**STATE OF MISSISSIPPI**

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**STATE AND SCHOOL EMPLOYEES HEALTH INSURANCE MANAGEMENT BOARD**

**REQUEST FOR PROPOSAL**

**FOR**

**PHARMACY BENEFIT MANAGER SERVICES**

**February 11, 2020**

Contact information for this request for proposal:

Pharmacy Benefit Manager Services RFP

c/o DFA - Office of Insurance

501 North West Street

Suite 901-B Woolfolk Building

Jackson, Mississippi 39201

[InsuranceRFP@dfa.ms.gov](mailto:InsuranceRFP@dfa.ms.gov)

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# INTRODUCTION

## Overview and Process

Mississippi’s State and School Employees Health Insurance Management Board (Board) is seeking a vendor to provide prescription drug benefit management services to the State and School Employees’ Health Insurance Plan (Plan). The Board desires to contract with a qualified, experienced Pharmacy Benefit Manager (PBM) capable of providing prescription drug benefit management services to large self-insured health plans, and having prior experience directly related to the services requested in this RFP. The Department of Finance and Administration (DFA) Office of Insurance provides administrative support to the Board, and is coordinating this Request for Proposal (RFP) with assistance from its consultant, The Segal Company Southeast, Inc. d/b/a Segal Consulting (Segal). The Board seeks to enter into a firm fixed price contract for the aforementioned services. A draft contract has been included as Appendix A in this RFP for your review and comment. This contract will be for four (4) years with an option to renew for one (1) additional year at the Board’s discretion. The effective date of this contract will be January 1, 2021. This procurement and any resulting contract shall be governed by the applicable provisions of the *Mississippi Public Procurement Review Board Office of Personal Service Contract Review Rules and Regulations*, a copy of which is available at 501 N. West Street, Suite 701E, Jackson, Mississippi 39201 for inspection or at <http://www.dfa.ms.gov/dfa-offices/personal-service-contract-review/pscrb-rules-regulations/>.

A copy of this RFP, including any subsequent amendments, along with a copy of all questions from vendors and responses to those questions, will be posted on DFA’s website under the heading “Bid and RFP Notices” at <http://www.dfa.ms.gov/bid-rfp-notices/>. Before the award of any contract, the vendor will be required to document to the Board that it has the necessary capabilities to provide the services specified in this RFP. The vendor may also be required to provide additional client references, as well as related project experience detail in order to satisfy the Board that the vendor is qualified. The Board may make reasonable investigations, as it deems necessary and proper, to determine the ability of the vendor to perform the work, and the vendor shall be required to furnish to the Board all information that may be requested for this purpose. The Board reserves the right to reject any proposal if the vendor fails to provide the requested information and/or fails to satisfy the Board that the proposer is properly qualified to carry out the obligations of the contract and to complete the work described in this RFP.

The Plan’s health insurance component is a self-insured, non-ERISA health insurance plan, currently providing health insurance coverage to approximately 195,000 participants. Eligible participants in the Plan include active, retired, and COBRA employees (and their enrolled dependents) of the State’s agencies, universities, community/junior colleges, school districts, and public library systems. Plan participants are located primarily within Mississippi, although a small number of participants reside in other states. Additional information describing the Plan can be found in the *2020 Plan Document* located in Appendix B.

The Plan currently offers options of Base Coverage or Select Coverage for active employees, COBRA participants, and non-Medicare eligible retirees. Each coverage type is independent of the other. Under Select Coverage prescriptions are subject to copayments after a $75 pharmacy deductible has been satisfied. The Base Coverage serves as a high deductible health plan in which pharmacy benefits are subject to copayments after the annual $1,800 deductible has been satisfied.

Blue Cross & Blue Shield of Mississippi (BCBSMS) is the current medical Third Party Medical Claims Administrator (TPA) and has served in this capacity since 1998. The TPA collects and provides the PBM with eligibility data and accumulation data such as deductible and out-of-pocket data, etc. The TPA is responsible for processing medical claims, and determining medical necessity guidelines for the Plan. Prime Therapeutics, LLC is the current PBM and has served in this capacity since 2016. The Plan currently utilizes Prime’s NetResults formulary which is a “closed” formulary. The Plan processed over $283 million in 2019 prescription drug charges on approximately 3.3 million claims in 2019. The Plan has a generic utilization rate of approximately 88.2%. Mail order currently represents less than 2% of claims.

The Board’s current pharmacy benefit manager contract with Prime Therapeutics, LLC is scheduled to expire on December 31, 2020, necessitating the need for this RFP.

The Board also contracts with the following vendors to assist in managing the Plan:

**ActiveHealth Management, Inc.** Medical Management/Population Health

**Blue Cross & Blue Shield of Mississippi** Third Party Medical Claims Administrator

**Cavanaugh** **Macdonald** **Consulting**, **LLC** OPEB Actuary

**Claim Technologies Inc.**  Medical Claims and Performance Audit Services

**Health Data and Management Solutions, Inc.** Decision Support Services

**PillarRx Consulting, LLC** Pharmacy Claims and Performance Audit Services

**The Segal Company Southeast Inc.** Consultant

**d/b/a Segal Consulting**

**Wm. Lynn Townsend, FSA, MAAA** Consulting Actuary

## Purpose and Goals

The purpose of this solicitation is to contract with a firm to provide pharmacy benefit management services including network pharmaceutical pricing through financial arrangements with pharmacies. The pharmacy network provided by the PBM must contain a sufficient number of pharmacies to provide to all participants adequate access, in-state as well as out-of-state, as determined cooperatively by the PBM and the Board. The pharmacy network will provide the Plan with a cost-effective network of pharmacies contracted at rates that are commensurate with the size of the Plan and its associated purchasing power. The PBM will provide clinical programs cost containment such as prior authorization, step therapy and specialty drug management, and a mail order distribution channel. The Board expects the PBM to be proactive in making recommendations that control costs.

The Board’s goal is to have a customizable formulary which provides access for our participants to clinically effective FDA-approved medications at the lowest net cost and to exclude any medications with proven low efficacy rates and high cost medications when lower cost clinically effective medications are available. The Board prefers to exclude overpriced medications which are simply reformulations of lower cost medications or combinations. It is the Board’s intent to have a fully transparent/pass-through financial pricing arrangement with the PBM. “Transparency” refers to financial arrangements which represent a direct and complete pass-through of all elements of negotiated provider pricing (e.g. discounts and dispensing fees, etc.). The Board must receive the full and complete amount of any discounts and rebates received by the PBM from any and all retail pharmacies, and manufacturer rebates. The PBM will not retain a differential between the amount reimbursed to the PBM by the Board for each transaction and the payments made to the retail pharmacies by the PBM or rebates. (See rebates definition in ***Section 3 – Definitions***.)

The only compensation the PBM will receive from or on behalf of the Board, for the services described in this proposal or any subsequent contract, shall be the PBM’s quoted administrative fees listed in the PBM’s proposal, or agreed upon in writing through subsequent discussion with the Board.

## Instructions to Proposers

**Proposals must be received in DFA’s Office of Insurance in Jackson, Mississippi by 2:00 p.m. CT on Tuesday, April 7, 2020. Any proposal received after the deadline will not be considered. Proposals submitted by fax or by electronic mail will not be considered.**

* + 1. Proposals must be submitted in writing to the following address:

**Pharmacy Benefit Manager Services RFP**

**c/o DFA - Office of Insurance**

**501 North West Street**

**Suite 901-B Woolfolk Building**

**Jackson, Mississippi 39201**

To prevent opening by unauthorized individuals, all copies of the proposal, including any and all attachments, must be sealed in one or more packages, and the package(s) **must be marked,** “**Proposals – Do Not Open**.”

1. Submit one (1) clearly marked printed original proposal, including any and all attachments. The proposal should include and be tabbed as follows:

Tab 1 – Introduction/Signed Proposal Cover Letter

Tab 2 – **Section 2** ***–*** Minimum Vendor Requirements Confirmation

Tab 3 – **Section 3** – Definitions

Tab4 – **Section 4** ***–*** Scope of Services Confirmation

Tab 5 – **Section 5** ***–*** Performance Standards

Tab 6 – **Section 6** ***–*** Questionnaire with Responses

Tab 7 – **Section 7** ***–*** References

Tab 8 – **Section 8** ***–*** Service Plan

Tab 9 – **Section 9** ***–*** Claims Re-Pricing

Tab 10 – **Section 10** ***–*** Fee Schedule

Tab 11 – **Section 11** ***–*** Signed Statutory Requirement Disclosure Statement

Tab 12 – **Section 12** ***–*** Signed Statement of Compliance

Tab 13 – Signed Acknowledgment of RFP Amendments (if any)

Tab 14 – Résumés for Key Staff

Tab 15 – Any Additional Information

1. Number each page of the proposal. Multiple page attachments and samples should be numbered internally within each document, and not necessarily numbered in the overall page number sequence of the entire proposal. The intent of this requirement is that the proposer submit all information in a manner so that it is clearly referenced and easily located.
2. In addition to the printed proposal, provide one electronic copy of the complete proposal including all attachments in a searchable Microsoft Office® format, preferably in Word® or Portable Document Format (PDF®) on flash drive or compact disc.
3. In addition to the electronic copy of the complete proposal, provide one electronic “blind” copy of your proposal including “blind” copies of all attachments and referenced documents with **all** vendor-identifying information removed and/or redacted. Vendor-identifying information includes but may not be limited to your firm’s name, logo, slogan, color scheme, as well as the names/identities of any of your staff. The “blind” copy shall also not include Tab 9, Claims Re-Pricing, Tab 10 or Tab 14. Fee Schedule or any other pricing information. This requirement is necessary to help ensure the anonymity of the proposers from the evaluation team that will review the aforementioned sections of your proposal. The “blind” copy should be provided in a searchable Microsoft Office format, preferably in Word. **It is mandatory that your electronic “blind” copy submission not contain any vendor-identifying information or pricing information from Section 9 – Claims Re-Pricing or Section 10, Fee Schedule. Proposals containing vendor-identifying information may be disqualified.**
4. Upon the execution of the NDA and confirmation of meeting the Minimum Vendor Requirements, the proposer will receive a sanitized historical claims file directly from Segal Consulting. The re-pricing of this file shall be submitted with the proposal as Tab 9.
5. The Board understands that the proposer may consider some of the information provided in the proposal to be confidential and/or proprietary. If any portion of the proposal is considered confidential or proprietary, the proposer shall also include an additional electronic “redacted” copy in PDF® of the complete proposal, including all appendices and exhibits, with all trade secrets or confidential commercial or financial information redacted. If the proposal does not contain any confidential information to be redacted, please state such in your Introduction/Signed Proposal Cover Letter. **Failure to submit an electronic “redacted” copy of your proposal or include a statement that no information will be redacted may cause your proposal to be considered incomplete and it may be rejected from consideration.**
6. Note that submitted proposals, including accompanying attachments, are subject to the “Mississippi Public Records Act of 1983,” codified as Miss. Code Ann. §§ 25-61-1 *et seq.*, (1972, as amended) and exceptions found in Miss. Code Ann. § 79-23-1 (1972, as amended DFA understands that the proposer may consider some of the information provided in the proposal to be trade secrets and/or proprietary. If any portion of the proposal is considered confidential or proprietary, DFA requests that each page of the printed proposal that the proposer considers confidential be conspicuously marked by being printed on a different color paper than non-confidential pages and be marked in the upper right hand corner of each page with the word “CONFIDENTIAL.” Confidential information may be identified by alternate font color and/or type on electronic copies of the proposal. **Failure to clearly identify trade secrets or confidential commercial or financial information may result in that information being immediately released subject to a public records request.**  Failure to secure a protective order through the chancery courts in the State of Mississippi may result in all information, even if previously identified as “confidential”, being released in response to a public records request.
7. In accordance with *Mississippi Public Procurement Review Board Office of Personal Service Contract Review Rules and Regulations Item 1-301*, “Any party seeking a protective order on a procurement contract awarded by state agencies shall give notice to and provide the reasons for the protective order to the party requesting the information in accordance with the Mississippi Rules of Civil Procedure. The notice and reasons for the protective order must also be posted on the Mississippi Procurement Portal for a minimum of seven (7) days before filing the petition seeking the protective order in a chancery court. Any party seeking a protective order in violation of this subsection may be barred by a state agency from submitting bids, proposals or qualifications for state procurements for a period not to exceed five (5) years.” Any records requested through a public records request shall be released no later than twenty-one (21) days from the date the third parties are given notice by the public body unless the third parties have followed the notification requirements and also filed in chancery court a petition seeking a protective order on or before the expiration of the twenty-one day time period.
8. Please respond to ***Section 4 – Scope of Services*** by restating each service listed and confirm your intention to provide the service as described by responding, “*Confirmed*”. If your firm can provide the service, but not exactly as described, respond, “*Confirmed, but with exceptions*”, and state the specific exceptions. If your firm intends to provide a listed service through a subcontractor, respond, “*Confirmed, service will be provided through subcontractor*”, and name the subcontractor. If your firm is currently unable to provide a listed service, respond by stating, “*Unable to provide this service*”. Any additional details regarding these services should be provided in your responses to the questionnaire, or as additional information included as an appendix to your proposal.
9. In preparing your written response to any RFP question or request for information, you are required to repeat each question, including the number, or requirement followed by your response. Please provide complete answers and explain all issues in a concise, direct manner. If you cannot provide a direct response for some reason (e.g., your firm does not collect or furnish certain information), please indicate the reason rather than providing general information that fails to answer the question. “Will discuss” and “will consider” are not appropriate answers.
10. Please respond to ***Section 5 – Performance Standards*** by restating each performance standard listed and confirm your agreement to be bound by this standard by stating, “*Confirmed*”. If your firm has exceptions to the standard, respond by stating, “*Confirmed, but with exceptions*”. Your exceptions should be included in ***Section 12 – Statement of Compliance***. If your firm cannot agree to the standard, respond by stating, “*Do Not Agree*”. Your reason for not agreeing should be included in ***Section 12 – Statement of Compliance***.
11. All information requested is considered important. If you have additional information you would like to provide, include it as Tab 15 to your proposal. It is the proposer’s sole responsibility to submit information relative to the evaluation of its proposal and the Board is under no obligation to solicit such information if it is not included with the proposal. The Board will use the information contained in your proposal in determining whether you will be selected for contract negotiations. The Board will consider the proposal an integral part of the contract and will expect you to honor all representations made in your proposal.
12. If the Board determines that the proposer has altered any language in the original RFP, the Board may, at its sole discretion, disqualify the proposer from further consideration. The RFP issued by the Board is the official version and will supersede any conflicting RFP language subsequently submitted in proposals.
13. All documentation submitted in response to this RFP and any subsequent requests for information pertaining to this RFP shall become the property of the Board and will not be returned to the proposer.
14. Failure to provide all requested information and in the required format may result in disqualification of the proposal. The Board has no obligation to locate or acknowledge any information in the proposal that is not presented under the appropriate outline according to these instructions and in the proper location.

