Specification No.: CBO-2023-01

Advertisement Date: April 12, 2023

Request for Proposal for Pharmacy Benefits Manager

For the City of Chicago (the "City" or the "Lead Agency")

And

Chicago Park District ("CPD"), Chicago Public Schools ("CPS"), Chicago Transit Authority ("CTA"), City Colleges of Chicago ("CCC"), and the Chicago Transit Authority Retiree Healthcare Trust ("Trust")

(Which are sometimes referred to individually as an Agency or a Municipal Agency, and collectively as the Agencies or Municipal Agencies)

Issued By Lead Agency:

- Chicago Benefits Office of the City of Chicago's Department of Finance

Commencement Date:

- Varies by Agency, see General Invitation section

Contract Period:

- May vary by Agency, but generally three years from Commencement Date with two options to renew the contract, each option for a period of one year

Website, Designated Email Address, SharePoint site:

- RFP, Exhibits, and Amendments (as applicable), will be posted on www.cityofchicago.org/benefits
- Communication shall be through the designated email address: PBM-RFP@CityofChicago.org
- Proposals shall be submitted via the Lead Agency's SharePoint site (Registration is required to access the site. Instructions for access to the site will be provided once registration is completed.)
- Physical copies of the proposals are also required

Registration:

- Registration is required by potential respondents in order to engage in this RFP
- Via the email address, potential proposers must notify the Lead Agency of the intent to submit a proposal
- Via the email address, the Lead Agency will provide the required registration and confidentiality statement forms that must be signed in order to: participate in the pre-submittal conference, receive claims files and other information, and be granted access to the Lead Agency's SharePoint site

Deadlines/Important Dates:

- Pre-Submittal Video Conference is scheduled for **April 17, 2023, at 9:30 a.m.** To register send a request to the email address above
- Questions may be submitted to the designated SharePoint site by the deadline of **April 21, 2023 by 4:30 p.m. Central Time**
- Proposals are to be submitted prior to, but no later than the deadline of **May 11, 2023, by 4:30 p.m. Central Time**
- Late proposals will not be accepted

Submit:

- Submit the proposal using the Lead Agency's SharePoint site (registration is required to access site)
- Submit Six Physical Proposals: Submit six physical proposals in 3-ring binders, signed and sworn to before a notary public.
- Delivery: All proposals shall be addressed and delivered to:

  Arlene Ortiz, Deputy Director/Benefits Manager
  Chicago Benefits Office, City of Chicago
  333 S. State Street, Room 400
  Chicago IL 60604
  Note: The Chicago Benefits Office accepts deliveries 8:30 a.m. – 4:30 pm Monday – Friday except holidays
- Submit one redacted copy of the proposal electronically for FOIA purposes via the Lead Agency's SharePoint site
- Additional Requirements: See further instructions in the Submittal Requirements section

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General Invitation

The Agencies are a group of several local governments and/or municipal entities with varying prescription drug benefits for their employees and their dependents. The tables below provide a brief overview of the Agencies for 2022, and a list of the current pharmacy benefit manager for each. In this RFP, the term "members" includes employees and their dependents covered by each Agency's plan:

Calendar Year 2022

	City of Chicago All Plans (PPO and HMO)	CTA PPO	Chicago Public Schools All Plans	City Colleges (PPO and Retiree Plans)	Chicago Park District (PPO + HMO)	CTA Retiree HC Trust* (All Plans)	Grand Totals
Avg. Elig. Members / mo.	81,942	17,978	76,257	1,352	3,348	1,568	182,445
Avg. Rx volume (# of fills) per month	71,728	15,905	59,287	2,862	2,657	1,909	154,348
Gross cost for calendar year 2022	$148,678,349	$35,402,214	$133,192,967	$5,569,839	$6,800,070	$6,044,414	$335,687,853
Specialty RX gross cost for calendar year 2022	$83,857,672	$13,127,943	$67,457,324	$3,554,961	$3,923,837	$2,449,481	$174,371,218

*All CTA Retiree Health Care Trust numbers in 2023 and going forward will be approximately 20% higher. This is due to the HMO that was fully insured in 2022 was carved-out to CVS as of 1/1/2023.

Pharmacy Benefit Manager

Agency	Anticipated Commencement Date	Incumbent
City of Chicago (HMO & PPO)	1/1/2024	CVS/Caremark (PPO & HMO)
Chicago Park District	1/1/2024	CVS/Caremark (PPO & HMO)
Chicago Public Schools	1/1/2024	HDHP/PPO/HMO CVS/Caremark
Chicago Transit Authority	1/1/2024	PPO: CVS/Caremark
City Colleges of Chicago	1/1/2024	CVS/Caremark (PPO)
Chicago Transit Authority Retiree Healthcare Trust	1/1/2024	CVS/Caremark (PPO & HMO & Staff Plan)

The Agencies request responses to provide the pharmacy benefit management services specified in the Scope. The Agencies are jointly requesting one proposal for all Agencies. Proposals shall not, however, include cross-subsidization of any Agency by higher rates or fees or less favorable terms for another Agency. There is no guarantee that all Agencies will select the same Proposer. Further, the Agencies reserve the right to (i) select one or more Proposers to provide the services; (ii) reject any and all proposals; and/or (iii) identify any areas where a conflict of interest may require limitations on a Proposer. The selected Proposer will be required to enter into a separate contract with each individual Agency to provide the Services in accordance with terms and conditions acceptable to that Agency.

The selected Proposer shall perform the services directly. Services may not be performed by a parent company, subsidiary, or affiliates unless expressly disclosed by Proposer in its proposal. Proposals by brokers are not allowed. A potential Proposer in the pharmacy benefit manager business must

- download the RFP,
- register by identifying the Proposer in an email to the designated email address, and,
- sign a confidentiality statement that will be emailed after you register.

If you fail to register and sign the confidentiality statement, you will not be provided the claims and census data.

Additional details: Identification includes the name of the Proposer, address, telephone number, email address and name of primary contact. Middlemen or agents of potential Proposers are not permitted to register. A confidentiality agreement will be emailed to each potential Proposer. It must be signed by an authorized officer of the potential Proposer and delivered to the email address, PBM-RFP@CityofChicago.org. Registered Proposers which have signed the confidentiality agreement will be provided the opportunity to download claims, census and other data for all Agencies. Claims data will be de-identified historical claims for the 2022 calendar year. Further, registered potential Proposers will receive email notification of addenda to the RFP.

A firm may propose as a joint venture or independently as a single Proposer, but not as both. If a joint venture proposal is rejected, no firm which has participated in the joint proposal can be considered to provide services unless it has separately submitted a proposal. Similarly, two or more firms may submit proposals as a prime contractor(s) and subcontractor(s) relationship. In the event of such an arrangement, the Agencies reserve the right to reject any subcontractor and accept only the primary contractor. The Agencies will not accept a subcontractor and reject the primary contractor; if a subcontractor wishes to be considered separately for a portion of the services, it shall submit a separate proposal. A “partnership”, “joint venture” or “sole proprietorship” operating under an Assumed Name must be registered with the Illinois County in which located, as provided in the Assumed Business Name Act (805 ILCS 405.0.01, et. seq.).

Incumbents who wish to be considered for future services are not automatically considered in the absence of a proposal. All current providers of any service within the ambit of this RFP for any of the Agencies who are interested in the future in providing those services must submit a proposal.

Responsibility for Monitoring Website. Proposers waive their right to have clarifications and/or addenda sent to them. Those desiring to submit a proposal shall be responsible for checking the website for clarifications and/or addenda. Failure to obtain clarifications and/or addenda from the website shall not relieve Proposers from being bound by additional terms and conditions, clarifications, addenda, or from considering additional information contained therein in preparing proposals. Note that there may be multiple clarifications and/or addenda. Any harm to a Proposer resulting from failure to so monitor shall not be valid grounds for a protest against award(s) made under this solicitation.

Pre-Submittal Conference. A pre-submittal conference will be held on **April 17, 2023, from 9:30am to 11:00am via video conference (lead Agency will provide the video conference link to registered entities),** unless another time/date/location is specified in an addendum. Attendance is optional. If you wish to attend, please notify the lead Agency via the email address.

Addenda to this RFP. If a Proposer is in doubt as to the meaning of a part of this RFP, a written request for interpretation thereof may be submitted to the designated email address set forth on the cover page of this RFP. Telephone or personal correspondence with any Agency regarding the RFP is prohibited and will receive no response. Any revisions of this RFP deemed necessary by the Lead Agency will be made only by an addendum issued by the Lead Agency, posted on the website. Notification of any addendum may be e-mailed to each Proposer who has registered via email as described above (but need not be as potential Proposers are responsible for monitoring the website). Failure on the part of the Proposer to receive any written addendum will not be grounds for any consideration including but not limited to extending any deadline, changes in or relaxation of any requirements of the RFP, or withdrawal of the RFP. Oral clarifications offered by any Agency or any representative or employee of any Agency will not be binding on the Lead Agency or any of the Agencies.

Questions: All questions regarding the RFP shall be submitted via e-mail to the designated email address by the questions deadline set forth on the cover page of this RFP. In your email identify the name of the Agency for which the question is intended if it is intended for fewer than all Agencies. Answers to questions received by the deadline will be posted on the website and notification may be e-mailed to potential Proposers who have registered (but need not be as potential proposers are responsible for monitoring the website). Questions received after the deadline will not be answered.

Termination of RFP. Each one of the Agencies reserves the right to terminate its participation in this RFP solicitation in part or in whole at any stage, if the Agency determines such action to be in its best interest. The receipt of proposals or other related submittal documents will in no way obligate the Agencies to enter into any contract of any kind with any party.

Contracting. The selected Proposer shall perform its services in accordance with the terms and conditions of a written contract (professional services agreement or PSA) entered into between the Proposer and the individual Agency, pursuant to negotiations between the Proposer and the Agency. The contract shall meet the minimum requirements for the services described in this RFP, and shall include, at the Agency's option, additional enhancements (if any) offered in the selected Proposer's proposal. In no event will an Agency enter into any contract offering fewer services than required by this RFP or at greater costs than offered in the selected Proposer's proposal or as the proposal is modified through subsequent submissions to the Agencies. If an Agency has provided a sample PSA for review by the Proposer, the Proposer will be considered to have accepted the terms set forth therein unless the Proposer makes specific written objections to contractual provisions. Proposers must identify specific provisions to which they object, propose revisions thereto, and identify any other changes requested in a redline utilizing "Track Changes" or an equivalent feature. References to a prior agreement with an Agency will be an inadequate response. The Agencies reserve the right, however, to negotiate with the selected Proposer on further edits to such sample PSA as needed to reflect changes to applicable law and regulations, changes in Agency policy or procedures, or other changes as the Agency deems necessary, and the Proposer shall negotiate in good faith regarding such additional edits.

Terminology. The terms used in this RFP shall have the meaning assigned to them by the respective Agencies' benefit plans, unless defined differently in context.

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Submittal Requirements and Proposer's Execution Page

General. An electronic copy of the proposal shall be submitted via the Lead Agency's SharePoint site, with all files in Word, Excel, or PDF format. Respondents will have two folders available on the SharePoint site for a redacted and a non-redacted copy of the proposal.

Physical proposals shall be submitted in sealed boxes. The outside of the boxes must clearly indicate the name of the RFP (i.e. "Pharmacy Benefit Manager" RFP) the specification number of the RFP (CBO-2023-01), the time and dates specified for receipt (see title page of this RFP) as well as the name and address of the Proposer. Personal delivery of proposals is recommended. Where proposals are sent by mail or other courier, the Proposer shall be responsible for timely delivery. If the delivery is delayed beyond the date and hour set for the proposal receipt the proposal may not be considered. Read the Agency Exhibits and comply with Agency specific requirements.

Physical Hard Copy in 3 Ring Binder - Exception. Financial statements may, as an option, be provided electronically via the SharePoint site provided by the Lead Agency.

Scope and Interrogatives. Reproduce each Scope requirement and confirm you propose to meet that requirement. Exceptions to your proposal to meet the Scope requirements shall be specific. Reproduce each Interrogative and address it. Your electronic response to the Scope and Interrogatives may be in either Microsoft Word or Microsoft Excel.

Instructions on first and second page of RFP. Proposals shall be submitted in accordance with the instructions of the first and second page of this RFP (e.g. by the submittal deadline, in the form and manner and to the delivery method, as set forth on the first page of this RFP).

Proposer's Execution Page. Proposals shall be accompanied by a Proposer's execution page, reproduced on the Proposer's letterhead, referring to Specification No.: CBO-2023-01, and signed by an authorized officer of Proposer, as follows:

"_____[insert name of Proposer] (A) represents and warrants that all responses to all interrogatives are true and correct, (B) proposes to perform each and every element of the Scope unless specifically excepted in its response, (C) hereby commits that, if selected will faithfully comply with all elements of its proposal unless otherwise accepted by the Agencies or with respect to an Agency by that Agency and *(D) authorizes release of information under the Freedom of Information Act to the extend not redacted in accordance with the submittal requirements of the RFP."*

Redacted Copies for FOIA. All material submitted may be made available in accordance with the Freedom of Information Act (FOIA) irrespective of whether the Proposal may contain trade secrets or other proprietary information. However, if the Respondent considers portions of its proposal to be confidential and not subject to FOIA, then such determination must be managed as follows:

- In addition to the proposal, provide one duplicate of the complete proposals redacted for FOIA purposes, in the same manner as the electronic copy above. The electronic unredacted proposal shall be in one subfolder or zip file, and the electronic redacted copy shall be in another subfolder or zip file. The two subfolders shall be clearly marked, redacted and non-redacted.
- The redacted content shall be blacked-out. Failure to black out redacted content (for example, claiming "the following paragraph is confidential" or "column 3 is confidential") will result in content being released under FOIA.
- Only content that is actually a trade secret or proprietary information shall be redacted.
- Provide a key, describing what content was redacted and why the redacted content was redacted, citing the specific FOIA reference which justifies the redaction being made. Cite to the Illinois Freedom of Information Act, 5 ILCS 140.

- Failure to follow this procedure will lead to release of data under a FOIA.
- Overly broad or wholesale redacting of content that is not a trade secret or other proprietary data shall constitute failure to follow this procedure.

