Solicitation Information
February 27, 2018

RFP# 7590551

TITLE: Medical Plan Administration and Pharmacy Benefit Plan for State Employees

Submission Deadline: April 9, 2018 at 11:00 AM (Eastern Time)

PRE-BID/ PROPOSAL CONFERENCE: YES

MANDATORY: NO, however recommended

DATE: Friday March 9, 2018 at 11:00 am – 12:00pm (Eastern Time)

LOCATION: Vendors can attend the pre-bid/proposal conference either in person or dial in on our conference line.

1. **In Person:** Department of Administration, Executive Conference Room – 4th Floor, One Capitol Hill, 4th Floor, Providence, Rhode Island 02908
2. **Call-in Conference Line:** 877-396-5618 / Code: 89356937

Questions concerning this solicitation must be received by the Division of Purchases at DOA.PurQuestions8@purchasing.ri.gov no later than **March 13, 2018 at 05:00 PM (EST).** Questions should be submitted in a *Microsoft Word attachment*. Please reference the RFP# 7590551 on all correspondence. Questions received, if any, will be posted on the Division of Purchases' website as an addendum to this solicitation. It is the responsibility of all interested parties to download this information.

BID SURETY BOND REQUIRED: NO

PAYMENT AND PERFORMANCE BOND REQUIRED: NO

Meredith Skelly, Interdepartmental Project Manager

NOTE TO APPLICANTS:

- Applicants must register on-line at the State Purchasing Website at www.purchasing.ri.gov
- Proposals received without a completed RIVIP Bidder Certification Cover Form attached may result in disqualification.

THIS PAGE IS NOT A BIDDER CERTIFICATION COVER FORM

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SECTION 1. INTRODUCTION

The Rhode Island Department of Administration/Division of Purchases, on behalf of the Office of Employee Benefits, is soliciting proposals from qualified firms to provide the administration of medical benefits and/or pharmacy benefits for the State of Rhode Island's ("State") approximately 14,500 eligible employees and non-Medicare retirees as described in detail in Sections 2 and 3, in accordance with the terms of this Request for Proposals ("RFP") and the State's General Conditions of Purchase, which may be obtained at the Division of Purchases' website at www.purchasing.ri.gov.

The initial contract period will begin approximately January 1, 2019 for three years. Contracts may be renewed for up to two additional 12-month periods based on vendor performance and the availability of funds.

This solicitation covers administrative services for two plans: the State's medical and pharmacy benefits plans. This solicitation therefore has two components and vendors can submit a proposal for both plans or for only one. The vendor must fully respond to and submit: the medical technical proposal if bidding on the medical administration; the pharmacy technical proposal if bidding on the pharmacy administration; or both the medical and pharmacy technical proposals if bidding on both the medical and pharmacy administration. If a vendor submits a proposal for both medical and pharmacy plans, the technical proposal should have two clearly identifiable and separate components, one for medical plan administrative services and one for pharmacy plan administrative services.

If a vendor submits a proposal for both the medical and pharmacy plans, their initial cost proposals should be based on stand-alone pricing (i.e., being awarded only medical or only pharmacy). As applicable, also clearly indicate any cost proposal modifications that would apply in the event the vendor were awarded both medical and pharmacy components. Otherwise, proposals submitted by vendors bidding on both benefits plans will be assumed to be identical in the event the vendor is awarded one benefit plan or both benefit plans.

The State reserves the right to award to one or multiple vendors. However, only one vendor will be awarded a contract for medical plan administrative services and only one vendor will be awarded a contract for pharmacy plan administrative services. One vendor may be awarded a contract for combined medical and pharmacy plan administrative services. Also see Section 6, "Proposal Contents," for additional proposal submission information.

This is a Request for Proposals, not a Request for Quotes. Responses will be evaluated on the basis of the relative merits of the proposal, in addition to cost; there will be no public opening and reading of responses received by the Division of Purchases pursuant to this solicitation, other than to name those offerors who have submitted proposals.

1.A. Instructions and Notifications to Offerors

1. Potential vendors are advised to review all sections of this RFP carefully and to follow instructions completely, as failure to make a complete submission as described elsewhere herein may result in rejection of the proposal.

2. Alternative approaches and/or methodologies to accomplish the desired or intended results of this RFP are solicited. However, proposals which depart from or materially alter the terms, requirements, or scope of work defined by this RFP may be rejected as being non-responsive.

3. All costs associated with developing or submitting a proposal in response to this RFP or for providing oral or written clarification of its content, shall be borne by the vendor. The State assumes no responsibility for these costs even if the RFP is cancelled or continued.

4. Proposals are considered to be irrevocable for a period of not less than 365 days following the opening date, and may not be withdrawn, except with the express written permission of the State Purchasing Agent.

5. All pricing submitted will be considered to be firm and fixed unless otherwise indicated in the proposal.

6. It is intended that an award pursuant to this RFP will be made to a prime vendor, or prime vendors in the various categories, who will assume responsibility for all aspects of the work. Subcontracts are permitted, provided that their use is clearly indicated in the vendor's proposal and the subcontractor(s) to be used is identified in the proposal.

7. The purchase of goods and/or services under an award made pursuant to this RFP will be contingent on the availability of appropriated funds.

8. Vendors are advised that all materials submitted to the Division of Purchases for consideration in response to this RFP may be considered to be public records as defined in R. I. Gen. Laws § 38-2-1, *et seq*. and may be released for inspection upon request once an award has been made.

   Any information submitted in response to this RFP that a vendor believes are trade secrets or commercial or financial information which is of a privileged or confidential nature should be clearly marked as such. The vendor should provide a brief explanation as to why each portion of information that is marked should be withheld from public disclosure. Vendors are advised that the Division of Purchases may release records marked confidential by a vendor upon a public records request if the State determines the marked information does not fall within the category of trade secrets or commercial or financial information which is of a privileged or confidential nature.

9. Interested parties are instructed to peruse the Division of Purchases website on a regular basis, as additional information relating to this solicitation may be released in the form of an addendum to this RFP.

10. By submission of proposals in response to this RFP vendors agree to comply with R. I. General Laws § 28-5.1-10 which mandates that contractors/subcontractors doing business with the State of Rhode Island exercise the same commitment to equal opportunity as prevails under Federal contracts controlled by Federal Executive Orders 11246, 11625 and 11375.

    Vendors are required to ensure that they, and any subcontractors awarded a subcontract under this RFP, undertake or continue programs to ensure that minority group members, women, and persons with disabilities are afforded equal employment opportunities without discrimination on the basis of race, color, religion, sex, sexual orientation, gender identity or expression, age, national origin, or disability.

    Vendors and subcontractors who do more than $10,000 in government business in one year are prohibited from engaging in employment discrimination on the basis of race, color, religion, sex, sexual orientation, gender identity or expression, age, national origin, or disability, and are required to submit an "Affirmative Action Policy Statement."

Vendors with 50 or more employees and $50,000 or more in government contracts must prepare a written "Affirmative Action Plan" prior to issuance of a purchase order.

a. For these purposes, equal opportunity shall apply in the areas of recruitment, employment, job assignment, promotion, upgrading, demotion, transfer, layoff, termination, and rates of pay or other forms of compensation.

b. Vendors further agree, where applicable, to complete the "Contract Compliance Report" (http://odeo.ri.gov/documents/odeo-eeo-contract-compliance-report.pdf), as well as the "Certificate of Compliance**"** (http://odeo.ri.gov/documents/odeo-eeo-certificate-of-compliance.pdf)**,** and submit both documents, along with their Affirmative Action Plan or an Affirmative Action Policy Statement, prior to issuance of a purchase order. For public works projects vendors and all subcontractors must submit a "Monthly Utilization Report" (http://odeo.ri.gov/documents/monthly-employment-utilization-report-form.xlsx) to the ODEO/State Equal Opportunity Office, which identifies the workforce actually utilized on the project.

For further information, contact Vilma Peguero at the Rhode Island Equal Employment Opportunity Office, at 222-3090 or via e-mail at ODEO.EOO@doa.ri.gov.

11. In accordance with R. I. Gen. Laws § 7-1.2-1401 no foreign corporation has the right to transact business in Rhode Island until it has procured a certificate of authority so to do from the Secretary of State. This is a requirement only of the successful vendor(s). For further information, contact the Secretary of State at (401-222-3040).

12. In accordance with R. I. Gen. Laws §§ 37-14.1-1 and 37-2.2-1 it is the policy of the State to support the fullest possible participation of firms owned and controlled by minorities (MBEs) and women (WBEs) and to support the fullest possible participation of small disadvantaged businesses owned and controlled by persons with disabilities (Disability Business Enterprises a/k/a "DisBE")(collectively, MBEs, WBEs, and DisBEs are referred to herein as ISBEs) in the performance of State procurements and projects. As part of the evaluation process, vendors will be scored and receive points based upon their proposed ISBE utilization rate in accordance with 150-RICR-90-10-1, "Regulations Governing Participation by Small Business Enterprises in State Purchases of Goods and Services and Public Works Projects". As a condition of contract award vendors shall agree to meet or exceed their proposed ISBE utilization rate and that the rate shall apply to the total contract price, inclusive of all modifications and amendments. Vendors shall submit their ISBE participation rate on the enclosed form entitled "MBE, WBE and/or DisBE Plan Form", which shall be submitted in a separate, sealed envelope as part of the proposal. ISBE participation credit will only be granted for ISBEs that are duly certified as MBEs or WBEs by the State of Rhode Island, Department of Administration, Office of Diversity, Equity and Opportunity or firms certified as DisBEs by the Governor's Commission on Disabilities. The current directory of firms certified as MBEs or WBEs may be accessed at www.odeo.ri.gov/offices/mbeco/mbe-wbe-php. Information regarding DisBEs may be accessed at www.gcd.ri.gov.

For further information, visit the Office of Diversity, Equity & Opportunity's website, at http://odeo.ri.gov/ and *see* R.I. Gen. Laws Ch. 37-14.1, R.I. Gen. Laws Ch. 37-2.2, and 150-RICR-90-10-1. The Office of Diversity, Equity & Opportunity may be contacted at 401-574-8670 or via email Dorinda.Keene@doa.ri.gov

13. HIPAA - Under HIPAA, a "business associate" is a person or entity, other than a member of the workforce of a HIPAA covered entity, who performs functions or activities on behalf of, or provides certain services to, a HIPAA covered entity that involves access by the business associate to HIPAA protected health information. A "business associate" also is a subcontractor that creates, receives, maintains, or transmits HIPAA protected health information on behalf of another business associate. The HIPAA rules generally require that HIPAA covered entities and business associates enter into contracts with their business associates to ensure that the business associates will appropriately safeguard HIPAA protected health information. Therefore, if a contractor qualifies as a business associate, it will be required to sign a HIPAA business associate agreement.

14. If a vendor intends to submit a proposal, they will need to request data from the State that contains non-public information. Therefore, vendors shall be required to complete and sign the attached "Data Request Form" and "Limited Use, Confidentiality and Nondisclosure Agreement." The State reserves the right to investigate any requests for the information in order to ensure the data shall be used for its intended purposes.

    Upon request, your organization will receive a USB drive containing the files for the Medical Plan Administration (see Section 2.B.1) and/or Pharmacy Benefits Plan (see Section 3.B.1.). The file(s) will be made available on a password protected, encrypted USB Drive available for pick up at the Division of Purchases, One Capitol Hill, 2nd Floor, Providence, RI 02908 and the Division is open Monday - Friday 8:30 AM – 4:00 PM EST.

    The USB Drive will be provided upon receipt of a signed "Limited Use, Confidentiality and Nondisclosure Agreement" and "Data Request Form." Neither the "Limited Use, Confidentiality and Nondisclosure Agreement" and "Data Request Form" shall be accepted if altered and/or redlined. Terms on the "Limited Use, Confidentiality and Nondisclosure Agreement" and "Data Request Form" must be accepted as presented to receive the applicable USB Drive.

    Please contact Meredith Skelly at DOA.PurQuestions8@purchasing.ri.gov or 401-574-8156 for scheduling a time window to deliver the executed, unaltered "Limited Use, Confidentiality and Nondisclosure Agreement" and "Data Request Form" and pick up the USB Drive(s). Please specify if you are picking up a Medical Plan Administration and/or Pharmacy Benefits Plan USB Drive(s). Once the USB Drive(s) is picked up, the applicable password to open the file will be provided via e-mail to the Vendor point of contact as designated by the Vendor on the "Data Request Form". **The USB Drive(s) and related files are to remain the property of the State and the Vendor shall return the USB Drive(s) and related files (with encryption and password protect intact) by the submission deadline, whether a proposal response is submitted or not.** All State files shall be removed from the Vendor's system(s) by the submission deadline.

15. Only one proposal for the administration of the medical benefits, or one proposal for the administration of the pharmacy benefits, or one proposal for the administration of both the medical and pharmacy benefits may be submitted by each bidder in response to this RFP. If a bidder submits more than one proposal for one or both of the plans, all proposals from that bidder may be rejected. For purposes of this RFP, the terms "bidder" or "vendor" are defined to include each direct and indirect parent corporations of the entity submitting a proposal in response to the RFP, and each direct and indirect subsidiary of each such parent corporation.

16. At the time of application and throughout the contract period, the vendor must be in compliance with all federal and state laws and regulations related to the conduct of business as a health plan, a utilization review agent, and a third-party administrator, including but not limited to the applicable provisions of RIGL 27-18.8, 27-18.9, 27-20.7, 27-20.8, 27-20.9, and 27-38.2-1.

17. A Word version of this RFP shall be posted as an attachment for the sole purpose to assist Bidders in ease of response to the various forms and embedded questionnaires. Bidders are not permitted to alter and/or redline the state's language and/or format. Any proposals received with alterations and/or redlines, may be grounds for disqualification.

SECTION 2: MEDICAL PLAN ADMINISTRATION

2.A. Introduction

The Medicare eligible retirees are not part of this RFP.

The State seeks a medical benefit partner that will meet the following objectives:

- Provide nationwide coverage to eligible State employees, non-Medicare retirees, and their dependents;
- Administer and support a wellness/health program and initiatives for the active population;
- Provide a high level of accountability around the member experience both in terms of quality care and administration;
- Manage the finances of the medical benefit program to optimize the cost/value;
- Improve the health of state employees and their dependents; and
- Contribute to the state's health policy goals around care transformation and payment reform to improve health care quality and reduce costs.

The State currently provides medical benefits to eligible employees, non-Medicare retirees, and their dependents on a self-funded basis through UnitedHealthcare. At present, the State offers two plans to active employees: *2014 Active Employee Plan* (a PPO plan) and *Choice Plus with HSA Plan* (an HSA-qualified plan). Non-Medicare eligible retirees also have two medical plan options: *Early Retiree Plan* (a PPO plan, the same as the *2014 Active Employee Plan*) and *Value Plan* (a PPO plan). (Prior to 2018, another active plan was available to certain unions that did not have their contracts ratified – *2008 Active Employee Plan*.)

There is a subgroup of approximately 830 eligible employees and non-Medicare retirees of the Rhode Island Public Transit Authority (RIPTA) who receive the same benefits as State employees. There may be some additional support services required of the medical administrator for this group

(e.g., direct contact to administrator's account representative) beyond that of a typical subgroup. RIPTA participants are not included in the census or claims experience provided.

The State currently provides and intends to continue to provide (through its medical administrator) two Medicare plan options offered to eligible OPC/BOG retirees only:

- Medicare Advantage Plan—a fully insured HMO product including both medical and prescription drug benefits (approximately 400 retirees enrolled), and
- Medicare Supplement Plan (known as *Plan 65*)—a self-funded medical-only plan. Plan 65 is a "Plan C" type of Medicare supplement plan (approximately 500 retirees enrolled).

There may be some additional support services required of the medical administrator for these plans. OPC/BOG Medicare retirees are not included in the census or claims experience provided. The logistics for these plans will be negotiated with the winning medical bidder. Vendors do not need to submit proposals for these plans with the medical proposal.

Failure to offer guarantees for the full 36 months of the initial contract period may negatively impact the analysis of a bidder's financial proposal.

2.B. Background

2.B.1. Population and Historical Information

Information was gathered from the current vendor, UnitedHealthcare, to assist in the preparation of the proposal.

The following files are available either on the USB drive of state data or posted as an attachment with the RFP:

- Census (Appendix B)*
- Detailed Claims Data (Appendices C.1, C.2, C.3, C.4)*
- Utilized Providers (Appendix D)*
- Claims and Enrollment Data (Appendix E)*
- Summary Plan Descriptions (SPDs) (Appendices F.1, F.2, F.3, F.4, F.5)
- Summaries of Benefits and Coverage (SBCs) (Appendices G.1, G.2, G.3, G.4, G.5)
- 2018 – 2019 Program Brochure (Appendix H)
- Cost Proposal Exhibits (Appendix I)

** These files will be provided on the USB drive of state data and Bidder must complete the Confidentiality and Nondisclosure Agreement and the Data Request Form to request this information. See section 1.C.14 for instructions on how to obtain the USB drive of state data.*

The State makes no representation regarding the data or the format in which the data is prepared.

The following benefit changes to the State medical plan were adopted since December 2014, the beginning of the claims experience period provided:

- Effective January 1, 2015, 2014 Active Employee Plan and Early Retiree Plan:
  - In-network deductible increased from $0 to $250/$500 per individual/family
  - In-network out-of-pocket maximum increased from $0 to $250/$500 per individual/family
  - Out-of-network deductible increased from $0 to $500 per contract

  - Out-of-network out-of-pocket maximum increased from $3,000/$6,000 to $3,250/$6,500 per individual/family
- Effective January 1, 2016:
  - UnitedHealthcare's Advocate4Me program was implemented
  - Out-of-network provider payments changed to MNRP
  - The diabetes prevention program and care management were added
  - The *Choice Plus with HSA Plan* was added
- Effective June 1, 2016:
  - UnitedHealthcare's Physical Health Solutions program was adopted
- Effective July 1, 2016:
  - Coverage for treatment of gender identity dysphoria was added
- Effective January 1, 2017:
  - Medical virtual visits and telemental health services were added
- Most of the State's union contracts expired on June 30, 2017. The State is currently in the process of union negotiations; therefore, the final January 1, 2019 plan design offerings are subject to change as result of these negotiations. The State's medical administrator is expected to administer the plan as negotiated.

2.B.2. Eligible Populations

The following employee and non-Medicare retiree populations are eligible for medical coverage:

- Population I: Actives
  - Active employees, COBRA and direct pay participants, and their dependents
  - RI State Police (both active and non-Medicare retirees receive the active plans)
  - Legislative, Judicial, and certain Disabled Retirees (these three groups receive active plans upon retirement)
- Population II: Non-Medicare Retirees
  - Retirees under age 65 and their dependents
  - Retirees over 65 who are not Medicare eligible

Subscriber Count as of November 2017:

- Population I: 12,757
- Population II: 1,686

Member Count as of November 2017:

- Population I: 30,925
- Population II: 1,998

State employees are eligible for coverage the first day of employment if they work 20 hours or more per week. Full time and part time employees have the same coverage.

Active employee contributions are 15%, 20%, 25%, or 35%, depending on employment status (full-time or part-time), salary band, and coverage tier (individual or family).

For non-Medicare retirees with retirement dates on or after October 1, 2008, the State uses a separately pooled rate and retiree contributions are 20% as long as the retiree is 59 years of age. For non-Medicare retirees who retired between July 1, 1989 and September 30, 2008 the State uses the same rates as active employees and contributions are based on a statutory formula taking age and years of service into account.

There is a subgroup of approximately 830 eligible RIPTA employees and non-Medicare retirees who receive the same benefits as State employees. There may be some additional support services required of the medical administrator for this group (e.g., direct contact to administrator's account representative) beyond that of a typical subgroup. RIPTA participants are not included in the census or claims experience provided.

There are approximately 900 Medicare-eligible OPC/BOG retirees on Medicare Advantage and Medicare Supplement plans that will require coverage and some additional support services. OPC/BOG Medicare retirees are not included in the census or claims experience provided. The logistics for these plans will be negotiated with the winning medical bidder. Vendors do not need to submit proposals for these plans with the medical proposal.

2.B.3. Service Profile

The State seeks a vendor to provide medical benefit services including:

- Provision of a comprehensive national provider network with uniform quality;
- Provision of cost effective contracting arrangements that can be demonstrated to represent direct savings to the State and plan participants;
- Provision of a comprehensive set of medical management services;
- Effective, efficient, and accurate claim processing;
- Payment of claims on a scheduled basis including issuance of reimbursement checks;
- Provision of Explanation of Benefits (EOB) Statements (available online in addition to print copies) to patients;
- Level 1 and 2 internal claims appeals for plan members, as well as willingness to cooperate and provide necessary documentation in the case of an external appeal;
- Provision of best-in-class member services and customer support;
- Accessible current coverage reports;
- An active third party liability (TPL) coordination of benefits (COB) function encompassing identification of TPL, cost avoidance, and collections;
- HSA accounts administration;
- COBRA administration;
- Superior level of account management and service;
- Sophisticated web-services for plan participants;
- Willingness and capability to administer eligibility for the State;
- Willingness and ability to provide the communication, tracking, reporting, and administrative services necessary to support the State's current wellness program and calendar, as well as to adopt any changes to the program;
- Commitment to successful implementation;
- Demonstrated commitment to supporting and building a strong system of primary care in the state; and
- Commitment to population health in Rhode Island.

In addition, the vendor will absorb the cost of all types of communications.

2.C. Scope of Work and Requirements

2.C.1. Plan Design

Current Plan Design:

The State currently offers a nationwide PPO plan and an HSA-qualified plan to the active employees and the non-Medicare retirees (Populations I and II).

The State also currently offers the additional, lower costing plan (*Value Plan)* to non-Medicare retirees (Population II).

Proposed Plan Design:

The State is currently in the process of union negotiations; therefore, the final January 1, 2019 plan design offerings are subject to change as result of these negotiations. The selected vendor is expected to administer the negotiated plans and to take a significant role in communicating any plan design changes resulting from collective bargaining.

The current plan designs are summarized and outlined in detail in the current Summaries of Benefits and Coverage and Summary Plan Descriptions (Appendices F and G). Additional information can also be found on the State's website http://www.employeebenefits.ri.gov/.

The State currently does not have a Medical Necessity requirement. Please confirm that you have the ability to administer a plan without this requirement if it is continued.

The State also reserves the right to make plan design changes during the life of the contract, including offering additional plans.

Please sign below indicating your ability to duplicate the current benefit plans requested and outlined in the attached documentation.

The signed Plan Design form should be included as attachment to the transmittal letter in order to be considered in the carrier evaluation process.

Accepted this _____ day of _____, 2018

Officer: _____

Signature: _____

Title: _____

Firm: _____

Phone: _____

Email: _____

2.D. Technical Proposal

This section includes instructions for preparing the technical section of the Medical Plan Administration proposal. Offerors are cautioned to review the instructions carefully. Failure to comply with these instructions in full may result in disqualification.

Responses should be in the order as presented in the RFP. Responses to 2.D.1, 2.D.2 and 2.D.3 may be included within the RFP document. Responses to 2.D.4 and 2.D.5 should be provided on a separate electronic Microsoft Excel format as referenced in Appendix D. Additional pages relevant to your proposal should be placed in an appendix with an organized Table of Contents.

Responses are required for all questions. Failure to respond to any question may result in rejection of the proposal.

The proposal must provide evidence of the offeror's ability to provide the services described in Section 2.B. of this RFP. **The proposal must consist of a transmittal letter and sections, each of which is outlined in detail below:**

Section	Title
2.D.1.	Transmittal Letter and Bid Form
2.D.2.	Performance Guarantees
2.D.3.	Questionnaire
2.D.4.	Geographic Network Access
2.D.5.	Provider Disruption

Offerors are advised to be concise and to the point in their responses.

