our DUR programs.

(6) Whether you currently administer a Retrospective DUR Program for other clients; and

Yes. As described above, CVS Caremark offers a versatile suite of retrospective DUR programs that play a role in almost all PBM contracts that we manage.

(7) The reporting capability for your described program.

[redacted]

[redacted]

Physician Education

A. DUTIES AND RESPONSIBILITIES

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

(1) Analysis of Physicians' drug or condition specific prescribing patterns;
(2) Educating Physicians about the clinical and economic aspects of their prescribing decisions. Any communication with Physicians prescribing medications for Enrollees shall make the Physician aware of the distribution channel most cost effective to the Programs and the Enrollee; and
(3) Reporting the results of its Physician Education initiatives to the State on a quarterly basis in a mutually agreed upon format.
(4) The Physician Education Program may not be funded by pharmaceutical manufacturers.

B. REQUIRED SUBMISSION

Please describe/present the Physician communication/education programs you propose for the Programs.

Describe your objectives and approach to Physician profiling and education including:

(1) Whether you currently administer a Physician profiling and education program for other clients similar to the Programs;

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

(2) A description of the method(s) and analysis you use to select Physicians for profiling and whether your clinical programs involve peer-to-peer Physician discussions;

CVS Caremark has more than a decade of experience in providing academic detailing services. The core tenets of our strategy are to promote prescribing habits that align with evidence-based medical guidelines, while considering patient safety and cost-effectiveness. In addition, a key differentiator in our approach is to create awareness of member-specific opportunities among certain physicians in helping them guide their patients on the path to better health.

Reinventing Physician Engagement and Academic Detailing

While traditional academic detailing occurs in a face-to-face environment with physicians, we are among the first organizations to leverage Surescripts' e-Prescribing channel to provide them targeted member-specific information about appropriate medication and care considerations. We believe this approach can achieve better physician engagement with educational outreach (e.g. evidence-based guideline messaging), while keeping in line with our academic detailing strategy.

To illustrate, our ePA (electronic prior authorization) solution helps physicians execute PA processing using the Surescripts channel as a medium, reducing the time it takes to administer a PA compared to traditional processes. We are piloting interactive ePrescribing messaging programs that will help physicians:

- Deliver prescription savings to patients at point-of-care by recommending cost-effective, medically equivalent brand to generic and retail to mail opportunities
- Improve patient adherence by alerting the prescriber to patient status and delivering information about therapy objectives and possible side effects.
- Identify potential gaps in care according to evidence-based guidelines and alerted through our patient history analysis.

We are also creating new e-Prescribing reports that will help physicians monitor their performance (i.e., generic dispensing, patient adherence rates) alongside peers and identify individual patients for opportunities to improve their care. These reports will not only help physicians and their patients achieve better adherence, health and savings, but clients will also experience lower plan costs because of the improved member health outcomes.

(3) The frequency of your educational efforts;

For general education, we will work with the Programs and incumbent medical carrier to determine the best frequency for physician communications (e.g. formulary mailings, updates on evidence-based treatment, etc.). For our additional strategies that center on using preferred communication channels such as Surescripts, our educational efforts and patient-specific opportunities will be as determined by patient needs. We can also discuss a custom messaging strategy with the Programs to streamline communications to physicians using e-Prescribing technology or via our physician portal.

(4) The number of Physicians you have contacted as part of a Physician Education Program and the results of those efforts in the areas of increased compliance with recommended protocols and modifying patient Prescription utilization;

[redacted]

(5) How you measure the effectiveness of your Physician profiling program including any statistical measures of the success of your efforts. (Do not include any reference to specific monetary savings); and

Through our enterprise reporting, we can help the Programs understand the penetration and impacts of e-prescribing within its prescriber base – by physician, by market, and by vendor. We have invested in reporting tools that combine Surescripts transaction and vendor supplemental reporting, along with claims data that indicate information such as prescription origin code. In addition to helping clients understand the physician-level e-prescribing impact and support pay-for-performance programs, we use that information to identify opportunities to improve e-prescribing results. With

one client we demonstrated a generic shift of 3.1% based on e-prescribing compared to a control group; another study measuring the impacts of generics messaging tied to specific medications showed a 6.5% increase in GDR in the ACE category, 12.4% in HMGs and 15.3% in SSRIs. We can look to further extend your clinical and cost-savings measures to the point of care through innovative programs such as first fill adherence and enhanced clinical messaging.
We also monitor each component of our retrospective DUR solutions and capture our physician intervention activities for our standard Clinical Management reports. We are able to assess the physician's action based on the type of intervention (e.g. drug interaction, abuse, gap in care, etc.), the outcome of the intervention, and any savings associated with the successful intervention.

(6) Whether you will adapt your Physician Education Program standards to meet the Program's needs as specified by the Department.

CVS Caremark will work with the Programs to establish program standards that align with the Programs' strategy. We believe that our innovation in physician connectivity will open new opportunities to the Programs and members by enabling physicians to receive timely, personalized communications that will alert them to member-specific opportunities as well as to use this user-friendly platform as a resource for evidenced-based guideline education and Programs-specific formulary and clinical information.

(7) Confirm that the Physician Education program will not be funded by pharmaceutical manufacturers.

CVS Caremark confirms.

Patient Education (Exclusive to DCS)

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

A. DUTIES AND RESPONSIBILITIES

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

(a) Analyzes drug utilization from a clinical standpoint to identify and facilitate communication with Enrollees that have chronic diseases to maximize health benefits of drug treatment;
(b) Analyzes drug utilization to identify and facilitate communication with Enrollees not managing their drug utilization in the most cost effective manner for the Enrollee;
(c) Reports the results of its patient education initiatives to the Department on a quarterly basis in a mutually agreed upon format; and
(d) The Patient Education Program may not be funded by Pharmacy manufacturers.

(2) Offerors may propose a voluntary Half Tablet Program which will allow Enrollees to pay half the regular Copayment at the point of service for half the quantity of double strength, eligible Prescriptions. If such is the case, the Offeror's proposal shall:

(a) Establish a list of drugs that would be appropriate to include in the Half Tablet Program including, but not limited to the drugs listed in Exhibit II.M, if deemed appropriate by the Offeror;

(b) Notify Enrollees of their eligibility to participate in the Half Tablet Program. Monthly, the Offeror must use utilization data to identify Enrollees newly eligible to participate in the Half Tablet Program and mail welcome/announcement letters to those Enrollees. These letters are subject to review and approval by the Department;
(c) Provide each Enrollee newly participating in the Half Tablet Program with one tablet splitter, at no charge to the Enrollee; and
(d) Load a file to transfer current Enrollees with qualifying Prescriptions into the Half Tablet Program as of January 1, 2014.

B. REQUIRED SUBMISSION

(1) Describe your objectives and approach to patient education including:

(a) Whether you currently administer a patient education program for other clients;

Yes. CVS Caremark is recognized in the marketplace as a member-centric PBM as we leverage our vertically-integrated business model to engage members in more effective ways, such as the point of service at CVS retail locations.

CVS Caremark's engagement strategy encompasses personalized interventions, consumer preferences, and point-of-service interactions, to best educate and interact with members and physicians.

Behavioral Insights Gained from Ongoing Research

CVS Caremark recently invested in two multi-year research partnerships. The first collaboration is with Harvard University (Medical School) and Brigham & Women's Hospital to conduct research designed to improve our basic understanding of how PBMs and pharmacies can improve care. To date, this partnership has yielded numerous peer-reviewed scientific publications. The second collaboration is the Behavioral Change Research Partnership, which has enlisted behavioral scientists and economists from academia to help CVS Caremark better understand member behavior around adherence.

Leveraging Technology to Influence Behavior Change

Members are more likely to listen and change their behaviors when information is personalized to their needs and delivered by a trusted source, at the most opportune moment. CVS Caremark's Consumer Engagement Engine – an industry first – gives us the ability to identify and act upon cost saving and health improvement opportunities through multiple CVS Caremark touch-points. The technology provides our CVS retail pharmacists, mail pharmacists, and Customer Care Representatives with actionable, personalized information to enable behavior change, including medication history, demographic data, and consumer preferences – all of which is delivered at the point of service, when the member is most engaged with their personal health care.

(b) The identification and selection of categories of drugs to apply retrospective review and the method(s) you propose to use to educate and inform patients;

[redacted]

(b) The number of educational interventions and the expected Enrollee response rate;

Given the variety and versatility of our communication strategy, it is difficult to assess the number of educational interventions that will be deployed for Program Enrollees. However, it is our objective to reach all members that have health care opportunities, such as a lower cost medication alternative, and adherence issue, or an opportunity to leverage lower cost channels – in alignment with the DCS stated objectives.

Within the past year, we have revitalized our member communication strategy to increase access to information, in a more user-friendly way, to broaden the scope of engagement and reach members according to their unique preferences.

(d) How you measure the effectiveness of your patient education program including any statistical measures of the success of your efforts. (Do not include any reference to specific monetary savings); and

CVS Caremark uses multiple methods to measure the effectiveness of our patient education strategy, depending on the type of intervention (e.g. cost savings opportunity, adherence opportunity, etc.). For example, through our adherence program, we track interventions at the member level and can therefore gauge members' response to interventions based on their ongoing utilization pattern.

(e) Confirm that the Patient Education Program will not be funded by Pharmacy manufacturers.

CVS Caremark confirms.

(2) If proposed, describe the Half Tablet Program for the DCS Program, including:

CVS Caremark is not proposing a Half Tablet program at this time as more than half of the brand drugs currently included in the program are expected to go off patent before 2014. CVS Caremark offers a soft edit Dose

Optimization program that can achieve cost savings for the program and members by coordinating with physicians during the retrospective review. Unlike a similar program with a hard edit, our proposed approach would mitigate any member disruption.

(a) Confirm which drugs listed in Exhibit II.M will be included in the Half Tablet Program.

Not applicable.
For the EGWP program, a Half Tablet program is not allowed per CMS guidance.

(b) Detail the criteria that will be used to identify additional drugs for inclusion in the Half Tablet Program. Provide a list of additional drugs you recommend to include in the Half Tablet Program and the basis for the recommendation.

Not applicable.

(c) Describe in detail the process to identify newly eligible Enrollees for the Half Tablet Program, including timeframes.

Not applicable.

(d) Describe how Enrollees will enroll in the Half Tablet Program. Confirm that a table splitter will be mailed at no additional cost to the Enrollee.

Not applicable.

(e) Confirm that if a Half Tablet Program is implemented, a half Copayment would be passed to Enrollees participating in the Programs at the point of service, upon presenting a valid script.

Not applicable.

Note: The costs of all the programs listed above are required to be in the claims administration fee.

Other Safety Related Programs

The Procuring Agencies are interested in any other clinical management or drug utilization review programs that are intended to promote the health and well being of Enrollees. Offerors may propose other programs of this nature, not already being utilized by the Programs as a requirement of the Contractor under duties and responsibilities set forth in the RFP. The State reserves the right, if allowed by NYS Finance Law, to participate in any such program(s) offered.

For any such program(s), the Offeror must clearly indicate whether or not there is a cost to the State for said program(s) (do not disclose the dollar amount, if any, in the Technical Proposal) and, if there is a cost, whether or not the cost is included in the Offeror's proposed Claims Administration Fee. If there is a cost for a program(s) and that cost is not included in the Offeror's proposed Claims Administrative Fee, Offerors are advised that the Department may be precluded by NYS Finance Law from participating in such program(s). Should the State choose to participate in such program(s), the State reserves the right to opt out of any such program(s) at any time during the term of the Agreements in such case(s), the Claims Administrative Fee shall be reduced by the cost incurred by the State for that program(s).

A. DUTIES AND RESPONSIBILITIES

Not applicable.

B. REQUIRED SUBMISSION

(1) Please describe the purpose of any other clinical management or drug utilization review programs that you are proposing to administer for the Program with the Pharmacy, Physicians, Enrollees, etc. Include a detailed description of how the program operates and its benefit to the Programs and Program's Enrollees.

[redacted]

[redacted]

(2) Identify the funding source behind any of the programs you are proposing and confirm whether or not the costs for the Program are included in the Claims Administration Fee.

[redacted]

16. PREFERRED DRUG LIST DEVELOPMENT AND MANAGEMENT (EXCLUSIVE TO DCS)

The selected Offeror is required to efficiently develop, administer and maintain multiple Preferred Drug Lists (PDL) that ensure Enrollee access to appropriate, quality pharmaceutical care based on sound clinical criteria. The DCS Program currently has four (4) formulary benefit designs: Traditional Empire Plan PDL, Flexible Formulary Drug List, Enhanced Flexible Formulary List, and the Excelsior Plan PDL. The DCS Program requires that all Covered Drugs be classified as preferred or non-preferred. PDL management, in particular designation of drugs as preferred (which generally means Level 1 or Level 2), non-preferred, or excluded, is critical to the clinical and financial success of the DCS Program. The Offeror must use sound clinical criteria in any decisions that are made to place or exclude drugs from the PDL's.

The PDLs generally feature Generic Drugs on the first level, Preferred Brand Drugs on the second level, and Non-Preferred Brand Drugs on the third level. The PDLs proposed for the DCS Program must include all drugs meeting the definition of Covered Drugs in this RFP. The selected Offeror is required to effectively communicate the content and requirements of the DCS Program's PDLs to Network Pharmacies, medical providers and Enrollees. The design of the DCS Program's Prescription Drug benefit does not require a Brand Drug in every therapeutic category. For the purpose of preparing a response to this RFP, if an Offeror proposes a Preferred drug list which does not include a Preferred Brand Drug in every therapeutic category, the Offeror must include the clinical rationale and financial implications of the Offeror's determination. Offerors will submit cost information as required in Section V, Cost Proposal of this RFP.