False Statements. Be advised, any person who knowingly makes a false statement of material fact to the city or any Agency in violation of any statute, ordinance or regulation, or who knowingly falsifies any statement of material fact made in connection with an application, report, affidavit, oath, or attestation, including a statement of material fact made in connection with a bid, proposal, contract or economic disclosure statement or affidavit, is liable to the city for a civil penalty of not less than $500.00 and not more than $1,000.00, plus up to three times the amount of damages which the city sustains because of the person's violation of this section. A person who violates this section shall also be liable for the city's litigation and collection costs and attorney's fees. The penalties imposed by this section shall be in addition to any other penalty provided for in the municipal code. (Added Coun. J. 12-15-04, p. 39915, § 1). Any person who aids, abets, incites, compels or coerces the doing of any act prohibited by this chapter shall be liable to the city for the same penalties for the violation. (Added Coun. J. 12-15-04, p. 39915, § 1). In addition to any other means authorized by law, the corporation counsel may enforce this chapter by instituting an action with the department of administrative hearings. (Added Coun. J. 12-15-04, p. 39915, § 1)

Evaluation Criteria

Minimum Recommended Qualifications. Proposers which do not meet the minimum recommended qualifications listed below will not be considered:

- Currently serves as pharmacy benefit manager for at least three accounts, each having at least 25,000 employees per account;
- Currently serves as pharmacy benefit manager for at least two accounts with at least 25,000 employees per account in which the majority of employees' employment is the subject of collective bargaining agreements;
- Has at least 5 years of experience as an organization in providing pharmacy benefit management services of the type to be procured through this RFP;
- Is licensed in the State of Illinois and has other licenses and certifications as may be necessary to provide the proposed services; and
- Has annual gross revenues of at least $2 billion during either 2021 or 2022.

General. The Agencies may consider any factors the Agencies deem necessary or desirable to determine the best overall value and most advantageous selection, based on the following criteria:

- Proposer's cost proposal and overall cost structure and approaches to controlling the cost of medications while providing appropriate access for members.
- Proposer's professional qualifications and specialized experience and local availability of key personnel committed to perform Services. Proposers should demonstrate having clients similar in size to the Agencies, or larger.
- The degree to which the Proposer accepts the Scope of Service requirements as presented by the Agencies.
- Compliance with the Submittal requirements.
- Effectiveness of pharmacy management programs including generic dispensing, specialty drug usage, patient health management, co-pay card optimization, place of service optimization and ability to work cooperatively and in a spirit of good faith with other Agency health, dental and wellness programs.
- Effectiveness of pharmacy management programs addressing opioids which may include appropriate limits or controls, prior authorization interventions, clinical review, opioid management, or other appropriate programs.
- No exceptions to Sample Terms and Conditions to be Included in Professional Services Agreement to the extent included in Agency exhibits, or if exceptions are noted the acceptability to the Agencies of those noted exceptions.
- The financial condition of Proposer, including but not limited to factors indicating financial stability to ensure performance over the duration of the contract.
- Disclosed or undisclosed legal concerns regarding Proposer or any of its divisions, subsidiaries, or parent, or any affiliate.
- Anything that may indicate any conflicts (or potential conflicts) of interest which might compromise the Proposer's ability to satisfactorily perform the proposed services, or which might undermine the integrity of the competitive procurement process.
- The level, relevancy, and quality of participation by MBE/WBE Agency requirements or policies.

Response. Proposers will also be evaluated on the quality of the response with regard to, *inter alia*, the following:

- "Will discuss," "will negotiate," and "will consider" are not appropriate answers.
- A reference to the current contractual terms by any incumbent is not an appropriate answer.

- Proposers must be able to clearly demonstrate strength and experience, as Contractor, in its ability to:
    - Administer and manage pharmacy benefits at an economical cost.
    - Offer competitive performance guarantees to the Agencies related to implementation and on-going services.
    - Be very responsive to changes in the health plan offerings required as the result of changes in collectively bargained benefits and/or arbitration awards and requests of the Agencies.
    - Rate quotations must include a minimum rate guarantee period of 36 months.
    - Adhere to the data security requirements disclosed in the Agency exhibits (e.g. the City of Chicago's Information Security and Technology Policies).
    - Sign each Agency's Business Associate Agreement.

Cost Proposal

Answer all the questions in Section O of the Interrogatives.

For the electronic version of your cost proposal, use Microsoft Excel wherever appropriate. Microsoft Word can be used for narrative responses.

Scope of Services

A. Statement of Services

The Agencies are soliciting Proposals for prescription drug pharmacy network and prescription drug mail order services as follows. However, the fact that a requirement is not set forth in the Scope of Services does not mean the requirement does not exist; this Scope of services is not exhaustive. It is supplemented in all cases by the Agency Exhibits and the Agencies reserve the right to add additional requirements to the Scope as necessary or as collectively bargained.

1. Provide ready access to retail network pharmacies where members can obtain prescription drugs in accordance with the terms of the applicable benefit plan.
    a. Provide pharmacy locations sufficient in number and hours of operation such that no member has to travel more than 5 miles to a pharmacy during the hours of 8:00 a.m. to 9:00 p.m., 7 days per week.
    b. Provide pharmacy locations sufficient in number and hours of operation that no member has to travel more than 10 miles to a pharmacy during the hours of 9:00 p.m. to 8:00 a.m., 7 days per week.
    c. Agencies with a substantial retiree population located outside the Chicagoland area may relax the mileage requirement for such population.

2. Provide ready access to a mail order pharmacy where members can obtain maintenance medications in accordance with the terms of the benefit plan.

3. Provide ready access to a specialty pharmacy where members can obtain specialty medications in accordance with the terms of the benefit plan.
    a. The specialty pharmacy shall be adequately and professionally staffed to ensure that members obtain the most up to date and accurate information about their medications and to the degree directed by the Agency, about their illnesses.
    b. The specialty pharmacy process shall not prevent or hinder the timely fulfillment of covered prescriptions.

4. Provide access to a program(s) that offers manufacturers' discount card access for plan members.

5. Provide claims processing services for products dispensed by participating pharmacies, including both mail and specialty pharmacies, in a manner that complies with applicable laws and rules, and provide and maintain toll free telephone access for participating pharmacies to address claims submission and utilization review issues.

6. Direct participating pharmacies to collect all applicable cost shares.

7. Maintain a database of participating pharmacies so that members and the Agencies may locate a participating retail pharmacy using the PBM's website.

8. Conduct retail pharmacy audits to ensure compliance with applicable pharmacy network agreements.

9. Create, credential, and manage a network of fully licensed and insured retail pharmacies to ensure the accuracy and quality of services provided to members who need prescription drugs at a price advantageous to the Agencies.

10. Offer high-quality, timely and personal customer service to Agency members during normal hours of business; make a toll-free number available to members.

11. Offer on-line services, including mail order prescription re-order, formulary information and other services generally available to other customers. No member (employee or dependent) may change enrollment information on the PBM system; eligibility changes can only be processed via an Agency data file or otherwise as described in Scope #93 below.

12. Offer a mobile app for services.

13. Provide and mail member identification cards and allow members to request replacement cards through web-based and mobile applications.

14. Prepare and mail all necessary communications to members about the start of services. The Agencies reserve the right to review all correspondence with members; however, the PBM retains responsibility for the accuracy of any communications it sends to members.

15. Ensure that drugs are dispensed in accordance with the FDA approved uses.

16. Provide Utilization Management Services to ensure cost-effective, efficacious use of prescription drugs by members who are covered by the benefit plans of the Agencies. Such Services must include, at a minimum, prospective, concurrent and retrospective review to identify, prevent and/or reduce medically or procedurally inappropriate dispensing activity.

17. Provide standard management and utilization reports, as well as non-standard management and utilization reports and ad hoc reports to the Agencies upon request.

18. Provide programs designed to encourage members to take medications as directed by their physicians.

19. Provide programs designed to identify members whose medications may conflict with each other or which may represent sub-optimal prescribing on the part of the prescribing physician. Provide physician education.

20. Provide programs designed to discourage the inappropriate use of opioid medications for pain control in accordance with current standards of medical and pharmacy practice related to opioid prescription and use.

21. Provide proof of extensive “cyber-security” protocols to protect member information, prescription fill information and other personal health information in the possession of the PBM and the management of same by the PBM.

22. As requested by the Agency, participate with other service providers to improve the quality and cost of services provided to members under their health benefit plans. Such participation may include data sharing and/or joint program development.

23. Complete a Business Associate Agreement (BAA) with each Agency and other service providers as may be required.

24. Provide programs designed to identify potential misuse of prescription medications including but not limited to opioid medications and other medications which are subject to medical and/or financial abuse.

25. Provide professional consulting services to Agencies about Prescription Drug Benefits on an on-going basis to ensure compliance with all laws and provide advice regarding benefit design and communication to members.

26. Each Agency has collective bargaining agreements in place. The selected PBM will provide all requested reports on an as needed basis in the time frames requested by the Agency to assist in the collective bargaining process or to allow the Agency to meet its obligations under the collective bargaining agreements. The PBM will consult collaboratively with Agency staff to identify cost savings, efficiencies and performance improvements during the life of the collective bargaining agreement(s) and extensions thereto.

27. Process member appeals or provide assistance to Agency in processing member appeals, at the option of the Agency.

28. Each Agency has negotiated different benefit terms regarding prescription drugs and has adopted its own plan(s) of benefits. Each Agency expects that the selected PBM will be completely familiar with the terms related to prescription drugs and will faithfully implement those terms into their administrative systems and processes. To the extent that a PBM fails to administer a plan(s) in accordance with its terms, the PBM will reimburse the Agency for any amounts charged to the Agency or to the member in error. The plan of benefits of each Agency is determined by that Agency, not by the PBM.

29. Provide a selection of prescription drug formularies to allow an Agency to better manage the cost of providing the prescription drug benefit to its members. If need be, the PBM must agree to develop a custom formulary that is consistent with the collective bargaining agreements in place at the effective date of service provision and consistent with the Agency's plan of benefits.

30. Negotiate rebate and other contracts with drug manufacturers that will inure to the benefit of the Agencies.

31. Negotiate contracts with retail pharmacies and pharmacy chains that are highly competitive and offer significant value to the Agencies.

32. Promptly notify an Agency of any prospective manufacturer settlement of which the PBM becomes aware.

33. Offer competitive pricing for the term of the contract and any extensions thereto.
    a. Unless there are contractual or other barriers specific to an Agency, the Agencies intend to select one vendor to become the PBM for the Agencies.
    b. The Agencies expect that each Agency will receive the benefits of the large group purchase and that unless the specific plan design features adopted by an Agency require different pricing requirements, all Agencies with similar plan designs will receive the same price offer from the selected PBM.

34. If requested by a particular Agency, provide either aggregate or individual stop loss coverage.

35. As required by the Agencies, comply with the Women's Business Enterprise (WBE), Minority Business Enterprise (WBE) and Disabled Business Enterprise (DBE) requirements, comply with the Disadvantaged Business Requirements, and comply with all other Agency specific requirements.

36. Cooperate fully and on a timely basis with the Agency in responding to an audit or a review by a regulatory body.

37. Conduct a comparative analysis of non-quantitative treatment limitations as required under the Mental Health Parity and Addiction Equity Act and update as required.

38. Execute contracts with the individual Agencies in a timely manner, generally before the effective date of the contract. However, should the contract not be executed prior to its effective date, Proposer must agree to provide discounts and rebates retroactive to the effective date; no financial term will be impacted by the date of execution of the contract. Each Agency Contract will contain certain mandatory provisions as set forth in the Agency's respective Exhibits.

Each respondent must confirm its agreement with and ability to provide the above listed scope of service items, 1 through 38. If you cannot or will not provide the requested services, so indicate in writing and explain why you cannot or will not provide the requested services in accordance with the above. If you are vague in your response or state "will discuss" or "generally agree" or "TBD,"" or the like, the Agencies may interpret such response as indicative of a respondent's inability to provide the service as described.

Also, the following minimum anticipated requirements are applicable to all Respondents for all Services proposed. Respondent must indicate whether it meets or does not meet the requirement, and explain any qualifications and/or requested modifications for each item. Any unanswered question may be interpreted as an indication that you cannot meet the requirement and may be cause for the rejection of the entire Proposal. In preparing your proposal, we recommend you duplicate each item and include your response after each.

The Respondent(s) must agree:

39. That in no case may Services be offered except by persons and firms authorized and duly licensed as required by federal, state and/or local laws or regulations. The Respondent(s) must provide evidence of a license to do business in the State of Illinois, and all other licenses and certifications as may be necessary to provide the Services requested.

40. To offer such Services in conformance with applicable federal and/or state laws and regulations, each Agency's ordinances, personnel policies, procedures, and rules, and the terms of the applicable benefit plans.

41. To provide these Services at a cost most advantageous to the Agencies.

42. To review and advise the Agencies on the prescription drug pharmacy network Services policy, Plan documents and/or certificates of coverage. The PBM will be responsible for advising the Agencies of all operational changes, industry-specific litigation, industry-specific practices, and pending proposed legislative changes that may affect provision of the Services or the coverage provided under the Agency's benefit plan or the operations, financing, administration, or terms thereof during the term of the contracts.

43. To provide any information that is necessary for the effective provision of the Services, including legal and legislative updates, and administrative advice and assistance as needed.

44. To perform any and all functions necessary to ensure financial control and accuracy of services provided to members, including services provided by the retail network pharmacies and the mail order pharmacy. If an Agency determines that benefit plan coverage has been provided to an individual or individuals ineligible for coverage, or that a prescription has been filled for a drug or supply that is excluded from coverage, the PBM must reimburse the Agencies for claims paid in error whether or not the PBM has recovered from the claimant.

45. To provide members with prescription drug mail order program Services in accordance with the terms of the applicable benefit plans.

46. At the option of the Agency provide higher fill-limits at certain retail dispensing locations. For example, "90-days at retail" where the PBM has negotiated better pricing, consistent with mail order pricing, at the given retail location.

47. To provide each Agency, via secure electronic transmission, a monthly report of prescriptions filled with data sufficient to allow analysis and audit. If an Agency determines that a prescription has been filled for an individual or individuals ineligible for benefits or that a prescription has been filled for a drug or supply that is excluded from coverage, the PBM must reimburse the Agency for benefits paid in error whether or not the PBM has recovered from the claimant.

48. To provide insurance covering all operations of the PBM and/or its subcontractors at no cost to the Agencies as set forth in each Agency's exhibit.

49. To maintain confidentiality of each Agency's employee records and any other information deemed proprietary or confidential by each Agency or by law. Weekly, bi-monthly and or monthly census information of members will be provided by each Agency's benefit management office or its delegate. This information must be used to determine eligibility for Services. While in the possession of the PBM, these records remain the property of each Agency and must be returned upon completion or termination of the Contract with the Agency or upon request by the Agency. While in use by the PBM, the confidentiality of these records must be maintained in accordance with all applicable laws and regulations and applicable Agency policies. This confidential information must not be used by the PBM for other than the purposes specified in any Contracts between the Agencies and the PBM. Any data provided by the Agencies to the PBM may not be sold, marketed, furnished or otherwise made available to any person or entity for any purpose. Any data provided to any person or entity regarding dispensing activity must be approved by the Agency prior to its release. The PBM must disclose the data transmission record, the frequency of reporting and the nature of the financial relationship between the PBM and the receiving party. Anonymized data exchanges are not permitted; anonymized member data shall not be retained by the PBM for its own use or use by others.

50. All records are the property of the applicable Agency and must be returned to the applicable Agency upon the completion or termination of any Contract with the Agency.

51. To permit a periodic audit of the Services it performed for the program by each Agency's staff or the Agency's appointed auditors.