2.D.1. Transmittal Letter and Bid Form

The transmittal letter is required and must be on official business letterhead and signed by an individual with legal authority to bind the offeror. It must include:

- A statement indicating that the offeror is a corporation or other legal entity and where it is incorporated
- A statement that the offeror has read, understands and accepts the requirements, responsibilities, and terms and conditions of the RFP
- A statement indicating that prices quoted are valid for one (1) year from the date the proposal is opened
- A statement of affirmative action that the offeror does not discriminate in its employment practices with regard to race, color, religion, age (except as provided by law), sex, marital status, political affiliation, national origin, or disability status, and complies with all applicable provisions of Public Law 101-335, Americans with Disabilities Act
- A statement identifying all amendments to the RFP received by the offeror. If no amendments have been received, a statement to that effect should be included
- Identification of the person who will serve as primary contact for the State, and that person's title, address, and telephone and fax numbers

2.D.2. Required Performance Guarantees

The State requires that each Bidder agree to the following performance standards and guarantees. As such, the following are minimum performance guarantee requirements and shall be included as part of your proposal. Note that if a subcontractor is used to provide any of the contracted services, the Bidder is accountable for the subcontractors' performance. Therefore, the Subcontractor's performance is held to the same performance standards and Subcontractor failure to perform places the Contractor at risk.

Reconciliation of all performance guarantees shall be completed annually within 180 days of policy year-end.

The performance guarantees may be subject to verification by an outside audit.

Please outline any deviations from the minimum required standards. Deviations will be considered but only granted when in the best interests of the State.

IMPORTANT NOTE: Bids that place less than the minimum required at risk for any of the performance guarantees listed below will receive 0 out of the total points allocated for performance guarantees.

Ref #	Category	Guarantee	At Risk[1]
S1	Service	85% of member calls resolved on first call	$20,000 per year
S2	Service	Average speed to answer <= 45 seconds	$20,000 per year
S3	Service	Call abandonment rate <= 3%	$20,000 per year
S4	Service	95% of written inquiries received from plan participants responded to within ten (10) business days	$25,000 per year
S5	Service	Service outage (website, customer service, etc.) of 24 hours or more, or any outages that exceed 4 hours that occur more frequently than twice per month unless caused by force majeure (ex, acts of God, power outage, cyberattack) other than routine maintenance.	$2,000 per day, maximum $20,000 per occurrence
S6	Service	Notification of service outage (website, customer service, etc.) at maximum within 4 business hours and notification of outage resolution within 2 business hours	$10,000 per occurrence
O1	Operations	90% of paper claims received from plan participants not requiring clarification processed within 10 business days	$25,000 per year
O2	Operations	Timeliness of non-investigated[2] claims paid (paper and electronic) – minimum of 90% within 14 calendar days	$60,000 per year
O3	Operations	Timeliness of non-investigated[1] claims paid (paper and electronic) – minimum of 99% within 30 calendar days	$60,000 per year
O4	Operations	Financial accuracy of claims payments 99%	$100,000 per year
O5	Operations	Payment accuracy of claims payments 97%	$100,000 per year
O6	Operations	100% of all marketing materials not specific to plan enrollees must be pre-approved by the State prior to distribution to plan enrollees	$20,000 per occurrence
O7	Operations	100% of all plan enrollee communications accurate	$5/erroneous document up to $75,000 penalty per contract year
O8	Operations	99% of eligibility updates received from the State processed within forty-eight (48) hours of receipt of a clean and complete eligibility file in an agreed upon format	$50,000 per year
O9	Operations	Contractor will respond to all independent auditor requests for clarification, following claims audits within 30 calendar days	$25,000 at risk per audit
O10	Operations	Timely and accurate implementation of all programs and program changes required by the State	$5,000 per day, maximum $100,000 per occurrence
O11	Operations	Documentation provided to the State of quality control testing prior to implementation of all programs and program changes	$10,000 per occurrence
R1	Reporting	95% of standard reports within 3 business days	$25,000 per year
R2	Reporting	90% Ad-hoc reports within 7 business days	$25,000 per year
R3	Reporting	Annual reports showing network performance on core primary care, hospital, and Accountable Care Organization quality measures as specified by the Rhode Island Health Insurance Commissioner.	$25,000 per year
R4	Reporting	Prompt delivery of semi-annual reports on the use of alternative payment models and value-based payments for the state employee population. The vendor shall use the report template currently issued by the Health Insurance Commissioner for commercial insurers.	$25,000 per year

[1] "At Risk" figures are defined as amounts payable to the State as described for each reference number (Ref #).
[2] "Non-investigated" means a claim in which all information is present that is required to adjudicate the claim. (A "clean" claim would be an appropriate description.)

2.D.3. Questionnaire

Offerors must answer the following questions:

If you do not answer a question, please state your reason(s) for not doing so. Alternatives will be considered but only granted when in the best interests of the State. Offerors are cautioned that failure to respond in full to all questions will affect the evaluation of the offeror's proposal.

This RFP sets forth the terms and conditions under which the State wishes to purchase medical benefit administration services for its employees/retirees. Your written proposal will be your offer to provide the requested services.

Proposals will be scored based on each answer provided within the questionnaire or explanation document. Do not refer to vendor provided attachments in response to the questions. Responses should reflect data specific to the market(s) to which you are responding. Do not default to nationally collected data or statistics unless the information or processes are identical. YOU MUST CLEARLY IDENTIFY ANY QUALIFICATIONS OR CONTINGENCIES ON YOUR PROPOSED FEES, PLAN DESIGN, AND PERFORMANCE GUARANTEES. Failure to do so could result in disqualification.

Your proposal and the written responses shall be the offer on which the State bases its acceptance decision. The State reserves the right to accept, reject, or modify the specifications stated herein to best meet the needs of the State and its employees.

The questionnaire is organized into the following sections:

A. Administrative, Member, & Claim Paying Services

B. Reporting, IT & Data Integration

C. Health Management Programs

D. Wellness Services

E. Place of Service Tiering

F. Innovative Provider Contracting

G. Experience, Stability, and Contractual

H. References

A. Administrative, Member, & Claim Paying Services

1. Which sales office would handle the general servicing of the State? How long has it been operational? What types of services does it provide?
2. What are the standard office hours for the sales and service office?
3. You will provide dedicated clinical, account management, and customer service staffing to the State. Specify the number and location of the dedicated individuals for all categories (customer service, claim processing, eligibility, quality improvement, wellness, etc.).
4. Confirm that account management personnel, as needed, will be available during regular business hours and during emergencies including being available for frequent telephone and on-site consultation with the State.

5. For the customer service center proposed for the State provide the following for 2017:
   a. Percent of calls abandoned
   b. Percent of calls handled by live representative
   c. Number of seconds to reach a live customer service representative
6. Do you have a formal training process for customer service reps? Please describe.
7. Do customer service reps have online access to real time claim processing information?
8. Do customer service reps have authority to approve claims?
9. Check all items below which pertain to calls handled by the customer service representatives:
   - ❑ All calls are recorded
   - ❑ CSRs document all calls
   - ❑ CSRs can make adjustments to claims during a call
   - ❑ Calls are documented verbatim
   - ❑ Calls are documented in summarization
10. Do you offer clients online access to information and services via the Internet or through CRT interface?
11. If yes, what information is accessible that is included in your financial cost proposal?
12. Can your organization send recovery letters to members who continue to use their medical card after their termination? Provide a description of your recovery process for claims incurred by members who continue to use their medical ID card after their termination.
13. Do you survey clients annually regarding program administration satisfaction? If yes, provide most recent aggregate results.
14. How many toll free numbers are available to the State and its members to handle claims or other member service issues?
15. What hours will the telephone lines be staffed? Please indicate if you are able to offer staffed hours on one or both weekend days and the proposed hours. Also, indicate if there is an additional cost to weekend hours in your response to the Financial Section.
16. Do you currently perform membership satisfaction surveys? Provide a copy of the latest results of the survey. What percent of members indicated that they were “satisfied or very satisfied” with the overall program?
17. Describe the escalation process for Member Service satisfaction and complaints.
18. Will you provide a quarterly summary of the types of member services calls received, including resolutions for reoccurring issues?
19. Do you provide member support services for selecting and/or locating network providers?
20. Please describe how your organization will assist the State in marketing how employees can get the most of their medical benefits. The described services must be included in your quoted administrative fees.
21. Are you able to customize messaging on point of sale EOB’s specific to the State’s plans?
22. How are out-of-network claims processed?

23. Do you have a program available for subscribers who may have dependents living out of state temporarily or permanently? Describe program and how claims incurred are processed, including claims pricing.

24. Do you have capabilities to handle the State's open enrollment function and ongoing monthly eligibility changes for medical and other (e.g., dental and vision) benefits? Any additional costs for online enrollment services must be separately quoted on the administrative fee exhibits.

ASO Banking/Claim Reimbursement Arrangements

25. At the State's direction, are you able to accommodate a financial arrangement where either: (1) the State is invoiced on a weekly basis for the prior week of claims, or (2) you maintain an advance deposit for paying claims that would be replenished on a weekly basis? Confirm you agree to either of these arrangements at the State's direction.

26. Confirm you will invoice the State on a monthly basis for administrative costs for the prior month.

27. Confirm that no penalties or interest will be charged to the State for late funding or late payment.

HIPAA Compliance

28. Confirm that your organization will comply with all HIPAA regulations and that you provide, upon request, supporting documentation outlining your organizations HIPAA policies and procedures as they relate to management of the medical benefit plan for the State.

29. Confirm that your organization is compliant with the Electronic Data Interchange ("EDI") Privacy and Security rules of the Health Insurance Portability and Accountability Act ("HIPAA"), and will execute the appropriate Business Associate Agreement ("BAA") as provided by the State.

COBRA & Self-Pay Administration

30. Currently, the State's medical benefits administrator provides its COBRA administrative services for medical, prescription drug, vision, and dental benefits. It sends weekly eligibility files to the State's prescription drug, vision, and dental administrators for eligibility maintenance and claim payment. Vendors receive notification via email about enrollments, changes, and terminations. In addition to weekly eligibility files, the State's medical benefits administrator sends a quarterly full file to the State's prescription drug benefits administrator.

31. Confirm you will support the State's current COBRA procedures as described above.

32. The State has a small population of direct pay participants who pay 100% of the State's premium rate for medical coverage as though they were active State employees. Historically, this population has been billed by the incumbent medical administrator. Confirm that you will continue to administer this program as indicated.

B. Reporting, IT & Data Integration

1. Indicate for each report noted below whether you can provide such a report at no additional cost. If you can provide the requested report as part of the services included in your financial cost proposal, indicate the frequency the report will be available.

Report	Will this be provided at no additional cost?*	If yes, indicate frequency	Will the State have online access to this information?
a. Eligibility Report which shows accuracy of updates and changes	❑ Yes ❑ No	*Will this be available upon request?*	❑ Yes ❑ No
b. Paid Claims Summary (by plan and by subgroups)	❑ Yes ❑ No		❑ Yes ❑ No
c. Detail Claim Listing (Utilization by individual claim, listing the provider information, submitted charge, allowable charge, paid)	❑ Yes ❑ No		❑ Yes ❑ No
d. Cost Sharing Report (Amounts determined to be ineligible, amounts applied to copays and coinsurance, and amounts adjusted for COB)	❑ Yes ❑ No		❑ Yes ❑ No
e. Detailed Utilization Report	❑ Yes ❑ No		❑ Yes ❑ No
f. High Amount Claimant Report	❑ Yes ❑ No		❑ Yes ❑ No
g. Ad-Hoc Utilization Reports	❑ Yes ❑ No	*Will this be available upon request?*	❑ Yes ❑ No
h. Reporting to support the State's Rewards for Wellness Program Calendar	❑ Yes ❑ No	*See the State's Program Calendar*	❑ Yes ❑ No
i. Health Management Reports (disease management, case management, gaps in care)	❑ Yes ❑ No		❑ Yes ❑ No
j. Detailed Claims Files for data analytics	❑ Yes ❑ No	*Monthly*	❑ Yes ❑ No
k. Reporting for the purpose of tracking combined medical and prescription drug plan provisions (e.g., deductibles and out-of-pocket maximums)	❑ Yes ❑ No	*Weekly*	❑ Yes ❑ No

* If applicable, indicate any costs associated with these reports in your response to the financial section. Describe any other claim/management reports you would be able to supply to the State or its designee regularly at no additional charge and the frequency with which they could be provided. Please provide sample reports.

2. Describe any other reports either Clinical or Financial in nature that would be provided to the State or its designee in order to help manage benefit costs. Please provide sample reports.
3. Describe in detail any programs designed to integrate medical and pharmacy data in order to create patient management and cost savings opportunities.
4. On average, what percentage of all claims are audited by your internal audit group?

5. Are audits performed on a pre- or post-disbursement basis?
   - ❑ Pre-Disbursement
   - ❑ Post-Disbursement
   - ❑ Both
6. Would there be a charge to the State for the required independent audit performed of your claim operation?
   - ❑ No
   - ❑ Yes
7. Explain your Coordination of Benefits (COB) procedures.
   A) Do you pursue COB prospectively or retrospectively to payments?
      - ❑ Prospectively
      - ❑ Retrospectively

   B) How often are records updated for new information on other coverage? Please describe how this data is gathered.
8. Please complete the following table of fraud detection programs:

Task	Formal Written Program	If yes, provide total # of events per 1000 covered lives)	Describe Program
A. Ineligible Claimant	❑ Yes ❑ No		
B. Assure that service billed is actually rendered	❑ Yes ❑ No		
C. Over billings	❑ Yes ❑ No		

9. Do you retain medical consultants for the review of any unusual claims or charges?
   - ❑ Yes
   - ❑ No

   If yes, explain the method in which such consultants are used and describe their qualifications, any affiliations and how they are compensated.
10. How do you reimburse multiple surgical procedures being performed during one operation?

    Is a reduced scale used for the 1st and subsequent procedures? *(Check only one)*
    - ❑ Yes
    - ❑ No
11. How are claims, customer service, case management, utilization review and case management systems linked? *(Check only one)*
    - ❑ Same system
    - ❑ Integrated, but different systems
    - ❑ Different systems, but accessible to all
    - ❑ Not linked
    - ❑ Some linked
    - ❑ Other, please specify:

12. Does your claims system have the capability to automatically match claims with utilization management information both in- and out-of-network?
    - ❑ Yes
    - ❑ No
13. Do you have an automatic audit process for large claims?
    - ❑ Yes
    - ❑ No

    Indicate how you define a large claim and provide detail of the audit review process.
14. Do you have electronic capabilities to administer eligibility for the State, including providing eligibility files and reporting, and coordinate with other carriers (e.g., prescription drug, dental, vision) on eligibility and enrollment? If there is an additional fee associated with providing these services, please indicate it in your response to the financial section of this RFP.
    - ❑ Yes
    - ❑ No

Claims and Appeals

15. Do you have a formal written appeal/grievance/reconsideration process for both self-funded and fully insured plans? *(Check only one)*
    - ❑ Yes
    - ❑ No

    If yes, please describe these processes, including how the appeal providers are chosen, who is retained for external appeals and what the turnaround time is from the time an appeal is submitted to when a decision on the appeal is reached.
16. Is there information regarding the option for an appeal, the timeframe, and the mailing address and all other information required by ACA claims and appeal rules in either the body of or attached to all claim and appeal notification letters? *(Check only one)*
    - ❑ Yes
    - ❑ No
17. Have your claims and/or UR staff been educated and trained on how to process claims and/ or pre-certification review under the new ACA guidelines? *(Check only one)*
    - ❑ Yes
    - ❑ No
18. Are you fully compliant with ACA claims and appeals regulations? *(Check only one)*
    - ❑ Yes
    - ❑ No
19. Are there any differences between your fully insured and self-funded claims processing systems? *(Check only one)*
    - ❑ Yes
    - ❑ No
20. Who is the fiduciary? Who is responsible for the second level of appeal?

C. Health Management Programs

Utilization Management

1. If your contracted physician requested that a Pap smear be evaluated by the following techniques, which ones would be considered payable under your organization? *(Check all that apply)*
   - ❑ a. ThinPrep
   - ❑ b. PapNet
   - ❑ c. AutoPap
   - ❑ d. Other device to perform Pap smear evaluation (List):_____
   - ❑ e. None of the above or unknown.

2. The National Institute of Health has classified the following services as Alternative Medicine practices. These practices are currently under NIH investigation to determine efficacy. Indicate whether any of the following services, when requested by enrollees are commonly considered eligible expenses by your organization. (Check all that apply)
   - ❑ a. Homeopathic services
   - ❑ b. Naturopathic services
   - ❑ c. Biofeedback
   - ❑ d. Herbal medicine
   - ❑ e. Chiropractic/spinal manipulation
   - ❑ f. Acupuncture
   - ❑ g. Acupressure
   - ❑ h. Yoga
   - ❑ i. Therapeutic massage
   - ❑ j. Rolfing
   - ❑ k. Trager/Feldenkrais manual healing techniques
   - ❑ l. Ayurvedic medicine
   - ❑ m. Nutritional therapy: macrobiotics, megavitamin
   - ❑ n. None of the above.
   - ❑ o. Other:_____

3. How long has your organization been performing Utilization Management services? (Check only one)
   - ❑ a. Less than 1 year
   - ❑ b. 1-3 years
   - ❑ c. 4-6 years
   - ❑ d. 7-9 years
   - ❑ e. 10 or more years

4. Are your services local, national, or international? (Check only one)
   - ❑ a. Local only
   - ❑ b. National, some states*
   - ❑ c. National, all states
   - ❑ d. National, all states plus international

   * Indicate the states you SERVE or DO NOT SERVE (whichever is shorter).

   _____

5. Are there any specific reporting or administrative procedures you would require of the State prior to implementation of your program?
   - ❑ a. Yes, explain: _____
   - ❑ b. No

6. Complete the grid to indicate the number of physicians (MD, DO) ROUTINELY available to your organization to assist in review.

	Full Time	Part Time
A. Number of physicians on staff in your Utilization Review office		
B. Number of physicians retained as consultants to review as needed		

7. Would you be agreeable to a periodic (e.g., twice a year) "round table" meeting with the State, Utilization Management firm, claims payor and consulting organization to discuss both positive and negative areas of the working relationship? (Check only one)
   - ❑ a. Yes, cost included in fees
   - ❑ b. No

8. If medical records are needed and a facility/provider charges your Utilization Management firm for the photocopy/postage expense, who pays that bill? (Check only one)
   - ❑ a. Utilization Management firm absorbs cost.
   - ❑ b. Patient
   - ❑ c. Employer/State

9. Does your Utilization Management firm subcontract for any portion of the following? (Complete all rows)

Service	Yes	To Whom	No	Service Not Available
a. Preservice review				
b. Concurrent review				
c. Discharge planning				
d. Psychiatric/substance abuse review				
e. Case management				

f. Bill audits				
g. Coding (ICD/DRG)				
h. Data entry				
i. Computer programming				
j. Physician advisor review				
k. HIPAA EDI services				

10. Do you have educational material, which informs enrollees regarding your U.R. services and procedures? (Check only one)
    - ❑ a. Yes, available for the State at no added cost
    - ❑ b. No, but can develop at no added cost
    - ❑ c. No, not available

11. Is your firm willing to assist the State if a dispute arises over payment/ nonpayment for health care services which your firm recommended were not medically necessary, appropriate and/or reasonable? (Check only one)
    - ❑ a. Yes, within our proposed fees
    - ❑ b. No, explain: _____

12. Does your utilization management firm have any affiliations with other business entities?
    - ❑ a. No
    - ❑ b. Yes, explain the nature of these affiliations: _____

Preservice Review

13. Indicate which services are reviewed under your preservice (precertification) review program (Check all applicable to your program):
    - ❑ a. Elective inpatient medical/surgical admissions
    - ❑ b. Elective outpatient surgery
    - ❑ c. Diagnostic services
    - ❑ d. Durable medical equipment
    - ❑ e. Corrective appliances/prosthetics
    - ❑ f. Skilled nursing facility
    - ❑ g. Home health/home enteral/parental therapy
    - ❑ h. Musculoskeletal services (e.g., chiropractic)
    - ❑ i. Medical services (e.g., physical therapy, Dr's office visits)
    - ❑ j. Psychiatric admissions (acute and residential)
    - ❑ k. Psychiatric outpatient therapy services
    - ❑ l. Substance abuse (e.g., detoxification, rehabilitation)
    - ❑ m. Other: _____
    - ❑ n. No preservice review offered

14. Precertification includes analysis and determination of which of the following (may check more than one):

- ❑ a. Appropriate Level of Care (e.g., inpatient versus outpatient)
- ❑ b. Reasonable Length of Stay for inpatient confinement
- ❑ c. Actual Medical Necessity and appropriateness of the surgery or service being requested (e.g., does service require performance)
- ❑ d. Necessity for the services of an Assistant Surgeon with each operative procedure analysis
- ❑ e. Necessity for a proposed Preoperative hospital day
- ❑ f. Necessity for a proposed 23-hour observation stay following outpatient surgery
- ❑ g. Patient resources for self-care
- ❑ h. Other: Explain _____

Case Management

15. Does your firm have an ACTIVE case management program?
    - ❑ a. Yes
    - ❑ b. No

16. What criteria are used to identify cases for medical case management? (Check only one)
    - ❑ a. No criteria used – we rely on our staff's clinical experience
    - ❑ b. Internally developed written criteria: Please describe and provide sample (or example) of how that criteria would apply to certain situations
    - ❑ c. Other purchased case management criteria: Please describe and provide sample (or example) of how that criteria would apply to certain situations_____

17. How and when are medical specialists involved in the case management process? Describe their credentials.

18. During case management, check which services your staff routinely performs on each case. (Check all that apply)
    - ❑ a. Redirect/channel patient/provider to correct in-network provider (e.g., non-network DME vendor redirected to use network DME vendor)
    - ❑ b. Negotiate discounts with non-network providers and vendors
    - ❑ c. Steer patient/physician to your firm's contracted vendors in order to obtain discounts
    - ❑ d. Evaluate and alter the proposed treatment plan toward a more creative treatment plan
    - ❑ e. Staff functions as patient ombudsman to answer questions and reassure patient/family
    - ❑ f. Staff functions to gather information from the patient's caregivers and physicians to report the status to the State or claims administrator
    - ❑ g. Discuss community resources
    - ❑ h. Identify the case manager available for call in questions
    - ❑ i. Other: _____

19. Indicate the frequency with which your firm sends summary data on case management services to the State. (Check only one)
    - ❑ a. No reports currently provided
    - ❑ b. Quarterly
    - ❑ c. Quarterly with an annual summary
    - ❑ d. Other:_____

Quality Control of Utilization Management Services

20. Are you able to provide an annual summary of the State's utilization statistics and your firm's overall savings?
    - ❑ a. Yes
    - ❑ b. No

21. Are you able to provide quarterly and ad-hoc reports of the State's utilization statistics and your firm's overall savings?
    - ❑ a. Yes
    - ❑ b. No

Telemedicine

22. Are you able to provide telemedicine services? If so, what types of services are available?
    - ❑ a. Yes
    - ❑ b. No

Disease Management

For the purpose of the following questions, "disease management" will refer to a **formal** program designed to improve the health, outcomes & quality of life of enrollees, as well as lower costs through a systematic approach to actively manage a population of enrollees with a specific disease.