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

Traditional Empire Plan PDL: Under the traditional Empire Plan PDL, all covered Generics are Level 1 and covered Brand Drugs are on either Level 2 or Level 3. A proposed PDL that includes Generics on Level 2 or Level 3 and/or includes Brand Drugs on Level 1 does not currently meet the Program requirements for the Traditional Empire Plan PDL and would not be acceptable. Drugs may not be excluded from the Traditional Empire Plan PDL. In addition, the current benefit design does not allow an Enrollee to appeal a drug's placement on the second or third level of the PDL. The Traditional Empire Plan PDL is updated once a year on January 1st. Mid-year changes to the PDL are generally not acceptable. However, mid-year changes resulting from drug recalls, the introduction of new clinically superior drugs, drugs off patent, or patient safety issues are allowed.

Flexible Formularies (two): Under the Flexible Formulary, Generics may be on Level 1 or excluded. Brand Drugs may be on Level 1, 2, or 3 or excluded. A proposed PDL that includes Generics on Level 2 or Level 3 does not meet the Program requirements for the Flexible Formulary Drug List and would not be acceptable. Drugs may be excluded from the Flexible Formulary based on sound clinical and financial criteria. Proposed drug exclusions must meet the following criteria:
Access to one or more drugs in select therapeutic categories may be restricted (not covered) if the drug(s) has no clinical advantage over other generic and brand name medications in the same therapeutic class. Drugs considered to have no clinical advantage that may be excluded include any products that:

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

For the 2012 Flexible Formulary, the following drugs were excluded from coverage: Acuvail, Adoxa, Amrix, Aplenzin, Asacol HD, BenzEFoam, Caduet, Clobex Shampoo, Coreg CR, Detrol LA, Dexilant (formerly Kapidex), Doryx, Edluar, Epdiuo, Extavia, Flector, Genotropin (except for the treatment of growth failure due to Prader-Willi syndrome or Small for Gestational Age), Humatrope (except for the treatment of growth failure due to SHOX deficiency or Small for Gestational Age), lansoprazole, Metozolv ODT, Momexin Kit, Naprelan, Neobenz Micro, Nexium, Norditropin (except for the treatment of short stature associated with Noonan syndrome or Small for Gestational Age), Olux/Olux-E Complete Pack, omeprazole/sodium bicarbonate capsule (generic Zegerid), Omnitrope (except for the treatment of growth failure due to Prader-Willi syndrome or Small for Gestational Age), Prevacid Ccapsules, Requip XL, Ryzolt, Soma 250, Terbinex, Testim, Treximet, Triaz, Twynsta, Veramyst, Xopenex Inhalation Solution, Zegerid Capsule, Ziana, Zipsor. In addition, the current benefit design does not allow an Enrollee to appeal a drug's placement on the second or third level of the PDL, nor to appeal a drug exclusion. The Flexible Formulary is updated once a year on January 1st. Mid-year changes to the PDL are generally not acceptable. However, mid-year changes resulting from drug recalls, the introduction of new clinically superior drugs, drugs off patent, or patient safety issues are allowed. The "Enhanced Flexible Formulary" adds a "Brand for Generic" feature to The Empire Plan's Flexible Formulary. With this feature, a brand-name drug may be placed on Level 1, or excluded, and the generic equivalent placed on Level 3, or excluded. With Department approval, these placements may be revised mid-year when such changes are advantageous to The Empire Plan. Effective January 1, 2013, a "New to You Prescriptions" program will be implemented for enrollees subject to the Enhanced Flexible Formulary. This program will require the enrollee to have two (2) 30-day fills of a newly prescribed medication at a Retail Pharmacy prior to being able to obtain a 90-day fill through the Retail Pharmacy or Mail Service Pharmacy.

Excelsior Plan PDL: Under the Excelsior Plan PDL, both Brand and Generic Drugs may be placed on Level 1, 2 or 3 or excluded. A proposed PDL that includes Generics on Level 2 or Level 3 and/or has Brand Drugs on Level 1 meets Program requirements and would be acceptable for the Excelsior Plan. Drugs may be excluded from the Excelsior Plan PDL based on sound clinical and financial criteria. In addition, the current benefit design does not allow an Enrollee to appeal a drug's placement on the second or third level of the PDL nor to appeal a drug exclusion. The Excelsior Plan PDL may be updated throughout the year. It is currently updated on January 1 and July 1 each year. The goal of the Excelsior Plan PDL is to offer a therapeutically sound formulary that result in a Plan design that costs a minimum of 15% less than The Empire Plan Flexible Formulary.

A. DUTIES AND RESPONSIBILITIES

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

(1) Developing and administering four multi-level formularies, consistent with the Program's four benefit designs. The Offeror's PDL's must be based on sound clinical criteria. The Offeror's Book of Business PDL for the Excelsior Plan PDL must include non-self administered, intravenous and intramuscular injectable drugs covered under the Excelsior benefit plan design. In designating a drug as preferred or non-preferred for the Empire Plan's Traditional PDL and Flexible Formulary drug lists, the Offeror must ensure that drugs recognized in documented medical evidence and studies as clinically superior to similar drugs in a therapeutic class be designated as preferred. In situations where there are multiple drugs in a therapeutic class of similar clinical characteristics, net costs shall be considered in determining a drug's status as preferred or non-preferred. For the Traditional Empire Plan PDL, generally, one or more single source Brand Drugs in a therapeutic category shall be designated as

preferred, unless there is compelling clinical reason for not promoting the use of the Brand Drug(s). The composition of the PDL for the Flexible Formulary and the Traditional PDL will be developed by the Offeror and reviewed annually by the Department;

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

(3) Developing Preferred Drug List's for each of the four benefit designs, subject to the review and approval of the Department, for the purpose of distributing printed copies to Enrollees and medical providers. Additionally, electronic copies will be developed for posting on the Department's website and the Offeror's customized website for the DCS Program in order to inform Enrollees and providers of the placement of the most commonly prescribed medications on each Preferred Drug List. The Department shall be responsible for the distribution of the printed PDL provided by the Offeror on an annual basis to Enrollees. The Offeror shall be responsible for producing and distributing all other copies of the printed PDL, including but not limited to supplies sent to agencies, those sent with Offeror mailings to Enrollees and individual requests by Enrollees or providers. The Offeror is required to promptly mail the Preferred Drug List to Enrollees who call requesting a copy. Printed copies of the Traditional Empire Plan PDL and Flexible Formulary Drug List from 2011 and 2012 are presented in Exhibits II.I through II.I.3. The Excelsior Plan PDL for 2012 is presented inExhibit II.I.4.

(4) Compiling and organizing the PDLs in two versions, limited to the most commonly prescribed medications for posting and distribution: an alphabetical listing of Preferred Drugs and a listing of Preferred Drugs categorized by therapeutic category. A full listing of the PDL must be available for posting on the website. The Offeror must work with the Department on the format of the PDL. The PDL that is developed for distribution to Enrollees, and providers and posted on the website must provide notice of the pending introduction of a generic equivalent for one or more strengths of a particular Brand Drug that could result in one or more strengths of the drug being moved to non- preferred status during the year. The PDL shall also list the name of the reference product in parenthesis next to the name of the Generic Drug (i.e. simvastatin (Zocor)) unless the Department otherwise directs. The PDL shall indicate those drugs that require Prior Authorization and those drugs eligible for the Half Tablet Program. The Offeror shall inform the Department of any rebate implications to the DCS Program as a result of including this information on the PDL.

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

(6) Developing and mailing a Department pre-approved disruption letter, via first class mail, to Enrollees who are affected by a drug's exclusion or a Preferred Brand Drug's reclassification to a non-preferred status unless the reclassification is the result of the introduction of an equivalent generic for the Traditional Empire Plan PDL and Flexible Formulary Drug Lists. Disruption mailings for the Enrollees in the Excelsior Plan will follow the disruption mailing plan employed for the Offeror's Book of Business PDL. Such letters must be sent to Enrollees who have utilized a medication at least once within the latest four month time period, regardless of the Days supply or whether the medication is categorized as maintenance or acute. An additional mailing must be sent to Enrollees who are new users of a medication between the date claims records were selected for the initial disruption mailing and the date that the PDL changes go into effect. Such communications should provide to the Enrollee information concerning clinically appropriate alternatives on the first and second level, when applicable, of the Preferred Drug List as of the effective date of the drug's exclusion or change from preferred to non-

preferred status. In situations where Enrollees are affected by a Generic Drug's reclassification to a Brand Drug, the Offeror agrees to send a disruption letter to affected Enrollees;

(7) Notifying the Department in writing when a Class I drug recall or voluntary drug withdrawal occurs. The Offeror must take proper action to help promote patient safety. The Offeror will review with the Department the need to communicate and at the Department's discretion will notify Enrollees, Network Pharmacies and/or prescribing Physicians of the Federal Food and Drug Administration drug or device recalls and manufacturer drug or device withdrawals at no additional cost to the Program. Such notification must be timely and all written materials subject to Department review and prior written approval. The Offeror must assist the Department in collecting monies from recalled products.

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

(9) Holding an annual meeting with the Department to review upcoming Traditional Empire Plan PDL and Flexible Formulary Drug List changes prior to the effective date of any changes. This meeting will include a review of the Offeror's Book of Business PDL strategy. Upon the Department's request the Offeror shall provide a detailed explanation of the clinical and/or financial basis for the decision to change the classification of the drug (s) on the Traditional Empire Plan PDL and Flexible Formulary Drug List as well as a detailed cost analysis of the impact of the changes to the Program.

(10) Assigning a new strength of a drug to the same PDL Level as the pre-existing strengths of the drug in the event a new strength of a drug already on the Traditional Empire Plan PDL or Flexible Formulary Drug List is shipped from the manufacturer or wholesaler;

(11) For the Traditional Empire Plan PDL and the Flexible Formulary Drug Lists, designating as Preferred all FDA approved Covered Drugs without therapeutically equivalent generics prescribed for the treatment of the following diseases; Cancer, Hepatitis, HIV and Diabetes. FDA approved organ transplant anti-rejection drugs shall also be designated as Preferred Brand Drugs. Post award, the Offeror may recommend other disease states where all the Covered Drugs prescribed to treat the illness would be designated as Preferred.

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

(13) The Offeror will be responsible for ensuring the Empire Plan Flexible Formularies and the Traditional Empire Plan Preferred Drug List will be electronically available to Medical Professionals on Rx Hub and Level 1 and Level 2 drugs will be designated as Preferred.

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

(15) The Offeror will be responsible for developing, recommending, and implementing Brand for Generic strategies for the Enhanced Flexible Formulary that are financially beneficial to the State. All Brand for Generic placements are subject to Department approval. These placements may be revised mid-year, with Department approval, when such changes are advantageous to The Empire Plan.

(16) The Offeror will be responsible for implementing and administering a "New to You Prescriptions" program. This program requires Enrollees to have two 30-day fills of a newly prescribed medication at a Retail Pharmacy prior to being able to obtain a 90-day fill through the Retail Pharmacy or Mail Service Pharmacy.

B. REQUIRED SUBMISSION

Preferred Drug List Management – **General**

(1) Do you currently develop, maintain and administer plans with three copay level benefit designs utilizing one or more Preferred drug lists? Detail your proposed plan and your capability to administer the Program's three different formulary benefit DCS Program designs.

[redacted]

(2) Describe the various preferred drug lists you have available:

(a) Do you have a standard three copay level preferred drug list used for your Book of Business?

Yes.

(b) Do you maintain multiple standard and custom preferred drug lists? Provide a description of the differences.

Yes. We maintain multiple preferred drug lists to cater to our diverse client base as CVS Caremark is an advocate of flexibility and customization to meet unique client needs and objectives. For example, we work with many health plans, and in most cases, we are required to accommodate a custom formulary to maintain alignment with the plan's objectives. In this case, we are offering a customized formulary for the Program's Flexible formulary and Enhanced Flexible Formulary designs, to drive lowest net cost, while protecting the financial interests of DCS Programs as outlined in the scope of the RFP.

(c) What is the goal of these alternative preferred drug lists?

The goal of maintaining alternative preferred drug lists is to best accommodate the needs of our diverse client base. As the longest standing PBM in the nation, with decades of experience serving unique clients and their endeavors to achieve optimal benefit provisions, we have found that a one-size-fits-all Preferred Drug List strategy is not advantageous to all clients, depending on their unique benefit strategies.
In this case, we are building from our standard preferred drug list as well as the Program's current Flexible/Enhanced Flexible Formulary designs to optimize the lowest net cost strategy for the near and long-term future, while justifying minimal member disruption with higher cost savings.

(d) What role do clients play in the development of your preferred drug lists?

(e) How often are changes made for both additions and deletions?

[redacted]

(f) Are there special considerations for biological and specialty Pharmacy products in your preferred drug list and/or process?

[redacted]

(3) What Preferred Drug Lists are you proposing to use in managing the DCS Program? Please provide copies. Are there any therapeutic classes that are composed of only Non-Preferred Drugs due to documented medical evidence of inferior clinical attributes of the Brand Drugs in comparison with competing generics and/or clinically documented safety concerns? What is your clinical rationale for limiting these drugs to Level 3?

[redacted]

(4) Explain how you would work with the medical carrier and the mental health and substance abuse carrier to ensure that participating providers in their networks are fully apprised of the level status of Covered Drugs.

[redacted]

[redacted]

(5) Confirm that the Empire Plan Flexible Formulary and the Traditional Empire Plan Preferred Drug List will be made available on Rx Hub and Level 1 and Level 2 drugs will be designated as Preferred. Describe how Rx Hub will be utilized for the benefit of the DCS Program including how it will encourage physicians to prescribe lower cost alternative medications to Enrollees.

[redacted]

(6) Describe the strategy which would be implemented to control Prescription Drug AWP increases.

[redacted]

[redacted]

(7) Describe how you will develop, recommend, and implement Brand for Generic strategies for the Enhanced Flexible Formulary that are financially beneficial to the State.

CVS Caremark has experience recommending and positioning brand medications on the first tier, during exclusivity periods. We executed a similar strategy for a Med D client, placing Lipitor at the generic copay level. We will work with the program to identify medications and associated time frames where this type of move would present financial advantages to the Program. We will leverage our analytic support to forecast utilization and financial impacts, based on Program-specific data.