52. To promptly rectify errors and resolve disputes in a manner satisfactory to the relevant Agency.

53. To work cooperatively and in good faith with each Agency to assure that all Services are rendered in a prompt and accurate manner to all members.

54. To meet with Agency representatives whenever necessary to promptly resolve any problems which occur related to the administration of any Contract(s).

55. In the event of class action lawsuits against members of the pharmaceutical related industries, such as pharmaceutical manufacturers, retailers AWP publishers, etc., upon request of an Agency, the PBM will provide all necessary data and reporting needed for the agencies to pursue actions in such lawsuits.

56. To complete the Contractor's disclosure forms (for example but not limited to, the Economic Disclosure Statement) or affidavits as may be required by each Agency as set forth in this RFP and to promptly update such forms when any material aspect of the submitted disclosure changes. (Failure to do so may be considered an event of default.)

57. To develop participant communication brochures, pamphlets and materials, subject to the approval of each Agency, which the Agency considers necessary to communicate Plan benefits. The development, production and distribution of materials must be at no cost to the Agencies. No contractual provision, correspondence to an Agency or other document will limit Contractor's responsibility for the accuracy and completeness of these materials or for compliance with all laws, statutes and ordinances.

58. To assist the Agency in the drafting and review of Plan documents and summaries and amendments thereto.

59. To use standardized data file formats and data transmission methods as may be required for the administration of the Services, subject to each Agency's approval.

60. To undertake all other necessary tasks to properly administer the Services for the members, including but not limited to, determining member eligibility at the point of sale for benefits in accordance with Agency provided eligibility information; sending communication materials on an as needed basis; responding to telephone and written or electronically submitted inquiries; instructing members as to the appropriate and cost effective use of prescription drug benefits and services; and reimbursing members for covered drugs and supplies purchased at out-of-network pharmacies pursuant to the applicable benefit plan.

61. To provide, at no cost to the Agency, training materials and on-site training sessions necessary for the implementation of services.

62. To participate in open-enrollment meetings on an as requested basis.

63. To provide required notifications to members in a timely manner. Required notifications include, among other items, changes in formulary drugs, changes in specialty drugs, and changes in program requirements related to dispensing activities that would change the members co-payment or days' supply provided per prescription.

64. To provide members and the Agencies with prompt, accurate and courteous service. The PBM must agree to make accurate and timely determinations of eligibility for participation in the Services in accordance with eligibility information provided by the Agencies. Timely service specifically includes prompt issuance of identification cards if required by the Agencies, prompt recording of overrides requested by an Agency, and immediate eligibility update requests.

65. To provide each Agency with periodic billing, no less frequently than monthly, for the medication furnished during the billing period. If the PBM has a standard file layout which includes the below listed information at a minimum, provide the standard file layout. Subject to applicable law on patient confidentiality, invoices must indicate the following information at a minimum:

    a. As applicable for a particular Agency, a unique identifying number such as Employee UID number or other unique number as specified by the Agency
    b. Member name
    c. Patient name and relationship to employee
    d. Patient date of birth
    e. Name of medication and count
    f. NDC (National Drug Code)
    g. Ingredient cost
    h. Dispensing cost
    i. Total cost
    j. Date of fill
    k. Therapeutic class
    l. Whether generic medication was used or if a generic medication was available and not used
    m. Price difference between generic and brand medication
    n. Regular member co-pay amount and
    o. Maximum Allowable Cost (MAC) member co-pay amount
    p. Whether a formulary drug was used or if a formulary drug was available and not used
    q. DAW information
    r. Co-insurance as applicable
    s. Deductible per claim and accumulated deductible
    t. AHFS class
    u. Dispensing pharmacy information including whether such pharmacy was part of a chain
    v. Prescribing physician information

66. If directed by an Agency, to encourage the filling of maintenance drugs through the prescription drug mail order program and to inform members of the advantages of refilling existing maintenance drug prescriptions through the prescription drug mail order program.

67. To maintain a cumulative record of the medications and or supplies prescribed for each member. The selected Respondent(s) must monitor drug interactions for members and, if a potential drug interaction might occur, must require that a dispensing pharmacy contact the prescribing physician for clarification of the prescription prior to the dispensing of the medication.

68. To participate in a data exchange with medical Plan administrators or other vendor selected by an Agency for purposes of Plan analysis to the extent permitted by law if directed by the Agencies.

69. To provide management information reports as requested by the Agencies. Section I Interrogatives, *Monitoring and Reporting,* outlines minimum reporting criteria. The Agencies reserve the right to make changes in the content and frequency of reporting requirements. The Respondent(s) must provide reports as requested to assist the Agencies in their collective bargaining activities.

70. To be appropriately licensed and to ensure that any Participating Providers are appropriately licensed, insured and of high quality and meet all other requirements specified by the PBM.

71. To negotiate terms and conditions of a Contract with each Agency on a timely basis.

72. To acknowledge that the Agencies may renew any Contract for up to 2 additional 1-year periods beyond the original term agreed to by the Agency and the selected Respondent(s). This requirement will differ by Agency depending on the final length of contract for the Agency.

73. To undertake all other necessary tasks to properly administer the prescription drug pharmacy network Services, the prescription drug mail order program Services or the integrated program as required by the Agencies.

74. In the event Proposer's organization is currently providing services to an Agency of the type procured under this RFP and is not selected to provide those services to that Agency under this RFP, to cooperate fully and take all actions necessary to smoothly transfer the services to another carrier or service provider selected by the Agency.

75. To cooperate fully and take all actions necessary to smoothly transfer the services in the event that another company is selected to provide the service(s) to any Agency following the expiration or termination of the Contract.

76. To provide performance guarantees regarding a successful transition for the initial term of any Contract with the applicable Agencies. These performance guarantees must provide financial payment to the Agency if performance thresholds are not met.

77. To provide performance guarantees for Services provided during the term of any Contract as set forth in Section P. below. These performance guarantees must be financial in nature.

78. To provide all renewal information to the Agencies at least 120 days prior to the expiration date of any contract period, in form and content acceptable to the applicable Agency.

79. To agree that any Contract may be terminated at any time without cause and without penalties to the Agency by the relevant Agency or for cause as set forth in the Contract with the Agency.

80. To staff the Agencies various work locations with company representatives to meet with the Agencies' employees on an as needed basis. These meetings generally occur as part of the annual open enrollment periods for employee benefits as well as health/wellness fairs.

81. To provide telephone (advisory) and online service about prescription Services for all members, 24 hours per day, 7 days per week.

82. To provide specified Services without regard to any waiting period, other than those related to quantity, fill and dosing requirements.

83. To provide a sufficient number of pharmacies in close proximity to the residences of covered members that are open and available to dispense medications from 8:00 a.m. to 9:00 p.m. 7 days per week. The Agencies reserve the right to determine sufficiency of access.

84. To provide a sufficient number of pharmacies within reasonable proximity to member's residences, including two pharmacies within 5 miles of the residences of members and one pharmacy within 10-miles of the residences of members that is open and available to dispense medications 24 hours a day, 7 days per week including holidays. The Agencies reserve the right to determine sufficiency of access.

85. To provide emergency contact information for key managers responsible for each Agency's account. Such key managers must include both operational and account management staff who are of sufficient authority within the organization as to be capable of and in a position to resolve emergency situations.

86. To pay paper claims submitted for pharmaceutical drugs obtained outside the pharmacy drug network program. Claims will be submitted using Respondent(s)'s standard claim form.

87. To provide a specific and/or aggregate "Stop Loss" contract for any non-self-insured Agency.

88. To provide written representation and warranty that all participating pharmacists and pharmacies and the PBM's own professional staff have met the PBM's credentialing criteria, licensing and/or certification and insurance requirements.

89. To regularly negotiate with pharmacy companies and drug manufacturers to ensure that the expected total cost to the Agencies and expected fees for the Services are as low as possible. Consistent with the volume of prescriptions purchased by the Agencies, the Respondent(s) must advise the Agencies as to the continued competitiveness of the price it is paying for drugs and Services.

90. To conduct drug utilization reviews, retrospectively, concurrently and prospectively.

91. To retain all records directly or indirectly, related to its performance of Services during the term of any Contracts and for a period of 7 years after termination or expiration of any Contract or until all pending disputes are resolved. The Agencies have the right to review, abstract, audit and copy all records and accounts of the PBM directly or indirectly related to any Contracts.

92. To permit enrollment information to be entered in two different ways: (A) for some Agencies (e.g., the City of Chicago) the Agency will provide eligibility information only via an eligibility data file; (B) for some Agencies (e.g. Chicago Park District) eligibility will be entered online via a portal into the pharmacy benefit manager's system; and (C) some Agencies may use both (A) and (B). The Agency examples in the preceding sentence are as of the date the RFP is published and may change.

93. To be a fiduciary for purposes of initial claim adjudication and appeals relating to prescription drug benefits.

94. To comply with all provisions of the Affordable Care Act (ACA) and any implementing rules and regulations which apply to the provision and administration of the services the Proposer will provide.

To the extent an ACA mandate applies to the Agency but not to the Proposer, the Proposer will fully cooperate with the Agency so that the Agency may fulfill its obligations under the ACA.

95. To maintain a Coordination of Benefits (COB) program to correctly pay claims and/or dispense medication in accordance with payment terms of the Agency's COB rules where more than one prescription drug coverage exists for an employee or dependent.

    To provide web-based applications and mobile applications that provide information to eligible persons regarding benefits/plan design, eligibility, pharmacy network participation, and key contacts, and other relevant info.

96. Assist the Agency in Section 204, Prescription Drug Data Collection (RxDC) reporting as required/requested by the Agency.

Interrogatives

A. General

A1. Provide the full name and address of your company (PBM headquarters) and the address(es) of your Chicago metropolitan area offices or the address of the location where the Agencies' accounts will be managed. Please confirm that all activities related to the Agency accounts will occur within the United States.

A2. What year was your company formed? Provide the history and present ownership of your company, including names, if any, of your company's subsidiaries and other entities that you own or that you are owned by. Also include a detailed description of licensure by state.

A3. Describe the organization and capitalization of your company, listing principal owners and shareholders and the percentage (if any) of ownership interest held by another organization, including their relationship to the proposing entity. Provide complete audited financial statement for the past three fiscal years.

A4. Document that your organization is licensed to do business in Illinois, and that your organization is in compliance with both the requirements of the insurance laws and the requirements of the duly constituted insurance regulatory authority of the State of Illinois and any other state in which your company operates.

A5. List all subcontractors and a complete description of the Services to be subcontracted related to the Scope of Services in this RFP, including firm names, addresses, and contact persons. Include descriptive information concerning subcontractor's organization, abilities, including licensing and examples of work on projects of similar size and scope. Also describe any business relationships including any ownership interest, partnership or joint venture with drug manufacturers, wholesalers, retail pharmacy chains, home healthcare service providers, medical equipment or supply manufacturers, and medical applications for mobile devices or other platforms. Describe the nature of such relationships including financial terms and commitments that you have made to have such vendors provide services as a regular part of your client arrangements.

A6. List all affiliates, subsidiaries, and any corporate parent that will provide any part of the services requested under this RFP. Describe the services to be provided by the entity and assign an expected percentage of revenue to be provided to said affiliates, subsidiaries or corporate parent. If said entities are domiciled outside of the United States, provide their locations.

A7. Do you now have or have you ever had a contract with any of the Agencies to provide any product or services? If so, list each such contract with date of inception and termination, including a brief description of the services provided.

A8. Is your organization currently engaged in or have any pending service contracts, which may result in a conflict of interest with the Agencies? If yes, describe the potential or actual conflict of interest.

A9. Has any part of your company or any of its officers, directors or owners filed for bankruptcy or reorganization within the last 2 years? If yes, provide all pertinent details of these actions.

A10. Is your organization involved in any litigation that could affect its ability to meet the RFP's requirements? Is your organization involved in any litigation that is the subject of significant import to the industry?

A11. Has your company's license been revoked, cancelled or suspended in the last 5 years? If yes, explain.

A12. Are your pharmacy programs under review or currently subject to sanctions from any state, health, insurance or consumer protection agency? From Medicare or Medicaid? From the US Department of Labor? Within the last five years?

A13. Are there any planned or pending agreements or negotiations to merge or sell your company within the next 9 to 24 months? If yes, include agreements, letters of intent, or comparable documents pertaining to such agreements or negotiations, which verify the company's structure. Has your company been acquired by or merged with another firm during the last ten years? If yes, explain.

A14. Describe your organization's financial stability, providing both your and any affiliated entities' three most recent annual financial stability ratings (e.g., Best's, Moody's and Standard & Poor's).

A15. List the types and amounts of professional liability coverage maintained by your organization.

A16. Your organization must represent and warrant that it is qualified to develop, maintain and administer a prescription drug pharmacy network (as specified in the Scope of Services) and that you have exercised all due diligence and professional judgment in the selection and retention of Participating Providers. State your understanding that the Agencies will rely upon these representations and warranties in its selection process and during the term of any Contract.

B. Administration and Operations

B 1. Is your company licensed to offer prescription drug pharmacy network Services? (a) Yes ___ No___ (b) mail order program Services? Yes___ No___ (c) Integrated Program? Yes___ No___ (d) Specialty Program? Yes___ No___

B 2. How long has your company provided: (a) prescription drug pharmacy network services? _____years. (b) prescription drug mail order program services? _____ years. (c) integrated program services? __years. (d) Specialty program services? __years.

Indicate the number of years or "not applicable"

B 3. Describe in detail (narrative and flow charts) the operation of each component of your prescription drug pharmacy network in providing services to the Agencies.

B 4. Provide a description of the resources you expect to commit to perform the Services required under the prescription drug pharmacy network services. Include the expected staffing levels in terms of category of employees to be utilized and number of full-time equivalent employees.

B 5. List the names and provide a brief work history of all key personnel that will be committed to perform the Services; include any experience with public sector and large employer plans, including those large employers who offer multiple plans with a variety of prescription drug benefit programs. Identify whether those key personnel will have responsibilities for clients in addition to the Agencies. For the proposed Account Manager, provide specific experience information related to accounts the size of the

Agency accounts. Also provide the names and telephone numbers of the individuals (exclude marketing representatives and account executives) within your organization able to answer technical and professional questions related to your RFP response.

B 6. Indicate the total number of clients for whom you provide services similar to the services called for in this RFP. Provide the number of clients based on the following ranges of covered lives:

Population Size	Number of Clients
a) 0 – 25,000	
b) 25,000 – 40,000	
c) 40,001 – 55,000	
d) 55,001 – 75,000	
e) 75,001 – and up	
Total Covered Lives	

B 7. Regarding your experience with unionized employee groups, describe your experience with collective bargaining units of (i) over 1000 employees and (ii) over 10,000 employees.

C. Financial

C 1. Describe your organization's growth during the past 3 years. Include a schedule of annual additions and deletions to your covered lives and number of clients. Demonstrate what steps you would take to successfully integrate the Agencies' membership for the expected start date of services).