## Important Dates

***NOTE: The Board reserves the right to adjust this schedule, as it deems necessary.***

|  |  |
| --- | --- |
| **February 11, 2020** | RFP Released |
| **March 5, 2020** | Required "Intent to Propose" letter and Non-Disclosure Agreement due to DFA – Office of Insurance |
| **March 5, 2020** | "Questions" due to DFA - Office of Insurance |
| **March 10, 2020** | Board Responses to Questions to be posted |
| **April 7, 2020 by 2:00 PM CT** | Proposals Due at DFA - Office of Insurance |
| **May 5, 2020** | Finalists Selected |
| **Week of May 11, 2020** | Presentations by Finalists\* |
| **May 27, 2020** | Notice of Intent to Award Distributed |
| **May 29, 2020** | Notice of Contract Award Published |
| **January 1, 2021** | Contract Effective Date |

\*The Board anticipates proposers selected as finalists will make presentations in Jackson, Mississippi. The Board shall not be responsible for any expenses incurred by the proposer for such presentation. Due to the constraints of the RFP timeline and the relative importance of presentations in the evaluation process, interested vendors are encouraged to be prepared to accommodate this schedule.

## Mandatory Intent to Propose

**All proposers are required to indicate their intention to propose and return a signed copy of the Non-Disclosure Agreement (NDA) *(Appendix C)* by 5:00 PM CT on March 5, 2020.** The NDA shall be signed by an officer, principal or owner. **Failure to submit an Intent to Propose and the signed NDA will disqualify proposer from being considered for these services.** These documents may be submitted via e-mail to [InsuranceRFP@dfa.ms.gov](mailto:InsuranceRFP@dfa.ms.gov), but an original hardcopy is also required. The original copy should be delivered to 501 N. West Street, Suite 901-B Woolfolk Building, Jackson, Mississippi 39201 and must be received by the deadline for submitting the electronic copy. Your intent to propose should indicate your organization’s primary contact, direct telephone number of contact, e-mail address, and facsimile number. The submission of an Intent to Propose does not obligate your firm to submit a proposal. A signed NDA is required in order to receive the claims file for re-pricing, which is required to be submitted with your proposal (see ***Section 9 – Claims Re-Pricing*** for details).

## Questions and Acknowledgment of Responses

Questions from potential proposers must be submitted in writing via email to [InsuranceRFP@dfa.ms.gov](mailto:InsuranceRFP@dfa.ms.gov) and must be received no later than **5:00 PM CT,** **March 5, 2020**, to ensure a response by the Board by the March 10, 2020 deadline. Responses to questions will be made available on DFA’s website under the heading “Bid and RFP Notices” at <http://www.dfa.ms.gov/bid-rfp-notices/> as an amendment to the RFP on March 10, 2020. Questions received after March 5, 2020, may be considered for response at the Board’s discretion, although there is no guarantee as to if or when the Board will respond. It is the proposer’s sole responsibility to regularly monitor the website for amendments and/or announcements concerning this RFP.

## Statutory Requirements

In accordance with Section 25-15-9(1)(a) of the Mississippi Code Annotated, each entity that submits a proposal in response to this RFP must provide a signed disclosure statement detailing any services or assistance it provided during the previous fiscal year to the Board and/or DFA in the development of the Plan. The statement must include a detailed description of the vendor’s participation in the development of the Plan, as well as any resulting compensation received from the Board and/or DFA during the previous fiscal year. If you did not provide such assistance to the Board and/or DFA, you must indicate in your signed disclosure statement that this provision does not apply to you. A list of persons, agents, and corporations who have contracted with or assisted the Board in preparing and developing the Mississippi State and School Employees’ Health Insurance Plan and a copy of the statutory requirement are contained in ***Section 11 – Statutory Requirement***.

## Statement of Compliance Requirement

Please carefully review the information located in***Section 12 – Statement******of Compliance*** and include a copy **signed by an officer, principal, or owner** of your firm with your completed proposal. Failure to submit a signed Statement of Compliance may result in your proposal being eliminated from further consideration. If you object to any of the terms and conditions included in the *Draft Pharmacy Benefit Manager Services Contract* (see Appendix A), or any requirements listed in this RFP, please note and explain your objections on the Statement of Compliance.Clauses in *italic* **blue** type in the *Draft Pharmacy Benefit Manager Services Contract* (see Appendix A) are deemed mandatory and are nonnegotiable.

## Corrections and Clarifications

The Board reserves the right to request clarifications or corrections to proposals. Any proposal received which does not meet any of the requirements of this RFP, including clarification or correction requests, may be considered non-responsive and eliminated from further consideration.

## Right of Negotiation

Discussions and negotiations regarding price and other matters may be conducted with a proposer who submits a proposal determined to have reasonable likelihood of being selected for award, but a proposal may be accepted without such discussions. The Board reserves the right to further clarify and/or negotiate with the proposer evaluated best following completion of the evaluation of proposals but prior to contract execution, if deemed necessary by the Board. The Board also reserves the right to move to the next best proposer if negotiations do not lead to an executed contract with the best proposer. The Board reserves the right to further clarify and/or negotiate with the proposer on any matter submitted.

## Acknowledgment of RFP Amendments

Should an amendment to the RFP be issued, it will be posted on DFA’s website under the heading “Bid and RFP Notices” at <http://www.dfa.ms.gov/bid-rfp-notices/>. Proposers must acknowledge receipt of any amendment to the RFP by signing and returning the amendment form with the proposal, by identifying the amendment number and date in the space provided for this purpose on the amendment form, or by letter. The acknowledgment must be received by DFA by the time and at the place specified for receipt of proposals. Please monitor the website for amendments to the RFP. Board responses to questions will be treated as amendments to the RFP and will require acknowledgment.

## Modification or Withdrawal of a Proposal

A proposer may withdraw a submitted proposal by submitting a written notification for its withdrawal to the Board, signed by the proposer, and e-mailed, or mailed to the Board at the address provided in ***Section 1.3 Instructions to Proposers*** prior to the time and date set for proposal opening. The Board shall not accept any amendments, revisions, or alterations to proposals after the due date unless requested by the Board. Late proposals shall not be considered for award and the proposer shall be so notified as soon as practicable.

## Cost of Proposal Preparation

All costs incurred by the proposer in preparing and delivering its proposal, making presentations, and any subsequent time and travel to meet with the Board regarding its proposal shall be borne at the proposer’s expense.

## Proposal Evaluation

All proposals received in response to this RFP by the stated deadline will receive a comprehensive, fair, and impartial evaluation. An evaluation committee will evaluate the proposals using a three-phase process, consisting of Compliance, Analysis, and Finalist phases. For proposals determined to be compliant and responsive to the RFP, consensus scoring will be used in the evaluation process using a 100-point scale. For proposals ultimately determined to be finalists, points may be added or deducted based on presentations and site visits, if applicable. Consensus scoring involves a solidarity or general agreement of opinion among evaluators, based on information and data contained in the RFP responses. The services of the Board’s consultant, Segal Consulting, will be utilized in the evaluation of ***Section 9 – Claims Re-Pricing*** and ***Section 10 - Fee Schedule***. The evaluation of any proposal may be suspended and/or terminated at the Board’s discretion at any point during the evaluation process at which the Board determines that said proposal and/or proposer fails to meet any of the mandatory requirements as stated in this RFP, the proposal is determined to contain fatal deficiencies to the extent that the likelihood of selection for contract negotiations is minimal, or the Board receives reliable information that would make contracting with the proposer impractical or otherwise not in the best interests of the Board and/or the state of Mississippi. The evaluation process, including evaluation factors and weights, is described below:

**Compliance Phase** - In this phase of the evaluation process, all proposals received will be reviewed by the procurement manager and/or designee to determine if the following mandatory requirements of this RFP have been satisfied:

1. **Original** copies of the Letter of Intent and Non-Disclosure Agreement submission deadline met
2. Proposal submission deadline met
3. Required format followed:
   * + - 1. Signed original complete printed proposal
         2. Electronic copy of complete proposal, including attachments in searchable Microsoft Office® format, preferably in Word® or Portable Document Format (PDF®) on flash drive or compact disc
         3. An electronic redacted copy of complete proposal, including attachments (as applicable)
         4. An electronic “blind” copy of your proposal, including “blind” copies of all attachments and referenced documents (as applicable)
4. Duration of proposal requirement met
5. Minimum Vendor Requirements met
6. Scope of Services Confirmation submitted
7. Performance Standards (Section 5) provided
8. Questionnaire (Section 6) answered
9. References (Section 7) provided
10. Service Plan (Section 8) answered
11. Claims Re-Pricing (Section 9) submitted
12. Fee Schedule (Section 10) provided
13. Signed Statutory Requirement Disclosure Statement (Section 11)
14. Signed Statement of Compliance with high degree of acceptance (Section 12)
15. Signed Acknowledgement of RFP Amendment(s) (Section 13), including the amendment with the Board’s Responses to Questions, if any posted
16. Résumés for Key Staff (Section 14)
17. Required proposal attachments provided, if any, and any additional information (Section 15)

Failure to comply with these requirements may result in the proposal being eliminated from further consideration. Those proposers passing the Compliance Phase will be evaluated further. The Board reserves the right to waive minor informalities in a proposal in this phase of the evaluation.

**Weight – The Compliance Phase of the evaluation is considered pass/fail.**

**Analysis Phase** **–** In this phase of the evaluation process, the evaluation committee will utilize consensus scoring to determine numerical scores for each qualified, but de-identified, proposal received, relative to the technical and management factors of each proposal. The procurement manager and/or designee will not participate in the numerical scoring of Technical and Management factors (as described below), but will evaluate the Cost factor for each qualified proposal. Evaluation factors are listed in order of their relative importance and weight:

1. Cost (Weight/Value – 50%) – The competitiveness of the proposed fees.
2. Technical (Weight/Value – 35 %) – The quality and completeness of the proposer’s solutions and action plans for providing the services identified, demonstrating understanding, responsiveness, effectiveness, efficiency, and value to the Board in proposed approach.
3. Management (Weight/Value – 15%) – The personnel, equipment, and facilities to provide timely access to pharmacy benefit manager services for a plan of comparable size; the ability to technically implement and maintain the structure and resources for providing all services listed in this RFP, demonstrating where applicable the ability to perform the service reflected by technical training, education and general experience of staff and a documented record of past performance of providing pharmacy benefit manager services.

Upon completion of the Analysis Phase, the evaluation committee will review and compare the numerical scores from among the remaining qualified vendors in order to determine finalists. The top scoring vendor, as well as all other vendors with scores within ten points of the top scoring vendor, will be named as finalists and will be further evaluated.

**Finalist Phase** **–** In this phase of the evaluation process, the evaluation committee will seek to determine from among the finalists whose proposal is the most advantageous to the Board. Points may be awarded or deducted as part of the finalist evaluation process based on the finalist presentation. This phase consists of the following components:

1. Record of Past Performance of Similar Work (Experience and Qualifications) – From among the finalists, client references will be contacted to verify demonstration of an acceptable level of past performance for programs of a similar size and complexity as the Board. **Weight/Value – This component of the evaluation is considered pass/fail.**
2. Finalist Presentations – At the Board’s discretion, finalists may be required to make a presentation to the evaluation committee. If scheduled, individual finalist presentations shall be held in Jackson, Mississippi, to allow the evaluation committee the opportunity to conduct technical interviews of the finalists, and to confirm/clarify information provided in the submitted proposals or otherwise gathered during the evaluation process. **Weight/Value – A maximum of 5 points may be added to or subtracted from the finalist’s numerical score derived from the Analysis Phase.**
3. Best and Final Offer – At the Board’s discretion, all finalists may be given the opportunity to provide a “best and final offer” relative to their financial proposal. The Board will notify finalists if a “best and final offer” may be submitted, and will establish a date and time for submission. Although a finalist is under no obligation to submit such an offer, any such “best and final” offer should include any applicable revised financial exhibits and must be signed by an appropriate representative of your firm. If a finalist chooses to not make a “best and final offer”, the financial proposal included in your firm’s response to the Request for Proposal will be considered as the “best and final offer”. NOTE: Unsolicited “best and final offers”, including but not limited to such offers submitted by non-finalists, will not be accepted. **Weight/Value – The numerical scores for the Cost factor from the Analysis Phase will be adjusted for any “best and final offer” received from a finalist.**
4. Upon completion of the evaluation of proposals, the evaluation committee will determine the top scoring proposal and provide a recommendation to the Board. The Board will make a determination as to the proposal deemed most advantageous to the Board and will authorize the issuance of an intent to award the contract to the selected vendor and authorize contract negotiations with the selected vendor. Subsequent to such authorization by the Board, all proposing vendors will be notified in writing of the contract award and will be afforded the opportunity to participate in a post-award debriefing.

## Post-Award Vendor Debriefing

Subsequent to the contract award, any proposing vendor may request a post-award debriefing, in writing, by U.S. mail or electronic submission. The request must be made within three (3) business days of distribution of the Notice of Intent to Award. A debriefing is a meeting and not a hearing. Therefore, legal representation is not required. Should the vendor prefer to have legal representation present, the vendor must notify DFA and identify the attorney. DFA shall be allowed to schedule and/or suspend and reschedule the debriefing at a time when a representative from the Office of the Mississippi Attorney General’s office can be present. For additional information regarding the process and procedure for the Post-Award Vendor Debriefing, please refer to the Mississippi Public Procurement Review Board Office of Personal Service Contract Review’s website at <http://www.dfa.ms.gov/dfa-offices/personal-service-contract-review/pscrb-rules>

## Right to Consider Historical Information

The Board reserves the right to consider historical information regarding the proposer, whether gained from the proposer’s proposal, conferences with the proposer, references, or any other source during the evaluation process. This may include, but is not limited to, information from any state or federal regulatory entity.