(8) Do you currently administer a "New to You Prescriptions" program or one similar to this for your book of business? Detail your proposed plan and your capability to administer the "New to You Prescriptions" program.

CVS Caremark has executed similar programs in the past for clients who leveraged this strategy as a way to help their members establish medication compliance prior to filling a costlier 90-day prescription and avoid medication waste due to first fill drop-offs. Our systems support this plan design rule, and we can also grandfather members who meet the two 30-day fill requirement during the 2013 plan year.

Preferred/Non-Preferred/Excluded Determination

(1) Describe in detail the process employed to determine whether a drug is designated as preferred, non-preferred or excluded, including:

(a) All standards and criteria used in this determination;

[redacted]

(b) The qualifications of the current participants in the review process, as well as any requirements related to ensuring that the participants in the process are independent, objective, and free of conflict of interest;

[redacted]

[redacted]

(c) The role of net cost in this determination;

CVS Caremark's proposed PDLs for the DCS Program are designed to achieve lowest net cost, while maintaining desirable access to clinically effective medications in each therapeutic class.

(d) Whether the designation of preferred/non-preferred or excluded status is governed by formal corporate policies and procedures detailing standards of review and criteria, is considered in reaching such determination;

[redacted]

[redacted]

(e) Whether the process is governed by formal procedures to ensure sound clinical examination resulting in quality pharmaceutical care;

[redacted]

(f) Whether a record is made of the process leading to preferred/non preferred or excluded designations and whether the Department will have access to either original records and/or summaries detailing the basis for designations;

Yes. All decisions are recorded, and once final recommendations are made by our P&T Committee, we can share rationale and documentation with the Program. Specifically, we can share detailed clinical rationale and supporting economic decisions within a summary document.

(g) How often a drug's preferred/non-preferred or excluded status is reviewed and revised and is the review process done on a predetermined scheduled basis? If so, what is the schedule for the review process and are there exceptions to these scheduled meetings;

To achieve the most up-to-date formulary strategy, our Trade department conducts therapeutic class reviews on a quarterly basis to ensure that our PDL maintain access to safe and clinically effective drugs at the lowest net cost to clients.

The P&T Committee reviews the standard formularies annually. The review is conducted by drug class to assure that the formulary recommendations previously established are maintained and to recommend additional changes for clinical appropriateness if advisable based on newly available pharmaceutical information.

(h) Whether the process is different for innovative new therapies than for therapies that already have a competitive alternative; and

[redacted]

[redacted]

(i) The conditions that would cause a drug's preferred, non-preferred, or excluded status to change and several recent examples.

Market factors and clinical recommendations contribute to a drug's status to change, including:

- Utilization trends
- Impact of generic drugs or drugs designated to become available over-the-counter
- Brand and generic pipeline
- Applicable manufacturer agreement
- Potential impact on members

(2) Describe the type of analysis you would perform when a Preferred Brand Drug is being considered for movement to a Non-Preferred Brand Drug list and vice versa.

[redacted]

(3) Provide a diagrammatic illustration of the process from receipt of notification of a new drug entry into the marketplace from the manufacturer, to the Preferred Drug List decision making process, identifying any and all clinical and financial considerations impacting the placement of the product. Please include estimated time frames.

Preferred Drug List Strategy

(1) How are Generic equivalents considered in your assessment of individual therapeutic categories on your Preferred Drug List?

When an A-rated generic becomes available, it is considered preferred and proactively encouraged. At that point, significant efforts are made to transition utilization to the lower cost generic product. Client plan design will direct the effort and can be very aggressive and only cover the generic, or be more moderate and require the member to pay the difference between the brand and the generic if the brand is chosen.
Where clinically appropriate, utilization management tools can be implemented to shift single source brands to the available generic product within the therapeutic category.

(2) How does your Preferred Drug List development process promote the use of the most cost effective drug within the therapeutically equivalent drugs in the class, including Generics. Provide three examples.

The CVS Caremark process of developing the PDL utilizes the lowest net cost approach. This approach considers the market share, AWP cost, and rebates provided by pharma. After multiple scenarios are run, the scenario with the lowest net cost is selected.

Examples include:

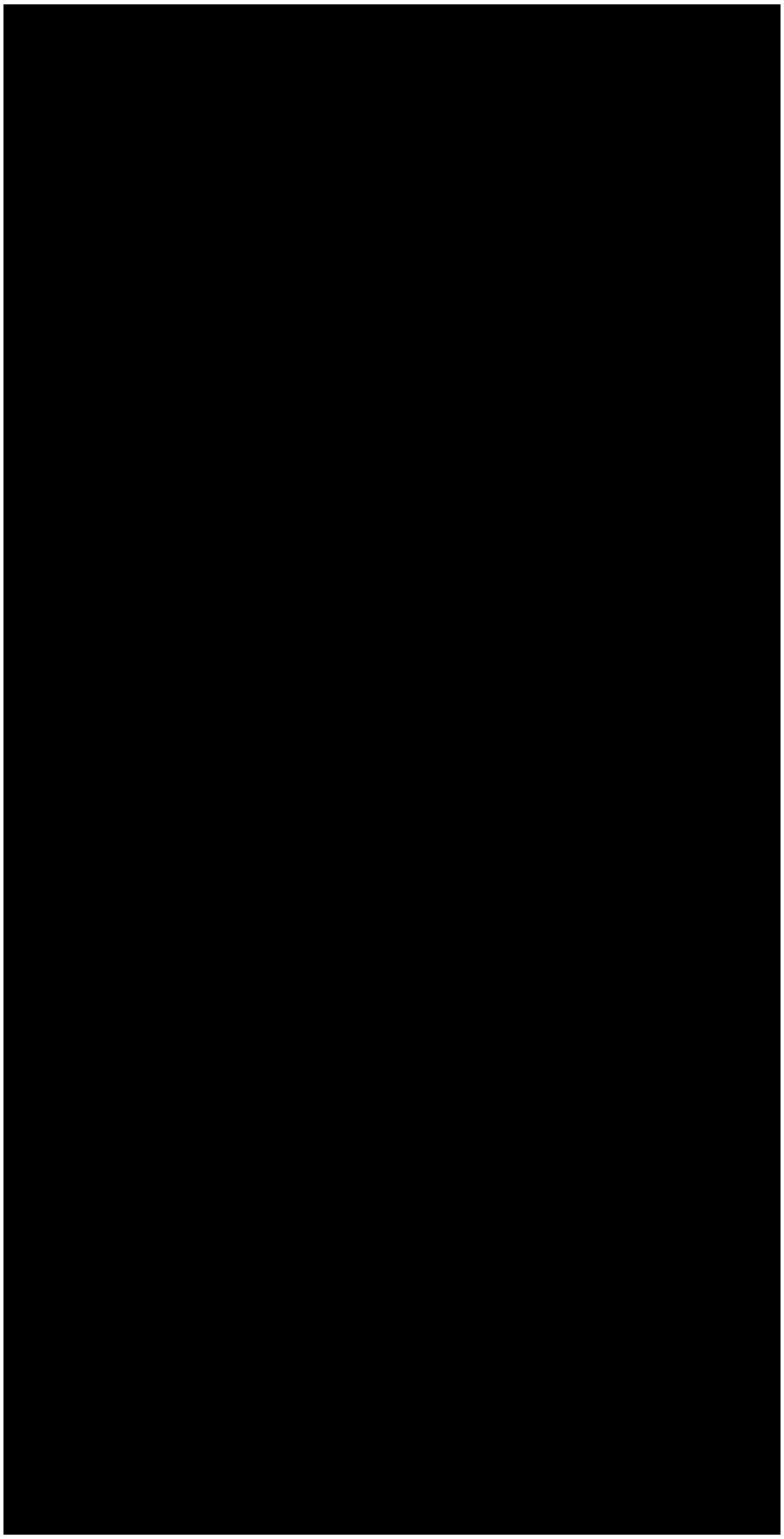
PPIs – (No preferred brand drugs) Our strategy is to promote appropriate generic use first and foremost. The drugs in the PPI class are considered interchangeable and therefore highly likely to switch to preferred products. A generic-only strategy creates the lowest net cost for the class, even after consideration of rebates.

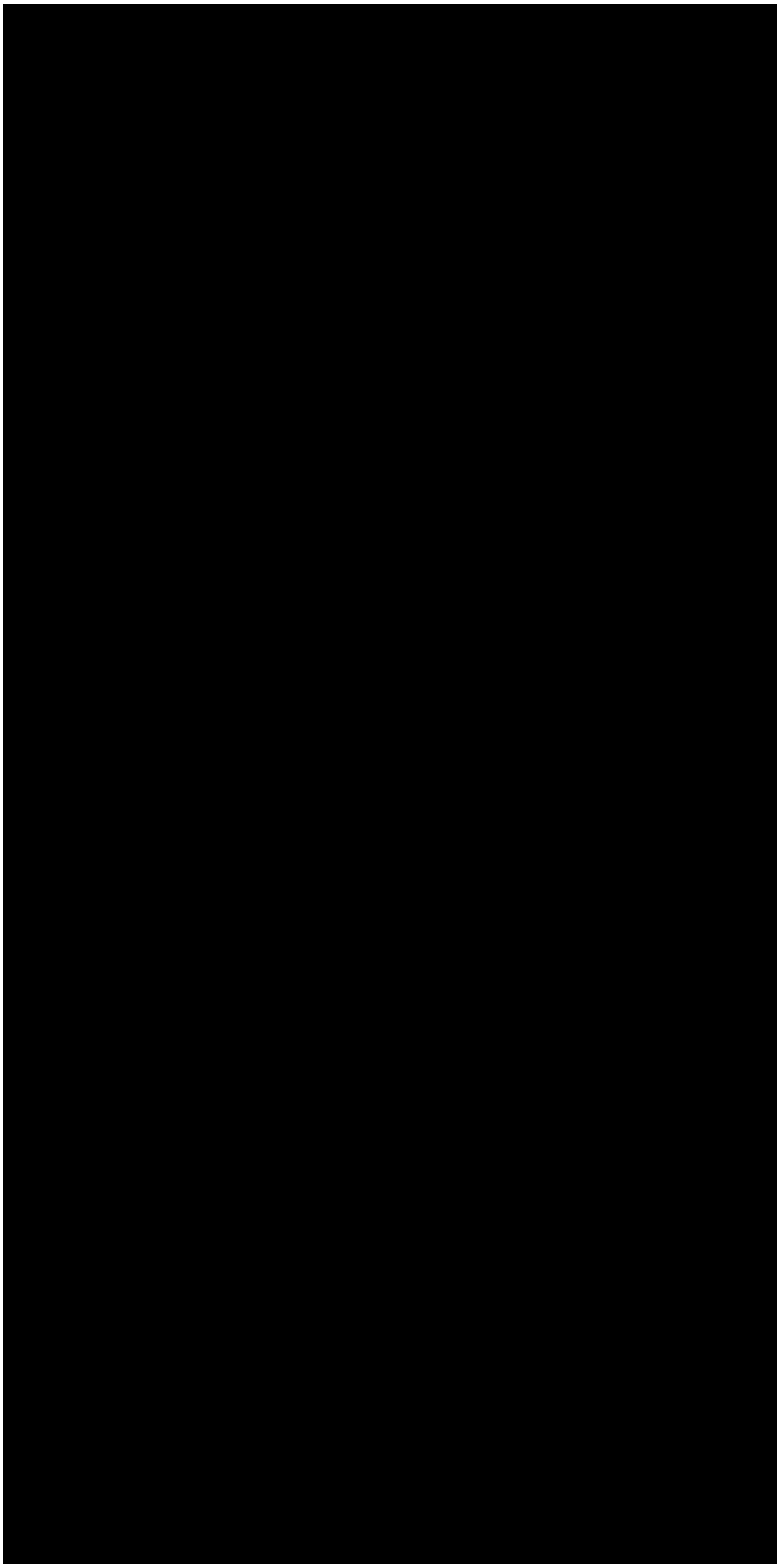
HMGs – (One preferred brand drug, Crestor) With the recent launch of atorvastatin, the class has moved towards a generic-only strategy. However, based on the remaining market share for Crestor, if the product was removed versus keeping the product on formulary, the lowest net cost currently would include Crestor as the lone preferred brand.

Inhalers – (One preferred brand drug, Proair HFA) Inhalers are highly interchangeable, with no generics available. The exclusive listing provides the lowest net cost based on rebate contracts and market shifting scenarios.

(3) Does your PDL strategy currently allow for drug exclusions? Do your proposed Flexible Formulary and Excelsior PDL's contain Drug exclusions? If so, please list proposed excluded drugs and rationale. Describe how you use exclusion leverage to negotiate rebates with Pharmacy manufacturers to provide the best value to the DCS Program.

[redacted]





(4) Describe your strategy and process for evaluating and determining the appropriate Preferred Drug List designation for the introduction of “me too” drugs including drugs with OTC equivalents. Please describe your current strategy and its rationale for the proton pump inhibitor class, statin class, and lifestyle drugs (Viagara, Levitra, etc.).

(5) Describe your strategy and process for determining the appropriate Preferred Drug List designation for the introduction of "successor drugs," including extended release products. Provide an example of this strategy.

[redacted]

(6) Please detail your strategy and process for determining the appropriate copay level designation for the introduction of "combination drugs" including, but not limited to any net cost analysis comparing the cost of the new combination drug and the cost of its component drugs. How does this process evaluate comparative cost when the new combination drug does not come in all strengths available in either of the component drugs or if the single combination drug does not meet the usual dosing levels of one of the component drugs? Please provide an example of this strategy.

[redacted]

(7) Explain how your business model ensures that the placement of drugs on the Preferred Drug Lists will result in the best value to the DCS Program and Enrollees. Describe how manufacturer contracting is integrated into this process.

The CVS Caremark process of developing the PDL utilizes the lowest net cost approach. This approach considers the market share, AWP cost, and rebates provided by pharma. After multiple scenarios are run the scenario with the lowest net cost is selected.