C 2. What percentages of annual expenditures have been paid to related parties (i.e., subsidiaries, affiliates or parent company; joint ventures or firms in which you hold an interest greater than 10%) for each of the past 3 years? Describe related party relationships. For example, if your mail order pharmacy is a separate but affiliated company, this question would apply.

C 3. Are member co-pays included in your corporate revenue calculation? If yes, explain. If no, why not? What effect does the co-pay revenue recognition or lack thereof, have on the total corporate financial landscape (e.g. revenue, expenses, rebates, incentives, etc.)?

C 4. What percent of your (a) gross revenue and (b) enrollment comes from the following sources? If the Pharmacy Benefit Manager is part of a larger organization, respond with respect to Pharmacy Benefit Manager clients. Percentages should total 100%. Include drug manufacturer revenue separately in the line indicated; if Manufacturer compensation is a reduction in the cost of goods purchased or an increase in the quantity of goods provided, so indicate and estimate the value as a percentage of gross revenue.

		Revenue	Enrollment (Lives)
A	Medicare		
B	Medicaid		
C	Employer Groups		
D	Manufacturers		N/A

E	Pharmacies		N/A
F	Other (provide details)		
	Total	100%	

C 5. List the following for each of your 5 largest current clients; indicate the type of program you are administering as well as your term of service with each.

a) name of client, address, telephone number and contact person
b) number of employees eligible
c) number of employees enrolled
d) number of retirees enrolled
e) number of covered lives
f) what MAC options are being utilized
g) annual prescription revenue received (all programs)
h) number of prescriptions filled in network through retail card program
i) number of prescriptions filled out-of-network through claims only
j) number of prescriptions issued by mail

C 6. List the 5 largest accounts that have terminated your services in the last 12 months. Include the following:

a) name of client, address, telephone number and contact person
b) number of employees enrolled
c) number of retirees enrolled
d) number of covered lives
e) date and reason for termination
f) description of all services provided to client

C 7. Describe in detail how your organization would implement the addition of more 175,000 members spread across several organizations to your client base. If you are selected and you are not the incumbent organization, explain how you will transition these groups from their existing carriers/administrators/service providers to your organization while providing continuity of service and the integrity of the historical information.

C 8. What do you suggest (for both the prescription drug pharmacy network and prescription drug mail order program) as initial parameters for “days too soon” edits? Would you require any claim history from the current pharmacy benefit manager? Why or why not?

C 9. Will you provide dedicated project/account managers who will act as the single point of contact during the development and implementation phase? Provide a detailed timetable (Gantt Chart) geared toward a 1/1/2024 implementation date, indicating the earliest completion dates your organization would be able to implement all significant tasks. This timetable must be of sufficient detail to serve as an actual work plan and must include, but not be limited to:

a) Initial planning meeting
b) Coordination with the benefit management staffs of the Agencies
c) Communications development and production
d) Network development
e) Development of systems capabilities
f) Contract development and execution.

C 10. Describe the types of marketing, promotional and employee-communication materials your company would use to promote/implement the Agencies' RX services. Provide samples or drafts of such materials.

C 11. How many new accounts are scheduled for implementation during the next twelve months? What type of accounts?

Account Type	New Enrollment (New Covered Lives
Prescription Drug	
Pharmacy Network and Mail Order Services	
Other, if any	

C 12. The Agencies are an aggregation of several local governments and/or municipal corporations with varying prescription drug benefit coverages for their members.

Labor contracts end at various times throughout the year: state your ability to change the benefit provisions of the Prescription Drug Benefits during the term of any Contract when directed to do so by the Agencies. How much notice is required to change a co-payment? An exclusion? A quantity limit? A formulary? If applicable, discuss any anticipated or potential impact to pricing or costs to the Agencies.

C13. Provide forms and or standard materials used in administering the prescription drug pharmacy network Services, including monthly billing and claim forms with file layouts, as applicable.

C 14. If you provide identification cards for members, what constitutes the employee member number? (e.g., unique identification number, payroll number, other). Describe the creation and mailing process, including timeframes to accomplish distribution. The Agencies, at their option, may request that your logo be placed on the face of their medical I.D. cards. Confirm your agreement with this request.

C 15. What are your general business hours? Hours for customer service? Do you have a toll-free number? Would there be a separate toll-free number for the Agencies?

C 16. When a Plan member calls the toll-free number, what are the qualifications of the person who answers the call? Is there an automated attendant? If so, how many choices is the caller offered (e.g., potential buttons to press). Is there a live person available during your hours of operation?

C 17. Describe your pharmacy benefit management record-keeping system, providing samples of standard reports and screen prints or record layouts detailing available claims information. Provide a sample contract file set-up package (materials needed to established plan parameters on your system).

C 18. Identify the types of errors and explain how you would rectify any errors made in the administration of the prescription drug pharmacy network Services.

C 19. Describe all internal and external audit processes conducted by your organization to maintain the integrity of the plan, including:

a) Who conducts internal audits? External audits?
b) Who decides how often internal or external audits are conducted?
c) What percentages of pharmacies receive desk audits?
d) How frequently are clients provided with internal quality audit reports?
e) How are settlements calculated?
f) Specify your fraud detection protocols.
g) How many on-site audits did you conduct last year?
h) What was the primary reason for on-site audits?
i) When was the last SSAE 16 or SOC series audit conducted for your firm? Were any deficiencies noted that would be of concern to a prospective client?

D. <u>Mail Order Services (Non-Specialty)</u>

D 1. For each of the last 2 years, provide the number of mail order prescriptions processed at each of your mail dispensing facilities. For forecast the number of prescriptions per week expected to be dispensed as well as dispensing capacity.

D 2. Do you pre-package or re-package medication for dispensing in your facility? If so, why? What percentage of the medications dispensed are pre-packaged? Re-packaged?

D 3. During the past 24 months, how many NDC numbers did you obtain for your pre-packaging/repackaging activity? For each NDC, which is unique to your facility, list the NDC number, the price as of and the NDC number and price of the most similar NDC number in use for general purposes.

D 4. Explain the methodology, standard operating procedures and pricing policy used in:
a. the pre-packaging processes
b. the re-packaging processes

D 5. Do registered pharmacists or other pharmacy technicians perform final quality control checks on each prescription before mailing? Describe.

D 6. Where is the dispensing facility that you would use to provide Service to the Agencies' account? Why did you select this particular facility? Why did you not select the other facilities? Do you have an Illinois facility?

D 7. How are prescriptions sent to participants? Via US mail? Via UPS? Is the answer the same for compound medications? (Note that Agency plan designs may exclude compound drugs) For liquid medications? What is the process for perishable medications?

D 8. Describe your quality assurance programs including controls on dispensing accuracy and member services. What happens if a prescription is lost in the mail? Are you willing to vary your shipping method if certain locations are not receiving the prescriptions in a timely manner? If not, why not?

D 9. What are your standards for prescription turnaround time, for both refills and new prescriptions? How do you define turnaround time? What has been your average turnaround time for 2020, 2021 and 2022 for each facility?

D 10. Provide a frequency distribution of your dispensing times by facility. Indicate the percentage of prescriptions that are dispensed within 1 day of receipt, 2 days, etc. Measure turnaround time (using working days not calendar days) from the receipt of the prescription until the drug is mailed. Are there any factors that would cause certain types of drugs to take longer when filling the prescription? If yes, specify.

D 11. State the days of the week and the hours each day that mail is delivered and picked up to/from your facility.

D 12. Do you fill prescriptions for a 90-day supply if the physician writes less than a 90-day supply with refills? Explain. Would you refuse to fill a prescription for a 30-day supply? Why or why not?

D 13. Provide the following information about your mail order pharmacy for each facility:

a. location of pharmacy
b. date the facility became operational
c. number of pharmacists employed at the facility
d. number of technicians employed at the facility
e. ratio of registered pharmacists to covered lives
f. dispensing capacity per week of the facility
g. number of prescriptions per week currently filled
h. number of prescriptions dispensed with an error
i. number of complaints received about timeliness
j. rate of generic fill
k. square footage of facility
l. days of the week and hours each day you dispense mail order drugs
m. other staff located at the facility, e.g., customer and client services.

D 14. If a medical plan has restrictions on the number of times a maintenance medication can be filled at retail, how is the member notified to go to mail for future prescriptions?

D 15. For compound medications, how do you determine medical necessity for a compound? Do you have any programs in place to avoid unnecessary dispensing of compound medications? If yes, please describe. If no, why have you not adopted any programs related to compound medications?

E. <u>Generic Drugs</u>

E 1. How does your company maintain the highest level of generic dispensing and quality at the most competitive price? Discuss how you maintain fresh and consistent supplies of quality generic drugs. Indicate from whom you purchase your generic drugs. How frequently does your inventory turnover? For your mail order pharmacy, does the pharmacy stock more than one generic for a particular drug? How many typically are stocked for a typical drug? When more than one is stocked how is the generic selected to fill a prescription selected?

E 2. Do you dispense only FDA (Food & Drug Administration) approved generics? Explain your dispensing philosophy related to name brand and generic drugs.

E 3. How will your company encourage generic substitution? Describe any switching programs employed in the Respondent(s)'s mail service facility and explain how the firm assures that there is no reduction in

the quality of service. Explain how savings generated through such programs will be passed on to the Agencies.

E 4. Do you track physician prescribing patterns, and do you educate physicians about their prescribing patterns? If yes, explain. If no, why not?

E 5. What is the percentage of generic drugs dispensed for your book of business in 2020, 2021 and 2022? Calculate the rate as a percentage of total drugs dispensed and as a percentage of all available generics. If possible, provide the ratio for the total and by type of plan (HMO or Indemnity, Mail or Retail, and Voluntary Formulary or Mandatory Formulary). Provide this information in terms of both dollars and number of prescriptions.

E 6. Can you administer Maximum Allowable Cost (MAC) programs for both the prescription drug pharmacy network and the mail order operations? Describe your MAC program, including why and how specific drugs are selected for the MAC list, and how that list is implemented. Include the number of generics on the list, percentage that MAC drugs represent of the total number of available generic drugs, method used to update MAC list and drugs added/dropped from the list over the past 24 months.

E 7. How do you track and measure the cost-effectiveness of the MAC program? Is the maximum MAC price based on a specific quantity/size (tablet or capsule)? Explain. Indicate if your program increased generic utilization and if so, how your costs were impacted.

E 8. What pricing source is used and/or would be used for MAC pricing? If you develop your own pricing, describe your methodology in detail. Provide a MAC price list.

E 9. What generic drugs or suppliers have you dropped from the mail order program because of quality or supply problems over the past 18 months?

E 10. If you purchase generic drugs from a different manufacturer and as a result the color, shape, size and/or base ingredients are different:

a. Do you notify the participant of the change? If yes, how? If no, why not?
b. If a participant's physician believes a particular generic's base ingredient, coating, etc. may trigger an allergy or adverse reaction in a patient (gluten sensitivity, for example) will you lock the generic to a generic from another manufacturer acceptable to the physician? Is there a cost?
c. If a participant's physician believes a particular generic's base ingredient, coating, manufacturing process, etc. provides an inconsistent blood serum level for a participant (seizure disorder medications, for example) will you lock the generic to a generic from another manufacturer acceptable to the physician? Is there a cost?

E 11. Provide a list of those generics you do not consider to be therapeutic equivalents to the brand drug. Who determines which drugs are not therapeutically equivalent? Describe the process.

E.12 When a drug is approved to be sold "over the counter" what analysis do you conduct for clients to determine the most economical course of action regarding the OTC drug and/or any existing generic or brand drugs? For example, discuss omeprazole. What would you advise a client regarding offering omeprazole in the same strength as the OTC?

E 13. Can you administer a Transparent Model Program (TMP) for both the prescription drug pharmacy network and the mail order operations? If yes, describe your proposed TMP for the Agencies. Include administrative costs and any other costs to be incurred by the Agencies exclusive of the pass-through of drug costs and provide a projection of TMP total costs inclusive of drug costs. Provide a comparison to your other proposal(s) (i.e. compared to MAC or AWP based proposals). How many clients do you serve using a TMP? How many of those clients cover over 20,000 subscribers?

E 14. What is your definition of a generic drug? How many versions of the "generic" must be available? During any exclusivity period related to first to file, have you ever negotiated with the brand manufacturer to fill with the brand drug until the first to file period is exhausted? Please describe any efforts you have taken to improve pricing during the exclusivity period for new generics (as applicable)? Under such circumstances are rebates continued?

E 15. As an alternative to a MAC, a client may elect to pay based on the generic dispensed (discount is applied per contract to the NDC for the specific drug dispensed). What are the advantages to such an arrangement? For an agency with a high rate of mail dispensing, would you agree to dispense the least cost safe generic? Why or why not?

E16. <u>Pricing Bases</u>:

a. Confirm that Medi-Span MONY Multisource indicators will be used to indicate Generics with a "Y" and Brands with either an "O", "M", or "N"
b. Confirm that all guarantees are calculated using the date sensitive Medi-Span AWP unit cost based on the 11-digit NDC of the actual product and the actual quantity that is dispensed.
c. Confirm that the generic guarantee is inclusive of single-source generics.
d. Confirm that no single-source generic or generic drug will be included in the brand drug component for the annual discount guarantee reconciliation.
e. Confirm that "House Generics"/ Brand claims with a DAW 5 will be included in the generic guarantee financial reconciliation calculations and GDR guarantee calculations.
f. Confirm that any rebates derived from "House Generics" or DAW 5 claims will be passed through at 100% to the Plan.
g. Confirm that members will pay the generic copay for any "House Generics" or DAW 5 claims.
h. Confirm that brands with a DAW code of 0, 1, 2, 3, 4, 6, 7, 8, and 9 will be included in the brand discount guarantees, dispensing fees, and minimum rebate guarantee calculations.
i. Confirm that any formulary excluded brand products that were adjudicated as a result of an exception process such as for medical necessity will be included in the discount, dispensing fee, minimum rebate guarantees and any rebates associated with such drugs will be passed through at 100% to Plan
j. Confirm that any penalty amounts paid by the member as a result of the DAW 1 or 2 penalty program will not be used by the PBM in discount guarantee reconciliations.
k. Confirm that all guarantees are calculated before the application of member cost share.
l. Confirm that both non-MAC and MAC priced Generic Drugs are to be included in the generic guarantee measurement.
m. Confirm that the PBM agrees to provide upon request any proprietary algorithms, hierarchy or other logic employed to define a prescription drug as generic or brand, as part of this competitive bid process or at any point during any resulting contract term.

n. Confirm that the PBM has read the individual plan design specific to each Agency and that the price offer(s) is in accordance with the terms of the Agency's current benefit plan. If any item of a pricing offer is contingent upon the Agency obtaining concessions/design changed in the Collective Bargaining process or is dependent upon a change in plan design or administrative processes, the proposer must so state. The PBM may propose more favorable pricing attendant upon changes in design or administration, but must propose pricing in accordance with the Agency's current co-payment, co-insurance, other cost sharing or other plan design structures.
o. Confirm that the PBM agrees to provide for an annual market check on contract terms including administrative fees; allowances; other financial guarantees including discount rates for retail, mail and specialty drugs; and rebates to ensure that the Agencies continue to receive competitive market rates.
p. Specify any conditions on your pricing offer.
q. In the event that an individual agency would decide to delay implementation beyond January 1, 2024, does your price offer and/or other terms change? How do they change for a July 1, 2024 date? For a January 1, 2025 date?