## Right to Reject, Cancel and/or Issue Another RFP

The Board specifically reserves the right to reject any or all proposals received in response to the RFP, cancel the RFP in its entirety, or issue another RFP.

# MINIMUM VENDOR REQUIREMENTS

The following minimum vendor requirements are mandatory. Failure to meet any of these requirements will result in disqualification of the proposal submitted by your firm. Please respond by restating each requirement, including the number, listed below with documentation that proves specifically how your firm meets that requirement. Please include in your responses the total number of years and types of experience of your firm. If, in the opinion of the evaluation committee, you fail to prove that your firm meets any of these minimum requirements, the proposal will be disqualified from further evaluation. If this happens, you will be notified of the decision and will have an opportunity to provide additional information to prove your firm does meet the minimum requirements. It is incumbent upon the disqualified vendor to respond timely and completely to any such notice as unreasonable delays and/or non-responsive submissions may result in the disqualification being upheld without further review.

**Please respond by restating each minimum vendor requirement and document how your firm meets these minimum criteria.**

1. The proposing vendor must provide services to at least one million (1,000,000) covered lives in its book of business as of January 1, 2020. The proposing vendor must provide sufficient detail to demonstrate it has significant experience in working with programs similar in size and complexity to the Plan. For each client, please specify:
2. Client name, include the name, title, address, e-mail address, and phone number of a person whom we may contact to confirm as needed,
3. The type of work your firm provided to the client,
4. The number of covered lives in the client’s group,
5. Contract effective dates for the time period(s) (beginning and end dates) your firm provided services to the client.
6. The proposing vendor must provide services to one employer client with at least one hundred thousand (100,000) covered lives as of January 1, 2020. The proposing vendor must provide sufficient detail to demonstrate it has significant experience in working with programs similar in size and complexity to the Plan. For each client, please specify:
7. Client name, include the name, title, address, e-mail address, and phone number of a person whom we may contact to confirm as needed,
8. The type of work your firm provided to the client,
9. The number of covered lives in the client’s group,
10. Contract effective dates for the time period(s) (beginning and end dates) your firm provided services to the client.
11. The proposing vendor must have at least eight years’ experience as of January 1, 2020, in providing the type and scope of services to be procured through this competitive process. The proposing vendor must provide sufficient detail to demonstrate it has significant experience in working with programs similar in size and complexity to the Plan. For each client, please specify:
12. Client name, include the name, title, address, e-mail address, and phone number of a person whom we may contact to confirm as needed,
13. The type of work your firm provided to the client,
14. The number of covered lives in the client’s group,
15. Contract effective dates for the time period(s) (beginning and end dates) your firm provided services to the client.
16. The proposing vendor must agree to secure an implementation bond or escrow account in the amount of one million dollars ($1,000,000) naming the Board as exclusive beneficiary to guarantee timely and complete establishment of the contract and related services. Such bond or escrow account must be secured within thirty (30) days of the date the contract is executed. Any failure of the PBM to perform timely and complete establishment of such services shall result in damages recoverable by the Board against the PBM’s implementation bond or escrow account. Upon the Board’s agreement that the PBM has complied with its responsibilities for establishing the pharmacy benefits management program and related administrative services, the implementation bond or escrow account shall be released. This requirement will not apply if the incumbent PBM with services established under the current contract is selected through this procurement process to enter into negotiations for the new contract.
17. Please confirm your agreement to comply with Mississippi Code § 25-15-301(6) as follows:

“Any corporation, association, company or individual that contracts with the board for the administration or service of the self-insured plan shall remit one hundred percent (100%) of all savings or discounts resulting from any contract to the board or participant, or both. Any corporation, association, company or individual that contracts with the board for the administration or service of the self-insured plan shall allow, upon notice by the board, the board or its designee to audit records of the corporation, association, company or individual relative to the corporation, association, company or individual's performance under any contract with the board. The information maintained by any corporation, association, company or individual, relating to such contracts, shall be available for inspection upon request by the board and such information shall becompiled in a manner that will provide a clear audit trail.”

1. All services directly related to the required pharmacy benefits management services must be performed within the United States. Indicate your agreement with this requirement and identify any locations outside the State of Mississippi in which you propose to provide the services described in this RFP.
2. The proposing vendor shall be in compliance with Mississippi Code Annotated § 79-4-15.01 regarding authorization to transact business in Mississippi.

# DEFINITIONS

1. “Allowable Charge” means the lesser of the amount payable under the terms of the pharmacy’s contract with the PBM for a covered medication or the cash price inclusive of all applicable customer discounts which a cash paying customer of the pharmacy pays for a covered medication.
2. “AWP” means the “average wholesale price” for a standard package size of a prescription drug from the most current pricing information provided to PBM by Medi-Span Prescription Pricing Guide, or following approval by the Board, any other nationally available reporting service of pharmaceutical prices as utilized by PBM as a pricing source for prescription drug pricing. The AWP used is based on the date sensitive 11-digit national drug code (NDC) of the actual package size dispensed as set forth by Medi-Span on the date the claim is dispensed.
3. “Brand Name Drug” means drug that has a trade name and is protected by a patent. A brand name drug may only be produced and sold by the pharmaceutical company holding the patent or a pharmaceutical company that has been licensed and authorized by the patent holder to produce and sell the drug. Medi-Span Multi-Source Indicator will be used for calculating aggregate financial guarantees. For prescription drug claims processed where the underlying prescription drug product is identified having a Multi-Source indicator code identifier of “M”, “N”, or “O” on the date dispensed, the claim should be considered a Brand claim unless otherwise noted as an exclusion. Claims processed where the Multi-Source indicator is a “Y” on the date dispensed will be considered as Generic claims.
4. “Compound Drug” shall mean a formulation containing one or more “Drug Products”, which is extemporaneously weighed or measured then prepared by a pharmacy in accordance with a physician’s prescription order. A compound drug prescription meets the following criteria: two or more solid, semi-solid or liquid ingredients, at least one of which is a covered medication that is not commercially available. Compound drug claims will only be covered for medications for which the compounded product is not commercially available.
5. “Copayment” means that portion for a covered presciption which, under the terms of the Plan, is required to be paid by the participant directly to the pharmacy. The Employee will pay the lower of:

(i) the copayment, coinsurance or deductible;

(ii) the plan-negotiated discount price contracted rate, plus dispensing fee; or

(iii) the pharmacy’s usual and customary charge for the drug product, MAC (maximum allowable cost) or retail cash price.

1. “Covered Service” means a prescription drug provided under the terms of this contract for which payment may be requested under terms of the Plan.
2. “Employee” means an eligible person who has satisfied the specifications of the Plan’s Plan Document’s eligibility guidelines and has enrolled for coverage under the Plan. Unless otherwise, “Employee” refers to an active employee, a retired employee or a COBRA participant.
3. “Formulary” means the PBM’s Performance Drug List (PDL), which is a list of preferred pharmaceutical products, created and maintained by the PBM, as amended from time to time, which: (a) has been approved by PBM’s pharmacy and therapeutics committee; (b) reflects the PBM’s recommendations as to which pharmaceutical products should be given favorable consideration by plans and their participants; and (c) includes all standard clinical programs, including but not limited to prescribing guidelines such as prior authorization, step therapy, and quantity level limits, if elected by the Board.
4. “Generic Drug” means a drug that is therapeutically equivalent (identical in strength, concentration, and dosage form) to a Brand Name Drug and that generally is made available when patent protection expires on the Brand Name Drug. The Board’s expectation is that Medi-Span Multi-Source Indicator will be used for calculating aggregate financial guarantees. For prescription drug claims processed where the underlying prescription drug product is identified having a Multi-Source indicator code identifier of “M”, “N”, or “O” on the date dispensed, the claim should be considered a Brand claim unless otherwise noted as an exclusion. Claims processed where the Multi-Source indicator is a “Y” on the date dispensed will be considered as Generic claims.
5. “Health Insurance Portability and Accountability Act (HIPAA)” shall refer to the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191.
6. “Health Management Vendor” means the vendor that provides health management services to the Plan including, but not limited to, hospital management services, continued stay management, discharge planning, retrospective review, review of high cost diagnostic procedures, and medical necessity review for specified medical services. This vendor also provides wellness and health promotion, case management, and disease management services.
7. “Limited Distribution Drugs” means specialty drugs which are distributed to either one (1) or a very limited number of pharmacies, distributors or wholesalers.
8. “Maximum Allowable Charge” means the maximum reimbursement payable to a Participating Provider for Covered Services under the terms of this Contract.
9. “Maximum Allowable Cost” or “MAC” means the unit price that has been established by the PBM for a multi-source drug (i.e., a drug with more than two sources) included on the MAC drug list applicable to the Board, which list may be amended from time to time by the PBM in maintaining its generic pricing program. A copy of such MAC drug list shall be provided to the Board prior to execution of this contract and thereafter upon the Board’s reasonable request.
10. “Network Pharmacy” means a retail pharmacy, home delivery pharmacy, specialty pharmacy or other facility that is duly licensed to operate as a pharmacy and is owned or operated by the PBM (or an affiliate) or has entered into a Network Pharmacy Agreement.
11. “Paid Claims” means as all transactions made on eligible participants that result in a payment to pharmacies or participants from the Plan or the Plan participant copayments. (Does not include reversals, rejected claims and adjustments.) Each unique prescription that results in payment shall be calculated separately as a paid claim.
12. “Participant” means an individual who is eligible to receive prescription drug services for which payment may be sought under the terms of the Plan.
13. “Participating Provider” means a pharmacy or pharmacist which has entered into a contract with the PBM to provide prescription drug services under this contract. All pharmacists employed by a Participating Provider are subject to all requirements imposed on Participating Providers under this Contract.
14. “Pharmacy Benefit Manager (PBM)” means the entity that administers the prescription drug portion of the Plan. The PBM is expected to provide pharmacy claims processing, mail order pharmacy services, and other services, such as rebate negotiations with drug manufacturers, development and management of pharmacy networks, Formulary management, drug utilization review programs, generic drug substitution, and disease management programs.
15. “Plan” means the self-insured Mississippi State and School Employees’ Health Insurance Plan as defined in Mississippi Code Annotated § 25-15-1 et. seq.
16. “Plan Document” means the document that states the benefits and eligibility terms of the Plan. The Plan Document is published and maintained by the Board. All benefits under the Plan are subject to the Plan Document.
17. “Rebate” means any compensation or remuneration of any kind received or recovered by the PBM, or any of its affiliates 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, or any of its affiliates, receives from a pharmaceutical manufacturer for administrative costs, formulary placement, and/or access.
18. “Specialty Drug” means pharmaceutical products that are typically expensive and require special handling and monitoring such as patient training, care coordination, adherence monitoring. They can be administered orally or through injection, infusion, inhalation, or other non-oral methods. Many are biologically developed (biologics) and can be used to treat chronic, life threatening, and rare conditions.
19. “Specialty Pharmacy” means a contracted pharmacy providing Specialty Drugs, including any specialty pharmacies owned by the PBM.
20. “Third Party Claims Administrator” means the organization under contract to the Board responsible for processing all medical claims, other than claims for prescription drug services, received from participants.
21. “Usual and Customary” or “U&C” means the amount a participating provider would charge to a cash paying customer for same strength, quantity, and dosage form of a covered drug, as of the date the prescription is filled.

# SCOPE OF SERVICES

This section contains information on services and procedures that the pharmacy benefit manager must provide, or adhere to, in servicing the Board’s account, either directly or through identified subcontractors. The descriptions are not all-inclusive, but are provided to alert you to services or procedures that may require additional planning or programming on your part. A description of the Plan’s current prescription drug copayment program is included in *Appendix B – 2020 Plan Document*.

For the services, please respond by restating each service listed, including the number, and confirm your intention to provide the service as described, respond by stating, “*Confirmed*”. If your firm can provide the service, but not exactly as described, respond by stating, “*Confirmed, but with exceptions*”, and state the specific exceptions. Any exceptions should also be noted in ***Section 12 – Statement of Compliance***. If your firm is currently unable to provide a listed service, respond by stating, “*Unable to provide this service”.* Any additional details regarding these services should be provided in your responses to the questionnaire, or as additional information included as an appendix to your proposal.

The PBM is expected to provide the following services:

## Account Service

1. The PBM must assign a dedicated, but not necessarily exclusive, account manager to participate in activities relative to all aspects of the contract between the Board and the PBM, and to meet with DFA staff on a quarterly basis to review Plan utilization, attend meetings with the Board’s meetings (if requested), and make recommendations regarding services and/or programs on a quarterly basis, to discuss performance, address administration issues and review reports. Please confirm that you agree to this.
2. The PBM must employ and assign a dedicated and exclusive clinical pharmacist to advise, consult, and participate in activities relative to all aspects of the contract between the Board and the PBM. Duties of the clinical pharmacist will include, but are not limited to, reducing wasteful spending through analysis and provider education, providing advice regarding drugs for which the Plan may require prior authorization for coverage, notification of blockbuster or pipeline drugs, FDA approval of new drugs, and education regarding therapeutic substitutions. The clinical pharmacist will be provided office space within the DFA – Office of Insurance, and must also reside in the State of Mississippi to participate in employer health/benefit fairs, and visit physician offices and pharmacies to discuss the preferred drug list, use of generics, prescribing and utilization patterns, and educate the provider community on the most up-to-date drug therapies. Though not an employee, nor under the direct supervision of the State, the clinical pharmacist will be expected to be physically present in the office during normal business hours to facilitate direct access by Board staff, except when offsite fulfilling other duties for the Plan. PBM must provide computer and other necessary equipment.
3. The PBM must provide consultative services regarding pharmacy benefit design including, but not limited to, formularies, allowable charges, generic drug incentives, implementation of programs which control utilization and optimize health, utilization review services, and evaluation of drug use and cost data.
4. The PBM is responsible for maintaining an adequate customer service staff to respond to inquiries from participants, providers, and DFA staff regarding the services provided by the PBM through a toll free telephone line. The service shall be available 24 hours, 7 days a week, other than scheduled maintenance times, to participants and providers.
5. The PBM is required to conduct at least one (1) customer satisfaction survey within the third quarter of the initial contract period and one (1) annually thereafter. The contents of the satisfaction survey must be agreed upon by the Board and the PBM.
6. The PBM is required to participate in activities with the TPA and/or DFA staff in responding to participant or provider inquiries or complaints relating to pharmacy benefit services.
7. The PBM, at its own expense, is required to participate in health/benefit fairs to educate participants.
8. The PBM must cooperate with the Board and with all other contractors of the Board with respect to the ongoing coordination and delivery of health care services, and in any transition of responsibilities.
9. The PBM agrees to provide competent and proficient account management staff and promptly address and respond to any staffing concerns with DFA.