23. Complete the following grid regarding your organization's FORMAL Disease Management (DM) program. (Check all that apply and complete columns b, c, d, and e)

Check the programs currently in place.	**b) Number # of years program in place?**	**c) Number of members currently participating in program?**	**d) Performed by in-house Staff or Outsourced**	**e) What data or results are you currently tracking to demonstrate the effectiveness of each Disease Management Program? (Attach added documentation as needed)**
a) Pre-Diabetes				
b) Adult-onset diabetes				
c) Hypertension				
d) Pediatric asthma				
e) Juvenile diabetes				
f) Epilepsy				
g) Rheumatoid arthritis				

Check the programs currently in place.	b) Number # of years program in place?	c) Number of members currently participating in program?	d) Performed by in-house Staff or Outsourced	e) What data or results are you currently tracking to demonstrate the effectiveness of each Disease Management Program? (Attach added documentation as needed)
h) Chronic obstructive pulmonary (COPD)				
i) Osteoarthritis				
j) Adult asthma				
k) Migraine headache				
l) Chronic renal failure				
m) Peptic Ulcer				
n) Major Depression				
o) Hemophilia				
p) Obesity				
q) Coronary Artery Disease				
r) High Risk Pregnancy				
s) Congestive Heart Failure (CHF)				
t) Lyme Disease				
u) Lower Back Pain				
v) Addiction/Substance Use Disorder				

24. Indicate the items that your organization incorporates into each disease management program that you administer. (Check all that apply)
    - ❑ a. Protocol to assist physician in making efficient diagnosis.
    - ❑ b. Periodic calls to discuss enrollee's compliance and health status.
    - ❑ c. Practice guidelines to develop consistency and effectiveness in treatment planning.
    - ❑ d. Provider survey on satisfaction with the disease management protocol.
    - ❑ e. Recommended drug therapy regimens.
    - ❑ f. Enrollee satisfaction with your disease management program.
    - ❑ g. Enrollee educational material (e.g., brochure, cards, video).
    - ❑ h. Patient's return demonstration of techniques or equipment taught to them.
    - ❑ i. Outcome measures indicating the CLINICAL effectiveness of program.
    - ❑ j. Outcome measures indicating the COST effectiveness of program.
    - ❑ k. Other: _____

25. An enrollee's entrance into your organization's disease management programs is typically prompted by which of the following: (Check all that apply)
    - ❑ a. A referral from the enrollee's physician.
    - ❑ b. Evidence of at least one bill (claim/encounter) for a pertinent diagnosis.
    - ❑ c. Enrollees identified via a health risk assessment survey.
    - ❑ d. Enrollees who have had at least one hospital admission for a pertinent diagnosis.
    - ❑ e. Enrollees identified by their prescription usage.
    - ❑ f. Enrollees with at least one ER visit for a pertinent diagnosis.
    - ❑ g. Enrollees who desire participation.
    - ❑ h. Other: _____

26. Do you receive any fees or revenue from any drug manufacturer, medical equipment provider, or other medical service provider or other third party for directly sponsoring or promoting any of your DSM programs?
    - ❑ a. No
    - ❑ b. Yes, describe: _____

27. Indicate how and when you use a Health Survey in the course of your disease management services.

28. Do you have the ability to collaborate with an outside disease management program?

D. Wellness Services

General

1. Please review the enclosed "Appendix H - 2018-2019 Program Brochure.pdf" describing the State's current wellness program and calendar (additional details can also be found on the State's website) and confirm your ability to provide the communication, tracking, reporting, and administrative services necessary to support the program, as well as adopt any changes to the program. If there is an additional fee associated with providing these expected services, please indicate it in your response to the financial section of this RFP.
2. Do you offer cost savings or other performance guarantees for any health improvement/coaching services offered? What specific clinical quality measures would you include and what dollar amounts would you be willing to put at risk? Please describe what benchmarks you would use to measure annual performance.
3. Please provide any reporting and/or case studies documenting risk reduction and/or health improvement results for clients that engage in your wellness services.
4. Can you use the State's medical and prescription drug data to determine case management, disease management and behavioral health support? If so, can you accept data from outside vendors (e.g., PBM) for predictive modeling?
5. Please describe how your organization will assist members with behavior change and healthy habit formation.

6. Will you offer subject matter experts to assist the State with health improvement and wellness integration efforts? If yes, would these experts be able to join the State Health Benefit Program and Wellness Workgroup for monthly meetings in person or by phone? Please indicate any additional fees that may apply in your response to the Financial Section.
7. How do you ensure compliance with state and federal regulations related to wellness programs?
8. Can you administer the State's current wellness program and ensure that it will comply with ACA, HIPAA, GINA, ADA, IRC, and any applicable federal and/or state law?

Scope of Work

9. Confirm your ability to provide each of the following wellness services that are currently available:
   a) Health Risk Assessment or Health Survey
   b) Biometric screenings
   c) Telephonic health consultation (e.g., 24-hour NurseLine)
   d) Online health consultation
   e) Data collection and reporting for incentive administration
   f) Educational programs, resources, and learning modules on health topics (e.g., behavioral health and substance use, nutrition, diabetes, medical self-care)
   g) Mobile apps, online tools, physical activity trackers, calculators, cost estimators, etc.
   h) Quarterly and annual reporting available online
   i) Communication/marketing materials and on-site (in person) programs promotion
   j) Compliance standards applied to these programs
10. List industry accreditations or National certifications for each of the above programs you offer.
11. Describe any other services or programs available for future consideration by the State including behavioral health assessments and health coaching.

Program Design, Implementation, and Administration

12. Describe the engagement process from a user's perspective. Is there a single sign on portal for users or multiple websites and points of entry?
13. Describe your program(s) or targeted campaign(s) towards pre-diabetics, cardio-vascular disease, obesity, and any other specific programs you offer.
14. Would you work collaboratively with disease management programs offered through the State's prescription drug benefit manager?
15. What recommendations would you make to improve the State's current wellness program? Are the incentive amounts appropriate based on your experience with other similar groups?

Health Risk Assessment or Health Survey

16. How do you administer and collect your Health Surveys?
17. Indicate if your Health Survey includes any academic institution collaboration.
18. How does your Health Survey guide member health management and risk reduction?

19. Indicate the methods that a member can complete the Health Survey (e.g., paper, online, telephonic).
20. Describe how the disease management and wellness programs are integrated together for a member with co-morbidities (e.g., member with obesity and diabetes).

Biometric Screening

21. Describe all biometric screening options you provide, with any requirements for each one. Can these be customized to the State's needs and budget?
22. Can your company provide on-site and off-site biometric screenings?
23. Are there any minimum participation requirements for a screening event? Any maximum participation limits?
24. Are biometric screenings available to all employees? Only health plan participants? Employees? Spouses? Dependents?
25. Can your company use/integrate outside biometric data in lieu of your standard biometric screenings?
26. How is scheduling, sign up, and day-of registration handled for screening events?
27. Do you electronically integrate the data you collect from a member at an onsite health screening program into the member's Health Survey, health coaching program, incentive program, personal health record, etc.?

Incentive/Participation Tracking

28. Confirm that your company will track participation and progress of participants according to the State's Rewards for Wellness Program Calendar and indicate participant status (active in progress, active completed, new or terminated participants)?
29. How do you validate member completion of preventive care screenings, wellness competitions, health education, health risk reduction, and outcomes based health screening results and/or improvements?
30. Can you accept participation data from the YMCA Diabetes Prevention Program (DPP) currently offered by the State?
31. Is there an appeals process? If so, how does it work?

Pricing Proposal

32. Please provide details of any allowance/budget related to health promotion that is included in your proposal.
33. Are you willing to put your fee at risk relative to performance guarantees? If so, what percentage amount of your fee will you return to the State if savings estimates are not reached? How will savings be measured?

E. Place of Service Tiering

While the State does not feature a "Place of Service Tiering" product at this time, it requires a response to the following:

1. Will your proposed "Place of Service Tiering" product have locations in all geographic regions of the State of Rhode Island prior to January 1, 2019?

2. Illustrate that your "Place of Service Tiering" providers offer lower cost lab and imaging services than the other providers in their geographic location.

3. What type of reporting will you provide to the State regarding:

   a. Your proposed "Place of Service Tiering" product

   b. Your high quality, high performance medical providers?

4. What impact do you expect the tiered network / your proposed "Place of Service Tiering" product will have on trend in 2019?

5. Provide a brief overview of your high quality or high performance network capabilities.

   a. Provide a listing of the markets where the network is currently available, including plans for future expansion.

   b. What types of medical providers/facilities are in your high performance network?

   c. Provide a detailed list of physician subspecialties that are included in your high performance network.

6. Will the information regarding State of Rhode Island providers and their designated tier category be made available to the State's members so they can make informed decisions about the cost and quality of the provider they choose?

F. Innovative Provider Contracting

1. Submit a plan that demonstrates the offeror's competency and capability to innovate using provider contracting and **which is** geared toward improving the quality, **and** efficiency of health care service delivery for state employees. Specifically, the offeror must address:
   - Ideas for advancing the use of value-based payment models
   - Incentivizing selection of high value providers
   - Incentivizing the use of high value services should the state decide to propose future innovations in the state employee health program

G. Experience, Stability, and Contractual

Financial Condition of Organization

1. Indicate your **most current** claims-paying abilities as rated by:

Independent Rating Agency	Rating	Date
AM Best		
Standard & Poors		
Moody's		
Fitch		
☐ Other ☐ Not Rated (select one and explain) _____		

2. Indicate **any reinsurance policies currently in place OR special cash reserves set aside**, to continue paying claims on existing policies in the event your organization ceases to operate due to bankruptcy, liquidation or other factors. (*Check only one)*

   ❑ a. None

   ❑ b. Reinsurance is in effect or separate reserves are held to cover contractual services for the following number of days: ___ ***(Response valid only if # of days provided)***

   ❑ c. Reserves as a percent of premium are _____% ***(Response valid only if % provided)***

   ❑ d. Other: _____

3. The Vendor shall submit an audited financial statement for the most recent fiscal year in a separate sealed envelope; label the envelope "Confidential - Audited Financial Statement." The financial information submitted shall remain confidential and shall not be public record. The financial information will be reviewed by the Bureau of Audits on a Pass/Fail basis. If the financial statement receives a "Pass" determination, the Vendor's proposal will move to the Technical Review committee for further evaluation. If the financial statement receives a "Fail" determination, the Vendor's proposal will be dropped from further consideration.

4. What fidelity and surety insurance or bond coverage do you carry to protect your clients? Specifically describe the type and amount of the fidelity bond insuring your employees that would protect the State in the event of a loss. [Please provide copies of such policies].

   a. Indicate your firm's liability INSURANCE LIMIT with regard to errors, omission, negligence, and malpractice.

   b. Annual dollar limit per occurrence: _____

   c. Provide name of insurer: _____

General Contract Provisions

To expedite a process of finalizing the contract once a vendor is elected, please include your firm's sample contract with your proposal for a self-funded arrangement.

5. Confirm you agree to include in your contract a hold harmless provision that indemnifies the State against liability that arises as the result of negligent acts, errors, omissions, fraud and other criminal acts committed by your officers, employees, and agents of the organization? *(Check only one)*

   ❑ a. Yes

   ❑ b. No

6. Confirm you agree to be bound by the terms of your proposal until a final contract is executed.

7. Confirm the contract will provide the State or its designee the right to audit the performance of the plan and services provided.

8. Indicate what services, records and access will be made available to the State or its designee to audit at no additional charge.

9. Indicate frequency and notice requirements that are part of the right to audit provision.

10. Do you agree that all books, records, lists or names, plates, seals, passbooks, journals and ledgers and all data specific to this Program shall be the property of and shall be used exclusively for this plan at the direction of the State? *(Check only one)*
    - ❑ a. Yes
    - ❑ b. No

11. Are there any special contract provisions that you believe will need to be added to address liability or other issues specifically related to your performance of duties as the medical benefits administrator for the State of Rhode Island?

Termination Clauses

12. At the outset of the contract with the State, how will coverage for treatment in progress be handled for the self-funded plan (if applicable)? *(Check only one)*
    - ❑ a. Will offer network discounts only if patient's provider is in-network.
    - ❑ b. No network benefits apply if treatment is in progress on first day of eligibility.
13. At the end of a client's contract, treatment in progress for the self-funded plan is covered as follows: *(Check only one)*
    - ❑ a. Network discounts apply until completion of treatment.
    - ❑ b. Network discounts cease to apply.

H. References

Provide the name of your five (5) largest public sector (states, municipalities, etc.) clients for which you provide comparable services as requested in this RFP.

For these five clients, provide:

- Key contact's name, including phone number and email address
- Address
- Number of active members (*i.e.*, employees and dependents)
- Number of non-Medicare retiree members
- A summary of the services provided by the Bidder to the client

The State reserves the right to contact any or all of these clients for references and consider the references' experiences with the bidder in the score.

Additionally, the State also reserves the right to use itself as a reference and consider its own experiences with the bidder in the score.

2.D.4. Geographic Network Access

Introduction:

One of the State's key objectives is to determine if your organization can provide accessible medical services to its employees. In order to assess your network's ability to meet the State's needs, please prepare a network access (GeoAccess® analysis) using residential zip codes and your network of providers.

Results are to be prepared in the following formats:

- GeoNetworks Report (Adobe Acrobat .pdf file)

In order for your organization's responses to be evaluated, it is critical that you comply with all instructions.

Upon request, your organization will receive a summary database in Microsoft Excel format. The database summarizes unique zip codes and total employees. The database will be made available on a password protected, encrypted USB Drive available for pick up at the Division of Purchases. See section 1.C.14 for instructions on how to obtain the USB drive of state data.

Summary of Census Information

The following fields are included in the file named Appendix B - Census.xlsx and defined as:

- Gender
- Age
- State – residential
- Zip Code – residential
- County – residential
- Relationship (employee, spouse, dependent child, domestic partner)
- Plan (*2008 Active Employee, 2014 Active Employee, Choice Plus with HSA, Early Retiree, Value Plan*)
- COBRA Flag
- Coverage Tier (individual, family)
- Medicare Primary Flag (Y/N)

Using the census data provided, complete the attached network access spreadsheet included in Appendix D using driving distance as the measurement of distance, not as the crow flies. The parameters of the report must include access to two (2) physicians within an eight (8) mile radius and one (1) hospital within fifteen (15) miles radius.

2.D.5. Provider Disruption

Offerors are to complete the provider disruption file accompanying this proposal. Detailed information on this file is referenced in Appendix D - Utilized Providers.

Upon request, your organization will receive a Microsoft Excel file needed to complete the provider disruption analysis. The file will be made available on a password protected, encrypted USB Drive available for pick up at the Division of Purchases. See section 1.C.14 for instructions on how to obtain the USB drive of state data.

Summary of Provider Utilization Information

The following fields are included in the file named Appendix D - Utilized Providers.xlsx:

National Provider Identification Number (if available)
Provider Tax Identification Number (if available)

Provider Name
Provider Address (if available)

- Street Address
- City
- Zip Code
- County
- State

Provider Specialty

Provider Type

Total Claim Count

Service Unit Count

Total Days (if applicable)

Offerors must indicate whether each provider is in your medical network by placing a "Y" or "N" in the designated columns. Please complete the medical provider disruption request using your PPO network.

Do not change the file format, re-sort the list provided, or delete any columns from the file. In addition, do not rename any of the worksheets.

2.E. Cost Proposal

General

This section must be completed in full. Bidders must propose fees for all the requested services. Your fee proposal needs to indicate the separate and distinct fees for each of the services requested. Offeror's are cautioned that failure to respond in full, or in part, to all questions may negatively affect the evaluation of the offeror's proposal, up to and including disqualification. You must complete each of the charts located in the "Appendix I - Cost Proposal Exhibits.xlsx" file.

Responses are due in the electronic Excel format provided.

Proposal Requirements

Potential offerors are cautioned that proposals must conform to the specification of this RFP. Each offeror must submit proposals for the current medical plans for the entire eligible population based on self-funded financial arrangement. Offerors are required to submit proposals for each of the first three (3) plan years of the initial 36-month contract. At the end of the 36-month contract, the State may seek to renew the contract with up to two one-year renewal periods.

2.E.1: Administrative Fees, Network Access Charges, and Wellness

Administrative & Program Fees

Complete the Administrative Fees and Wellness Charts in the attached Excel spreadsheet assuming a January 1, 2019 effective date. Fees should be on a per subscriber (contract) per month basis. Please provide answers only as applicable for quote. Fees must be provided in the format provided. **[See the "Administrative Fee – Medical" and "Administrative Fee – Wellness" Tabs in "Appendix I - Cost Proposal Exhibits.xlsx"]**

All fees to be included in monthly billing are to be broken out in detail for each service proposed or provided, i.e. specific for disease management; case management, utilization review, etc.

Additionally, provide detail on any service fees that may be charged on per claim basis, i.e. subrogation, MRI review services, etc.

Please complete separate charts for the following: plans without an HSA and the plan with an HSA. If only one administration chart is completed, it will be assumed the same fees apply for all requested plans and there are no plan specific fees (*e.g.*, HSA administration fee).

If a vendor submits a proposal for both the medical and pharmacy plans, their initial cost proposals should be based on stand-alone pricing (i.e., being awarded only medical or only pharmacy). As applicable, also clearly indicate any cost proposal modifications that would apply in the event the vendor were awarded both medical and pharmacy components. Otherwise, proposals submitted by vendors bidding on both benefits plans will be assumed to be identical in the event the vendor is awarded one benefit plan or both benefit plans.

Claims Trend Guarantee

Provide the non-Medicare participant (active and retiree plans) claims trend your organization is willing to guarantee for each year of the contract. Your guarantee should state the percentage of your administration fee that will be at risk.

	CY 2019 (over CY 2018)	**CY 2020 (over CY 2019)**	**CY 2021 (over CY 2020)**
Guaranteed Trend (%)	___%	___%	___%
Amount at Risk for not meeting Trend Guarantee	___% of your administrative fee	___% of your administrative fee	___% of your administrative fee

Bidder should provide an explanation of the basis for their proposed trend guarantee, including if they are willing to tie their trend guarantee to an index (e.g., CPI-Urban less food and energy plus X%) which is preferred by the State.

Trend guarantee will be based on the following methodology:

- The trend guarantee will apply to all claims incurred through all medical plans administered by the selected carrier for all non-Medicare participants (active and retiree plans).
- The actual 2019 incurred claims number will be measured using medical claims that were incurred during the 2019 calendar year and paid during that calendar year and a six-month run-out period through June 2020, removing claims in excess of $250,000. This total will be divided by the actual enrollment during the policy year. (Same methodology applies for CY 2020 and 2021.)
- The actual 2018 incurred claims number will be measured using medical claims that were incurred during the 2018 calendar year and paid during that calendar year through June 2019, removing claims in excess of $250,000. This total will be divided by the actual enrollment during the policy year. All the necessary supporting claims and enrollment data for the 2018 calendar year will be obtained by the State from its current medical administrator and provided to the Contractor.
- Claims will include the amounts that are the responsibility of both the member and the employer to mitigate distortions created by plan design changes. The actual 2019 trend will be calculated by dividing the adjusted 2019 incurred claims per member per month (calculated as described above) by the adjusted 2018 incurred claims per member per month (calculated as described above) less 1. (Same methodology applies for CY 2020 over 2019 and for CY 2021 over CY 2020.)

- A member continuously enrolled 12 months would count as 12 member months.

As a point of reference, the State's estimated paid medical claims trend per member per month for the last three calendar years ended December 2016 are summarized in the chart below.

Calendar Years	CY 2016 (over CY 2015)	CY 2015 (over CY 2014)	CY 2014 (over CY 2013)
Estimated Trend	6.9%	2.6%	-0.1%

2.E.2: Provider Reimbursement & Discounts

This section refers to spreadsheets that must be completed based on your current network provider contracts and experience. Worksheets should be completed separately for the indicated locations.

Claims Repricing Analysis

Please reprice the claims provided in detailed claims experience files referenced in Appendices C.1, C.2, C.3, and C.4. The repricing should be based on eligible charges (column "CHARGED_AMOUNT" on the repricing claims files) and your current (as of March 1, 2018) network provider contractual fee arrangements. **The claims repricing amounts shall be based on actual data and shall not include any assumptions regarding projected discounts or assumed increases in billed charges.**

- Provide the sum of all repriced claims by category (Hospital Inpatient, Hospital Outpatient, Professional, Other) and by in-network and out-of-network based on the eligible charges in the column "CHARGED_AMOUNT". [See the "Claims Repricing" Tab in "Appendix I - Cost Proposal Exhibits.xlsx"]

  Responses are due in the electronic Excel format provided.

- Provide an explanation detailing how you repriced the claims, noting any and all adjustments and methodologies.
- Provide a reconciliation that ties your claims repricing back to the total charged amount provided.

1. **Confirm your repricing is based on your current network provider contractual fee arrangements. "Current" is defined as the discounts the State would achieve through your network as of March 1, 2018. The repriced amounts should reflect what you would have paid a provider if the claim was incurred on March 1, 2018.**
2. **Confirm your repricing is based on actual data and does not include any assumptions regarding projected discounts or assumed increases in billed charges.**
3. **Confirm that you have provided an explanation summarizing how you repriced claims, noting any and all adjustments and methodologies.**
4. **Confirm you have not omitted any adjustments or methodologies from your explanation on how you repriced the claims.**
5. **Confirm that you have provided the claims reconciliation for all charges provided in the claims file.**

Physician Reimbursement

1. **Physician Discount Analysis.** Complete this spreadsheet for network physicians only. Provide your current (as of March 1, 2018) average physician discounts negotiated in the 3-digit zip codes 027, 028, 029 as well as your average physician negotiated discounts in the State of Massachusetts. These discount percentages shall be based on actual achieved discounts and shall not be based on projected or expected discounts. **[See "Physician Discount" Tab in "Appendix I - Cost Proposal Exhibits.xlsx"]**

   Responses are due in the electronic Excel format provided.
2. Indicate non-network equivalent Reasonable & Customary Percentile used for non-network reimbursement.
3. Indicate source of non-network Reasonable & Customary Allowances (Ingenix, Medicare, ADP, Other).

Hospital and Outpatient Facility Charges

Hospital Discount Analysis. Complete this spreadsheet for network hospitals only. Provide your current (as of March 1, 2018) average inpatient and outpatient hospital discounts negotiated for the entire State of Rhode Island, for each of the five State of Rhode Island counties, and for the City of Boston, Massachusetts. **These discount percentages shall be based on actual achieved discounts and shall not be based on projected or expected discounts. [See "Hospital Discount" Tab in "Appendix I - Cost Proposal Exhibits.xlsx"]**

Responses are due in the electronic Excel format provided.

Capitation and Other Risk Sharing Arrangements

1. Are any of the benefits or services you offer reimbursed through a capitated arrangement? If yes, please list all services that are capitated.
2. For any of the capitated services listed in the prior question, does the State have the option of paying for these services on a fee-for-service basis as opposed to a capitated basis?
3. Confirm that the State will have access to reports which will show the actual fee-for-service claims experience and utilization for any benefits or services that are under a capitated arrangement?
4. Provide information on any other risk sharing arrangements (e.g., ACO), including but not limited to:
   - the specifics of the arrangements,
   - monthly assessments,
   - settlements or anticipated settlements,
   - trend, and
   - whether they include upside and downside provider risks.
5. Provide examples of success stories for such other risk sharing arrangements.

2.E.3. Financial Questions

The State requires that the following reports be included at no additional cost. All reports should be State-specific and automatically sent electronically to the State at the frequency noted below. Through the implementation process with the selected vendor the State will identify the desired group structure. The State will have approximately 75 distinct groups of employees/retirees.

If you respond 'No' to any of the reporting requirements, please explain why.

1. Monthly paid claims by population, product, and group number
   - ❑ a. Yes
   - ❑ b. No
2. Monthly enrollment (including all dependent information) by product, population, and group number
   - ❑ a. Yes
   - ❑ b. No
3. Monthly large claims (greater than $100,000) notification (de-identified)
   - ❑ a. Yes
   - ❑ b. No
4. Monthly Paid/Incurred claims triangle
   - ❑ a. Yes
   - ❑ b. No
5. Semi-annual reporting of large loss claim payments by diagnosis
   - ❑ a. Yes
   - ❑ b. No
6. Semi-annual claims by provider type
   - ❑ a. Yes
   - ❑ b. No
7. Semi-annual utilization reports (broken out by inpatient, outpatient, hospital, and physician by diagnosis and cost) by population, product, and group number
   - ❑ a. Yes
   - ❑ b. No
8. Semi-annual Major Diagnostic Category (MDC) utilization analysis
   - ❑ a. Yes
   - ❑ b. No
9. Semi-annual network utilization
   - ❑ a. Yes
   - ❑ b. No
10. Semi-annual high frequency out-of-network providers
    - ❑ a. Yes
    - ❑ b. No
11. Semi-annual COB report
    - ❑ a. Yes
    - ❑ b. No
12. Monthly subrogation/third party liability report
    - ❑ a. Yes
    - ❑ b. No
13. Monthly full detailed claim file for data analytics
    - ❑ a. Yes

- ❑ b. No

14. Weekly reporting for the purpose of tracking combined medical and prescription drug plan provisions (e.g., deductibles and out-of-pocket maximums)
    - ❑ a. Yes
    - ❑ b. No
15. Semi-Annual Disease Management outreach, engagement and outcomes; case management and clinical program participation; gaps in care, inflation trend, potential ROI (the reports should include comparisons of current and prior experience periods)
    - ❑ a. Yes
    - ❑ b. No
16. Reporting necessary to support the State's Rewards for Wellness Program Calendar, including tracking of engagement and participation in wellness activities
    - ❑ a. Yes
    - ❑ b. No
17. Annual year-end reconciliation
    - ❑ a. Yes
    - ❑ b. No
18. Ad-hoc utilization reports
    - ❑ a. Yes
    - ❑ b. No

City and Town Utilization of State Contract

The state has a preference to allow cities and towns within the state to obtain medical plan administration services at the same administrative fees offered to the State. Please state whether your plan, if awarded the State business, will be willing to offer contracts to cities and towns within the State at the same administration fees that are offered to the State. Each city or town would have its own separate contract and banking arrangements.

