State of Mississippi State and School Employees Health Insurance Management Board
Request for Proposal for Pharmacy Benefit Manager Services

Amendment Number One
Vendor Questions and Board Responses
March 10, 2020

1. **Do you anticipate extending the bid due date?**

   At this time, we anticipate completing the procurement as scheduled in the Request for Proposal.

2. **What additional details are you willing to provide, if any, beyond what is stated in the bid documents concerning how you will identify the winning bid?**

   The evaluation process is described in the Request for Proposal Section 1.14 Proposal Evaluation.

3. **Was this bid posted to the nationwide free bid notification website at www.mygovwatch.com?**

   No.

4. **Other than your own website, where was this bid posted?**

   In addition to the Department of Finance and Administration's website, this Request for Proposal was posted on the Mississippi Contract/Procurement Opportunity Search Portal, as well as advertised in the Clarion Ledger newspaper, in accordance with the Mississippi Public Procurement Review Board's Office of Personal Service Contract Review Rules and Regulations.

5. **Please confirm that all rebate guarantees should be on a per brand claim basis, in accordance with the following:**

   > **162. 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.**

   If this is the case, please also confirm that the table in Section 10 – Fee Schedule should be "Specialty rebates Guaranteed rebate per Specialty Brand Claim".

   Confirmed. Minimum rebates guarantees should be provided on a per brand claim basis. NOTE: The guarantees are the minimum rebates to be provided, as the Board shall be entitled to receive the greater of the guaranteed minimum or 100 percent of all rebates received by the PBM, as defined in the RFP. In addition, if rebates are received on non-brand claims, that rebates are likewise due back to the Board.

6. **Please provide the days' supply requirement for the Retail 90 offering.**
   1-30 days at 1 copay
   31-60 days at 2 copays
   61-90 at 3 copays

7. **Section 3, Definitions, Q22. Please confirm manufacturer coupons or copay card programs cannot be used or included in the calculation of the any rebate guarantees.**

   Confirmed. Savings generated by coupons or copay cards shall not be used in calculating rebate guarantees. However, in the event a participant utilizes a copay card or a discount card in addition to their Plan benefits, any savings earned are to be passed back to the Board at 100% of the total value of the rebate or manufacturer reimbursement payments.

8. **Section 4.12 Appeals Resolution. Please confirm ALL appeals (e.g. First, Second and Third/IRO level appeals) are to be provided at no cost. If accurate, please provide the total number of appeals by appeal type, for CY 2019.**

   Confirmed. All appeal processing is to be provided by the PBM at no additional cost. CY 2019 appeals statistics are not available.

9. **Section 4.28 Full Disclosure and Independent Review. Given the statement in Section 1.2 that "the Board must receive the full and complete amount of any … manufacturer rebates," please confirm that manufacturer copay coupons and copay assistance programs are not included in the definition of Rebates to the extent the Board does not receive a financial benefit.**

   Confirmed. Refer to Question #7.

10. **Section 4.30 Formulary Management, Item #3 and Section 8.2 Plan Design and Formulary Management. Please clarify the Board's intention with regards to bidders providing a "customizable formulary". Please provide an example of the type of change(s) the State implemented with their incumbent PBM.**

    As stated in Section 1.2 Purpose and Goals, 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. To the extent your formulary does not meet the requirements of Section 1.2, we reserve the right to negotiate changes with regard to the impact to the Plan. The Board acknowledges that any changes to the formulary may impact rebate guarantees and it is expected that the PBM will provide such impact analysis and work in good faith with the Board to ensure the economies of both parties are maintained so that the overall goal of driving to the lowest net cost is achieved. Any changes made with the current PBM are not considered relevant to this procurement.

11. **Section 2: Minimum Vendor Requirements, Item #1. Please clarify the intent of this question and if the proposing vendor is required to provide a reference with at least one million covered lives. If not, would it be acceptable for the proposing vendor to provide a statement indicating the number of lives it currently has under management for PBM services.**

    Proposers should list a sufficient number of clients, including all requested information per client listed, to document the proposer provides within the total book of business the relevant services to at least 1,000,000 covered lives.