F. <u>Systems Support/Technology</u>

F 1. Do you own or lease your PBM systems? If owned, is it purchased? Developed in-house or by an outside consultant? How is the system(s) maintained, enhanced or upgraded? Secured? What are your data warehousing capacities? To what degree do you use "cloud" based applications?

F 2. The selected Respondent(s) must be able to process data from eligibility files provided by the Agencies. These files will contain information regarding employees, their spouses and dependents eligible for the program. The Agency file layouts are included in a folder entitled "EligLayouts". There are three different file layouts:

EDI 834 format: CPD, CPS, CoC.
RX51 format: CTA, CTA Retiree Health Care Trust
QL1000 format: City Colleges of Chicago (CCC)

F 3. Respondent(s) must be capable of accepting the Agencies' eligibility files through some form of electronic transmission. For example, the following forms are acceptable: encrypted E-mail or SFTP. Indicate whether you would prefer to accept electronic transmission. These eligibility files will be sent to you at least monthly and for some Agencies weekly. Your system must be capable of accommodating such monthly and weekly transmissions and your proposal shall specifically state your ability to accommodate these transmissions.

F 4. Assuming that eligibility files were received by (example 1) 1:00 p.m. central time on Friday, and (example 2) six a.m. on Tuesday, in each example at what date and time could the Agencies expect that the data would be updated on your system?

F 5. The Agencies prefer to send files that will contain all currently covered members. Also included will be records of recently terminated members; these records would be clearly marked as terminations and would contain termination effective dates. Respondent(s) must be able to process these terminations

as quickly as possible, using the termination date provided. State your ability or capacity to process "full file" census data and terminations.

F 6. The Respondent(s)'s computer system must be able to maintain eligibility at a dependent level. Provide sample screen prints from your eligibility system, demonstrating information stored at a dependent level. If a dependent is terminated, what impact does that have on subsequent transmissions? On reporting? Explain.

F 7. How long has your claims system been operational?

F 8. Describe your system's hardware, operating system and application software. Where is the system located?

F 9. Provide a detailed history of significant systems and methodology changes and enhancements over the last 2 years (or since system implementation if less than 2 years). Include a description of your process to ensure all client edits are transferred.

F. 10. Reserved

F 11. For what period of time do you maintain claim transactions online?

F 12. For what period of time do you maintain claim transactions in a machine-readable form, e.g., archived magnetic tapes or compact disks or other media?

F 13. Do you have plans to significantly alter or enhance your claims administration capabilities? If so, describe.

F 14. Describe your system support, if any, for physicians writing electronic prescriptions.

F 15. For your 5 largest clients during the past 2 years, how many times have you: (a) changed processing systems requiring a history data transfer? (b) changed platforms? (c) changed time period for which history is kept on-line?

F 16. Do you have an automated dispensing system in your mail order pharmacy? If yes, describe it in detail.

F 17. Do your mail order pharmacies use the same system that you use for retail claim processing? Why or why not?

F 18. What percentage of the total time that your automated dispensing system is scheduled to operate have you experienced down time during each of the prior 2 years? Have you experienced an episode of down time, which lasted more than 24 consecutive hours? If yes, how many such episodes have there been?

F 19. Describe your disaster recovery program, and the procedures followed when your system fails. How quickly can the backup system be put in place? What historical or current data would be lost due to a power failure affecting the central system? How would lost files be recreated? Is any current day's input lost if there is a power failure affecting work stations but not the central system?

F 20. Describe your disaster recovery program if your telephone system fails. Has your telephone system experienced an episode of down time which lasted more than 24 consecutive hours?

F 21. Describe your computer security system. Who would have access to the Agencies' data? What restrictions are there to computer access? Are passwords stored in an encrypted form? Are they changed on a regular basis? Where is the central system located? Explain the degree to which cyber security principals are embedded in your organization? Do you have a formal cyber security program for your employees? What is the content of the program? How can members be assured if they use your web or mobile applications that their data is secure? During the last five years has your firm experienced a data breach? If so, describe what happened and what steps you took to correct the issue(s) including member outreach and protection.

F 22. When was the last time a system security audit was performed?

F 23. Describe the process used by your company to comply with the Health Insurance Portability and Accountability Act (HIPAA) Electronic Data Interchange (EDI), Privacy, and Security requirements. (Have there been any breaches of Protected Health Information (PHI) within the last five years? If yes, provide a description of such events (including type of PHI involved and number of individuals impacted) and the steps taken to resolve the breach and avoid similar breaches in the future.

F 24. Describe the security of your Internet connected systems. How does your system prevent intrusion by persons not authorized to access system/information? How is access to your system controlled? What are your secure file transfer protocols?

F 25. Provide a specific description of your system's ability to track work in process. Describe all information available to the Agencies and their customer service staffs.

F 26. How does your systems' staff interact with your eligibility and customer service staffs? For example, if eligibility files have been received but not yet processed, how are service inquiries for newly eligible (but not processed) members responded to? Who is responsible for processing changes in benefit design? What is the testing process to ensure any changes are accurate?

F 27. What reports are used to reconcile eligibility changes? For whom are the reports prepared? How are they used in eligibility processing?

F 28. To the extent the following items have not been covered in your response, please provide additional information:

1. Is your staff trained on all Privacy and Security requirements? Describe your training program and enforcement policy.
2. Does your system produce sufficient audit trails to satisfy the HIPAA Privacy and Security regulations?
3. How is security set up in the system? What are the different levels of security?
4. Is your system database encrypted?
5. Are system data backups encrypted?
6. Are all electronic transmissions of PHI, including eligibility files, authorizations, reports, etc., encrypted or sent via secure means? Which encryption methods do you support for e-mails and file transmissions? Please describe.
7. What are your procedures for data destruction prior to hardware and media disposal?

8. Which EDI Transactions sets have you implemented and for those remaining, what is the target implementation date? If you plan to outsource to outside entity, who will be that business partner?

F 29. Describe your coordination of benefit capabilities for Medicare and non-Medicare coverages. Does your company's system maintain the name and address of other carriers/plans and an indication of a primary or secondary status? Is such status maintained for each covered person? Is COB applied for retail, mail and paper claims?

F 30 State the number of genders your system currently recognizes in addition to male and female. Describe any planned future changes.

F31. Describe your web-based services for members. Describe your security for these web-based services for members. Be specific as to what members can do with your applications. Do you have a mobile app? How does the functionality of the mobile app differ from the functionality of the web-app?

F 32. Have any of your computer-based systems or applications ever been hacked? If yes, please describe the situation in detail and explain what steps you took to reduce vulnerability and address member security concerns/

G. <u>Customer Support Services</u>

G 1. Describe any outside consulting organization(s) that assists you in any phase of the design, implementation or day-to-day operation of the prescription drug pharmacy network program, prescription drug mail order program or the integrated program.

G 2. Describe your customer service department, indicating the number of personnel who will be associated with each phase of implementation of an Agency's program from the inception through delivery of services. Include your telephone system, workflow patterns, system interfaces and management structure. Also advise us as to whether you will have a dedicated customer service unit and/or line(s) for the Agencies or Agency, and if there will be an additional charge.

G 3. Do you offer special programs or services for retirees (Medicare eligible persons)? If so, describe.

G 4. Do you provide toll free numbers for clients and their members? What are the hours of operation and how many full-time customer service representatives would be provided to service the Agencies accounts?

G 5. Do you provide emergency telephone service during all other hours? If so, what is the nature of the service that is available?

G 6. How often can your staff answer a telephone request on the first call, versus how often your staff has to call back? Indicate how you ensure callbacks are made.

G 7. What are the results that you have achieved for your telephone customer service units in the last 6 months with respect to:

a) abandonment rates
b) busy signals

c) average time in queue
d) average call time

G 8. Does your organization provide a customer service "hot line" for urgent inquiries regarding benefits? What are the "hot line" customer service hours? Who is given access to this service? What reports or controls do you have regarding the quality of service (including monitoring member satisfaction, relative to promptness, courteousness, and accuracy) that your customer service unit provides?

G 9. Are experienced pharmacists available to assist program members? If so, describe the nature of the assistance (i.e., education, mail program components). During what hours and what days is this assistance available? Do they make recommendations or suggestions for particular medications or generics?

G 10. Provide an overview of your process for complaint handling, including a description of the formal process and ways in which complaints are used for corrective action. Include in your discussion complaints originating from clients, members, providers and staff. Provide a statement of how you expect to resolve: a) employee complaints; b) provider complaints; c) Agency complaints. Will this procedure differ for retail, mail order and/or out-of-network providers? Similarly describe your process for referral to Independent Review Organizations, including reasons for referral, description of the internal and final external review processes for a clinical appeal.

G 11. Indicate under what conditions a member could be terminated from coverage by your organization.

G 12. Describe the grievance procedure in detail for the employee, for the provider and any role the Respondent would expect the Agencies to take in the procedures. Indicate whether the grievance procedure includes an appeals board comprised of all interested parties (i.e., employee, employer (Agencies), clinicians, health plan representatives) that meet periodically to resolve grievances and make recommendations regarding improvements to patient care and administrative processes

G 13. Do you have an established member complaint log for both administrative and clinical problems? Describe the procedure for providing feedback to the employer. Also provide the following statistics:

a. The number of grievances submitted in the last 2 years;
b. The subjects of the grievances (e.g., provider courtesy, quality care, promptness, claim denial, accuracy, etc.);
c. Results of the grievance process by subject in the following categories:
    1. Denials upheld
    2. Denials modified
    3. Denials overturned
    4. Other

G 14. Under certain circumstances, the Agencies may have to respond to a Grievance filed by a member pursuant to an existing collective bargaining agreement. Under these circumstances would you provide professional persons as needed to testify at a grievance hearing to present testimony regarding the instant case? For example, at the conclusion of an Independent Review, the member might still be dissatisfied with the denial (assuming the IRO upheld the clinical denial) and would file a grievance. What assistance would you offer the Agency in defending such a grievance?

G 15. Members are at various levels of sophistication regarding their knowledge of the plan of benefits, their health status, and/or their knowledge of prescription drugs. What steps have you taken over the past five years to increase members' understanding of these variables? In customer service? In the way you communicate to members? In the design of your web and mobile applications? Have you worked with specific clients to improve these factors regarding their membership? If yes, what were the programs and what were the results of those programs? Are your marketing/communication materials "one size fits all" or do you customize those materials for segments of the employer population? What is the basis for the segmentation? Do you conduct communication audits to determine if your written and digital materials are effective? If yes, what changes have you made as a result of said audits? If you have not conducted said audit, why not?

G 16. If you are not the current PBM to any Agency, would the addition of this book of business require that you hire and train new customer services representatives? What would be the process by which any new representatives would be trained to be fully operational as of the transition date?

G 17. Do your customer service representatives work from home or from an office? What are your security procedures for work-from-home employees? What percentage of your CSRs work from home?

H. Plan Administration

H 1. If you currently have an operational prescription drug pharmacy network in the metropolitan Chicago area, provide a map of the facilities and a description of the provider network(s) in detail.

H 2. Each Agency will routinely provide the enrollment information via electronic transmission. Enrollment and termination information for PHSA participants may be provided on paper. A full, positive census of PHSA enrollment and termination data is provided on a weekly basis. Describe how you would update eligibility for PHSA participants.

H 3. Using the summary zip code data provided for each Agency, provide a Geo-Access analysis by zip code of your retail pharmacy network, using a 2-mile radius. Provide a separate analysis using 5 miles as the radius for your 24-hour retail pharmacy outlets. Please conduct the analysis using the five-digit zip codes.

H 4. State the reasons pharmacists/pharmacies may be terminated from the network.

H 5. The Agencies expect to be billed no more frequently than monthly. Some of the agencies will want a claim file submitted with the invoice or shortly thereafter. At a minimum, the Agencies will require that the invoices contain the following information:

a. group number
b. member social security number
c. member name
d. patient name and relationship to employee
e. name of medication and count
f. dispensing cost
g. shipping cost (if applicable)
h. total cost
i. date of order
j. formulary or non-formulary

k. NDC (National Drug Code)
l. therapeutic class
m. whether generic medication was used or if generic medication was available and not used.
n. price difference between generic and brand
o. applicable tax
p. adjustments

The Agencies reserve the right to request additional information as necessary. If any of the above items are not available, explain.

H 6. Do you agree to provide the claim file with the invoice?

H 7. Describe your quality assurance controls for eligibility screening.

H 8. How would weekly full-file refreshes be processed?

H 9. Are both the retail and the mail order pharmacies able to access a common database to verify eligibility, benefit information and drug utilization information?

H 10. If databases for the retail and the mail order programs are not common, how will utilization review control be implemented? How often is retail utilization data merged with mail order utilization data? Is a combined patient profile (retail and mail order utilization) used when utilization review is conducted? Within what timeframe would eligibility information be transferred from the retail to the mail order database and vice versa?

H 11. The Agencies maintain several different Benefit Plans (as set forth in the individual Agency Exhibits). How will you administer these Plans in the retail network setting, the mail order setting, and for out-of-network paper claims? Is there any term or condition in any of the benefit plans which you are unable to administer? If yes, describe the term and indicate why you cannot administer it. If you are able to administer all benefit terms exactly as written, so indicate in writing in your response to this question.

I. Monitoring and Reporting

I 1. The Respondent must provide electronically, a complete package of monthly, quarterly and yearly management and utilization reports by secure data transfer, to include at minimum, the following information:

a. Total number of approved and/or denied claims
b. Total number of claims & associated dollars by eligibility type
c. Total number of prior authorization requests (indicate drug)
d. Average time for prior authorization approval/denial
e. Total number of approved prior authorization requests (indicate drug)
f. Total number of denied prior authorization requests (indicate drug)
g. Average time for prior authorization appeals
h. Total number of renewals of prior authorization requests
i. Total number of denied prior authorization requests appealed
j. Number of prior authorizations not resolved within 24-hours
k. Annualized savings and basis for savings

l. Annualized savings per drug category (generic, single source and multi-source)
n. Total dollar amount of claims by eligibility type
o. Top 10 reasons for denial
p. Average time in working days for adjudication of mail order, retail and paper, in and out-of-network claims.
q. Reasons why prior authorizations were not resolved in 24-hours

I 2. The Agencies may require Agency specific reports. What standard utilization activity and management reports will you provide in addition to those requests at no cost to the Agencies? What is the frequency of this reporting?