## On-Line Access for Board Staff

The PBM must provide to Board staff read-only access to its claims processing and eligibility system. Access by the Board’s staff must include, at a minimum, review of participant claims history and participant eligibility information. Additionally, the PBM agrees to allow access to its member website with a dummy login prior to the go-live date.

## Pharmacy Network Service

1. The PBM is responsible for the delivery of quality prescription drug services to participants through discount arrangements or other financial contracts with participating pharmacies. The PBM must maintain a pharmacy re-credentialing process at least every three years or as otherwise required by URAC or CMS.
2. The PBM is required to maintain a separate credentialing process for specialty and compound pharmacies. The PBM is required to provide an open credentialing process for specialty network without unnecessary restrictions such as limited application period, licensed in at 50 states, etc.
3. The PBM is required to provide on-line access to a directory of participating pharmacies, including their names, addresses and telephone numbers. Participating pharmacy information must be regularly maintained and updated.
4. The PBM agrees to notify DFA staff at least 60 days in advance regarding termination of a current pharmacy chain or independent pharmacy. PBM agrees to also notify impacted participants within 15 days of termination.
5. The PBM must include independent pharmacies in the proposed retail network and all guarantees proposed are inclusive of independent pharmacies.

## Staffing

The PBM will hire and maintain sufficient staff to meet the needs of the Board and the Plan’s participants.

## Communication Materials/Forms

The PBM, at its own cost, is responsible for designing, printing, and distributing brochures, preferred drug lists, and forms, cobranded, and with the Board’s approval, as necessary and required to establish and administer pharmacy services and programs. Communication materials/forms will be mailed to participants, employer units, and the Board.

## Identification Cards

The PBM, at its own cost, must provide routine distribution of ID cards, including printing, mailing, and postage. The PBM, at its own cost, will provide ID cards directly to the participant’s home address for (1) the initial enrollment of the Plan, (2) future new enrollees, (3) participants who change coverage category (e.g. single to family), and (4) replacement of lost cards. Participants with single coverage should receive one (1) ID card; participants with dependent coverage should receive at least two (2) ID cards. The information to be printed on each ID card will include, at a minimum, the participant’s name and identification number, Plan name, the PBM name and toll free customer service telephone number.

## Data Transfers and File Maintenance Requirements

1. The PBM will receive updated eligibility information from the Board’s TPA based on the current specifications. It is the PBM’s responsibility to coordinate the data transfer with the Board’s TPA to ensure an efficient and accurate process. The PBM is also responsible for the electronic transfer of prescription drug claim information to the Board’s TPA for purposes of coinsurance maximum, out-of-pocket limit, and deductible accumulation.
2. The PBM is responsible for the electronic transfer of prescription drug claim information to the Board’s health management vendor, and for accepting the electronic transfer of information from the Board’s health management vendor relative to enrollment in the Plan’s tobacco cessation program or other programs that may require special pharmacy benefits.
3. The PBM is responsible for the electronic transfer of prescription drug claim information to the Board’s decision support services vendor. The Board currently contracts with Health Data and Management Solutions, Inc. (HDMS) for decision support services.

## Claims Processing Services

1. The PBM’s claims processing services must include, at a minimum, verification of eligibility, review of claims in accordance with the Plan benefits, receipt, processing, adjustment, and authorization of claim payments, provision of claim forms, and provision of explanation of benefit (EOB) forms for paper claims.
2. The PBM must maintain, at a minimum, the following information for all claims: participant name, participant identification number, patient name or other specific identifier, claim number, pharmacy number, pharmacy name, service date, mail/retail indicator, formulary flag, specialty indicator, ingredient cost, dispensing fee, sales tax amount, plan paid amount, copayment amount, NDC, and drug name.
3. The PBM must be able to accommodate multiple plan designs such as the Plan’s current Base Coverage and Select Coverage as described in *Appendix B – 2020 Plan Document*, and must be able to process claims with a deductible that is integrated with the medical plan deductible (i.e. Base Coverage).
4. The PBM must adjudicate all claims according to “lowest of” logic such that members and the Plan pay the lowest cost of the contracted price or the pharmacy’s usual and customary amount (including the pharmacy’s sale price, if any). PBM will not be allowed to adjudicate claims based on ‘zero balance logic” or on a minimum copayment amount, and retail pharmacies will not be allowed to collect a minimum payment.
5. Any pharmaceutical provider tax is to be paid by the PBM.

## Federal Reporting

As required by Federal law, the PBM, after discussions and negotiations with the Board, will prepare and file reports required by the Federal Government.

## Coordination of Benefits

The PBM is responsible for providing coordination of benefits (COB) services. The TPA provides information regarding a participant’s COB status to the PBM. The PBM must reject primary payment for participants for whom the Plan is secondary and must provide for secondary payment of prescription drug claims submitted, either electronically or by submission of a hard copy claim form to be obtained from the PBM. Benefits for secondary claims, are based upon the allowable charge, less the amount paid by the primary carrier, less the applicable copayment for that prescription drug. Any additional cost for this service must be included in the financial proposal.

## Quality Control

The PBM is responsible for quality control processes to regularly evaluate the performance and accuracy of the claims processing systems and the claims processing staff. Findings of quality control evaluations will be provided to the Board.

## Appeal Resolution

The PBM must provide an appeal process for claims partially or fully denied for payment upon the request of a participant or provider in accordance with guidelines outlined in the Plan Document at no extra cost to the Board.

## Prior Authorization Program

The PBM must provide prior authorization services to promote cost management while ensuring that participants can access needed prescription drugs. The prior authorization program must use evidence-based guidelines and the latest clinical literature and outcomes data, as well as FDA guidelines. The PBM will advise the DFA regarding those drugs for which the Plan may benefit by requiring prior authorization for coverage. The PBM's staff, under the supervision of clinical pharmacists, will review participant prescriptions for those drugs requiring prior authorization and/or medical necessity review in accordance with criteria, definitions and procedures developed by the PBM.

## Management Reporting

The PBM must provide management reports, with content and in a format approved by the Board, at no additional charge. These reports will be provided, at the Board’s request, in a hard copy and/or electronic format. The PBM must provide to assigned DFA staff access to web-based reporting tools for management and other reports. The PBM is also expected to have the capability of providing ad hoc reports at the Board's request.

## Drug Utilization Review (DUR)

The PBM is required to provide a concurrent, prospective and retrospective DUR system to assist pharmacy providers in screening certain drug categories for clinically important potential drug therapy problems at the time the prescription is dispensed to the participant. The DUR program must provide an evaluation of drug therapy before each prescription is filled by means of an online, real-time, electronic point-of-sale claims management system. Evaluation must include, at a minimum, monitoring for therapeutic appropriateness, over-utilization and under-utilization, appropriate use of generic products, and screening for potential drug therapy problems due to therapeutic duplication, drug-disease contraindications, drug interactions, incorrect drug dosage or duration of drug treatment, physician profiling, and clinical abuse/misuse and, as necessary, introduce remedial strategies in order to improve the quality of care of the participant.

## Step Therapy

The PBM is required to provide a step therapy program designed to optimize rational drug therapy while controlling costs by defining how and when a particular drug or drug class should be used based on a patient’s drug history.

## Dosage Optimization

The PBM is required to provide a dose optimization program designed to slow the rising cost of prescription drugs and help increase patient compliance with drug therapies. As part of the dose optimization program, the PBM must work with the participant, the health-care provider and pharmacist to replace multiple doses of lower strength medications with a single dose of higher-strength medications where appropriate.

## Medication Adherence Program

The PBM is required to provide a comprehensive pharmacy care program to improve medication adherence for participants with chronic conditions. As part of the medication adherence program, the PBM will provide telephonic coaching that will involve calls to participants from a health educator who is specially trained in the chronic condition. The calls will involve coaching participants on behavioral reinforcement strategies that will help them to continue taking their medications on schedule; calls will also include specially tailored education for the chronic condition. Doctors will receive written educational information on the rates of medication adherence, implications of non-adherence, and methods for improving adherence. Doctors will also receive alerts on participants who are not filling their medication prescriptions.

## Quantity Limits

The PBM is required to provide a limitation program for drugs which are indicated only for a specific therapeutic period or are limited to certain amounts. If, based on on-line adjudication, the quantity of a covered drug is not approved by the PBM, the prescribing physician must be allowed to contact the PBM for prior approval of additional quantities based on documentation of medical necessity.

## Early Refill

The PBM is required to process requests from participants, pharmacists, and providers for early refills or advance supplies of a medication due to vacations, dosage changes, or for lost or destroyed medication.

## Website

The PBM will develop and maintain a searchable public website that is accessible to participants and providers with no access restriction or registration requirement except for those functions which allow for review of a participant’s prescription claim history, or that include other forms of personal health information. The website contains at a minimum:

1. A current provider directory
2. Ability to conduct a zip-code based pharmacy proximity search
3. Claim forms for both primary and secondary coverage
4. On-line mail order refill capabilities
5. Mail order forms
6. Formulary or preferred drug list
7. Total Drug Cost (participant and Plan payment) as well as alternative drug price check functionality
8. Research drug interactions, side effects, and risks of drugs
9. Determine the availability of generic substitutions
10. Health/wellness information

## Field and Desk Audits

Pharmacy field and desk audit services must be included in the administrative fee, and the PBM must provide an annual report of audit activities and findings. Any errors will be addressed and corrected in a timely manner by the PBM. Any amounts recovered due to a field or desk audit will be 100% refunded to the Board.

## Specialty Medication and Supplies

1. The PBM is required to provide a Specialty Network for prescription fulfillment and distribution of specialty medications and supplies, pharmaceutical care management services, customer service, utilization and clinical management, integrated reporting, and claims processing. The specialty medication program must include, at a minimum, patient profiling focusing on the appropriateness of specialty medication therapy and care, and the prevention of drug interactions. The program must also include patient education materials, patient monitoring, adherence programs, and compliance programs. Programs such as drug utilization review, drug limitation (step therapy, quantity and supply limits) and prior authorization services must be extended to the specialty medication program. Channel distribution (retail, specialty, mail pharmacy) must be optimized for plan and participant savings.
2. The Specialty Network must open and comply with the State’s “any willing provider” statutory requirements (Section 83.9.6 subs 3(b)). Note: An exclusive central fill distribution channel is not acceptable.
3. Specialty medications must be deliverable to the participant’s residence or the participant’s physician’s office. The PBM must provide to participants a toll free telephone access to a registered nurse, pharmacist, or patient care coordinator (as appropriate) twenty-four (24) hours per day, seven (7) days per week.
4. The Specialty Pharmacies must be properly licensed, certified or credentialed to operate in the applicable states where dispensing specialty operations reside.
5. The Specialty Pharmacies must collect copayments for specialty mail order services with no balance billing of unpaid copayments allowed.
6. The PBM must provide an overall specialty discount guarantee for those drugs dispensed through the exclusive specialty drug program in addition to a claim by claim, the greater of will apply.
7. The PBM agrees during the life of the contract no new therapeutic classes will be added to the specialty drug list without written consent of the State.
8. The PBM will adjudicate all specialty claims at the lesser of: (a) the contracted discount plus dispensing fee or (b) MAC plus dispensing fee.
9. The PBM will guarantee Retail/Specialty unit cost equalization meaning that Specialty unit costs for medications dispensed at non-retail specialty pharmacies prior to participant cost sharing, and dispensing fees will be no greater than the unit cost for the same NDC-11 at Retail.
10. The PBM will 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 Specialty 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.

## Mail Order Services

1. The PBM must make available a mail order prescription drug program to process and dispense covered prescription drugs. Programs such as drug utilization review, drug limitation, and prior authorization services must be applied to mail order services and must be consistent with the retail channel.
2. The PBM’s mail order service must provide to participants toll free telephone access to a pharmacist and customer service representative twenty-four (24) hours per day, seven (7) days per week.
3. The PBM will guarantee that discounts provided on mail order claims should meet or exceed those of retail.

## Annual Explanation of Benefits

The PBM must be capable of providing an annual on-line explanation of benefits (EOB) to each participant utilizing the prescription drug program. The purpose of the annual EOB is not only to provide the participant with a complete list of prescription drugs processed through the prescription drug program, but to educate the participant regarding potential savings based on therapeutic and generic substitutions, dosage optimization, etc. At a minimum, the explanation of benefits should include:

1. Name and Address of PBM
2. Toll Free Number for PBM
3. Participant’s Name and Address
4. Participant’s Identification Number
5. Patient's Name
6. Provider Name
7. Claim Date of Service
8. Type of Service
9. Total Charges
10. Discount Amount
11. Allowed Amount
12. Excluded Charges
13. Amount Applied to Deductible
14. Copayment or Coinsurance Amount
15. Total Patient Responsibility
16. Total Payment Made and To Whom

## Rebates

1. The Board shall be entitled to receive the greater of: (1) the guaranteed minimum per claim rebate amount, or (2) 100% of all rebates received by the PBM attributable to the Board’s utilization that the PBM receives from any and all pharmaceutical manufacturers or intermediaries or other similar sources. These sources may include, but will not be limited to, market share incentives; promotional allowances; commissions; educational grants; Inflation protection; implementation allowances; clinical detailing; or rebate submission fees. The intermediary will pay the PBM 100% of the rebates it receives that are directly attributable to prescription drug claims paid by the Board, allowing the PBM to pay the Board 100% of the rebates collected, regardless of who collected them (the PBM or the intermediary). With regard to rebates received by the PBM from any intermediary, the Board shall have audit rights to ensure compliance by the PBM and its intermediary with transparency and rebate submission requirements. The PBM must ensure that, to the extent that the Plan’s prescription drug purchases are included, any agreement the PBM now has, or subsequently enters into with an intermediary for rebate collection, contain sufficient language to provide the Board free and direct audit access to the financial records, claims data, remittance data, contracts (e.g. pharmacy network, pharmaceutical manufacturer, etc.), reports and other information required by the Board to verify that the Transparency requirement is being met by the PBM and the intermediary. Any fees or cost associated with rebates administration should be included in the PBM’s bundled administration fee.
2. The PBM will offer price or inflation protection guarantees and please define the dollars at risk your organization will commit to in this guarantee.
3. The PBM must pass through price protection received from manufacturers through rebates to the Plan.
4. The PBM will provide an NDC level report on earned rebate dollars and all ancillary fees received by your organization from pharmaceutical manufacturers for medications dispensed for the state in addition to the monthly and annual reconciliation reports.
5. The PBM must provide rebate reporting by therapeutic category and by manufacturer on a quarterly basis and down to the NDC level.
6. The PBM’s confirms their manufacturer agreements contain provisions that limit the amount the manufacturer can raise the AWP price of prescription drugs each year.
7. The PBM will charge one overall administrative fee for all pharmacy services which shall include, but not be limited to, fees for rebate management, retail management, formulary management, and network management.