12. **Section 7: References, Item #3. Similar to items #1 and #2, is it acceptable to "List up to three clients…" that have discontinued use of services since January 1, 2019"**

    *No. As stated, proposers should list **all** clients who have discontinued the use of their services since January 1, 2019.*

13. **RFP Section 1.2 (Purpose and Goals); RFP Section 4.27 (Transparency) and Appendix A – Draft PBM Agreement, Section 2(AA) (Transparency). The referenced sections contain statements that the PBM's actual reimbursement amount to the retail pharmacy and third-party mail order or specialty pharmacies, if any, must be passed through to DFA without mark-up or increase. The sections state that this requirement does not apply to mail order or specialty pharmacies owned by the PBM. However, the sections also state that the only compensation that the PBM will receive from or on behalf of the Board is the quoted administrative fee. For the avoidance of any doubt, please confirm that it is acceptable for PBMs that own their own mail order and specialty pharmacies to receive reimbursements above their costs for the drugs dispensed (i.e., "spread" or "margin"), so long as such drugs are dispensed in accordance with the pricing commitments in the proposal, as this differential between the cost of the drugs dispensed and the reimbursement amount will constitute compensation to the PBM.**

    Confirmed.

14. **RFP Section 2 (Minimum Vendor Requirements), item 4. Does DFA have a preferred format for the implementation bond? If so, will you please provide a specimen?**

    As stated in the Request for Proposal, vendors have the option of submitting an implementation bond (which would be secured through commercial means) or the establishment of an escrow account. The Board will be named as "exclusive beneficiary to guarantee timely and complete establishment of the contract and related services".

15. **RFP Section 12 (Statement of Compliance). Is it acceptable for a bidder to provide any objections it may have to the Draft Pharmacy Benefit Manager Administrative Contract in the form of a redline, including alternate requested language and an explanation? If language is contained in Section 4 of the RFP and also contained in the Draft Pharmacy Benefit Manager Services Contract, is it appropriate for the bidder to identify any related objection twice (once each in relation to both portions of the RFP)? If any of the bidder's responses to the questionnaire or other portions of the RFP would result in additional terms being added to the final contract, which terms do not conflict with any terms in the Draft Pharmacy Benefit Manager Services Contract, should the bidder include those additional terms in the Statement of Compliance?**

    No. The Request for Proposal requires the proposer to note and explain any objections to the terms and conditions included in the draft contract, as well as any requirements in the RFP, in the Statement of Compliance. If the same objection is related to multiple sections, for clarity, the objections should be included multiple times. In addition to including any objections in the Statement of Compliance, proposers may also include a redline version of the draft contract.

16. **Section 5. Performance Standards: For the Performance Guarantee related to Retail Claims Financial and Processing Accuracy, are you expecting the results to be based on audit methodology?**

Yes. The Board expects the PBM to maintain an internal audit process to quarterly self-report the results. As stated in the RFP, "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 detailed 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."

17. **Section 5. Performance Standards: For the Performance Guarantees related to Customer Service, is the scope for PBM Member Services and Pharmacy Help Desk only, or are these intended to be related to Mail Pharmacy as well?**

    The Board expects Mail Pharmacy operations to provide customer service to meet the same or similar standards. Proposers may likewise suggest alternative standards for mail pharmacy operations that may be considered if selected for contracting.

18. **Section 5. Performance Standards: For the Performance Guarantee related to Written and Telephone Inquiry Response Rate, what are you expecting to be measured in this Performance Guarantee vs. the written inquiries Performance Guarantee in the Customer Service section?**

    Please disregard the Performance Standard titled "Written and Telephone Inquiry Response Rate", as this will be negotiated with the selected PBM.

19. **Section 5. Performance Standards: For the Performance Guarantee related to Data Transfers, who will be designated as the Third-Party Administrator (TPA)?**

    Currently, the Board's medical claims TPA is Blue Cross & Blue Shield of Mississippi.

20. **Section 5. Performance Standards: For the Performance Guarantee related to Data Transfers, what file types are in scope?**

    Refer to Section 4.7, Data Transfers and File Maintenance Requirements, of the RFP.

21. **Section 5. Performance Standards: For the Performance Guarantee related to Data Transfers, is this related to eligibility and/or claims corrections?**

    Refer to Section 4.7, Data Transfers and File Maintenance Requirements, of the RFP.