I 3. Do you provide integrated reports to clients reflecting the prescription drug pharmacy network and the prescription drug mail order program's utilization patterns? If so, describe. Provide sample copies of standard and optional reports.

I 4. Do you provide actual and potential generic vs. brand dispensing and savings reports? If you do not currently do so, will you do so for the Agencies?

I 5. Describe in detail all cost containment efforts you would undertake to maximize the Agencies' savings on prescription drugs.

I 6. Do you have the capability to monitor and report excessive or unusual utilization patterns by physician, by member, by pharmacy, for retail, mail and combined retail and mail? If so, explain the criteria for each. If not, how will this concern be addressed?

I 7. What process does your organization use to alter physician prescribing habits?

I 8. In some instances (e.g., low stock or participant request) a pharmacy may dispense less than the full quantity of pills the prescription would allow. When the balance of the prescription is issued does this result in the patient paying 2 co-payments when they could have paid one? Does the pharmacy receive two dispensing fees? Does the PBM receive additional revenue? Under what circumstances will this trigger the "refill too soon" edit? Explain.

I 9. Do you have the capability to identify possible fraud and abuse for retail, mail and combined retail and mail dispensing activity? If so, explain the criteria for each program. If not, how will you address this concern? What were the results of your fraud and abuse program for 2021 and 2022? Be specific.

I 10. How are pharmacy DAWs (dispensed as written) charged to the account? How are the different DAW categories billed to the account?

I 11. Will you provide reports that can be compared to national and industry statistics and project future trends based on our past utilization data, enrollment?

I.12 Certain of the Agencies offer prescription drug programs to Medicare eligible retirees. These agencies must submit cost data to Medicare in order to collect the employer group subsidy. Do you agree to provide required data in the form and manner specified by CMS in order to maximize the amount of subsidy received by the agency? List all the other services you provide related to the RDS program including any additional administrative services.

I 13 Describe your programs for Medicare eligible participants. Do you submit data to Medicare for the employer subsidy program? What are the costs for this service? For those employers for whom you submit data, what results have been achieved: As a percentage of projected subsidies, what was the amount of settled subsidies? Describe your subsidy tracking system.

I 14 Describe your opioid dispensing protocols. How do you identify potential overuse of opioids? What specific edits are applied to opioid dispensing? Under what circumstances would your system reject an opioid prescription fill request? Do your responses differ depending on whether dispensing is at mail or retail? Do you profile physicians based on their opioid dispensing patterns? If yes, what is the profiling activity? If no, why not? What programs specifically targeted to opioid dispensing do you make available to clients? Have you identified any pharmacists, physicians or members for referral for consideration for criminal prosecution? Does your organization participate in any federal, state or local task forces formed to identify potentially aberrant behavior related to opioid dispensing or use? If yes, which ones? What have been the results of such task force efforts?

I 15 At least one Agency provides prescription drugs for persons diagnosed with certain mental health and substance use disorders. They individually authorize patients for a limited set of medications. Such medications are then billed to the appropriate entity within the Agency. These persons are not employees and/or dependents of employees. Can you accommodate this practice?

J. Claims Processing/Third Party Liability

J 1. What is the average turnaround time to process paper prescription drug claims? How do you define turnaround time? Explain, using the following:

a) 90% of claims processed & sent within ____business days of receipt
b) 99% of claims processed & sent within ____ business days of receipt
c) investigated claims

J 2. How do you assure that turnaround time will be maintained during periods of heavy utilization or turnover in staff? During transition from an existing vendor?

J 3. What are the claim processing standards as they relate to timeliness, accuracy, volume and productivity? What are the standards for: (a) financial accuracy – correct calculation of claim payment; and, (b) procedural accuracy – correct application of policy provisions?

J 4. Do you subcontract any part of your claim processing operations? If yes, would you use a subcontractor on the Agencies' claims? If yes, who is the subcontractor?

J 5. What percentage of claims are pended because they require additional information for processing? If a claim is received with missing information, explain how it will be handled.

J 6. What are the minimum data fields required to process paper claims?

J 7. What are your procedures for handling denied claims? Describe the procedures you have in place to track the timeliness of a denial. Will you send denied claims with explanations back to members? If so, explain the process. Provide a copy of an EOB (Explanation of Benefits) and a list of applicable denial messages.

J 8. What documentation do you maintain for outstanding information or follow-up requests? How do you follow-up these requests? On what software system is the tracking system based?

J 9. Can your claims processing system accommodate special plan design features that the Agencies require?

J 10. What is the address(es) of the claim processing location that would process the Agencies' out-of-network claims?

J 11. Provide the following information:
a) total number of paper prescription claims processed during 2020, 2021 and 2022.
b) total number of electronic prescription card claims processed during 2020, 2021 and 2022.

J 12. How do you process out-of-network claims? Do they go through the same processing edits as network claims? If not, what are the differences? Do you have experience in working with a medical claims payer to coordinate data on out-of-network retail claims for inclusion in calendar year deductibles and annual out-of-pocket accumulators? If so, describe how this interface works. Is there a cost for this service? If yes, what is it?

J 13. What system controls do you have in place to avoid paying duplicate claims submitted at separate times? Duplicate claims submitted at the same time?

J 14. Medicare now covers certain retail prescription drugs and medical supplies under Part B. What program or processes do you have in place to ensure that Medicare is primary payer for these Part B covered drugs and supplies?

J.15 How do you monitor additions to the Medicare Part B covered drug list?

J 16. Certain of the agencies use an outside vendor for third-party liability and subrogation recovery services. The agencies would like you to identify a person within your organization who can prepare exhibits of paid RX dispensing activity on an ad hoc basis. Will you agree to provide this service at no additional cost? (This would be expected to be of minimal volume.)

K. Disease Management/Pharmacy Case Management Program

K 1. How do you typically work with case management and or utilization review vendors in medical plans? What information do you typically exchange?

K 2. Have you developed any criteria by which you will refer cases? If yes, what are the criteria?

K 3. Do you use criteria to identify cases that should be considered for a specific disease case management protocol? If yes, provide examples of the selection criteria. What specific disease management programs do you offer?

K 4 The Agencies have various programs in place with their existing vendors (both medical plan and pharmacy vendors), how would you transition such programs so as to have it be seamless (or near seamless) from a member perspective?

K 5 Certain of the Agencies have asked that the PBM provide a file of claim activity to the medical case/care manager for inclusion in case/care management program activity screening. Will you agree to provide these files to the same vendors for no additional charge?

K 6 If both a medical plan and a PBM have similar programs related to certain disease states (e.g. diabetes, MS, transplant), how would work with the other vendor to ensure that the member is not "fatigued" by repeat contacts for similar purposes? What do you believe is the most successful way to integrate services across the various vendors?

K 7 Some of the Agencies' medical plans include coverage for infertility services and require prior approval for services, including fertility medications. The Agencies wish to ensure that a member does not receive a denial for medical services because the patient has not met the criteria of "infertility" and at the same time receive fertility medications because the PBM is applying no standard definition or a different definition than that which exists in the medical plan. Are you willing to cede to the medical plan utilization management function such definitional activities? Will you allow the medical plan utilization management vendor to provide a prior authorization for such medications?

K 8 The City of Chicago has a wellness program that includes certain Health Improvement Programs for certain chronic conditions including diabetes, coronary artery disease, chronic kidney disease, etc. What role would your staff be willing to play in the administration of such programs?

K 9 To the extent that your program services have integrated successfully with other vendor services for the same employer/medical plan, what lessons have you learned? Are there some programs that are a natural "best fit" for the PBM and/or for the medical care/case manager? Provide examples of successful integration with care/case management and wellness programs.

K 10. For each program, provide the following:

a. name of program
b. effective date of program
c. description of program
d. number of lives covered under program and percentage of total book of business this represents
e. sample communication materials
f. results to date

a) Clinical
If a drug supply or device is offered as part of or studied as part of the program:
1. Who is the manufacturer?
2. What are the competing products? Who manufactures the competing product(s)?
3. Why was the selected drug or supply selected?
4. What consideration was paid or is offered for the use of the drug, supply or device?

b) Have you done any controlled tests of the program? What were the results?

c) On what basis do you evaluate the success of the program?
Financial (be specific as to sources of savings and indicate if savings are hard or soft dollar savings).
1. incremental drug costs

2. fees
3. savings
4. cost to client if program is elected

K 11. The file of prescription drugs provided with this RFP includes an individual patient ID so that all drugs for a single member dispensed during the activity period can be grouped together to create a "picture" of each member regarding their use of prescription drugs. Review this information and propose a suite of review/control/education and other programs that you feel are most appropriate for each Agency. If all programs you suggest are recommended for each Agency, so state and provide support for the recommendations.

K 12. For each program you recommend in Question K 12., directly above:
a) describe the program in detail;
b) explain any fees or other charges associated with the program;
c) quantify any projected savings;
d) quantify any performance guarantees including both financial and non-financial guarantees;
e) develop a time table for implementation
f) provide sample communication materials

K 13. Check the following edits you monitor on a retrospective basis for your prescription drug pharmacy network and prescription drug mail order programs. Time Period Reviewed, refers to the amount of historical data normally included in each review.

Edit	Retro	Frequency of Review	Time Period of Review
Under Utilization			
Over Utilization By therapeutic class			
Over Utilization By Medical Condition			
Over Utilization: controlled substances			
Over Utilization: questionable drugs (e.g. growth hormones, etc.)			
Over Utilization: Pharmacy dispensing			
Over Utilization: Physician prescribing			

K 14. For those edits you have checked, define what each means to you. Describe how you perform the edit in each setting, and estimate the clinical and financial value of the edit.

K 15. Do you use data developed from your retrospective review edits in your quality assurance program to monitor the effectiveness of your drug utilization program? How do you evaluate the effectiveness and how is it reported to the client?

K 16. Who are the individuals responsible for managing the utilization review program? What are their credentials? How often is the program reviewed and updated?

K 17. Have you established any preferred relationships with medical utilization review organizations? If yes, with whom? Describe those relationships.

L. <u>Pharmacy Networks</u>

L 1. Do you currently have any pharmacy networks established? For each such network, (a) what retail chains are included in the network? (b) How many separate pharmacy locations are in the network? (c) What discounts are available in each network? (d) What network was used in your answers to the pricing section of the RFP? Have the major chains agreed to provide services at the prices you have quoted?

L 2. Would you agree to add to your network to meet the needs of the Agencies? If yes, provide the costs if any, that would be associated with doing this.

L 3. Describe the criteria used in pharmacy selection. Describe the process by which you credential, monitor and periodically re-credential pharmacies. How often are retail pharmacy contracts updated?

L 4. What are the typical hours of operation and days of operation for your Network Pharmacies?

L 5. How many registered pharmacists are in the network? What is the ratio of the number of registered pharmacists to the number of prescriptions filled in the network?

L 6. Whom should a member contact to resolve any questions about coverage for retail? Who would the pharmacy contact to resolve questions of coverage for retail prescription benefits?

L 7. Describe any software utilized to detect fraud by pharmacies, members or physicians. What results have you obtained from your fraud detection program? What have been the end results of any fraud investigation? (i.e. dismissals, fines, convictions, etc.)

L 8. How do you audit network pharmacies? Electronically? If yes, describe the indicators you audit and the frequency with which you audit. Will the Agencies have the right to independently audit retail pharmacies within the network?

L 9. Do you perform any on-site audits of network pharmacies? If so, how often and what percentage of pharmacies? What do you audit? If, as the result of an audit, you determine that a pharmacy was engaging in fraudulent conduct and/or was dispensing in a manner to increase its reimbursement, and the Agencies' members received prescription drugs from the pharmacy, would you make an adjustment to the Agencies' bills for periods in which the errors were detected? Why or why not?

L 10. Do you have a toll-free number available for retail pharmacists? How often do you communicate with the participants in the network? Do you have printed Pharmacy Network directories? Are there additional costs to the Agencies for a custom directory?

L 11. If the Agencies were able to consider a network that didn't offer every drugstore chain in the metropolitan Chicago area, how would retail pricing change? For example, if the Agencies were willing

to eliminate one of the two dominant chains, while maintaining good access to 24-hour pharmacies, what concessions would you (the PBM) make? Would you (the PBM) be willing to go directly to the chain(s) to improve pricing for the Agencies as their dispensing activity is highly concentrated in metropolitan Chicago (Cook and collar counties)?

M. Formulary Program

M 1. Describe the available formulary options that you offer for the prescription drug pharmacy network and the prescription drug mail order and specialty medication program Services. Provide a description of the goals for each formulary (e.g. maximize generic utilization; maximize brand rebates; etc.). How do you evaluate whether your formulary is meeting the stated goals?

M 2. Provide your formulary options in computer readable format (Microsoft Excel or Access preferred). List the NDC number, the therapeutic class, the name of the drug, the manufacturer, the AWP 100 price as of December 1, 2022 and the proposed rebate the Agencies would receive per unit dispensed. Based on each Agency's dispensing activity as reflected in the provided drug activity file, which of your formularies is most similar to the formulary offered by the Agency today?

M 3. What is the minimum formulary rebate guarantee amount you are offering to the Agencies for each of the first three contract years? In addition to the minimum guarantee amount, do you agree to "true up" rebates so that the Agencies receive 100% of the rebates you receive from manufacturers?

M 4. How do you influence the prescribing patterns of physicians when competing drug therapies are available? Explain any formal initiatives you apply to alter physician prescribing habits. Do you offer programs that are incentive-based to encourage the use of formulary prescription drugs? If yes, describe.

M 5. How are your formulary product alternatives established? Have you seen an impact on other medical costs or improvements in health status? How do you select drugs for inclusion in the formulary? Who are the individuals that select these drugs? What are their backgrounds and credentials? How have your formulary alternatives changed over time? Do these P&T professionals receive any money from drug manufacturers? Provide a detailed overview of how a drug is accepted or rejected for inclusion in your formularies.

M 6. How many drugs are included in your formulary? What actions do you take prospectively with physicians, pharmacies and plan participants with respect to the addition and deletion of individual drugs? How often do your formulary drugs change and what is the process for announcing these changes?

M 7. Will the cost of formulary drugs be less than non-formulary drugs in the same category? Explain why or why not.

M 8. How does a pharmacist use your formulary and what is the pharmacist expected to do? How does a member use your formulary?

M 9. Do you have a system in place to determine quickly and accurately the medical necessity of requests for non-formulary drugs? How do you evaluate these requests? What is the pharmacist required to do?

M 10. How will your company manage compliance with the formulary program? What reporting will be available to monitor formulary performance?

M 11. How will you keep the Agencies apprised of new FDA approvals, label changes, recalls, new generics or other issues that could affect the Agencies' Benefit Plans?

M 12. Will you submit the Agencies prescription drug data to pharmaceutical manufacturers who provide formulary rebates for certain drugs? If no, why not? If so, describe the time line for reporting and receiving these rebates. Indicate how and how often they will be credited to the Agencies accounts. What percentage or share of rebates do you propose to keep? What is the dollar amount of your expected formulary retention?