- ❑ a. Yes
- ❑ b. No

2.F. ISBE Proposal

See Appendix A in this RFP document for information and the MBE, WBE, and/or Disability Business Enterprise Participation Plan form(s). Bidders are required to complete, sign and submit these forms with their overall proposal in a sealed envelope. Please complete separate forms for each MBE, WBE and/or Disability Business Enterprise subcontractor/supplier to be utilized on the solicitation.

SECTION 3. PHARMACY BENEFITS PLAN

3.A. Introduction

The State seeks a pharmacy benefit management partner to duplicate the current prescription drug benefit plan designs and that will meet the following objectives:

- Provide nationwide coverage to eligible State employees, non-Medicare retirees, and their dependents;
- Provide a high level of accountability around the member experience both in terms of quality care and administration; and
- Manage the pharmacy benefit program to optimize the cost/value.

The State is non-grandfathered plan under PPACA.

The Medicare eligible retirees are <u>not</u> part of this RFP.

3.B. Background

3.B.1 Plan Design and Historical Information

During the year ended November 30, 2017, prescription drug benefits were provided to 15,350 members (or approximately 35,100 covered lives), representing 478,150 annual scripts and annual drug spend of $65.5 million (before member copayments).

Included in these counts is a subgroup of approximately 830 eligible employees and non-Medicare retirees of the Rhode Island Public Transit Authority (RIPTA) who receive the same benefits as State employees. There may be some additional support services required of the pharmacy administrator for this group (e.g., direct contact to administrator's account representative) beyond that of a typical subgroup. RIPTA's claims are also included in the data provided with this RFP.

Information was gathered from the current pharmacy benefits vendor, CVS Health, to assist in the preparation of the proposal.

The following files are either available on the USB drive of state data or posted as an attachment with the RFP:

- Detailed Claims Data Database (Appendix Rx-A)*
- Top 100 Utilized Brand Prescriptions Spreadsheet (Appendix Rx-B)*
- SORI Plan Design Summary (Appendix Rx-C)
- Prescription Benefits at a Glance (2017 Plan Year) (Appendix Rx-D)
- Retiree Value Plan SBC (2018) (Appendix Rx-E)
- SORI Clinical Programs Summary (Appendix Rx-F)
- Preventive Therapy Drug List 0118 (Appendix Rx-G)
- Specialty Management Drug Categories (Appendix Rx-H)

** These files will be provided on the USB drive of state data and Bidder must complete the Confidentiality and Nondisclosure Agreement <u>and</u> the Data Request Form to request this information. <u>See section 1.C.14 for instructions on how to obtain the USB drive of state data.</u>*

The State makes no representation regarding the data or the format in which the data is prepared.

Most of the State's union contracts expired on June 30, 2017. The State is currently in the process of union negotiations; therefore, the final January 1, 2019 plan design offerings are subject to change as result of these negotiations. The State's pharmacy benefits administrator is expected to administer the plan as negotiated.

3.B.2. Eligible Populations

The following employee and non-Medicare retiree populations are eligible for pharmacy benefits coverage:

- Population I—Actives
  - Active employees, COBRA and direct pay participants, and their dependents
  - RI State Police (both active and non-Medicare retirees receive the active plans)
  - Legislative, Judicial, and certain Disabled Retirees (these three groups receive active plans upon retirement)
- Population II—Non-Medicare Retirees
  - Retirees under age 65 and their dependents
  - Retirees over 65 who are not Medicare eligible

State employees are eligible for coverage the first day of employment if they work 20 hours or more per week. Full time and part time employees have the same coverage.

Active employee contributions are 15%, 20%, 25%, or 35%, depending on employment status (full-time or part-time), salary band, and coverage tier (individual or family).

For non-Medicare retirees with retirement dates on or after October 1, 2008, the State uses a separately pooled rate and retiree contributions are 20% as long as the retiree is 59 years of age. For non-Medicare retirees who retired between July 1, 1989 and September 30, 2008 the State uses the same rates as active employees and contributions are based on a statutory formula taking age and years of service into account.

There is an additional group of approximately 830 eligible RIPTA employees and non-Medicare retirees who receive the same benefits as the State and will require some additional support services. RIPTA's claims is included in the data provided with this RFP.

3.B.3. Service Profile

The State seeks a vendor to provide comprehensive pharmacy benefit manager (PBM) services including but not limited to the following:

- Claims Adjudication
- Ability to Integrate PBM Services with Other Vendors (e.g., Medical Health Savings Account (HSA), Utilization/Care/Disease Management), as applicable
- Eligibility Maintenance
- Patient and Provider Education
- Systematic Prospective, Concurrent, and Retrospective Drug Utilization Review
- Clinical Programs
- Network Pharmacy Management
- Formulary Management and Rebate Sharing

- Data Reporting (standard and ad-hoc reporting)
- Distribution of ID Cards and Pharmacy Directories
- Mail Service Pharmacy
- Specialty Pharmacy Program
- Complete Availability of IT services, including Online/Real Time Availability to the State and/or its Designee(s)
- Pricing Administration
- Member Services
- Ad Hoc Reporting
- Website with Membership Portal

In addition, the vendor will absorb the cost of all types of communications.

This RFP requests pricing on a "hybrid transparent" basis, which allows for spread-pricing at retail but requires 100% pass-through of rebate revenue (retail, mail and specialty) being sent to the State. Bids on a "pass through" discount model are acceptable; however, "pass through" bids will be measured based on the minimum discount, and 100% pass-through of rebate revenue (retail, mail and specialty) is required to be sent to the State. All pricing arrangements will be evaluated based on minimum guaranteed discounts, fees, and rebates.

3.C. Scope of Work and Requirements

The State's current PBM is CVS Health, utilizing CVS Health's national pharmacy network, and the CVS Health Standard Control Formulary (with exclusions) for non-specialty medications and the CVS Health Advanced Control Specialty Formulary (with exclusions) for specialty medications.

3.C.1. Current Plan Designs

The State's pharmacy benefits utilize a three-tier plan design. After one (1) fill of a maintenance prescription at a retail pharmacy, members can elect to either fill maintenance prescriptions at:

- A CVS Retail Pharmacy (Maintenance Choice) or CVS Mail Service for 90 day supplies at the 90 day copay amount, or
- Any participating retail pharmacy for 30 day supplies at the 30 day copay amount by calling CVS Health Customer Care to Opt-out.

Specialty prescriptions reflect an exclusive Specialty Pharmacy Program arrangement; claims for specialty products are not dispensed at retail except for those special drugs the Specialty Pharmacy Program is unable to dispense.

Member copayments for the State's prescription drug plans are illustrated in the table below:

Choice Plus w/ HSA Plan / 2014 Plan / Early Retiree Plan	Retail (up to 30 day supply)	Maintenance Choice (up to 90 day supply)	Mail (up to 90 day supply)
Tier 1 (Generic)	$7	$14	$14
Tier 2 (Preferred Brand)	$25	$50	$50
Tier 3 (Non-Preferred Brand)[1]	$45	$90	$90

Retiree Value Plan	Retail (up to 30 day supply)	Maintenance Choice (up to 90 day supply)	Mail (up to 90 day supply)
Tier 1 (Generic)	$10	$25	$25
Tier 2 (Preferred Brand)	$30	$75	$75
Tier 3 (Non-Preferred Brand)[2]	$50	$125	$125

For members in the Choice Plus w/ HSA Plan, a $1,500 individual / $3,000 family combined medical/Rx deductible is applicable, up to a $3,000 individual / $6,000 family combined medical/Rx out of pocket maximum, except for drugs on the Preventive Therapy List.

For members in the 2014 Plan, a $6,350 individual / $12,700 family Rx-only out of pocket maximum is applicable.

Please also review the following documents provided as attachments to the RFP posting:

- SORI Plan Design Summary (Appendix Rx-C)
- Prescription Benefits at a Glance (2017 Plan Year) (Appendix Rx-D)
- Retiree Value Plan SBC (2018) (Appendix Rx-E)
- Preventive Therapy Drug List 0118 (Appendix Rx-G)

The State requires vendors to duplicate and administer the current coordination with the HSA Plan (i.e., combined medical/Rx deductibles and out of pocket maximums), duplicate and administer the current prescription drug plan design copayments, retail (30-day) and mail (90-day) supply limits, and maintenance choice opt-out program, and administer a comparable Preventive Therapy Drug List. If no deviations are noted in your proposal, it will be assumed that your organization can administer the current plan designs exactly as described above and written in the documents noted above.

	Response
1. Confirm you will duplicate and administer the current coordination with the HSA Plan (e.g., combined medical/Rx deductibles and out of pocket maximums).	
2. Confirm you will duplicate and administer the current prescription drug plan design copayments, retail (30-day) and mail (90-day) supply limits, and maintenance choice opt-out program.	
3. Confirm you will provide and administer a comparable Preventive Therapy Drug List.	

1 The Tier 3 brand copay does apply for brand Rx's without a Tier 2 brand or generic alternative.
2 The Tier 3 brand copay does apply for brand Rx's without a Tier 2 brand or generic alternative.

	Response
4. Are there any therapy classes or drugs that are not on your current Preventive Therapy Drug List today and if so, please list them.	
5. Indicate any other deviations in your proposal from the current plan designs as described above and written in the documents noted above.	

3.C.2. Current Clinical and Other Programs

The State participates in prior authorization, step therapy and dose optimization programs, and quantity limitations and exclusions apply to some drugs, as well as other clinical and utilization management programs.

Please review the following files:

- SORI Clinical Programs Summary (Appendix Rx-F)
- Specialty Management Drug Categories (Appendix Rx-H)

The State requires vendors to offer clinical and other programs similar to its current programs. Any additional fees associated with these programs must be provided in your response to Section 3.E.1 Administrative Fees in the Cost Proposal Section of this document. The State must be notified of any deviations from the current clinical and other programs. If no deviations from the current clinical and other programs are identified within your response, the State will assume the prescription drug plan can be duplicated exactly.

Confirm that you are proposing to administer similarly the State's current clinical and other programs outlined in the following chart, and note below any deviations from the current clinical and other programs. Please specify if any additional fees apply in your response to 3.E.1 Administrative Fees in the Cost Proposal Section of this document. It is important to address pricing specific to the clinical and other programs that are in place currently.

Clinical and Other Programs	Response
1. Prior Authorization - See prior authorization drugs as indicated in SORI Clinical Programs Summary (Appendix Rx-F)	
2. Generic Step Therapy - See step therapy (generics first) drugs as indicated in SORI Clinical Programs Summary (Appendix Rx-F)	
3. Drug Quantity Management/Limits – See drugs covered with quantity limits as indicated in SORI Clinical Programs Summary (Appendix Rx-F)	
4. Dose Optimization	
5. Safety and Monitoring The basic safety program targets high-risk drug classes, focusing on controlled substances, and inappropriate use and misuse related indicators such as poly-pharmacy, provider shopping and high-total controlled substance claims volume. The enhanced program includes high-touch interventions for more complex cases. The interventions include, for example, advanced lettering (to both members and prescribers) and Prescriber tool kits.	
6. Drug Savings Review – a program that improves physician prescribing	

Clinical and Other Programs	Response
7. Specialty Guideline Management – a program that includes prior authorizations, step therapy and quantity limits for specialty drugs. Note that specialty utilization management may be included in 1, 2, 3 or 4 above. (Appendix Rx-H).)	
8. Pharmacy Advisor Support – a voluntary program, where a member chooses how the PBM communicates to them; for example, through phone calls, texts or letters reminding them that it is time to refill a prescription. The program is about education to member and about adherence.	
9. Compound Drug Strategy – Include a description of your current compound strategy and what it includes.	
10. Opioid Utilization Management Strategy – Include a description of your standard program offer and indicated whether it coincides with the CDC guidelines.	
11. 340B Pricing	

Additional information regarding the State's pharmacy benefits program can also be accessed at:

- http://www.employeebenefits.ri.gov/benefits/active/health/prescription.php
- http://www.employeebenefits.ri.gov/benefits/retiree/medical/under65.php

The State reserves the right to make plan design changes, including offering additional plans, and clinical and other program changes during the life of the Contract. In addition, the PBM shall provide financial modeling to assist the State with consideration of plan, clinical and other program changes.

The State is currently in the process of union negotiations; therefore, the final January 1, 2019 plan design offerings are subject to change as result of these negotiations. The selected vendor is expected to administer the negotiated plans.

This signed Scope of Work and Requirements form should be included as an attachment to the transmittal letter in order to be considered in the vendor evaluation process.

Accepted this _____ day of _____, 2018

Officer: _____

Signature: _____

Title: _____

Firm: _____

Phone: _____

Email: _____

3.D. Technical Proposal

Narrative and format: The separate technical proposal should address specifically each of the required elements:

General:

This section includes instructions for preparing the technical section of the proposal. Offerors are cautioned to review the instructions carefully. Failure to comply with these instructions in full may result in disqualification.

Proposal Requirements:

Responses should be in the order as presented in the RFP. Sections 3.D.1 – 3.D.4 have been provided in a Word version document and are posted as an attachment to the solicitation; responses to 3.D.1, 3.D.2, 3.D.3 and 3.D.4 may be included within the RFP document. Responses to questions 3.D.4.46, 3.D.4.47, and 3.D.4.48 in 3.D.4 should also be provided on a separate electronic Microsoft Excel format as referenced in Appendix Rx-B. Additional pages relevant to your proposal should be placed in an appendix with an organized Table of Contents. Responses are required for all questions. Failure to respond to any question may result in rejection of the proposal.

The proposal must provide evidence of the offeror's ability to provide the services described in Section 3.B. of this RFP. **The proposal must consist of a transmittal letter and sections, each of which is outlined in detail below:**

Section	Title
3.D.1	Transmittal Letter and Bid Form
3.D.2	Requested Contractual Requirements
3.D.3	Vendor Accountability and Performance Guarantees
3.D.4	Questionnaire

Offerors are advised to be concise and to the point in their responses.

3.D.1: Transmittal Letter and Bid Form

The transmittal letter is required and must be on official business letterhead and signed by an individual with legal authority to bind the offeror. It must include:

- A statement indicating that the offeror is a corporation or other legal entity and where it is incorporated
- A statement that the offeror has read, understands and accepts the requirements, responsibilities, and terms and conditions of the RFP
- A statement indicating that prices quoted are valid for ninety (90) days from the date the proposal is opened
- A statement of affirmative action that the offeror does not discriminate in its employment practices with regard to race, color, religion, age (except as provided by law), sex, marital status, political affiliation, national origin, or disability status, and complies with all applicable provisions of Public Law 101-335, Americans with Disabilities Act
- A statement identifying all amendments to the RFP received by the offeror. If no amendments have been received, a statement to that effect should be included
- Identification of the person who will serve as primary contact for the State, and that person's title, address, and telephone and fax numbers

3.D.2: Requested Contractual Requirements

The State requests the following contractual terms. You are required to respond to each contractual term and indicate your organization's willingness to comply. Indicate "yes" if your organization can comply **as written**, or "no" and provide an explanation if not able to comply **as written**. Any requested contractual term left unanswered shall be considered a "no" response.

Term/Termination

	Yes	No, Please Explain:
3.D.2.1 The PBM will provide a signature ready contract incorporating all agreed upon provisions within this RFP. Contract document will be submitted along with proposal response.		
3.D.2.2 The PBM agrees to a three-year Initial Term effective January 1, 2019.		
3.D.2.3 The State will have the right to terminate the PBM with or without cause given a 90-day notice period after the initial 12-month period elapse, without penalty to the State.		
3.D.2.4 PBM agrees to a mid-contract term market check, that may start as soon as the second quarter of the second contract year, conducted by an independent third party to ensure the State is receiving appropriate current pricing terms competitive with the industry (as compared to other PBMs) based on its volume and membership, and will improve pricing in the event that the State's contract terms are less than current. The State will have the right to terminate without penalty if the pricing terms are not industry competitive.		
3.D.2.5 PBM agrees to implement new pricing within 90 days of completion of the market check or signature of contract. Acceptance of the new pricing will apply for the remainder of the Initial Term and will NOT result in extension of the contract, unless requested by the State. The financial guarantees for any partial contractual year that results from the implementation of new pricing will still be guaranteed, reconciled and the PBM will still make payments for any shortfalls for those partial contractual years with less than 12 months and those contractual years with over 12 months.		
3.D.2.6 The PBM contract will not include automatic renewal language.		
3.D.2.7 PBM contract will provide 120-days advance notice of renewal rates, which shall then be subject to negotiation and written agreement between the parties.		

Definitions

3.D.2.8 Confirm you agree to the following contract definitions:

	Yes	No, Please Explain:
a. "Hybrid Transparent" – The PBM agrees to pay participating pharmacies at the PBM's contracted rate. In the event that the amount paid to the participating pharmacy does not equal the amount invoiced the State, the PBM may retain the difference. The PBM agrees to pass through 100% of ALL rebate revenue earned and will not charge an administrative fee for this arrangement. The PBM also agrees to disclose details of all programs and services generating financial remuneration from outside entities.		
b. "Rebates" - Compensation or remuneration of any kind received or recovered from a pharmaceutical manufacturer attributable to the purchase or utilization of covered drugs by eligible persons, including, but not limited to, incentive rebates categorized as mail order purchase discounts; credits; rebates, regardless of how categorized; market share incentives; promotional allowances; commissions; educational grants; market share of utilization; drug pull-through programs; implementation allowances; clinical detailing; rebate submission fees; and administrative or management fees. Rebates also include any fees that PBM receives from a pharmaceutical manufacturer for administrative costs, formulary placement, and/or access.		
c. AWP (Average Wholesale Price) is based on date sensitive, 11-digit NDC as supplied by a nationally-recognized pricing source (i.e., First DataBank, Medi-Span) for retail, mail order, and specialty adjudicated claims (subject to outstanding litigation).		
d. Member Copay - Members will pay the lowest of the following: plan copay/coinsurance, plan-negotiated discounted price plus dispensing fee, usual and customary (U&C), MAC (maximum allowable cost) or retail cash price.		
e. State eligibility and claim data - All eligibility and claims records are the sole property of the State and must be made available upon request to the State and its representatives. Selling or providing of the State's data to ANY outside entities must be approved in advance, reported on a monthly basis and all income derived must be disclosed and shared per agreement with the State. Even if PBM has not "sold" the data, it is NOT free to use the data for analyses that they publish or provide to outside industries.		

	Yes	No, Please Explain:
f. Paid Claims - Defined as all transactions made on eligible members that result in a payment to pharmacies or members from the State or the State member copays. (Does not include reversals, rejected claims and adjustments.) Each unique prescription that results in payment shall be calculated separately as a paid claim.		
g. Members - All eligible employees, COBRA participants and retirees, and their eligible dependents, enrolled under the State's prescription benefit program.		

3.D.2.9 Brand and Minimum Generic Discount Guarantees for both mail and retail shall be defined as follows: (1-Aggregate Ingredient Cost/Aggregate AWP)

	Yes	No, Please Explain:
a. Aggregate Ingredient Cost prior to application of plan specific co-payments will be the basis of the calculation.		
b. Aggregate AWP will be from a single, nationally recognized price source for all claims. Please indicate source.		
c. Dispensing Fees are not included in the Aggregate Ingredient Cost.		
d. Zero balance due claims or zero amount claims will be included in the guaranteed measurement for AWP, ingredient cost, achieved discounts or dispensing fee calculations at the discounted cost before copay.		
e. All guarantee measurements shall be calculated prior to the copayment being applied.		
f. Both the Aggregate Ingredient Cost and Aggregate AWP from the actual date of claim adjudication will be used.		
g. Aggregate AWP will be the date sensitive, 11-digit NDC of the actual product dispensed.		
h. Non-MAC, MAC, single-source and multiple source generic products are to be included in the generic guarantee measurement.		
i. Compounds, OTC claims, and claims with ancillary charges will be excluded from the guarantee measurements for retail and mail order components.		
j. The guarantee measurement must exclude the savings impact from DUR programs, formulary programs, utilization management programs, and/or other therapeutic interventions.		
k. Measurement will be performed annually via independent audit utilizing date-sensitive AWP derived from a single, nationally recognized price source for all claims.		

	Yes	No, Please Explain:
3.D.2.10 The PBM agrees to provide upon request any proprietary algorithms, hierarchy or other logic employed to define a prescription drug as generic or brand.		

Financial - General

	Yes	No, Please Explain:
3.D.2.11 The PBM will invoice the State twice monthly for claims and once monthly for the administrative services.		
3.D.2.12 Confirm that if the State disputes all or a portion of any invoice, the State will pay the undisputed amount timely and notify the PBM in writing, of the specific reason and amount of any dispute before the due date of the invoice. The PBM and the State will work together, in good faith, to resolve any dispute. Upon resolution, the State or the PBM will remit the amount owed to the other party, if any, as the parties agree based on the resolution.		
3.D.2.13 There are NO additional fees (beyond those outlined in the Financial Section) required to administer the services outlined in this RFP. Any mandatory fees, including clinical and formulary program fees, must be clearly outlined in the Cost Proposal Section.		
3.D.2.14 All applicable fees include the cost of claims incurred/filled during the effective dates of this contract regardless of when they are actually processed and paid (run-out).		
3.D.2.15 PBM will provide run-out claims processing for the State after contract termination.		
3.D.2.16 The PBM agrees to a review and to negotiate the pricing applied to newly introduced generic drugs annually.		
3.D.2.17 The PBM agrees to adjudicate prescription claims for compound medications with the same dispensing fees and logic associated with traditional claims.		
3.D.2.18 All pricing will be effective and guaranteed for the term of the agreement and will not include adjustments for claims volume shifts amongst the various provider channels (e.g., mail utilization rates decline or 90-day retail utilization increases).		
3.D.2.19 Confirm all pricing will be effective and guaranteed for the term of the agreement and will not be modified or amended if the State implements or adds a 100% member paid plan design such as a high deductible health plan/consumer-driven health plan option.		
3.D.2.20 Confirm all pricing will be effective and guaranteed for the term of the agreement and will not be modified or amended if State’s membership decreases by 30% or less.		
3.D.2.21 All applicable administrative fees will be on a per paid claim basis as defined in 3.D.2.8. Definitions.		