(8) Describe how the anticipated upcoming release of a new Generic drug impacts the placement of its Brand Drug equivalent on the Preferred Drug Lists. Will the rebates available for similar Brand Drugs impact its placement? Does your proposed Preferred Drug List have drugs anticipated to go generic in 2012 as non-preferred? Please explain the rationale for such classification.

[redacted]

[redacted]

[redacted]

Voluntary Drug Recalls, Withdrawals, and Drug Lawsuits/Settlements

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

To help anticipate and prepare for any FDA-defined class of recall (Wholesale, Retail, or Patient Level), we closely monitor safety-alert Web sites for information on product irregularities − including fraudulent drug activity. This way we can respond rapidly (i.e., request verification of purchasing, request product "holds" or "inspections" in CVS Caremark's pharmacies) and create appropriate communications for CVS Caremark's clients and their members.

In addition, CVS Caremark's pharmacies report product discrepancies/irregularities. Upon receipt, all sites review their stock, and the results are entered into a central log. This process gives CVS Caremark a head start on a potential drug recall. We work diligently to ensure that the irregular products are replaced in a timely manner, reducing any negative effect on members and our pharmacy operations.

Drug Recall Communication

We process recalls differently for the "member-level" (critical) vs. the "routine-level."

With a routine-level recall, our pharmacies are notified immediately and given instructions on how to segregate and return the affected product to the manufacturer.

A member-level recall requires that any product "in-house" be segregated for return and that a notification process be launched immediately. The member is instructed ***via a phone call or letter***, depending upon the type of recall/withdrawal, on what to do with the product and how it is to be replaced. This instruction is at the direction of the manufacturer or distributor.

In either case, communication with our pharmacies is immediate through e-mail. The pharmacy takes whatever action is necessary and responds on the status within 24 hours. If not all of the information is available on the issuance of the recall, a call is placed immediately to the manufacturer for verification.

Reimbursement

A product withdrawal usually means that a particular product will cease to be manufactured and distributed. In this instance CVS Caremark would send letters to members and prescribers notifying them that at a given future date, the prescribed medication will no longer be available. The client would be notified as well since the withdrawal may have some formulary impact or result in member disruption.

No claim reversal would occur either to member or client.

In the case of product withdrawal the manufacturer would be charged for the administrative costs associated with the letter construction and postage concerning mailing of the letters.

If a product is recalled, CVS Caremark would prepare letters to be sent to the client, prescriber, and member. Affected product in the pharmacy would be quarantined. A mail tag to return the affected product would be sent to the member for return of the recalled product. All recalled product would be shipped to the manufacturer or the manufacturer's designee for destruction.

For recalled product, CVS Caremark would charge an administrative fee for letter construction, letter copying, postage associated with mailing the letters. In addition, the manufacturer would be charged shipping costs associated with pick-up and return of the recalled product.

The transacted claim for the recalled product would be reversed, both with respect to the client and the member. CVS Caremark can produce a report that would identify the beneficiaries that received the recalled product and a report that also confirms that all of these claims were reversed to the client and the beneficiary.

(2) Describe your process for identifying drug lawsuits and settlements on behalf of the Program. Confirm that the Offeror will notify the Department in a timely manner of class action lawsuits or settlements in which the Program may participate. Confirm that the Offeror will credit the Program for net recoveries within fifteen (15) Days upon receipt by the Offeror. Describe how the Offeror's actual costs incurred in the settlement will be allocated to the Program.

CVS Caremark provides assistance to clients when CVS Caremark has knowledge of class action lawsuits for third party payors. CVS Caremark will provide clients with the necessary drug spend information that is required for the client to submit a claim to the fund administrator. CVS Caremark's Analytics and Outcomes department sets up a database that can be accessed by the appropriate Account Managers for this purpose. If the Program files their own claims, we will provide the Program with the same level of assistance.

If the Programs request CVS Caremark to directly file claims on its/their behalf or otherwise directly pursue recoveries, to the extent permitted by the settlement or award, CVS Caremark will do so. CVS Caremark will coordinate with the Programs on the approach, depending on the circumstances of the particular situation, and may utilize the resources of a third-party consultant or legal counsel, as appropriate. CVS Caremark will log its actual expenses in engaging such parties or otherwise outside of the scope of services otherwise provided and will provide the Department or NYSIF, as applicable, with itemized billing for such expenses. CVS Caremark confirms to credit the Programs for net recoveries within fifteen days.

Preferred Drug List Development and Management (Exclusive to NYSIF)

The selected Offeror is required to efficiently develop, administer, and maintain a single Preferred Drug List (PDL) that ensures Claimant access to appropriate, quality pharmaceutical care based on sound clinical criteria. The Program requires that all Covered Drugs be classified as preferred or non-preferred. PDL management, in particular designation of drugs as preferred (which generally means Level 1 or Level 2), non-preferred or excluded, is critical to the clinical and financial success of the Program. The Offeror must use sound clinical criteria in any decisions that are made to place or exclude drugs from the PDL.
The PDL generally features Generic Drugs on the first level, Preferred Brand Drugs on the second level, and Non-Preferred Brand Drugs on the third level. The PDL proposed for the Program must include all drugs meeting the definition of Covered Drugs in this RFP. The selected Offeror is required to effectively communicate the content and requirements of the Program's PDL to Network Pharmacies, medical providers, and Enrollees. The design of the NYSIF Program does not require a Brand Drug in every

therapeutic category. For the purpose of preparing a response to this RFP if an Offeror proposes a Preferred drug list which does not include a Preferred Brand Drug in every therapeutic category, the Offeror must include the clinical rationale and financial implications of the Offeror's determination. Offerors will submit cost information as required in Section V, Cost Proposal of this RFP.
Note: Do not include any cost information in the technical proposal.

A. DUTIES AND RESPONSIBILITIES

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

(1) Creating and maintaining a formulary that is tailored to NYSIF specifications, including the categorization of drugs, e.g. drugs requiring prior authorization, covered drugs dispensed not requiring prior authorization;
(2) Providing NYSIF with a list of therapeutic categories routinely excluded from coverage;
(3) Agreeing that the Offeror does not and will not accept payments from drug companies to promote specific products;
(4) Notifying NYSIF a minimum of three weeks prior to any additions, deletions and modifications to the existing formulary and whether or not the affected drugs are covered or require prior authorization;
(5) Notifying NYSIF a minimum of three weeks prior to the inclusion of new drugs in the formulary and specify whether or not the drugs are covered or require prior authorization; and,
(6) Providing NYSIF with an electronic file of all formulary drugs including dosages, NDC numbers, GCN and GC3 codes. The frequency of this file submission will be determined by NYSIF and will be provided upon vendor selection.

B. REQUIRED SUBMISSION

(1) Describe how you will create and maintain a formulary that is tailored to NYSIF specifications, including the categorization of drugs, e.g. drugs requiring prior authorization, covered drugs dispensed not requiring prior authorization;

(2) Provide in electronic format, preferably Excel, a list of therapeutic categories you routinely exclude from coverage;

In order to maintain compliance with NYSIF requirements, CVS Caremark is not proposing to exclude any therapeutic categories for the NYSIF formulary.

(3) Confirm that you do not and will not accept payments from drug companies to promote specific products;

CVS Caremark confirms.

(4) Confirm you will notify NYSIF a minimum of three weeks prior to any additions, deletions and modifications to the existing formulary and whether or not the affected drugs are covered or require prior authorization;

CVS Caremark confirms.

(5) Confirm you will notify NYSIF a minimum of three weeks prior to the inclusion of new drugs in the formulary and specify whether or not the drugs are covered or require prior authorization; and,

CVS Caremark confirms.

(6) Confirm you will provide NYSIF with an electronic file of all formulary drugs including dosages, NDC numbers, GCN and GC3 codes. The frequency of this file submission will be determined by NYSIF and will be provided upon vendor selection.

CVS Caremark confirms.

Voluntary Drug Recalls, Withdrawals, and Drug Lawsuits/Settlements

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

To help anticipate and prepare for any FDA-defined class of recall (Wholesale, Retail, or Patient Level), we closely monitor safety-alert Web sites for information on product irregularities − including fraudulent drug activity. This way we can respond rapidly (i.e., request verification of purchasing, request product "holds" or "inspections" in CVS Caremark's pharmacies) and create appropriate communications for CVS Caremark's clients and their members.

In addition, CVS Caremark's pharmacies report product discrepancies/irregularities. Upon receipt, all sites review their stock, and the results are entered into a central log. This process gives CVS Caremark a head start on a potential drug recall. We work diligently to ensure that the irregular products are replaced in a timely manner, reducing any negative effect on members and our pharmacy operations.

Drug Recall Communication

We process recalls differently for the "member-level" (critical) vs. the "routine-level."

With a routine-level recall, our pharmacies are notified immediately and given instructions on how to segregate and return the affected product to the manufacturer.

A member-level recall requires that any product "in-house" be segregated for return and that a notification process be launched immediately. The member is instructed *via a phone call or letter*, depending upon the type of recall/withdrawal, on what to do with the product and how it is to be replaced. This instruction is at the direction of the manufacturer or distributor.

In either case, communication with our pharmacies is immediate through e-mail. The pharmacy takes whatever action is necessary and responds on the status within 24 hours. If not all of the information is available on the issuance of the recall, a call is placed immediately to the manufacturer for verification.

Reimbursement

A product withdrawal usually means that a particular product will cease to be manufactured and distributed. In this instance CVS Caremark would send letters to members and prescribers notifying them that at a given future date, the prescribed medication will no longer be available. The client would be notified as well since the withdrawal may have some formulary impact or result in member disruption.

No claim reversal would occur either to member or client.

In the case of product withdrawal the manufacturer would be charged for the administrative costs associated with the letter construction and postage concerning mailing of the letters.

If a product is recalled, CVS Caremark would prepare letters to be sent to the client, prescriber, and member. Affected product in the pharmacy would be quarantined. A mail tag to return the affected product would be sent to the member for return of the recalled product. All recalled product would be shipped to the manufacturer or the manufacturer's designee for destruction.

For recalled product, CVS Caremark would charge an administrative fee for letter construction, letter copying, postage associated with mailing the letters. In addition, the manufacturer would be charged shipping costs associated with pick-up and return of the recalled product.

The transacted claim for the recalled product would be reversed, both with respect to the client and the member. CVS Caremark can produce a report that would identify the beneficiaries that received the recalled product and a report that also confirms that all of these claims were reversed to the client and the beneficiary.

(2) Describe your process for identifying drug lawsuits and settlements on behalf of the Program. Confirm that the Offeror will notify the Department in a timely manner of class action lawsuits or settlements in which the Program may participate. Confirm that the Offeror will credit the Program for net recoveries within fifteen (15) Days upon receipt by the Offeror. Describe how the Offeror's actual costs incurred in the settlement will be allocated to the Program.

CVS Caremark provides assistance to clients when CVS Caremark has knowledge of class action lawsuits for third party payors. CVS Caremark will provide clients with the necessary drug spend information that is required for the client to submit a claim to the fund administrator. CVS Caremark's Analytics and Outcomes department sets up a database that can be accessed by the appropriate Account Managers for this purpose. If the Program files their own claims, we will provide the Program with the same level of assistance.