## Transparency

1. The Board must have a transparent financial pricing arrangement from the PBM. “Transparency” refers to financial arrangements which represent a direct and complete pass-through of all elements of negotiated provider pricing (e.g. discounts and dispensing fees, etc.). The Board must receive the full and complete amount of any discounts received by the PBM from any and all retail pharmacies. The PBM will not retain a differential (i.e. spread) between the amount reimbursed to the PBM by the Board for each transaction and the payments made to the retail pharmacies by the PBM.
2. The Board will not apply the above standard to mail order or specialty pharmaceutical transactions when owned by the PBM. For these mail order or specialty pharmaceuticals, the Board will accept the best possible discount arrangements from the PBM as it relates to discounts from AWP. Rebates generated through mail order and/or specialty pharmaceuticals will be subject to the transparency requirement described below.
3. The only compensation the PBM will receive, attributable to the Plan’s utilization shall be from or on behalf of the Board, for the services described in this proposal or any subsequent contract, shall be the PBM’s quoted administrative fees listed in the PBM’s proposal or agreed upon in writing through subsequent discussion with the Board.
4. The PBM agrees to disclose details of all programs and services generating financial remuneration from outside entities.

## Full Disclosure and Independent Review

The Board must have access to all of the PBM’s financial records including the Maximum Allowable Cost (MAC) list used to adjudicate the Plan's claims, claims data, remittance data, contracts (e.g. pharmacy network, pharmaceutical manufacturer, etc.), reports and other information required by the Board to verify that the transparency requirement is being met by the PBM during the period covered by the contractual term. Full disclosure as used herein would include, but not be limited to, auditing the following types of financial arrangements:

1. Any amount paid for the Plan by the PBM to retail pharmacies under contract with the PBM’s retail network is subject to audit even though the PBM may deem said contracts proprietary and confidential;
2. Rebates or any other monies or fees, which include administrative fees, paid to the PBM by pharmaceutical manufacturers are subject to review for audit purposes;
3. Any amount paid for the Plan by the PBM to a mail order or specialty pharmacy, when not owned by the PBM, will be subject to audit, whether or not the contract is considered proprietary and confidential by the PBM;
4. Discounts negotiated directly by the PBM with manufacturers shall be subject to audit; and
5. Aggregate rebate collecting, reporting, and contractual arrangements.

The Board, at its discretion, may use the services of an independent reviewer to perform reviews/audits of the PBM’s records on behalf of the Board. The Board and its independent reviewer will comply with all applicable confidentiality laws and will not reveal any confidential information acquired as a result of the review/audit. The Board has the right to review/audit records for the entire term of the agreement without limitation up to two times per calendar year. Any claims information, documents, etc. which the PBM may deem as containing “trade secrets” will not preclude an examination of such items through the audit process. The PBM will provide the Board assistance in the audit reviews by providing access to records, copies of claims data, access to reasonable support staff, etc. at no cost to the Board. The PBM will cooperate with the independent reviewer and agree to respond to any inquiries by the independent reviewer within the agreed upon schedule. The PBM will, within 60 days of final report being issued by Auditor, complete the final reconciliation and submit any and all reimbursement to the Plan. The PBM will not restrict the size of the claims sample reviewed by the independent reviewer which may include a review of 100% of all claims for the period under review. The Board will bear the cost of any fees charged by its independent reviewer.

## Market Checks

The Board may perform, or have performed on its behalf, following the twelfth (12th) month of the effective date services being provided and annually thereafter, a market check or an assessment of market conditions, pharmaceutical pricing, dispensing fees, and any other matters, services, or price drivers pertaining to this contract to determine if the terms of the contract are competitive with the then current market conditions. The market check will be allowed annually for the life of the contract.

If the Board or its designee provides the PBM with a written report conducted by a third party audit firm that takes into account, in the aggregate, the general plan design, formulary, clinical and trend programs utilized by the Board, participating network, utilization, and demographics for generally comparable plans that indicate a 1% or greater savings, the PBM will have the opportunity to respond, within thirty (30) days of receipt of the third party auditor market assessment, with a proposed amendment to the contract for new pricing terms that are mutually agreed upon and implemented no later than sixty (60) days after the third party audit firm report is completed and provided to the PBM. If the parties cannot come to agreement on the new terms, the Board reserves the right to terminate the contract with 120 days advance notice without penalty.

## Formulary Management

1. The PBM must administer all the provisions outlined in the *Appendix B* - *2020 Plan Document*.
2. The PBM must adhere to, develop and administer an evidence and value-based formulary program including ongoing pharmacy and therapeutics committee review and maintenance.
3. The PBM must provide a customizable formulary which provides access to clinically effective medications as the lowest net cost.
4. The PBM agrees that drugs will not be excluded from coverage unless required by FDA or the plan sponsor.
5. The PBM must provide plan design, clinical and utilization management program and formulary modeling service at no charge.

## Manufacturer Coupons/Patient Assistance Programs

1. The PBM agrees to have programs in place to counter the use of manufacturer's coupons/patient assistance programs that promote the dispensing of higher cost brand name drugs when a lower cost generic or alternative is available. Describe the PBMs strategy to combat the use of manufacturer's coupons.
2. The PBM will administer a variable copayment plan design to leverage available specialty drug manufacturer patient assistance programs.
3. The PBM’s variable copayment plan design, if selected, will be in place for the life of the contract.

# PERFORMANCE STANDARDS

Please respond by restating each of the performance standards listed below, and confirm your intention to meet this standard as described, respond by stating, “*Confirmed*”. If your firm would like to propose a different standard, respond by stating, “*Confirmed, but with exceptions*”, and state your proposed standard and the justification for the requested change. Any exceptions should also be noted in ***Section 12 – Statement of Compliance***.

The Board reserves the right to reduce or waive any fees at risk if, in the Board’s sole discretion, failure to meet a performance standard was due to extraordinary circumstances.

| **Performance Standard** | **Description of Standard** | **Fees at risk** |
| --- | --- | --- |
| Pharmacy Network Access | 95% of all participants within 5 miles of 1 participating pharmacy  Measurement Period: Annually | $25,000 Annually |
| Network Pharmacy POS Compliance | 99% of time internal on-line system available  Measurement Period: Quarterly | $20,000/Quarter |
| Retail Paper Claims Processing Time | 95% of prescriptions reimbursed or responded to within 15 business days of receipt  Measurement Period: Quarterly | $20,000/Quarter |
| Retail Claims Financial and Processing Accuracy | 99.5% of all claims paid with NO errors (i.e. correct drug, correct form, correct strength, correct patient, correct AWP, correct copayment, or correct deductible). Retail claims adjudication accuracy is the total number of retail claims paid correctly divided by the total number of retail claims paid.  Measurement Period: Quarterly | $20,000/Quarter |
| Mail Order Claims Processing Time | 95% of prescriptions requiring NO intervention to be shipped within 2 business days (as measured from date order received at the PBM to date order shipped)  Measurement Period: Quarterly  95% of prescriptions requiring administrative or clinical intervention to be shipped within 5 business days (as measured from date order received at the PBM to date order shipped )  Measurement Period: Quarterly | $20,000/Quarter  $20,000/Quarter |
| Mail Order Claims Financial and Processing Accuracy | 99.5% of all claims paid with NO errors (i.e. correct drug, correct form, correct strength, correct patient, correct AWP, correct copayment, or correct deductible). Mail order claims adjudication accuracy is the total number of mail order claims paid correctly divided by the total number of mail order claims paid.  Measurement Period: Quarterly | $25,000/Quarter |
| Rebate Remittance Time | 100% of all rebate dollars received by the PBM remitted to the Board within 60 days of the rebates being received by PBM.  Measurement Period: Quarterly | $20,000 |
| Customer Service | 90% of calls answered by a live customer service representative within 30 seconds during open hours  <5% of calls abandoned  100% of written inquiries responded to within 10 business days  Measurement Period: Quarterly | $5,000/Quarter  $5,000/Quarter  $5,000/Quarter |
| Account Service | Subjective satisfaction of Board with the contractual and administrative relationship based on mutually agreed satisfaction survey.  Measurement Period: Annually | $40,000/Annual |
| ID Card Distribution | 95% of ID cards mailed within 15 days of receipt of eligibility data (for monthly changes) or request for replacement card  Measurement Period: Quarterly  Average time to mail ID cards for ongoing eligibility (from the clean eligibility information provided) is ≤ 5 business days  Measurement Period: Quarterly | $10,000/Quarter  $5,000/Quarter |
| Reporting Requirements\* | Quarterly reports provided to Board ≤ 30 calendar days after the end of the quarter  Measurement Period: Quarterly | $10,000/Quarter |
| Written and Telephone Inquiry Response Rate\* | 98% response within 5 business days +  100% within 7 business days  Measurement Period: Quarterly | $10,000 per each 1% below standard with $135,000 Annual Max |
| Data Transfers\* | 99% of error transactions from the data transfer sent to the TPA will be corrected and returned to the TPA via data transfer within two (2) business days of receipt of the error report.  100% will be corrected and returned with 15 business days.  Measurement Period: Quarterly | $10,000/Quarter  $10,000/Quarter |
| Annual Independent Audit \*\* | Finalize the audit schedule with the Independent Auditor/DFA during the month of December each year and meet the agreed to deadlines. | $1,000 per each day of delay |
| Annual Independent Audit Reconciliation\*\* | Within 60 days of final report being issued by the Independent Auditor, the PBM will complete the final reconciliation and remit any and all reimbursement to the Plan. | $50,000 + $1,000 per day after deadline |

**Measurement of Performance**

\*The Board will use the PBM’s internal reports to measure the PBM’s performance relative to the standards included in this Exhibit. The PBM’s internal reports and/or data (including detail claims data) supporting the PBM’s internal reports may be reviewed/audited by the Board, or at the Board’s discretion, by an independent reviewer. The report and determination of the independent reviewer shall be final, binding and conclusive as to an administrative review on PBM and the Board; provided, however, that before a final report and determination is issued, the Board and PBM shall each have a reasonable opportunity to review the non-proprietary supporting documentation and proposed report of the independent reviewer and to provide any comments to the independent reviewer.

\*\*The Board will rely on the collaboration with the successful use proposer and contracted vendor in accordance with section ***4.28 Full Disclosure and Independent Review*** to determine if the performance standards related to the annual independent audit are satisfied.

**Payment of Liquidated Damages**

In the event the Board determines that the PBM has not met a given Performance Standard, under which liquidated damages are payable to the Board for failure to comply, PBM shall remit the applicable at-risk fees for failing to meet the corresponding Performance Standard to the Board within forty-five (45) days after the end of the measurement period.

**Measurement Period**

Quarterly and Annual Measurement Periods are measured based on the calendar year.

# QUESTIONNAIRE

1. Provide the name, title, mailing address, e-mail address, and telephone number of the contact person for this proposal.
2. State the full name of your firm, and provide the address, and telephone number of your principal place of business.
3. List the office that will service the Board. If it is located at a different address than the home office, provide the complete address, phone number, and facsimile number for this office.
4. Describe your organizational structure. Indicate whether your firm operates as a corporation, partnership, individual, etc. If it is incorporated, include the state in which it is incorporated, and list the names and occupations of those individuals serving on your firm’s Board of Directors.
5. List the name and principal occupation or business of any person or entity owning 10% or more of your firm.
6. Describe any ownership or name changes your firm has been through in the past three years. Are any ownership or name changes planned?
7. Describe any changes in the organizational structure that have occurred within your firm over the past twenty-four months or are anticipated during the next twenty-four months including, but not limited to, addition or elimination of product or business lines, mergers, acquisitions, etc.
8. How long has your firm been providing pharmacy benefit management services? Please indicate the month and year in which your firm was established.
9. What was the average number of employees of your firm during calendar year 2019? Please list the net change in the number of employees in your firm from December 2018 to December 2019, with explanation if change is significant.
10. State if the proposed account executive, any officers or principals and/or their immediate families are, or have been within the preceding twelve months, employees of the State of Mississippi.
11. Provide a brief description of any outside vendors or subcontractors that will be involved in providing key services detailed within your proposal. Please include the term of your current contract with each vendor or subcontractor. Describe the nature of the relationship with the subcontractor, including any ownership interest.
12. Has your firm ever been involved in a lawsuit involving any area covered by this RFP? If yes, provide details including dates and outcomes.
13. During the past five (5) years, has your firm, related entities, principals or officers ever been a party in any material criminal litigation, whether directly related to this RFP or not? If so, provide details including dates and outcomes.
14. Has your firm been cited or threatened with citation within the last three years by federal or state regulators for violations of any federal, state, or local law or federal, state or local regulation? If the answer is yes, please describe the circumstances in detail.
15. Has your firm had any HIPAA breaches or incidents determined to be reportable to the U.S. Department of Health and Human Services (DHHS) within the last three years? If the answer is yes, please describe the circumstances and the corrective action in detail.
16. Confirm that your firm is not presently debarred, suspended, proposed for debarment, declared ineligible or voluntarily excluded from covered transaction by any federal department or agency, or by any political subdivision or agency of the State of Mississippi.
17. Does your firm currently perform any work for, services to or receive compensation from any third party administration company or any insurance company?
18. Provide the names of any organizations of which you own or control more than five (5) percent.
19. Provide a complete résumé for each staff member (in Tab 14 of your proposal) who will be assigned to render services to the Board, including detailed information on any special training or designations.
20. Is your firm licensed or authorized to provide the proposed services in the State of Mississippi?
21. List your organization’s accreditation or service/quality ratings, including year obtained and certification duration if applicable.