	Yes	No, Please Explain:
3.D.2.22 Each distinct pricing guarantee (including rebates) will be measured and reconciled on a component (e.g. retail 30 brand, retail 30 generic, retail 90 brand, retail 90 generic, mail order brand, mail order generic, specialty drugs at participating retail pharmacies, and specialty drugs via the PBM's Specialty Pharmacy) basis only and guaranteed on a dollar-for-dollar basis with 100% of any shortfalls recouped by the State. **Surpluses in one component may not be utilized to offset deficits in another component.**		
3.D.2.23 The PBM will provide a financial reconciliation report within 60 days after the end of each contractual year, and the report will include the contractual and actual discounts and dispensing fees for each component (e.g., retail 30 brands, retail 30 generics, retail 90 brands, retail 90 generics, mail brands, mail generics, specialty drugs via participating retail pharmacies, specialty drugs via the PBM's Specialty Pharmacy).		
3.D.2.24 The PBM agrees that any shortfall between the actual result and the guarantee will be paid, dollar-for-dollar, to the State within 90 days of the end of each contractual year.		
3.D.2.25 The PBM's financial reconciliation that occurs after the end of the contract year will use the lower of the AWP pricing at the point of adjudication or the retroactive AWP pricing, if the pricing source the PBM uses issues retroactive AWP pricing for that annual reconciliation time period.		
3.D.2.26 All pricing submitted will **NOT** be contingent on participation in any proposed clinical management programs, group medical or behavioral health programs proposed by you or any other vendor other than programs that are requested by the State. Further, the pricing guaranteed in the Financial Section of this RFP reflects a) the PBM's broadest national network, and b) the PBM's broadest formulary offering without significant drug coverage disruption/exclusions, without mandated utilization management unless otherwise authorized or requested by the State.		
3.D.2.27 No pricing will be contingent on specific utilization patterns. For instance, pricing terms contingent on limited utilization in a specific geographic location (*e.g.,* Rhode Island) is unacceptable.		
3.D.2.28 The PBM will NOT implement, administer, or allow any program that results in the conversion from lower discounted ingredient cost drug products to higher ingredient cost drug products or increases member's cost share without the prior written consent of the State or its designee.		
3.D.2.29 Mail order pricing and rebates will apply to all claims that adjudicate at mail regardless of days' supply.		

	Yes	No, Please Explain:
3.D.2.30 PBM agrees that mail order and specialty drug dispensing fees will remain constant throughout the contract term and will not be increased for any increases in postage charges.		
3.D.2.31 The PBM will guarantee Retail/Mail Order unit cost equalization meaning that Mail Order unit costs prior to member cost sharing, dispensing fees, and sales taxes charged will be no greater than the unit cost for the same NDC-11 at Retail.		
3.D.2.32 The PBM agrees to produce a date-sensitive comparison report showing unit costs charged to the State at a GCN-level, and reimburse the State on a dollar-for-dollar basis for all instances where mail order unit costs exceed retail unit's costs. Report and reconciliation will be provided on a quarterly basis, without a request being made by the State.		
3.D.2.33 The State will be notified of any switch to the source of the aggregate AWP with at least a 180-day notice. In the event that a switch is made it must be price neutral and acceptable to the State.		
3.D.2.34 The PBM will be responsible for collecting any outstanding member cost shares for prescriptions dispensed through the mail order facility. The PBM will not invoice the State for any uncollected member cost shares even if there is a debit threshold in place.		

Financial - Rebates

	Yes	No, Please Explain:
3.D.2.35 Guaranteed rebates per prescription will be based on all brand prescriptions dispensed, not on formulary prescriptions dispensed.		
3.D.2.36 Rebates are guaranteed on a minimum (i.e., not fixed) basis, and the PBM will pass through 100% of the rebates to the State.		
3.D.2.37 Over-performance of minimum rebate guarantees will not be used to offset performance guarantee shortfalls in other areas.		
3.D.2.38 Rebates will be paid upon signature of: 1) the Letter of Agreement/Intent, OR 2) Pricing Implementation Document, OR 3) contract.		
3.D.2.39 The PBM will provide to the State quarterly rebate payments and reports listing detailed rebate utilization and calculations and reconcile rebate guarantees to verify that the State is at least receiving the guaranteed rebates, within sixty (60) days of the quarter's close, without a request being made by the State.		

	Yes	No, Please Explain:
3.D.2.40 The PBM will provide the annual rebate report within 90 days of the end of each contract year. Any shortfall between the actual result and the minimum rebate guarantees will be paid, dollar-for-dollar, to the State within 90 days of the end of the contract year.		
3.D.2.41 All rebate revenue earned by the State will be paid to the State regardless of their termination status as a client. Lag rebates will continue to be paid to the State after termination until 100% of earned rebates are paid.		

Formulary Management

	Yes	No, Please Explain:
3.D.2.42 With the exception of FDA recalls or other safety issues, the PBM agrees to notify the State or its designee in advance of 90 days when a formulary drug is targeted to be moved to or from the non-specialty and specialty preferred drug list. The PBM must provide a detailed disruption and financial impact analysis at the same time. No greater than two percent (2%) of participants will be disrupted by any formulary deletions or all deletions in total, on an annual basis.		
3.D.2.43 With the exception of FDA recalls or other safety issues, the PBM agrees to notify the State or its designee in advance of 90 days when a drug is targeted to be moved to or from a preferred or non-preferred non-specialty/specialty formulary tier. The PBM must provide a detailed disruption and financial impact analysis at the same time. No greater than two percent (2%) of participants will be disrupted by any non-specialty/specialty formulary deletions or all deletions in total, on an annual basis.		
3.D.2.44 With the exception of FDA recalls or other safety issues, the PBM agrees to remove drugs from coverage or the non-specialty and specialty formulary at most one-time per year and no greater than two percent (2%) of participants will be disrupted by any non-specialty and specialty formulary deletions or all non-specialty and specialty deletions in total, on an annual basis.		
3.D.2.45 No alterations to financial guarantees will be made on non-specialty and specialty formulary drug exclusions. The State has the right to opt in or opt out of any additional non-specialty/specialty formulary drug exclusions without penalty.		

Retail Network Management

	Yes	No, Please Explain:
3.D.2.46 The PBM will not withhold any financial recoveries from audits performed on the contracted pharmacy network including mail order and specialty pharmacies. Any recoveries will be disclosed and credited to the State.		
3.D.2.47 The PBM will not charge the client or offset any costs from an audit recovery should the PBM have to pursue additional collection action to recover audit discrepancies.		
3.D.2.48 The PBM agrees that it will not remove any participating network pharmacies that impact greater than 2% of the State's prescriptions without communicating to the State at least sixty (60) days in advance of the scheduled change. If the change is not agreeable to the State, the State will have the right to terminate the agreement without penalty.		
3.D.2.49 The PBM agrees to offer improved pricing terms to the State if greater than 2% of members are impacted by proposed changes to the participating pharmacy network.		

Audit Rights

	Yes	No, Please Explain:
3.D.2.50 PBM agrees that all financial pricing components (discounts, dispensing fees, rebates) are subject to independent, electronic audit utilizing date sensitive AWP information on an NDC level from a nationally recognized pricing source (e.g., MediSpan).		
3.D.2.51 The State or its designee will have the right to audit annually, with an auditor of its choice, (for both claims and rebate audits), with full cooperation of the selected PBM, the claims, services and pricing and/or rebates, including the manufacturer rebate contracts held by the PBM, to verify compliance with all program requirements and contractual guarantees with no additional charge from the PBM.		
3.D.2.52 The State or its designee will have the right to audit up to 36 months of claims data at no additional charge from the PBM.		
3.D.2.53 The State or its designee will have the right to audit, with an auditor of its choice, at any time provided the State gives 90-days advance notice.		
3.D.2.54 The PBM will provide complete claim files and documentation (i.e., full claim files, financial reconciliation reports, inclusion files, and plan documentation) to the auditor within 30 days of receipt of the audit data request as long as a non-disclosure agreement is in place between the auditor and the PBM.		
3.D.2.55 The PBM agrees to a 30-day turnaround time to provide the full responses to all of the sample claims and claims audit findings.		

	Yes	No, Please Explain:
3.D.2.56 PBM will correct any errors that the State, or its representative, brings to the PBM's attention whether identified by an audit or otherwise.		
3.D.2.57 The State or its designee will have the right to audit up to 12 pharmaceutical manufacturer contracts during an on-site rebate audit at no additional charge from the PBM.		
3.D.2.58 The audit provision shall survive the termination of the agreement between the parties for a period equivalent to the Initial Term of the contract.		
3.D.2.59 The State will not be held responsible for time or miscellaneous costs incurred by the PBM in association with any audit process including, all costs associated with provision of data, audit finding response reports, or systems access, provided to the State or its designee by the PBM during the life of the contract. Note: This includes any data required to transfer the business to another vendor and money collected from lawsuits and internal audits.		

Legal Responsibilities

	Yes	No, Please Explain:
3.D.2.60 The PBM shall indemnify, defend and hold harmless the State, its officers, directors, employees and agents from and against any and all claims, actions, demands, costs, and expenses, including reasonable attorney fees and disbursements, as a result of a breach by the PBM of any of its obligations under the Agreement or arising out of the negligent act or omission or willful misconduct of the PBM or its employees or agents.		
3.D.2.61 PBM agrees to hold the State harmless for any HIPAA Violations made by the PBM or its Network Pharmacies.		
3.D.2.62 The PBM will agree to defend claims litigation based on its decisions to deny coverage for clinical reasons.		
3.D.2.63 The PBM acknowledges that it is compliant with the Electronic Data Interchange ("EDI"), Privacy and Security Rules of the Health Insurance Portability and Accountability Act ("HIPAA"), and will execute the appropriate Business Associate Addendum ("BAA") as provided by the State. PBM also agrees that in the event of a privacy violation or data breach, that the PBM will notify the State and the impacted members to a breach and provide any required remedies.		
3.D.2.64 The PBM agrees that this Agreement or any of the functions to be performed hereunder shall not be assigned by either party to another party, absent advance notice to the other party, and written consent to said assignment, which consent shall not be unreasonably withheld. In the event either party shall not agree to an assignment by the other party, then this agreement shall terminate upon the effective date of said assignment.		

	Yes	No, Please Explain:
3.D.2.65 The PBM must agree that in the event of a dispute between the parties, about the payment or entitlement to receive payment, or any administrative fees hereunder, the PBM and the State shall endeavor to meet and negotiate a reasonable outcome of said dispute. In NO event shall PBM undertake unilateral offset against any monies due and owed the State, whether from manufacturer rebates, credit adjustment or otherwise.		
3.D.2.66 The PBM will respond to and incorporate future Health Care Reform changes in full compliance with the law and at no additional cost to the State.		
3.D.2.67 The PBM will agree to handle claims/appeals processing in accordance with the minimum requirements of ERISA as amended by the Patient Protection and Affordable Act (PPACA).		
3.D.2.68 The PBM will agree to be responsible for selecting and contracting the external review organizations sufficient to allow the State to comply with ERISA as amended by the PPACA.		

Implementation/Ongoing

	Yes	No, Please Explain:
3.D.2.69 The PBM agrees to load all current prior authorizations, open mail order refills, specialty transfer files, claim history files, and accumulator files that exist for current members from the existing PBM at NO charge to the State (with no charges being deducted from the implementation allowance for file loading or IT).		
3.D.2.70 The PBM agrees to send at least 12 months of claims history data, all current prior authorizations, open mail order refills, specialty transfer files, and accumulator files that exist for the State participants to the next/successor PBM at NO charge if the State terminates the contract with or without cause.		
3.D.2.71 PBM agrees to waive any charges to the State or the State's medical plan claims administrators such as a set-up fee, a programming fee or a monthly fee, for establishing a connection with a Third Party Administrator/Claims processor for real-time, bidirectional data integration, including non-standard data integration formats.		
3.D.2.72 PBM agrees to absorb any programming or other administrative costs to meet any existing or future requirements of PPACA.		

	Yes	No, Please Explain:
3.D.2.73 The PBM agrees to provide weekly and/or monthly data transmissions (may include feeds to data warehouses) to at least 10 chosen vendors at no charge and two full, annual electronic claims files, in NCPDP format, at no charge as needed. PBM will also interact/exchange data with all vendors as needed at no additional charge.		
3.D.2.74 The PBM agrees that all future edits required because of plan design changes implemented by the State shall be completed, after testing, by the PBM within 30 days of request/advisory by the State.		
3.D.2.75 The PBM will provide draft SPD language, language for employee communication materials, etc. for any clinical programs that are to be implemented.		
3.D.2.76 The PBM agrees to provide online, real time, claim system access to the State or its designee, including access to historical claims data for up to three (3) years following termination of the agreement.		

Account Service

	Yes	No, Please Explain:
3.D.2.77 The PBM agrees to obtain the State's approval for all member communication materials before distribution to members.		
3.D.2.78 The PBM will not automatically enroll the State in any programs that involve any type of communications with members or alterations of members' medications, without express written consent from the State.		
3.D.2.79 The State reserves the right to review, edit, or customize any communication from the PBM to its membership.		
3.D.2.80 The PBM mail order service must notify the individual member, the State or its designee prior to substituting products that will result in higher member co-pay.		
3.D.2.81 Confirm the PBM will, at a minimum, duplicate the plan features and levels of coverage presently offered by the State without impacting the proposed pricing.		

3.D.3: Vendor Accountability and Performance Guarantees

Respond to the following vendor accountability and performance guarantee standards outlined in this section. Please outline any deviations from the proposed standards. Deviations will be considered but only granted when in the best interests of the State. Offeror's are cautioned that failure to respond in full, or in part, to all standards may negatively affect the evaluation of the offeror's proposal, up to and including disqualification.

This RFP sets forth the terms and conditions under which the State wishes to procure pharmacy benefits for its employees. Your written proposal will be your offer to provide the requested services. Note that if a subcontractor is used to provide any of the contracted services, you are accountable for the subcontractors' performance. Therefore, the subcontractor's performance is held to the same performance standards and subcontractor failure to perform places you at risk.

Any requested clarification of your proposal shall be provided in writing. Similarly, any modification of proposal terms that may occur during the proposal process shall be provided in writing.

Your proposal and the written responses described above shall be the offer on which the State bases its acceptance decision. The State reserves the right to accept, reject, or modify the specifications stated herein to best meet the needs of the State and its employees.

The exhibit below identifies the specific performance guarantees that shall be the basis of performance responsibilities for any resulting contract. The State will be looking for a flat dollar ($) amount for each performance guarantee listed below.

Bidders are encouraged to place a material amount at risk per contract year; a bidder's willingness to offer meaningful guarantees will be reflected in their score.

Performance guarantee metrics may be self-reported, but are subject to independent audit by the State. All guarantees shall be set and measured annually.

	Response
3.D.3.1 Provide the total amount per contract year at risk for performance guarantees. At time of contract, the parties shall mutually agree to the allocation of the at risk funds.	

3.D.3.2 You are required to respond to each performance guarantee by indicating your organization's willingness to agree to each performance guarantee. Bidders are required to provide the measurement basis by specifying for each proposed performance guarantee (in the far right column in the chart following) whether the guarantee will be measured based on State account specific performance or the bidder's book-of-business performance. Bidders are strongly encouraged to provide guarantees on the State account specific performance for the majority of the measurements. Using a book-of-business measurement for many of the guarantees diminishes or eliminates their value to the State and this will be reflected in the bidder's score.

Important Note: Bids that place nothing at risk for performance guarantees will receive 0 out of the total points allocated for performance guarantees.

	Standard	**Confirm Willingness to Guarantee [Yes/No]**	**Measurement Criteria [BOB or State Specific]**
	Confirm the State may allocate the preferred weighting (e.g., 0% to 30%) for the Performance Guarantees below prior to the start of each Contractual Year.		

	Standard	Confirm Willingness to Guarantee [Yes/No]	Measurement Criteria [BOB or State Specific]
Implementation Performance Guarantees			
Clean Implementation	No systems errors, ID card delays, and the State's online access to all tools prior to effective date		
Implementation Timeline	Implementation team will be assigned and introduced to the State at least 6 months in advance of effective date		
Implementation Team	Implementation team members will not change and will be responsible for the accurate installation of all administrative, clinical and financial parameters for the State's program		
ID Card Mailing	All ID cards will be mailed at least 10 days prior to the effective date and will be 100% accurate (provided that a valid eligibility file was received at least 15 days prior to the effective date)		
Implementation Satisfaction Scorecard	Assigned Account Executive will work with the State prior to the start of implementation to agree on terms of a satisfaction scorecard to be issued to the State after effective date for completion		
Ongoing Performance Guarantees			
Payment Accuracy & System Performance			
Protected Health Information	PBM guarantees no incidents in violation of HIPAA Security Rules which results in a transmission of electronic PHI for the State's covered members. This is measured and reported on a quarterly basis and on a State-specific basis.		
Plan Design Change Administration Accuracy	Implementation of all plan design changes will be 100% accurate. This is measured and reported on a quarterly basis and on a State-specific basis.		
Pricing Change Accuracy	Implementation of all pricing changes will be 100% accurate. This is measured and reported on a quarterly basis and on a State-specific basis.		
Financial accuracy (electronic and paper claims)	Percentage of claim payments made without error relative to the total dollars paid will be at least 99%. This is measured and reported on a quarterly basis and on a State-specific basis.		

	Standard	Confirm Willingness to Guarantee [Yes/No]	Measurement Criteria [BOB or State Specific]
Mail Service Non-Financial Accuracy	The mail service pharmacy shall guarantee dispensing accuracy of at least 99.996% (correct participant name, correct participant address, correct drug, correct dosage form, and correct strength). This is measured and reported on a quarterly basis and on a State-specific basis.		
System Downtime	At least 99.5% access to its systems by all the retail pharmacies in PBM's network 24 hours a day, 7 days a week, 365 days a year. This is measured and reported on a quarterly basis and on a State-specific basis.		
Invoicing Errors	All invoicing errors will be credits back to the State by next billing cycle or PBM will pay interest. This is measured and reported on a quarterly basis and on a State-specific basis.		
Claims Eligibility Data	Eligibility loads not to exceed 24-hours after receipt. This is measured and reported on a quarterly basis and on a State-specific basis.		
Eligibility Data Error Reporting	Eligibility file error reporting on all eligibility file updates will be provided to the State within 2 business days. This is measured and reported on a quarterly basis and on a State-specific basis.		
Eligibility Error Rate Audits	Error rate identified through quarterly audits shall not exceed, on an average basis, 2%. This is measured and reported on a quarterly basis and on a State-specific basis.		
Retail Pharmacy			
Retail Pharmacy Audit	100% of participating retail pharmacies will be subject to automated review audits and 20% of participating pharmacies will be subject to further investigation (e.g., desk audits, on-site audits, etc.) as a result of the automated review audits. This is measured and reported on a quarterly basis and on a State-specific basis.		
Retail Pharmacy Turnover	Less than 5% of retail pharmacies will leave the retail network. This is measured and reported on a quarterly basis and on a State-specific basis.		

	Standard	Confirm Willingness to Guarantee [Yes/No]	Measurement Criteria [BOB or State Specific]
Account Management			
Contracting Cooperation	Response to recommended contract language changes within 10 business days. This is measured and reported on a quarterly basis and on a State-specific basis.		
State Approval of Member Communications	100% of all member communications will be approved by the State - exceptions for drug recalls and urgent patient safety communications. This is measured and reported on a quarterly basis and on a State-specific basis.		
Online Reporting Data Availability	Online reporting data will be available within an annual average of fifteen (15) business days after the billing cycle that contains the last day of the month. This is measured and reported on annual basis and on a State-specific basis.		
Claims Detail File	All claims detail files sent to external vendors will be provided within 8 days of request or scheduled delivery date. This is measured and reported on a quarterly basis and on a State-specific basis.		
Delivery of Standard Reports	Within 30 days of end of reporting quarter. This is measured and reported on a quarterly basis and on a State-specific basis.		
Accuracy of Standard Reports	All standard reports provided will be 100% accurate. This is measured and reported on a quarterly basis and on a State-specific basis.		
Pharmacy Audit Resolution	48 hours after receipt of findings. This is measured and reported on a quarterly basis and on a State-specific basis.		
PBM Account Team's Performance	The PBM account team's performance for each Contract Year will receive an average of 3 or better on a scale of 1 to 5 (5 being the best based on a range of performance criteria agreed to between the State and the PBM at the beginning of such Contract Year) from the PBM’s benefits staff. This is measured and reported on an annual basis and on a State-specific basis.		
Account Management	Account team members will remain constant for at least the first 18 months of		

	Standard	Confirm Willingness to Guarantee [Yes/No]	Measurement Criteria [BOB or State Specific]
Turnover	the contract period, unless a change in account management staff is requested by the State. This is measured and reported on a quarterly basis and on a State-specific basis.		
Issue Resolution: The State Staff Involvement / Escalation	PBM will resolve member issues within 48 business hours for any case that required the involvement of the State's staff due to incorrect or incomplete information being provided by the PBM. If not resolved within 48 hours, a penalty will be applied per case, up to an annual maximum. This is measured and reported on a quarterly basis and on a State-specific basis.		
Member Services			
Mail Turnaround – Prescriptions not requiring intervention	95% of prescriptions dispensed within average of 2 business days and 100% within average of 3 business days. This is measured and reported on a quarterly basis and on a State-specific basis.		
Mail Turnaround – Prescriptions requiring intervention	95% of prescriptions dispensed within average of 4 business days and 100% within average of 5 business days. This is measured and reported on a quarterly basis and on a State-specific basis.		
Paper Claims Turnaround	95% of prescriptions reimbursed within average of 10 business days and 100% within average of 14 business days. This is measured and reported on a quarterly basis and on a State-specific basis.		
ID Cards Mailing	98% of all ID cards are sent within 5 business days of receipt of eligibility. 100% mailed within 10 business days. This is measured and reported on a quarterly basis and on a State-specific basis.		
Replacement ID Card Mailing	Standard replacement ID cards will be produced within an annual average of five (5) business days of the request. This is measured and reported on a quarterly basis and on a State-specific basis.		
Mailing Member Materials	All applicable member materials (for example, mail order forms) will be mailed at least 10 days prior to the effective date and will be 100% accurate (provided that eligibility file was received at least 30 days prior to the effective		

	Standard	Confirm Willingness to Guarantee [Yes/No]	Measurement Criteria [BOB or State Specific]
	date). This is measured and reported on a quarterly basis and on a State-specific basis.		
Phone Average Speed of Answer	100% of calls to the State-specific toll free line shall be answered within 20 seconds (excluding IVR). This is measured and reported on a quarterly basis and on a State-specific basis.		
Phone Abandonment Rate	All calls to the State-specific toll free line shall be answered with an abandonment rate of 3% or less. This is measured and reported on a quarterly basis and on a State-specific basis.		
Written Inquiry Answer Time	95% of inquiries responded to in 5 business days - 100% in 20 business days. This is measured and reported on a quarterly basis and on a State-specific basis.		
Member Satisfaction Survey	The PBM agrees to conduct a Member Satisfaction Survey for each contract year and that the Satisfaction Rate will be 90% or greater. A penalty per Contract Year may be assessed against the PBM for failure to meet this standard. “Member Satisfaction Rate” means (i) the number of Eligible Persons responding to PBM annual standard Patient Satisfaction Survey as being satisfied with the overall performance under the Integrated Program divided by (ii) the number of Eligible Persons responding to such annual Patient Satisfaction Survey; the State must provide timely approvals and responses, and a minimum of 20% of surveys must be returned for the Performance standard to be applicable. This is measured and reported on a quarterly basis and on a State-specific basis.		

	Standard	Confirm Willingness to Guarantee [Yes/No]	Measurement Criteria [BOB or State Specific]
Issue Resolution: Verbal Inquiries	PBM will resolve 99% of all telephone issues at the first point of contact (the number of telephone inquiries completely resolved at the time of initial contact divided by the total number of calls). This is measured and reported on a quarterly basis and on a State-specific basis.		
Issue Resolution: Written Inquiries	PBM will resolve 98% of all written inquiries within 10 business days of receipt of inquiry. This is measured and reported on a quarterly basis and on a State-specific basis.		

	Response
3.D.3.3 Confirm the penalties described above will not be the sole and exclusive remedy available to the State for such failure. Confirm the PBM will pay any amount owed to the State and/or its members if the State fails to properly administer claims.	

3.D.4: Questionnaire

Offerors must answer the questions in this section.

Provide an answer to each question even if the answer is "not applicable" or "unknown." Answer the question as directly as possible. If the question asks "How many…" provide a number. If the question asks, "Do you…" indicate "Yes" or "No" followed by any additional narrative explanation. Offerors are advised to be concise and to the point in their responses. Where you desire to provide additional information to assist the reader in more fully understanding a response, refer the reader of your RFP response to your appendix/attachments. However, direct responses to all of the RFP questions must be provided and will be looked upon favorably. Offerors are cautioned that failure to respond in full to all questions will affect the evaluation of the offeror's proposal.

This RFP sets forth the terms and conditions under which the State wishes to procure pharmacy benefits for its employees. Your written proposal will be your offer to provide the requested services.