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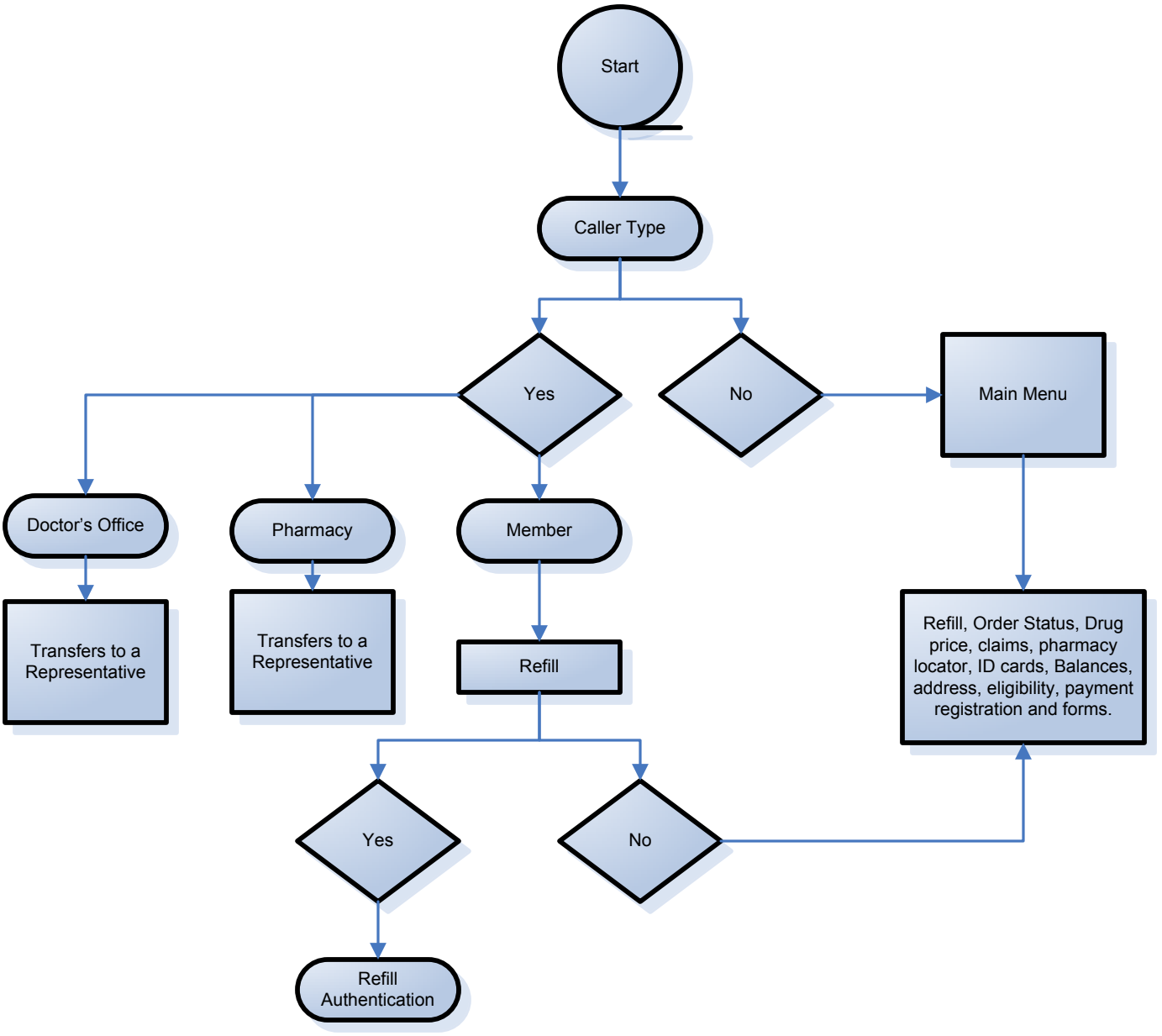
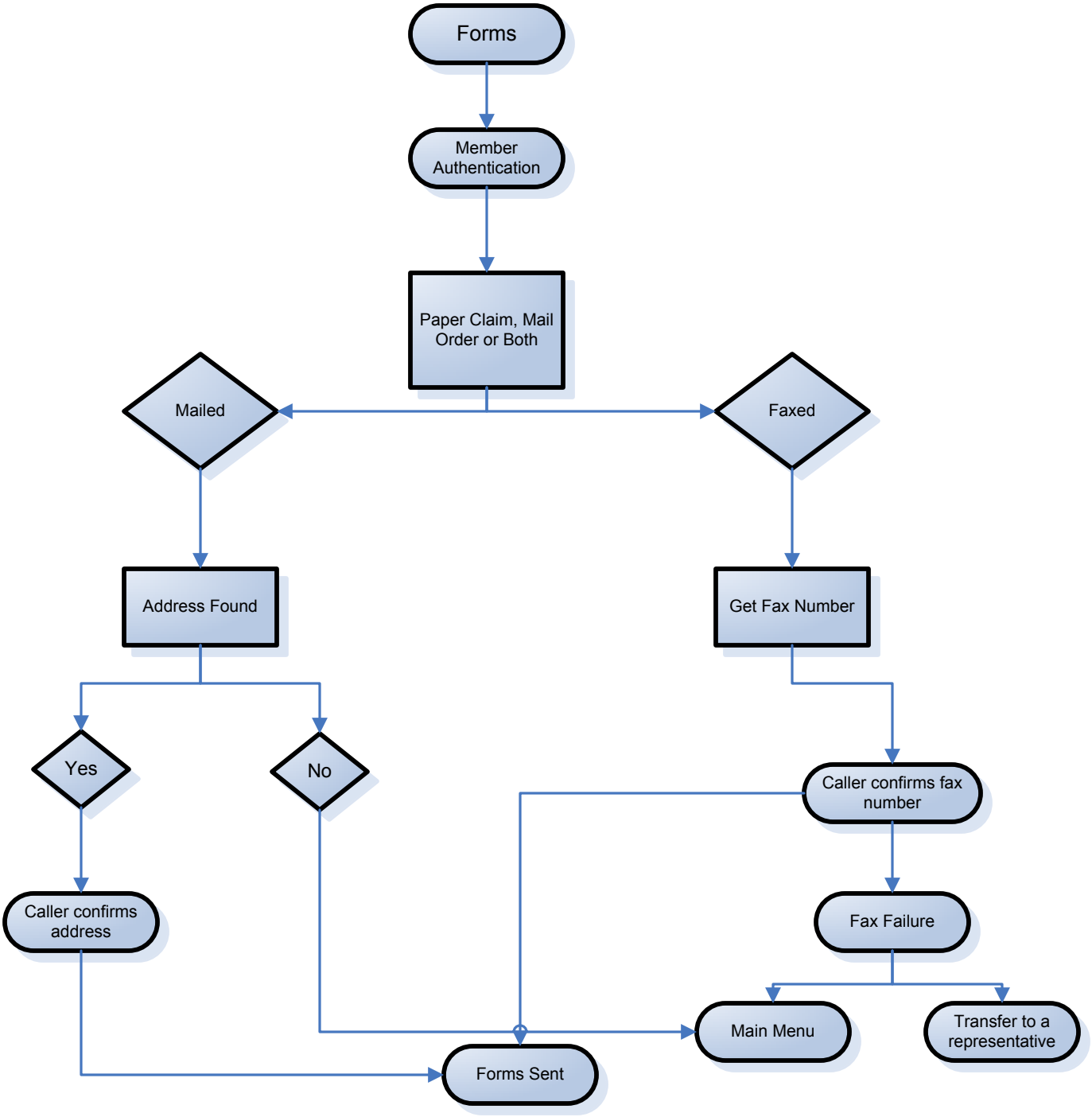
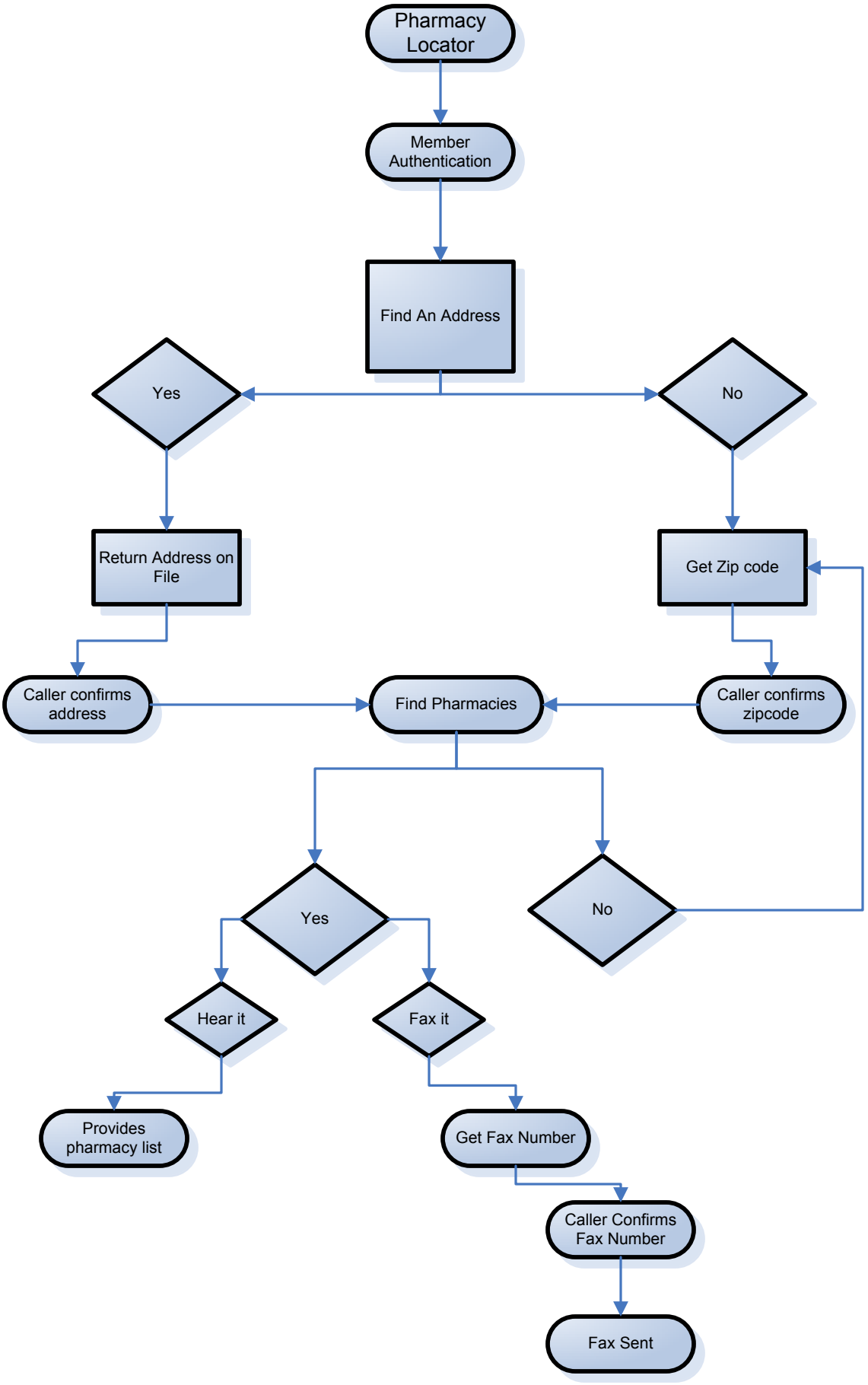
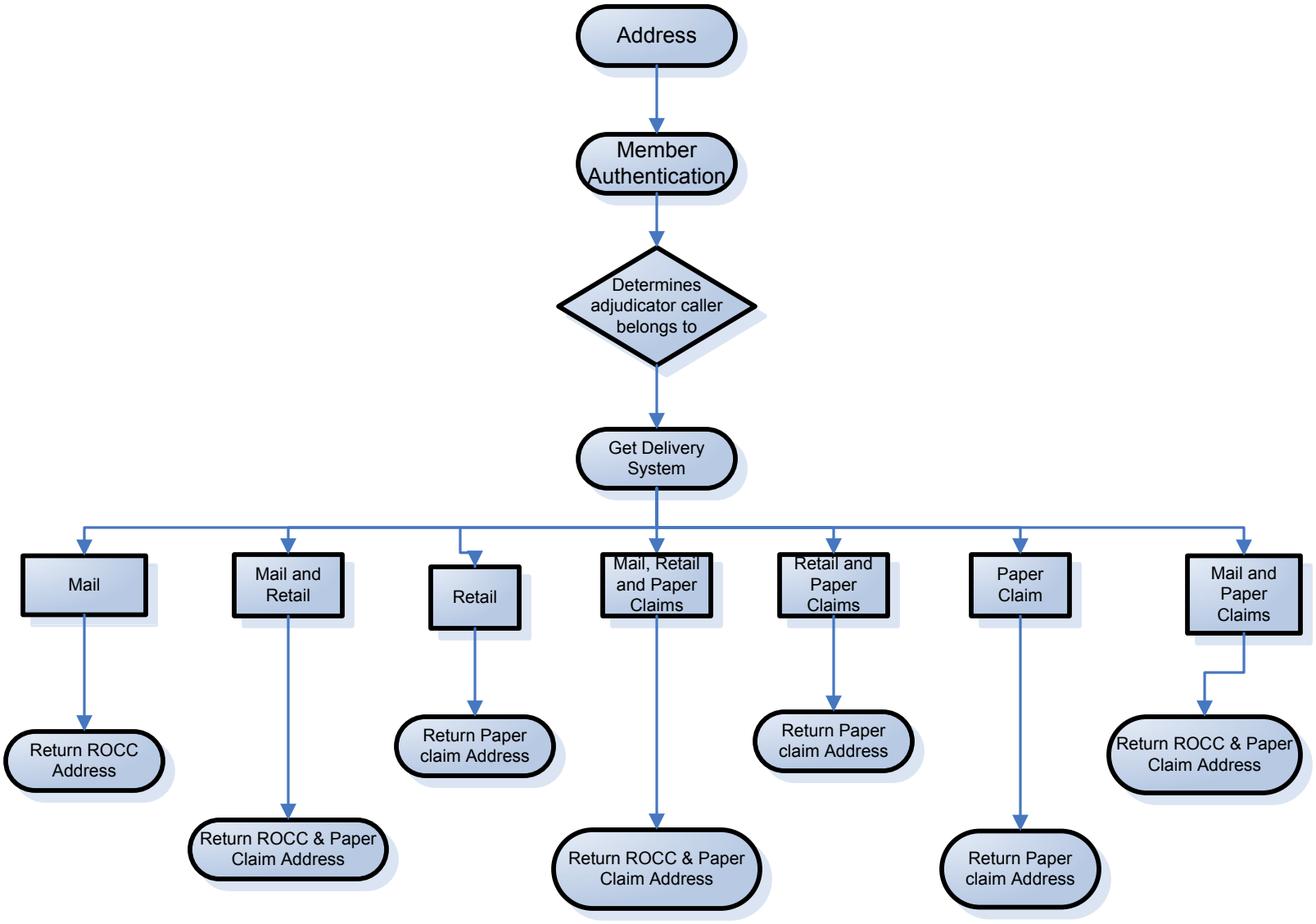
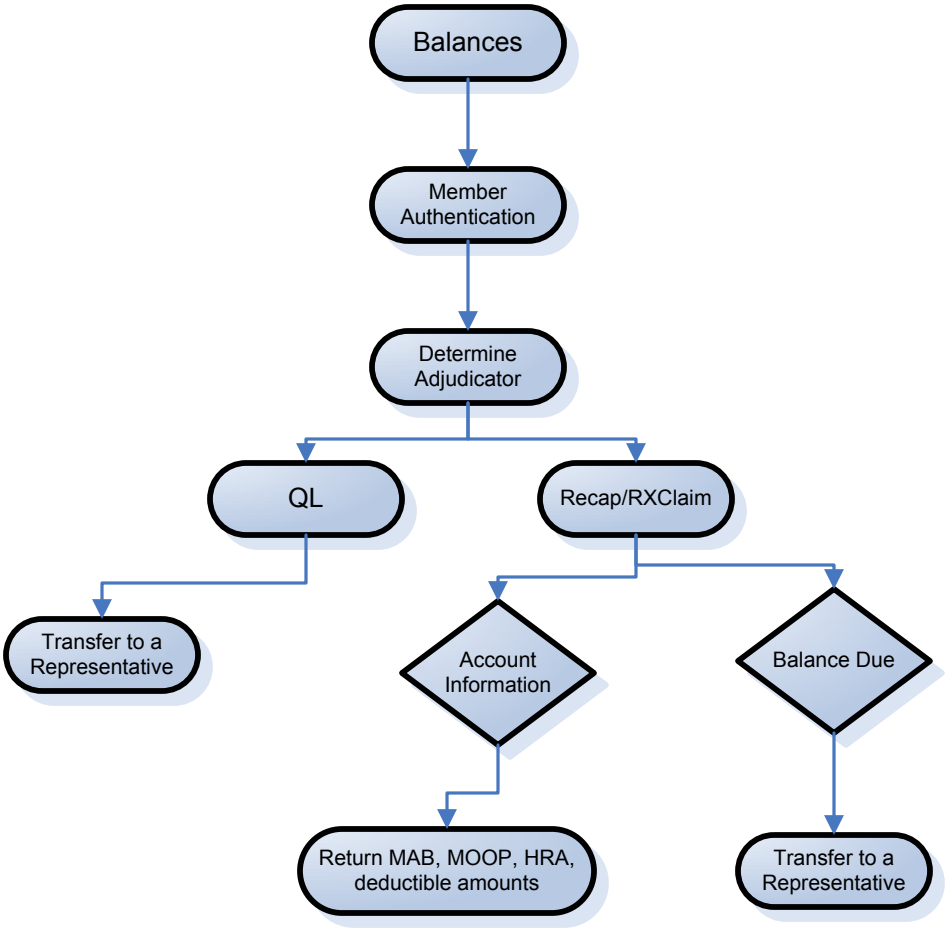
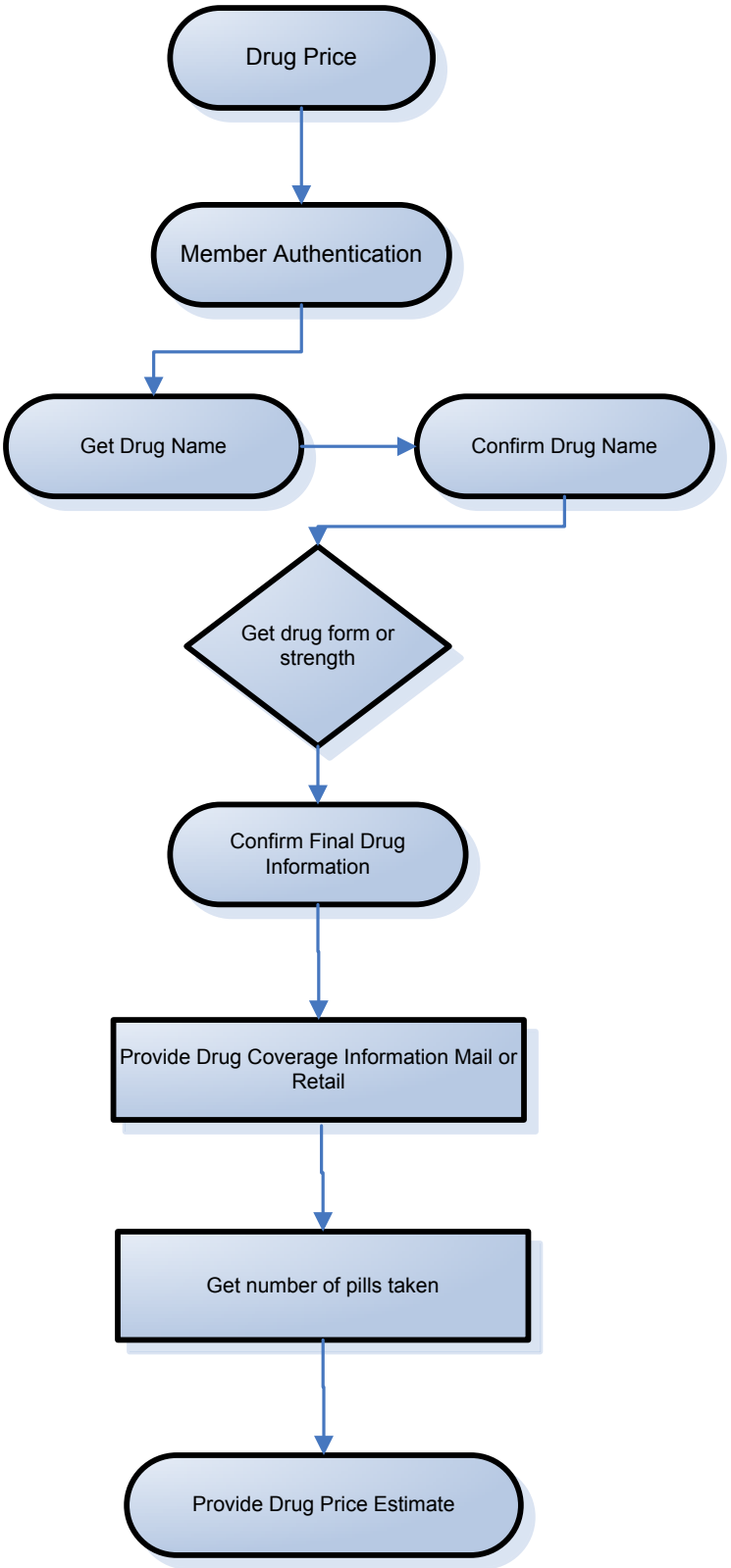