M 13. Provide samples of rebate performance reports.

M 14. For those clients that have formulary programs, what is the average rebate per script (defined as a 34 day supply) where a rebate was offered for:
a) passive formularies
b) open formularies
c) closed formularies

M 15. Do manufacturers pay you an administration or other fee? How much is it? What soft dollar or free good concessions do you receive? As a percent of total hard and soft dollar concessions/payments from manufacturers, what percentage do you believe that you are providing back to the Agencies? What is your definition of a "rebate" and "a rebateable" script?

M 16. As part of your formulary program, do you expect the Agencies to share AWP (Average Wholesale Price) savings? Do you have any NDC lockouts? If yes, explain how that will save the Agencies money.

M 17. For the state in which you propose to fill mail order prescriptions, describe the formulary procedures and requirements. Describe any legislative enactments that may affect mail order drug dispensing in that state.

M 18. What effect does the consolidation of the pharmacy industry in the larger health care industry have on formulary rebates? If you are part of an organization that includes a pharmaceutical manufacturer, describe what impact common ownership has on your behavior. For example, are formulary drug selections, therapeutic switching programs or other programs impacted? How would the Agencies be benefited as a result of such integration? If your organization includes retail pharmacies, describe what impact common ownership has on your behavior and describe any advantages that would accrue to the Agencies as a result of common ownership. Are there any inherent detriments to either form of combination? If the PBM is a wholly-owned or partially owned subsidiary or parent company to a health plan(s), does/will that ownership have any effect on the PBM business? If there are synergies that you believe will arise from the combined ownership/integration of the PBM and a health plan, will those synergies accrue to the benefit of the Agencies if the Agencies are not using the health plan administrator? If so, how? If no, why not?

M 19. When do your formulary contracts expire? Do you expect to renew on the same or different terms? Explain your responses in detail. Will you be negotiating new formulary contracts during the initial term of this contract.

M 20. How will you support the use of formulary drugs beyond plan design? How will you communicate to members and prescribers regarding formulary changes? How often? What are your criteria for a formulary exception? How would a member know that an exception is available?

M 21. In O-16, you are asked to identify whether the drugs dispensed to Agency members are on the formulary you are proposing for the Agency or Agencies. Please prepare a disruption report identifying those drugs which will require the plan member to make a change (i.e. the currently prescribed drug is not on your formulary) and how many members will be subject to the change in formulary. What is the standard process/schedule for communicating changes to members about a formulary change? How will you demonstrate to members that your firm is sensitive to disruption issues? What member centric processes are available to ease concerns related to drug switching?

N. <u>Drug Utilization Review</u>

N 1. How do you compile a patient profile when you begin to administer the drug-card, the mail order and or the integrated program? Do you include over-the-counter medications in your patient profile? How frequently do you update the patient profile? What is the mechanism by which the patient profile is updated?

N 2. Describe your Drug Utilization Review (DUR) edits. Specify if edits are different for prospective, concurrent and retrospective Drug Utilization Review. If you are using purchased software, have you modified it? If yes, describe the nature of the modification(s).

N 3. Indicate which of the following utilization review edits which are performed for your prescription drug pharmacy network program, prescription drug mail order program and your integrated programs**.** **PROSPECTIVES** (**PROSP**.) edits refer to those done prior to the filling of a prescription. **CONCURRENT** (**CONCUR**.) edits refer to those done when a prescription is refilled. **RETROSPECTIVE** (**RETRO**.) edits refer to those done after a prescription has been filled/refilled. For any edit, which is performed only at Mail, enter M. For any edit, which is performed only at Retail, enter R. For any edit, which is performed at both Mail and Retail, enter B. For any edit, which is not performed, enter 0.

Edit	PROSP.	CONCUR.	RETRO
Monitoring for Therapeutic Appropriateness			
Therapeutic Duplicate			
Drug/Drug Duplicate			
Early Refills			
Drug Interactions:	-	-	-
Drug to Drug			
Drug to Allergy			
Drug to Age			
Drug to Gender			

Edit	PROSP.	CONCUR.	RETRO
Drug to Disease			
Incorrect drug dosage or duration of drug treatment			
Over utilization			
Under utilization			
Dispensing Limits			
Mfg. Recommended Dosage			
High-Cost Drugs			
Investigational Drugs			
Generic Availability			
Fraud			
Other (Specify)			

N 4. For those edits you indicated you perform, define what each means to you. Describe how you perform the edit in each setting, and estimate the clinical and financial value of the edit.

N 5. Are over-the-counter drugs included in your edits for drug interactions?

N 6. Under what circumstances will the concurrent edits indicate that a prescription should not be filled? Is there a difference for retail dispensing, mail order dispensing and specialty drug dispensing?

N 7. If a pharmacist fills a prescription when the concurrent edits indicate it should not be filled, is the pharmacist denied payment?

N 8. How long is each patient history profile maintained for the prescription drug pharmacy network program? prescription drug mail order program? Specialty drug program(s)?

N 9. How do you encourage medication compliance? As an example, let's say that an employer has 55% compliance on hypertension medications. First, by what means do you determine a member to be compliant with a medication regimen? Do you integrate medical claim data if it is available? Does the integration of medical claim data improve your ability to identify compliance? What steps can you take to improve medication compliance? Can plan design play a role in medication compliance? How so? If you took over a case that had 55% compliance on hypertensive medications, how would you evaluate and use that information? Do you try to make changes on a therapeutic class by therapeutic class basis or try to increase compliance across the board? How would you increase compliance? Would you recommend plan design changes?

N 10. Are all formularies of equivalent value to the member and to the plan? What has your organization done in the area of formulary management that makes you different? Do you partner with manufacturers in ways that benefit the member and the plan? Please provide examples of your creative and innovative management of your formularies with specific emphasis on how they have helped the plan and the member.

N 11. With which organizations do you contract to provide IRO (Independent Review Organization) reviews? What is cost for an IRO with each of your selected vendors? For 2022, how many appeals went to IRO? What percentage of IROs upheld the internal decision? What percentage modified the internal decision? What percentage fully rescinded the internal decision? Under your proposal, who pays for the IROs?

O. Pricing

O 1. What is your source for determining drug prices and how often is the cost basis updated? Is your price based on the Average Wholesale Price (AWP)? If not, what is it based on? If the basis is currently AWP, what will it be if AWP disappears as a standard of pricing?

O 2. Retail pharmacy providers must price at the lower of cost calculated at the agreed rate or usual and customary. How will you assure that this is the basis for pricing? How do you define and determine "usual and customary" prices? If a particular drug is priced as a loss leader at a retail outlet, will such pricing (assuming it is lower) be passed back to the Agencies?

O 3. Are charges such as postage and dispensing fees included in your mail order program rate structure? Are shipping costs included in the dispensing fee? If not, define the cost, and indicate relevance if any, to the level of participation of the Agencies.

O 4. What is the dollar amount of your total drug acquisition costs for the past 3 years for:
a) retail stores, if applicable
b) mail order dispensing

O 5. Is drug purchasing for the mail order facilities done centrally, regionally or locally? If you organization purchases for retail stores as well, is purchasing done for both retail and mail pharmacies in the same purchases?

O 6. Reserved

O 7. Do you provide any additional discounts for the most utilized drugs? If so, describe the nature of these discounts.

O 8. On what basis do you intend to bill the Agencies for your generic drugs? If you have multiple MAC programs, be specific as to costs. Are you willing to base the Agencies' cost on the specific generic purchased? If yes, how will you ensure economical pricing? Are you willing to base an employee's cost on the difference between the brand AWP and the lower of the MAC AWP or the specific generic AWP? If you answer no to the above questions, explain.

O 9. Indicate how often your MAC list is updated and the criteria for adding and deleting products from the list. Also, provide a copy in an Excel file format of your current MAC list including prices and AWP.

O 10. If you have more than one MAC program, will you provide us with your pharmacy reimbursement and/or remittance data? Do you pay the pharmacies less than you will charge our plan, if so, what is the spread? Do you charge the pharmacy anything for transmitting claims? If yes, are you willing to share that fee with the Agencies?

O 15. Provide for each entity a report by therapeutic class; that displays formulary dispensing within class. For each therapeutic class, what percentage of drugs dispensed (include dollars and volume) were in the formulary? For any class with less than 70% formulary dispensing, please analyze (prescription drug pharmacy network and prescription drug mail order program Services) the results and advise us as to how you would increase formulary dispensing.

O 16. Included for potential Respondents who have registered is a file for each Agency containing claims transactions by plan, for a full year (for calendar year 2022). Please return this file to the Agencies with the following information as of April 1, 2023 appended to the file:

a. The AWP for the Quantity dispensed as of April 1, 2023 for the NDC specified;
b. An indication as to whether the drug is:
    1. A single source brand;
    2. A multi-source brand;
    3. A generic drug
    4. A branded generic;
    5. A brand specialty drug;
    6. A generic specialty drug;
    7. A biosimilar specialty drug.
c. An indication as to whether the drug is on the formulary you are proposing for the entity
d. The minimum guarantee amount for any rebate associated with the drug
e. The discounted pricing for the drug consistent with your proposal to the Agencies. For generic drugs two prices should be provided and clearly identified as such:
    1. MAC pricing; (If multiple MAC prices are being offered, display each price separately); and,
    2. Fixed-discount off of AWP pricing.

O 17. Provide a detailed written price proposal for retail, mail and specialty drug dispensing including basis of discount, minimum guaranteed rebate amount (or an estimate of rebate performance in excess of a minimum guaranteed amount), dispensing fees, administrative fees (if any) and any other fees related to the dispensing activity. Provide expected pricing terms.

O 18. What is your best estimate of your ability to improve formulary performance? Please submit a separate summary file for any drugs dispensed that are not on the formulary you are recommending for a particular agency and indicate to which drugs the member would be switched. If any drug to be switched is of a different cost (AWP100's) than the drug to which it is being switched, indicate the incremental cost difference and any changes (increments or decrements) to the guaranteed rebate amount so that we may estimate the "net/net" value of your formulary.

O 19. Prepare a written summary of all fees associated with your care management activities including prior authorizations, step therapy, appeal reviews, special utilization or patient management programs, etc. For any program that you are proposing for any Agency, provide an estimate of savings or reduced costs associated with the programs net of any fees or retentions. Include any fees associated with either RDS submissions or Employer Group Waiver plans for Medicare eligible persons. Your answers to Q 17. and Q 19. should comprise your entire price proposal.

O 20. How many of your clients are paying for drugs and services under a transparency model? What is your definition of a transparency model? How many of your contracts call for a 100% pass-back of all discounts, rebates, manufacturer concessions whether hard or soft dollar, switching incentives,

grants/studies, etc. with a fixed fee paid to you for all plan administration services? Under such arrangements, what are your typical fees?

O 21. Will you provide mail order pricing at retail locations for mail order quantities dispensed (i.e. for a ninety-day supply), at no extra cost to the Agency: (A) at one retail pharmacy chain, (B) on a cost neutral basis at several retail pharmacy chains and if so state which chains, and (C) on a cost neutral basis at all retail pharmacy chains?

O 22. One or more agencies currently participate in a retail 90-day maintenance drug program. Through this program, members are able to obtain an 84-90 days' supply maintenance prescription at CVS retail pharmacies at applicable mail-order pricing terms and guarantees. The Agencies request a pricing option for a similar 90-day retail network with at least one major retail chain, in which members are able to obtain 84-90 days' supply of maintenance prescriptions at the applicable mail order cost to the plan.

O 23. Group Purchasing Organization (GPO)

a. Please confirm your PBM's rebate contracting relationships (e.g., direct contracting with pharma, outsourced contracting via third-party entities, PBM-owned and/or organization-owned group purchasing organization (GPO) subsidiary/affiliate, other).
b. Please disclose the applicable rebate GPO entities including legal name(s) and location(s).
c. Will a rebate GPO apply to commercial and/or EGWP contracts?
d. Please confirm that subject to mutually-agreed upon confidentiality and audit provisions, the PBM will provide support transparency for the plan's verification of rebate calculations, rebate sharing, contract compliance, and the dollar amount of any discrepancies. The PBM will provide the plan's auditor with access to rebate manufacturer contracts, as well as all applicable rate schedules, applicable administrative fees, access fees, etc.

P. Performance Standards & Penalties

The Respondent must agree to abide by the Performance Standards and Penalties specified in the following table. Additionally, the Respondent must offer its own performance guarantees if in addition to or in excess of the described standards. Respondent must name each standard and indicate if it agrees to meet or exceed the stated standard. Note any exception to the standard or measurement process.

P 1.

Service Performance Standards	Guarantee	Penalty (Frequency TBD by Agency and PBM)
1. Network Size	99% of all members must have access to at least two network pharmacies within 5 miles of their residence during normal business hours; a twenty-four pharmacy must be available within ten miles.	To be measured by Geo Access reports produced by the Contractor annually for each Contract. For each full percentage point below the standard, the PBM will be assessed a penalty amount of 5% of the non-prescription revenue received under the contract

		during the year in which the failure occurred.
2. Claims Adjudication Accuracy	Respondent must agree to a financial accuracy rate of at least 99% for all RX claims processed at network pharmacies.	To be determined at end of any Contract year. For each quarter percentage point below standard, PBM will be assessed penalty amount of 5% of the non-prescription revenue received under the contract during the year in which the failure occurred.
3. Point-of-sale Network – System Availability	Respondent must agree that system down time will be no greater than 2 hours per incident; not to exceed 2 incidents per contract year.	Penalty to be assessed at time of violation of 5% of the non-prescription revenue received under the contract during the year in which the failure occurred.
4. Formulary Rebates	Respondent must agree that any payments resulting from the formulary rebate process, and all rebate reporting will be made within 60 days of the receipt of payment from manufacturer. Reporting must describe the source of the rebate by NDC and date payment was received from manufacturer, and must be made available within 10 business days of payment.	The penalty for each violation will be equal to 50% of the amount of rebates not paid on a timely basis. Such payments will be in addition to the rebate

5. Reporting Requirements	Respondent must agree to provide all the reports specified in this RFP within the stated time periods, and to provide the on-line query capability described in the Respondent's response.	Failure in any month to provide the required reports will result in a penalty amount of 5% of the non-prescription revenue received under the contract during the year in which the failure occurred
6. Desk Audits	Respondent must agree to perform desk audits	Failure to perform these audits will result in a

	on at least 10% percent of pharmacy providers in each contract year.	penalty amount of 5% of the non-prescription revenue received under the contract during the year in which the failure occurred.
7. On-Site Audits	Respondent must agree to perform on-site audits for at least the top 10% of providers that are identified as outliers, pursuant to the desk audits, in each year of any Contract.	Failure to perform these audits will result in a penalty amount of 5% of the non-prescription revenue received under the contract during the year in which the failure occurred.
8. Call Answering Time	100% of all requests to speak with a customer care representative will be answered by a customer care representative within an average of 30 seconds from the time the caller requests to speak to a customer care representative. (Excludes calls routed to an interactive voice response (IVR) system until such time as the caller requests to speak to a customer service representative.)	Failure in any month, to meet this standard will cause a penalty amount of 5% of the non-prescription revenue received under the contract during the year in which the failure occurred.
9. Call Abandonment Rate	No more than 3% of calls may be abandoned.	Failure in any month, to meet this standard will cause a penalty amount of 5% of the applicable fees to be deducted.
10. Prior Authorizations	All requests for Prior Authorization must be acted upon within 72 hours	Failure in any month, to meet this standard will cause a penalty amount of 5% of the non-prescription revenue received under the contract during the year in which the failure occurred.