Proposals will be scored based on each answer provided within the questionnaire or explanation document. Do not refer to vendor provided attachments in response to the questions. Responses should reflect data specific to the market(s) to which you are responding. Do not default to nationally collected data or statistics unless the information or processes are identical. YOU MUST CLEARLY IDENTIFY ANY QUALIFICATIONS OR CONTINGENCIES ON YOUR PROPOSED FINANCIAL TERMS, FEES, PLAN DESIGN, AND PERFORMANCE GUARANTEES. Failure to do so could result in disqualification.

Your proposal and the written responses described shall be the offer on which the State bases its acceptance decision. The State reserves the right to accept, reject, or modify the specifications stated herein to best meet the needs of the State and its employees.

The questionnaire is organized into the following sections;

- Organizational Stability and Experience
- Administrative, Member and Claim Paying Services
- Reports, IT and Data Integration
- Formulary Management and Rebates
- Drug Utilization Review
- Network Management and Quality Assessment
- Mail Order
- Specialty Pharmacy Program
- Network Disruption
- References
- Allowances

Organizational Stability and Experience

	Response
3.D.4.1 Provide the latest annual report, financial statement, SSAE 16 or SAS 70 type II, and other financial reports that indicate the financial position of your organization.	

3.D.4.2 From these documents, please provide the following:

	Response
a. Current ratio	
b. Debt to equity ratio	

3.D.4.3 Complete the following table:

	Response
a. Parent Company	
b. Year PBM Established	
c. Total Number of Covered Lives (CY 2017)	
d. % Covered Lives from top 10 Clients (CY 2017)	
e. Total Number of Covered Lives (CY 2016)	
f. Total Number of Scripts Dispensed (CY 2017)	
g. Total AWP Dollars Processed (CY 2017)	
h. Total Number of Clients (CY 2017)	
i. Number of Group Plans Terminated in Past 12 Months	

	Response
3.D.4.4 Indicate the number of any outstanding legal actions pending against your organization.	
3.D.4.5 Can you assure the State these legal actions will not disrupt business operations?	
3.D.4.6 What general and professional liability coverage do you currently have in place for the entity that is bidding to protect the State from losses or negligence?	
3.D.4.7 Describe the type and amount of the fidelity bond insuring your employees that would protect the State in the event of a loss.	

	Yes	No, Please Explain:
3.D.4.8 Confirm that your organization will comply with all HIPAA regulations and that you provide, upon request, supporting documentation outlining your organizations HIPAA policies and procedures as they relate to management of the prescription benefit plan for the State.		

Administrative, Member and Claim Paying Services

3.D.4.9 Confirm you agree to the following service specifications:

	Yes	No, Please Explain:
a. The State chooses to be invoiced on a bi-weekly (every two weeks) basis for the prior two weeks of claims to be paid via electronic wire with the State as the originator of the transaction. However, the State will accept invoicing on a semi-monthly (twice a month) basis for the prior two weeks (approximately) of claims. The State would agree to make payment within five business days of receipt of the invoice. Confirm you agree to this arrangement.		
b. The State chooses to be invoiced on a monthly basis for administrative costs for the prior month to be paid via electronic wire with the State as the originator of the transaction. The State would agree to make payment within five business days of receipt of the invoice. Confirm you agree to this arrangement.		
c. Confirm you agree to send quarterly reports electronically as well as present mid-year and annual meetings in person with the State to discuss plan performance, present financial results, etc. At a minimum, the State expects that the Account Executive and the Pharmacist Account Executive attend these meetings.		
d. Confirm you provide automated services that are available 24/7.		
e. PBM agrees to implement eligibility updates within 24 hours of receipt.		
f. Confirm you agree to attend open enrollment meetings and other meetings as requested by the State.		

	Yes	No, Please Explain:
g. Confirm you will provide designated/dedicated clinical, account management, and customer service staffing to the State. The State requires that the vendor assign individuals to the State for account management and clinical support on a regular and ongoing basis. The State requires that the vendor's customer service team also be assigned to the State and have the appropriate knowledge of the State's plans of benefits. It is understood that these individuals may be assigned to other plans.		
h. Confirm that the clinical/account management personnel will be available as needed during regular business hours and during emergencies, including being available for frequent telephone and on-site consultation with the State.		
i. Confirm that you provide a live person to answer the customer service phone lines 24 hours per day, seven days per week. An option to speak to a representative as part of an interactive voice response system is acceptable.		
j. Confirm you will offer the State's staff online access to information and services via the Internet or through CRT interface.		
k. Confirm you have the ability to produce temporary ID cards and/or proof of benefits in "real time".		
l. Confirm your organization will send recovery letters to members who continue to use their drug card after their termination.		
m. Confirm you provide member support services for selecting and/or locating network pharmacies.		
n. Confirm you provide member support services for formulary look-ups.		

	Yes	No, Please Explain:
3.D.4.10 Confirm that no penalties or interest will be charged to the State for late funding/payment.		

3.D.4.11 For the customer/member service center proposed for the State provide the following:

Location of the call center:	Response
a. Days of Operation	
b. Hours of Operation	

3.D.4.12 For the customer/member service center proposed for the State provide the following for CY 2017:

	Response
a. Percent of calls abandoned	
b. Percent of calls handled by live representative	
c. Number of seconds to reach a live customer service representative	

Confirm:	Yes	No, Please Explain:
3.D.4.13 All member service call recordings and notes between the PBM and the State's members will be the State's property.		
3.D.4.14 PBM agrees to document 100% of the State's member service calls through call recordings and call notes. PBM will forward call recordings, written transcripts, and call notes at the State's request within two business days of the request being made.		
3.D.4.15 PBM agrees to provide the State with a dummy login to access the PBM's member website prior to the go-live date.		
3.D.4.16 PBM will provide the State with a virtual tour of its CSR system and any custom messaging system.		
3.D.4.17 The PBM agrees to, at minimum, quarterly calls to review member service issues. The PBM agrees to allow the State to review member service quality issues to the resolution endpoint.		
3.D.4.18 The PBM agrees to a minimum of one annual meeting with call center executives to discuss services regarding enrollment and member issues.		
3.D.4.19 Can you produce replacement ID cards within 24 hours, if necessary?		
3.D.4.20 Do you currently perform membership satisfaction surveys?		

	Response
3.D.4.21 If performed, provide a copy of the latest results of the survey. What percent of members indicated that they were "satisfied or very satisfied" with the overall program?	
3.D.4.22 How do you remind members regarding refills and compliance? Indicate methods and frequency of interventions.	
3.D.4.23 How often is the Internet directory updated?	
3.D.4.24 What services are available to members via the Internet? Provide detail regarding current Internet capabilities.	
3.D.4.25 Describe security systems and protocols in place to protect confidential patient records.	
3.D.4.26 Is the site VIPPS certified and licensed in every state?	

3.D.4.27 Indicate if the following resources will be designated (have other clients) or dedicated (have no other clients other than the State).

	Response (Dedicated / Designated)
a. Account Manager	
b. Implementation Manager	
c. Clinical Account Executive	
d. Financial Analyst	
e. Call Center Service Representative	
f. Claims Advocate	

3.D.4.28 Please provide the following information regarding the proposed account team:

	Name of Team Member	Years of PBM Experience	Number of Assigned Accounts	Location
a. Strategic Account Executive				
b. Account Manager				
c. Implementation Manager				
d. Clinical Account Executive				

3.D.4.29 Please provide the PBM's Book-of-Business Turnover Rate for the following divisions:

	CY 2017 (Percent)
a. Overall Book-of-Business	
b. Strategic Account Executives	
c. Account Managers	
d. Client-Facing Clinical Pharmacists	

Reports, IT and Data Integration

3.D.4.30 Please indicate for each report noted below whether you can provide such a report. If you can provide the requested report, indicate the price or if the cost is included in the basic administrative fee.

	Yes/No	Cost	Frequency
a. Eligibility Report (that shows accuracy of updates and changes)			
b. Paid Claims Summary (Ingredient cost, days supply, dispensing fees, taxes, copay totals by month)			
c. Detail Claim Listing (Utilization and Ingredient cost by individual claimant, listing the Drug name and dosage, submitted charge, allowable charge, paid)			
d. Cost Sharing Report (Amounts determined to be ineligible, amounts applied to copays and coinsurance, and amounts adjusted for COB)			

	Yes/No	Cost	Frequency
e. Detailed Utilization Report (# of prescriptions submitted by single source brand, multi-source brand and generic drugs, including average AWP, Ingredient cost per Rx, Dispensing fee, and average days supply)			
f. Top Drug Report (detail of cost and utilization by top drug products)			
g. High Amount Claimant Report			
h. Therapeutic Interchange Report (detailing success rates and cost impacts of PBM initiated interchanges)			
i. Drug Utilization Review activity and Savings Report by type of edit			
j. Member Compliance and Adherence to Therapy			
k. Formulary Savings and Rebate Report			
l. Paid Claims Summary (see b.) (showing total number of claims, eligible charges and claim payments for each category)			
m. Prior Authorization and Clinical Program Reporting			
n. Specialty Rx Reporting			
o. Pharmacy Cost and Utilization Reporting (includes number of patients, scripts, dollar volume)			

	Yes	No, Please Explain:
3.D.4.31 Confirm that you are able to transfer the State's Rx data to the medical administrator and coordinate with the medical administrator to administer combined medical/Rx deductibles and out of pocket maximums, as applicable.		
3.D.4.32 Confirm that you will provide to the State timely alerts/information regarding new drugs, changes in drug indications, new or changes in medical/prescribing guidelines, etc., that may result in increased/unexpected costs for the State, and shall provide financial/impact modeling and assist the State with consideration of plan, clinical and other program changes to address/manage the issue, as applicable.		
3.D.4.33 Do you agree to provide at no cost to the State annual member electronic EOB statements?		

Formulary Management and Rebates

	Yes	No, Please Explain:
3.D.4.34 Confirm that you will pass through 100% of formulary rebates from manufacturers of generic drugs in addition to brand and specialty drugs.		

	Yes	No, Please Explain:
3.D.4.35 Confirm that you indicated, in the financial section of this RFP, if you require a formulary management fee and the amount or percentage proposed. Other than these fees, confirm that you guarantee that 100% of all rebates collected will be passed through to the State.		
3.D.4.36 Confirm that you guarantee that any formulary switches which are not economically advantageous to the State on an ingredient cost basis will be reported and reimbursed to the State on a dollar-for-dollar basis using the least expensive, therapeutically equivalent alternative drug as the basis for reimbursement.		
3.D.4.37 Confirm a member is able to obtain an excluded prescription through a Prior Authorization without impact to the guaranteed rebates.		
3.D.4.38 If requested by the State, the PBM agrees to grandfather the current formulary (preferred) list and respective copayments for up to 90 days following the contract effective date with no impact on the minimum rebate guarantees.		

	Response
3.D.4.39 Provide the name of the Formulary you are proposing to the State. If applicable, provide the number of drug exclusions as well as a list of the excluded drugs and the therapeutic alternatives.	
3.D.4.40 Provide the name of the Specialty Formulary you are proposing to the State. If applicable, provide the number of drug exclusions as well as a list of the excluded drugs and the therapeutic alternatives.	
3.D.4.41 Does the PBM use an external organization for rebate aggregation? If so, which one?	
3.D.4.42 Are any P&T committee members employed by or under contract with any drug manufacturers?	
3.D.4.43 Are any P&T members directly employed by your organization?	
3.D.4.44 Do you have a Formulary Grievance Process in place to address member concerns regarding formulary alternatives? If yes, explain this process in detail.	
3.D.4.45 Are any generic drugs considered “non-preferred” on your proposed formulary (i.e., subject to the “non-preferred” copay)? If yes, please describe in detail and provide examples. If no, then your response to question 3.D.4.49 should be 100% for generics at both retail and mail.	

3.D.4.46 For the State’s attached top Retail 30 brand prescriptions by cost during December 2016 through November 2017 (Appendix Rx-B), please indicate whether each brand drug will be considered “preferred”, “non-preferred”, or “excluded.” Please make sure that you answer "preferred" for only those situations where the exact drug listed is considered “preferred.” For example, if Flonase is listed and is not considered “preferred” on your proposed formulary, then you should answer "preferred" or “excluded”, even though the generic equivalent may be considered “preferred” (i.e., you should only answer "preferred" if the brand Flonase is considered “preferred”).

3.D.4.47 For the State's attached top Retail 90 brand prescriptions by cost dispensed at retail during December 2016 through November 2017 (Appendix Rx-B), please indicate whether each brand drug will be considered "preferred", "non-preferred", or "excluded." Please make sure that you answer "preferred" for only those situations where the exact drug listed is considered "preferred." For example, if Flonase is listed and is not considered "preferred" on your proposed formulary, then you should answer "preferred" or "excluded", even though the generic equivalent may be considered "preferred" (i.e., you should only answer "preferred" if the brand Flonase is considered "preferred").

3.D.4.48 For the State's attached top Mail brand prescriptions by cost during December 2016 through November 2017 (Appendix Rx-B), please indicate whether each brand drug will be considered "preferred", "non-preferred", or "excluded." Please make sure that you answer "preferred" for only those situations where the exact drug listed is considered "preferred." For example, if Flonase is listed and is not considered "preferred" on your proposed formulary, then you should answer "preferred" or "excluded", even though the generic equivalent may be considered "preferred" (i.e., you should only answer "preferred" if the brand Flonase is considered "preferred").

3.D.4.49 Based on the State's attached detailed claim-by-claim prescription drug data during December 2016 through November 2017 (Appendix Rx-A), please indicate what percent of retail 30, what percent of retail 90, what percent of mail, and what percent of specialty generic and brand prescriptions are currently considered "preferred" on your proposed formulary:

	Retail ≤ 30 days (Percent)	**Retail >30 days (Percent)**	**Mail Order (Percent)**	**Specialty (Percent)**
a. Preferred Generics as a Percent of all Generics:	%	%	%	%
b. Preferred Brands as a Percent of all Brands:	%	%	%	%

3.D.4.50 Based on the State's attached detailed claim-by-claim prescription drug data December 2016 through November 2017 (Appendix Rx-A), please complete the following table based on your proposed formulary:

Formulary Drug Exclusions	**Retail ≤ 30 days**	**Retail >30 days**	**Mail Order**	**Specialty**
a. Number of Prescriptions				
b. Number of Patients				

Drug Utilization Review

	Yes	**No, Please Explain:**
3.D.4.51 Confirm that reported savings from drug utilization review will be based on a State-specific claim-by-claim analysis.		

3.D.4.52 It is expected that all pharmacies will have real-time online edits. If this is not the case, indicate the deviation. For the following section, please indicate in your response if there are discrepancies between the retail pharmacy network and mail order capabilities.

	Real Time Edit Criterion (Yes/No)	% of Pharmacies that Satisfy Criterion (Percent)	% of Pharmacies with real time, Online edits (Percent)	Percent of Total Rxs Denied (In CY 2017) (Percent)
a. Eligible Employee/ Dependent				
b. Eligible Drug				
c. Contract Price of Drug				
d. Drug Interactions				
e. Duplicate Prescription				
f. Refill too Soon				
g. Proper Dosage				
h. 7Proper Days Supply				
i. Generic Availability				
j. Patient Copayments				
k. Other (List)				

3.D.4.53 Provide most recent quarterly book of business savings for the following programs:

	Response
a. Concurrent DUR _____% of Total Ingredient Costs	%
b. Retrospective DUR _____% of Total Ingredient Costs	%
c. Prior Authorization _____% of Total Ingredient Costs	%

	Response
3.D.4.54 What criteria and methodologies are used to identify and monitor high cost claimants?	
3.D.4.55 How do you guard against the filling of separate prescriptions for the same or similar drugs at different pharmacies on the same day? Within five days after the initial fill?	
3.D.4.56 Will you reimburse the State for any amounts paid for any day supply dispensed for each claimant beyond the indicated amount? [During instances of lost or stolen Rxs, the State and patient will be responsible for their respective cost shares.]	
3.D.4.57 Do you have edits or programs in place designed to detect and address potential drug fraud and/or abuse?	
3.D.4.58 If yes, explain and include a listing of the specific drugs targeted by this program.	
3.D.4.59 If yes, please describe the plan sponsor and enrollee outreach after fraud or abuse is identified.	
3.D.4.60 If yes, please detail the controls put into place after fraud or abuse is identified.	

	Response
3.D.4.61 Are there charges associated with your organization's fraud and/or abuse programs or edits?	

3.D.4.62 Identify which of the following edits are performed at the point-of-sale:

	Performed at the Point of Sale (Yes or No)
a. Ineligible participant	
b. Pre-existing condition	
c. COB	
d. Benefit maximums for certain drug types	
e. Drug is inappropriate for the patient due to age	
f. Drug is inappropriate for the patient due to gender	
g. Quantity versus Time	
h. Allergy	
i. Incorrect AWP or formula price	
j. UCR input	
k. Duplicate Prescription	
l. Refill too soon	
m. Incorrect dosage	
n. Prescription splitting	
o. Drug interactions	
p. Over utilization	
q. Under utilization	
r. Aggregate Benefit Maximums	
s. Possible Narcotic Abuse	
t. Other POS Edits (provide list)	

Network Management and Quality Assessment

	Yes	No, Please Explain:
3.D.4.63 Confirm that safeguards exist for preventing one group's experience from being charged to another.		
3.D.4.64 Confirm that you guarantee that the State will be charged the generic price and the member charged the generic copay if a generic is out of stock.		
3.D.4.65 Confirm that the State has the ability to pend payments to pharmacies currently identified by the State and reported to PBM as engaging in suspicious dispensing practices.		
3.D.4.66 Confirm that you will set a maximum reimbursement dollar limit on all compounded claims and notify the State when the limit is exceeded.		

	Yes	No, Please Explain:
3.D.4.67 Confirm that the State will receive a 90-day notice, when possible, of any event or negotiation that may cause a disruption in the retail pharmacy network access.		

Mail Order

	Yes	No, Please Explain:
3.D.4.68 Confirm that you will set the threshold for the uncollected member cost share at mail at $250.		
3.D.4.69 Confirm that you will be responsible for collection of member cost share and will be at risk for uncollected monies.		

3.D.4.70 Complete the following for your proposed mail order facility for the State:

	Response
a. Mail-order facility location	
b. Days of Operation	
c. Hours of Operation	

3.D.4.71 Complete the following for your proposed mail order facility for the State for CY 2017:

	Response
a. Total Scripts Filled	
b. Utilization as Percent of Capacity	
c. Average Turnaround with No Intervention Required	
d. Average Turnaround Intervention Required	

3.D.4.72 Complete the following for your proposed mail order facility for the State:

	Response
a. Number of full-time Clinicians/Pharmacists on staff at facility	
b. Number of part-time Clinicians/Pharmacists on staff at facility	
c. Number of Registered Pharmacists	
d. Number of Pharmacy Technicians	
e. Number of Other clinical staff (specify)	
f. Which organizations are used for delivery services?	

	Response
3.D.4.73 Does your mail order facility have auto refill?	
3.D.4.74 If so, confirm members will have the ability to turn auto refill ON and OFF via the website and via phone.	

Specialty Pharmacy Program

	Yes	No, Please Explain:
3.D.4.75 Confirm that members will not incur any additional costs for the delivery of specialty drugs.		
3.D.4.76 Can your organization implement a separate plan design for specialty drugs (e.g., fourth copay tier), if requested?		
3.D.4.77 PBM agrees to notify the State and its members at least 60 days prior to the addition of a drug to the specialty drug list and at least 90 days prior to a deletion of a drug from the specialty drug list.		
3.D.4.78 The State reserves the right to approve any addition to the specialty drug list.		

Network Disruption

	Yes	No, Please Explain:
3.D.4.79 Confirm that your proposal is based on your broadest network.		

3.D.4.80 What is the current number of retail pharmacies in your network?

	Response
a. Rhode Island	
b. National	

	Response
3.D.4.81 List any pharmacy chain with over 50 stores that are excluded from your quoted network.	

3.D.4.82 Based on all the State's retail prescriptions during November 1, 2016 through October 31, 2017 (Appendix Rx-A), please prepare a "disruption" analysis and complete the following table. As indicated, provide the requested information for all pharmacies located within the State of Rhode Island and all pharmacies located outside of Rhode Island. (**Your analysis is to exclude all pharmacies and prescriptions with a Mail Order indicator.**)

Retail Pharmacies	Located in the State of RI	NOT in the State of RI	All Retail Pharmacies
a. Total retail pharmacies in claims data:			
b. Total retail pharmacies in your network:			
c. Total retail prescriptions in claims data:			
d. Total retail prescriptions in your network:			

References

3.D.4.83 Provide the name of your five (5) largest public sector (states, municipalities, etc.) clients for which you provide comparable services as requested in this RFP. For these five clients, provide:

	Client Name	Contact Name	Phone Number	E-Mail	Number of Members	Contract Start Date
1						
2						
3						
4						
5						

3.D.4.84 Provide the name of a client that recently terminated services with your organization not due to a merger or acquisition. For this former client, provide:

	Client Name	Contact Name	Phone Number	E-Mail	Number of Members	Contract Start Date
1						

Allowances

3.D.4.85 Please complete the following table:

Allowance	Description	Response
Implementation	Place the $ (dollar) Per Member amount or the flat dollar ($) amount you are offering the State.	
Pre-Implementation Audit	Place the flat dollar ($) amount you are offering the State to be used to conduct a pre-implementation audit.	
Audit	Place the dollar ($) Per Member amount or the flat dollar ($) amount you are offering the State to be used annually to verify the State is receiving discounted costs and major services as contracted, as well as 100% of rebates.	
General Pharmacy Program Management	Place the $ (dollar) Per Member amount or the flat dollar ($) amount you are offering the Plan for general expenses related to the management of the pharmacy benefits program such as pharmacy claim and rebate audits, communication expenses, clinical programs, consulting fees or be used as a credit against claim invoices.	

This signed Technical Proposal form should be included as an attachment in order to be considered in the vendor evaluation process.

Accepted this _____ day of _____, 2018

Officer: _____

Signature: _____

Title: _____

Firm: _____

Phone: _____

Email: _____

3.E. Cost Proposal

Narrative and format: The separate cost proposal should address specifically each of the required elements:

General:

This section includes instructions for preparing the cost section of the proposal. Offerors are cautioned to review the instructions carefully. Failure to comply with these instructions in full may result in disqualification.

Proposal Requirements:

Potential offerors are cautioned that proposals must conform to the specification of this RFP. Responses should be in the order as presented in the RFP. Sections 3.E.1 – 3.E.4 have been provided in a Word version document and are posted as an attachment to the solicitation; responses to 3.E.1, 3.E.2, 3.E.3, and 3.E.4 are to be included within the RFP Word version document. Additional pages relevant to your proposal should be placed in an appendix with an organized Table of Contents. Responses are required for all questions. Failure to respond to any question may result in rejection of the proposal.

The proposal must consist of all sections, including signed forms, each of which is outlined in detail below:

Section	Title
3.E.1	Administrative Fees
3.E.2	Prescription Drug Pricing
3.E.3	Generic Drugs - Dispensing Rate Guarantees
3.E.4	Specialty Pharmacy Program Pricing

Offerors are advised to be concise and to the point in their responses.

Each offeror must submit proposals for the current pharmacy benefit program for the entire eligible population. Offerors are required to submit proposals for each of the first three (3) plan years of the initial 36-month contract. At the end of the 36-month contract, the State may seek to renew the contract with up to two one-year renewal periods.

All fees must be binding until the assumed implementation date specified in this proposal and must be guaranteed for a minimum of the initial January 1, 2019 to December 31, 2021 contract period.

If a vendor submits a proposal for both the medical and pharmacy plans, their initial cost proposals should be based on stand-alone pricing (i.e., being awarded only medical or only pharmacy). As applicable, also clearly indicate any cost proposal modifications that would apply in the event the vendor were awarded both medical and pharmacy components. Otherwise, proposals submitted by vendors bidding on both benefits plans will be assumed to be identical in the event the vendor is awarded one benefit plan or both benefit plans.

Outlined below are the assumptions and requirements to be used in preparing your response:

1. The new Contract will cover all claims incurred on and after January 1, 2019. The prior claims run-off will be paid under the existing contract.
2. Employees and their dependents are eligible for pharmacy benefit coverage on their date of hire.