Start
Caller Type
Yes
No
Main Menu
Doctor's Office
Pharmacy
Member
Transfers to a Representative
Transfers to a Representative
Refill
Refill, Order Status, Drug price, claims, pharmacy locator, ID cards, Balances, address, eligibility, payment registration and forms.
Yes
No
Refill Authentication

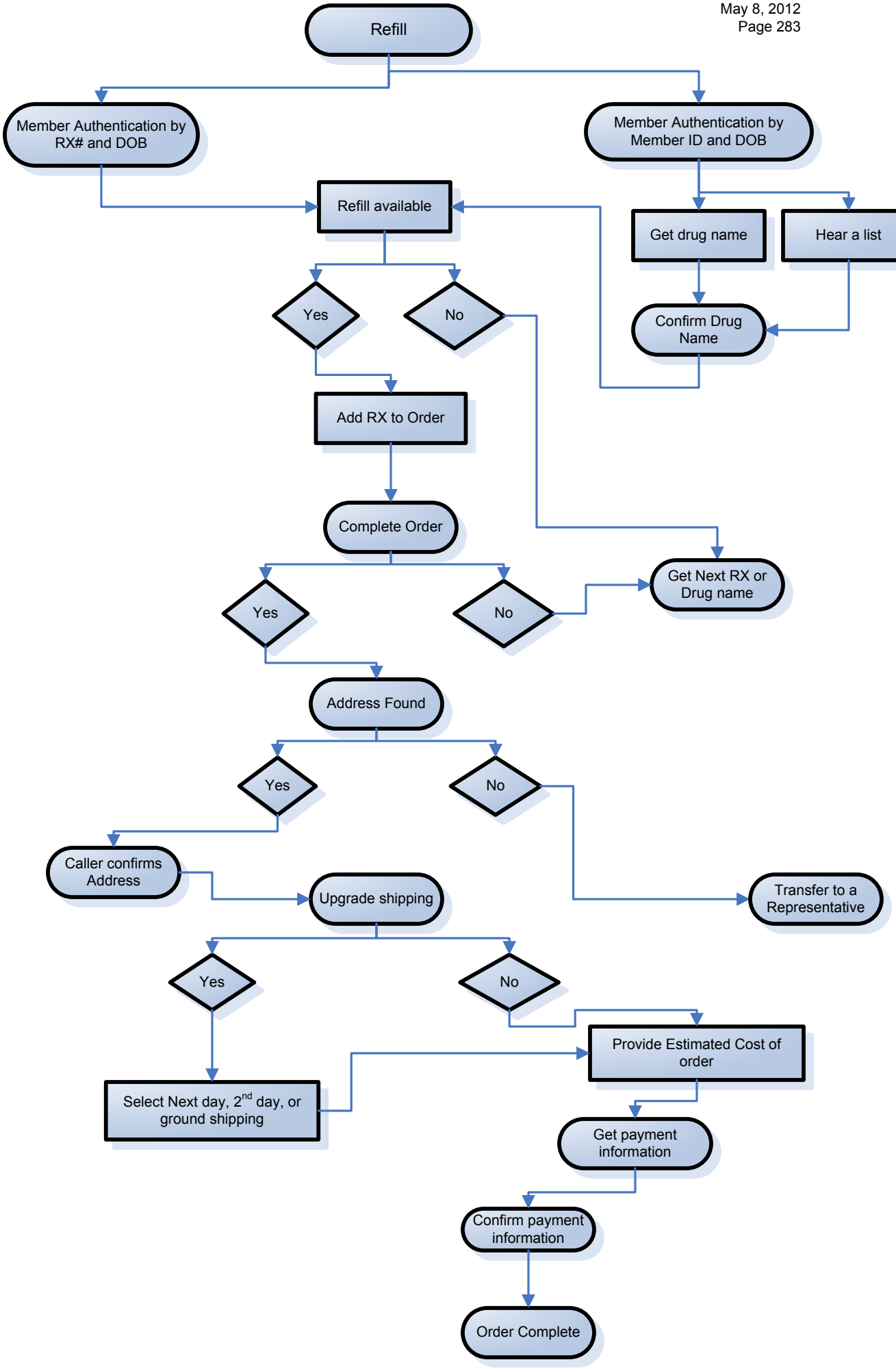

Forms
Member Authentication
Paper Claim, Mail Order or Both
Mailed
Faxed
Address Found
Get Fax Number
Yes
No
Caller confirms fax number
Caller confirms address
Fax Failure
Main Menu
Transfer to a representative
Forms Sent

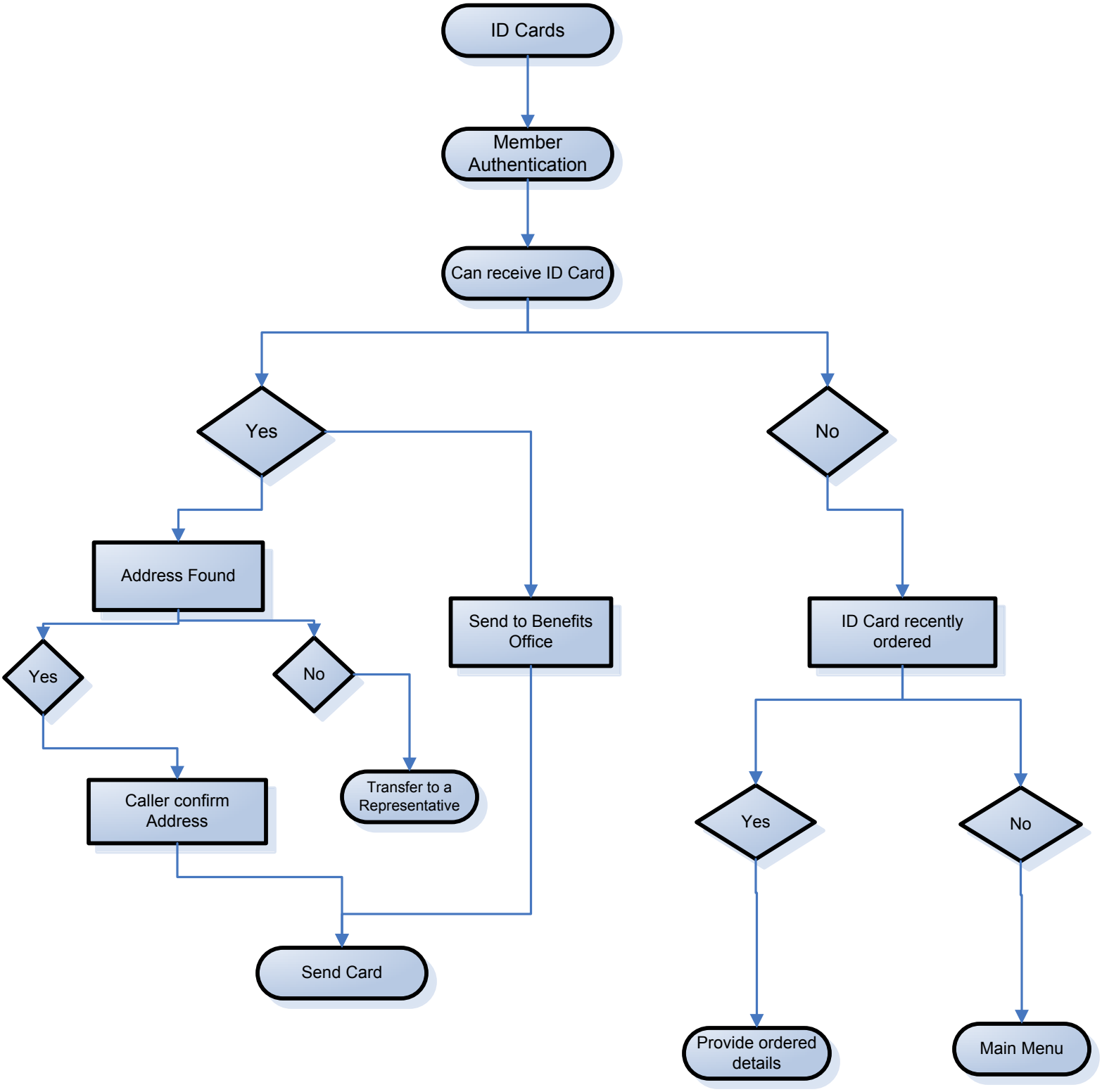

Pharmacy Locator
Member Authentication
Find An Address
Yes
No
Return Address on File
Get Zip code
Caller confirms address
Find Pharmacies
Caller confirms zipcode
Yes
No
Hear it
Fax it
Provides pharmacy list
Get Fax Number
Caller Confirms Fax Number
Fax Sent