22. **Section 8. Service Plan: Regarding Question 10a. Can you confirm "participants" means the members and not the pharmacies?**

    Confirmed. "Participant" is defined in Section 3 Definitions as an individual who is eligible to receive prescription drug services for which payment may be sought under the terms of the Plan.

23. **Section 8. Service Plan: Regarding Question 123. *Describe your process for ensuring medications are covered only for the DFA approved indications.* To the best of our knowledge, the DFA does not have any oversight of prescription drugs or their indications. Should it say DEA or FDA? If not, can you please explain what oversight they will have?**

    Please disregard DFA, and replace with Food and Drug Administration (FDA).

24. **Section 11. Statutory Requirement: Please confirm if this needs to be signed, as a signature section wasn't provided. If yes, does it need to be signed by an officer, principal or owner?**

    Confirmed. A signature is required.

25. **Can you please confirm what Retiree services the Board has in place today? Is the Board interested in EGWP services?**

    No. The Plan does not provide pharmacy benefits to Medicare eligible retirees.

26. **Can you please confirm the goal of the Board to have a custom formulary be offered or are they interested in a standard formulary that allows for some customization? Our question is in reference to *1.2 Purpose and Goals, the second paragraph*.**

    Refer to Question 10.

27. **Is the Board interested in pricing for a narrow retail network?**

    Not at this time. The Board may consider this option in future years if market changes and the Board's needs justify such a plan design option.

28. **What is the breakdown for the number of Active and Retiree lives?**

    As of March 1, 2020, the Plan's enrollment included 112,752 active employees with 52,251 dependents, 7,950 non-Medicare retirees with 1,938 dependents, and 665 COBRA participant with 318 dependents. The remaining 20,000+ Medicare primary participants and their dependents do not have pharmacy coverage provided by the Plan.

29. **Please confirm that the PBM services provided to Retirees are not Medicare/EGWP?**

    Confirmed.

30. **Can an extension be granted to April 13? The reason for the extension request is that the claims data is not scheduled to be released until March 6, which is approximately four weeks after the RFP was released. An extension will help ensure that the claims data is appropriately analyzed to provide the best PBM solution to the Board.**

    Not at this time. Refer to Question 1.

31. Can you please confirm when the claims data will be issued?

Claims data will be available the week of March 9, 2020.

32. Can confidential items be placed into a separate confidential information document for the non-redacted proposal versions?

Please refer to Section 1.3 Instructions to Proposers of the Request for Proposal for instructions on the form, content, and labeling of proposals, as well as the limited protections allowed relative to confidential information.

33. Please confirm Appendix E is for reference only?

Confirmed. Appendix E – "Top 50 Pharmacies Utilized by Participants" is provided to assist proposers in responding to questions in Section 8.1 Network Operations.

34. Can a census be supplied?

No. This information is not considered relevant.

35. Can a copy of the formulary be supplied?

No. This information is not considered relevant.

36. Can you show us a sample markup of confidential items for the non-redacted proposal?

Refer to Question 32.

37. Can you please define what "dedicated but not exclusive" means? It is in reference to *4. Scope of Services, 4.1 Account Service, Question 1 & 2*.

The selected PBM must assign a dedicated account manager to work with the Board. At the PBM's discretion, the account manager may be exclusive to the Board, and work with no other clients of the PBM, or may also serve as account manager to other clients. Whether or not exclusive, the dedicated account manager assigned by the PBM must be accessible and responsive to the Board.

38. Does the Board offer retirees a Medicare Part D Prescription program such as an EGWP (Employer Group Waiver Plan), RDS (Retiree Drug Subsidy), or similar? If so, Would the Board utilize X Rx's RDS or EGWP Part D Programs?

No. Refer to Question 25.

39. Can you please clarify what type of forms you are referring to for *4. Scope of Services, 4.21 Website C. Claim forms for both primary and secondary coverage*?

This item refers to participant-submitted paper claim forms.

40. Can you please clarify what reporting is required to be due ≤ 30 calendar days after the end of the quarter? This question is in reference to *5. Performance Standards, Reporting Requirements*.

The content, frequency and format of the PBM's standard reports will be agreed to during implementation. This will include but is not limited to quarterly reports to reflect performance, utilization, financial results, etc., some of which to be used in measuring compliance with performance guarantees.

41. Section 4.6 – Can the Board please provide the number of ID cards provided to members for the most recent 12 month period available?