3. Assume that all employees and dependents currently enrolled will continue to be enrolled.
4. Assume that the current enrollment remains constant for the plan years beginning 2019.
5. No rate revision may occur if enrollment varies by less than +/-15 percent at any time after the effective date.
6. Commissions are not to be included in your proposal.
7. During the pre-installation period and the post-installation period (three (3) months after the implementation date), your organization will provide on-site Customer Service Representatives as needed. These individuals will assist employees with questions regarding enrollment, the network and its administrative procedures, etc. In addition, the vendor shall work with the State's Office of Employee Benefits staff to achieve the most appropriate level of periodic on-site support.
8. Bidders are required to complete all financial forms as instructed. Bidders should provide proposed fees and minimum guarantees separately for each year of the three-year contract, so that the State's pricing terms keep pace with expected market trends.
9. This RFP requests pricing on a "hybrid transparent" basis, which allows for spread-pricing at retail but requires 100% pass-through of rebate revenue (retail, mail and specialty) being sent to the State. Bids on a "pass through" discount model are acceptable; however, "pass through" bids will be measured based on the minimum discount, and 100% pass-through of rebate revenue (retail, mail and specialty) is required to be sent to the State. All pricing arrangements will be evaluated based on minimum guaranteed discounts, fees, and rebates.
10. Administrative fees and dispensing fees are requested on a per-prescription paid basis. Note that fees must be based on prescriptions dispensed (not adjustments, errors, or redo's) and include, but not be limited to, the following services:
    - Claims Adjudication
    - Ability to Integrate PBM services with Other Vendors (e.g., Medical HSA, Utilization/Care/Disease Management), as applicable
    - Providing/Distributing ID cards (initial, duplicate, additional and replacement cards), pharmacy directories, and formulary lists
    - Standard systems edits (must include "refill-too-soon" edit)
    - Systematic Prospective, Concurrent, and Retrospective Drug Utilization Review
    - Network Pharmacy Management
    - Formulary Management and Rebate Sharing
    - Clinical Programs
    - Eligibility Verification and Maintenance
    - Member/Customer Service, including dedicated Toll-free Telephone and Website with Membership Portal
    - Patient and Provider education
    - Complete Availability of IT services, including Online/Real Time Availability to the State and/or its designee(s)
    - Data Reporting & Data File Requests
    - Ad-hoc reporting
    - Mail Service Pharmacy
    - Specialty Pharmacy Program
    - Pricing Administration

Any deviations from these assumptions must be clearly noted below.

3.E.1 Administrative Fees

3.E.1.1 Complete the following Administrative Fee Table:

ADMINISTRATIVE SERVICES	1/1/2019-12/31/2019	1/1/2020-12/31/2020	1/1/2021-12/31/2021
a. Electronic Claims Administration Fee	$ _____ per Rx	$ _____ per Rx	$ _____ per Rx
b. Manual Claims Administration Fee	$ _____ per Rx	$ _____ per Rx	$ _____ per Rx
Indicate which of these services are included for no additional cost:	**Yes/No**	**Yes/No**	**Yes/No**
a. Toll Free Phone Lines			
b. Monthly Data Feeds to the State or Designee(s)			
c. Prospective DUR			
d. Concurrent DUR			
e. Retro DUR			
f. Standard Reports			
g. Ad Hoc Reports			
h. COB Program			
i. Mandatory Mail Program			
j. Dose Optimization Program			
k. Prior Authorization Program			
l. Step Therapy Program			
m. Quantity Limitations			
n. Custom System Overrides			
o. Annual EOB Statements			
p. Retro Termination Letters			
q. Group Coding			
r. Drug Notification Letters			
s. Formulary Administration/Management			
t. ID Cards			
u. Pharmacy Directories and other member materials			
v. Standard 1st level appeals processing			
w. Standard 2nd level appeals processing			
x. Urgent appeals processing			
y. Overrides			
z. Audit Recovery Fees			
aa. Compound Drug Management			
bb. Opioid Drug Management			

Services above that have additional costs (i.e., services marked "N" above) (show fees separately below). (For example, for clinical and other programs listed in 3.C.2, if cost is separate and/or PMPM basis, provide pricing for those programs.)	**Response**	**Response**	**Response**

	Response
3.E.1.2 Detail all services and supplies to be provided under your basic fees that are not included in your response to question 3.E.1.1.	
3.E.1.3 Detail all data related services included under the base administrative fees including ad hoc reporting, electronic claims files, plan design options, custom mailings, etc.	
3.E.1.4 Detail all data related services not included under the base administrative fees including ad hoc reporting, electronic claims files, plan design options, custom mailings, etc.	

	Yes	**No, Please Explain:**
3.E.1.5 Confirm there is no additional fee for coordination with a high deductible health (HDHP)/HSA plan.		
3.E.1.6 Will there be any additional charges if plans/benefits are restructured or new classes of eligible members are added? If so, how are these charges determined and state amount of charges?		
3.E.1.7 Confirm postage is included in ID card generation, duplicate cards, all mail order prescriptions, and any mailings.		
3.E.1.8 Confirm that quoted fees include postage paid mail order envelopes for member prescription submission.		
3.E.1.9 Confirm that multi-language communication phone line support is included in the base administrative fee. List the languages available to the State members speaking to your customer service representatives.		
3.E.1.10 Confirm disabled (e.g., hearing-impaired) member calls will be facilitated through your member services area.		

This signed Administrative Fees form should be included as an attachment in order to be considered in the vendor evaluation process.

Accepted this _____ day of _____, 2018

Officer: _____

Signature: _____

Title: _____

Firm: _____

Phone: _____

Email: _____

3.E.2 Prescription Drug Pricing

AWP Reimbursement Basis - Complete the following tables using the drug reimbursement that your organization is willing to guarantee on a dollar-for-dollar basis for each year of the contract. Columns marked "AWP Discount" are to be completed using a discount from 100% AWP and dispensing fee logic. All guarantees must be based on the AWP unit cost dispensed at the point of sale, and post September 26, 2009 AWP rollback.

NOTES:

[1]. Including both single source and multi-source brands.
[2]. Post September 26, 2009 AWP rollback
[3]. Including single-source generics.

3.E.2.1 **Year 1 (1/1/2019-12/31/2019)**

Broadest Retail Network	**AWP Discount Retail Supply Up to 30 days**	**AWP Discount Retail Supply 31-90 days**	**AWP Discount Mail Supply 1-90 days**
Brand Drugs[1]			
Discount from AWP[2] for all brands	%	%	%
Dispensing Fee Per Rx	$ ____ per Rx	$ ____ per Rx	$ ____ per Rx
Generic Drugs[3]			
Discount from AWP[2] for all generics (composite discount of MAC and Non-MAC prices, discounted AWP, or usual and customary retail price)	%	%	%
Dispensing Fee Per Rx	$ ____ per Rx	$ ____ per Rx	$ ____ per Rx
Rebates			
Two Tier Plan – Per Brand Rx	$ ____ per Brand Rx	$ ____ per Brand Rx	$ ____ per Brand Rx
Three Tier Plan – Per Brand Rx	$ ____ per Brand Rx	$ ____ per Brand Rx	$ ____ per Brand Rx

3.E.2.2 **Year 2 (1/1/2020-12/31/2020)**

Broadest Retail Network	**AWP Discount Retail Supply Up to 30 days**	**AWP Discount Retail Supply 31-90 days**	**AWP Discount Mail Supply 1-90 days**
Brand Drugs[1]			
Discount from AWP[2] for all brands	%	%	%
Dispensing Fee Per Rx	$ ____ per Rx	$ ____ per Rx	$ ____ per Rx
Generic Drugs[3]			
Discount from AWP[2] for all generics (composite discount of MAC and Non-MAC prices, discounted AWP, or usual and customary retail price)	%	%	%
Dispensing Fee Per Rx	$ ____ per Rx	$ ____ per Rx	$ ____ per Rx
Rebates			
Two Tier Plan – Per Brand Rx	$ ____ per Brand Rx	$ ____ per Brand Rx	$ ____ per Brand Rx
Three Tier Plan – Per Brand Rx	$ ____ per Brand Rx	$ ____ per Brand Rx	$ ____ per Brand Rx

3.E.2.3 **Year 3 (1/1/2021-12/31/2021)**

Broadest Retail Network	**AWP Discount Retail Supply Up to 30 days**	**AWP Discount Retail Supply 31-90 days**	**AWP Discount Mail Supply 1-90 days**
Brand Drugs[1]			
Discount from AWP[2] for all brands	%	%	%
Dispensing Fee Per Rx	$ ____ per Rx	$ ____ per Rx	$ ____ per Rx
Generic Drugs[3]			
Discount from AWP[2] for all generics (composite discount of MAC and Non-MAC prices, discounted AWP, or usual and customary retail price)	%	%	%
Dispensing Fee Per Rx	$ ____ per Rx	$ ____ per Rx	$ ____ per Rx
Rebates			
Two Tier Plan – Per Brand Rx	$ ____ per Brand Rx	$ ____ per Brand Rx	$ ____ per Brand Rx
Three Tier Plan – Per Brand Rx	$ ____ per Brand Rx	$ ____ per Brand Rx	$ ____ per Brand Rx

3.E.2.4 Confirm the pricing listed in the tables above reflects:

	Yes	No, Please Explain:
a. All guarantees are calculated using the date sensitive AWP based on the 11-digit NDC of the actual product dispensed		
b. All-in generic guarantee inclusive of Non-MAC, MAC single-source and multiple source generics		
c. Drugs with an "Insufficient Supply" are included in the guarantees		
d. Select, sole source or authorized generics from at least one FDA-approved generic manufacturer with exclusivity or limited availability, supply or competition will be included in the generic pricing guarantees and excluded from the brand pricing guarantees.		
e. No single-source generic or generic drug will be included in the brand drug component for the annual discount guarantee reconciliation.		
f. Member Cost Share at the point-of-sale (for retail and mail) is based on the lowest of the plan copay/coinsurance, usual and customary charges, negotiated discounted ingredient cost plus dispensing fee or retail cash price		
g. All guarantees are calculated before the application of member cost share		
h. Guaranteed rebates per prescription will be based on all brand prescriptions dispensed, not on formulary prescriptions dispensed.		
i. Rebates are guaranteed on a minimum (i.e., not fixed) basis, and the PBM will pass through 100% of the rebates to the State.		
j. All guarantees (including rebates) are stand-alone with no offsetting (within or across channels)		
k. Any guarantee shortfalls are paid on a dollar-for-dollar basis		
l. Compounds, OTC claims, and claims with ancillary charges will be excluded from the guarantee measurements for retail and mail order components.		
m. The guarantee measurement must exclude the savings impact from DUR programs, formulary programs, utilization management programs, and/or other therapeutic interventions.		
n. The State's current plan designs qualify for the proposed rebate guarantees.		

	Response
3.E.2.5 Indicate whether pricing reflects spread-pricing at retail and 100% pass-through of rebate revenue (retail, mail and specialty) to the State OR reflects a "pass through" discount model and 100% pass-through of rebate revenue (retail, mail and specialty) to the State.	

	Response
3.E.2.6 Provide your proposed source for AWP data.	
3.E.2.7 Please confirm your proposed drug type designation or classification (e.g. brand, generic) source (i.e., First DataBank, Medi-Span, Redbook, Other). If other, please specify.	

This signed Prescription Drug Pricing form should be included as an attachment in order to be considered in the vendor evaluation process.

Accepted this _____ day of _____, 2018

Officer: _____

Signature: _____

Title: _____

Firm: _____

Phone: _____

Email: _____

3.E.3 Generic Drugs - Dispensing Rate Guarantees

3.E.3.1 Complete the table below for contract Years 1, 2, and 3. Note that generic dispensing rate (GDR) guarantees include only true instances of generic dispensing (i.e., exclude multi-source brand drugs dispensed under member-pay-difference plan designs).

Guaranteed GDR	Retail ≤ 30 days	Retail >30 days	Mail Order 1 – 90 days
1/1/2019-12/31/2019	%	%	%
1/1/2020-12/31/2020	%	%	%
1/1/2021-12/31/2021	%	%	%

	Response
3.E.3.2 What dollar amount are you prepared to put at risk for failure to meet your GDR guarantee?	

	Yes	No, Please Explain:
3.E.3.3 Confirm the PBM's Generic Dispensing Rate Guarantee will be measured and reconciled on a component basis and a shortfall in one delivery channel will not be used to offset a shortfall in another delivery channel.		

This signed Generic Drugs - Dispensing Rate Guarantees form should be included as an attachment in order to be considered in the vendor evaluation process.

Accepted this _____ day of _____, 2018

Officer: _____

Signature: _____

Title: _____

Firm: _____

Phone: _____

Email: _____

3.E.4 Specialty Pharmacy Program Pricing

	Response
3.E.4.1 Please provide your organization's definition and qualification criteria of a "specialty drug product."	
3.E.4.2 Provide an AWP-based pricing list of all specialty pharmaceuticals that your company dispenses and distributes to providers and patients. Your pricing must include adequate supplies of ancillaries such as needles, swabs, syringes, and containers. The following items must be included in your list: a. Product Name b. Therapeutic Group/Therapeutic Category c. Guaranteed Minimum AWP Discount	

3.E.4.3 Complete the following table under the proposed Exclusive specialty arrangement:

Exclusive Specialty Pharmacy Program	1/1/2019-12/31/2019	1/1/2020-12/31/2020	8/1/2021-7/31/2021
a. Overall Effective Discount (OED) Guarantee	%	%	%
b. Confirm New to Market Specialty Drugs and New to Market Limited Distribution Specialty Drugs will be included in the above OED guarantee			
c. Dispensing Fee - Per Prescription	$ ____ per Rx	$ ____ per Rx	$ ____ per Rx
d. Administrative Fee - Per Prescription	$ ____ per Rx	$ ____ per Rx	$ ____ per Rx
e. Minimum Rebate Guaranteed - Per Prescription	$ ____ per Rx	$ ____ per Rx	$ ____ per Rx

	Response
3.E.4.4 Please describe any price inflation guarantee you are putting forth for specialty drugs.	
3.E.4.5 Please provide the Exclusive specialty pharmacy program guaranteed default discount guarantee.	
3.E.4.6 Are your proposed guarantees for your retail/mail program contingent upon the State's purchase of your specialty drug program?	

3.E.4.7 Based on the State's attached prescription drug claims information experience during December 2016 through November 2017 (Appendix Rx-A), indicate the percent retail and mail specialty prescriptions and specialty AWP on the following table:

	Response
a. Rxs Considered Specialty at Retail as a Percent of all Retail Rx's	%
b. AWP for Rxs Considered Specialty at Retail as a Percent of all Retail AWP	%
c. Rxs Considered Specialty at Mail as a Percent of all Mail Rx's	%
d. AWP for Rxs Considered Specialty at Mail as a Percent of all Mail AWP	%

	Response
3.E.4.8 Based on the State's attached prescription drug claims experience during December 2016 through November 2017 (Appendix Rx-A) for prescriptions that were dispensed at mail and are considered specialty under your proposal, and your Exclusive specialty pharmacy program pricing list provided in response to question 3.E.4.2 in Specialty Pharmacy Program Pricing, what is the weighted average AWP discount for these specialty prescriptions?	%
3.E.4.9 How are ingredient costs for specialty drugs dispensed at retail determined? Are specialty drugs dispensed at retail included under the retail guarantees? If not, provide an AWP-based overall discount and/or pricing list for all specialty pharmaceuticals dispensed at retail.	
3.E.4.10 Confirm the State will have the ability to annually renegotiate and/or "carve-out" specialty drug pricing and service terms without penalty or changes to the financial guarantees.	

This signed Specialty Pharmacy Program Pricing form should be included as an attachment in order to be considered in the vendor evaluation process.

Accepted this _____ day of _____, 2018

Officer: _____

Signature: _____

Title: _____

Firm: _____

Phone: _____

Email: _____

3.F. ISBE Proposal

See Appendix A for information and the MBE, WBE, and/or Disability Business Enterprise Participation Plan form(s). Bidders are required to complete, sign and submit these forms with their overall proposal in a sealed envelope. Please complete separate forms for each MBE, WBE and/or Disability Business Enterprise subcontractor/supplier to be utilized on the solicitation.

SECTION 4: EVALUATION AND SELECTION

Proposals shall be reviewed by a technical evaluation committee ("TEC") comprised of staff from State agencies. The TEC first shall consider technical proposals. The Medical Plan Administration and Pharmacy Benefits Plan proposals will be evaluated separately and scored as defined in Section 4.A. and 4.B.

4.A. Medical Plan Administration Evaluation

Technical proposals must receive a minimum of 40 (80%) out of a maximum of 50 points to advance to the Cost Proposal and ISBE proposal evaluation phase. Any technical proposals scoring less than 40 points shall not have the accompanying cost or ISBE participation proposals opened and evaluated. The proposal shall be dropped from further consideration.

Technical proposals scoring 40 points or higher will have the cost proposals evaluated and assigned up to a maximum of 50 points in cost category bringing the total potential evaluation score to 100 points. After total possible evaluation points are determined ISBE proposals shall be evaluated and assigned up to 6 bonus points for ISBE participation.

The Division of Purchases reserves the right to select the vendor(s) or firm(s) ("vendor") that it deems to be most qualified to provide the goods and/or services as specified herein; and, conversely, reserves the right to cancel the solicitation in its entirety in its sole discretion.

Proposals shall be reviewed and scored based upon the following criteria:

Criteria	Possible Points
Required Performance Guarantees	5 Points
Questionnaire	20 Points
Geographic Network Access	5 Points
Provider Disruption	20 Points
Total Possible Technical Points	**50 Points**
Cost proposal*	50 Points
Total Possible Evaluation Points	**100 Points**
ISBE Participation**	6 Bonus Points
Total Possible Points	**106 Points**

*Cost Proposal Evaluation:

The vendor with the lowest cost proposal shall receive one hundred percent (100%) of the available points for cost. All other vendors shall be awarded cost points based upon the following formula:

(lowest cost proposal ÷ vendor's cost proposal) x available points

For example: If the vendor with the lowest cost proposal (Vendor A) bids $65,000 and Vendor B bids $100,000 for monthly costs and service fees and the total points available are fifty (50), Vendor B's cost points are calculated as follows:

$65,000 ÷ $100,000 x 50 = 32.5

**ISBE Participation Evaluation:

a. Calculation of ISBE Participation Rate

1. ISBE Participation Rate for Non-ISBE Vendors. The ISBE participation rate for non-ISBE vendors shall be expressed as a percentage and shall be calculated by dividing the amount of non-ISBE vendor's total contract price that will be subcontracted to ISBEs by the non-ISBE vendor's total contract price. For example if the non-ISBE's total contract price is $100,000.00 and it subcontracts a total of $12,000.00 to ISBEs, the non-ISBE's ISBE participation rate would be 12%.

2. ISBE Participation Rate for ISBE Vendors. The ISBE participation rate for ISBE vendors shall be expressed as a percentage and shall be calculated by dividing the amount of the ISBE vendor's total contract price that will be subcontracted to ISBEs and the amount that will be self-performed by the ISBE vendor by the ISBE vendor's total contract price. For example if the ISBE vendor's total contract price is $100,000.00 and it subcontracts a total of $12,000.00 to ISBEs and will perform a total of $8,000.00 of the work itself , the ISBE vendor's ISBE participation rate would be 20%.

b. Points for ISBE Participation Rate:

The vendor with the highest ISBE participation rate shall receive the maximum ISBE participation points. All other vendors shall receive ISBE participation points by applying the following formula:

(Vendor's ISBE participation rate ÷ Highest ISBE participation rate
x Maximum ISBE participation points)

For example, assuming the weight given by the RFP to ISBE participation is 6 points, if Vendor A has the highest ISBE participation rate at 20% and Vendor B's ISBE participation rate is 12%, Vendor A will receive the maximum 6 points and Vendor B will receive (12% ÷ 20%) x 6 which equals 3.6 points.

4.B. Pharmacy Benefits Plan Evaluation

Technical proposals must receive a minimum of 40 (80%) out of a maximum of 50 points to advance to the Cost Proposal and ISBE proposal evaluation phase. Any technical proposals scoring less than 40 points shall not have the accompanying cost or ISBE participation proposals opened and evaluated. The proposal shall be dropped from further consideration.

Technical proposals scoring 40 points or higher will have the cost proposals evaluated and assigned up to a maximum of 50 points in cost category bringing the total potential evaluation score to 100 points. After total possible evaluation points are determined ISBE proposals shall be evaluated and assigned up to 6 bonus points for ISBE participation.

The Division of Purchases reserves the right to select the vendor(s) or firm(s) ("vendor") that it deems to be most qualified to provide the goods and/or services as specified herein; and, conversely, reserves the right to cancel the solicitation in its entirety in its sole discretion.

Proposals shall be reviewed and scored based upon the following criteria:

Criteria	Possible Points
Requested Contractual Requirements	20 Points
Vendor Accountability and Performance Guarantees	5 Points
Questionnaire	25 Points
Total Possible Technical Points	**50 Points**
Cost proposal*	50 Points
Total Possible Evaluation Points	**100 Points**
ISBE Participation**	6 Bonus Points
Total Possible Points	**106 Points**

*Cost Proposal Evaluation:

The vendor with the lowest cost proposal shall receive one hundred percent (100%) of the available points for cost. All other vendors shall be awarded cost points based upon the following formula:

(lowest cost proposal ÷ vendor's cost proposal) x available points

For example: If the vendor with the lowest cost proposal (Vendor A) bids $65,000 and Vendor B bids $100,000 for monthly costs and service fees and the total points available are fifty (50), Vendor B's cost points are calculated as follows:

$65,000 ÷ $100,000 x 50 = 32.5

**ISBE Participation Evaluation:

a. Calculation of ISBE Participation Rate

1. ISBE Participation Rate for Non-ISBE Vendors. The ISBE participation rate for non-ISBE vendors shall be expressed as a percentage and shall be calculated by dividing the amount of non-ISBE vendor's total contract price that will be subcontracted to ISBEs by the non-ISBE vendor's total contract price. For example if the non-ISBE's total contract price is $100,000.00 and it subcontracts a total of $12,000.00 to ISBEs, the non-ISBE's ISBE participation rate would be 12%.

2. ISBE Participation Rate for ISBE Vendors. The ISBE participation rate for ISBE vendors shall be expressed as a percentage and shall be calculated by dividing the amount of the ISBE vendor's total contract price that will be subcontracted to ISBEs and the amount that will be self-performed by the ISBE vendor by the ISBE vendor's total contract price. For example if the ISBE vendor's total contract price is $100,000.00 and it subcontracts a total of $12,000.00 to ISBEs and will perform a total of $8,000.00 of the work itself , the ISBE vendor's ISBE participation rate would be 20%.

b. Points for ISBE Participation Rate:

The vendor with the highest ISBE participation rate shall receive the maximum ISBE participation points. All other vendors shall receive ISBE participation points by applying the following formula:

(Vendor's ISBE participation rate ÷ Highest ISBE participation rate
x Maximum ISBE participation points)

For example, assuming the weight given by the RFP to ISBE participation is 6 points, if Vendor A has the highest ISBE participation rate at 20% and Vendor B's ISBE participation rate is 12%, Vendor A will receive the maximum 6 points and Vendor B will receive (12% ÷ 20%) x 6 which equals 3.6 points.

4.C. General Evaluation

Points shall be assigned based on the vendor's clear demonstration of the ability to provide the requested goods and/or services. Vendors may be required to submit additional written information before the TEC to clarify statements made in the proposal.

SECTION 5. QUESTIONS

Questions concerning this solicitation must be e-mailed to the Division of Purchases at **DOA.PurQuestions8@purchasing.ri.gov** no later than the date and time indicated on page one of this solicitation. No other contact with State parties is permitted. Please reference **RFP # 7590551** on all correspondence. Questions should be submitted in writing in a Microsoft Word attachment in a narrative format with no tables. Answers to questions received, if any, shall be posted on the Division of Purchases' website as an addendum to this solicitation. It is the responsibility of all interested parties to monitor the Division of Purchases website for any procurement related postings such as addenda. If technical assistance is required, call the Help Desk at (401) 574-8100.