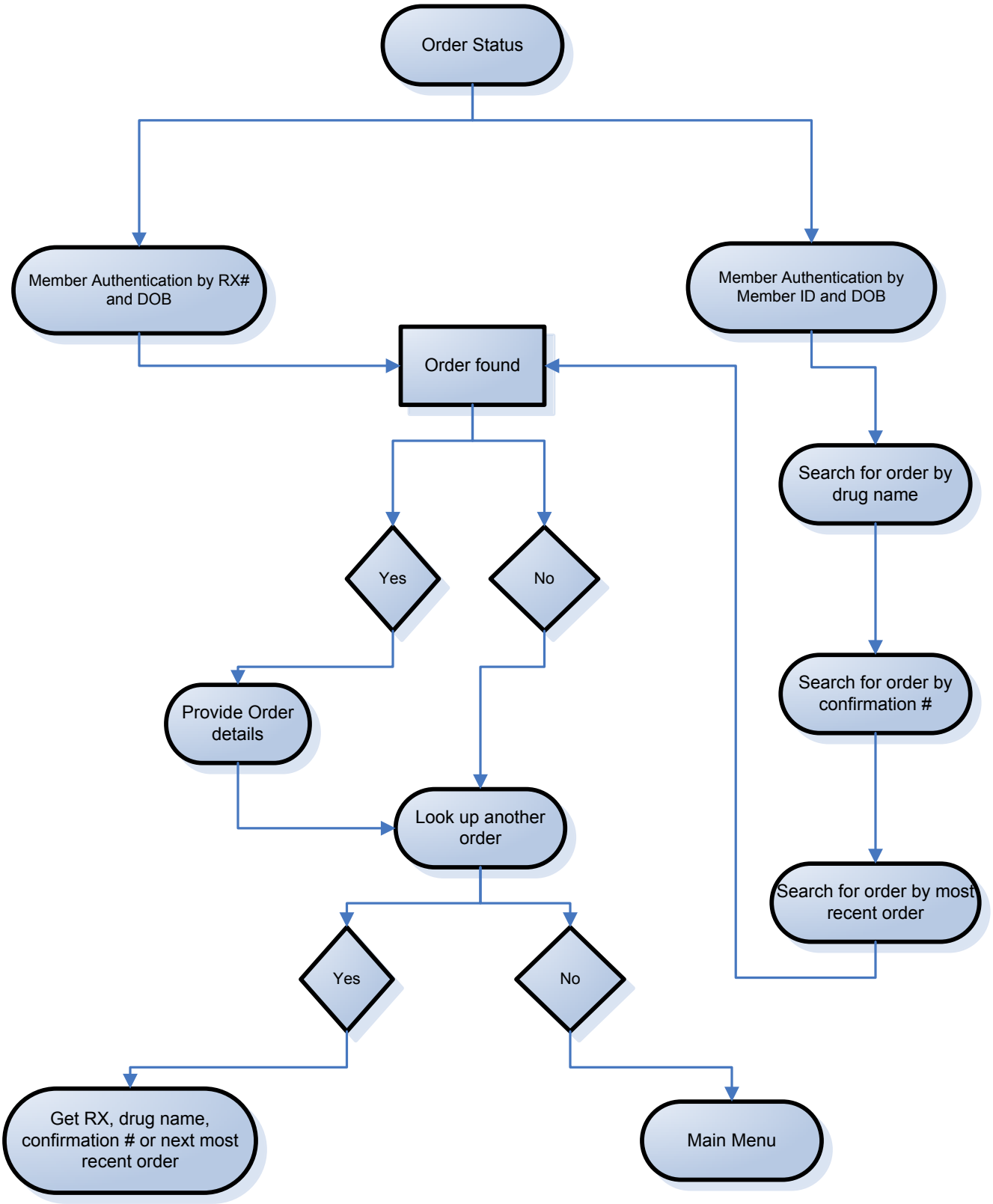

Address
Member Authentication
Determines adjudicator caller belongs to
Get Delivery System
Mail
Mail and Retail
Retail
Mail, Retail and Paper Claims
Retail and Paper Claims
Paper Claim
Mail and Paper Claims
Return ROCC Address
Return ROCC & Paper Claim Address
Return Paper claim Address
Return ROCC & Paper Claim Address
Return Paper claim Address
Return Paper claim Address
Return ROCC & Paper Claim Address

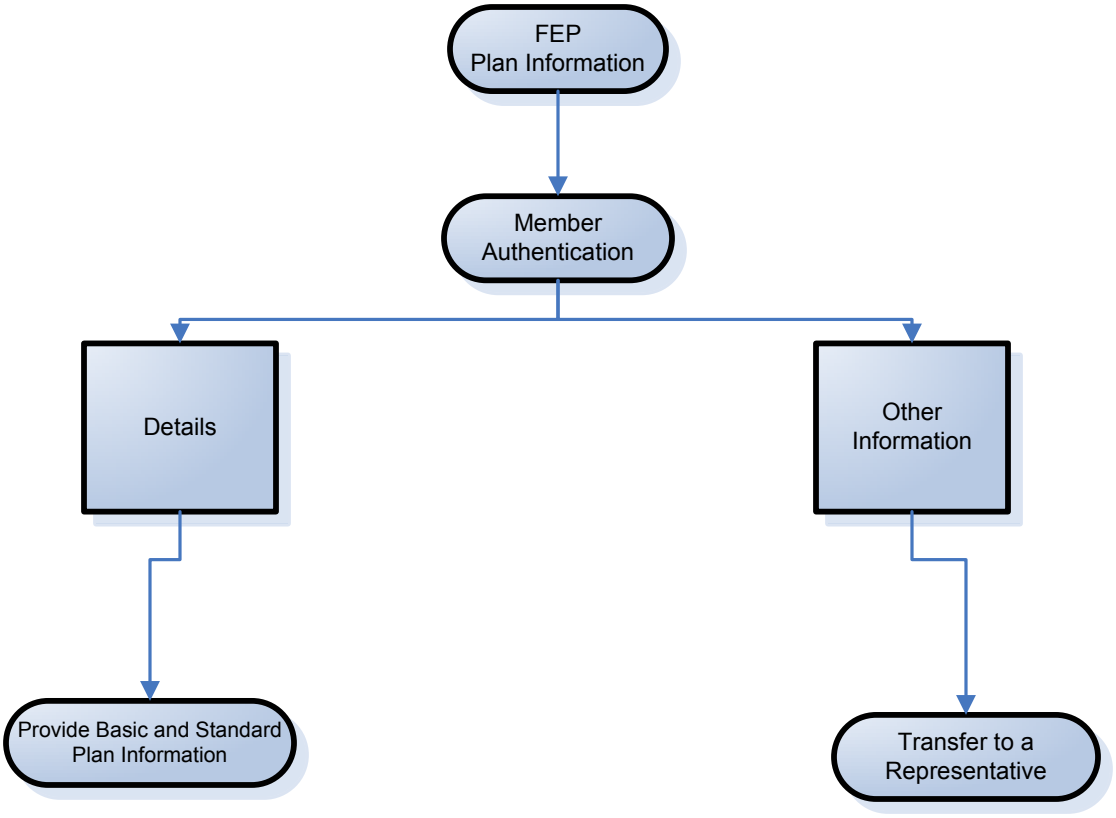

Balances
Member Authentication
Determine Adjudicator
QL
Recap/RXClaim
Transfer to a Representative
Account Information
Balance Due
Return MAB, MOOP, HRA, deductible amounts
Transfer to a Representative

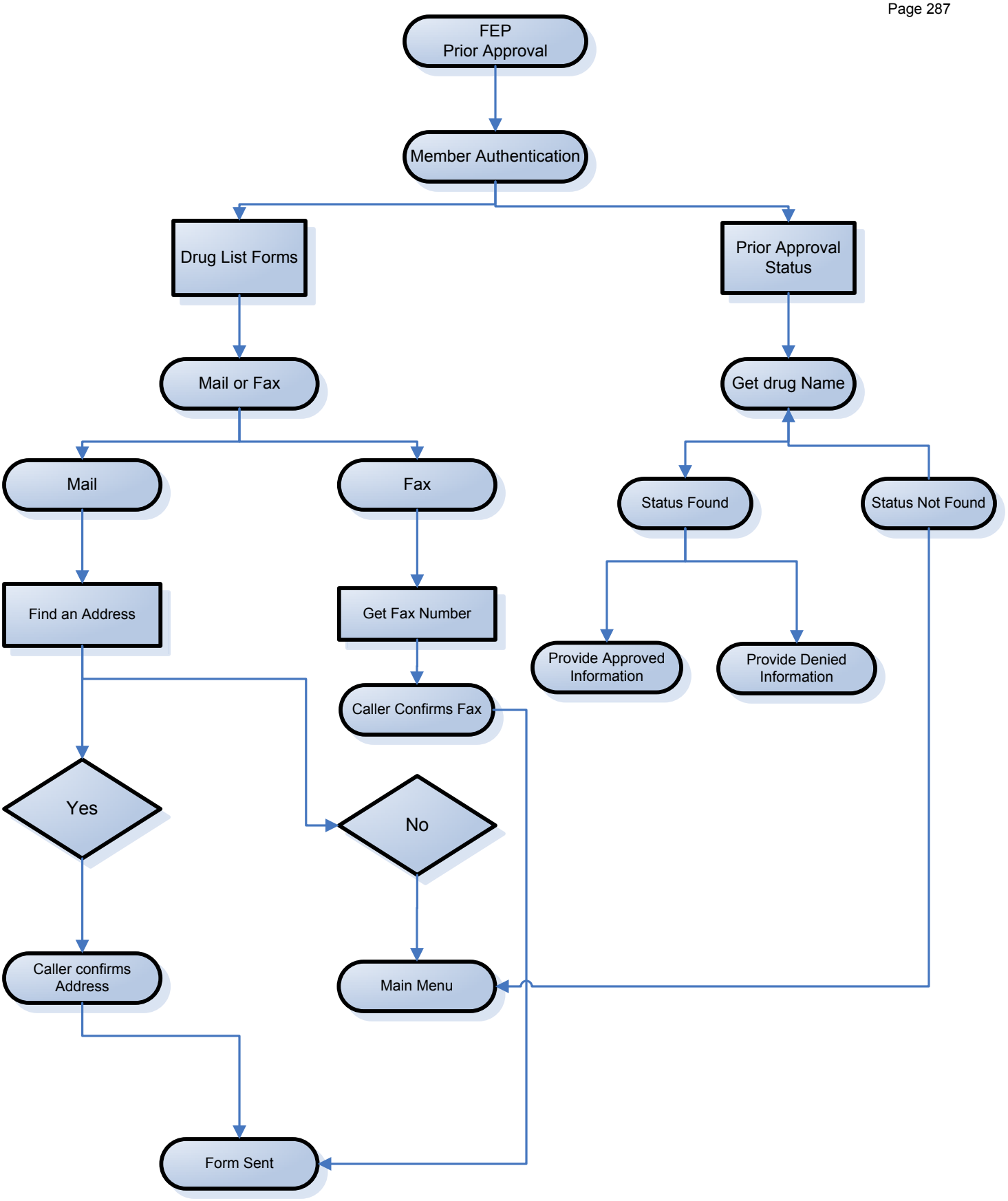

Drug Price
Member Authentication
Get Drug Name
Confirm Drug Name
Get drug form or strength
Confirm Final Drug Information
Provide Drug Coverage Information Mail or Retail
Get number of pills taken
Provide Drug Price Estimate

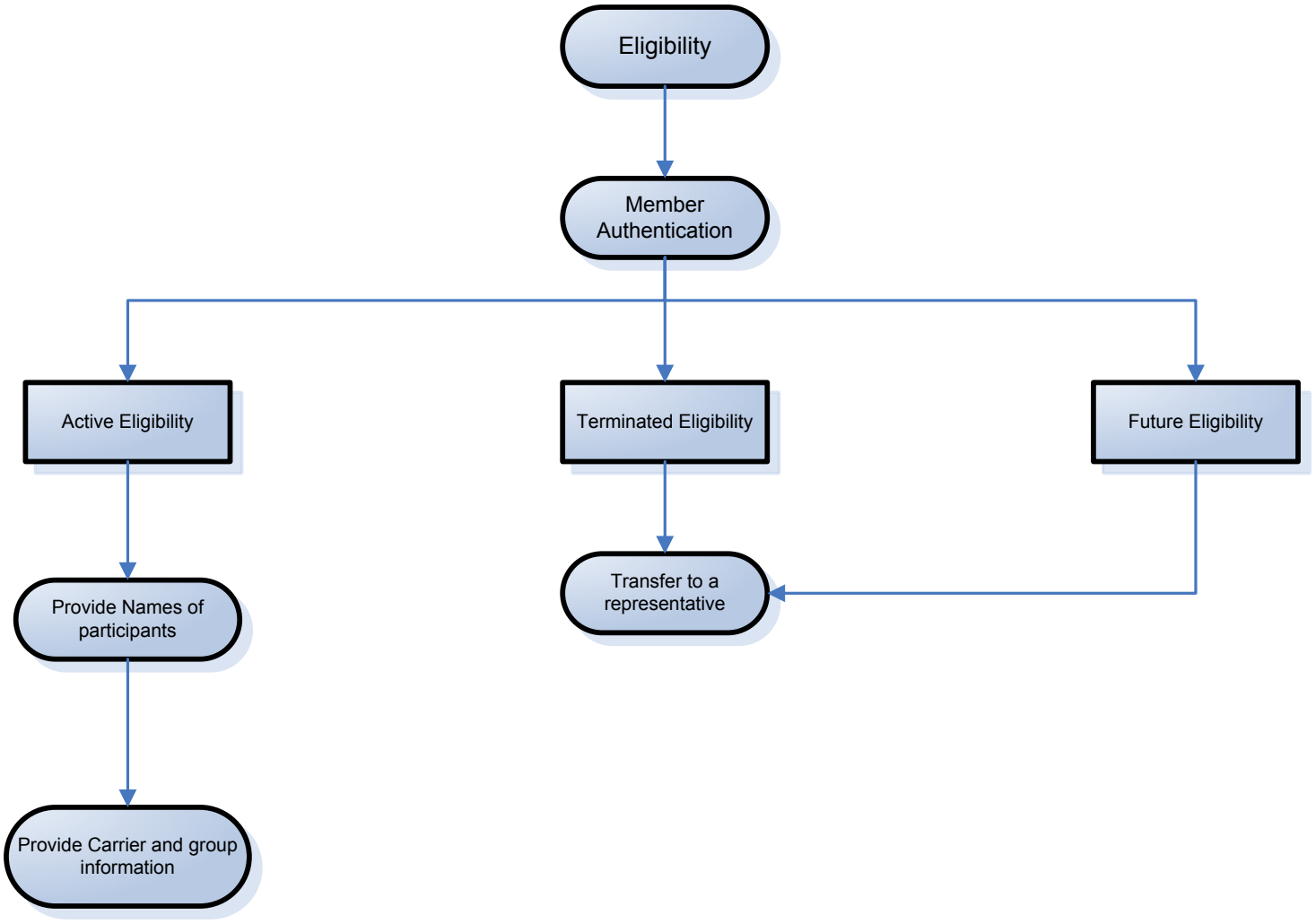

Refill
Member Authentication by RX# and DOB
Member Authentication by Member ID and DOB
Refill available
Get drug name
Hear a list
Yes
No
Confirm Drug Name
Add RX to Order
Complete Order
Yes
No
Get Next RX or Drug name
Address Found
Yes
No
Caller confirms Address
Upgrade shipping
Transfer to a Representative
Yes
No
Select Next day, 2nd day, or ground shipping
Provide Estimated Cost of order
Get payment information
Confirm payment information
Order Complete