# REFERENCES

1. List up to three clients for whom your firm has provided services similar to those requested in this RFP. For each client, specify the type of pharmacy benefit management services provided by your company, the number of covered lives in the client’s group, and the period of time retained as a client. One of the three must be the longest standing client and one must be the client with the largest employee population. For each client, the list must specify:

#### Client name, include the name, title, address, e-mail address, and phone number of a person whom we may contact to confirm as needed,

#### The type of work your firm provided to the client,

#### The number of covered lives in the client’s group,

#### Contract effective dates for the time period(s) (beginning and end dates) your firm provided services to the client.

1. List up to three governmental clients for whom your firm has provided one or more of the services requested in this RFP. If possible, please list three additional clients besides any previously listed references. For each client, specify the type of work performed by your firm, the number of covered lives in the client’s group, and the period of time retained as a client. For each client, the list must specify:
2. Client name, include the name, title, address, e-mail address, and phone number of a person whom we may contact to confirm as needed,

#### The type of work your firm provided to the client,

#### The number of covered lives in the client’s group,

#### Contract effective dates for the time period(s) (beginning and end dates) your firm provided services to the client.

1. List all clients that have discontinued use of your services since January 1, 2019 and your understanding of their discontinued use of your services. For each client, the list must specify:

#### Client name, include the name, title, address, e-mail address, and phone number of a person whom we may contact to confirm as needed,

#### The type of work your firm provided to the client,

#### The number of covered lives in the client’s group,

#### Contract effective dates for the time period(s) (beginning and end dates) your firm provided services to the client.

#### Reason discontinued

# SERVICE PLAN

## Network Operations

***Participant Access***

Note: *Responses to the questions below should reflect only those pharmacies currently under contract with your network and not include projections for future growth or expansion. If more than one network is proposed, address each question separately relative to each network. Refer to Appendix E - Top* 50 *Pharmacies Utilized by Participants for a listing of the top 50 pharmacies utilized by participants.*

1. Do you have an operating network of pharmacies in Mississippi? When was it established? How many pharmacies are currently under contract in Mississippi?
2. For the network you are proposing to use, what is the total number of network pharmacies within the State of Mississippi? How many are independent pharmacies? How many are chain pharmacies?
3. Please provide a copy of your directory of participating pharmacies in the State of Mississippi for each network proposed.
4. Do you charge any fees to pharmacies for participation in your network? If yes, please describe the nature of the fees and provide the amount of the fee charged.
5. Do you charge pharmacies transaction fees, directly or indirectly (e.g., “click” or “switch” fees) for submitting claims to your firm? If so, please describe all such fees, including any differences between paid and rejected claim submissions, and the fees you receive from retail pharmacies for this arrangement.
6. How would your network provide PBM services to out-of-state retirees and other out-of-area plan participants?

***Quality Control***

1. What are the criteria for acceptance of a pharmacy into your network?
2. How often do you re-credential pharmacies in your network? Describe the credentialing and re-credentialing process.
3. How often do you physically visit your network pharmacies? Which elements of performance are audited?
4. Describe your pharmacy network auditing programs and services, clearly indicating how frequently the program is run and the process to investigate any findings that are deemed potentially fraudulent. Also describe all programs (and interventions) available for retail, specialty, and long term care pharmacy networks to:
   1. Identify potential abuse patterns by participants
   2. Identify over-prescribing by doctors
   3. Identify potential fraud by dispensers and/or participants
5. Describe ongoing assessments used to monitor quality and performance of pharmacies in the network.
6. Do you agree to accept responsibility for collecting overpayments from the retail pharmacy if the pharmacy charges more than the contracted price for any and all prescription drug claims, and reimbursing the Board for any overpayments?
7. Do your network contracts include any incentives for retail pharmacies regarding the dispensing of generics or preferred products?

***Mail Order Operations***

1. Describe your mail order program.
2. List all of your mail order locations (include pharmacy name, location, length of operation, average fill accuracy for 2018 and 2019, facility prescription capacity and current volume).
3. Do you own mail order facilities or contract with another PBM? If contracted, how long has this relationship been in place?
4. Describe by what methods your mail order pharmacy is able to accept prescriptions (e.g. mail, fax, phone, email, e-prescribing, etc.).
5. What delivery service does your mail order use to deliver prescriptions? Do you offer alternative delivery options (e.g. priority overnight, etc.)? If so, what is the cost of these services?
6. Describe your process for transitioning a client from an existing mail order facility to your facility.
7. Will lost or damaged orders be fulfilled with no additional cost to the Plan and its participants? How does the PBM handle prescriptions returned by the participants?
8. Describe your process for notifying participants of the expiration date of their current script, next refill date, number of remaining refills, prescriptions not on formulary, generic substitution availability, etc.
9. Describe any programs for participant outreach to encourage switching of maintenance drug prescriptions to mail order from retail, or for optimization of savings for both the plan and participant.
10. Describe your mail order “auto fill” program, if one is available. Describe the day supply refill metric to manage the “auto-fill” program and controls in place to avoid wastage or stockpiling?
11. Describe the type and frequency of reports routinely provided to your clients relative to your mail order pharmacy program. Advise if your reports contain the number of discontinuations during the first month of therapy by drug, reason for discontinuation, patient interventions for side effects, and adherence outcomes.

***Specialty Operations***

1. How do you define a specialty drug?
2. Does your firm provide a specialty pharmacy program?
3. Do you own the specialty pharmacy or contract with one? If contracted, how long has this relationship been in place?
4. Identify the location(s) of the specialty pharmacy facility (if specialty drugs are dispensed from separate facilities) that will primarily service the Plan. Include pharmacy name, location, length of operation, average fill accuracy for 2018 and 2019, facility prescription capacity and current volume
5. What delivery service does your specialty program use to deliver prescriptions? Do you offer an alternative delivery options (e.g. priority overnight, etc.)? If so, what is the cost of these services?
6. Will lost or damaged orders be fulfilled with no additional cost to the Plan and its participants? How does the PBM handle prescriptions returned by the participant?
7. Describe your process for notifying participants of expiration date of their current prescript, next refill date, number of remaining refills, prescriptions not on formulary, generic substitution availability, etc.?
8. Describe any programs for participant outreach to encourage switching specialty medications for optimization of savings for both the plan and participant.
9. Describe your “auto fill” program, if one is available. Describe the day supply refill metric to manage the “auto-fill” program and controls in place to avoid wastage or stockpiling?
10. Does the specialty pharmacy contact the participant prior to shipping each prescription to ensure medication is still required?
11. Describe the shipping process and quality controls utilized by the specialty pharmacy to assure stability of temperature sensitive medications.
12. Can specialty be shipped directly to the doctor’s office for administration?
13. Describe any initiatives your firm has that are designed to assist plan sponsors in lowering the cost of specialty drugs dispensed or administered in the doctor’s office and reimbursed through the medical plan?
14. Describe your ability to monitor and align specialty utilization between the medical and pharmacy channels, including assessing, monitoring, and optimizing participant cost sharing and clinical rule parity.
15. What chronic diseases are managed through your specialty pharmacy program?
16. Describe your specialty pharmacy program including the frequency of contact, telephonic and other, with patients and physicians, the qualifications of staff, etc.
17. Describe how your specialty pharmacy program manages the appropriate dispensing of medications to minimize the waste of prescription drugs. Does your specialty pharmacy have any cycle management programs for potentially toxic medications, that would include aspects such as enhanced communication, adverse drug event monitoring, therapy response monitoring, participant’s adequate supply monitoring, new start partial fill (to increase adherence and potential cost savings), adherence monitoring, and physician outreach to corroborate doses taken, dosage changes, side effects experienced, and pharmacist recommended interventions.
18. Describe the type and frequency of reports routinely provided to your clients relative to your specialty pharmacy program. Advise if your reports contain the number of discontinuations during the first month of therapy by drug, reason for discontinuation, patient interventions for side effects, and adherence outcomes.
19. Provide a list of drugs included in your variable copayment plan design.
20. Confirm you provided the most recent Limited Distribution Drug Indicator in the attachment for the previous question. If not, please provide your proposed Limited Distribution Drug List with NDC in an Excel File.
21. Provide a list of any specialty drug products that are excluded from your specialty drug pricing guarantees (OED, Dispensing Fee, and/or Rebate).
22. The PBM confirms the specialty discount guarantees, fees, and rebates include limited distribution medications and new to market medications.
23. Provide an AWP-based pricing list in Excel of all specialty pharmaceuticals, including Limited Distribution Drugs that your company dispenses and distributes to providers and patients for your proposed specialty pharmacy program. Your pricing must include adequate supplies of ancillaries such as needles, swabs, syringes, and containers. The following items must be included in your list:
    1. Product Name
    2. Therapeutic Group/Therapeutic Category
    3. NDC
    4. Guaranteed Minimum AWP Discount and Dispensing Fee for all specialty pharmacy program prescriptions for the specialty arrangement.
    5. Limited Drug Designation
24. Describe your strategy for controlling the increasing cost of the specialty medications.
25. Describe the participant enrollment process in the patient assistance program and describe the claims adjudication process under the variable copayment plan, including the role of the participant, PBM, and pharmacy.

***Compounding Operations***

1. Does your firm provide a compounding pharmacy program? How do you define compounding medications?
2. List all of your compounding pharmacies (include pharmacy name, location, length of operation, average fill accuracy for 2018 and 2019, facility prescription capacity and current volume). Do you own compounding pharmacy facilities or contract with another PBM? If contracted, how long has this relationship been in place?
3. Does your firm exclude compounds derived from bulk powders?
4. Does your firm exclude compounding kits?
5. Describe any initiatives your firm has that are designed to assist plan sponsors in lowering the cost of compounding medications?
6. Describe the type and frequency of reports routinely provided to your clients relative to your compounding pharmacy program.

## Plan Design and Formulary Management

1. Please describe the formulary being utilized for this proposal. Please provide your recommended formulary in an electronic format in Tab 15 of your proposal.
2. Please describe your formulary development process. Is your formulary approved by a committee? If so, provide the committee profile including the profession of each participant.
3. How often is your formulary updated? Would you be willing to establish a formulary specific to the Plan’s program? Please provide your recommended formulary in an electronic format in Tab 15 of your proposal.
4. Will you agree to allow customization to a formulary if specifically requested by the Plan? If so, please explain the process.
5. To what extent do you use evidence-based effectiveness studies in the development of your preferred drug list(s)? What are the sources of research used?
6. Will you agree to grant the Board prior notice for the addition or deletion of drugs from the Plan’s prescription drug formulary or preferred drug list?
7. Will you agree to grant the Board prior notice for the addition or deletion of drugs from the Plan’s prescription drug formulary or preferred drug list?
8. Describe your process for administering a generic incentive.
9. Can you administer a plan design where the participant’s cost for a brand drug is the generic copayment plus the difference in cost between the generic and brand drug?
10. Can you administer a generic incentive plan design where the participant’s cost for a brand drug is the brand copayment plus the difference in cost between the generic and brand drug?
11. Can you administer a generic incentive plan design where the participant’s cost for a brand drug is the generic copayment plus the difference in cost between the generic and brand drug when there are different generic copayments?

## Client/Participant Services

1. Describe your customer service structure for clients and participants for all programs (i.e., mail order, specialty drugs, and prior authorization). Include organization, hours and days of operation, staffing, and training.
2. Would you be willing to assign a dedicated, but not necessarily exclusive, customer service representative team to the Board’s account?
3. Confirm that participants have access to a toll-free number for claim/participant services inquiries. Provide the hours the toll-free number is staffed. How will after-hours calls be handled? Confirm that your proposal provides a fee quotation for supplying this service.
4. The Board requires that you assign a dedicated, but not necessarily exclusive, account manager to meet with DFA staff on a quarterly basis to review Plan utilization, attend the Board’s meetings (if requested), make recommendations regarding services and/or programs on a quarterly basis, to discuss performance, address administration issues and review reports. Please confirm that you agree to this.
5. Confirm you are willing to assign one (1) dedicated and exclusive pharmacist residing in the State of Mississippi to visit physician offices and pharmacies and participate in health/benefit fairs to work out of the Office of Insurance office?
6. What services are available to accommodate special populations, including non-English speaking, hearing and vision impaired?
7. Please provide a sample of the most recent customer survey and the results in Tab 15. Confirm that your proposal includes a fee for supplying this service and is included in the bundled administrative fee.
8. Does your firm provide communication/patient education materials to participants? How often? Would you be willing to customize these materials for the Plan? Please provide a sample of the most recent communications release. Confirm that your proposal includes a fee for supplying this service and is included in the bundled administrative fee, including the cost of mailing any communication materials to participant home locations.
9. Confirm that you are willing to develop and maintain a website as described in the ***Section 4 – Scope of Services***. Please provide a web address to view as an example of the website you propose for the Plan. The Board does not require that you develop a website for exclusive use by the Plan.
10. Please refer to ***Section 4 – Scope of Services*** for the Board’s website requirements. Describe your web-based program available to participants. Does the program allow participants to check to status of a claim, view and print submitted claim activity, confirm the price of medications, review therapeutic alternatives, check the preferred/non-preferred, generic status of a medication, etc.?
11. Describe any online tools available for comparing drug pricing between pharmacies.
12. Describe any online/mobile tools for demonstrating to participants savings associated with changing medications from their current prescriptions.
13. Does your online tool display the total cost of the drug?
14. Describe areas of innovation that your firm has developed and implemented that improves the quality of care provided to participants, or improves cost control for your clients.
15. Does your firm release communications to participants that are negatively impacted by changes to the preferred drug list? How often? Please provide a sample of the most recent communications release in Tab 15. Confirm that your cost is included in the bundled administrative fee for supplying this service, including the cost of mailing any preferred drug list changes to participant home locations.
16. How do you track and monitor participant and provider inquiries? What is your turn around time in responding to participant complaints?
17. Define your telephone service objectives in terms of: 1. Average call pick-up time; 2. Average time on hold; 3. Percentage of calls receiving busy signals; and 4. Abandonment rates. In each of these service areas, please provide the actual results for the last twelve months that were measured by your firm.
18. Describe your formal grievance procedure for addressing participant problems.
19. Please describe the process participant appeals process. Specifically, your response should indicate how first level appeals are managed, who is responsible for making the determination and the timing for issuing a response.
20. Please describe the process for independent external appeals.
21. What information is required to be contained on the ID card given to participants? Include a sample ID card. Can the ID card be customized for the Board? At a minimum, ID cards must include the participant name, participant identification number, the network name and the toll free customer service line number. Can the medical identification number be used as the pharmacy card identification number if provided by the TPA?
22. You are required to generate ID cards and distribute the ID cards to participants. Confirm that your cost is included in the bundled administrative fee for all costs related to ID cards, including the cost of mailing the ID cards to participant home addresses.
23. Do you provide an annual explanation of pharmacy benefits (EOB) to participants? Does the explanation of pharmacy benefits include cost saving alternative recommendations for the participant? Please provide a sample including a list of all messages that can be displayed on the EOB.
24. The PBM shall maintain on file, at a minimum, the following information relative to each processed claim: the claimant’s name, claim number, provider number, provider name, service dates, type of services, amount of charges, amount allowed, amount applied to the deductible, and reason codes. Confirm that you will comply with this requirement.