This data is not available.

42. Section 4.12 – Can the Board please provide the number of appeals in 2019?

Refer to Question 8.

43. Section 4.30, #4 – Section 1.1 indicates "The Plan currently utilizes Prime's NetResults formulary which is a "closed" formulary." However, Section 4.30, #4 specifies that "drugs will not be excluded from coverage unless required by the FDA." Can the Board please 1) confirm that the Plan does currently utilize a "closed" formulary which includes standard PBM exclusions, and 2) that such exclusions are not applicable to requirement 4.30, #4?

The Board currently utilizes a closed formulary. With regard to Section 4.30, Formulary Management, #4, this should read, "The Board reserves the right to exclude products."

44. Can the Board please confirm that no Employer Group Waiver Plan (EGWP) services are requested at this time?

Refer to Question 25.

45. Section 5. PERFORMANCE STANDARDS:
Please clarify which written response performance guarantee (Customer Service or Written and telephone Inquiry Response Rate) we should adhere to as there appears to be a duplicate.

Refer to Question 18.

46. Section 4.12. Appeal Resolution: Please provide the number of level 1 initial determinations, of level 2 initial determinations, and external reviews for the Plan during 2019.

Refer to Question 8.

47. Section 8.3. Client/Participant Services: "How is the retail network name currently included on your ID cards?

The network name refers to the Plan and the PBM names. As stated in Section 4.6, Identification 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."

45. **Section 3. DEFINITIONS: Section 3, paragraph 22 of the RFP provides a definition of Rebates that includes "incentive rebates categorized as mail order purchase discounts". Bidder does not contract for or receive any incentive rebates that it seeks to categorize as mail order purchase discounts, however its affiliated mail order and specialty drug pharmacies do receive bona fide purchase discounts for things like prompt payment of invoices, total volume of drugs purchased to stock the pharmacy, etc. These amounts are not associated with any specific client's formulary elections or claim volume, but are factored into Bidder's cost of goods and reflected in the mail and specialty pharmacy discount guarantees we can offer. Please confirm that the successful PBM is not expected to pass through these bona fide purchase discounts separately from its mail and specialty pharmacy discount guarantees.**

    Confirmed.

46. **In addition, would the Board consider removing from the definition of "Rebates" the reference to "any of its affiliates"? Bidder may be affiliated with pharmacies or other entities that receive "value" from pharmaceutical manufacturers in the form of product discounts or fees for care management or other services provided in connection with the dispensing of products (i.e. "bona fide service fees").**

    The Board is not inclined at this time to change the definition of rebates as provided in the RFP. If a proposer objects to the definition and wishes to suggest alternative language, it should be noted in the submitted Statement of Compliance.

47. **Minimum Vendor Requirements #1: Are the client(s) requested here only enough to validate this minimum threshold of one million lives in the bidder's book of business as of January 1, 2020?**

    Refer to Question 11.

48. **Minimum Vendor Requirements #3: Are the clients requested here only those similar to the Plan that have been clients of the bidder for at least eight years as of January 1, 2020?**

    No. The requirement is for the proposing vendor to possess at least 8 years of related experience providing services to one or more clients, not all of which necessarily with the <u>same</u> client.

49. **Section 4.23.6: "Is the overall specialty discount guarantee limited to drugs dispensed through the exclusive specialty drug network only?**

    Yes

50. **Section 4.26.4 and 5:**
    In 4.26.4, the reports are listed as monthly and annual, however in 4.26.5 (and in all other RFP sections), these types of reports are listed as quarterly and annual. Please confirm that quarterly reporting is intended, since monthly reporting of rebates would be very challenging.

    The Board prefers to receive rebates attributable to the Plan as soon as possible after they are received by the PBM. Required monthly and quarterly reporting will be discussed with the selected vendor and agreed upon during implementation.

51. Section 4.30.4: Given that the Plan's current formulary, NetResults, is a "closed" formulary (Section 1.1.), please confirm that 4.30.4 is not intended to prevent bidder from offering it's closed or exclusion formulary?

Refer to Question 43.