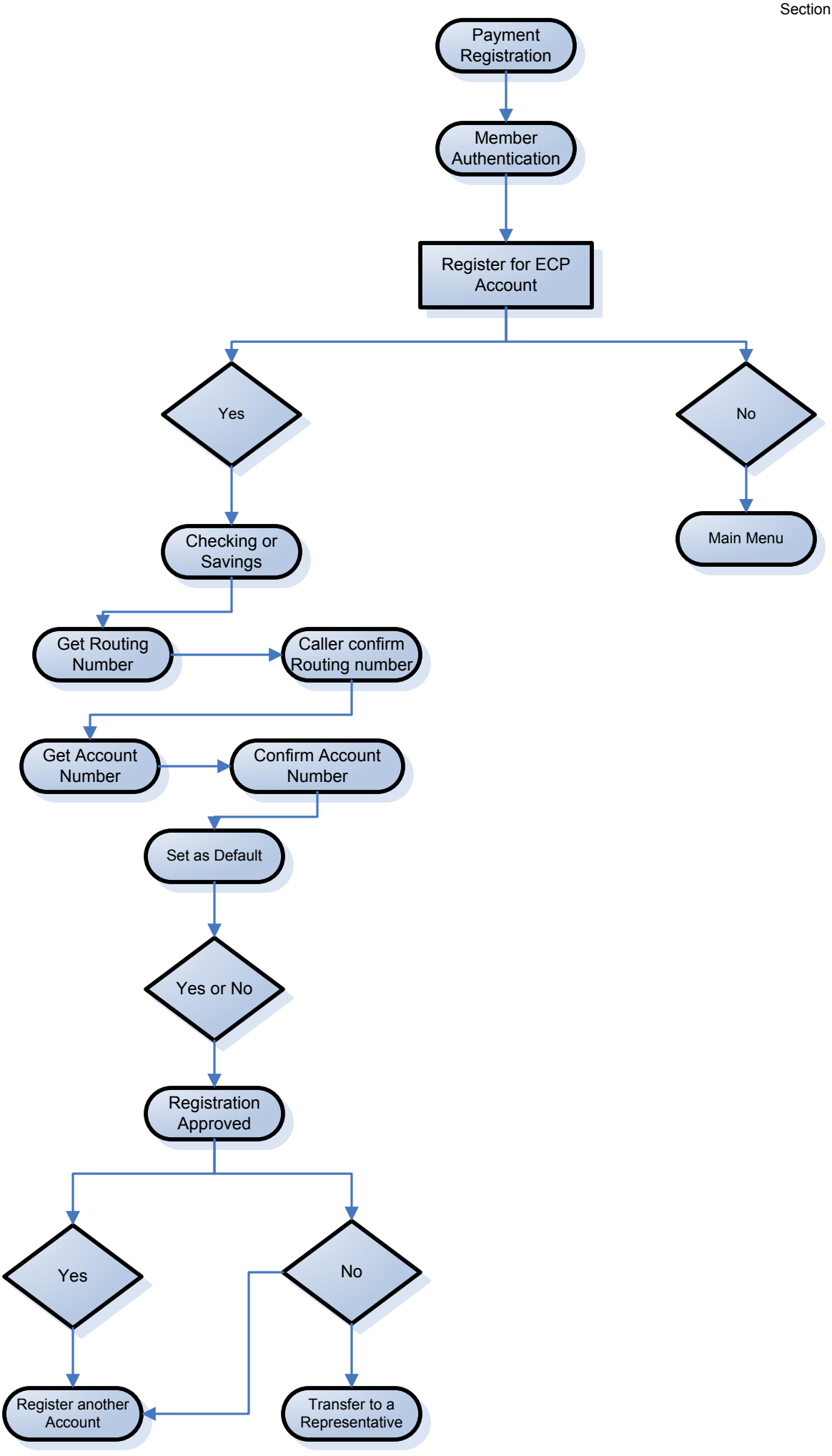

ID Cards
Member Authentication
Can receive ID Card
Yes
No
Address Found
Send to Benefits Office
ID Card recently ordered
Yes
No
Caller confirm Address
Transfer to a Representative
Yes
No
Send Card
Provide ordered details
Main Menu

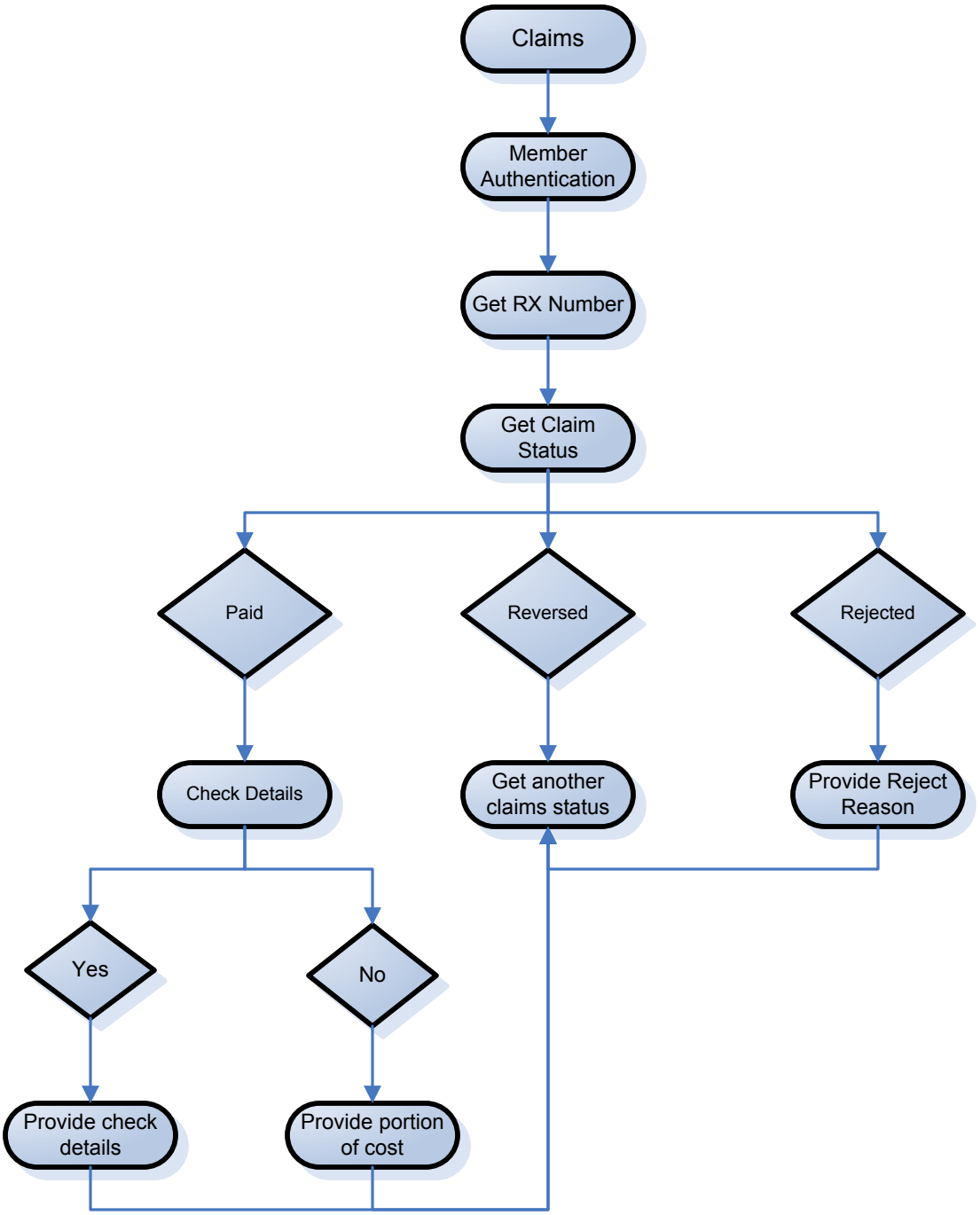

Order Status
Member Authentication by RX# and DOB
Member Authentication by Member ID and DOB
Order found
Search for order by drug name
Yes
No
Search for order by confirmation #
Provide Order details
Look up another order
Search for order by most recent order
Yes
No
Get RX, drug name, confirmation # or next most recent order
Main Menu

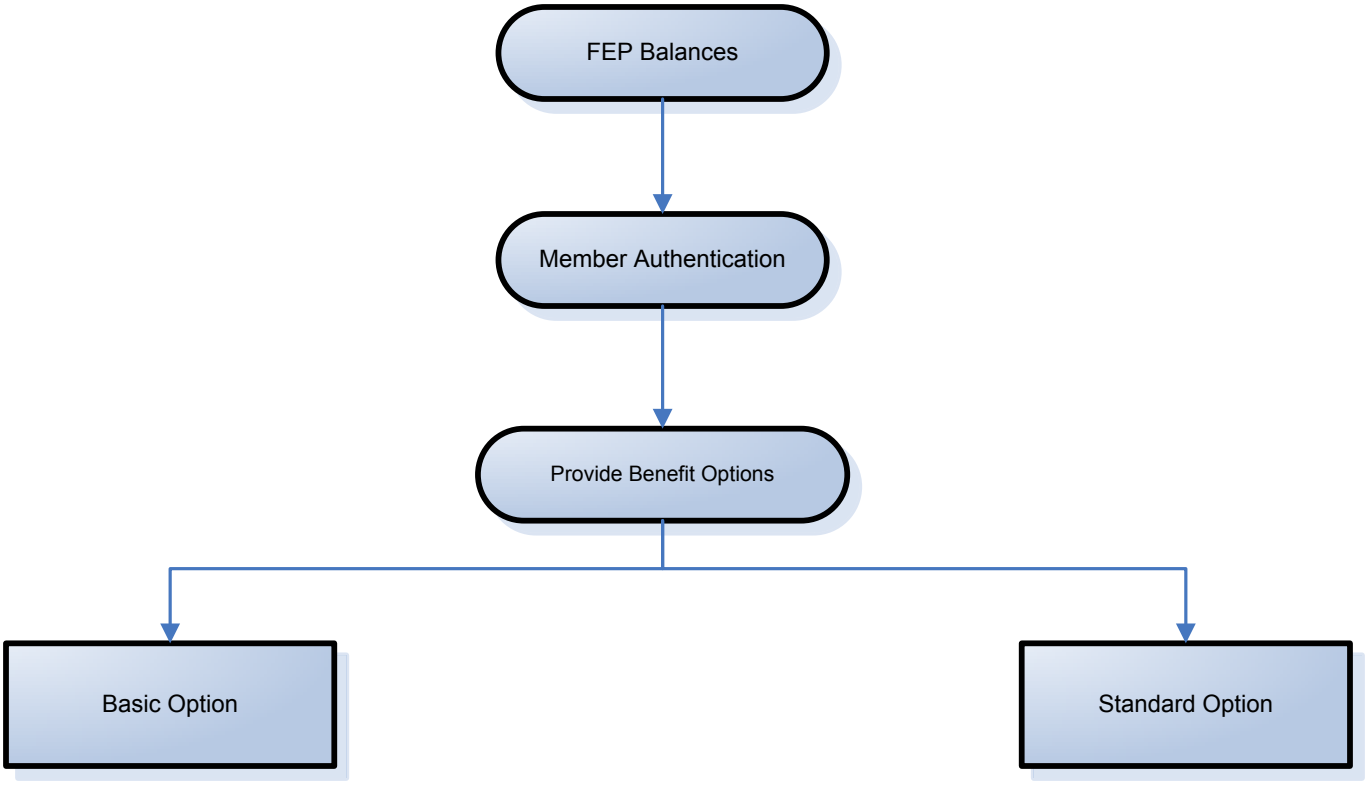

FEP
Plan Information
Member
Authentication
Details
Other
Information
Provide Basic and Standard
Plan Information
Transfer to a
Representative


FEP
Prior Approval
Member Authentication
Drug List Forms
Prior Approval
Status
Mail or Fax
Get drug Name
Mail
Fax
Status Found
Status Not Found
Find an Address
Get Fax Number
Provide Approved
Information
Provide Denied
Information
Caller Confirms Fax
Yes
No
Caller confirms
Address
Main Menu
Form Sent


Eligibility
Member Authentication
Active Eligibility
Terminated Eligibility
Future Eligibility
Provide Names of participants
Transfer to a representative
Provide Carrier and group information


Payment Registration
Member Authentication
Register for ECP Account
Yes
No
Checking or Savings
Main Menu
Get Routing Number
Caller confirm Routing number
Get Account Number
Confirm Account Number
Set as Default
Yes or No
Registration Approved
Yes
No
Register another Account
Transfer to a Representative


Claims
Member Authentication
Get RX Number
Get Claim Status
Paid
Reversed
Rejected
Check Details
Get another claims status
Provide Reject Reason
Yes
No
Provide check details
Provide portion of cost


FEP Balances
Member Authentication
Provide Benefit Options
Basic Option
Standard Option