Q. Other

Q 1. How do you distinguish yourself from your competitors?

Q 2. With the rising cost of drugs, as a group, we are seeking ways to manage growth in costs while offering comprehensive coverage. What will you do to assist us in managing the prescription costs increases?

Q 3. How do you respond when a drug company says that by taking money from them due to an overpriced drug or the encouragement of substitution, you are reducing research dollars?

Q 4. In a brief summary, state your case for why the Agencies should contract for Services with your organization.

Q 5. The PBM market continues to consolidate. What are the advantages of contracting with a market leader? What are the advantages of contracting with PBMs with lesser membership?

Q 6. Mental Health Parity and Addiction Equity Act (MHPAEA) information:

a. Has the PBM developed written policies explaining how the Non-Qualitative Treatment Limitations (NQTLs) are applied to mental health and substance use disorders and medical/surgical benefits?
b. Has the PBM documented:
    i. The *reasons* for applying NQTLs to both mental health and substance use disorder benefits?
    ii. The *sources* used in developing the NQTLs?
    iii. Has the PBM identified the decision makers implementing the NQTLs?
    iv. Has the PBM determined whether the decision makers have comparable expertise with both mental health and substance use disorder and medical/surgical benefit claims?
c. Specify which of the following NQTLs the PBM has developed policies for and attach a copy of the policies.
    i. Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;
    ii. Prior authorization or ongoing authorization requirements;
    iii. Concurrent review standards;
    iv. Formulary design for prescription drugs;
    v. For plans with multiple network tiers (such as preferred providers and participating providers), network tier design;
    vi. Standards for provider admission to participate in a network, including reimbursement rates;
    vii. Plan or issuer methods for determining usual, customary, and reasonable charges;
    viii. Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as “fail-first” policies or “step therapy” protocols);
    ix. Exclusions of specific treatments for certain conditions;
    x. Standards for providing access to out-of-network providers; and,
    xi. Exclusions based on failure to complete a course of treatment,

d. Has the PBM developed a standard process for replying to any Mental Health and Substance Use Disorder Parity Disclosure Request forms or similar inquiries received from plan participants or counsel for same or inquiries received by clients from regulatory bodies? Please either detail the process or provide a copy of your internal procedures. Which entity or person within your organization is responsible for processing such requests?
e. How many Mental Health and Substance Use Disorder Parity Disclosure Request forms or similar inquiries have you processed within the last two years?

Q 7. Please provide a detailed and comprehensive explanation of all of the parties, steps and financing, both pre-sale and post-sale for an employee who "purchases" a prescription drug under an employee self-funded health plan. Assume that the medication is correctly prescribed by a physician. Include a description of all transactions in which the PBM is involved related to the purchase of medication, price-setting, dispensing, pharmacy contracting, rebate contracting, submission and payment; identify all hard-dollar and soft-dollar flows among the parties, both affiliates and associates and sub-contractors that occur before and after the prescription medication is dispensed.

Q 8. Various litigation matters have suggested that certain generic drug manufacturers may have conspired to fix prices within a narrow band and as a consequence those entities which ultimately pay for generic drugs were/are harmed because competition is illusory. What industry or internal resources exist to "police" the market for such anti-competitive behaviors? What would you describe as a successful intervention your organization has made or is making to encourage competitiveness that would be to the benefit of payors?

Q 9. Does your organization have any program that supplies drugs to providers in a medical office, clinic or home setting? If yes, what drugs? How many clients are using this service? What have your results been for the last two years? What opposition have you met from providers?

Q 10. Does your organization submit rebates for drugs provided in a medical setting, either a physician's office or clinic or the out-patient or in-patient hospital setting? For how many organizations do you do so? For which drugs are you doing so? Please describe the basis on which you submit for rebates, at what cost and what the expected rebate would be.

Q 11. Do you agree to the terms of the sample professional services agreement ("PSA"), if any, that the Agency has included with this RFP for your review? If your answer is "No," you must identify specific provisions to which you object, propose revisions thereto, and identify any other changes requested in a redline utilizing "Track Changes" or an equivalent feature. References to a prior agreement with an Agency will be considered to be an inadequate response. (Note, your failure to object to a specific provision will be deemed acceptance of such provision as is. Note further that the Agencies reserve the right to negotiate with the selected Proposer on further edits to such sample PSA as needed to reflect changes to applicable law and regulations, changes in Agency policy or procedures, or other changes as the Agency deems necessary, and you must negotiate in good faith regarding such additional edits.

Q 12. What services will you provide to assist the Agencies in meeting the Section 204, Prescription Drug Data Collection (RxDC) reporting requirements? Is there a fee for these services? If yes, what is the fee? If there is a fee, please also include the fee when reporting pricing.

R. Specialty Drugs

R 1. There has been an explosion (both price and utilization) in specialty drugs over the past several years. Name the top five strategies you have put in place to measure and manage the effectiveness of specialty drugs. Name the top five strategies you have put in place to manage the utilization of specialty drugs. Name the top five strategies you have put in place to manage the cost of specialty drugs.

R 2. Does the same P&T Committee manage the specialty drug formulary as your non-specialty formulary? If no, please provide the work histories and clinical qualifications of the Specialty P & T Committee. What is the appointment process for inclusion on this Committee? How do you ensure adequate representation of all medical specialties? What resources are available to the group during the process of evaluation and decision? Does the group develop the Medical Necessity criteria at the same time that they conduct the evaluation? If no, who creates and authorizes the Medical Necessity criteria?

R 3. What contracting strategies do you use in negotiating formulary placement for specialty drugs with manufacturers? How do those strategies benefit members and the plans?

R 4. Are specialty medications dispensed from a single pharmacy? Do you have relationships in place for the distribution of certain of the specialty drugs? Which drugs? Are they exclusive relationships at your option or at the option of the manufacturer?

R 5. Oftentimes, a member won't know that a drug is a specialty drug until he or she has a "problem" at the point of sale. How do you diminish the number of such encounters? Do you allow a first fill at a local pharmacy? Do you provide immediate communications to members at the point of sale? Who provides those communications?

R 6. When a member first receives a specialty medication do you attempt to establish communication with the member to determine if the member has any questions about the drug or its place in the treatment plan? If yes, what do you do? If yes, is this a separate program that requires a fee?

R 7. How do you decide which drug is a "specialty" drug? For example, Cyclosporine has been a stable generic medication which some have moved to their Specialty drug formulary. Who decides what drugs get moved? What is the basis for the decision? How many formerly non-specialty drugs have you moved to your Specialty formulary in 2020, 2021 and in 2022? Provide a breakdown by formerly generic and formerly brand.

R 8. Do you dispense lower quantities of specialty medications until you know whether the patient is stable on the medication? Why or why not? Describe your quantity limits for newly prescribed specialty medications.

R 9. Do you evaluate the effectiveness of specialty drugs? How? Do you have any provisions in place if a patient is failing a specialty drug therapy for the manufacturer to refund the costs of the medication? How are such arrangements managed and audited?

R 10. How do you set the price you charge an account for specialty drugs?

R 11. Have you done any research to determine how co-payment and co-insurance for specialty drugs influences medication compliance? As you have seen insurers and medical plan sponsors move to more aggressive higher out of pocket costs for members, have you seen a reduction in medication compliance? What would you suggest is an optimal co-pay or co-insurance level for specialty medications?

R 12. What is the waiver process for obtaining a non-formulary specialty drug? Who makes such decisions?

R 13. What controls have you applied to compounded drugs? Do you make exceptions to your controls? If a compound medication is denied, does a pharmacist employed by your organization contact the prescribing physician to discuss alternatives to the compound medication?

R 14. Do you have a relationship with an infusion therapy center? If yes, with which firms? Should the employer encourage use of such centers? How does your relationship with the center work on a practical basis—how does the member know of the existence of the arrangement? How do you capture members before they have begun a relationship with another provider? Do you encourage home infusion therapy?

R 15. Many specialty drug management firms exist—meaning that they don't offer full PBM services but have instead decided to specialize in specialty drugs. Would you object to the Agencies deciding in the future to remove specialty drugs from the PBM scope of services and instead contract with such a specialist firm? What are your arguments as to why "specialty" specialty drug services are unnecessary? What advantages do these firms offer from your perspective? Has your organization outsourced any features of specialty drug management services? If yes, what services and to whom and why?

R 16. Provide five examples of how your specialty drug management services have improved patient compliance and improved the patient's comprehension of their health status. If you offer specialty drug counseling or management programs, how do those programs benefit the member and the plan?

R 17. How do you manage manufacture co-pay cards designed to skirt formulary limits? If a formulary specialty drug manufacturer offers a co-pay card, how do you integrate the benefits of that arrangement so that it benefits both the plan and the member? If you have outsourced your co-pay card revenue capture program, to whom has it been outsourced? Is the entity an affiliate or associate? If the company is not an affiliated or associated company, for how many PBMs does the entity provide services? If the entity provides services to only your PBM, please discuss the history of the company including when it was formed, any related parties and discuss why the relationship was created. Using claim data provided with this RFP, identify what you believe the opportunities for savings are and a projection of first-year savings under the program you are proposing for the agencies. Be specific as to any required plan language needed to maximize savings.

R 18. What are your specialty criteria for HEP-C drugs? For PCSK-9 drugs? For rheumatoid arthritis drugs?

R 19. Given the growing cost and utilization of specialty drugs, how have your cost and utilization management strategies changed? What is your organization doing now that will change the trajectory or improve management of specialty drugs?

R 20. Discuss your formulary strategy with respect to biosimilars. Provide an example of a biosimilar and discuss how your organization would make formulary placement decisions for the first eighteen months following market availability.

R 21. Are there instances in which your organization continues to recommend brand usage because the net cost of the brand (AWP discount plus rebate) produces the lowest net cost? Please provide a few examples and discuss your strategy.

R 22. If any Agency elects to have generic pricing not including a MAC, does your answer to the previous question (R 21.), change? Will you permit the Agency to continue to require generic dispensing?

S. Medicare Part D Services

S 1. What products/programs do you offer for Medicare Part D coverage? Do you have standard plans for standalone Part D coverage? Will you customize to meet the plan sponsor's goals for support of its Medicare eligible members? Include both "standard" and wrap plans. Please provide the number of covered lives for each product. For how long have you been offering Medicare Part D plans?

S 2. How many employer groups are offering a non-Part D plan with Retiree Drug Subsidy (RDS) payments?

S 3. What has been the financial experience of Part D plan costs (with a wrap) as compared to RDS plans? Is drug mix or size of group a determining factor?

S 4. If a group wished to move to a Part D plan with a wrap to mimic an existing plan of benefits, what would be the implementation process? By what date would a plan have to decide to have an effective date of January 1, 2024? Would you be willing to work towards that date even if the contract effective date were January 1, 2024?

S 5. As the member out of pocket expense gap (the "donut" hole) is closing through 2024, will that diminish the cost of the wrap? Is there any reason to complete a transition from an RDS to a Part D-wrap plan before 2024?

S 6. Are you offering any Medicare Part D plans in the metropolitan Chicago area for Medicare beneficiaries for 2023? If yes, please provide the plan(s) of benefits and the premium amounts. How many lives are participating in these generally available plans? What is your rating for these plans?

S 7. What charges would apply for RDS claim submission? Are there administrative charges associated with the Part D-wrap plans? What are they?

S 8. Are there any incremental benefits that you offer to your commercial Medicare Part D population that you would offer to Agency members?

T. Rebate Guarantees and Reconciliation Agreements

Proposer must specifically note their agreement with each of the following or provide a detailed explanation of any deviations from these standards:

T 1. The Proposer agrees that each Agency's guarantees must be measured and reconciled separately.

T 2. The Proposer agrees that each distinct non-rebate pricing guarantee (including discounts and dispensing fees) will be measured and reconciled on a component basis only (e.g. retail brand, retail generic, retail 90 brand, retail 90 generic, mail order brand, mail order generic, specialty drugs at participating retail pharmacies, specialty drugs at the PBM's specialty pharmacy, limited distribution drugs at participating pharmacies that are not the PBM's specialty pharmacy, and limited distribution drugs at the PBM's specialty pharmacy) and guaranteed on a dollar-for-dollar basis with 100% of any shortfalls recouped by each agency. Surpluses in one component may not be utilized to offset deficits in another component (e.g. retail brand, retail generic, retail 90 brand, retail 90 generic, mail order brand, mail order generic, specialty drugs at participating retail pharmacies, specialty drugs at the PBM's specialty pharmacy, limited distribution drugs at participating pharmacies that are not the PBM's specialty pharmacy, and limited distribution drugs at the PBM's specialty pharmacy).

T 3. The Proposer agrees that each distinct rebate guarantee will be measured and reconciled on a component basis only (e.g. retail brand, retail generic, retail 90 brand, retail 90 generic, mail order brand, mail order generic, specialty drugs at participating retail pharmacies, specialty drugs at the PBM's specialty pharmacy, limited distribution drugs at participating pharmacies that are not the PBM's specialty pharmacy, and limited distribution drugs at the PBM's specialty pharmacy) and guaranteed on a dollar-for-dollar basis with 100% of any shortfalls recouped by each agency. Surpluses in one rebate component may only be utilized to offset deficits in another rebate component. Rebates surpluses will not be utilized to offset deficits in any other non-rebate guaranteed component, including any pricing guarantee components.

T 4. The Proposer agrees that retail 30, retail 90, mail order, specialty at retail, specialty at mail order, and any other channel or drug type that contains a specific guarantee are to be reconciled on a separate component basis given that they have separate guaranteed rates. A surplus for any of these guarantees will not be used to offset a shortfall for any of the other components.

T 5. The Proposer will provide a financial reconciliation report within 90 days after the end of each contractual year separately, for each of the agencies. The report will include the contractual and actual discounts and dispensing fees for each component (e.g. retail brand, retail generic, retail 90 brand, retail 90 generic, mail order brand, mail order generic, specialty drugs at participating retail pharmacies, specialty drugs at the PBM's specialty pharmacy, limited distribution drugs at participating pharmacies that are not the PBM's specialty pharmacy, and limited distribution drugs at the PBM's specialty pharmacy)

T 6. The Proposer agrees that any shortfall between the actual result and the guarantee will be paid, dollar-for-dollar, to each agency within 90 days of the end of each contractual year.

T 7. The Proposer agrees that any rebates earned during the contract term will be paid to Agencies after the contract term has ended.