## Claims Administration

1. Describe your procedure for processing paper and out of network claims submissions. Provide turnaround statistics for paper and out-of-network claims processed in 2019.
2. Describe your process and capabilities for real time, point of sale coordination of benefits?
3. Describe the situations where you would utilize a retrospective (off-line) process for coordinating benefits and payments. Describe your process for retroactive collection of payments from primary payers identified. If your firm does not perform such collections directly, describe your process for collecting information about other primary payment amounts.
4. Does your claims system have the capability to identify approval of prescription drugs by exception? (e.g. normally excluded by the plan, excluded by participant group)
5. Does the system comply with the National Council on Prescription Drug Program (NCPDP) standards?
6. What process is required from your network pharmacies when submitting claims for compounded drugs? What pricing algorithm do you use for pricing these drugs? Do you support and does your network use the NCPDP D.0 transaction standard format which allows listing of all ingredients?
7. Does the pharmacist have the capability to override the system? Please provide an example of a situation where the pharmacist might apply the override capability.
8. Describe the online systems access that will be granted to the Board for viewing data including, but not limited to: participant benefits, eligibility, participant and group records, prescription information, formulary lists, prior authorizations, accumulators, claim detail, claim data as submitted at point-of-sale, point-of-sale denials, COB data, drug pricing, historical data, mail service prescription data, transaction audit trails, MAC pricing files, specialty drug lists, etc.
9. Describe your capability to administer a plan design that includes the use of Health Reimbursement Accounts and integrated deductibles with the health plan.

## System Interface

1. You are required to work with the TPA to develop system interfaces for accepting eligibility information, including ongoing additions/deletions of participants. Please confirm your ability to comply with this requirement.
2. Does your system flag participant ID numbers when an ID card is reported as lost or stolen to prevent fraudulent claims? What procedures are pharmacies instructed to follow when an individual tries to use a lost or stolen card?
3. Does your system monitor and flag early drug refills? What consumption percentage is your standard policy? Can this function be overridden for vacations, lost medicine, etc.?
4. Does the system track physician-specific data and dispensing patterns? How is this information used to change physician behavior? Are you willing to share this information with the Board?
5. Do you issue report cards on physicians? What information is captured on these report cards? Explain how this information is shared with physicians and how frequently. Are you willing to share this information with the Board? Provide an example, if applicable.
6. Does the system maintain patient medication profiles? What information is captured on these profiles? Provide an example, if applicable.
7. Discuss situations where your participating pharmacists have been unable to access the system and the number and frequency of such incidents. Describe the procedures used for dispensing prescription drugs to participants in cases where there are problems accessing the computer network system. What was the percent of time your system was unavailable to pharmacies during calendar year 2019?
8. Confirm that you have the capability to coordinate deductible accumulations with the TPA for participants covered under a High Deductible Health Plan, and include any data interface costs in your proposal.

## Data Reporting

1. Due to potential time delays associated with the existing eligibility reporting process, do you have a standard report that would capture claims data for employees who receive prescription drugs after their termination under the Plan?
2. Describe the type and frequency of reports routinely provided to your clients. Provide examples in an appendix to your proposal.
3. Does your system provide web-based reporting tools that allow the client to view, print, and download reports? If so, please describe reporting capabilities, claim look-up functions, standard report writers, and any associated costs assuming five users. Describe any ad hoc reporting capabilities provided through these web-based tools. In what formats can the reports be downloaded? How many months of reports are maintained online? Also, explain what type of security is offered to protect the information.
4. Confirm that you can interface with the Board’s data management vendor, Health Data and Management Solutions, Inc. (HDMS). Confirm that your proposal includes the cost of this requirement.
5. Describe your capability to produce ad hoc reports. Provide examples of previously prepared ad hoc reports and associated programming charges. What is the typical turnaround time for producing ad hoc reports?
6. Do you sell or report any data from your clients, either specifically or in aggregate, to any organizations? If so, please disclose these arrangements in detail.

## Clinical Programs and Utilization Management

1. Describe your drug utilization review (DUR) and management services, such as:
   1. Prospective DUR
   2. Concurrent DUR
   3. Retrospective DUR
   4. Physician profiling
   5. Case Management and Medication Therapy Management
   6. Prior Authorization
   7. Dosage and Quantity Limitations
   8. Step Therapy
   9. Dose Optimization
2. Describe your DUR problem identification process for all three levels of DUR (Prospective, Concurrent, and Retrospective), the intervention process, including methods, frequency, and success rates. Please describe three significant retrospective DUR cases that demonstrate the value of such services in terms of tangible results.
3. Describe how you manage requests from participants for early refills or advance supplies of medications.
4. Describe the dedicated clinical resources that support your DUR and cost containment efforts. Provide names and résumés of key staff members (in Tab 14 of your proposal).
5. Does your firm perform internal analyses of client specific data to develop recommendations for program improvement? What factors do you take into consideration when evaluating recommendations? Specifically address who would be conducting the analysis and provide their qualifications and experience.
6. How are physicians educated about drug utilization? Formularies and preferred drug lists? Generic therapeutic substitution? Provide samples of provider educational materials. Do you conduct any detailing of physicians? What have been the results of these efforts?
7. What is the average percentage savings from your DUR interventions? For purposes of this statistic, percentage savings is defined as DUR savings compared to total claims actually paid.
8. Please describe your medication adherence program including your experience in positively impacting physician and participant behavior relating to medication adherence. How long has your medication adherence program been in place?
9. Describe your drug limitation program for medications which are indicated only for a specific therapeutic period or are limited to certain amounts.
10. Describe your process for ensuring medications are covered only for the DFA approved indications.
11. Do you have the capability to collect the diagnosis on claims?
12. Do you currently or have plans to use the diagnosis code to determine if the drug is being described for the approved indication?
13. Please describe your prior authorization process including who performs the medical authorization function.
14. Confirm that utilization management rules will apply to all channels (retail, mail, and specialty), and then also across channels.
15. Describe available medication therapy management (MTM) programs.
16. Do you contact patients to remind them of upcoming refills, to verify receipt of medications, to confirm the patient’s understanding of proper administration of medications, etc.? Please describe these interactions.
17. Provide examples of communications that are distributed to patients and physicians through your specialty pharmacy program.
18. Are you offering clinical guarantees to the Board? If yes, please describe the guarantee and your savings calculation methodology.

## Full Disclosure and Independent Review

1. Any resulting contract will include a Business Associate Agreement between the selected Pharmacy Manager and the Board. The Board’s contract for audit services will also include a Business Associate Agreement. Will you require a separate NDA with our contracted auditor? If so, please explain the rationale behind this requirement.
2. Please detail your process for participating in an audit including staff assignment.
3. What is your lead time for supplying information for an audit?
4. If there is a delay in the audit, caused by the PBM not meeting the agreed to schedule, are you willing to deploy resources to shorten the time for other sections of your response to get the audit back on the timeline? If so, please explain this process.

## Legal and Liability Issues

1. Please indicate the liability insurance requirements that each pharmacy must maintain to be considered a participant in your network. How does your firm verify that each participating pharmacy has complied with the insurance requirements, and how do you monitor the renewal of insurance protection each year?
2. Please provide a copy of the most recent annual report for your organization, and for your parent organization (if applicable).
3. Please provide your firm’s (and those of your parent organization, if applicable) most recent audited financial statements including any auditor’s recommendations or opinions.
4. Please attach a copy of your standard contract with participating pharmacies.

## Implementation Services

1. Describe your implementation plan to meet a network start date of January 1, 2021, clearly identifying tasks, critical events, time lines, and the responsible parties.
2. Describe your plan set-up testing and controls procedures to ensure accurate plan set-up.
3. Describe the most frequent problems you have encountered during previous transitions for plans of this size. How were these resolved?
4. Please confirm that your financial proposal includes all costs associated with implementation services.

## Financial

1. What is your firm’s approach to ensuring the benefit of low cost generic retailers that sell discounted generics (e.g. $4 maintenance generics)? Does your firm have the ability to capture these claims for reporting and clinical edit purposes?
2. What is the data source you currently use for drug reimbursement (e.g., Medi-Span, etc.)?
3. Does your PBM engage in any cost shifting from either external or internal sources which improve the actual or perceived price of one service while increasing the actual or perceived price of another service provided by the PBM to the Board? Explain.
4. What percentage of retail and mail order claims are currently priced at MAC? Are you willing to guarantee a MAC inclusion rate for retail and/or mail if applicable? If so, state the guarantee.
5. Do you apply MAC pricing for any specialty drugs? If so, how many?
6. What percent of your total claims paid in 2019 have been paid at U&C? What is the average discount for U&C brand claims? What is the average discount for U&C generic claims?
7. Confirm that for every claim paid at the provider’s U&C amount, the PBM shall allocate the entire U&C amount to the Ingredient Cost, and shall not allocate any of the U&C amount to the dispensing fee.
8. Provide a detailed methodology for the calculation of each of the guaranteed financial terms listed in in ***Section 10 –*** ***Fee Schedule***. Describe any variation in the calculation of the guaranteed financial terms from the methodology required to re-price the claim file that is required for this RFP.
9. Describe how/if specialty drug guaranteed discounts are updated and the frequency of the updates?
10. The Board describes a “script” as a paid prescription only (excludes duplicates, reversals, etc.). Confirm you will abide by this definition in calculating any fees based on a per script basis.
11. Confirm that all discount guarantees are direct savings off of AWP and not the result of incremental savings due to repackaging of prescriptions or other clinical services. Does your mail order pricing assume a specific package size? If so, describe the package size used in mail order.
12. When a prescription costs less than the copayment amount at either retail or mail, how do you ensure that the participant will pay the lowest amount?
13. For your current book of business, please provide the following annual statistics. Please indicate the time period represented and whether data reflects active employees only, or active employees and retirees, dependents.
    1. Cost per participant (paid claim)
    2. Cost per insured employee (paid claim)
    3. Number of prescriptions per participant
    4. Number of prescriptions per insured employee
    5. Average day supply per prescription
    6. Average ingredient cost – per brand, generic
14. For your current book of business, what is the most recent statistic (percentage) of drugs which were dispensed as generic? If possible, distinguish between clients who include any pharmacy incentive programs or MAC plan designs. Please indicate any new program that might be employed by the Board to improve this statistical average.
15. Please summarize how you handle (a) MAC; (b) lower of U&C and plan pricing, and (c) acquisition package size pricing compliance by pharmacies in the network you propose.
16. Do you maintain more than one MAC list? If so, will more than one MAC list be used for the Board’s program? Please describe how more than one MAC list is utilized.
17. For the Board’s program, will you apply the same MAC list and MAC pricing for both the retail and mail channels?
18. How many drugs are on your MAC list? How often do you change MAC pricing? What method do you use to communicate with clients any updates in your MAC pricing and MAC lists?
19. Confirm that you have provided the rebate guarantees you will provide the Board. The rebate guarantee should be based on a per brand script basis only. You may list separate guarantees for retail, specialty and mail.
20. Confirm that you are willing to make the Board whole in the event you fail to meet pricing and/or rebate guarantees by individual guarantees without offsets of one financial guarantee’s potential under-performance with another financial guarantee’s potential over-performance.
21. Describe the payment cycle for compensating pharmacies.
22. Describe your preferred billing cycle for claims, and for administrative fees to the Board.

## Fees

1. Complete the “Financial Proposal” form located in in ***Section 10 –*** ***Fee Schedule***. Confirm that all fees are guaranteed through the potential five-year term of the contract.
2. Confirm that your proposal is valid for **180 days** from the date proposals are due.