52. Fee Schedule: The Fee Schedule includes a single row for each element of Retail Network pricing (brand discount, generic discount, brand dispensing fee, and generic dispensing fee). Does the Board want a separate Retail 90 network, with more aggressive pricing than Retail 30? If so, what days' supply would differentiate the Retail 90 network from the Retail 30 network, e.g. 35+ or 60+ or 83+? If the Board does not want a separate Retail 90 network, then please confirm that the rates quoted should be a blend of 30 day and 90 day network pricing.

Yes. Please include any information related to a Retail 90 network in Tab 15 of your proposal as directed in Section 1.3, Instructions to Proposers. See page 10 of the Plan Document. Retail 90 medications should be defined as greater than 83 days or 84-90 days.

53. General: Will the Board please provide a summary of the number and types of clinical reviews completed for their population during 2019? Prior Authorization reviews in 2019?

This information is not available.

54. Section 3 Definitions:
In Section 3, the definition of "Brand Name Drug" and "Generic Drug" indicates that "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." Please indicate where any types of excluded claims should be noted for the discount, dispensing fee, and rebate guarantees. Please also clarify that if a claim type is not specifically listed by each bidder as excluded, they will be assumed to be included in the bidder's pricing offer.

N/A. Discounts will be calculated based on the Multi-Source indicator on the day the drug is dispensed. No claims are to be excluded.

55. Draft Contract, Section 5: The fees listed in Exhibit A – Fee Schedule for Pharmacy Benefit Management Services 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. There are certain conditions that may occur throughout the life of a PBM contract which may require modifications to pricing; these generally include 1) a material change in lives/demographics, 2) client-driven changes in formulary, plan design, or clinical programs implemented, or 3) a change in law that impacts the level of rebates available in the marketplace. Please confirm if the Board will allow adjustments to pricing terms under these circumstances and that adjustments for any other purposes will not be allowed.

As stated in the draft contract, the pricing is firm unless the contract is duly amended. Any necessary amendments will be negotiated between the Board and the PBM.

56. On page 6 of the RFP, confirm current NetResults formulary is exclusionary.

Confirmed. The Plan currently utilizes a closed formulary.

57. Section 1.3, question #5 discusses the "blind" proposal copy requirement. Please confirm this copy should be the original proposal in a blank Word document without any vendor-identifying or pricing information.

Confirmed. The requirement is for an electronic "blind" copy in a searchable Microsoft Office® format, preferably in Word® or Portable Document Format (PDF®). The "blind" copy should also include all attachments.

58. In Section 2 of the RFP, please confirm what "for each client" means in questions #1, 2, and 3. Is the Board only looking for information for those clients that are similar in size and complexity to the State's plan? Can references be duplicated if they fit in several categories (not only in Section 2, but also Section 7 of the RFP)?

Client references requested in Section 2 and in Section 7 should be responsive to the respective questions in each section. In Section 2, the same reference, if qualified, may be used to document compliance with more than one minimum vendor requirement. In Section 7, proposers should provide at least three unique client references, if available, in responding to questions 1 and 2, so that at least six unique client references are provided. References listed in response to Section 2 may also be listed in responding to Section 7.

59. In Section 4.1, please state what the difference is between "dedicated" and "exclusive" members of the account team.

Refer to Question 37.

60. Section 4.27, question #2 references a transparency requirement described "below." What requirement does this refer to?

Please disregard the word "below", and replace it with "herein" .

61. Is the Board willing to change the "fees at risk" structure to "per life" under Section 5. Performance Standards?

If a proposer objects to the standard and wishes to suggest alternative language, it should be noted in the submitted Statement of Compliance.

62. Please provide zip code/census file.

Refer to Question 34.

63. What does the current "variable copayment" program look like today?

The Board does not currently have a variable copayment program.

64. How many calls are currently received by the call center per month?

The Board's pharmacy customer service center currently averages of 4,300 calls per quarter.

65. Please provide a breakdown of Active vs. Retiree lives.

Refer to Question 28.

66. Please provide the total number of PAs processed in 2019 as well as the approval rate %.

Refer to Question 56.

NOTE: This Amendment Number One is hereby made a part of the State and School Employees Health Insurance Management Board's Request for Proposal for Pharmacy Benefit Manager Services (RFP). This document must be signed and returned with your response to the RFP to acknowledge that you received the amendment and that you have accounted for it in your response to the Request for Proposal.

_____ _____

Authorized Signature of Proposer Date

_____

Printed Name of Proposer