SECTION 6. PROPOSAL CONTENTS

Proposal MUST be submitted in the requested RFP format. Do not edit the Word and Excel RFP files in any way such as adding or deleting rows, columns, or cells, or otherwise changing the file format. See Instructions to Offerors #17 in Section 1.A. on proper use to the Word version of the RFP document. Failure to comply with the specifications provided may negatively impact the analysis of bidders' proposal and may be grounds for deeming a proposal non-responsive.

Proposals shall include the following:

6.A. All Proposals

6.A.1. One completed and signed RIVIP Bidder Certification Cover Form (included in the original copy only) downloaded from the Division of Purchases website at www.purchasing.ri.gov. *Do not include any copies in the Technical or Cost proposals.*

6.A.2. One completed and signed Rhode Island W-9 (included in the original copy only)

downloaded from the Division of Purchases website at http://www.purchasing.ri.gov/rivip/publicdocuments/fw9.pdf**.**
Do not include any copies in the Technical or Cost proposals.

6.B. Medical Plan Administration Proposal

6.B.1. Two (2) completed original and copy versions, signed and sealed Appendix A. MBE, WBE, and/or Disability Business Enterprise Participation Plan. Please complete separate forms for each MBE/WBE or Disability Business Enterprise subcontractor/supplier to be utilized on the solicitation. *Do not include any copies in the Technical or Cost proposals.*

6.B.2. Technical Proposal – Technical proposal should be in the order as presented within this RFP. Responses to Sections 2.D.1, 2.D.2 and 2.D.3 may be included within the RFP Word document (do not PDF your response). Responses to Sections 2.D.4 and 2.D.5 should be provided on a separate electronic file in Microsoft Excel format (do not PDF your response). Responses are required for all questions; failure to respond to any question may result in rejection of the proposal. The technical proposal is limited to one hundred (100) pages (this excludes any appendices and as appropriate, resumes of key staff that will provide services covered by this request). Please include the following:

a. One (1) Electronic copy on the state provided Medical Plan Administration USB Drive marked "Technical Proposal - Original".
b. One (1) printed paper copy, marked "Technical Proposal - Original" and signed.
c. Eight (8) printed paper copies

6.B.3. Cost Proposal - A separate, signed and sealed cost proposal. - Cost proposal should be provided in accordance with the requirements of this RFP. Responses to Sections 2.E.1 and 2.E.2 must be provided on a separate electronic file in Microsoft Excel format (do not PDF your response). Responses to Section 2.E.3 may be included within the RFP Word document (do not PDF your response). Responses are required for all questions; failure to respond to any question may result in rejection of the proposal.

a. One (1) Electronic copy on the state provided Medical Plan Administration USB Drive, marked "Cost Proposal -Original".
    i. Cost proposal file must be password protected. Include the written password in the printed paper copy.
b. One (1) printed paper copy, marked "Cost Proposal -Original" and signed.
    i. Provide password for electronic cost proposal file on cover page of paper copy.
c. Eight (8) printed paper copies

6.C. Pharmacy Benefits Plan Proposal

6.C.1. Two (2) completed original and copy versions, signed and sealed Appendix A. MBE, WBE, and/or Disability Business Enterprise Participation Plan. Please complete separate forms for each MBE/WBE or Disability Business Enterprise subcontractor/supplier to be utilized on the solicitation. *Do not include any copies in the Technical or Cost proposals.*

6.C.2. Technical Proposal – Technical proposal should be in the order as presented within this RFP. Responses to Sections 3.C.1, 3.C.2, 3.D.1., 3.D.2., 3.D.3., and 3.D.4. are to be provided in electronic Microsoft Word file format within the provided RFP Word document (do not PDF

your response). Responses to questions 3.D.4.46, 3.D.4.47, and 3.D.4.48 in Section 3.D.4 are to be provided on the separate Appendix Rx-B electronic file in Microsoft Excel format (do not PDF your response). Responses are required for all questions; failure to respond to any question may result in rejection of the proposal. The technical proposal is limited to one hundred (100) pages (this excludes any appendices and as appropriate, resumes of key staff that will provide services covered by this request). Please include the following:

a. One (1) Electronic copy on the state provided Pharmacy Benefits Plan USB Drive marked "Technical Proposal - Original".

b. One (1) printed paper copy, marked "Technical Proposal -Original" and signed.

c. Eight (8) printed paper copies

6.C.3. Cost Proposal - A separate, signed and sealed cost proposal. - Cost proposal should be in the order as presented within this RFP. Responses to Sections 3.E.1, 3.E.2, 3.E.3, and 3.E.4 are to be provided in electronic Microsoft Word file format within the provided RFP Word document (do not PDF your response). Responses are required for all questions; failure to respond to any question may result in rejection of the proposal.

a. One (1) Electronic copy on the state provided Pharmacy Benefits Plan USB Drive marked "Cost Proposal -Original".
   i. Cost proposal file must be password protected. Include the written password in the printed paper copy.

b. One (1) printed paper copy, marked "Cost Proposal -Original" and signed.
   i. Provide password for electronic cost proposal file on cover page of paper copy.

c. Eight (8) printed paper copies

6.D. Formatting of proposal response contents

6.D.1 Formatting of USB Drive(s) – Use of the state issued Medical Plan Administration and/or Pharmacy Benefits Plan USB Drives (s) are required for the technical proposal and cost proposal. If a vendor is bidding on both plans, the applicable Proposal response must be on the corresponding USB Drive (i.e., Medical Plan Administration Technical and Cost proposals provided on the Medical Plan Administration Plan USB Drive). Keep proposal files separate between the Medical Plan Administration and/or Pharmacy Benefits Plan USB Drives and in separate technical and cost proposal folders on the USB Drive(s). Inter-mingled files may be grounds for disqualification.

All USB Drives submitted must contain separate files as follows:

a. Technical Proposal with Vendor's name

b. Cost Proposal with Vendor's name, password protected (see Section 6.B.3 and 6.C.3)

Vendors are responsible for testing their files before submission as the Division of Purchase's inability to open or read a file may be grounds for rejection of a Vendor's proposal. All files should be readable and readily accessible on the USB Drive(s) submitted with no instructions to download files from any external resource(s). If a file is partial, corrupt or unreadable, the Division of Purchases may consider it "non-responsive". USB Drives other than the state provided USB Drive or any other electronic media shall not be accepted. Please note that files s submitted, shall not be returned.

6.D.2. Formatting of written documents and printed copies:

- **a.** For clarity, the technical and cost proposals shall be typed. These documents shall be single-spaced with 1" margins on white 8.5"x 11" paper using a font of 12 point Calibri or 12 point Times New Roman.
- **b.** All pages on the technical proposal and cost proposals are to be sequentially numbered in the footer, starting with number 1 on the first page of the narrative (this does not include the cover page or table of contents) through to the end, including all forms and attachments. The Vendor's name should appear on every page, including attachments. Each attachment should be referenced appropriately within the proposal section and the attachment title should reference the proposal section it is applicable to.
- **c.** The cost proposal shall be typed using the formatting provided on the provided within the RFP.
- **d.** Printed copies are to be only bound with removable binder clips.

SECTION 7. PROPOSAL SUBMISSION OR USB DRIVE(S) RETURN

Interested vendors must submit either proposals to provide the goods and/or services covered by this RFP on or before the date and time listed on the cover page of this solicitation. **Vendors are to submit proposals using the state issued USB drive(s); the USB drive(s) MUST be returned on or before the date and time listed on the cover page of this solicitation.** Responses received after this date and time, as registered by the official time clock in the reception area of the Division of Purchases, shall not be accepted.

Proposals should be mailed or hand-delivered in a sealed envelope marked "**RFP# 7590551**" to:

RI Dept. of Administration
Division of Purchases, 2nd floor
One Capitol Hill
Providence, RI 02908-5855

NOTE: Proposals received after the above-referenced due date and time shall not be accepted. Proposals misdirected to other State locations or those not presented to the Division of Purchases by the scheduled due date and time shall be determined to be late and shall not be accepted. Proposals faxed, or emailed, to the Division of Purchases shall not be accepted. The official time clock is in the reception area of the Division of Purchases.

SECTION 8. ESTIMATED RFP TIMETABLE

The State will implement the plan on January 1, 2019.

The following timetable is anticipated:

Action	**Due Date** (Eastern Time)
RFP Released	Tuesday, February 27, 2018
Pre-proposal Conference	Friday, March 9, 2018 (see cover page for details)
Deadline for Questions Period	Tuesday, March 13, 2018 at 5:00 PM ET
Responses to Questions Received by Deadline	No later than Wednesday, March 21, 2018
Proposal Submission Deadline	Monday, April 9, 2018 at 11:00 AM ET
Selection of Vendor	June 15, 2018
Contract Finalized	July 31, 2018
Implementation / Finalizing Plan Designs	July – December 2018
Open Enrollment	November – December 2018
Plan Effective Date	January 1, 2019

This is a tentative schedule and all dates are subject to change at the sole discretion of the State.

SECTION 9. CONCLUDING STATEMENTS

Notwithstanding the above, the Division of Purchases reserves the right to award on the basis of cost alone, to accept or reject any or all proposals, and to award in the State's best interest.

Proposals found to be technically or substantially non-responsive at any point in the evaluation process will be rejected and not considered further.

If a Vendor is selected for an award, no work is to commence until a purchase order is issued by the Division of Purchases.

The State's General Conditions of Purchase contain the specific contract terms, stipulations and affirmations to be utilized for the contract awarded for this RFP. The State's General Conditions of Purchases can be found at the following URL:
https://www.purchasing.ri.gov/RIVIP/publicdocuments/ATTA.pdf.

APPENDIX A. PROPOSER ISBE RESPONSIBILITIES AND MBE, WBE, AND/OR DISABILITY BUSINESS ENTERPRISE PARTICIPATION FORM

A. Proposer's ISBE Responsibilities (from 150-RICR-90-10-1.7.E)

1. Proposal of ISBE Participation Rate. Unless otherwise indicated in the RFP, a Proposer must submit its proposed ISBE Participation Rate in a sealed envelope or via sealed electronic submission at the time it submits its proposed total contract price. The Proposer shall be responsible for completing and submitting all standard forms adopted pursuant to 105-RICR-90-10-1.9 and submitting all substantiating documentation as reasonably requested by either the Using Agency's MBE/WBE Coordinator, Division, ODEO, or Governor's Commission on Disabilities including but not limited to the names and contact information of all proposed subcontractors and the dollar amounts that correspond with each proposed subcontract.

2. Failure to Submit ISBE Participation Rate. Any Proposer that fails to submit a proposed ISBE Participation Rate or any requested substantiating documentation in a timely manner shall receive zero (0) ISBE participation points.

3. Execution of Proposed ISBE Participation Rate. Proposers shall be evaluated and scored based on the amounts and rates submitted in their proposals. If awarded the contract, Proposers shall be required to achieve their proposed ISBE Participation Rates. During the life of the contract, the Proposer shall be responsible for submitting all substantiating documentation as reasonably requested by the Using Agency's MBE/WBE Coordinator, Division, ODEO, or Governor's Commission on Disabilities including but not limited to copies of purchase orders, subcontracts, and cancelled checks.

4. Change Orders. If during the life of the contract, a change order is issued by the Division, the Proposer shall notify the ODEO of the change as soon as reasonably possible. Proposers are required to achieve their proposed ISBE Participation Rates on any change order amounts.
5. Notice of Change to Proposed ISBE Participation Rate. If during the life of the contract, the Proposer becomes aware that it will be unable to achieve its proposed ISBE Participation Rate, it must notify the Division and ODEO as soon as reasonably possible. The Division, in consultation with ODEO and Governor's Commission on Disabilities, and the Proposer may agree to a modified ISBE Participation Rate provided that the change in circumstances was beyond the control of the Proposer or the direct result of an unanticipated reduction in the overall total project cost.

B. MBE, WBE, AND/OR Disability Business Enterprise Participation Plan Form:

Attached is the MBE, WBE, and/or Disability Business Enterprise Participation Plan form. Bidders are required to complete, sign and submit with their overall proposal in a sealed envelope. Please complete separate forms for each MBE, WBE and/or Disability Business Enterprise subcontractor/supplier to be utilized on the solicitation.

STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS
DEPARTMENT OF ADMINISTRATION
ONE CAPITOL HILL
PROVIDENCE, RHODE ISLAND 02908

MBE, WBE, and/or DISABILITY BUSINESS ENTERPRISE PARTICIPATION PLAN

Bidder's Name:
Bidder's Address:
Point of Contact:
Telephone:
Email:
Solicitation No.:
Project Name:

This form is intended to capture commitments between the prime contractor/vendor and MBE/WBE and/or Disability Business Enterprise subcontractors and suppliers, including a description of the work to be performed and the percentage of the work as submitted to the prime contractor/vendor. Please note that all MBE/WBE subcontractors/suppliers must be certified by the Office of Diversity, Equity and Opportunity MBE Compliance Office and all Disability Business Enterprises must be certified by the Governor's Commission on Disabilities at time of bid, and that MBE/WBE and Disability Business Enterprise subcontractors must self-perform 100% of the work or subcontract to another RI certified MBE in order to receive participation credit. Vendors may count 60% of expenditures for materials and supplies obtained from an MBE certified as a regular dealer/supplier, and 100% of such expenditures obtained from an MBE certified as a manufacturer. This form must be completed in its entirety and submitted at time of bid. **Please complete separate forms for each MBE/WBE or Disability Business Enterprise subcontractor/supplier to be utilized on the solicitation.**

Name of Subcontractor/Supplier:					
Type of RI Certification:	□ MBE □ WBE □ Disability Business Enterprise				
Address:					
Point of Contact:					
Telephone:					
Email:					
Detailed Description of Work To Be Performed by Subcontractor or Materials to be Supplied by Supplier:					
Total Contract Value ($):		Subcontract Value ($):		ISBE Participation Rate (%):	
Anticipated Date of Performance:					

I certify under penalty of perjury that the forgoing statements are true and correct.

Prime Contractor/Vendor Signature	Title	Date
Subcontractor/Supplier Signature	**Title**	**Date**

M/W/Disability Business Enterprise Utilization Plan - RFPs - Rev. 5/24/2017

LIMITED USE, CONFIDENTIALITY AND NONDISCLOSURE AGREEMENT

This Limited Use, Confidentiality and Nondisclosure Agreement ("Agreement") is entered into for the benefit of the State of Rhode Island ("State"), by and through Division of Purchases, and the _____ ("Vendor") (collectively hereinafter "Parties").

The Parties acknowledge that certain confidential and/or sensitive information and/or material may be disclosed to the Vendor during the request for proposal process for Medical Benefits Administration and Pharmacy Benefit Plan for the State of Rhode Island, in order to assist the Vendor in formulating a proposal in response to RFP# 7590551. The State will release this "Confidential Information," as defined below, to the Vendor for the limited purpose of assisting the Vendor in formulating a proposal and pursuant to the terms and conditions contained in this Agreement.

NOW THEREFORE, in consideration of the above premises and the promises contained herein, the Contracting Parties agree as follows:

1. Whenever used in this Agreement, the term "Confidential Information" shall mean (i) information exempt from disclosure to the public or other unauthorized persons under either the Rhode Island General Laws or federal statutes; or (ii) information in any medium related RFP# 7590551; or (iii) any other information which the State has identified to the Vendor in writing as confidential at the time Confidential Information is released to the Vendor or within thirty (30) days after such release; or (iv) information that would ordinarily be reasonably considered confidential or proprietary in the light of the circumstances surrounding its release to the Vendor. Confidential Information may take the form of, but is not limited to, plans, calculations, charts, concepts, know-how, inventions, licensed technology, design sheets, design data, diagrams, system design, materials, hardware, manuals, drawings, processes, schematics, specifications, instructions, explanations, research, test procedures and results, equipment, identity and descriptions of components or materials used, any and all personal and/or confidential information pertaining to personnel. Confidential Information may be in tangible or intangible form. The State's failure to expressly identify Confidential Information as such shall not in any way lessen or negate the Parties' obligation to keep such information confidential in accordance with this Agreement.

2. Notwithstanding the foregoing, the term Confidential Information shall not be construed to include information that (i) is or becomes readily available in public records or documents, other than as a result of an inappropriate disclosure by the Parties or other entity or persons acting on behalf of the Parties, or (ii) can be documented to have been known by the Parties prior to its release to the Parties by the State, or (iii) is disclosed pursuant to applicable Rhode Island law and/or federal law, judicial action or government regulations.

3. The Parties acknowledge that the Confidential Information is confidential and proprietary information and that its protection is essential. The purpose of this Agreement is to enable State to make disclosure of the Confidential Information to the Vendor for the limited purpose of formulating a proposal in response to RFP# 7590551, while still maintaining rights in and control over the Confidential Information in conformance with such mandate. The purpose is also to preserve confidentiality of the Confidential Information and to prevent its unauthorized disclosure during the RFP# 7590551 process. The vendor shall not use the Confidential Information for any other purpose as stated herein. It is understood that this Agreement does not grant the Parties an express or implied license or an option on a license, or any other rights to or interests in the Confidential Information.

4. The Parties shall require its employees, officers, independent contractors, and subcontractors, agents and any other entities acting on its behalf (collectively "Affiliates") to:

    a) Copy, reproduce or use Confidential Information only for the purpose described herein and not for any other purpose unless specifically authorized to do so in writing by the State; and

b) Not permit any other person to use or disclose the Confidential Information for any purpose other than those expressly authorized by this Agreement; and

c) Disclose such Confidential Information only to those of its Affiliates who require knowledge of the same for the purpose described herein; provided such Affiliates are obligated to maintain the confidentiality of the Confidential Information and otherwise comply with the terms of this Agreement; and

d) Implement physical, electronic and managerial safeguards to prevent unauthorized access to or use of Confidential Information, including without limitation, providing Affiliates a copy of the terms of this Agreement and any other non-disclosure agreement the State may provide for said Affiliates' signature. Such restrictions will be at least as stringent as those applied by the Parties to its own most valuable confidential and proprietary information.

5. The acts or omissions of the Parties' Affiliates with respect to the Confidential Information shall be deemed to be acts or omissions of the Party.

6. The Parties will not remove, obscure or alter any confidentiality or trade secret notation from the Confidential Information without the State's prior written authorization.

7. Confidential Information will remain the exclusive property of the State unless as otherwise provided for in any agreement and/or the contract between the State and the Vendor; upon completion of the review of the Confidential Information, or whenever requested by the State, the Parties will promptly destroy or return to the State all Confidential Information and all copies thereof, including summaries, reports or notes based thereon, unless otherwise expressly authorized otherwise by the State in writing.

8. The Parties agree that the breach of the terms of this Agreement would cause irreparable damage to the State. Therefore, the Parties agree that the State has the right to seek an order to restrain the Vendor from breaching this Agreement. If the State does seek such an order, the Parties agree at this time to waive any claim or defense that the State has an adequate remedy at law or in damages. The State shall have the right to commence any and all legal action, whether in law and/or in equity, the State determines is necessary and required pursuant to this Agreement, to include but is not necessarily limited to, any alleged violation of this Agreement by the any of the Parties and/or Affiliates.

9. This Agreement sets forth the entire agreement of the Parties with respect to the use and disclosure of the Confidential Information and may be modified only by a writing signed by the Parties. This Agreement will be construed and enforced in all respects in accordance with the laws of the State of Rhode Island. The Parties consent to the exclusive jurisdiction of the Superior Court of the State of Rhode Island and exclusive venue in Providence County, Providence, Rhode Island.

10. The term of this Agreement shall be concurrent with award of a contract by the State under RFP# 7590551.

Signed and agreed by an authorized agent of the Vendor,

Signature: _____

Title: _____

Firm: _____

Phone: _____

Email: _____

DATA REQUEST FORM

1. We have signed and are returning the "Limited Use, Confidentiality and Nondisclosure Agreement" with this completed "Data Request Form".

2. We confirm that we are requesting this information for the sole purpose of responding to the State of Rhode Island's Medical Plan Administration and/or Pharmacy Benefits Plan RFP# 7590551. As a recipient of this information, we will not use or disclose it for any other purpose than to respond to the State's RFP# 7590551. We will destroy this information upon the completion of the RFP process.

3. We confirm that we are able to provide the benefits and services requested in the RFP# 7590551 and our proposal will meet the requirements identified in this RFP document.

4. We confirm that the state provided USB drive(s) with the RFP data shall be returned by the RFP submission deadline, regardless if a proposal is submitted or not.

We confirm:

- ☐ We are able to provide the requested benefits and all the required administrative services;
- ☐ We are requesting this information for the sole purpose of responding to the State's RFP;
- ☐ We will not use or disclose this information for any other purpose than to respond to the State's RFP;
- ☐ We will destroy this information upon the completion of the RFP process;
- ☐ Our proposal will not include commissions;
- ☐ Our proposal will include complete response to all sections of this RFP, including both the technical and cost sections;
- ☐ The state provided USB Drive(s) with the RFP data shall be returned by the submission deadline; and
- ☐ We are requesting the following USB Drive(s):
  - ☐ Medical Plan Administration
  - ☐ Pharmacy Benefits Plan.

Signature:	**Contact for Password Transmission:**
Accepted this _____ day of _____, 2018 Officer: _____ Signature: _____ Title: _____ Firm: _____ Phone: _____ Email: _____	Name: _____ Title:_____ Phone:_____ Email:_____

SUBMISSION CHECKLIST

This checklist is provided to assist the bidder in preparing a bid proposal for submission. It is not a substitute for a thorough review of the Instruction to Bidders nor a comprehensive list of all bid proposal requirements. Each bidder is responsible to review the Instructions to Bidders and to comply with all requirements of the Solicitation.

A. **Medical Plan Administration** - The items listed below are required in order for your proposal to be considered.

General:

- ☐ Signed Plan Design Form (Section 2.C.1)

Technical Proposal (Section 2.D.)

- ☐ Transmittal Letter (Section 2.D.1)
- ☐ Vendor Performance Guarantees (Section 2.D.2)
- ☐ Questionnaire (Section 2.D.3)
- ☐ Certified Financial Statements (Section 2.D.3., Question G.3., Page 31)
- ☐ Sample Contract for Self-Funded Arrangements (Section 2.D.3, Sub section G. General Contract Provisions, Pages 31-32)
- ☐ References (Section 2.D.3.H)
- ☐ Geographic Network Access (Section 2.D.4)
- ☐ Provider Disruption (Section 2.D.5)

Cost Proposal (Section 2.E.)

- ☐ Network Discounts (Section 2.E.3)
- ☐ Financial Questions (Section 2.E.3)

ISBE Proposal (Section 2.F.)

- ☐ ISBE Proposal (Sections 2.F and 6.B.1)

B. **Pharmacy Benefits Plan** - The items listed below are required in order for your proposal to be considered.

General:

- ☐ Signed Scope of Work and Requirements (Section 3.C.)

Technical Proposal (Section 3.D.)

- ☐ Transmittal Letter and Bid Form (Section 3.D.1)
- ☐ Requested Contractual Requirements (Section 3.D.2)
- ☐ Vendor Accountability and Performance Guarantees (Section 3.D.3)
- ☐ Questionnaire (Section 3.D.4)
- ☐ Financial Statements (Question 3.D.4.1)
- ☐ Completed Appendix Rx-B (Question 3.D.4.46, 3.D.4.47, and 3.D.4.48)

Cost Proposal (Section 3.E.)

- ☐ Administrative Fees (Section 3.E.1)

- ☐ Prescription Drug Pricing (Section 3.E.2)
- ☐ Generic Drugs - Dispensing Rate Guarantees (Section 3.E.3)
- ☐ Specialty Pharmacy Program Pricing (Section 3.E.4)

ISBE Proposal (Section 2.F.)

- ☐ ISBE Proposal (Sections 3.F and 6.B.1)

C. **All Proposals** - The items listed below are required in order for your proposal to be considered.

- ☐ R.I.V.I.P Generated Bidder Certification Cover Sheet (Section 6.A.1.)
- ☐ Completed and Signed W-9 (Section 6.A.2.)
- ☐ All Submissions Compliant with Content and Formatting Requirements (Section 6)
- ☐ **Return state provided USB Drive(s) (required even if not submitting a proposal)**