# CLAIMS RE-PRICING

1. The Board requires a claim re-pricing and formulary analysis using the proposed pharmacy network and PBM proposed contracted rates. The claim file will be distributed to qualified proposers by Segal Consulting after submission of an Intent to Propose and the executed Non-Disclosure Agreement (NDA) found in *Appendix C* *– Non-Disclosure Agreement.*
2. The claim file will be sent to qualifying proposers via secure electronic transfer after receiving the executed NDA. The claim file will contain twelve months of claims history including the following: NDC, Quantity, Day Supply, Date Filled, DAW code, Retail/Mail Indicator, and Formulary Flag. Proposers should not be concerned with U&C, zero balance, full copayments or submitted pricing, as the Board intends to use the data to compare your AWP discounts, dispensing fee, MAC and Specialty Pricing in a manner which does not contain alternative assumptions by proposing PBMs. In addition, all ancillary assumptions and caveats used in your analysis should be thoroughly detailed with your submission. Please use your proposed discounts, current MAC pricing where applicable, and AWP as published on January 1, 2020.
3. PBM’s should take the following into account for both claims adjudication and aggregate discount guarantees. The Medi-Span Multi-Source Indicator as of January 1, 2020 should be used. For prescription drug claims processed where the underlying prescription drug product is identified having a multi-source indicator code identifier of “M”, “N”, or “O” on January 1, 2020, the claim should be considered a brand claim unless otherwise noted as an exclusion. Claims processed where the multi-source indicator is a “Y” on January 1, 2020 will be considered as generic claims.
4. The claims re-pricing response file should include all provided data as well as the addition of your MAC Flag, MAC unit price, Billed Ingredient Cost, Billed Dispense Fee, Total Drug Cost, Final Pricing Indicator (how you would have priced the claim; AWP Discount or MAC) and Tier Indicator (applying the proposed formulary) for each claim.
5. Re-price all claims using proposed discounts and pricing, but if additional savings opportunities are identified during re-pricing, these savings opportunities can be included and explained as notes in the table.
6. Please identify how the methodology used in the re-pricing (other than the fixed AWP date of January 1, 2020) varies from any future calculation methodologies used by your PBM, should it be selected, in calculating performance guarantees or related discount performance during the term of the contract.
7. The PBM must complete and submit a Formulary Disruption analysis for your proposed formulary in the format below. In addition please provide an excel file with the detail of the formulary disruption for each drug by NDC 11 code for your formulary with exclusions and without exclusions.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Type of Change | **Participant Impact** | **% of Total Participants** | **Number of Scripts Impacted** | **% of Total Scripts (including all brands and generics)** |
| No Change |  |  |  |  |
| Positive (higher-cost tier to lower tier) |  |  |  |  |
| Negative (lower tier to higher-cost tier) |  |  |  |  |
| Moving from covered to not covered/Excluded |  |  |  |  |
| Total |  |  |  |  |
| Name of #1 Drug that is Moving from Covered to Not Covered/Excluded based on impacted Participants: [Indicate Member and Script Impact.] |  |  |  |  |
| Name of #2 Drug that is Moving from Covered to Not Covered/Excluded based on impacted Participants: [Indicate Member and Script Impact.] |  |  |  |  |
| Name of #3 Drug that is Moving from Covered to Not Covered/Excluded based on impacted Participants: [Indicate Participant and Script Impact.] |  |  |  |  |

1. The completed files shall be submitted with proposals.

# FEE SCHEDULE

The Board’s requirements regarding compensation are as follows:

1. The fees listed in ***Section 10 –*** ***Fee Schedule*** shall constitute the entire compensation due to the PBM for services and all of the PBM’s obligations hereunder regardless of the difficulty, materials, or equipment required. The fees include, but are not limited to, all applicable taxes, fees, general office expense, travel, overhead, profit, and all other direct and indirect costs, incurred or to be incurred, by the PBM. The Board shall not provide any prepayments or initial deposits in advance of services being rendered. Fees for services provided by the PBM shall be billable to the Board in arrears on a monthly basis. Only those services agreed to by contract shall be considered for reimbursement/compensation by the Board. Payment for any and all services provided by the PBM to the Board and/or the Plan shall be made only after said services have been duly performed and properly invoiced. The fees listed inin ***Section 10 –*** ***Fee Schedule*** of this contract are firm for the duration of this contract and are not subject to escalation for any reason, unless this contract is duly amended.
2. The PBM must submit all invoices, in a form acceptable to the Board (provided that such acceptance will not be unreasonably withheld) with all the necessary supporting documentation, prior to any payment to the PBM of any administrative fees. Administrative fees must be invoiced on a monthly basis, in sufficient detail and format as determined by the Board. Such invoices shall include, at a minimum, a description of the service(s) provided, the quantity or number of hours billed, the compensation rate, the time period in which services were provided, total compensation requested for each individual service being billed, and total administrative fees requested for the period being invoiced. The Board agrees to make payment to the PBM on any undisputed amounts within thirty (30) days from the date services were rendered or the date of receipt of the invoice, whichever comes last. Upon the effective date of termination of this contract, the PBM’s obligation to provide any further services under this contract shall cease. The PBM shall, however, remain liable for any obligations arising hereunder prior to the effective date of such termination. No additional compensation will be provided by the Board for any expense, cost, or fee not specifically authorized by this contract, or by written authorization from the Board.
3. The payment of an invoice by the Board shall not prejudice the Board's right to object or question any invoice or matter in relation thereto. Such payment by the Board shall neither be construed as acceptance of any part of the work or service provided nor as an approval of any costs invoiced therein. The PBM's invoice or payment may be subject to further reduction for amounts included in any invoice or payment theretofore made which are determined by the Board, on the basis of audits, not to constitute allowable costs. Any payment shall be reduced for overpayment or increased for underpayment on subsequent invoices. For any amounts which are or shall become due and payable to the Board and/or the Plan by the PBM, the Board reserves the right to (1) deduct from amounts which are or shall become due and payable to the PBM under contract between the parties; or (2) request and receive payment directly from the PBM within fifteen (15) days of such request, at the Board’s sole discretion.
4. Compensation to the PBM for travel expenses for quarterly meetings and annual onsite trainings are included in the bundled fee. In the event the Board requests and authorizes the PBM for the performance of any of the services covered under this Contract for which travel expenses are not already included, compensation to the PBM for travel, meals and/or lodging must be approved in advance and shall be allowed subject to the following criteria:
   1. In order to be compensable by the Board, travel expenses must be reasonable and necessary for the fulfillment of the project and contractual obligations;
   2. Air travel reimbursement will be limited to “Coach” or “Tourist” class rates, and must be supported by a copy of an original invoice;
   3. Meals and lodging expenses will be reimbursed in the amount of actual costs, subject to the maximum per diem as defined in the Federal Register. A copy of all hotel receipts must be provided. A copy of meal receipts is not necessary;
   4. Taxi fares, reasonable rental car expenses, and airport parking expenses will be reimbursed in the amount of actual costs, and must be supported by a copy of an original receipt/invoice;
   5. Personal automobile mileage and related costs are not compensable expenses;
   6. Time spent in “travel status” is not compensable.

FEE SCHEDULE

|  | **Year 1 – 2021** | **Year 2 - 2022** | **Year 3 – 2023** | **Year 4 – 2024** | **Year 5 – 2025** |
| --- | --- | --- | --- | --- | --- |
| **\*\*\* All Fees are assumed guaranteed unless otherwise noted** |  |  |  |  |  |
| **Retail Network:** | | | | | |
| Discount from AWP Brand Retail (Discounts are to be guaranteed prior to the application of the member’s cost share.) | % | % | % | % | % |
| Discount from AWP for all generics (Including MAC and Non-MAC prices, and Single Source Generics) | % | % | % | % | % |
| Dispensing Fee Brand | $ | $ | $ | $ | $ |
| Dispensing Fee Generic | $ | $ | $ | $ | $ |
| **Administrative Services for Retail Network** | | | | | |
| Electronic Claims Processing (per script) | $ | $ | $ | $ | $ |
| Paper Claims Processing (per script) | $ | $ | $ | $ | $ |
| **Mail Order Network** | | | | | |
| Is the mail order facility owned by your company? Yes No | | | | | |
| Discount from AWP Brand (Discounts are to be guaranteed prior to the application of the member’s cost share.) | % | % | % | % | % |
| Discount from AWP for all generics (Including MAC and Non-MAC prices, and Single Source Generics) | % | % | % | % | % |
| Dispensing Fee Brand | $ | $ | $ | $ | $ |
| Dispensing Fee Generic | $ | $ | $ | $ | $ |
| **Specialty Drugs** | | | | | |
| Aggregate AWP discount |  |  |  |  |  |
| **Administrative Services for Mail Order Network** | | | | | |
| Electronic Claims Processing (per script) | $ | $ | $ | $ | $ |
| Paper Claims Processing (per script) | $ | $ | $ | $ | $ |
| **Rebates- Minimum Rebate Guarantees with 100% Pass Through (Including Limited Distribution Drugs and New to Market Drugs)** | | | | | |
| Guaranteed rebate per retail Brand claim | $ | $ | $ | $ | $ |
| Guaranteed rebate per mail Brand claim | $ | $ | $ | $ | $ |
| Guaranteed rebate per Specialty Claim | $ | $ | $ | $ | $ |
| **Miscellaneous Services** | | | | | |
| Please indicate with “included” if cost is in base administrative fee, or indicate the additional cost if not included in base fee and provide the basis for the fee (e.g. per script, PEPM, etc.) |  |  |  |  |  |
| Drug Utilization Review |  |  |  |  |  |
| Standard Reports |  |  |  |  |  |
| Ad-hoc Reports |  |  |  |  |  |
| Programming Charges |  |  |  |  |  |
| Fraud Protection |  |  |  |  |  |
| Enrollment Support (cost per additional day of support beyond assumed support levels) |  |  |  |  |  |
| Prior authorization |  |  |  |  |  |
| Step Therapy |  |  |  |  |  |
| Medication Adherence Program |  |  |  |  |  |
| Medication Therapy Management Program (MTM) |  |  |  |  |  |
| On-site claim audits |  |  |  |  |  |
| COB |  |  |  |  |  |
| Annual Explanation of Benefits |  |  |  |  |  |
| Computer Programming |  |  |  |  |  |
| Other (Please describe) |  |  |  |  |  |

[1] Medi-Span Multi-Source Indicator will be used for calculating aggregate financial guarantees and all purposes under this Contract. For prescription drug claims processed where the underlying prescription drug product is identified having a multi-source indicator code identifier of “M” (cobranded product), “N” (single source brand), or “O” (original brand) on the date dispensed, the claim should be considered a brand claim unless otherwise noted as an exclusion. Claims processed where the multi-source indicator is a “Y” (generic) on the date dispensed will be considered as generic claims.

[2] The Board will not pay any up-front fees prior to the January 1, 2021, effective date for services. All implementation fees or charges must be included in the administration fees quoted above. All fees or charges related to PBM services must be identified in the fee proposal above.

[3] A script is defined as a paid claim made on eligible participants that result in a payment to pharmacies or participants from the Plan or the Plan participant copayments. It does not include reversals, rejected claims and adjustments.

By submission of this proposal, we hereby certify that the fees submitted in response to the RFP have been arrived at independently and without, for the purpose of restricting competition, any consultation, communication, or agreement with any other proposer or competitor relating to those fees, the intention to submit a proposal, or the methods or factors used to calculate the fees proposed. By submission of this proposal, we hereby certify that we have not retained any person or agency on a percentage, commission, or other contingent arrangement to secure this contract.

# STATUTORY REQUIREMENT

In accordance with Section 25-15-9(1)(a) of the Mississippi Code, each entity that submits a proposal in response to this RFP **must provide a disclosure statement detailing any services or assistance it provided during the previous fiscal year to the Board and/or DFA in the development of the Plan including any resulting compensation for these services. If you did not provide such assistance to the Board and/or DFA, indicate in your statement that this provision does not apply to you.**

Section 25-15-9(1)(a), Mississippi Code Ann., states in part:

*“…The board may employ or contract for such consulting or actuarial services as may be necessary to formulate the plan, and to assist the board in the preparation of specifications and in the process of advertising for the bids for the plan. Those contracts shall be solicited and entered into in accordance with Section 25-15-5. The board shall keep a record of all persons, agents and corporations who contract with or assist the board in preparing and developing the plan. The board in a timely manner shall provide copies of this record to the members of the advisory council created in this section and those legislators, or their designees, who may attend meetings of the advisory council. The board shall provide copies of this record in the solicitation of bids for the administration or servicing of the self-insured program. Each person, agent or corporation that, during the previous fiscal year, has assisted in the development of the plan or employed or compensated any person who assisted in the development of the plan, and that bids on the administration or servicing of the plan, shall submit to the board a statement accompanying the bid explaining in detail its participation with the development of the plan. This statement shall include the amount of compensation paid by the bidder to any such employee during the previous fiscal year. The board shall make all such information available to the members of the advisory council and those legislators, or their designees, who may attend meetings of the advisory council before any action is taken by the board on the bids submitted. The failure of any bidder to fully and accurately comply with this paragraph shall result in the rejection of any bid submitted by that bidder or the cancellation of any contract executed when the failure is discovered after the acceptance of that bid….”*

**Failure to provide this disclosure statement may result in your proposal being eliminated from further consideration**.

The following is a list of persons, agents, and corporations who have contracted with or assisted the Board in preparing and developing the State of Mississippi State and School Employees’ Health Insurance Plan within the past fiscal year:

**Vendors:**

ActiveHealth Management, Inc.

Blue Cross & Blue Shield of Mississippi

Cavanaugh Macdonald Consulting, LLC

Claim Technologies Incorporated

Pillar Rx Consulting LLC

The Segal Company Southeast, Inc. d/b/a Segal Consulting

Wm. Lynn Townsend, FSA, MAAA

International Business Machines (IBM Watson Health)

**State and School Employees Health Insurance Management Board Members**:  
Liz Welch (Chairman) – Interim Executive Director, Department of Finance and Administration

Christopher J. Burkhalter (Vice-Chairman) – Consulting Actuary, Burkhalter Consulting Actuaries

Mike Chaney – Commissioner, Mississippi Insurance Department

Dr. Alfred Rankins, Jr. – Commissioner, Institutions of Higher Learning

Mark Formby – Chairman, Workers’ Compensation Commission

Kelly Hardwick – Executive Director, State Personnel Board

Dr. Andrea Mayfield – Executive Director, Mississippi Community College Board

Ray Higgins, Jr. – Executive Director, Public Employees’ Retirement System

Dr. Carey Wright – State Superintendent of Education

Larry Fortenberry – President, Executive Planning Group

The Honorable J. Walter Michel – Chairman, Senate Insurance Committee

The Honorable Gary Chism – Chairman, House Insurance Committee

The Honorable W. Briggs Hopson – Chairman, Senate Appropriations Committee

The Honorable John Read – Chairman, House Appropriations Committee

**Department of Finance and Administration, Office of Insurance Staff:**

Richard D. Self – State Insurance Administrator

Cindy Bradshaw – Deputy Director

Chris Shaman – Director, Benefits and Participant Services

Latasha Holmes – Director, Accounting and Analysis

John Anderson – Director, Special Programs

Terri Ashley – Director, Compliance and Audit

# STATEMENT OF COMPLIANCE

This section contains the Statement of Compliance and *Draft Pharmacy Benefit Manager Services Contract*. You must submit a signed Statement of Compliance with your proposal. If you object to any of the terms and conditions included in the draft contract provided in ***Appendix A* *– Draft Pharmacy Benefit Manager Services Contract***, or any requirements listed in this RFP, please note and explain your objections on the Statement of Compliance.

Statement of Compliance

We agree to adhere to all conditions and requirements as set forth in the Mississippi State and School Employees Health Insurance Management Board’s Request for Proposal for Pharmacy Benefit Manager, dated February 11, 2020, including the conditions contained in the draft contract included as ***Appendix A - Draft Pharmacy Benefit Manager Services Contract***, except as listed below:

An original signature is required below.

Name Date

Title

Company

Please have the appropriate officer sign this statement and include it as a part of your proposal.

# Appendix A

## *Draft Pharmacy Benefit Manager Services Contract*

# Appendix B

## *2020 Plan Document*

# Appendix C

## *Non-Disclosure Agreement*

# Appendix D

## *Specialty Drug List and Guaranteed Discounts*

# Appendix E

## *Top 50 Pharmacies Utilized by Participants*